October 2026

Private health insurance basics

Executive summary

The primary purpose of health insurance is to protect people against the uncertainty and high cost of healthcare expenses. A single severe health incident can lead to medical bills that cost tens of thousands of dollars. Health insurance is intended to make these costs more predictable by requiring a regular premium payment and limiting out-of-pocket expenses.

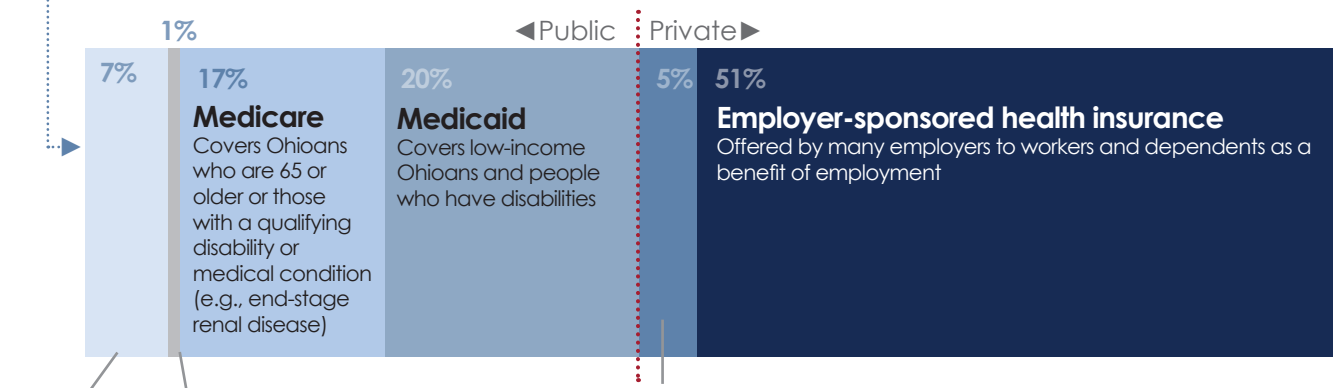
In 2024, almost **7%** of Ohioans were uninsured

In 2024, 93.1% of Ohioans had health insurance coverage, leaving about 820,000 Ohioans uninsured. People who are uninsured face significant financial, health and care access issues, including a higher likelihood of premature death.

3 Key findings for policymakers

1. **Health insurance protects against negative health and financial outcomes**, including premature death, medical debt and more.
2. **Employer-sponsored insurance is the most common form of health coverage in Ohio.** Individual plans differ in terms of costs and benefits.
3. **The cost of private health insurance has increased significantly for Ohioans** in recent years, including for employer-sponsored coverage and ACA marketplace plans.

Sources of health insurance in Ohio, 2024



Note: Respondents may report having more than one type of coverage; however, individuals are sorted into only one category of insurance coverage.
Source: U.S. Census Bureau, American Community Survey 1-year estimates, as compiled by KFF

About Health Insurance Basics

This brief provides a summary of private health insurance in Ohio. The full brief, along with additional resources, can be found at the end of this summary and on **HPIO's website**.

Main components of health insurance

Despite variation across different types of health insurance, including whether it is public or private, the fundamental components of health insurance are similar. Important components of health insurance include:

Enrollment and insurance pools

Insurance works by spreading financial risk across a larger population that will include some people who require more health services and others who require less, or even none. By pooling the premiums of many people together, ideally with different levels of healthcare needs, the total cost of care becomes more predictable.

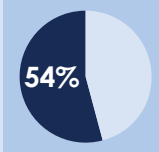
To protect the stability of insurance pools, there are certain restrictions on when a person (i.e., insurance consumer) can enroll or disenroll from a plan, including qualifying life events such as a job change or having a baby.

Costs and payments

Consumers are often responsible for different types of costs related to their coverage, including:

Premiums	A set amount paid in regular increments (usually monthly) to keep insurance, regardless of whether the covered individual or family receives any health services.
Out-of-pocket expenses (cost sharing)	Expenses that a consumer pays for themselves when receiving health services, which can take different forms. Insurance plans usually have an **out-of-pocket maximum**, which is an amount (excluding premiums) after which the insurer will cover all care costs.
▶ **Deductible**	A set amount that a consumer pays during a benefit period or plan year for covered services before the insurer begins to make payments toward those services.
▶ **Co-payment**	A flat rate dollar amount paid by a consumer directly to the provider at the time of receiving a covered healthcare service.
▶ **Co-insurance**	A method of cost sharing in which the consumer is required to pay a defined percentage of their medical costs, usually after their deductible has been met.

High-deductible health plans (HDHPs) have become a common form of coverage in private insurance markets. HDHPs have a higher deductible compared to a traditional health plan but can typically be purchased for a lower monthly premium and can be paired with tax-advantaged savings accounts.



In 2024, 54% of private-sector workers in Ohio had HDHPs.

Coverage and networks

- **Covered benefits:** The set of services, items or treatments that an insurance plan will cover.
- **Provider network:** Groups of healthcare providers contracted with an insurer to provide services under a health plan based on specified terms and negotiated reimbursement rates.

Regulation of health insurance

Both the state and federal governments play a role in regulating health insurance, including public programs and private health plans.

State regulation. The Ohio Department of Insurance (ODI) is the state's insurance regulatory agency. ODI is responsible for licensing health plan issuers, ensuring compliance with insurance laws, reviewing rate filings, investigating fraud and more.

Federal regulation. While states have primary responsibility, federal policies can pre-empt state requirements. The Centers for Medicare and Medicaid Services and the U.S. Department of Labor both hold important regulatory roles, among other agencies. The Affordable Care Act made major federal changes to health insurance regulation, which included banning denials for pre-existing conditions, expanding Medicaid and creating health insurance marketplaces.

Types of private health insurance

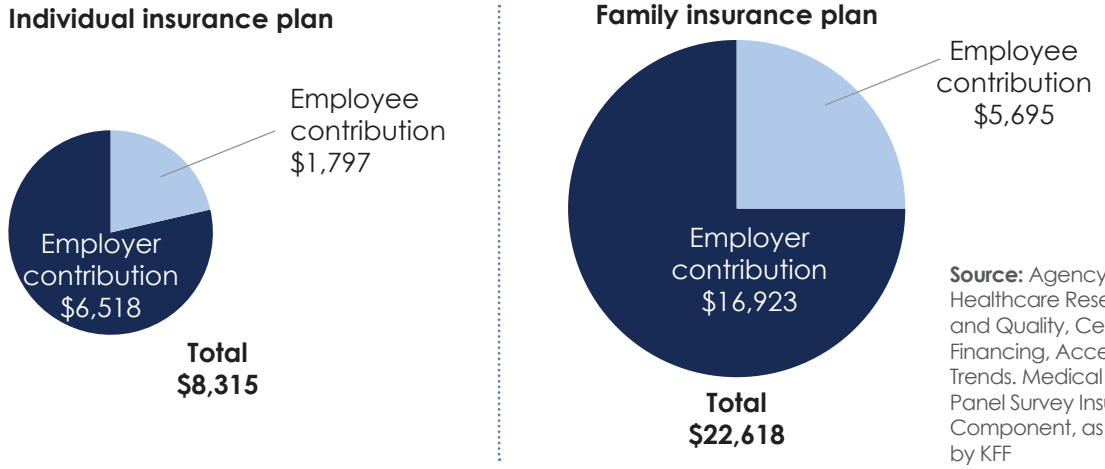
There are two main forms of private insurance: employer-sponsored and ACA marketplace/private direct purchase, which are the focus of this brief.

Employer-sponsored insurance (ESI)	
Ohioans covered	**~5.9 million** (2024)
Coverage eligibility	Offered by many employers to individuals and dependents as a benefit of employment.
Costs for Ohioans	**Premium.** The average annual employee contribution in 2024 was $1,797 for an individual plan or $5,695 for a family plan. Employers cover 75-80% of the total premium, on average. **Cost sharing.** Varies substantially by plan. The average deductible in 2024 was $2,278 for individual coverage and $4,358 for family coverage.
Regulation	Self-insured plans (usually offered by larger employers) are regulated federally by the Employee Retirement Income Security Act (ERISA). Fully insured plans are subject to state-level regulations.

To recruit and retain employees, many employers offer health insurance as part of a benefits package. Because health insurance is non-taxable and because the employer often pays a portion of the premium, health insurance is an attractive benefit for employees, making it the most common form of coverage in Ohio.

Costs have risen considerably for employer-sponsored plans over the last decade, including premiums and out-of-pocket expenses like deductibles. In Ohio, the average full employer-sponsored premium in 2024 for a family plan was over $22,000.

Average annual employer-sponsored premium for individual and familiy plans in Ohio, 2024



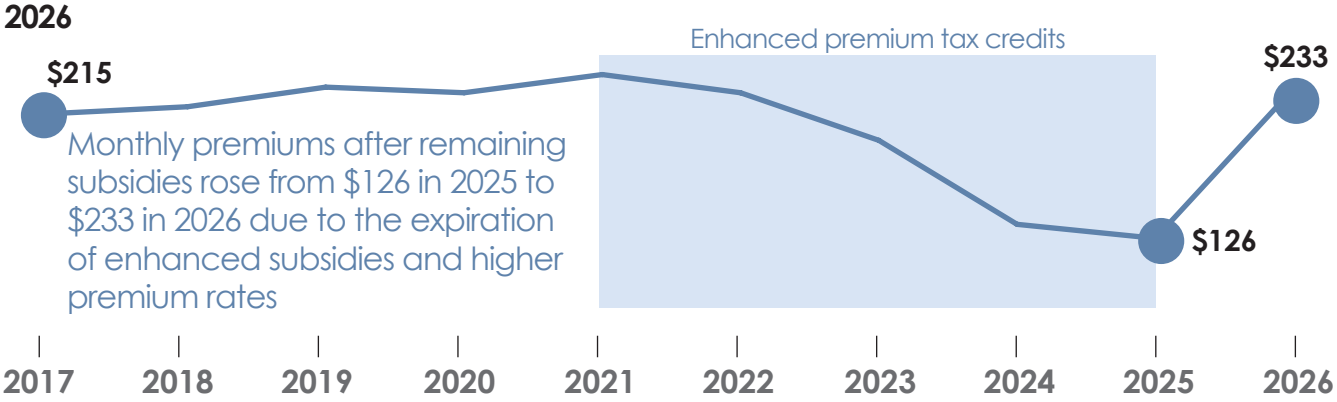
Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey Insurance Component, as compiled by KFF

ACA marketplace and direct-purchase coverage	
Ohioans covered	**~550,000** (2024)
Coverage eligibility	Anyone can select a plan through the ACA marketplace or directly from an insurer (subject to enrollment sign-up periods or experiencing qualifying events). People with low incomes may be eligible for subsidized Marketplace coverage.
Costs for Ohioans	Varies significantly by plan and whether the consumer is eligible for subsidies. The average Marketplace plan premium in 2026 after subsidies was $233 per month in Ohio. Many plans also have large deductibles and other required cost sharing.
Regulation	The ACA regulates marketplace and off-exchange plans, including the availability of marketplace subsidies and plan benefit requirements. States also have roles in regulating these plans.

After ESI, the main sources of private insurance in the U.S. are available through the ACA marketplace or (less commonly) off-exchange coverage directly from an insurer.

Due to the passage of enhanced subsidies in 2021 following the COVID-19 pandemic, marketplace coverage in Ohio rose to nearly 600,000 in 2025, but has since declined to about 470,000. A main reason for this is that premiums increased by 85% between 2025 and 2026 after enhanced subsidies expired (for more information, see HPIO's policy brief on **updated Ohio enrollment in the federal ACA marketplace**). Data on off-exchange enrollment and costs were not available.

Average monthly premiums per person for ACA marketplace plans in Ohio, 2017-2026



Source: Centers for Medicare and Medicaid Services, Marketplace Open Enrollment Period Public Use Files

The ACA sets clear requirements for the individual coverage market, including both on-exchange marketplace plans and off-exchange plans. These plans must cover essential health benefits and adhere to actuarial ratings requirements.

Certain forms of direct-purchase coverage serving specific populations or situations may not be subject to state or federal consumer protection and comprehensive coverage requirements, including farm bureau plans and short-term coverage.

Additional resources

- **Health Insurance Terminology Basics Blog** (State Health Access Data Assistance Center)
- **The Regulation of Private Insurance** (KFF)
- **What Consumers Need to Know About Health Coverage That Doesn't Comply with the Affordable Care Act** (Commonwealth Fund)
- **Medicaid Basics** (Health Policy Institute of Ohio)
- **Health Insurance Guide** (Ohio Department of Insurance)
- **The Affordable Care Act 101** (KFF)

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