What Qualifies as "Minimum Essential Coverage" under the Affordable Care Act?

An individual is considered to have **minimum essential coverage** for any month in which he or she is enrolled in one of the following types of coverage for at least one day. Newest changes are noted in italics.

- An employer-sponsored group health plan *offered in a state, which is defined as the 50 states plus the District of Columbia. This includes plans offered by, or on behalf of, an employer to an employee, e.g. multiemployer plans, single employer collectively bargained plans, plans sponsored by third parties such as professional employer organizations, temporary staffing agency, etc.*
- An individual health insurance policy *offered in the individual market in a state or through an Exchange/Marketplace in a territory.*
- A government plan such as Medicare, Medicaid, Children's Health Insurance Program (CHIP), TRICARE (a U.S. Department of Defense Military Health System) or veterans coverage
- Insured student health coverage
- Self-insured student health coverage*
- Medicare Advantage plan
- State high risk pool coverage*
- Coverage for non-U.S. citizens provided by another country**
- Refugee medical assistance provided by the Administration for Children and Families
- Coverage for AmeriCorp volunteers**

*Designated as minimum essential coverage for plan/policy years beginning on or before December 31, 2014. For coverage beginning after December 31, 2014, sponsors of high risk pool or self-funded student health coverage may apply to be recognized as providing minimum essential coverage.