(1) Unless a refund is requested by or for the enrollee, the Exchange must, within 45 calendar days of discovery of the error, apply the excess premium paid by or for the enrollee to the enrollee's portion of the premium (or refund the amount directly). If any excess premium remains, the Exchange must then apply the excess premium to the enrollee's portion of the premium for each subsequent month for the remainder of the period of enrollment or benefit year until the excess premium is fully refunded (or refund the remaining amount directly). If any excess premium remains at the end of the period of enrollment or benefit year, the Exchange must refund any excess premium within 45 calendar days of the end of the period of enrollment or benefit year, whichever comes first.

(2) If a refund is requested by or for the enrollee, the refund must be provided within 45 calendar days of the date of the request.

(i) *Calculation of advance payments of the premium tax credit when policy coverage lasts less than the full coverage month.* (1) For plan years beginning with 2024 and beyond, when an Exchange determines that an individual is eligible for advance payments of the premium tax credit and the enrollee is enrolled in a policy for less than the full coverage month, including when the enrollee is enrolled in multiple policies within a month, each lasting less than the full coverage month—

(i) In an Exchange using the Federal eligibility and enrollment platform, the amount of the advance payment of the premium tax credit paid to the issuer of the policy must equal the product of—

(A) The advance payments of the premium tax credit applied to the policy for one month of coverage divided by the number of days in the month; and

(B) The number of days for which coverage is being provided in the month under the policy described in paragraph (i)(1)(i) of this section.

(ii) [Reserved]

(2) For plan years beginning with 2024 and beyond, a State Exchange operating its own platform will be required to calculate advance payments of the premium tax credit in accordance with a methodology that does not cause the amount of advance payments of the premium tax credit applied to an enrollee's monthly premium to exceed their expected monthly premium assistance credit amount when the enrollee is enrolled in a policy for less than the full coverage month, including when the enrollee is enrolled in multiple policies within a month, each lasting less than the full coverage month, and to prospectively report the methodology it intends to implement in the subsequent plan year to HHS under § 155.1200(b)(2).

[77 FR 18444, Mar. 27, 2012, as amended at 78 FR 15533, Mar. 11, 2013; 78 FR 42320, July 15, 2013; 78 FR 65095, Oct. 30, 2013; 87 FR 27389, May 6, 2022]

§ 155.345 Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-existing Condition Insurance Plan.

(a) *Agreements.* The Exchange must enter into agreements with agencies administering Medicaid, CHIP, and the BHP, if a BHP is operating in the service area of the Exchange, as are necessary to fulfill the requirements of this subpart and provide copies of any such agreements to HHS upon request. Such agreements must include a clear delineation of the responsibilities of each agency to—

(1) Minimize burden on individuals;

(2) Ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay, based on the date the application is submitted to or redetermination is initiated by the Exchange or the agency administering Medicaid, CHIP, or the BHP;

(3) [Reserved]

(4) Ensure compliance with paragraphs (c), (d), (e), and (g) of this section.

(b) *Responsibilities related to individuals potentially eligible for Medicaid based on other information or through other coverage groups.* For an applicant who is not eligible for Medicaid based on the standards specified in § 155.305(c), the Exchange must assess the information provided by the applicant on his or her application to determine whether he or she is potentially eligible for Medicaid based on factors

not otherwise considered in this subpart.

(c) *Individuals requesting additional screening.* The Exchange must notify an applicant of the opportunity to request a full determination of eligibility for Medicaid based on eligibility criteria that are not described in §155.305(c), and provide such an opportunity. The Exchange must also make such notification to an enrollee and provide an enrollee such opportunity in any determination made in accordance with §155.330 or §155.335.

(d) *Notification of applicant and State Medicaid agency.* If an Exchange identifies an applicant as potentially eligible for Medicaid under paragraph (b) of this section or an applicant requests a full determination for Medicaid under paragraph (c) of this section, the Exchange must—

(1) Transmit all information provided on the application and any information obtained or verified by, the Exchange to the State Medicaid agency, promptly and without undue delay; and

(2) Notify the applicant of such transmittal.

(e) *Treatment of referrals to Medicaid on eligibility for advance payments of the premium tax credit and cost-sharing reductions.* The Exchange must consider an applicant who is described in paragraph (d) of this section and has not been determined eligible for Medicaid based on the standards specified in §155.305(c) as ineligible for Medicaid for purposes of eligibility for advance payments of the premium tax credit or cost-sharing reductions until the State Medicaid agency notifies the Exchange that the applicant is eligible for Medicaid.

(f) *Special rule.* If the Exchange verifies that a tax filer's household income, as defined in 26 CFR 1.36B–1(e), is less than 100 percent of the FPL for the benefit year for which coverage is requested, determines that the tax filer is not eligible for advance payments of the premium tax credit based on §155.305(f)(2), and one or more applicants in the tax filer's household has been determined ineligible for Medicaid and CHIP based on income, the Exchange must—

(1) Provide the applicant with any information regarding income used in the Medicaid and CHIP eligibility determination; and

(2) Follow the procedures specified in §155.320(c)(3).

(g) *Determination of eligibility for individuals submitting applications directly to an agency administering Medicaid, CHIP, or the BHP.* The Exchange, in consultation with the agency or agencies administering Medicaid, CHIP, and the BHP if a BHP is operating in the service area of the Exchange, must establish procedures to ensure that an eligibility determination for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions is performed when an application is submitted directly to an agency administering Medicaid, CHIP, or the BHP if a BHP is operating in the service area of the Exchange. Under such procedures, the Exchange must—

(1) Accept, via secure electronic interface, all information provided on the application and any information obtained or verified by, the agency administering Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange, for the individual, and not require submission of another application;

(2) Notify such agency of the receipt of the information described in paragraph (g)(1) of this section and final eligibility determination for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions.

(3) Not duplicate any eligibility and verification findings already made by the transmitting agency, to the extent such findings are made in accordance with this part.

(4) Not request information or documentation from the individual already provided to another agency administering an insurance affordability program and included in the transmission of information provided on the application or other information transmitted from the other agency.

(5) Determine the individual's eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions, promptly and without undue delay, and in accordance with this subpart.

(6) Follow a streamlined process for eligibility determinations regardless of

the agency that initially received an application.

(h) *Adherence to state decision regarding Medicaid and CHIP.* The Exchange and the Exchange appeals entity must adhere to the eligibility determination or appeals decision for Medicaid or CHIP made by the State Medicaid or CHIP agency, or the appeals entity for such agency.

(i) *Standards for sharing information between the Exchange and the agencies administering Medicaid, CHIP, and the BHP.* (1) The Exchange must utilize a secure electronic interface to exchange data with the agencies administering Medicaid, CHIP, and the BHP, if a BHP is operating in the service area of the Exchange, including to verify whether an applicant for insurance affordability programs has been determined eligible for Medicaid, CHIP, or the BHP, as specified in §155.320(b)(1)(ii), and for other functions required under this subpart.

(2) *Model agreements.* The Exchange may utilize any model agreements as established by HHS for the purpose of sharing data as described in this section.

(j) *Transition from the Pre-existing Condition Insurance Plan (PCIP).* The Exchange must follow procedures established in accordance with 45 CFR 152.45 to transition PCIP enrollees to the Exchange to ensure that there are no lapses in health coverage.

[77 FR 18444, Mar. 27, 2012, as amended at 77 FR 31515, May 29, 2012; 78 FR 42320, July 15, 2013; 78 FR 54136, Aug. 30, 2013]

§155.350 Special eligibility standards and process for Indians.

(a) *Eligibility for cost-sharing reductions.* (1) The Exchange must determine an applicant who is an Indian eligible for cost-sharing reductions if he or she—

(i) Meets the requirements specified in §155.305(a) and §155.305(f);

(ii) Is expected to have a household income, as defined in 26 CFR 1.36B–1(e) that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested.

(2) The Exchange may only provide cost-sharing reductions to an individual who is an Indian if he or she is enrolled in a QHP through the Exchange.

(b) *Special cost-sharing rule for Indians regardless of income.* The Exchange must determine an applicant eligible for the special cost-sharing rule described in section 1402(d)(2) of the Affordable Care Act if he or she is an Indian, without requiring the applicant to request an eligibility determination for insurance affordability programs in accordance with §155.310(b) in order to qualify for this rule.

(c) *Verification related to Indian status.* To the extent that an applicant attests that he or she is an Indian, the Exchange must verify such attestation by—

(1) Utilizing any relevant documentation verified in accordance with §155.315(f);

(2) Relying on any electronic data sources that are available to the Exchange and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently accurate and offer less administrative complexity than paper verification; or

(3) To the extent that approved data sources are unavailable, an individual is not represented in available data sources, or data sources are not reasonably compatible with an applicant's attestation, the Exchange must follow the procedures specified in §155.315(f) and verify documentation provided by the applicant in accordance with the standards for acceptable documentation provided in section 1903(x)(3)(B)(v) of the Social Security Act.

[77 FR 18444, Mar. 27, 2012, as amended at 78 FR 42321, July 15, 2013]

§155.355 Right to appeal.

Individual appeals. The Exchange must include the notice of the right to appeal and instructions regarding how to file an appeal in any eligibility determination notice issued to the applicant in accordance with §155.310(g), §155.330(e)(1)(ii), or §155.335(h)(1)(ii).