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).

Subpart E—Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans

§155.400 Enrollment of qualified individuals into QHPs.

(a) *General requirements.* The Exchange must accept a QHP selection from an applicant who is determined eligible for enrollment in a QHP in accordance with subpart D, and must—

(1) Notify the issuer of the applicant's selected QHP; and

(2) Transmit information necessary to enable the QHP issuer to enroll the applicant.

(b) *Timing of data exchange.* The Exchange must:

(1) Send eligibility and enrollment information to QHP issuers and HHS promptly and without undue delay; and

(2) Establish a process by which a QHP issuer acknowledges the receipt of such information.

(3) Send updated eligibility and enrollment information to HHS promptly and without undue delay, in a manner and timeframe as specified by HHS.

(c) *Records.* The Exchange must maintain records of all enrollments in QHP issuers through the Exchange.

(d) *Reconcile files.* The Exchange must reconcile enrollment information with QHP issuers and HHS no less than on a monthly basis.

(e) *Premium payment.* Exchanges may, and the Federally-facilitated Exchanges and State-Based Exchanges on the Federal Platform will, require payment of a binder payment to effectuate an enrollment or to add coverage retroactively to an already effectuated enrollment. Exchanges may, and the Federally-facilitated Exchanges and State-Based Exchanges on the Federal Platform will, establish a standard policy for setting premium payment deadlines:

(1) In a Federally-facilitated Exchange or State-Based Exchange on the Federal Platform:

(i) For prospective coverage to be effectuated under regular coverage effective dates, as provided for in §155.410(f), the binder payment must consist of the first month's premium, and the deadline for making the binder payment must be no earlier than the coverage