COVERED CALIFORNIA

Data Integrity Process Guide

Section One: Reconciliation
Section Two: Internal Disputes

Version 10

Individual Market

July 2021

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Section One:

Data Integrity Process Guide for Reconciliation

1. Introduction

Document Purpose

The Reconciliation Process Guide defines the scope and expectations for reoccurring reconciliation. Fundamental to this process is the ability to readily find, track, and resolve artifacts that result from transactions between Covered California and its carriers through the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS).

The resolution process will be performance tuned over time to accommodate for enrollment complexity and the transparency needed for root cause analysis. Covered California may revise the process and file formats in later versions of this guide.

Table 1 - Revisions of Section One: Reconciliation

DATE	REVISION #	REVISION DESCRIPTION
06/03/2015	1.0	Initial version
08/11/2015	1.5	L2 and L3 updates
02/20/2016	2.0	GoBack and Carrier Action updates
03/01/2017	2.5	Update
05/25/2017	3.0	Update
02/06/2019	4.0	Update L2 description & add Internal Disputes
05/28/2019	5.0	State Subsidy Update
10/18/2019	6.0	State Subsidy/ L2-Update
12/27/2019	7.0	Removal of Missing Member File
02/19/2020	7.5	Update
04/17/2020	8.0	L2 Update – L2-Q and L2-R
6/04/2020	9.0	Financial Carrier Action File
10/1/20	9.5	Carrier Action File and Carrier Action Confirmation
7/23/2021	10	Update to file layout and rules due to New Policy - $0 Premium Bills

Intended Users

Covered California provides this Reconciliation Process Guide to the account managers and staff of the enrollment, payment processing, and supporting technical teams of Qualified Health Plans (QHP) / Qualified Dental Plans (QDP) who handle electronic transactions with Covered California through the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS).

2. Reconciliation Scope

Data Reconciliation Schedule

Covered California and CalHEERS engage in a monthly Reconciliation Process with all carriers taking part in the individual market; including both health and dental carriers. Covered California's Data Integrity Unit applies key lessons learned from earlier benefit years. The Data Integrity Unit will continue to engage carriers in all eligibility and enrollment reconciliation efforts.

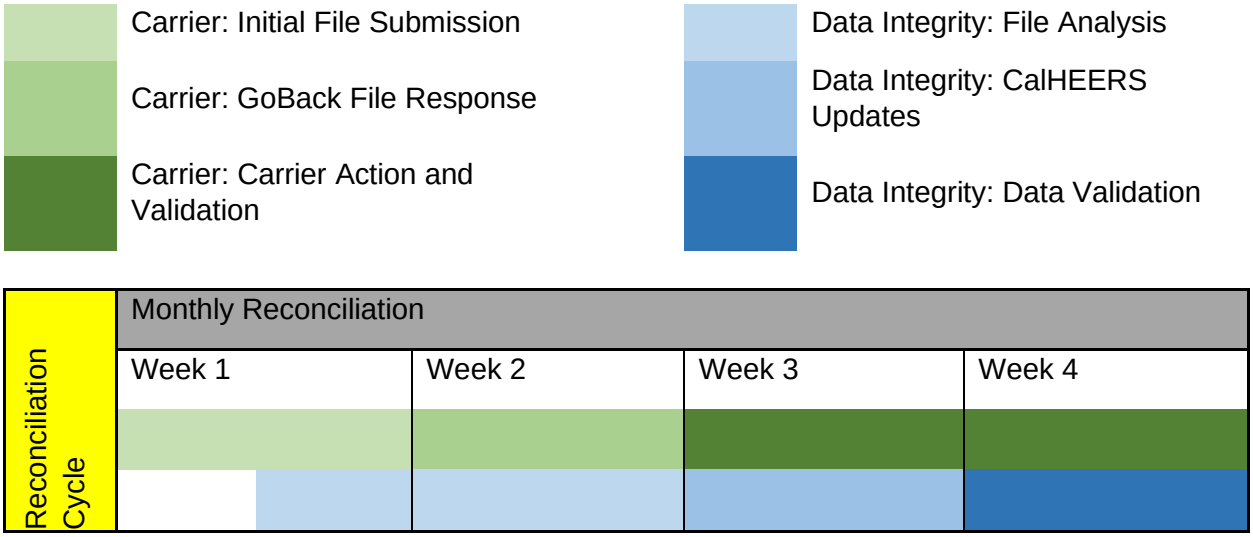


Figure 1 - Monthly Data Reconciliation Cadence

Reconciliation Data Model

The Program Integrity Unit serves as the single point of contact for reconciliatory activities between CalHEERS and all carriers taking part in the individual market. The reconciliation data model uses tiered enrollment validations and the simplicity of atomic processing rules. This process design achieves the performance agility needed by the California Health Benefit Exchange, its carriers, and consumers alike.

Health exchange marketplaces are inherently asynchronous transactional systems. The Reconciliation Process evaluates the nature of enrollment transactions and bring synchronicity between the carrier's systems and CalHEERS where necessary. Serving as the single point of service, the Reconciliation Process gives operational efficiency to core business processes at an enterprise level. Carrier synchronization of consumer enrollment (A) ensures consistency of Federal reporting to both the Center for Medicare and Medicaid Services (CMS), the Internal Revenue Service (IRS), and the Franchise Tax Board (FTB), (B) supports precise business analytics for market research and quality measures, (C) promotes correct billing of carrier assessments, and (D) promotes successful Consumer Experience.

The Data Integrity Unit works closely with internal departments to solution discrepancies that arise in the underlying data. Similarly, Covered California expects that each carrier will coordinate their reconciliatory efforts with the respective internal departments; including Enrollment, Service Center, Finance, and any Technical vendors.

3. Weekly Reconciliation File

Covered California will deliver a Reconciliation File to the carriers each week. This Weekly Audit File gives a one-way comprehensive snapshot view of the full enrollment population for carriers to reference.

For those members who are missing from a carrier's system, the carrier should reconstitute transactions from the weekly recon file. This reconstitution of new enrollments (A) may use either a new Enrollment ID or Maintenance to an existing Enrollment ID, and (B) will include all associated values. For any maintenance transactions on existing enrollments, the carrier will apply the associated values on a going forward basis only. Where there is any concern over applying these rules, please contact the Plan Management Division by way of your Plan Manager and the Program Integrity Unit.

4. Monthly Reconciliation process

This section includes the summary process flow and the accompanying activity narrative for the Covered California and carrier data Reconciliation process.

Each Reconciliation Cycle uses the Weekly Audit File that offers a comprehensive snapshot view of the full enrollment population. Each Reconciliation Cycle is based on a specific file, referenced by the audit date in the first column of that Weekly Audit File. Both Covered California and the carriers use this date in the file naming convention. There is a separate audit date for Health versus Dental Reconciliation files.

Another useful reference for tracking Reconciliation Cycles is the “Anchor Date.” This refers to the Weekly Audit File generated the week of the correlating Recon Cycle for file comparison.

During the later phase of each monthly reconciliation, Covered California expects the carriers to action various resolution methods. Future iterations of the Reconciliation Process will include both 834s and system data fixes as stipulated by the reconciliation analysis, processing rules, and corresponding root cause findings.

Figure 2- Data Reconciliation Process Diagram

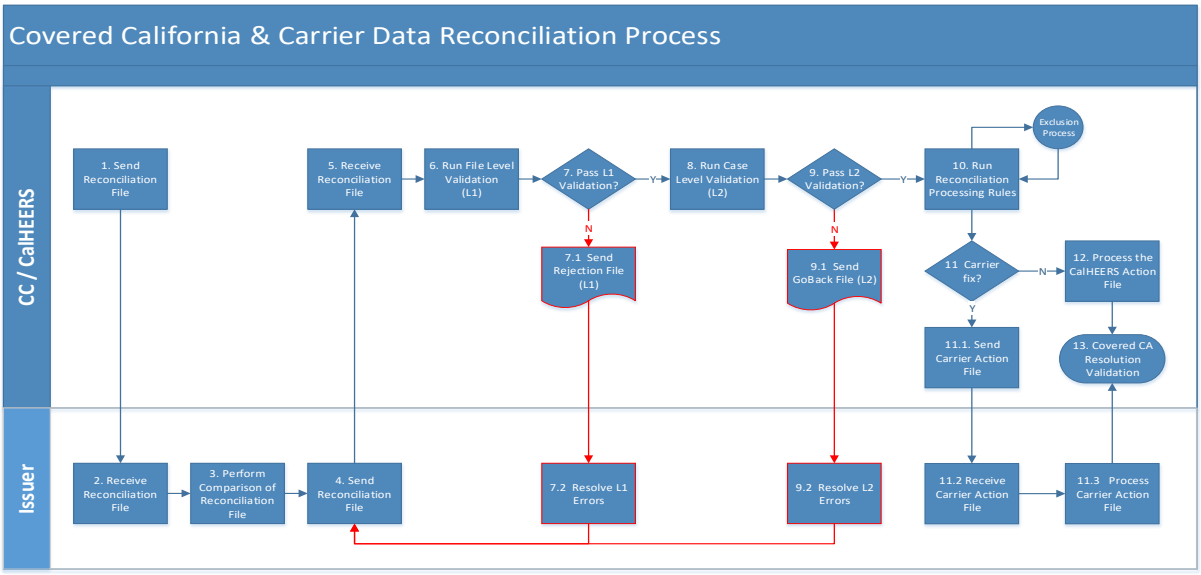


Table 2 - Data Reconciliation Process Narrative

Ref #	Activity	Actor	Activity Detail
1	Send Reconciliation CSV File	CC / CalHEERS	Each Reconciliation Cycles is based on the Weekly Reconciliation CSV file sent during the week of the Anchor Date stipulated in the reconciliation schedule as the start of that cycle. **File naming convention:** <HIOS ID>_INDV_ENROLLMENT_RECON_HEALTH_<Audit Date YYYYMMDD >.<Benefit Year>.csv.zip <HIOS ID>_INDV_ENROLLMENT_RECON_DENTAL_<Audit Date YYYYMMDD >.<Benefit Year>.csv.zip **Example:** 55555_INDV_ENROLLMENT_RECON_HEALTH_20150520.2015.csv.zip
2	Receive Reconciliation CSV File	Carrier	Carriers can expect the Weekly Reconciliation files via the same method and location as 834s are received. The layout for the Weekly Audit file includes all the fields in the carrier's initial submission plus four fields that do not entail a carrier submission (LANGUGE_WRITTEN, LANGUAGE_SPOKEN, PHONE_NUMBER, and INDV_RESP_AMT
3	Perform Comparison of Reconciliation File	Carrier	Since weekly reconciliation files are a snapshot view of consumer enrollments, it is of vital importance to Anchor each Reconciliation Cycle off the designated file. Carriers should prepare and execute the file comparison in agreement with field mapping that is unique to each carrier's data model. This action produces a comparative view of all the enrollment segment details needed for processing rules to find the root cause of a discrepancy and the resolution method. Once the carrier completes a comparison extract, they will perform file level validations. Some of the main file level validations include the following: • No enrollment duplications per member. By concatenating Fields 4 (Enrollment ID) & 5 (Member ID) there should be no duplicate values. • All required fields hold properly formatted data. (See Null Allowed column of the Weekly Reconciliation File Layout document). • Verify all fields are in the correct format, with no added characters or other formatting. • Benefit End Dates should not be blank for an enrollment. High Dates are not acceptable return values. • Cancellations should be consistently identifiable by having the same Benefit Start and End Dates. • No added columns having comments, notes etc. • No trailers, extra lines at the base of the file. The word 'NULL' does not occur in the file. All null values should be blank.

Ref #	Activity	Actor	Activity Detail
4	Send Reconciliation File	Carrier	Carriers should use the Data Integrity area of the Plan Management Extranet site to send inbound Response files for the Reconciliation process. If there are provisioning or technical questions on using the Extranet, please contact your Plan Manager or the Data Integrity Unit. **File naming convention:** from_<HIOS ID>_INDV_ENROLLMENT_RECON_HEALTH_<Audit Date YYYYMMDD >.<Benefit Year>.csv.zip from_<HIOS ID>_INDV_ENROLLMENT_RECON_DENTAL_<Audit Date YYYYMMDD (AUDIT DATE)>.<Benefit Year>.csv.zip **Example:** from_55555_INDV_ENROLLMENT_RECON_HEALTH_20150520.2015.csv.zip
5	Receive Reconciliation File	CC / CalHEERS	Covered California keeps each Reconciliation file in the Extranet data library.
6	Run File Level Validation (L1)	CC / CalHEERS	Upon receipt of each Reconciliation File, Covered California validate its contents for accuracy and completeness. Covered California runs File level validations (L1) per the field requirements detailed in **Table 4 – Layout of Inbound Reconciliation File**.
7	Pass L1 Validation	CC / CalHEERS	Covered California will return a file that fails L1 Validation to the carrier in its entirety. An L1 Rejection is avoidable through comprehensive review prior to submission of the Reconciliation file. See **Activity 7.1: Send Rejections File (L1).** Covered California keeps the files that pass L1 Validation and runs the case level validations (L2) next. From this point onward, the process partitions reconciliation files and routes records based on whether the case has any L2 flags for basic enrollment errors. See **Activity 8: Run Case Level Validation (L2)**
7.1	Send Rejections File (L1)	CC / CalHEERS	Covered California will notify Carriers of L1 File Rejections through email communication.
7.2	Resolve L1 Errors	Carrier	The carrier will review and resolve the L1 errors and resubmit the file. **File naming convention:** from_<HIOS ID>_INDV_ENROLLMENT_RECON_HEALTH_<Audit Date YYYYMMDD>.<Benefit Year>.csv.zip from_<HIOS ID>_INDV_ENROLLMENT_RECON_DENTAL_<Audit Date YYYYMMDD >.<Benefit Year>.csv.zip **Example:** 55555_INDV_ENROLLMENT_RECON_DENTAL_20150520.2015.csv.zip
8	Run Case Level Validation (L2)	CC / CalHEERS	Covered California passes each file that passes L1 Validation on for Case Level Validation (L2). An L2 rejection is any enrollment or eligibility submission that violates standard business rules.

Ref #	Activity	Actor	Activity Detail
			These Case level rejections (L2) include: Subscriber to Member enrollment agreement, invalid coverage dates, policy violations, and other data presentation requirements.
9	Pass L2 Validation?	CC / CalHEERS	A case that fails L2 enrollment validation will return to the carrier in its entirety at the case level. See **Activity 9.1: Send GoBack File (L2)** A case that passes L2 Validation moves forward in the recon process. Complete and correct cases will run through the Reconciliation processing Rules Engine. See **Activity 10: Run Reconciliation processing Rules Engine**
9.1	Send GoBack File (L2)	CC / CalHEERS	Covered California returns L2 Rejection Files to the carrier at the case level. That is, if an L2 rule flags a single enrollment for a member, then the GoBack File will return the entire case. The L2 rejection file has an added column that flags which row(s) have an error within the file. The rejection file use discrepancy codes to label the errors type. As the Reconciliation Process has matured this error labeling has gained more granularity. **File naming convention:** <HIOS ID>_INDV_ENROLLMENT_HEALTH_GOBACK_<Audit Date YYYYMMDD>.<Benefit Year>.csv.zip <HIOS ID>_INDV_ENROLLMENT_DENTAL_GOBACK_<Audit Date YYYYMMDD>.<Benefit Year>.csv.zip **Example:** 55555_INDV_ENROLLMENT_RECON_HEALTH_GOBACK_20150520.2015.csv.zip
9.2	Resolve L2 Errors (L2)	Carrier	An L2 Rejection is any enrollment or eligibility submission that violates standard business rules. Carriers must review these cases and make any necessary changes to resolve the error type provided. Covered California expects that GoBack files will take 2-3 business days to resolve. As cases increase in complexity the coordination and communication with CoveredCA will proportionally increase. With maturity of the Reconciliation process, GoBack files will take 1-2 Business days to resolve. As familiarity with the error codes increases processing efficiency will proportionally increase. **Return File Naming Convention:** from_<HIOS ID>_INDV_ENROLLMENT_RECON_HEALTH_GOBACK_<Audit Date YYYYMMDD>.<Benefit Year>.csv.zip from_<HIOS ID>_INDV_ENROLLMENT_RECON_DENTAL_GOBACK_<Audit Date YYYYMMDD>.<Benefit Year>.csv.zip **Example:** from_59042_INDV_ENROLLMENT_RECON_HEALTH_GOBACK_20150520.2015.csv.zip

Ref #	Activity	Actor	Activity Detail
10	Run Reconciliation processing Rules Engine	CC / CalHEERS	All those cases that pass Case Level Validation (L2) run through the Reconciliation processing Rules Engine. The Processing Rules Engine separates matching vs. discrepant enrollment records. For each discrepancy, the Processing Rules Engine evaluates the pair of Carrier vs. CalHEERS records. The rule logic includes period of enrollment, status, member information, and eligibility components. *Data Integrity will only notify a Carrier if the GoBack Response file is NOT accepted. A carrier will NOT receive notification until the Carrier Action file and Error report are produced. See **Activity 11: Carrier Fix**. Exclusions Process: Exclusions are any case that another Covered California business channel is actively resolving. This includes the following: Appeals, Escalations, Informal Resolution, tickets, and other workstreams. Reconciliation does not specify carrier or CalHEERS fixes for excluded cases.
11	Carrier Fix	CC / CalHEERS	The Processing Rules Engine assigns a fix owner to each case that the processing engine shows as actionable. If the Rule Engine names the carrier as the owner, Covered California generates a carrier resolution file. See **Activity 11.1: Send Carrier Action File** If the Rules Engine finds CC / CalHEERS is the owner, a CC / CalHEERS Action file will be generated. See **Activity 12: CalHEERS Action File.**
11.1	Send Carrier Action Files	CC / CalHEERS	As an output of the Reconciliation Process Rules Engine, CC / CalHEERS will produce a two Resolution Files. The Resolution File Generation are the products of the reconciliation cascade. The Resolution Files will include both values for all reconcilable fields, and two accompanying flags: Record Origin and carrier Action. • Record Origin: This flag will designate, for a particular row, where the data originated. (e.g. CalHEERS or carrier) • Carrier Action: This flag will designate, for each pair of rows, the method identified for resolution. (e.g. 834, Data Fix, etc.)
11.2	Receive Carrier Action Files	Carrier	Carriers can retrieve their Action files from the Data Integrity section of the Plan Management Extranet.
11.3	Process Carrier Action File	Carrier	During the initial state of the Reconciliation process, it is expected that Resolution Files will take approximately 1-2 Weeks to resolve based on volume. It is anticipated that as resolutions increase in complexity, the coordination and communication with CoveredCA will proportionally increase. There may be unique circumstances where a multi-step process is required between carriers and CalHEERS. As the Reconciliation Process matures, it is expected that carrier Action Files will take approximately 1 Week to resolve. As familiarity with the error codes increases it is expected that processing efficiency will proportionally increase.
12	Process CalHEERS Action File	CC / CalHEERS	

Ref #	Activity	Actor	Activity Detail
13	Resolution Validation	CC / CalHEERS	CoveredCA and CalHEERS will routinely validate the cases identified during the resolution process are no longer discrepant. Those cases which persist from one Reconciliation Cycle to the next, without resolution, will be escalated as required. Covered California will closely monitor comprehensive metrics and performance standards throughout the benefit year. During the Initial State of the Reconciliation process, it is expected that cases identified for resolution will not have the discrepancy persist for longer than 3 consecutive cycles. All resolution cases that are out of compliance with aging guidelines will be escalated to Leadership. As the Reconciliation Process matures, it is expected that cases identified for resolution will not have the discrepancy persist for longer than 2 consecutive cycles. As the reconcilable field list proportionally expands with the maturity of this process, the tracking and performance metrics will become more sophisticated to identify compliance standards.

5. Reconciliation File

Weekly Reconciliation File

The weekly reconciliation file will contain an overview of all enrollment. This file will be used as a basis for our reconciliation file. A significant and important difference between weekly and inbound carrier reconciliation files are the following four fields:

- LANGUGE_WRITTEN
- LANGUAGE_SPOKEN
- PHONE_NUMBER
- INDV_RESP_AMT

While carriers should expect to see these columns populated in the weekly reconciliation files, inbound carrier response should not include these fields.

Reconciliation File Rules

The following fields should be opened as a text field to prevent any leading zeros from being dropped or converted to scientific notation prior to comparison:

Table 3 - Fields to Open as Text

Field #	Field Name
6	CREATION_TIMESTAMP
7	LAST_UPDATED_TIMESTAMP
11	RATING_AREA
72	SSN
75	MEMBER_RELATIONSHIP_TO_SUB
84	RESIDENTIAL_COUNTY_FIPS_CODE

90	BROKER_ID
92	BROKER_FEDERAL_EIN
93	BROKER_LICENSE_NUMBER
94	BROKER_CERTIFICATION_NUMBER

Reconciliation CSV files should use the following CSV dialect:

1. Line Terminator = LF i.e. \n
2. Text Qualifier = ""
3. Encoding = UTF-8

For those members who are missing from the Reconciliation File, carriers are expected to utilize the defined field list and technical field requirements of the Reconciliation File to send all relevant information to Covered California for review. See Step 4, Section 4.1: Monthly Reconciliation process, Table 1: Data Reconciliation Process Narrative for file naming convention.

The reconciliation file has four data categories associated with it.

- Primary,
- Enrollment,
- Financial and;
- Application

Each carrier will provide data associated to our four data categories. For our monthly financial values **Null** is required for months when no coverage occurred, but monthly financial values must be populated for every month there is coverage including when status is Pending.

For PREMIUM_PAID_THROUGH_DATE, **Null** is allowed when a status is Cancel or Pending, **Null** is not allowed when the status is Confirm or Term.

For APTC_AMOUNT, STATE_SUBSIDY_AMOUNT,GROSS_PREMIUM_AMOUNT, NET_PREMIUM_AMOUNT, CSR_AMOUNT, CA_PREMIUM_CREDIT_AMOUNT **Null** is not allowed. These fields should always contain the value that is given on an 834 file.

Inbound Reconciliation File Layout

Table 4 – Layout of Inbound Reconciliation File

	#	Field	Description	Technical Field Description	Null Allowed
Primary	1	AUDIT_DATE	The date the file was created	date format: YYYYMMDD	N
	2	CASE_ID	10 Digit AHBX Case ID	Int	N
	3	SUBSCRIBER_ID	CalHEERS issued subscriber key	Int	N
	4	MEMBER_ID	CalHEERS issued Member key	Int	N
	5	ENROLLMENT_ID	A Key uniquely identifying a	Int	N

	#	Field	Description	Technical Field Description	Null Allowed
			family/policy enrollment/segment		
	6	CREATION_TIMESTAMP	Date the initial enrollment was created	date format: YYYYMMDDhhmmss	N
	7	LAST_UPDATED_TIMESTAMP	Date the initial enrollment was last modified	date format: YYYYMMDDhhmmss	N
	8	PREMIUM_PAID_THROUGH_DATE	Premium paid through date	date format: YYYYMMDD	Y
	9	PLAN_TYPE	Health or Dental	char(3), allowed values: HLT, DEN	N
	10	RENEWAL_FLAG	Flag indicating renewal/renewal type	char(1), allowed values: A, M (auto/manual)	Y
	11	RATING_AREA	Rating Area Code	char(7), like 'R-CA%'	N
Enrollment	12	BENEFIT_START_DATE	Member's start date for benefits for a specific enrollment segment/period. Any one member/subscriber can have multiple start dates depending on their transaction history (term/re-enroll, maintenance, etc.).	date, format: YYYYMMDD	N
	13	BENEFIT_END_DATE	Member's end date for benefits for a specific enrollment segment/period. Any one member/subscriber can have multiple start dates depending on their transaction history (term/re-enroll, maintenance, etc.).	date, format: YYYYMMDD	N
	14	MEMBER_STATUS	Enrollee level status for a specific enrollment segment/period. Any consumer can have multiple historic enrollment statuses (cancelled, terminated etc. (specific to the segment/period)) and a single current enrollment status.	varchar(7) Allowed Values: PENDING, CONFIRM, TERM, CANCEL	N

	#	Field	Description	Technical Field Description	Null Allowed
	15	PLAN_ID	16 Digit CMS Plan ID	Char(16)	N
Financial	16	GROSS_PREMIUM_AMOUNT	Policy Level GROSS Premium	decimal(6,2)	N
	17 18 19 20 21 22 23 24 25 26 27 28	GROSS_PREMIUM_JAN GROSS_PREMIUM_FEB GROSS_PREMIUM_MAR GROSS_PREMIUM_APR GROSS_PREMIUM_MAY GROSS_PREMIUM_JUN GROSS_PREMIUM_JUL GROSS_PREMIUM_AUG GROSS_PREMIUM_SEP GROSS_PREMIUM_OCT GROSS_PREMIUM_NOV GROSS_PREMIUM_DEC	Monthly Level GROSS Premium	decimal(6,2)	Y
	29	APTC_AMOUNT	Policy level APTC amount as designated by the consumer for a specific enrollment segment/period	decimal(6,2)	N
	30 31 32 33 34	APTC _JAN APTC_ FEB APTC_ MAR APTC_ APR APTC_ MAY	Monthly level APTC amount as designated by the consumer for a specific enrollment segment/period	decimal(6,2)	Y

	#	Field	Description	Technical Field Description	Null Allowed
	35	APTC_ JUN			
	36	APTC_ JUL			
	37	APTC_ AUG			
	38	APTC_ SEP			
	39	APTC_ OCT			
	40	APTC_ NOV			
	41	APTC_ DEC			
Financial	42	STATE_SUBSIDY_AMOUNT	Policy level STATE SUBSIDY amount as designated by the consumer for a specific enrollment segment/period	decimal(6,2)	N
	43	STATE_SUBSIDY_JAN	Monthly level State Subsidy amount as designated by the consumer for a specific enrollment segment/period	decimal(6,2)	Y
	44	STATE _SUBSIDY_FEB			
	45	STATE_SUBSIDY_MAR			
	46	STATE_SUBSIDY_APR			
	47	STATE_SUBSIDY_MAY			
	48	STATE_SUBSIDY_JUN			
	49	STATE_SUBSIDY_JUL			
	50	STATE_SUBSIDY_AUG			
	51	STATE_SUBSIDY_SEP			
	52	STATE_SUBSIDY_OCT			
	53	STATE_SUBSIDY_NOV			
	54	STATE_SUBSIDY_DEC			
	55	CA_Premium_Credit_AMOUNT	Policy level CA_Premium_Credit amount as designated by the consumer for a specific enrollment segment/period	decimal(6,2)	N
	56	CA_PREMIUM_CREDIT_JAN	Monthly level CA_Premium_Credit amount as designated by the consumer for a specific enrollment segment/period	decimal(6,2)	Y
	57	CA_PREMIUM_CREDIT_FEB			
	58	CA_PREMIUM_CREDIT_MAR			
	59	CA_PREMIUM_CREDIT_APR			
	60	CA_PREMIUM_CREDIT_MAY			
	61	CA_PREMIUM_CREDIT_JUN			
	62	CA_PREMIUM_CREDIT_JUL			
	63	CA_PREMIUM_CREDIT_AUG			
	64	CA_PREMIUM_CREDIT_SEP			
	65	CA_PREMIUM_CREDIT_OCT			
	66	CA_PREMIUM_CREDIT_NOV			
	67	CA_PREMIUM_CREDIT_DEC			

	#	Field	Description	Technical Field Description	Null Allowed
	68	NET_PREMIUM_AMOUNT	Policy Level NET Premium	decimal(6,2)	N
	69 70 71 72 73 74 75 76 77 78 79 80	NET_PREMIUM_JAN NET _PREMIUM_FEB NET_PREMIUM_MAR NET _PREMIUM_APR NET _PREMIUM_MAY NET _PREMIUM_JUN NET_PREMIUM_JUL NET _PREMIUM_AUG NET _PREMIUM_SEP NET_PREMIUM_OCT NET _PREMIUM_NOV NET_PREMIUM_DEC	Monthly Level NET Premium	decimal(6,2)	Y
Application	81	CSR_AMOUNT	Policy Level CSR Amount for a specific enrollment segment / period	Decimal (6,2)	N
	82	FIRST_NAME	Member First Name	varchar(100)	N
	83	MIDDLE_NAME	Member Middle Name	varchar(100)	Y
	84	LAST_NAME	Member Last Name	varchar(100)	N
	85	SSN	Social Security Number	char(9)	Y
	86	BIRTH_DATE	Member DOB	date format: YYYYMMDD	N
	87	DATE_OF_DEATH	Date of death if applicable	date format: YYYYMMDD	Y
	88	MEMBER_RELATIONSHIP_TO_SUB	Relationship of the Member to the Subscriber	char(2)	Y
	89	GENDER	Gender, Allowed Values: M, F	char(1)	N
	90	RACE_ETHNICITY_TYPE	Race Code)	varchar(500)	Y
	91	EMAIL_ADDRESS	Email Address	varchar(250)	Y

	#	Field	Description	Technical Field Description	Null Allowed
	92	RESIDENTIAL_ADDR_LINE1	Street Address of Residence	varchar(1000)	N
	93	RESIDENTIAL_ADDR_LINE2	Street Address of Residence Continued	varchar(1000)	Y
	94	RESIDENTIAL_CITY_NAME	City of Residence	varchar(1000)	N
	95	RESIDENTIAL_STATE_CODE	State of Residence	char(2)	N
	96	RESIDENTIAL_ZIP_CODE	Zip Code of Residence	char(5)	N
	97	RESIDENTIAL_COUNTY_FIPS_CODE	Address Information Derived from RESIDENTIAL_ZIP_CODE	char(5)	N
	98	MAILING_ADDR_LINE1	Street Mailing Address	varchar(1000)	N
	99	MAILING_ADDR_LINE2	Street Mailing Address Continued	varchar(1000)	Y
	100	MAILING_CITY_NAME	City Mailing Address	varchar(1000)	N
	101	MAILING_STATE_CODE	State Mailing Address	char(2)	N
	102	MAILING_ZIP_CODE	Zip Code Mailing Address	char(5)	N
	103	BROKER_ID	CalHEERS Assigned Broker ID	Int	Y
	104	AGENT_BROKER_NAME	Latest Broker Name	varchar(100)	Y
	105	BROKER_FEDERAL_EIN	Latest Broker Federal EIN	varchar(50)	Y
	106	BROKER_LICENSE_NUMBER	Latest Broker License Number	varchar(50)	Y
	107	BROKER_CERTIFICATION_NUMBER	Latest Broker Certification Number	varchar(50)	Y
	108	BROKER_DELEGATED_TO_CASE_DATE	The date the broker was delegated to the case	date format: YYYYMMDDhhmmss	Y
	109	ISSUER_SUBSCRIBER_ID	Carrier Assigned Subscriber Key	varchar(50)	Y
	110	ISSUER_MEMBER_ID	Carrier Assigned Member Key	varchar(50)	Y

6. GoBack File

L2 Validation Rules

The following table provides the Error Codes and corresponding rules that apply during the Case Level L2 Validation. Covered California may flag more than one Error Code on an individual record. When multiple error types apply to a single record, the Covered California will concatenate the codes. As enrollment scenarios dictate, the Covered California has developed new L2 validation rules and adjusted others.

Table 5 – Basic Error codes for Case-level (L2) Validations

CODES	RULE

L2 - A	The MEMBER_ID and ENROLLMENT_ID concatenation must be globally unique (duplicate)
L2 - B	The unique count of MEMBER_ID and ENROLLMENT_ID concatenations must equal the count on the original Reconciliation File. The original Reconciliation File must be returned in its entirety (missing row)
L2 - C	If MEMBER_STATUS is CANCEL, BENEFIT_START_DATE must equal BENEFIT_END_DATE
L2-D	If Null allowed is N, value is required
L2-E	The member's enrollment dates (BENEFIT_START_DATE and BENEFIT_END_DATE) must be contained within the subscriber's enrollment dates for each ENROLLMENT_ID
L2-F	For any enrollment the BENEFIT_START_DATE must be equal to or less than BENEFIT_END_DATE
L2-G	Each BENEFIT_START_DATE and BENEFIT_END_DATE must be in the reconcilable year
L2-H	Any confirmed or terminated enrollment having a non-zero duration of coverage must have a PREMIUM_PAID_THROUGH_DATE year. For the subscriber, the PREMIUM_PAID_THROUGH_DATE cannot be greater than the BENEFIT_END_DATE.
L2-I	A member having an overlap in coverage. Note that in order to resolve the overlapping coverage, an enrollment change may be required on another record
L2-J	Enrollment record has a functionally invalid combination of status and benefit coverage dates. e.g. "TERM" with no end date, "CANCEL" where benefit start date and benefit end date are not equal or "TERM" where benefit start date and benefit end date are equal. The end date for "PENDING" and "CONFIRM" records must reflect the last day of the benefit year.
L2-K	The enrollment status is submitted as "PENDING" for a record which was either created or transacted (whichever is later) at least 60-Days prior to audit date
L2-L	START_DATE is greater than CalHEERS START_DATE
L2-M	START_DATE is less than CalHEERS START_DATE
L2-N	For Health issuers, NET PREMIUM must always be greater than or equal to zero dollars (NP ≥ 0). For Dental issuers, NET PREMIUM must always be greater than zero dollars (NP > 0). Also, the Gross Premium less the APTC, State Subsidy, California Premium Credit must equal the Net Premium (GP - APTC - State Subsidy, California Premium Credit = NP).
L2-O	For the Subscriber, (1) in any month before coverage starts or after coverage ends the financial value field(s) must be left blank (i.e., null), (2) there must be a monthly financial value for every month of coverage in the enrollment, (3) if coverage start date is the coverage end date, then all monthly financial values must be left blank.
L2-P	If the enrollment status is "CONFIRMED" with a PREMIUM_PAID_THROUGH_DATE of more than 150 days prior to the AUDIT_DATE, then status should be "TERM".

L2-Q	A plan change in CalHEERs but it's not reflected in the carrier file, resulting on a Confirm for the incorrect enrollment.
L2-R	Enrollments that contain a Mid-month start or end date and do not have a prorated financial value.
<blank>	If a case appears on the GoBack file with no discrepancies, then there exists an error for this household with another carrier. Once the case is validated for accuracy, no corrective action is required.

GoBack File Layout

	#	Field Header
Primary	1	AUDIT_DATE
	2	CASE_ID
	3	SUBSCRIBER_ID
	4	MEMBER_ID
	5	ENROLLMENT_ID
	6	CREATION_TIMESTAMP
	7	LAST_UPDATED_TIMESTAMP
	8	LAST_PREMIUM_PAID_DATE
	9	PLAN_TYPE
	10	RENEWAL_FLAG
	11	RATING_AREA
Enrollment	12	BENEFIT_START_DATE
	13	BENEFIT_END_DATE
	14	MEMBER_STATUS
	15	PLAN_ID
Financial	16	GROSS_PREMIUM_AMOUNT
	17-28	GROSS_PREMIUM_(X12)
	29	APTC_AMOUNT
	30-41	APTC_(X12)
	42	STATE_SUBSIDY_AMOUNT
	43-54	STATE_SUBSIDY_(X12)
	55	CA_Premium_Credit_AMOUNT
	56-67	CA_Premium_Credit (x12)
	68	NET_PREMIUM_AMOUNT
	69-80	NET_PREMIUM_(X12)

	81	CSR_AMOUNT
Application	82	ISSUER_SUBSCRIBER_ID
	83	ISSUER_MEMBER_ID
	84	DISCREPANCIES

The table on the left provides the outbound GoBack File layout that carriers will receive from Covered California. The outbound GoBack File from Covered California has a truncated field list to minimize the file size and volume of data being transferred.

By design, the inbound carrier GoBack Response file will replace those enrollment records submitted on the initial carrier Response file. As such, it is vital that the inbound carrier GoBack Response must adhere to the Reconciliation File format by including all required fields (110) as defined in Table 4, Layout of Inbound Reconciliation File. Any inbound GoBack File will be expressly rejected in its entirety when the before mentioned field requirement is not followed.

Carriers may find instances where a case that is not on the GoBack file requires resubmission. The GoBack process allows for the resubmission of any case. All validations run again for every record in each case, even records that did not originally get flagged on submission. Carriers will not receive notification from Data Integrity Unit for an inbound GoBack Response that meets the file requirements for resubmission and the file is accepted. Data Integrity Unit will only notify a carrier, through email communication, if the GoBack file was rejected or resubmission is required.

7. Error Report

Once Covered California loads and runs the case-level validations on the inbound GoBack Response file, each carrier will receive an Error Report. The purpose of this report is to indicate which cases had a persistent L2 validation error, for which the inbound GoBack Response did not resolve. The monthly Reconciliation Process does not accommodate a Response file to this Error Report, except under exceptional circumstances as approved by Data Integrity.

The expectation is that the carrier will review the persistent L2 validation errors and include corrective action in the initial response of the following Reconciliation Cycle. Covered California reviews cases that exhibit persistent L2 validation errors. Each carrier will be expected to meaningfully respond to enquires over these errors. This may include root cause analysis of 834 transactions, enrollment validations, or payment verification from the carrier system.

8. Carrier Action Files

Processing Rules Engine

All cases that pass Case Level Validation (L2) then run through the Reconciliation processing Rules Engine. Once Covered California successfully loaded all the inbound GoBack Response files, then the Processing Rules Engine evaluates every enrollment submitted through the Reconciliation Process that passed all previous validations.

The Processing Rules Engine initially identifies accurate and discrepant enrollment records, as well as financial discrepancies. For each discrepancy, the Processing Rules Engine will evaluate a case for completeness with respect to: Period of Enrollment, Current Status, Member Identifying Information, Financial values, and Eligibility Components.

The cases that pass L2 level validation will also be run against the Financial Rules Engine.The Financial Rules Engine identifies financial discrepancies between CalHEERS and the carrier system. The Financial Carrier Action File presents the monthly financial values that remain after any enrollment discrepancy has been resolved.

The Premium Paid Through Date is a vital logical operator that contributes to the accuracy of the enrollment information as submitted by the carrier. This is especially true for the reconciliation of terminated and cancelled enrollments potentially related to non-payment of premiums. The premium paid through date denotes:

- ***the day of the month through which a consumer has paid their coverage in full***.

For example, in the instance of a cancellation, the benefit start, and end date should be equal, and the premium paid through date should be Null. In the instance of a confirmed enrollment, that was not auto-renewed, a valid premium paid through date is expected to be within the same benefit year as coverage being reported. Any auto-rewed enrollment with a premium paid through date in the previous benefit year will receive an error flag but will not be deemed invalid. As consumers may pay for several months into the future, the premium paid through date may extend as far as the last day of the benefit year for a confirmed enrollment during any given Reconciliation Cycle.

1.1. Carrier Action File Layout

After Covered California runs the Processing Rules Engineand the Financial Rules Engine each carrier will receive two carrier Action Files.

The first file specifies the discrepancies between CalHEERS and carrier records that the rules engine identified as requiring an enrollment update to the carrier system. Similarly, through the Reconciliation process, Covered California identifies those cases that require an update in CalHEERS.

The table below illustrates all the fields included in the carrier Action File layouts.

Table 6 - Carrier Action File layouts

	#	Field Header
Primary	1	RECORD_ORIGIN
	2	AUDIT_DATE
	3	CASE_ID
	4	SUBSCRIBER_ID
	5	MEMBER_ID
	6	ENROLLMENT_ID
	7	CREATION_TIMESTAMP
	8	LAST_UPDATED_TIMESTAMP
	9	PREMIUM_PAID_THROUGH_DATE
	10	PLAN_TYPE

	11	RENEWAL_FLAG
	12	RATING_AREA
Enrollment	13	BENEFIT_START_DATE
	14	BENEFIT_END_DATE
	15	MEMBER_STATUS
	16	PLAN_ID
Financial	17	GROSS_PREMIUM_AMOUNT
	18-29	GROSS_PREMIUM_(x12)
	30	APTC_AMOUNT
	31-42	APTC_(x12)
	43	STATE_SUBSIDY_AMOUNT
	44-55	STATE_SUBSIDY (X12)
	56	CA_Premium_Credit_Amount
	57-68	CA_Premium_Credit_(x12)
	69	NET_PREMIUM_AMOUNT
	70-81	NET_PREMIUM_(x12)
	82	CSR_AMOUNT
Application	83	ISSUER_SUBSCRIBER_ID
	84	ISSUER_MEMBER_ID
	85	ISSUER_ACTION

The file layouts have been designed to support both manual and automated approaches to carrier Action processing. Each enrollment record is presented as an ordered pair, differentiated by the Record Origin field in the first column (A). The Record Origin will denote either carrier or CalHEERS as the data source for that record. For those who manually process the file, this serves as intuitive visualization of the required action. On the other hand, those taking a technical approach can join the records to each other to support automated review.

The carrier Action field at the end of the files, column (BT), stipulates the reconcilable field that requires an update in the carrier's system of record. This will be a combination of enrollment status, benefit start date, and benefit end date. For the Financial Carrier Action file column (CG) will stipulate the reconcilable field that requires a financial update to the carrier system of record. This will be a combination of Gross Premium, APTC, State Subsidy, California Premium Credit and Net Premium.

In the example below, the carrier would be required to update the status to TERM and apply the end date of 07/31/2016.

Table 7 - Example of a carrier Action

RECORD_ORIGIN	START_DATE	END_DATE	MEMBER_STATUS	ISSUER_ACTION
ISSUER	20160301		CONFIRM	Carrier must update Status and End Date
CalHEERS	20160301	20160731	TERM	

RECORD_ORIGIN	START_DATE	END_DATE	MEMBER_STATUS	ISSUER_ACTION
ISSUER	20160301		CONFIRM	Carrier must update Status and End Date
CalHEERS	20160301	20160731	TERM	

Covered California expects that enrollment records identified for resolution will not have the discrepancy persist for longer than 3 consecutive monthly Reconciliation Cycles. If the carrier disagrees with a stipulated updated in the Carrier Action for both enrollment and financial, then Covered California expects that carrier to submit the record in question to the next Covered California's Internal Reconciliation Dispute Process. Carriers can submit a supplemental file to dispute identified discrepancies found in the Covered California enrollment reconciliation file in accordance with the defined list of fields and technical requirements.

Covered California encourage carriers to utilize Covered California's Dispute Process, prior to submitting premium tax credit disputes to the Center for Medicaid and Medicare Services or the Center for Consumer Information and Health Insurance Oversight.

9. Carrier Action Confirmation

As of 2021 benefit year, Covered California required carriers to provide evidence through email confirmation that the enrollment and financial changes identified through the Reconciliation Process have been implemented. The confirmation will be required to be submitted to Data Integrity within ten (10) business days of receiving the carrier action files. If Carriers cannot complete required changes, Carriers should provide an action plan of implementation to the Data Integrity within ten (10) business days from the carrier action files provided.

10. Exclusion Process

The exclusion process sets aside cases from Reconciliation that other business channels are actively resolving and therefore should not be subject to resolution by the processing rules engine. Exclusions include the following routine business processes: Appeal, Escalation, Informal Resolution, and Help Desk Tickets. It is important to note that through each of these processes, the expectation is that both CalHEERS and the carrier's system will end up in alignment.

The Reconciliation Process excludes cases at the end of the Reconciliation Cycle. As a result, each excluded case carries with it the appropriate validation, error, and discrepancy flags that the Recon Process assigned before the exclusion action. This ensures that sufficient monitoring capacity is in place for those cases that are excluded for a prolonged period. The proactive monitoring of excluded cohorts provides valuable insight into the accuracy of the impacted enrollment records in both CalHEERS and the carrier's system.

Appendix A: Sample Reconciliation Scenarios

The Reconciliation File includes a comprehensive snap shot of a household's enrollment. To ensure correct interpretation of the data, below are sample Reconciliation scenarios found in the file sent from Covered California to the carriers (Step 1 & 2 in Figure 3: Data Reconciliation Process Diagram):

Transaction Example 1: Reconciliation File with Multiple Transactions

Scenario:

- On 12/13/2016 a one-member household completes the initial application and plan selection (Plan ID: 55555CA038000301) for a 01/01/2017 benefit start date
- On 04/05/2017 the primary applicant adds a dependent and selects a new plan (Plan ID: 55555CA038000304)
- On 09/10/2017 the primary applicant reports a change in income that makes the household eligible for a new CSR tier. The household selects a new plan (Plan ID: 55555CA038000306).

November 2017 Reconciliation File

CASE _ID	SUBSCRIBER _ ID	MEMBER _ ID	ENROLLMENT _ ID	CREATION _ TIMESTAMP	LAST _ UPDATED _ TIMESTAMP	BENEFIT _ START _ DATE	BENEFIT _ END _DATE	MEMBER _ STATUS	PLAN _ID	GROSS _ PREMIUM _ Amount	GROSS _ PREMIUM _JAN	GROSS _ PREMIUM _FEB	GROSS _ PREMIUM _MAR
5000000001	11111	11111	13579	20161213…	20170405…	20170101	20170430	TERM	55555CA038000301	350	350	350	350
5000000001	11111	11111	43080	20170405…	20170910…	20170501	20170330	TERM	55555CA038000304	425	425	425	425
5000000001	11111	11112	43080	20170405…	20170910…	20170501	20170930	TERM	55555CA038000304	425	425	425	425
5000000001	11111	11111	102708	20170910…	20171010…	20171001	20171231	CONFIRM	55555CA038000306	300	300	300	300
5000000001	11111	11112	102708	20170910…	20171010…	20171001	20171231	CONFIRM	55555CA038000306	300	300	300	300

Continuation of November 2017 Reconciliation File

CASE _ID	APTC _ AMOUNT	APTC _ AMOUNT _JAN	APTC _ AMOUNT _FEB	APTC _ AMOUNT _MAR	NET PREMIUM _AMOUNT	NET _PREMIUM _JAN	NET _PREMIUM _FEB	NET _PREMIUM _MAR	RESIDENTIAL _ ADDR _LINE1
5000000001	100	100	100	100	250	250	250	250	123 Sunny Beach Dr.
5000000001	150	150	150	150	175	175	175	175	123 Sunny Beach Dr.
5000000001	150	150	150	150	175	175	175	175	123 Sunny Beach Dr.
5000000001	200	200	200	200	100	100	100	100	123 Sunny Beach Dr.
5000000001	200	200	200	200	100	100	100	100	123 Sunny Beach Dr.

Transaction Example 2: Reconciliation File with Maintenance Transaction (Address Change)

Scenario:

- On 12/13/2016 a two-member household completes the initial application and plan selection for a 01/01/2017 benefit start date
- On 12/15/2016 the primary applicant changes their residential address from 123 Sunny Beach Dr. to 555 Main St through the Covered California portal

October 2016 Reconciliation File

CASE _ID	SUBSCRIBER _ ID	MEMBER _ ID	ENROLLMENT _ ID	CREATION _ TIMESTAMP	LAST _ UPDATED _ TIMESTAMP	BENEFIT _ START _ DATE	BENEFIT _ END _DATE	MEMBER _ STATUS	PLAN _ID	GROSS _PREMIUM	APTC _ AMOUNT	RESIDENTIAL _ ADDR_LINE1
5000000001	11111	11111	123456	20161213	20161213	20170101	20171231	CONFIRM	55555CA038000301	500	100	123 Sunny Beach Dr.
5000000001	11111	11112	123456	20161213	20161213	20170101	20171231	CONFIRM	55555CA038000301	500	100	124 Sunny Beach Dr.

November 2016 Reconciliation File

CASE _ID	SUBSCRIBER _ ID	MEMBER _ ID	ENROLLMENT _ ID	CREATION _ TIMESTAMP	LAST _ UPDATED _ TIMESTAMP	BENEFIT _ START _ DATE	BENEFIT _ END _DATE	MEMBER _ STATUS	PLAN _ID	GROSS _PREMIUM	APTC _AMOUN	RESIDENTIAL _ ADDR _LINE1
5000000001	11111	11111	123456	20161213	20161215	20170101	20171231	CONFIRM	55555CA038000301	500	100	555 Main St
5000000001	11111	11112	123456	20161213	20161215	20170101	20171231	CONFIRM	55555CA038000301	500	100	555 Main St

Transaction Example 3: Reconciliation File with Reinstatement Transaction

Scenario:

On 12/13/2015 a two-member household completes the initial application and plan selection for a 01/01/2016 benefit start date

On 04/13/2016 the policy is terminated with an end of the month benefit end date of 05/30/2016

On 11/01/2016, as a result of an Appeal decision, the policy is reinstated into the same plan and with the initial benefit start date of 01/01/2016

October 2016 Reconciliation File

CASE _ID	SUBSCRIBER _ ID	MEMBER _ ID	ENROLLMENT _ ID	CREATION _ TIMESTAMP	LAST _ UPDATED _ TIMESTAMP	BENEFIT _ START _ DATE	BENEFIT _ END _DATE	MEMBER _ STATUS	PLAN _ID	ATPC _ AMOUNT	GROSS _ PREMIUM	RESIDENTIAL _ ADDR _LINE1
5000000001	11111	11111	222222	20141213…	20160413…	20160101	21060430	TERM	55555CA038000301	100	500	123 Sunny Beach Dr.
5000000001	11111	11112	222222	20141213…	20160413…	20160101	21060430	TERM	55555CA038000301	100	500	123 Sunny Beach Dr.

November 2016 Reconciliation File

CASE _ID	SUBSCRIBER _ ID	MEMBER _ ID	ENROLLMENT _ ID	CREATION _ TIMESTAMP	LAST _ UPDATED _ TIMESTAMP	BENEFIT _ START _ DATE	BENEFIT _ END _DATE	MEMBER _ STATUS	PLAN _ID	ATPC _ AMOUNT	GROSS _ PREMIUM	RESIDENTIAL _ ADDR _LINE1
5000000001	11111	11111	222222	20141213…	20161101…	20160101	20161231	CONFIRM	55555CA038000301	100	500	123 Sunny Beach Dr.
5000000001	11111	11112	222222	20141213…	20151101…	20160101	20161231	CONFIRM	55555CA038000301	100	500	123 Sunny Beach Dr.

Appendix B: Reconcilable Fields

The following table provides clarification on how the data returned by the carriers in the Reconciliation fields will be managed.

Matching (M) - These fields may be leveraged to match from the Reconciliation File to the carrier's database

Reconcilable (R) - These fields will be the core reconcilable fields for running the Reconciliation processing Rules (Step 10, Figure 3: Data Reconciliation Process Diagram)

Discovery Analysis (D) - These fields will be used for discovery analysis in order to determine the discrepancy frequency between Covered California and the carriers. This analysis will contribute to the prioritization of expanding the reconcilable fields in subsequent cycles.

	#	Field Header
Primary	1	RECORD_ORIGIN
	2	AUDIT_DATE
	3	CASE_ID
	4	SUBSCRIBER_ID
	5	MEMBER_ID
	6	ENROLLMENT_ID
	7	CREATION_TIMESTAMP
	8	LAST_UPDATED_TIMESTAMP
	9	PREMIUM_PAID_THROUGH_DATE
	10	PLAN_TYPE
	11	RENEWAL_FLAG
	12	RATING_AREA
Enrollment	13	BENEFIT_START_DATE
	14	BENEFIT_END_DATE
	15	MEMBER_STATUS
	16	PLAN_ID
Financial	17	GROSS_PREMIUM_AMOUNT
	18-29	GROSS_PREMIUM_(x12)
	30	APTC_AMOUNT

	31-42	APTC_(x12)
	43	STATE_SUBSIDY_AMOUNT
	44-55	STATE_SUBSIDY (X12)
	56	CA_PREMIUM_CREDIT_AMOUNT
	57-68	CA_PREMIUM_CREDIT (X12)
	69	NET_PREMIUM_AMOUNT
	70-81	NET_PREMIUM_(x12)
	82	CSR_AMOUNT
Application	83	ISSUER_SUBSCRIBER_ID
	84	ISSUER_MEMBER_ID
	85	ISSUER_ACTION

Section Two:

Data Integrity Process Guide for Internal Disputes

11. Document Purpose

A carrier can submit a dispute file to Covered California from a current or prior reconciliation period to identify root cause for the discrepancy. This Dispute Process Guide defines the expectations for submitting disputes to the Covered California Data Integrity Team.

Table 8 - Revision History

DATE	REVISION #	REVISION DESCRIPTION
04/2018	1.0	Initial version
06/2018	2.0	Updates to D2 Rule Set
09/2018	3.0	Updates to carrier dispute flags
01/2018	4.0	2019 Q1 review
05/2019	5.0	State Subsidy Update
10/2019	6.0	State Subsidy Update\ Dispute Flag updates
02/2020	7.5	Update
04/2020	8.0	No Update
07/2021	10	Update to File Layout and rules due to New policy - $0 Premium Bills.

Reconciliation disputes consist of the following:

- Enrollment Differences
- Financial Differences

The Data Integrity Unit works closely with internal Covered California operations to monitor and solution disputes that arise after Reconciliation Cycles.

Dispute Scope

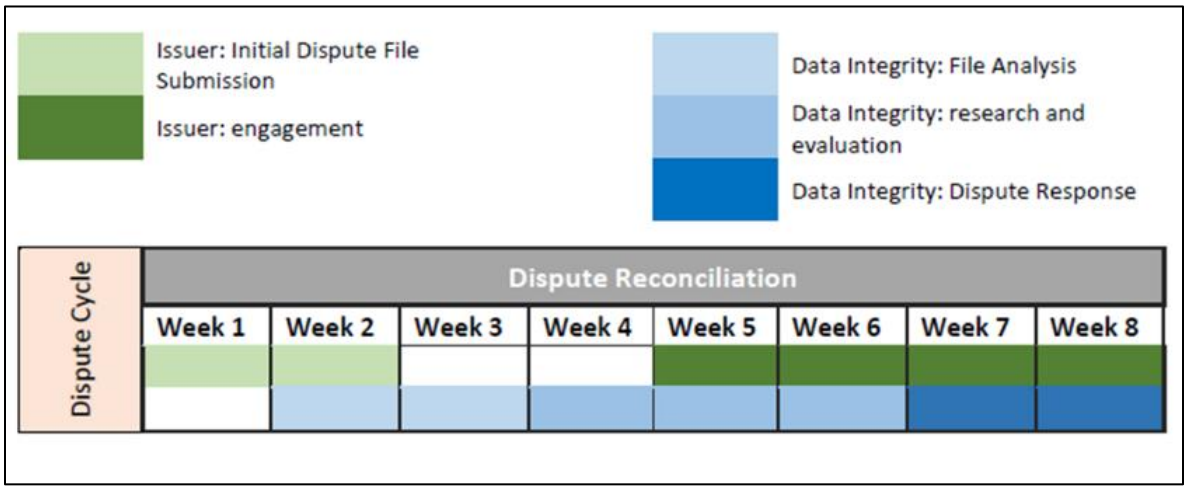
Carriers must submit all disputes by the deadline indicated in the cycle calendar and follow the standards outlined in this process guide. After receiving each carrier dispute file, Covered California will use these standards to evaluate validity.

Carriers must always dispute at a case level. When a case contains one or more disputed records, then the carrier's submission includes all enrollment segments and all members within the case for the benefit year.

The carrier may not concatenate multiple dispute flags on a single row of their dispute submission. The carrier will assign a single discrepancy flag per row in their submission. If the carrier believes more than one dispute category applies to any enrollment segment for a member, then they must submit additional rows for the same REM_ID.

Covered California evaluates each dispute file based on the corresponding Reconciliation Cycle.

Table 9 - Monthly Data Reconciliation Schedule



- Week 1: Initial Dispute File Submitted
- Week 2: D1 Validation verifies accuracy and completeness of submitted records
- Week 3: D2 Validation flags records that are non-disputable errors.
- Week 4: D3 Internal Research begins
- Week 5: D3 Internal Research continues
- Week 6: Review completed D3 Research
- Week 7: Compile and generate Final Disposition report for carriers
- Week 8: Provide Final Disposition to carriers

12. Dispute Process

This section includes a summary process flow for the Covered California and carrier Reconciliation Dispute process. Each Dispute Cycle begins with the carrier submitting a dispute file to the Data Integrity Unit. The Carrier Reconciliation & Dispute Calendar indicates the Dispute Cycle's start date (Reconciliation Anchor Date) and major milestones. During each Dispute Cycle, the Data Integrity unit will engage with carriers as needed during the research and evaluation phase to gain insight during root cause analysis.

Internal Dispute Process Narrative

The following flow chart, Process Flow for the Internal Dispute Process shows each step in any given Dispute Cycle graphically. Next, the "Process Flow Description" provides Activity Details that correspond to each of these steps in the Reconciliation process in a narrative, tabular format.

Covered California Dispute Process Flow

Figure 3 - Process Flow for the Internal Dispute Process

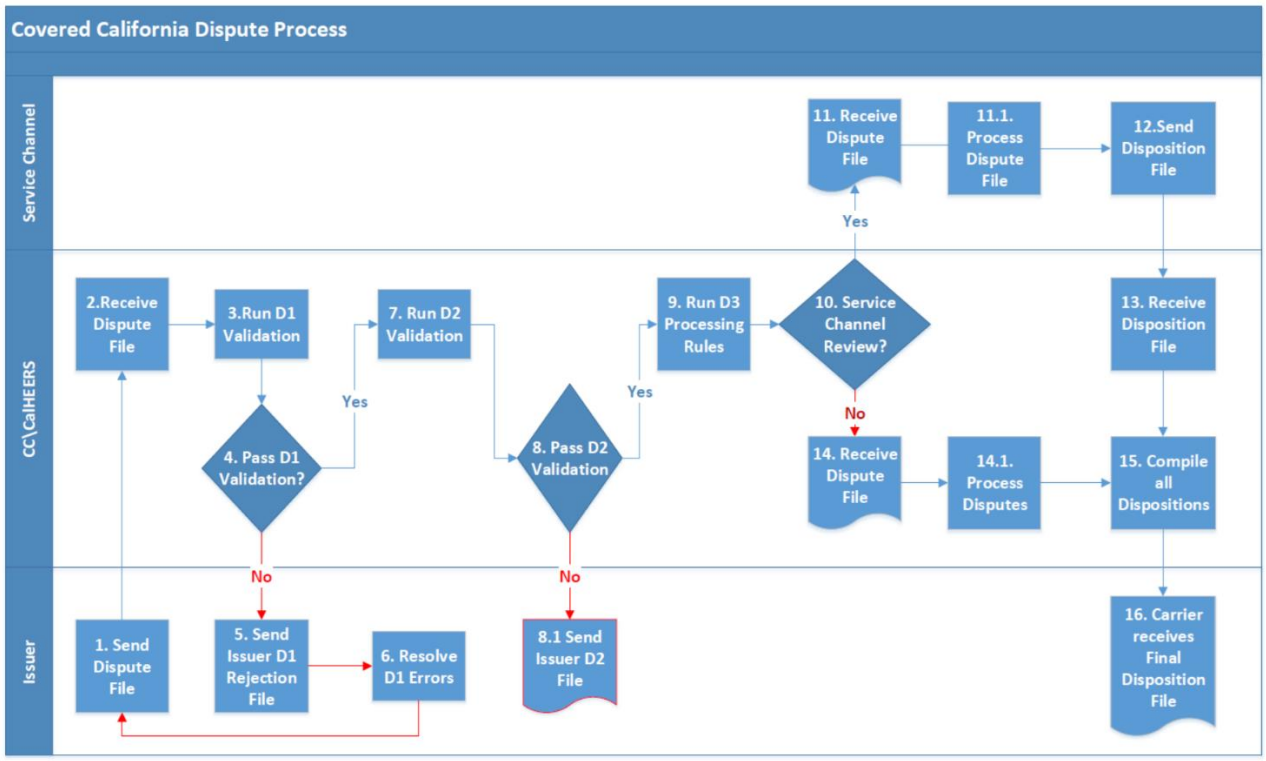


Table 10 - Process Flow Description

Ref	Activity	Actor	Activity Detail
1	Send Dispute File	Carrier	The carrier submits a Dispute file via upload to the Data Integrity area of the Plan Management Extranet site. Each Dispute Cycle addresses discrepancies for the benefit year specified in the carrier Reconciliation and Dispute Calendar. Unlike Reconciliation Cycles, the Audit Date for dispute files is the submission deadline on the Dispute Calendar. **File naming convention:** from<HIOS ID>_DISPUTE_RECON_HEALTH_<Audit Date YYYYMMDD>.<Benefit Year>.CSV.zip from<HIOS ID>_DISPUTE_RECON_DENTAL_<Audit Date YYYYMMDD>.<Benefit Year>.CSV.zip **Example:** from_55555_DISPUTE_RECON_DENTAL_<20190102>.<2018>.CSV.zip

Ref	Activity	Actor	Activity Detail
2	Receive Dispute File	CC / CalHEERS	Each Reconciliation file remains in the Extranet data library and Covered California accesses the file from there.
3	Run D1 Validation	CC / CalHEERS	Upon receipt of each Dispute File, Covered California validates for accuracy and completeness in accordance with the field requirements detailed in Section 4 Dispute File Layout Table.
4	Pass D1 Validation?	CC / CalHEERS	After Covered California completes each carrier's file level validations (D1), a PASS results in a YES pathway on the flow chart (step 7) while a NOT PASS results in a NO loop (steps 5 & 6).
5	Carrier receives D1 Rejection File	Carrier	Carriers will receive notice of D1 File Rejections through email communication
6	Resolve D1 Errors	Carrier	The carrier will review and resolve the D1 errors and resubmit the file using the same naming convention as the original submission. The process flow then repeats the D1 validation steps.
7	Run D2 Validation	CC / CalHEERS	After a carrier's submission file passes D1 Validation, Covered California performs Basic Error Validation (D2). A D2 rejection applies to any records that receives a Non-Disputable Flag. Section 5 - "D2 File Validations" delineates the eleven Basic Error (D2) rejection categories.
8	Pass D2 Validation	CC / CalHEERS	After Covered California completes each carrier's Basic Error validations (D2), a PASS results in a YES pathway on the flow chart (step 9) while a NOT PASS results in a single response (step 8.1).
8.1	Carrier receives D2 File	Carrier	Covered California will post a D2 Validation Report to the to the Data Integrity area of the Plan Management Extranet site. A single row can receive more than one Non-Disputable Flag. **File naming convention:** <HIOS ID>_D2_VALIDATION_ REPORT_<Audit Date YYYYMMDD>.<Benefit Year>.CSV.zip

Ref	Activity	Actor	Activity Detail
9	Run D3 Processing Rules	CC / CalHEERS	After a carrier's submission file passes D2 Validation, Covered California runs the Dispute Processing Rules (D3).
10	Internal Review	CC / CalHEERS	After Covered California executes the Dispute Processing Rules (D3), the process follows branches in one of two directions. If the root cause analysis requires investigation of a case management workstream, then the Data Integrity Unit routes the issue to the appropriate Covered California Service Channel (steps 11 -12). If the root cause analysis does not require this type of specialized routing, then the Data Integrity Unit proceed with the investigation (steps 14-15).
11	Routing Dispute File	Service Channel	Data Integrity refers the cases requiring Service Channel processing to the appropriate Covered California operational unit.
12	Send Disposition File	Service Channel	The Service Channels submit their disposition for assigned disputes back to the Data Integrity Unit.
13	Receive Disposition File	CC / CalHEERS	That Data Integrity unit proceeds in accordance with each Service Channel disposition
14	Receive Dispute File	CC / CalHEERS	For any dispute that does not require Service Channel research, the Data Integrity Unit proceed with the investigation, providing secondary analysis to determine the appropriate resolution.
14.1	Process Disputes	CC / CalHEERS	The Data Integrity Unit investigate their assigned disputes in detail and arrive at an authoritative disposition regarding each record
15	Compile all Dispositions	CC / CalHEERS	The dispute process consolidates Service Channel and Data Integrity Dispositions into a single report
16	Carrier receives Final	Carrier	Carriers receive the second and Final Disposition Report within the closing week of the Dispute Cycle. The naming convention for this report is as follows:

	Disposition File		<HIOS ID>_DISPUTE_DISPOSITION_RESPONSE_CYCLE<Cycle Number>_HEALTH_<Audit Date YYYYMMDD>.<Benefit Year>.CSV.zip <HIOS ID>_DISPUTE_DISPOSITION_RESPONSE_CYCLE<Cycle Number>_DENTAL_<Audit Date YYYYMMDD>.<Benefit Year>.CSV.zip

Disputable Fields

Carriers must provide all case data associated with each disputed record. The ISSUER_DISPUTE_ FLAG Column must contain a number that corresponds to the appropriate dispute type. The dispute type categorically identifies the reason the carrier has submitted this record to the Dispute process. A single row may only contain only one dispute flag. If a member has an enrollment segment with multiple issues, then the carrier provides an additional row for each issue / flag. This means that, unlike a Reconciliation file, the REM_ID (concatenation of Member_ID and Enrollment_ID) may populate more than one row. Covered California will reject any disputes submitted with a dispute flag not listed below. These allowable reason codes are 1.1, 1.2, 1.3, 2.1, 3.1, 4.1, 4.2, 5.4, 5.5, 5.6, 5.7, 5.8, 6.1, 7.1.

Table 11 - Example of carrier's dispute reason

ISSUER_SUBSCRIBER_ID	ISSUER_DISPUTE_FLAG	COMMENTS
12345	1.2	System issue caused cancellation

The following table describes possible dispute types and respective Reasons:

Table 12 – Carrier reason codes for disputes

Dispute Type	Dispute Flag (Only 1 dispute flag allowed per record)	Definition
Reinstatement - Cancel to Term	1.1	Occurs when Issuer requests coverage restoration for a member.
Reinstatement - Term to Confirm	1.2	
Reinstatement - Cancel to Confirm	1.3	
Duplicate	2.1	Occurs when Issuer indicates they have two segments of coverage with different financial amounts having Start and End Dates that match a CalHEERS enrollment

M 834	3.1	Occurs when Issuer indicates they have received different information via manual 834
834 Failure - End Date	4.1	Occurs when an Issuer indicates an 834 failure
834 Failure - Start Date	4.2	
Financial – QHP Monthly GP ≠ CH Monthly GP	5.4	Carrier Indicates a dispute in monthly APTC, monthly Gross Premium, monthly State Subsidy, monthly CA_Premium_Credit, or monthly Net Premium.
Financial – QHP Monthly APTC ≠ CH Monthly APTC	5.5	
Financial – QHP Monthly CAPS ≠ CH Monthly CAPS	5.6	
Financial – QHP Monthly Net Premium ≠ CH Monthly Net Premium	5.7	
Financial – QHP Monthly California Premium Credit ≠ CH Monthly CA Premium Credit	5.8	
Missing CalHEERS	6.1	Occurs when an Issuer indicates that a member exists in their system, but not in CalHEERS
Other - QHP = CH	7.1	QHP enrollment and financial data is equal to CalHEERS enrollment and financial data; however, Issuer indicates a request for further review.

Dispute Submission Guidance

When preparing their dispute file, the carrier must follow the parameters outlined in this guide.

Disputed cases are only those with an active enrollment for the benefit year of the Dispute Cycle.

With one exception, each row in the dispute submission must contain both an Enrollment ID and Member ID.

The exception occurs only for Dispute Flag 6.1, when a carrier indicates that a member exists in their system, but not in CalHEERS. If a dispute's Enrollment ID is associated with a benefit year that differs from the allowable dispute year, Covered California will reject the record to the carrier.

Each disputed record must contain all other correlating carrier data elements (Case ID, Subscriber ID, etc.).

Because Dispute Cycles do not have a GoBack loop, it is important to avoid any basic submission errors.

Dispute File naming convention:

When submitting a dispute use the following naming conventions

from<HIOS ID>_DISPUTE_RECON_HEALTH_<Audit Date YYYYMMDD>.<Benefit Year>.CSV.zip

from<HIOS ID>_DISPUTE_RECON_DENTAL_<Audit Date YYYYMMDD>.<Benefit Year>.CSV.zip

NOTE: Carrier's must submit a Dispute file via upload the Data Integrity area of the Plan Management Extranet site

D1 - Validations

All dispute files undergo D1 validation. During this process, Covered California assesses files for accuracy and completeness. These validations run in accordance with the field requirements detailed in the Dispute File layout (See table below).

Carrier submitted disputes that do not pass D1 technical validation cannot move forward in the dispute process. Data presentation requirements ensure that Covered California can evaluate each record successfully and consistently.

Dispute File layout

For any monthly financial values, the carrier should use **NULL** rather than "0", for months where no coverage occurs. Carriers must populate monthly financial values for every month there is coverage; including when status is *pending*.

The carrier must not leave any of the primary fields **NULL** except column 10, RENEWAL_FLAG

The carrier must not leave any Enrollment fields **NULL:**

- BENEFIT_START_DATE
- BENEFIT_END_DATE
- MEMBER_STATUS
- PLAN_ID

The carrier must not leave the following financial fields **NULL**:

- APTC_AMOUNT,
- GROSS_PREMIUM_AMOUNT,
- NET_PREMIUM_AMOUNT,
- CSR_AMOUNT
- STATE_SUBSIDY_AMOUNT

These fields should always contain the value from the 834 EDI file.

The carrier must not leave the following application fields **NULL**

- CSR_AMOUNT
- FIRST_NAME
- LAST_NAME
- BIRTH_DATE

Also, the submission must include a valid ISSUER_DISPUTE_FLAG.

Dispute File Layout & Field Descriptions

Table 13 - Technical field description for disputes

	#	Field	Description	Technical Field Description	Null Allowed
Primary	1	AUDIT_DATE	The creation date of the dispute file	Date format: YYYYMMDD	N
	2	CASE_ID	10 Digit AHBX Case ID	INT	N
	3	SUBSCRIBER_ID	CalHEERS issued	INT	N
	4	MEMBER_ID	CalHEERS issued	INT	N
	5	ENROLLMENT_ID	A key uniquely identifying a family/policy/enrollment/segment	INT	N
	6	CREATION_TIMESTAMP	The creation date of the initial enrollment	Date format: YYYYMMDDhhmmss	N
	7	LAST_UPDATED_TIMESTAMP	Date enrollment was last modified	Date format: YYYYMMDDhhmmss	N
	8	PREMIUM_PAID_THROUGH_DATE	Premium paid through date	Date format: YYYYMMDD	Y
	9	PLAN_TYPE	Health or Dental	Char(3), allowed values: HLT, DEN	N
	10	RENEWAL_FLAG	Flag indicating renewal/renewal type	Char(1) allowed values: A, M (auto/manual)	Y
	11	RATING_AREA	Rating area Code	Char(7), like 'R-CA%'	N
Enrollment	12	BENEFIT_START_DATE	Members start date for benefits for a specific enrollment segment/period. Any one member/subscriber can have multiple start dates depending on their transaction history (term/re-enroll, maintenance, etc.)	Date format: YYYYMMDD	N
	13	BENEFIT_END_DATE	Member's end date for benefits for a specific enrollment segment/period. Any one member/subscriber can have multiple start dates depending on their transaction history (term/re-enroll, maintenance, etc.).	Date format: YYYYMMDD	N
	14	MEMBER_STATUS	Enrollee level status for a specific enrollment segment/period. Any consumer can have multiple historic enrollment statuses (cancelled, terminated etc. specific to the segment/period) and a single current enrollment status.	Varchar(7) Allowed values: PENDING, CONFIRM, TERM, CANCEL	N
	15	PLAN_ID	16 Digit CMS Plan ID	Char(16)	N

	#	Field	Description	Technical Field Description	Null Allowed
Financial	16	GROSS_PREMIUM_AMOUNT	Policy level Gross Premium	Decimal(6,2)	N
	17 18 19 20 21 22 23 24 25 26 27 28	GROSS_PREMIUM_JAN GROSS_PREMIUM_FEB GROSS_PREMIUM_MAR GROSS_PREMIUM_APR GROSS_PREMIUM_MAY GROSS_PREMIUM_JUN GROSS_PREMIUM_JUL GROSS_PREMIUM_AUG GROSS_PREMIUM_SEP GROSS_PREMIUM_OCT GROSS_PREMIUM_NOV GROSS_PREMIUM_DEC	Monthly Level GROSS Premium	Decimal (6,2)	Y
	29	APTC_AMOUNT	Policy level APTC amount as designated by the consumer for a specific enrollment segment/period.	Decimal (6,2)	N
	30 31 32 33 34 35 36 37 38 39 40 41	APTC_JAN APTC_FEB APTC_MAR APTC_APR APTC_MAY APTC_JUN APTC_JUL APTC_AUG APTC_SEP APTC_OCT APTC_NOV APTC_DEC	Monthly level APTC amount as designated by the consumer for a specific enrollment segment/period.	Decimal (6,2)	Y
	42	STATE_SUBSIDY_AMOUNT	Policy level State Subsidy amount as designated by the consumer for a specific enrollment segment/period.	Decimal (6,2)	N
	43 44 45 46 47 48 49 50 51 52 53 54	STATE_SUBSIDY_JAN STATE_SUBSIDY_FEB STATE_SUBSIDY_MAR STATE_SUBSIDY_APR STATE_SUBSIDY_MAY STATE_SUBSIDY_JUN STATE_SUBSIDY_JUL STATE_SUBSIDY_AUG STATE_SUBSIDY_SEP STATE_SUBSIDY_OCT STATE_SUBSIDY_NOV STATE_SUBSIDY_DEC	Monthly level State Subsidy	Decimal (6,2)	Y

	55	CA_PREMIUM_CREDIT_AMOUNT	Policy level California Premium Credit amount as designated by the consumer for a specific enrollment segment/period.	Decimal (6,2)	N
	56 57 58 59 60 61 62 63 64 65 66 67	CA_PREMIUM_CREDIT_JAN CA_PREMIUM_CREDIT_FEB CA_PREMIUM_CREDIT_MAR CA_PREMIUM_CREDIT_APR CA_PREMIUM_CREDIT_MAY CA_PREMIUM_CREDIT_JUN CA_PREMIUM_CREDIT_JUL CA_PREMIUM_CREDIT_AUG CA_PREMIUM_CREDIT_SEP CA_PREMIUM_CREDIT_OCT CA_PREMIUM_CREDIT_NOV CA_PREMIUM_CREDIT_DEC	Monthly level California Premium Credit	Decimal (6,2)	Y
	68	NET_PREMIUM_AMOUNT	Policy level NET Premium	Decimal (6,2)	N
	69 70 71 72 73 74 75 76 77 78 79 80	NET_PREMIUM_JAN NET_PREMIUM_FEB NET_PREMIUM_MAR NET_PREMIUM_APR NET_PREMIUM_MAY NET_PREMIUM_JUN NET_PREMIUM_JUL NET_PREMIUM_AUG NET_PREMIUM_SEP NET_PREMIUM_OCT NET_PREMIUM_NOV NET_PREMIUM_DEC	Monthly level NET Premium	Decimal (6,2)	Y
Application	81	CSR_AMOUNT	Policy level CSR Amount for a specific enrollment segment/period	Decimal(6,2)	N
	82	FIRST_NAME	Member First Name	Varchar(100)	N
	83	MIDDLE_NAME	Member Middle Name	Varchar(100)	Y
	84	LAST_NAME	Member Last Name	Varchar(100)	N
	85	SSN	Social Security Number	Char(9)	Y
	86	BIRTH_DATE	Member DOB	Date format: YYYYMMDD	N
	87	ISSUER_SUBSCRIBER_ID	Carrier Assigned Subscriber Individual Key	Varchar(50)	Y
	88	ISSUER_MEMBER_ID	Carrier Assigned Individual Key	Varchar(50)	Y

	89	ISSUER_DISPUTE_FLAG	Carrier assigned dispute flag	**Varchar(5) Allowed values: 1.1, 1.2, 1.3, 2.1, 3.1, 4.1, 4.2, 5.4, 5.5, 5.6, 5.7, 5.8, 6.1, 7.1,**	N
	90	COMMENTS	Carrier Comments	Varchar(350)	Y

Carrier comments

Covered California encourages carrier comments for each record submitted for dispute. Prior to submitting a dispute, a carrier is expected to identify what and where there is a discrepancy and communicate the root cause for each dispute record. Comments add valuable context during the research and evaluation phase of the Dispute Cycle and may assist in the identification of issue root cause. During carrier and Data Integrity unit discussions in the engagement phase of the cycle, participants may also review or reference carrier comments. When providing a comment, it is critical that carriers indicate the precise type of enrollment or financial data change requested. For example, in a Financial dispute (where carrier Dispute Flag is 5.4, 5.5, 5.6, 5.7, or 5.8), if a carrier disputes an enrollment's monthly financial value, then the carrier must note exactly which month(s) are in dispute in the COMMENTS field of the dispute file.

In the example figure below, the carrier provides a clear and concise description of the change requested. This clarification is critical during active dispute research and evaluation. See figures below.

Figure 4 – Example of using carrier comments in disputes

Gross_Premium_Amount	Gross_Premium_Amount_JAN	Gross_Premium_Amount_FEB	Gross_Premium_Amount_MAR	Gross_Premium_Amount_APR	(Columns T-BO)	Issuer_Dispute_FLAG	COMMENTS
1274.28	1274.28	1274.28	984.25	984.25	XX	5.4	Gross Premium amount for April 2018 should be 984.25

APTC_Amount	APTC_Amount_JAN	APTC_Amount_FEB	APTC_Amount_MAR	APTC_Amount_APR	(Columns T-BO)	Issuer_Dispute_FLAG	COMMENTS
275.25	275.25	275.25	275.25	275.25	XX	5.5	APTC amount for March 2018 should be 275.25

13. D2- File Validations

The Following table details Non-Disputable Flags (errors) and corresponding rules that Covered California applies during D2 record level validation. Covered California may flag an individual record for more than one Non-Disputable Flag.

Table 14 - D2 error codes for disputes

Non-Disputable Flag	Rule
D2 - A1	When ISSUER_DISPUTE_FLAG = "6.1", and the MEMBER_ID and ENROLLMENT_ID submitted = CH REM ID

D2 – A2	When ISSUER_DISPUTE_FLAG is “6.1,” and ENROLLMENT_ID = NULL, and CASE_ID and MEMBER_ID submitted = CH CASE_ID and MEMBER_ID
D2 – A3	When ISSUER_DISPUTE_FLAG is 6.1, and ISSUER_ENROLLMENT_ID + MEMBER_ID submitted = CH REM ID, and CH SUBSCRIBER_ID provided by carrier is not accurate
D2-B	The Audit Date, MEMBER_ID, ENROLLMENT_ID and ISSUER_DISPUTE_FLAG concatenation must be globally unique (no duplicates)
D2-C	ISSUER_DISPUTE_FLAG value is not “1.1, 1.2, 1.3, 2.1, 3.1, 4.1, 4.2, 5.4, 5.5, 5.6, 5.7, 5.8, 6.1, or 7.1”
D2-D	When Null allowed is N, then field must contain a value
D2-E	When carrier disputed enrollment data does not match correlating enrollment value submitted in the most recent Reconciliation Cycle
D2-F	For any carrier Dispute record, the BENEFIT_START_DATE must be equal to or less than BENEFIT_END_DATE
D2-G	Carrier Dispute record BENEFIT_START_DATE and BENEFIT_END_DATE must be within allowable benefit year
D2 -H	When carrier has the enrollment’s status as CONFIRM or TERM, and PREMIUM PAID THROUGH DATE = NULL
D2- J	Carrier dispute record has a functionally invalid combination of status and benefit coverage dates. (E.g. "CANCEL" where BENEFIT_START_DATE and BENEFIT_END_DATE is not equal)

14. The Dispute Response file Layout

The table below describes the technical formatting requirements for the Dispute Response file.

Note: carriers who submit a dispute file receive Dispute Response files during week 3 and week 8 of each Dispute Cycle.

Table 15 – Layout for the Dispute Response file

Primary	1	AUDIT_DATE
	2	CASE_ID
	3	SUBSCRIBER_ID
	4	MEMBER_ID
	5	ENROLLMENT ID
	6	CREATION_TIMESTAMP
	7	LAST_UPDATED_TIMESTAMP
	8	PREMIUM_PAID_THROUGH_DATE
	9	PLAN_TYPE
	10	RENEWAL_FLAG
Enr ollm	11	RATING_AREA
	12	BENEFIT_START_DATE
	13	BENEFIT_END_DATE
	14	MEMBER_STATUS

	15	PLAN_ID
Financial	16	GROSS_PREMIUM_AMOUNT
	17-28	GROSS_PREMIUM_(X12)
	29	APTC_AMOUNT
	30-41	APTC_(X12)
	42	STATE_SUBSIDY_AMOUNT
	43-54	STATE_SUBSIDY_(X12)
	55	CA_PREMIUM_CREDIT_AMOUNT
	56-67	CA_PREMIUM_CREDIT_(X12)
	68	NET_PREMIUM_AMOUNT
	69-80	NET_PREMIUM_(X12)
Application	81	FIRST_NAME
	82	MIDDLE_NAME
	83	LAST_NAME
	84	BIRTH_DATE
	85	ISSUER_SUBSCRIBER_ID
	86	ISSUER_MEMBER_ID
	87	ISSUER_DISPUTE_FLAG
	88	NON_DISPUTABLE_FLAG
	89	STATUS

The Dispute Response file provides carriers with an initial status update for each dispute submitted that contains a D2 error. Covered California flags any record that does not pass D2 validation according to the *applicable D2 error* and returns the findings to the respective carrier via the Dispute Response file. The carrier may correct records returned to them and resubmit for evaluation at the beginning of a subsequent Dispute Cycle. Thus, it is paramount that carriers scrutinize disputes meticulously for accuracy and consistency prior to submission.

Covered California may also return Dispute records to the carrier if the dispute is determined invalid. Invalid disputes are those that conflict with the Covered California member's eligibility. Covered California flags these disputes in the Dispute Response file under the "STATUS" column accordingly.

Disputable Records

Disputable records are those that pass all D1 and D2 validations and do not conflict with member eligibility requirements. The Data Integrity unit categorizes these records and distributes them internally within Covered California to identify issue root cause. During the research phase of the Dispute Cycle, the Data Integrity unit tracks the current working status of the dispute record.

Dispute Status

Each dispute returned in the Dispute Response file includes a single status in the "STATUS" column. A dispute's status provides carriers with visibility into where a dispute record falls within Covered California research and resolution channels. When Covered California returns a dispute via reporting to the carrier with an "In Progress" Status, this means that the dispute is still in research. Covered California provides status updates for these disputes in subsequent carrier reporting.

Note: If a dispute is still in an "In Progress" status at the close of a Dispute Cycle, the respective carrier will see the same dispute appear in reporting for the next Dispute Cycle - even if the carrier has not submitted the dispute again in the following cycle.

For records that fail D2 validation, the "STATUS" column also contains the associated D2 Error. Below is a table that describes each Status designations that carriers should expect to see in the STATUS column:

Table 16 - Dispute Disposition categories

Status	Definition
IN PROGRESS	The Data Integrity unit has assigned the dispute record to a Covered California research channel
CLOSED CH = ISSUER	Covered California has researched the dispute record, identified root cause, and applied final updates. In this status, the CalHEERS and carrier enrollment elements match.
CLOSED CH <> ISSUER	Covered California has researched the dispute record, identified root cause, and applied final updates. In this status, the CalHEERS and carrier enrollment elements do not match.
CLOSED CH <> ISSUER_CCA POLICY	Covered California has researched the dispute record, identified root cause, and applied final updates. In this status, the CalHEERS and carrier enrollment elements do not match because of a conflict with Covered California Policy requirements.
INVALID – ELIGIBILITY	The dispute conflicts with the consumer's eligibility
INVALID – PERSISTENT	Covered California closed the dispute (CLOSED CH = ISSUER, CLOSED CH <> ISSUER, **or** CLOSED CH <> ISSUER_CCA POLICY) in a previous Dispute Cycle.
D2 – X	The dispute record did not pass D2 validation. The STATUS column shows the dispute record's D2 Error.

15. Dispute Disposition Report

At the end of each Dispute Cycle, carriers receive a Dispute Disposition Report. The Dispute Disposition Report includes the most recent status disposition (as defined in the table above) for each valid dispute submitted during the Dispute Cycle and identifies where the dispute resides within Covered California's research and resolution path. Covered California will not evaluate Disputes with a *Closed* or *Invalid* type status in subsequent Dispute Cycles. Covered California returns records with these dispositions to the carrier without further evaluation.

The table below details each field in the Dispute Disposition Report:

Table 17 - Layout for the Dispute Disposition Report

	#	Field Header
Primary	1	AUDIT_DATE
	2	CASE_ID
	3	SUBSCRIBER_ID
	4	MEMBER_ID
	5	ENROLLMENT_ID
	6	CREATION_TIMESTAMP
	7	LAST_UPDATED_TIMESTAMP
	8	PREMIUM_PAID_THROUGH_DATE
	9	PLAN_TYPE
	10	RENEWAL_FLAG
	11	RATING_AREA
Enrollment	12	BENEFIT_START_DATE
	13	BENEFIT_END_DATE
	14	MEMBER_STATUS
	15	PLAN_ID
Financial	16	GROSS_PREMIUM_AMOUNT
	17-28	GROSS_PREMIUM_(x12)
	29	APTC_AMOUNT
	30-41	APTC_(x12)
	42	STATE_SUBSIDY_AMOUNT
	43-54	STATE_SUBSIDY (X12)
	55	CA_PREMIUM_CREDIT_AMOUNT
	56-67	CA_PREMIUM_CREDIT (X12)
	68	NET_PREMIUM_AMOUNT
	69-80	NET_PREMIUM_(x12)
	81	CSR_AMOUNT
Application	82	FIRST_NAME
	83	MIDDLE_NAME
	84	LAST_NAME
	85	BIRTH_DATE
	86	ISSUER_SUBSCRIBER_ID
	87	ISSUER_MEMBER_ID
	88	ISSUER_DISPUTE_FLAG
	89	DISPUTE_DISPOSITION_FLAG
	90	**COMMENTS**

Dispute Disposition Report File naming convention:

Carriers receive the first Dispute Cycle report within the first 3-4 weeks of the Dispute Cycle.

The naming convention for this report is as follows:
<HIOS ID>_DISPUTE_RESPONSE_HEALTH_<Audit Date YYYYMMDD>.<Benefit Year>.CSV.zip

<HIOS ID>_DISPUTE_RESPONSE_DENTAL_<Audit Date YYYYMMDD>.<Benefit Year>.CSV.zip

Carriers receive the second and final Dispute Cycle report within the closing week of the Dispute Cycle. The naming convention for this report is as follows:

<HIOS ID>_DISPUTE_DISPOSITION_RESPONSE_CYCLE<Cycle Number>_HEALTH_<Audit Date YYYYMMDD>.<Benefit Year>.CSV.zip

<HIOS ID>_DISPUTE_DISPOSITION_RESPONSE_CYCLE<Cycle Number>_DENTAL_<Audit Date YYYYMMDD>.<Benefit Year>.CSV.zip