Vignette II

The "C, F, and J" thing

In some circumstances, a person is covered by more than one health insurance plan. For instance, children may be covered under the plans of both parents. Similarly, retired workers may be eligible for Medicare,[1] but may still be on the plan of their former employer. If each plan paid the usual 80% of medical expenses for a given service, a patient would receive benefits in excess of the actual bills. But U.S. insurance companies that provide group coverage have signed a nationwide agreement to coordinate the benefits received under multiple coverages. Coordination of benefits (COB) is a fairly common task. In the most common case, the primary carrier covers the first 80%, and then the secondary carrier takes care of the remaining 20%. But coordination clauses can become rather complicated, sometimes leaving both customers and processors confused.

Especially confusing was a new plan for retired employees covered by both Alinsu, through their former employer, and Medicare. This plan is known as coordination of benefit "by reduction" because Alinsu reduces its liability by the amount of Medicare payments. In other words, rather than filling the gap between Medicare payments and the actual bills, as in regular coordination, Alinsu merely fills the gap between Medicare's coverage and its own. So if a treatment is covered by Medicare at 70% and by Alinsu at 80%, Alinsu pays only 10%. If Medicare coverage is equal to or higher than its own, Alinsu pays nothing.

What makes this situation difficult is that Alinsu compares the two coverages, not on a case-by-case basis, but as aggregates for the patient over an entire year. Because earlier claims can influence later claims, the calculation of benefits often appears random. A kind of bill that usually results in a payment can suddenly receive no payment and equally suddenly result in a payment again, depending on what else has happened in between. Customers are usually bewildered and often infuriated by this appearance of randomness.

Benefit Reduction Worksheet

A.	Agg Prev Alinsu Benefit	$	_____	(C Prev. Stmnt.)
B.	Al Ben Current Claim	+	_____	
C.	Tot Al Agg Benefit	=	_____	
D.	Agg Prev Medicare Benefit		_____	(F Prev. Stmnt.)
E.	Medicare Ben Current Claim	+	_____	
F.	Total Medicare Agg Ben		_____	
G.	Al Total Liability (C - F)		_____	
H.	Al Prev Payments	-	_____	(J Prev. Stmnt.)
I.	Ben Now Due (enter 0 if negative figure results)	=	_____	
J.	Total Al Paymnts Released (H + I)	$	_____	

**C, F, J must be noted in claimant file for future calculations.

Figure 0.4. The COB worksheet.

To calculate these benefits, claims processors used the worksheet shown in Figure 0.4. The COB worksheet, as I will call this form here, was briefly introduced to claims processors in the training class. The instructor did not attempt a detailed explanation of the concept of coordination, nor did the trainees ask for one. After a brief introduction, the training quickly focused on the use of the worksheet. Ignoring the content of the labels of each line, the class performed the operations line by line with a few sets of fictitious numbers. The instructor showed the class where to find the values to be entered on the various lines of the worksheet and where to store the results of lines C, F, and J. After a few exercises, no one had any trouble getting the correct answers.

The introduction of the training class, however, was not the real thing. The fictitious numbers they used did not require a commitment to the answers. It was "on the floor" that the real learning was to take place. There, the coordination of benefits caused problems. Processors did not like the procedure. Though they were able to perform the calculations of the procedure correctly by simply following the instruc-

tions on the worksheet, they were usually surprised by the results they obtained:

> It works both ways to where ninety-nine percent of the time they get no benefit. It's a lot of work for nothing. You see, I am so confused on this, and I have to pay these claims.

Because of their inability to ascertain the reasonableness of their results, the less experienced processors usually asked someone for help whenever they had to do such a calculation. They all knew what to do, but they needed the confirmation of someone with experience. And yet even the person who often helped them, a very experienced and knowledgeable old-timer, was not sure herself why certain results were reasonable. Because she had seen enough of those claims go through quality review successfully, she had gathered enough confidence in the calculation as prescribed to trust that whatever numbers she arrived at were somehow correct. However, just why these numbers were correct and why they were reasonable remained obscure to her.

If all claims processors had to do was calculate benefits to be paid, the coordination of benefits by reduction would have just become yet another activity whose broader meanings were outside of their purview. Many of these COB calculations, however, resulted in phone calls from customers who could not understand the brief message that explained why their claims were denied:

> THIS ADJUSTMENT REDUCES OUR BENEFITS BY PAYMENT MADE BY MEDICARE IN ACCORDANCE WITH THE PROVISION OF THE GROUP PLAN.

Claims processors expected those calls: "You know this is gonna get you a phone call, you just know it. It never fails." Furthermore these phone calls were known to be difficult: "And anger, a lot of anger. I don't blame them for being angry."

Not only were customers usually upset at receiving benefits in a seemingly random fashion, but the processors also felt ill-equipped to explain how benefits were calculated:

> I know my car runs, but I could not tell you how. And that's not good enough when people call and want to know about their money! But it's embarrassing when you call and you say, "Well, I don't know how, but that's how much money you got. Sorry." I mean, it's embarrassing not to have the information.

Even in the meeting that was eventually called to address the problem, the presentation did not engage claims processors with the underlying insurance concepts and with the kind of information that would

enable them to talk with customers. They were repeatedly told to explain to callers that benefits were calculated as aggregates in order to ensure "fairness." Now, it is a true and relevant piece of information that some of the confusion is due to the aggregate character of the calculation. The meeting, however, focused on the definition of the term *aggregate* as a term. Through it all, the notion of aggregate remained an abstract one and fairness but a vague ideal. These terms and the daily activity of using the worksheet remained disjoint. There was no discussion of what aggregates did in this case, of what kind of "fairness" they created, or of how precisely the procedure of the worksheet implemented the principle. Neither was there any discussion of what the customers' issues were, of the types of questions they asked, or of the kinds of explanation they expected. Claims processors I spoke to did not find that the meeting had helped them very much.

ETIENNE So what do you understand about it?

SHEILA I understand it. I just don't know how to explain it to a caller. I know how to do it on the computer, everything just fine. And I can do, you know, when it's not "C, F, and J," I can explain that just fine. But when it comes to "C, F, and J," it's like you said in the meeting, you can't tell them "I subtracted this line from this line," you can't do that. And I don't know what to tell [them], that's the only thing.

ETIENNE So you really don't understand the meaning of what Alinsu is trying to do there?

SHEILA Not really.

ETIENNE Not really? And the meeting that [the unit] had [with an instructor] did not help?

SHEILA No, because she did not tell us why we were doing it, she just told us "this is how you do it." And I don't really think she told us why.

MAUREEN She never went into it, just that it was an aggregate thing for the whole year. So I guess that's all you need to know: there is an aggregate.

The jargon of the office had come to reflect the processors' own "line-by-line" relation to the coordination of benefits by reduction. Instead of referring to it by its official name, they just called it "the C, F, and J thing."

Coda 0

Understanding

As a nickname for the COB worksheet, the claims processors' expression "the C, F, and J thing" is quite telling. It names the activity not by reference to the insurance concepts it implements but by reference to lines in the worksheet. Indeed, the location of the data and the calculation are prescribed in terms of lines within the worksheet itself, to the point where knowing what to do next does not require any interpretation of the worksheet's underlying purpose. If one assumes that the worksheet has been designed correctly, then one need not take any responsibility for the outcome of the calculation and its implementation of actual contractual relations. The worksheet was specifically designed with this assumption in mind. Instead of giving claims processors the capacity to figure out how to do the calculation, the designers of the worksheet decided to prescribe exactly how to do it, step by step. The form removed from the execution of the procedure the need to assume responsibility for its meaning.

This kind of form is very common, not only in claims processing but in all kinds of activities. Many people who fill out U.S. tax returns, for instance, would be hard-pressed to explain the exact meanings of some of the calculations involved in the various forms, tables, and worksheets, as intended by those who designed them. Still, the line-by-line instructions are clear enough that taxpayers can comply, whether or not they would themselves be able to come up with the calculation process or the information requested. Compliance does not require understanding.

Yet, the question of whether Ariel and her colleagues understood the COB worksheet does not have a single answer. For each way in which the worksheet can be argued to be transparent, one can find a way in which it can be argued to be opaque.

- In procedural terms, claims processors all agreed that the worksheet was, as they called it, "self-explanatory." To them, what to do was clear enough. The worksheet was transparent.

- In other ways, however, the worksheet provided claims processors with little sense of what Alinsu was trying to do with this procedure. The very technique by which computational steps were made transparent also rendered invisible the reasons that the calculation was the way it was: institutional systems and legal contracts, insurance concepts and economic issues, definitions of fairness and employment relations. With respect to these issues, the worksheet was not transparent at all.[1]
- Explanations provided to claims processors were neither sufficient nor clear enough to give them some grasp on these issues. In fact, beyond a unit meeting and the showing of a video that promoted courtesy in customer relations, there was no major action undertaken to make information more readily available. In the end, the whole COB incident was never resolved. It merely dissolved into the broader experience of marginalization that characterized the processors' relations to the business of the company. They would have preferred to know what the procedure was about, but the benefit of going out of their way to do so was not evident. The phone calls were uncomfortable and embarrassing moments, but they were not too frequent. Instead of spending their energy worrying about the issue, claims processors put their effort into creating a work atmosphere in which that bit of ignorance would not be a liability. In this silent achievement of a local definition of competence, I would say that claims processors understood the worksheet, its introduction in the training class, and its use in the office rather well. They understood what it was telling them about their position within the corporation and the expectations invested in their relations to their work. In this sense, the worksheet was rather transparent, after all.

As an occupation, medical claims processing at Alinsu is very much focused on procedures, on how to follow them, and on how to use such artifacts as forms, worksheets, computer screens, and manuals. This focus starts during training and continues as trainees join their units. What claims processors learn cannot easily be categorized into discrete skills and pieces of information that are useful or harmful, functional or dysfunctional. Learning their jobs, they also learn how much they are to make sense of what they do or encounter. They learn how not to learn and how to live with the ignorance they deem appropriate. They learn to keep their shoulders bent and their fingers busy, to follow the rules and to ignore the rules. They learn how to engage and disengage, accept and resist, as well as how to keep a sense of themselves in spite

of the status of their occupation. They learn to weave together their work and their private lives. They learn how to find little joys and how to deal with being depressed. What they learn and don't learn makes sense only as part of an identity, which is as big as the world and as small as their computer screens, and which subsumes the skills they acquire and gives them meaning. They *become* claims processors.

Words like "understanding" require some caution because they can easily reflect an implicit assumption that there is some universal standard of the knowable. In the abstract, anything can be known, and the rest is ignorance. But in a complex world in which we must find a livable identity, ignorance is never simply ignorance, and knowing is not just a matter of information. In practice, understanding is always straddling the known and the unknown in a subtle dance of the self. It is a delicate balance. Whoever we are, understanding in practice is the art of choosing what to know and what to ignore in order to proceed with our lives.