C-Care

by Archer Crosley, MD

What Can Work?

What can work is when individual doctors, providers, hospitals and other providers say to the patient: "I will cover all your healthcare needs that I can provide at my establishment for so many dollars per month. I only require a copay for each visit that I may waive at my discretion in order to modulate patient flow." A scheme need not be any more complicated than that. Such an arrangement can be made on one piece of paper, and each class of provider can provide his or her own agreement. There is no reason why specialists can not group together to provide a specialist package for so many dollars per month. Hospitals, therapy companies, DME companies can do likewise. No coordination of different providers is necessary as each patient can easily write seven or eight checks each month just as they do for gas, power, and trash collection for their homes. If the patient wants to leave the arrangement they only need not pay their bill.

What is C-Care?

C-Care is the alternative to government-run healthcare. C-Care unbinds the government ropes that tie you up in knots. It exists to keep healthcare sane.

To finance healthcare for all, taxpayers may pay for policies who can not afford them and receive a tax credit for doing so.

Under C-Care, all conditions are covered and there are no deductibles which impede access to healthcare. To keep costs under control the individual is empowered to make a reasonable copay on ALL healthcare expenditures. For the poor a copay fund is established from which co-pays are subtracted, the remainder going to the patient at year's end.

The copay, however, is at the discretion of the provider. Each provider can opt to charge or not charge at any time, without penalty, a copay in order to modulate flow.

Fee for service no longer exists under C-Care as all providers are paid on availability to that patient which means that each provider receives a monthly fee based upon the patient's election. If a patient decides to leave that provider, the provider will no longer receive a monthly fee for that patient. The patient or provider may terminate the contractual relationship at any time.

Patients may pay providers individually or they may pay through their company. The payment is made after the period of provider availability has expired, and there is no warranty or guarantee of future services. It matters not that the patient visited the provider during the time period as providers are being paid for availability, not for services rendered.

Companies or patients will make checks payable to the following entities: primary provider, specialty group, hospital, dme, pharmacy, lab, therapy. As need be, each provider may have to select a resource provider as a backup for extraordinary expenses - payable in a similar scheme. All provider classes are reimbursed every month whether the patient is seen or not. It will no longer be necessary for the provider to engage in complex coding, nor will it be necessary to code in a diagnosis. Those codes were worthless anyway as providers were entering codes that paid not those that told the truth.

C-Care will yield the biggest bang for the buck because patients will have full access to care, yet they will be in command of who their provider will be. Because providers are paid a *more* fixed amount, tests and procedures in the office will be performed more wisely. Companies wishing to sell machines, tests and supplies to providers will have to be more realistic in their prices.

The cost of drugs will lower as pharmacists become more selective in which medicines to stock. Hospitals likewise will become better at delivering higher quality care for a cheaper price. Therapy companies will become better at educating patients into doing much of their therapy at home.

Under C-Care, the government enjoys no blank-check rights to view any patient's medical information without specific, written permission, as there is no need to do so for payment. Under C-Care, doctors are free to pursue their own method of record-keeping as customized record-keeping is integral to the well-functioning of each provider and patient. Under C-Care providers are free to transmit pertinent medical information to each other minus government-mandated gobbledygook thus ensuring more effective communication.

Finally, under C-Care, no central repository of medical information is warranted. This is bad news for the control freaks, elitists, tyrants, megadata deviants who derive sexual thrills at viewing large amounts of useless data, and the immoral genetic engineers at Los Alamos who had hoped to use this massive collated data against the people of the United States of America should they decide to step out of line.

Of course, big business will attempt to destroy this model as their misguided ambition is to grow as big as a cancer cell. Large companies, and their clueless, unenlightened leaders don't know why they want to be cancer cells; they just do. So, to combat this, the people will have to insist that a company, any company, for the health of the body can only grow so big.

With a greater number of medium-sized companies competing against each other, innovation will flourish as costs are driven down. This makes sense to most people. Of course, if you attended an elite business school which specializes in reverse-engineering people from bright to stupid, this plan will be lost on you.

C-Care In A Nutshell

- Credits
- Copays
- Code-less
- Confidential and
- Courage to be Capital-Free

Credits

Everyone covered though matching tax credits.

Copays

Waive-able copays only. No deductibles.

Code-less

No codes. Providers submit nothing to an insurance company who enjoy no right to know anything about your medical history.

Confidential

Private medical records that no megadata deviant may ever be entitled to see without express, non carte-blanc, permission.

Courage to be Capital-free

Pharmaceuticals and DME insured under their own plan until Congress musters the guts to treat pharmacy as labor, not capital.

What Does Capital-Free Mean?

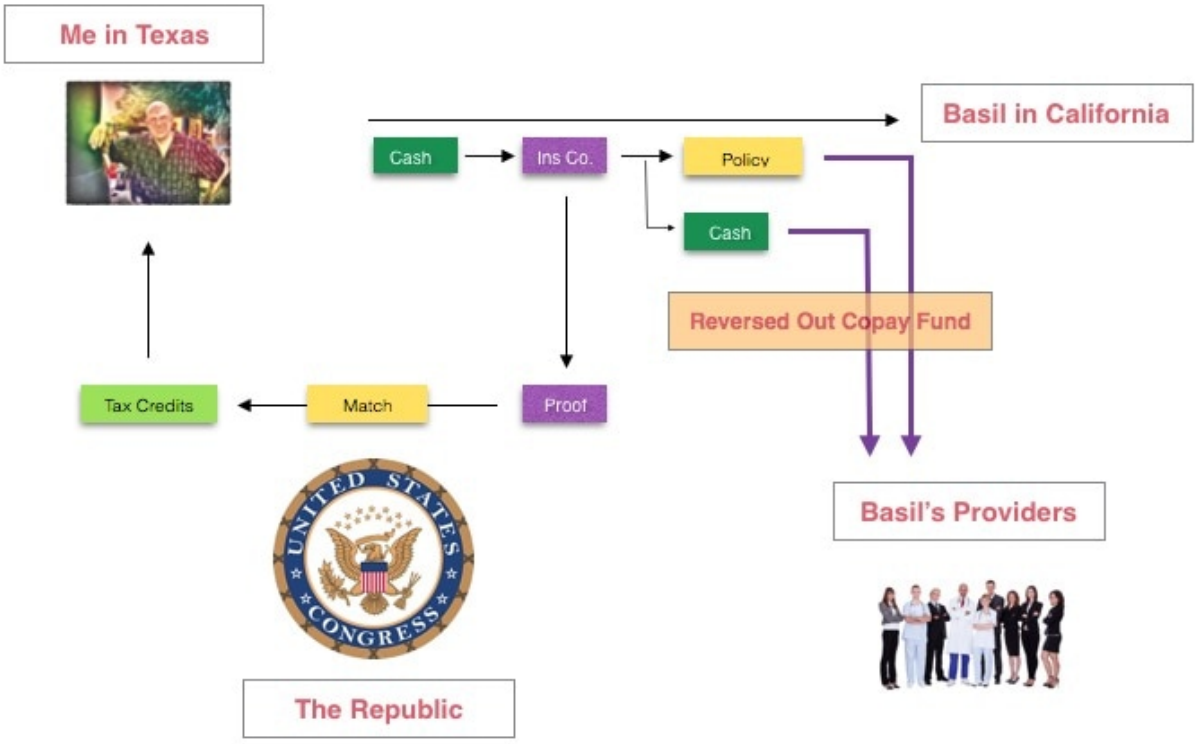
What is driving up healthcare costs is the cost of pharmaceuticals. The costs of pharmaceuticals is being driven up largely because of US patent law, Wall Street, our insurance vehicles, people's expectations that medicines should be covered, and the insatiable greed of many CEOs who feel that their Wharton degree entitles them to become billionaires.

Pharmacy is currently treated as capital rather than labor. By this I mean that everyone else in healthcare is expected to take a haircut or a cutback because they represent labor. And people think, rightly so, that healthcare workers should not gouge the system. Yet the pharmaceutical industry is not viewed as labor, although it is. The pharmaceutical industry hides behind the inanimate nature of the drug as if to say: It's the drug's fault, not our fault. Yet, drugs do not grow on trees; nor are they pulled out of the ground. Pharmaceuticals are made by the labor of man.

Why should pharmaceutical companies not have to contribute their fair share in cutting healthcare costs? They should. Yet if they do, this will cut into their bottom line; and rich shareholders will lose money as the stock price dives downward. Too fucking bad. The pharmaceutical companies have to pay their fair share.

Until they do, though, we will need to isolate pharmacy from the rest of us in healthcare. Providers, hospitals and other healthcare workers should not have to subsidize the pharmaceutical industry by taking cutbacks. Americans need to know and feel who is driving up the cost. Separating pharmaceuticals - not pharmacists who can be reimbursed as other providers - will put the spotlight on the pharmaceutical industry. This alone will help to put pressure on Big Pharma and our Congress to reform patent law and the very nature of the pharmaceutical industry into a utility of sorts where Wall Street titans can not reap huge monetary gain.

Matching Tax Credits to Cover Everyone



Everybody is Covered Overnight.

A Computer Matches up Givers and Receivers

Won't Tax Credits Encourage People to Buy Expensive Policies?

Maybe not.

To prevent this possibility we can stipulate that only 90% of a policy is tax credited in order to ensure that providers keep premiums low. Or we could say that the entry fee to obtain any policy is equal to a multiple of the monthly premium. For example, let's say one provider has a monthly fee of $75 per month. The entry fee might be a multiple of three times the monthly fee or $225 dollars. There are any number of schemes we can develop to prevent providers from concocting outrageous premiums. And we can place all this data on a computer and play around with the parameters to see which combination of incentives gives the best bang for the buck.

Okay, but what about the matching policy for the poor who can't afford the entry fee or the 10% remainder? We can waive that remainder because the important function of limiting providers from concocting outrageous premiums has been achieved. The matched policy will be linked equivalently to the purchased policy.

Who Constructs the Policy?

The policy is constructed from the bottom up. Various providers - doctors, hospitals, pharmacists -set their monthly coverage fee and copay for availability and service provided. These are presented as choices to the patient. The patient selects from the buffet and then pays the monthly premium.

Who will set up the buffet? Well, it could be a traditional insurance company. Or it could be any new type of packager. It could be an individual entrepreneur.

Who Will Pay For The Policy?

It could be an individual, a company on behalf of an individual or an individual on behalf of another individual.

How Will A Company Justify Paying Different Amounts For Different Workers?

The company, if it is paying the bill, doesn't have to justify anything. But it can always offer an equal amount for each employee, the difference being covered by the employee. It won't matter anyway because the amount is tax credited. So who cares?

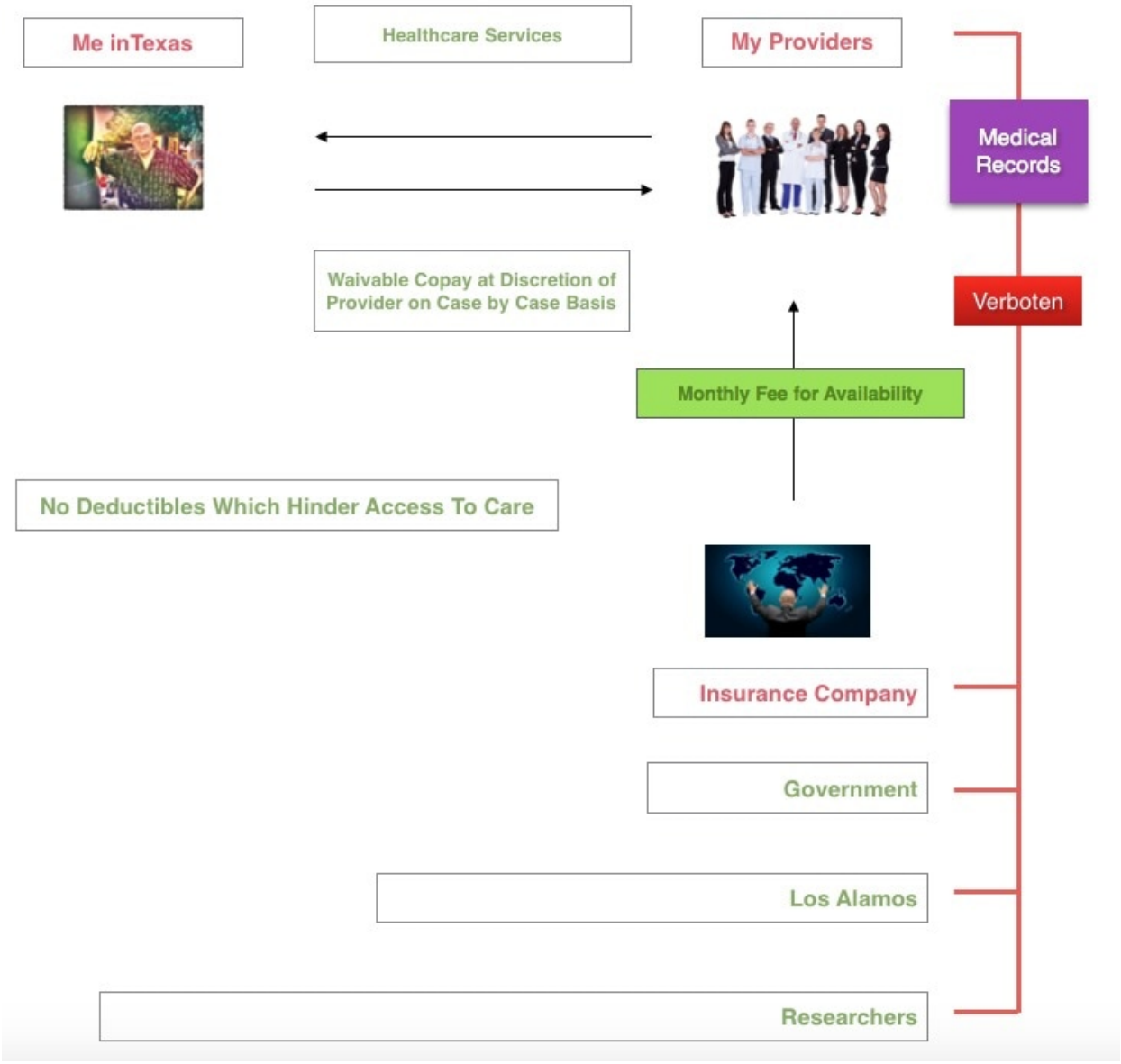
Why Reversed-Out Copay Funds?

The reversed out co-pay fund is for those indigent who don't even have the money for co-pays. I also think it's wise so that we don't have to listen to liberals scream about the little people. It falls on deaf ears to explain to liberals that the whole point of any policy let alone government is to not have little people at all. Unfortunately, America has been beaten down into thinking that little people are something we should have a lot of.

After the Trump victory, I asked my Mom if she had watched the inauguration. Of course, I already knew she hadn't watched much of it because she hates Trump. Well, there must have been hours and hours of this inauguration. Surely she would have gotten something positive out of it, I thought. No. She went on and on about some stupid fucking bracelet that Trump's daughter wore. Apparently this bracelet must have been worth a lot of money. After my mom had finished ranting, I said to her, "So what, Mom. Who cares about a stupid bracelet?" And my mom screeches back over the phone at me: Well, what about the little people?

Since no rational discussion is possible with a liberal, any plan that includes tax credits and matching tax credits must include a reversed-out copay fund. We just need to shut these people up.

Copay Scheme



Why is the Copay Necessary?

The copay is necessary to give motivation to the provider. If the provider does not receive a reasonable copay, that provider will get lazy as he or she has already received the monthly fee. The copay also allows the provider to modulate patient volume. If volume is low, the provider can waive the copay totally at his or her discretion on an individual basis without penalty. If the volume is high, the provider can keep the copay to lessen volume if he or she is getting overwhelmed. Naturally, the provider can not jack up the copay without proper notice.

Isn't a Waivable Copay on a Case by Case Basis Discriminatory?

The provider still has to follow the laws of the United States government. If the provider discriminates based upon race or gender, he or she still has to face the consequences. But it is certainly acceptable for a provider to waive a copay for those who might be financially hurting.

Are there Deductibles?

No. Deductibles hinder access to healthcare and as such are asinine. Plus patients do not understand or do not want to understand deductibles. They wonder why they are paying when they have already paid.

What Are Reversed Out Copay Funds?

Reversed out copay funds are copay funds for the poor from which money is extracted to make copays. The remainder at the end of the year they get to keep.

Why is C-Care Codeless?

Codes invite never-ending complexity. One code invites two codes which invites four codes and so on. Plus, codes give the illusion of precision in healthcare - an imprecise field if ever there was one. By getting rid of the codes, we save much headache for the provider as many diseases don't fit neatly into a coded category.

Some may argue that a provider should get more money for spending more time with the patient. Well, that is what the monthly premium covers. The copay does not exist to punish patients but to give them a measure of accountability for their own health. In the long run things even out and the provider will spend a short amount of time for some patients and a longer amount of time with others.

Why Are Insurance Company's Not Given Information?

Because they are not entitled to know anything about your health. This goes to the heart of our society - public versus private. C-Care states that a healthy society must ensure privacy of the patient's health and medical information. Once the government knows your health and its weak points, they own you lock, stock and barrel.

What About Big Data?

Big data and megadata deviants can crawl up your driveway and beg you for it. Trust me, we don't need these people; they need us.
Is C-Care Insurance?
Yes, but not really. C-Care is a pay as you go for availability plus service. There is no sequestering money for future needs. A patient may leave at any time within one month's notice. A provider is not obligated to provide any service in the future as C-Care covers past availability and service.

By accepting a monthly premium each individual provider is essentially insuring his or her own practice.

What is the Underlying Philosophy Behind C-Care?

The philosophy behind C-Care is that we should look at the motivations behind patients and providers as the principal guide to developing and implementing policies that are global, elegant, practical, workable and as headache-free as possible.

Will C-Care Work?

Let's hope so. I tried to model this plan based upon people's motivations.

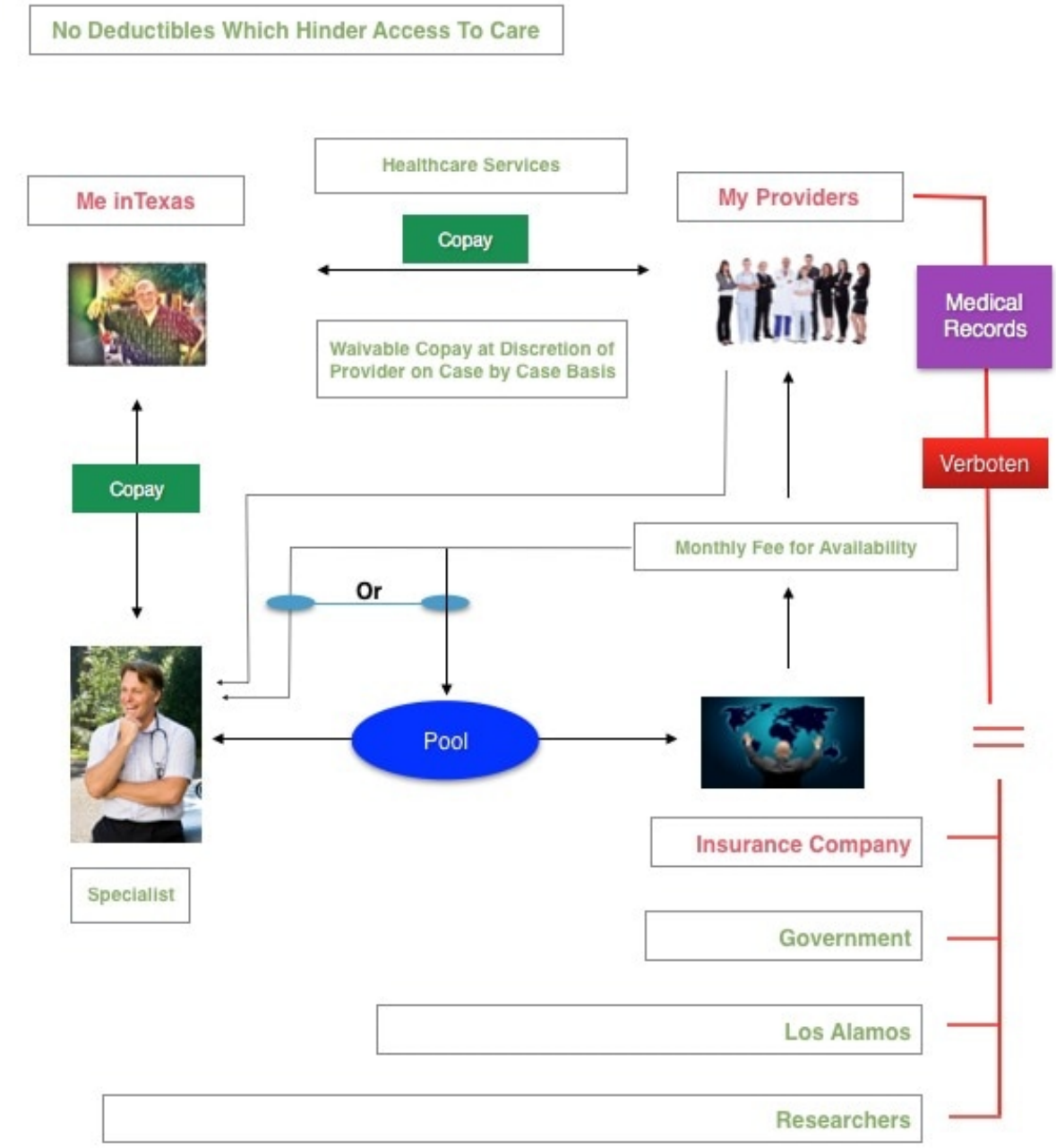
How are Primary Care Providers Paid?

Primary care providers are paid on a monthly basis depending upon he patient's selection of that provider. So if I, Archer Crosley, am selected by 1,000 patients at a rate of $50 per month, I will receive $50,000 per month. Plus I may charge a copay waive-able at my discretion. I may choose to waive the copay for poor patients. I may choose to waive the copay if my patient volume is low. I can choose to waive the copay on one patient and keep the copay on another.

How are Specialists Paid?

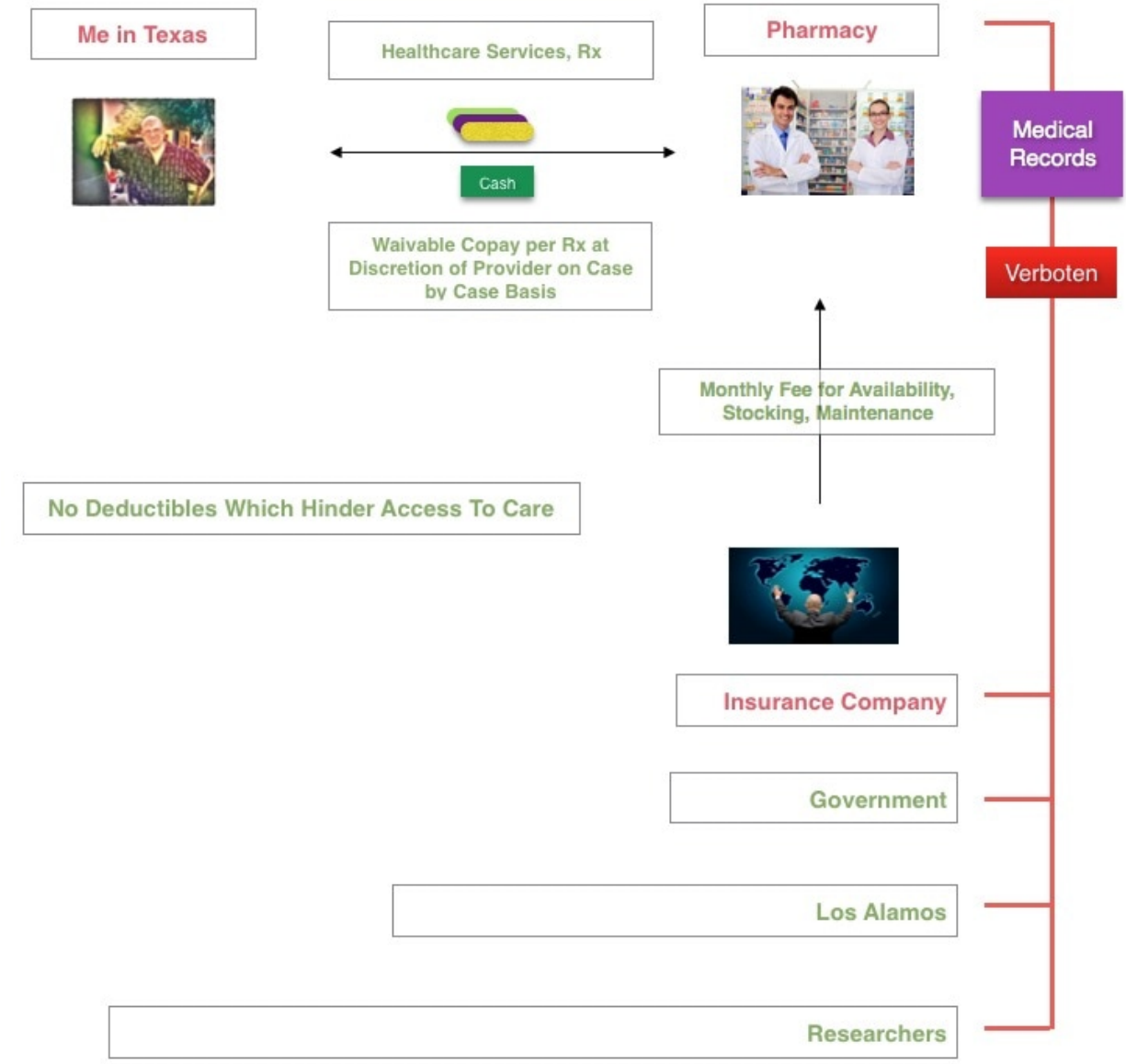
Because specialists are not always required as opposed to primary care providers it may be best to reimburse them as salaried professionals (from a pool) plus copay. So John Cardiologist would be paid $200,000 per annum plus copay that he may also waive at his discretion similar to the model explained under primary care. Such specialists would be part of a specialty group that would then be chosen by the patient. The patient would have the option to select from several groups. There would probably have to be a public option for those communities that are not big enough to have a large specialty group. The public option could also exist for those providers who are either excluded from a group or who choose not to join. For example, a state could have a large pool of independent specialists. The patient would select the public option and pay $50 per month. The monies would go to the state fund covering specialists from which specialists would be paid. A similar model would exist for private specialty groups.

Specialist Reimbursement Scheme



How are Pharmacists and DME Providers Paid?

Pharmacists and DME providers are paid on a monthly basis to cover their stocking and maintenance functions plus a fee per prescription so as to give incentive to provide good service. The pharmacist will no longer be able to mark up drugs for resale. The pharmacist will be chosen by the patient as their pharmacy home. So if John Pharmacist is chosen by 1,000 patients at a rate of $50 per month, he will receive $50,000 per month base plus fee per prescription.

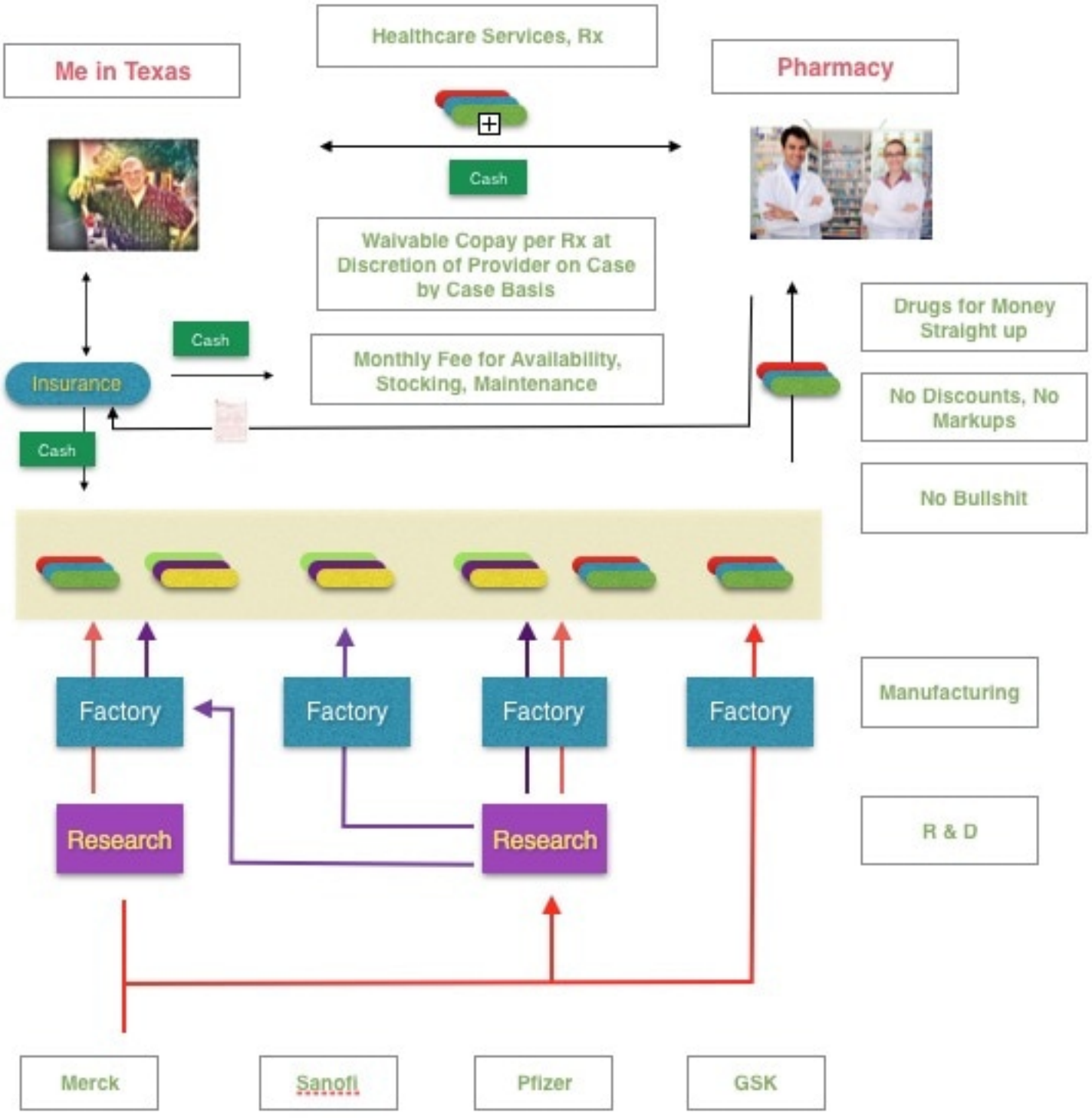


Big Pharma

Here is a schematic of how Big Pharma fits into the equation. Important to note is that pharmacists do not buy the meds with cash from Big Pharma. Rather the pharmacist is a steward of Big Pharma's meds. When the patient receives the prescription, the paperwork is submitted and Big Pharma gets paid; thus Big Pharma has to wait to get paid just like the rest of us. Awww, poor baby. Also, there are no bullshit games permitted within the system such as discount cards and such. Nobody is permitted to gouge the system by up-marking a med. Pharmacists will get paid based upon a fixed amount for their stewardship of the meds, plus a variable amount reflected in the copay when the patient receives the meds. Deductibles are out the window. Patients don't fully understand them nor do they like them. Plus deductibles hinder access to healthcare. Another idea bites the dust.

By busting up the patent laws and enabling sharing of research, we allow the marketplace to develop competitive ways to manufacture a med cheaper and better. We prevent one company from monopolizing a drug and gouging the public - which we have seen quite a bit of lately. Why should we be surprised, though? When ignorant elitist professors, the morning talk show boobs and their fawning groupies tell the Big Pharma CEOs that they are Jesus Christ on steroids, what else can we expect?

Big Pharma Scheme



Merck develops drug (red); sells rights to develop and/or manufacture to Pfizer and GSK. GSK elects to manufacture. In addition to manufacture, Pfizer chooses to modify the drug creating brand new drug (purple). Pfizer sells rights to manufacture to Sanofi and to Merck. Merck sells its original plus the one it bought off Sanofi.