Offices

Don McCormick

Community Organizer

921 CR3704 B

Splendora, Texas 77372

866-373-8510 office

713-585-0073 cell

Staff Residences

Creation of a Complete Health Care *System* for a Small Community

(Size: 300 Households)

Goal: Healthcare based on the expressed wants and needs of the participating members of a local non-profit 501c3 association that has a health care mission and authority to provide services that are required by the membership. Every household is represented in the membership and each medical care provider is also a member of the association.

Process:

1. **Survey** at least 1000 potential members in the selected community to determine their health care wants and needs.
2. Based on the surveys construct a ***System*** that matches the wants and needs of the potential membership.
3. Interview each person who expressed an interest in the ***System*** and get their help in bringing like-minded people into the local association to fulfill the expressed wants and needs.
4. Have each person join the association to build the medical services cooperative together.
5. Have a health care coordinator meet with each member in their home to listen and create a health care assessment record that can be confidential and can be compiled to determine exactly the kind of medical care providers and facilities that will be needed to serve the enrolled members.
6. Enroll each person into a service plan that matches their exact medical needs based on their health risk assessments.
7. Enroll the needed medical care service providers that are required to fulfill the needs of each member.

The time frame for completion of the seven steps is 60 to 90 days.

The cycle for the renewal of this cooperative is each quarter.

The expected grow rate is between 300 and 600 households per year.

That rate of grow would be consistent with other health care cooperatives that have been successful during the last 80 years in the United States both in their cost and quality of care.

Our experience in the last five years has been that this ***System*** is complete in that it includes everyone without any preexisting conditions, any copayments, or deductibles, and cost ½ as much as the current employer or government sponsored health insurance programs.

Do you want to be a partner in building such a ***System*** in this Community?

There is a reward for filling out the **Survey** that is worth $120 in the current market.

For each family that completes the Survey and sends it to TBT we will provide **Free Membership in Doc Wellbee for six months.** The benefits of their services are on the next Page.

Reward for Completing the Survey Questions and returning them to TBT

Six Months Free Membership in **Doc Wellbee** which includes the following:

This is a nationwide Discount Medical Services Organization

1. **Dental, 40% to 60% discounts**
2. **Vision, 40% to 60% discounts**
3. **DME, 40% to 60% discounts**
4. **Road Service, Towing and Assistance 7/24/365 (25 Miles)**
5. **Telemedicine, Talk with a Primary Care Physician 7/24/365 (no copay)**
6. **Prescription Drugs, 40% to 60% discounts**

Multi-specialty Clinic Plans for Splendora

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A Practical Path to Universal Health Care

By Don McCormick

Cost analysis of healthcare in the United States by experts has not changed the behavior of anyone using or delivering healthcare services and supplies. Healthcare has cost too much and has increased at a rate that is unmatched in any other segment of the economy. The analysts have said that the aging population is not a significant factor. The kinds of diseases and injuries and their frequency and intensity have been predictable. Analysts say the core problem is pricing driven by technology and the idea that doctors can cure death and that is what people want. There is some discussion about whether the politics which protects free enterprise is obstructing a needed public service that should operate more like other public service jobs: teacher, soldier, government worker, police, and fire personnel. There is no confidence that politics will change healthcare delivery or cost. Certainly, the ACA laws now in effect do not address that issue, at least, economically.

In my opinion, in healthcare there is neither a law of large numbers nor any actuarial certainty. There is a belief in magic, confidence that insurance companies (Public and Private) can pool large numbers of people in risk groups and then compete with one another so that prices for buyers will be low enough to be affordable by anyone who shops intelligently. The result of that belief in magic is that tens of millions of people do not buy health insurance. When we have done surveys of thousands of these people, we find that price competition is not a consideration in their decisions. Insurance is either not a necessity in their life because they do not need it now or the cost they are willing to pay is less than 10% of the actual cost even if that cost is not inflated by greed and market conditions.

Suppose a family (spouses and two children) take home income is $60,000 a year and the expenses are as follows:

	Item	Amount
1.	Housing	$15,000
2.	Food	$ 6,000
3.	Utilities	$ 2,500
4.	Taxes	$ 6,000
5.	Autos	$ 8,000
6.	Clothes	$ 2,500
7.	Lia & Prop Ins	$ 3,000
8.	Saving	$ 6,000
9.	Phones	$ 2,000
10.	Entertainment	$ 2,000
11.	Fuel	$ 4,000
Total		$57,000

That leaves $3,000 to pay for everything not considered by most people to be needed priorities.

Many families do not make $60,000 gross. Health care from the magical insurance market and the unregulated medical care providers cost not less $16,000 for this family of four. (The

$16,000 is the best price in the United States even when the Sharing Ministries are included. The average cost is about $24,000). The $16,000 is more than five times the available income this hypothetical family can spend. So, "Magic" and the "Free Market" will not solve this problem.

We all need to think about this problem in a new way by seeing healthcare as part of the necessities of life. In the hypothetical list of income and expenses listed above are many types of expense in which local groups of families can cooperate in getting products and services of higher quality and at lower cost.

Housing, Food, Utilities, Autos, Phones and Fuel are the most obvious types of expenses that can be done cooperatively. They make up $37,500 of the $57,000 in expenses. Saving in those areas can be as much as $15,000 dollars and doing healthcare cooperatively can reduce the most competitive rates by 20% to 30%. So, through local cooperation people who earn $60,000 per year can have complete healthcare without out-of-pocket expenses including insurance that is needed for catastrophic losses. People who earn less per family will likely require a subsidy which can come from the people within the cooperative and would increase their cost by about 4% but it would result in universal coverage within the local cooperative and without regard to the magic of insurance (public or private).

How big must a local cooperative be to enable sound management of family budgets? A group of 300 households represents about $18,000,000 per year in cooperative buying power assuming a median family take home income is $60,000. Given the ability of such a large group to transfer catastrophic risk to an insurer, this group is ideal size. That is also the size group in which good relationships and rapid communications can be maintained even without advanced technology. As the Economist E.F Schumacher said: "Small is Beautiful."

Using benchmark data from insurance claims is unsound in predicting cost in any specific group. The same would be true when the group cooperated in the areas of housing, food, utilities, and transportation. You must do bottom-up budgeting in each area that uses services and products. In healthcare, start with a comprehensive health care assessment of each person in the group of 300 households. There are no short cuts to this and no simple phone application. It requires trained medical experts to listen first to each person and their description of both their wants and needs and their complaints. Then a trusted relationship with each person must be established in which there can be an agreed reality and an objective analysis to enable a medical and financial plan for each family. The sum of this is your group's health plan and its cost. At this point the benchmark is meaningless unless it accidently matches your final cost analysis. If it does then you can just laugh because it will change, and you will adjust and go back to the basics.

To understand what goes into a benchmark for pricing we have an example from the claim's history of 45,000 people in four different age brackets: 0-17, 18-44, 45-64, and 65+. The data was gotten from HMOs that were high performing managed care plans from the reports they filed with the State of Texas. The reports they filed compared closely with the actuarial analysis of the patient population done before the claims were incurred. This means that with moderate price control through in-network contracting and rules about hospitalizations and use of diagnostic testing the actuaries and the participating physicians came close to the same numbers in the projections and in the final reporting. It does not mean that either are correct in the actual

cost. Usually both are too high, and the delta is in the pocket of the insurer and sometimes part of it is in the pockets of the physicians, but not much of it and not to every practice. Our collected data in summary was as follows:

Annual $ Cost PMPY

Age Brackets	0-17	18-44	45-64	65+	Weighted Average all Brackets
Hospital	696	1224	1860	4500	1898
Professional	878	1587	2390	3630	2076
Administrative	336	611	986	1396	822
Total Cost	1910	3422	5236	9526	4796

Costs of Medical and Hospital services as reported in the United States including Out-of-Pocket payments was $11,559 per person in 2020. The difference between U.S.A. reported cost and the average cost we experienced is "managed care." We do not show the actual premiums charged by the insurers which are about 20% above our costs and the unnecessary hospitalizations and professional fees make up the rest of the difference shown ($11,559-$4,796=$6,763). We would look like the rest of the developed world if health care were done cooperatively and managed correctly. We are free to change this or to remain in the dark paying for our magical insurance system.

We Must Create Patient/Doctor Health Plans

22 Declarations About Why It Should Be Done

1. Have voluntary **Universal Medical Benefits** now without political nonsense.
2. Be an equal owner with each Patient and Doctor in your Community.
3. Oversee your own healthcare while you learn the science of Medicine.
4. The Plan is the most comprehensive and least expensive in the United States.
5. It is ½ of the cost of the health care in the United States with better health outcomes.
6. It is reinsured by A+ rated international insurance companies.
7. It gives the patients freedom to design the kind of skilled team of medical care providers that fit their healthcare wants and needs.
8. There is no financial "**Black Box**," no hidden prices or surprise services.
9. Providers agree in advance to be paid monthly based on published Medicare Fee schedules which are reviewed annually and not arbitrarily changed by third parties.
10. There is no two-inch-thick small print directory of every doctor and hospital in town. Instead there is the **patient's personal phone directory of every doctor and medical facility he or she will need** to address his or her medical problem. Patients know where they can go in advance and who will be advising them.
11. There are no middlemen to take away saving in the system that is rightfully used to improve medical care or lower patient costs.
12. The principles that support this are fostered by sharing responsibilities and resources and stem from the virtues of Love, Peace, Truth, Tolerance and Cooperation.
13. Help and Education are the key components of the Association designed to last for thousands of years and separated from the contingencies of financial peaks and valleys.
14. No "**Black Box**" hides what anyone does or says. It is freedom for patients and their advisors.
15. All costs are known and audited.
16. All benefits belong to the members and to no individual or group.
17. Last year health care in the USA cost each person an average of $11,559.
18. Half that cost was waste and greed and did not go to either doctors or patients.
19. Cost is based on prices and frequency of use.
20. In practice, neither prices nor use are regulated which is why cost is double.
21. Voluntary regulation by agreement within your own association and community corrects this faulty economic practice.
22. Stop the insanity. Be together, learn, do the right things always.

Patients Are the Stakeholders in and Providers of Their Own Health Care

Many people claim to be health care providers, but few people play that role. Let us say who is not a health care provider so that we may cut to chase. **Insurers are not**, they are trustees of other people's money or capitalists. **Hospitals are not**, they are builders and maintenance people and would-be capitalists. **Pharmaceutical and equipment manufacturers are not**, they are inventors and vendors and capitalists too. **People who study the art and science of medicine can be health care providers if the patients invite them to share their suffering and offer advice and treatment.** The **real health care provider is the patient**, whether the

care is taken in ignorance or with insight and good results. The most knowledgeable person in the universe is a mere whirling dervish without the attention and understanding and actions of the patient. This is true even before a medical problem is manifest and before any expert advice or treatment is sought. Whatever is wrong with a person happens before the consultation and before the professional health care providers ever know of the sickness or injury. So, when we fix a broken healthcare system, patients must be the stakeholders within the system. That is where we will begin to make improvements.

We will need some empathy because it is among those people who are not yet suffering that the cure for what afflicts us will be found. It is among those who are temporarily able bodied (TABS) that the mark of wisdom must be engraved. We who make government possible can make government order things done in a general way and in ways that have little or nothing the do with what is possible and what patients do for themselves. There is nothing of "Pollyanna" here. Some patients will choose to die, some will choose to poison themselves over many years, and some will take good care of their bodies despite all the negative influences and bad advice they may get. The fix will be in the nature of man to see what is working to make someone else live well and then in making the thoughts and actions of that person part of their life and their understanding.

It is hard to be empathetic. It is hard to even shed a tear for another person's loss if it is not your own loss. When you read the obituaries do you cry? If you do, you will soon go insane because to be touched by every death you see would rob you of all vitality and send you into hiding. So, the empathy we need is in seeing ourselves in the place of the sufferer and that place is in the future. It will be noble and wise to avoid that suffering and in doing so create a paradigm for health. You are the healer; you own your body and you know what is in movement and in thought and in relationship to the people around you. You also see what you do not know, and it is in that state that advisors and healers enter your personal space and share your thoughts and make empathy possible.

Gather the patients first. These are the stakeholders in a health care system. Let them invite their professional advisors and healers. Having trustees for money and buildings and suppliers of goods and services follows what patients want to fund. If that funding is little or much, it does not matter. It is the patient's lives that count, not the other things. We are all patients. Buildings, machinery, supplies, chemicals, currency, and government are not patients, but expediencies.

A New Local Cooperative

A starting point for a local cooperative that wants to establish a health plan has already been created, It includes everyone that wants to be a member, has no pre-existing conditions exclusions, uses a direct monthly payment model for primary care, specialties, lab and imaging, has s discount medical plan for pricing of products and services not included in the direct monthly payments, has indemnity insurance that will cover about 90% of the first $80,000 in hospital claims and stop loss insurance the will cover 100% of the next $5,000,000 in both professional and hospital claims. It cost $425 a month for adults and $250 a month for children.

Those are as good as any prices in the world and less than half the cost of the current private and public systems in the United States.

1. The Association membership that enables this plan is through TBT, a 501c3 organization chartered in 1994.
2. The Direct Monthly Payment Agreement is with the Local Multi-specialty Group and is built upon the choices of the members in their local area.
3. The Discount Medical Benefits are from Affordable Family Health (Doc Wellbee) and include Dental, Vision, DME, Hearing, Drugs, and Roadside Service, all of which are at 50% to 80% discounted.
4. The Indemnity Insurance is from an A rated company.
5. The Stop Loss is from an A rated company.

There are no deductibles or copayments in the plan, but a member could have out of pocket expenses if they use providers that do not have advance agreements with the Cooperative at prices close to the Medicare rates. The Patient Advocates in TBT work out the payments and prices with the providers for the members and have been doing so for many years with success in getting the fair prices for members.

The ideal indemnity insurance for this Cooperative would be a plan that paid up to $5000 for the first day of either outpatient or inpatient services at Medicare Rates and then $3,000 per day for up to 20 days at the Medicare rates for admitted patients. It would be a group policy issued to the TBT organization with a deposit premium of $100 per month per member patient and after the six months the premium would be $20 per month plus the actual claims above the deposit premiums already collected and paid at Medicare rates. It will provide the insurer with a 20% margin for administration, sales, and profits. The policy should be annual and in this system the cost automatically adjusts to the real experience monthly after the first six months.

Survey Form

Name:____________________ ____________ _______________
First Middle Last

Address:_______________ _____________ ____ _____________
Street City ST ZIP

Phone#:_________________ Email:_________________________

Survey

1. When someone in your home gets sick of injured who do you call?

   ____

2. If it is not an emergency and you need medical advice and care, would you rather go to a doctor's office or have a doctor come to your house? Check One ___ Home ___ Doctor's Office

3. Do you have any of these health plans now?
   Check all that apply:
   a. Medicare? ___
   b. Medicaid? ___
   c. Group Insurance with my employer? ___
   d. Private Insurance? ___
   e. None of the above? ___
4. If you have a health plan now, is it 100% coverage? ___Yes __No

5. If not, does it have a deductible and how much? $________

6. If this community develops a health plan for all the residents and it is 100% coverage, less expensive, and nurses and physicians take care of you in your home, would you like to know more about it?

   Yes___ No ___

Survey Completion Reward: Six Months Free Membership in **Doc Wellbee** which includes the following:

This is a nationwide Discount Medical Services Organization

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3. **DME, 40% to 60% discounts**
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5. **Telemedicine, Talk with a Primary Care Physician 7/24/365 (no copay)**
6. **Prescription Drugs, 40% to 60% discounts**

A Complete Health Plan
In Your Neighborhood
If 300 Households Cooperate

1. Everyone in the group can be a member regardless of their health conditions or financial circumstances.
2. You will have an advocate to help you find and use whatever medical services you want and need.
3. The cost will be what you can afford and it has been our experience in the last ten year that is ½ the usual cost in the United States.
4. You will have care from a primary care physician or nurse in you home when you need it.
5. You will have no deductibles or coinsurance.
6. Your payments to physicians and nurses of all types will be on a direct monthly payment plan.
7. You will have insurance to cover hospital costs at Medicare Rates without deductibles or coinsurance. The insurance is written on a group basis to your association and is from A rated companies.
8. It is not an employer-based health plan so you can keep it regardless of your job status yet your employer can contribute to the cost without it being taxable.
9. If you have coverage from Medicare, Medicaid, Medicare Advantage, or a retirement plan then your cost to be in this group will be reduced substantially and will improve on whatever you now use.
10. There are a host of extra benefits in the form of discounts just because you are in a cooperative.