HEALTH CARE

BY the people · FOR the people

www.VeltmeyerForCongress.com
Dear Friends,

Thank you for taking the time to review this booklet which discusses the “Health Care for the People, by the People” health care reform plan. This is the one plan that actually offers a realistic path to reducing the outrageous cost of health care in America as well as the skyrocketing premiums and deductibles that are denying medical assistance to millions of our fellow citizens.

This plan addresses the true cost drivers of health care today as well as the medical second-guessing by third-party payers which is resulting in the denial of critically-needed testing and treatment to so many people. My own wife, Laura (whose story you will read here), is a striking example of what happens when insurance company executives and faceless government bureaucrats are given veto control over the treatment recommendations of medical professionals.

Through a three-part approach comprised of:

1. The Medical Association Membership (MAM) model for routine and preventive care

2. Emergency Catastrophic Care (ECC) for life-threatening health events, emergencies, and accidents

3. National Health Savings Accounts (NHSA) to cover the costs of pre-existing conditions, specialists, and longer-term hospital care

We can make all Americans enjoy better health care and unimpeded access to a physician or health care provider of their choice at a one-third savings off the current system.

To learn more, please visit our website at www.VeltmeyerforCongress.com

Sincerely yours,

James Veltmeyer, MD
MEET OUR FOUNDER
Dr. James Veltmeyer

Dr. James Veltmeyer is one of San Diego’s leading physicians and a national leader in the battle for common-sense and affordable health care reform. He is the author of the Medical Association Membership (MAM) direct-payer health reform plan which has been covered in both local and national media, such as The La Mesa Courier, East County Magazine, KNSJ Community Radio, Real Talk San Diego, KSEE-24 News, ABC News 10, Brett Winterble Show, KFMB AM 760, Direct Primary Care Journal and Concierge Medicine Today. The MAM would restore the doctor-patient relationship by limiting the role of government and private insurance companies in the health care process.

A graduate of UC San Diego and the Ross University School of Medicine, he completed his residency through the UC San Francisco system where he became Chief, overseeing 36 doctors. Dr. Veltmeyer, a member of the San Diego Critical Care Medical Group, has been elected for four years (2012, 2014, 2016, 2017) by his colleagues in the San Diego County Medical Society as a “Physician of Exceptional Excellence,” the most prestigious honor awarded to a “Top Doctor” in San Diego County. He is among a select group of San Diego physicians who was chosen four of the last fifteen years and he consistently ranks in the top 1% to 2% for patient satisfaction. He is currently the Chief of the Department of Family Medicine at SGH where he provides senior leadership to over 200 doctors.

Dr. Veltmeyer had an unlikely journey to his current position as one of our area’s most respected doctors. Born in South America, his family became homeless when his father abandoned his mother and siblings. His mother made the heartbreaking decision to send James alone (at age 11) to live with an aunt in the United States. After a two-year effort to obtain a visa, his aunt in El Cajon was able to bring James to live with her in San Diego County. Finally, when he was 19, his mother followed and he became the sole provider for his family, holding down multiple jobs while attending school full-time.
Recognizing that education is the ladder to success, James worked hard at local schools like Grossmont High and lived the life of many young immigrants, fighting to achieve the American Dream and now working to see it passed on to his children and future generations.

Dr. Veltmeyer is Board Certified in Family Medicine and holds credentials from the Drug Enforcement Administration, Advanced Life Support in Obstetrics, Advanced Cardiovascular Life Support and NeoNatal Resuscitation. He is a member of the American Board of Family Medicine and the American Academy of Family Physicians. He is also a longtime member of SGH’s BioMedical Ethics Committee.

Dr. Veltmeyer is married and he and his wife Laura are the parents of two children, Olivia 7, and Landon 5. They are parishioners of All Hallows Catholic Church in La Jolla where both his children attend school. An avid sportsman, Dr. Veltmeyer enjoys surfing on San Diego’s world-renowned beaches, as well as golf, tennis, skiing, and chess.
REDUCING THE HIGH COST OF HEALTH CARE
by Dr. James Veltmeyer

The United States of America carries the unenviable distinction of having the highest health care costs anywhere on the planet, eating up $4 trillion per year or 20% of Gross Domestic Product (GDP). That’s four times the percentage of the economy the year John F. Kennedy became president! Yet, we no longer enjoy the best health statistics on record, being surpassed by other nations in such critical indicators as infant mortality. And, access to care is being increasingly rationed by insurance companies which have usurped the role of making life and death decisions from physicians and other health care providers.

Can we achieve better health care while reducing costs, possibly by as much as one-third or $1 trillion (enough to pay for President Trump’s infrastructure plans)? Yes, we can. However, it will require a fundamentally different approach than the grossly expensive and inefficient third-party payer system we have relied on for decades.

My “Health Care by the People, for the People” model will guarantee access to truly affordable medical treatment at reasonable premiums, stimulate free market competition and price transparency among providers, eliminate wasteful administrative bureaucracy, and prohibit insurers from delaying or denying necessary medical procedures.

Today, we Americans pay more and get less than almost any other industrialized, First-World nation. We pay as much as $21,000 for an MRI that could cost as little as $400. $60,000 for a gall bladder removal that could cost $3,000 at a physician-directed surgery center. On average, a routine surgery at a hospital costs ten times what it really should cost. Cui bono? The insurance companies and their bean counters and the hospitals with their grandiosely-compensated executives. It’s called skimming off the top.
“Health Care by the People and for the People” offers a three-part solution out of this nightmare.

**First,** the Medical Association Membership (MAM) permits patients to access physicians for a low monthly fee for routine and preventive care: physicals, blood tests, and minor medical procedures that can be performed in a doctor’s office. No deductibles, no copays, unlimited visits, and no long waiting room lines. The monthly fees may vary, but are normally in the range of $50 to $100 per month per patient. Obviously, older patients who need to see their doctor more often would be charged at the higher end of that scale and younger people at the lower end. Children are even less, sometimes as low as $20 per month. By empowering providers to treat patients more proactively, the need for ER and hospital stays is drastically reduced, as much as 70% or more. Medicare patients receive a $100 per month voucher to pay for the membership; Medicaid patients $50 per month.

**Second,** Emergency Catastrophic Coverage (ECC) is available from a private health insurance company to pay for life-threatening health events or accidents and ensure that no one is bankrupted by medical bills. ECC would cover up to two weeks of hospitalization and or ICU care. At premiums of approximately $150 to $200 per month, most Americans will be able to afford this. Those that can not are eligible to receive a voucher from the government to pay. Those who have the means but still refuse to purchase such coverage are ultimately responsible for that decision and the costs they incur. Health insurance companies will again be carefully confined and corralled to fulfill the original concept of their trade: protecting us from something truly cataclysmic, not a profit-maximizing racket to see how many millions CEOs can be paid and how many medical treatments can be vetoed.

**Third,** Americans will have National Health Care Savings Accounts, possibly paid by employers in lieu of premiums paid for employer-sponsored health insurance. That can be encouraged by repealing the federal government’s $250 billion tax subsidy for
work-based health insurance, freeing employees from the chains of staying in jobs they dislike just to receive the health benefits and liberating employers from the costly burden of providing and administering health insurance. The funds deposited into these accounts can be used to pay for specialist visits, pre-existing conditions, and hospitalization/ICU medical care over the two-week catastrophic coverage.

The objective of this tripartite program is to make all Americans enjoy better health care and unimpeded access at a one-third savings off the current system. Imagine the cost of your entire health care plan for $200 to $300 a month. It’s time for Health Care by the People and for the People now!

“Americans pay more and get less than almost any other industrialized, First-World nation.”

*Dr. James Veltmeyer is a prominent La Jolla physician and surgeon voted “Top Doctor” in San Diego County in 2012, 2014, 2016 and 2017. Dr. Veltmeyer can be reached at dr.jamesveltmeyer@yahoo.com*
MAM
Medical Association Membership

Places doctors and patients in charge of health care, not government or insurance companies

Today, patients are being denied coverage for necessary medical procedures, such as important cancer tests or back surgery. Insurance companies are routinely rejecting the best advice of medical professionals seeking to heal their patients and restore them to good health. Under MAM, doctors and patients will again make these life-saving decisions and the removal of the meddle-some third-party from the equation will stimulate price competition and choice which will drive down the costs of medical procedures, just as the cost of Lasik surgery—not covered by insurance—has tumbled in recent years as technology has improved.

Prompt access to a doctor of your choice at truly affordable prices

Your MAM membership at perhaps $75 to $100 per month and lower for children will give you the access to any doctor of your choice, whenever you need to make that office visit. Your physician will be able to spend quality time with you, no longer trying to force more patients into fixed office hours in order to maintain stable revenues for his or her practice or make up for falling reimbursements. The wasteful paperwork, form filling, and costly claims processing will be eliminated because the MAM is a contract, just between your doctor and you to provide the medical services you really need when you need them.
Low monthly fees, no co-pays

Again, the monthly MAM membership fee will be low, probably $75 to $100 per month. That’s probably less than you pay for cable TV, to get channels you don’t even watch! In some places, it is as low as $50 per adult and $10 for children. For this fee, you can see your doctor as often as necessary. You won’t have any co-pays or waiting for appointments. Your doctor will have the opportunity to really get to know you and your health issues and the traditional bond between doctor and patient will be restored. Unlimited office visits, same day appointments, routine care and basic tests at no additional charge. The MAM will offer you these services and possibly more (such as EKGs) for your low monthly or annual fee. These services could easily add up to many hundreds (or even thousands) of dollars per month under our current health insurance system. One office visit alone – with no copay – can easily be $150 or more. Copays themselves can be as high as $40 or $50 for each visit. Under MAM, you can see your doctor as often as you need to, possibly for as little as $50 per month, not per visit. And you won’t wait days to get an appointment or wait forever for the doctor to call you in.

Medications at negotiated or wholesale prices

In some parts of the country, doctors with direct primary care practices are bringing down the cost of expensive medications by negotiating directly with the drug companies for better or wholesale pricing. The MAM will encourage this type of approach to bringing down the outrageous cost of some prescriptions. We should also allow the importation of cheaper drugs from abroad which are perfectly safe to use and force Big Pharma to compete for customers.

Full coverage for Medicaid patients

The MAM is not just for the wealthy or those who can afford the monthly membership. It is for everyone and intended to cover everyone, including poor and low-income patients currently on Medicaid. They will be issued a government voucher or debit card for the cost of the fee in order to access direct primary care as well. We know for a fact that Medicaid patients often receive sub-standard care due to the small reimbursements and
the fact that fewer and fewer doctors are accepting Medicaid patients. MAM will solve this growing crisis. In fact, this program can also work for Medicare patients as well.

**Emergency Catastrophic Care (ECC)**

You are probably wondering what happens if you have an accident or, God forbid, develop cancer or require heart surgery. That’s where your catastrophic or “wraparound” insurance coverage would come into play, covering you for a life-threatening medical event, not the sniffles, just as insurance is intended for. As life-threatening medical events are relatively uncommon, your catastrophic policy will be fairly inexpensive and very affordable, probably about $200 per month. ECC would cover up to two weeks of hospitalization or ICU care. Those who cannot afford the premium will receive a voucher from the government to purchase the policy. Amazingly, current law forbids a healthy young person – who rarely needs to see the doctor – from purchasing an inexpensive catastrophic policy. With MAM, insurance will return to its primary purpose, covering us when something really bad occurs. And, health insurance will again be fully portable, not tied to an employer. You will “own” your catastrophic policy like you “own” your car insurance. People won’t be forced to take jobs they don’t want or stay in jobs they hate just to keep medical insurance. This will be a revolution in the way we approach health care in America since the post-World War II years. And, most importantly, insurance companies – in exchange for having the routine coverage mandates rolled back – could no longer refuse to pay for a medical treatment recommended by a qualified provider.

**National Health Savings Accounts (NHSA)**

All Americans will have a National Health Savings Account which will pay for specialist visits, pre-existing conditions, and hospitalization/ICU care over the two-week catastrophic period. Through repeal of the federal government’s massive $250 billion tax subsidy for employer-paid health insurance, employers will be free to deposit the savings in premiums into NHSA accounts for their employees. Employees will then be able to “own” their personal savings account just as they “own” their IRA or 401K. For self-employed individuals, they will be able to contribute unlimited amounts to their NHSA and claim a full tax deduction for the contribution.
Removes burdensome regulations and restrictions on doctors that make it difficult to practice medicine

Doctors are being crushed by a myriad of unnecessary government regulations. The situation is so bad that surveys show that 43% of physicians are considering retiring in the next five years. This will lead to a serious doctor shortage in this country if the bleeding isn’t stopped. Doctors must spend several hours per day, not treating patients, but navigating federal and state regulations, completing insurance claims forms, dealing with complex coding requirements, and negotiating with insurance companies over prior approvals and payment rates. The Direct Primary Care Coalition estimates that 40% of all primary care revenue goes to claims processing and profit for insurance companies.

Enhances competition, brings health care costs down

With the role of the government and insurance companies rolled back, the free market can again function in medicine. There will be greater competition and greater transparency in costs, as patients will now be in control of their health care dollar, free to shop around for the best pricing on routine medical care and doctors are not weighed down by bureaucratic regulations and restrictions that only contribute to the high cost of health care.

Can the Medical Association Membership work?

Yes, it can. Variations of the MAM are already working in many parts of the United States. In fact, over 5,000 physicians are now providing some form of direct primary care, up from less than 200 in 2005. And, it is showing successful results. A study in the American Journal of Managed Care showed that decreases in preventable hospital use resulted in $119.4 million in savings in one recent year alone. A five-state study showed patients in direct primary care practices experienced 56%
fewer non-elective admissions, 49% fewer avoidable admissions, and 63% fewer non-avoidable admissions than patients of traditional practices. In addition, patients were readmitted much less frequently for acute myocardial infarction (heart attack), congestive heart failure, and pneumonia, respectively. A British study of another direct primary care system showed 35% fewer hospitalizations, 65% fewer ER visits, 66% fewer specialist visits, and 82% fewer surgeries. Please visit https://www.holtondirectcare.com, http://neucare.net and http://santacruzdpc.com for examples of where variations of MAM are working.

How much will the MAM cost?

For purposes of comparison, consider that there are 56 million Medicare recipients and 74 million Medicaid/CHIP recipients in the United States today. 56 million recipients each receiving a $100 per month voucher (an average charge for someone 65 and older in a direct primary care practice) ($1,200 per year) equals $67.2 billion.

| We spent approximately $673 billion on Medicare in 2016, meaning the MAM cost would be 10% of overall Medicare spending. | For Medicaid, 74 million recipients receiving a $50 per month voucher (an average charge for a typical younger person) ($600 per year) equals $44.4 billion. | We spent about $553 billion on Medicaid last year, meaning the MAM would be less than 10% of overall Medicaid spending. |

In total, MAM would cost under this formula $111.6 billion versus $1.226 trillion for Medicare and Medicaid combined. Granted, most of the cost of Medicare and Medicaid is probably for hospitalization and high-cost medical care, so we’re not exactly comparing apples to apples, but, for a simple comparison, it shows the minimal cost of private sector solutions as opposed to big government solutions. Remember that someone once said that if we simply took all the money the federal government spends on poverty programs and just sent a check to every recipient sufficient to lift him or her out of poverty, it would be one-third of what we’re spending. Regarding insurance premiums, most research shows an average healthy person could purchase a catastrophic policy for $75 to $100 per month.

How can we enact the MAM?

We need to convince Congress that making cosmetic changes to Obamacare won’t work. Continuing in any way with the subsidies, taxes, mandates, and regulations is
doomed to failure. We need to convince our elected representatives to enact REAL reform, not fake reform that does nothing to save lives or bring down costs.

There are policies that need to be changed right away:

1. We need to fix the IRS definition of direct primary care for Health Savings Accounts so that consumers can pay fees through their HSAs.
2. Change current law so that Medicare patients can pay their doctors directly outside of the traditional Medicare program.
3. Encourage states to permit Medicaid patients to pay doctors directly for routine primary care, possibly through establishing Medicaid medical accounts.
4. Work with states to ensure that insurance commissioners don’t improperly classify direct primary care as a “health plan.”
5. Remove laws and regulations at the state level which restrict the growth of direct primary care practices.
6. Allow the Secretary of Health and Human Services greater authority to promote the expansion of these practices.

The Primary Care Enhancement Act (H.R. 365) would reform the IRS tax code to recognize fees paid to direct primary care practices as qualified health expenses and deserves your support. Eighteen states have passed laws defining these practices as outside the scope of state insurance regulation (unfortunately, California is not one of them). HHS regulations concur, but the IRS is one of the only regulatory bodies that sees it differently.

Finally, because health care is so critical to each and every one of us, we need to replace legislators who refuse to vote for real health care reform. We need a revolution at the ballot box in 2018 and 2020 to ensure that we can continue to provide Americans with the best medical care at the most affordable price. When we can get the government and the insurance companies out of health care, we can put patients and doctors back in control.
HEALTH CARE

BY the people · FOR the people

by Dr. James Veltmeyer

No issue touches our lives more directly than our health and health care. It’s an issue that touches us and our families more directly and more deeply than taxes, immigration, or civil war in Syria. It is profoundly personal because it deals so clearly with matters of life and death.

I should know. I’m a doctor.

Thankfully, Americans continue to be blessed with the best health care system in the world. We live longer and healthier than our parents and grandparents because of innovation, technological breakthroughs and advances in the treatment of deadly diseases, new life-saving drugs, and better diets and lifestyles.

Yet, things are not working exactly the way they should, at least not in our medical delivery system. Costs are exploding. Insurance premiums are skyrocketing. Deductibles are through the roof. Many people – especially those on Medicaid – receive sub-standard treatment. Doctors are buried in paperwork and regulations which take time away from patients. Sometimes, it seems like our parents and grandparents actually did have it better, with $10 for an office visit, house calls, and not spending hours on the phone fighting with insurance companies over coverage of some medical procedure.

Health care reform has been part of our nation’s ongoing political debate since the late 1940s when President Truman first proposed national health insurance. This was on the heels of World War II when employer-paid health insurance first became widespread as a substitute for higher wages which were then under wartime controls.

Prior to World War II, almost every American paid for his or her routine health care out-of-pocket. They might carry a catastrophic insurance policy in the event that the unthinkable occurred – an accident, heart attack or cancer, requiring hospitalization. Costs were stable.
By the time the mid-1960s arrived, President Johnson was in the midst of building his “Great Society” and government-paid health care was part of his program. That’s when we saw the introduction of Medicare for senior citizens and Medicaid for the poor. And, since the mid-1960s, we have seen nothing but a continuous upward spike in medical costs compared to the stability we enjoyed for years when the role of insurance companies and government was limited.

As we progressed through the 1970s, 1980s, and 1990s, medical costs continued to climb as government benefits became more generous and government mandates forced insurance companies to cover more and more medical procedures. Many insurance companies left the market (as they are currently doing with the Obamacare exchanges) and more and more Americans were left with fewer choices and less competition. The federal government’s solution, both with the failed “Hillarycare” of 1993-94 and with the enactment of the Affordable Care Act in 2010 was that more government mandates, subsidies, and regulations could solve the problem.

Yet, how could you cure the disease with what caused the disease in the first place?

Let’s think for a moment about your car or house insurance. Do you rely on your employer to provide it? Of course not. Does it cover oil changes and tune-ups? Of course not. Are your premiums and deductibles relatively stable? Probably so.

The same model applies to health care. Once the consumer was divorced from the cost of his own care, it became “something for nothing.” Someone else was paying for it, the insurance or the government. So, why not run to the doctor for every case of the sniffles? And, for the providers, it became a gold mine. Since the patient isn’t paying for it, let’s just bill Blue Cross or Medicare for anything we think we can get. Maybe $400 for an aspirin or $1,000 for an enema! What I propose is a return to basics, the fundamentals that are time-tested that worked before and can work again.

What I propose is a system where doctors and patients are again in charge, not the government, insurance companies, drug companies or hospital billing bureaucracies.
What I propose is “The Medical Association Membership” plan dedicated to giving people of all ages and backgrounds prompt access to a quality doctor at truly affordable prices.

The fundamental goals of MAM are simple:

1. Health care BY the people and FOR the people (vs. rationed care)
2. Encourage individual Americans to manage their own health care
3. Preventive and maintenance medicine access for all

MAM is a variation of the direct primary care option that is being increasingly used across the country with successful results. Direct primary care involves direct payment, usually in the form of a low monthly fee, by the patient to a doctor of his or her own choosing. The patient receives unlimited office visits, same day appointments, 24/7 access to their physician, routine care, basic tests at no additional charge and in some cases more services, like free EKGs and/or medications at negotiated or wholesale cost. Medicaid and Medicare patients could access the same service with a voucher provided by the government.

No government or insurance bureaucracies to deal with. Less paperwork and forms to complete. Just the doctor and patient.

Beyond primary care, when we are dealing with catastrophic health issues, hospitalization, MRIs, the need to see specialists, etc., patients can purchase a basic catastrophic or “wraparound” insurance policy at premiums that are a fraction of what a present-day comprehensive policy costs.

At the same time, “The Medical Association Membership” unburdens doctors from the stifling regulations and restrictions that make it more and more difficult to practice medicine. Diagnostic codes are eliminated, state and federal regulations on providers are pared back, and malpractice reform becomes a reality. We can also do away with the restrictions placed on importing cheaper drugs from abroad.
In conclusion, the MAM offers Americans a third way. An alternative to the left’s goal of single-payer and the current hodgepodge of various third-party payers, control by giant insurance companies or unaccountable government bureaucracies. MAM eliminates the “middleman,” the biller and collector, and provides a health care system independent of government, insurance companies, Big Pharma, hospital CEOS, and the grossly expensive layers of bureaucratic meddlers who should not be interfering in the doctor-patient relationship. By allowing patients to pay fees to providers directly, it will enhance competition, thus driving down the cost of health care.

As individual Americans and medical professionals, we can again take charge of this critical and profoundly personal aspect of our lives. Let us take back health care and join together to build a healthier world for our children and grandchildren.

Dr. James Veltmeyer is a prominent La Jolla physician and surgeon voted “Top Doctor” in San Diego County in 2012, 2014, 2016 and 2017. Dr. Veltmeyer can be reached at dr.jamesveltmeyer@yahoo.com
WHAT WOULD YOU SAY?

What would you say to a young mother of two, a 5-year old and a 7-year old after being told she is dying of cancer? Here’s some important background information: The mother has a PPO health insurance plan with the highest monthly premiums, but has been denied insurance coverage by non-elected bureaucrats, pharmaceutical companies, insurance companies and special interest groups, all participating in authoring the Affordable Care Act (aka Obamacare). So, what would you say to her? I need to know. You see, I’m the young mother’s husband; father to the children. I’m also a doctor who gets emotional.

My wife was diagnosed with aggressive breast cancer on July 17, 2015 and has been fighting for her life since and Obamacare, which supports profit-based corporate greed, is making it almost impossible for her to win her battle.

On July 16, 2015, after her daily 45 minutes of exercise, she discovered a large right-side breast lump while removing her sports bra. When I came home late from working at the hospital she asked me to check her chest because she had noticed a lump on her breast. On my initial palpation, I believed it was her pectoral muscle but I instantly froze when I felt the other side of her chest and I could feel her chest wall. I quickly phoned my close friend who is a top oncologist at Sharp Grossmont Hospital. We planned to have an ultrasound-guided mass biopsy first thing in the morning.

...what I accomplished on this day is comparable to parting the Red Sea! All because I am a doctor and have resources that most Americans don’t have.

We met Dr. Zu at Grossmont Hospital, where he immediately ordered an ultrasound guided biopsy - but her insurance denied what the expert had ordered and they requested that she get an x-ray followed by a mammogram. The insurance company was advised of a recent normal mammogram eight months prior; however, they have a protocol to follow and told us that if we wanted the doctor-required and requested mass biopsy, Laura (my wife) must undergo a repeat insurance-mandated mammogram. So, we waited for two hours for
the health insurance-mandated mammogram. Just the same as had happened eight months earlier, the pictures were normal - the mammogram once again did not detect the breast mass because her cancer was on her chest wall and, even when the mammogram squeezed her breast implants, it did not come close to picking up her palpable 8cm breast mass.

We then had to wait for eight more hours outside the radiology department where I work to obtain a pre-authorization for the doctor’s requested and obviously needed ultrasound-guided biopsy of her breast mass. Dr. Zu talked to the pathologist and the biopsied tissue confirmed her breast cancer.

I think you will realize that what I accomplished on this day is comparable to parting the Red Sea! All because I am a doctor and have resources that most Americans don’t have. In the pre-Obamacare era, if you could afford health insurance, it would have taken you at least two months to learn what I accomplished in one day, months during which time the mass would have continued growing and spreading. Now, if you have an insurance card, the insurance companies tell the doctors in the hospital: if we diagnose someone with a tumor or suspected cancer, a full workup is to be done as an outpatient because it is not deemed as an emergency. I don’t know about you, but I wanted to get her mass biopsied at the exact moment - and not a second later.

The mass core biopsy showed high-grade intraductal and invasive ductal carcinoma ( Grade 3 ). And, the right axillary lymph node biopsy revealed she has metastatic, poorly differentiated ductal carcinoma. Chemotherapy was scheduled to start in two days from her biopsy results. Unfortunately, Laura’s insurance company immediately notified everyone that Dr. Zu was “out of network” and Laura therefore couldn’t have him as her oncologist. I told the health insurance representative that was impossible because we have the high premium PPO health insurance with them – which, by definition, means there is no “out of network.” She replied that I was

...my wife has gone through three chemo therapy cycles, radiation therapy, radical bilateral mastectomies and was significantly delayed by the insurance company’s interference at every stage...
right: I could select and have any of the 57 oncologists available to us that are within the 25-mile radius from where we live. I said to her it doesn’t make sense, we pay tens of thousands of dollars a year for the best insurance coverage for two young adults and our children. She then explained that our policy has a local PPO coverage that limits us to doctors within a 25-mile radius from where we live. However, she also advised me that if we wanted to keep her oncologist we must pre-pay $25,000 to cover the “out of network” fees. And this would be in addition to our required initial co-pay of $6,750!

So, I contacted another close friend who happens to be a thoracic surgeon who knows personally a top oncologist in San Diego County. We were provided an initial meeting the next day and scheduled her first chemo cycle three days after that meeting. Before starting her chemo, the expert oncologist requested a PET scan which was adamantly denied by our high premium PPO health insurance and this forced my wife to go through a variety of less exact diagnostic imaging studies to stage her cancer. MRI brain, bone scan as well as CT scans of the chest, abdomen, and pelvis. As a comparison, it is important to note that pharmaceutical companies exclusively use PET scans on their subjects to stage cancer when researching and developing chemo agents to fight cancer, and subsequent PET scans are used for surveillance to determine whether the chemo is effective or did not work.

A PET scan is so accurate it will detect cancer cells before they even become a tumor. That is why pharmaceutical companies exclusively use PET scans in their work and is the reason why PET scans are considered by doctors to be the best imaging methodology in finding and treating cancer patients.

To summarize my wife’s basic health therapy to date: my wife has gone through three chemo therapy cycles, radiation therapy, radical bilateral mastectomies and was significantly delayed by the insurance company’s interference at every stage of chemotherapy and surgical intervention that she has gone through. The only PET scan approved was after her bilateral mastectomies which revealed that her prior chemotherapy was ineffective because 34/37 lymph nodes are still positive for cancer. And even this PET scan was initially denied!

Subsequently, she underwent additional chemotherapy followed by chemotherapy with unprecedented concurrent radiation therapy because of the seriousness of her
condition – yet, again, again she was denied post-treatment surveillance PET scans. She consequently underwent additional bone scan, MRI brain, CT scan chest, abdomen and pelvis, which exposed her body to additional needless radiation exposure from the tests. Nine months later, in November 2016, she underwent breast reconstruction surgery that was complicated with an abscess as well as chronic cellulitis both of which required surgical chest washout, right breast remedial surgery and several months of IV antibiotics.

However, prior to her bilateral mastectomies, she had a redness-type rash covering her bilateral chest that extended to the right side of her back. She was diagnosed with dermatitis related to her chemo, bacterial and fungal infections, zoster infection and natural skin changes from chemotherapy, radiation, etc. Last month, Laura decided to go a dermatologist in La Jolla at a “cash-only” practice. I eagerly agreed for my wife to proceed with a skin biopsy that cost $1,400. Frankly, it was a blessing that she underwent the skin biopsy because the dermatologist told us that it revealed metastatic breast cancer. An immediate call was made to Laura’s oncologist and he requested a PET scan which was, as usual, denied by the insurance company.

We have a very young dying mom of two who wants to live. It is obvious that her three chemo cycles, radiation treatments, and radical bilateral mastectomies have not cured her and yet her health insurance is denying her basic health diagnoses that her doctor, the cancer expert, is recommending so he can be better informed to attempt to save her life. I just couldn’t wait for the usual bureaucratic time-wasting process and decided to immediately get the PET scan done and I paid for it out of my pocket. Incredibly, the cancer center told us that they could not, and would not, schedule a PET scan even though I wanted to pay for it. So, forced to use the bureaucratic process despite our wishes, we waited for two more long weeks for the final insurance approval.

During this time, my wife was told at least six different times that she did not have
insurance coverage and needed to get another health insurance that would cover her needed therapy. At the end of the two-week period, she was then told that she had an additional policy and if a payment was made they would activate this new policy and would continue with her oncological treatment. This policy was unknown to her but we made the $1,000+ payment and that policy was activated. During all of this, our 5-year old son, our 7-year old daughter and I were left without any health insurance coverage because our policy had somehow been terminated. She was told to reinstate us; we will need to wait until this coming summer 2017 when enrollment period opens up again.

...if you are dying and you don’t want to die and you want to live long enough to be at your daughter’s wedding, you don’t want or deserve to hear that your health insurance company will not cover the medications that you need to survive...

A PET scan was finally authorized after two weeks of denial from the health insurance company. She underwent her PET scan study on Monday, March 6, 2017. The following day, we met with her oncologist and he showed us her PET scan. While viewing the PET scan on his office computer, the doctor informed us that everything highlighted in red – other than her heart - was cancer. Her whole chest highlighted red as well as the right side of her neck. She now has metastatic breast cancer to her chest, lungs and right side of her neck. The doctor told us that Scripps Institution had partnered with MD Anderson Cancer Center which is the #1 Breast Cancer Research Institution in the country. He said that he had four new chemo agents available for cases like my wife - for that second and moment, it made me happy and I silently said, “Thank you, God.” However, the doctor cautiously said that we have to be conscious of the cost of the chemotherapy because “your health insurance will not cover its cost. But, I will seek help from the Breast Cancer Foundation to help share the cost.”

Now, if you are dying and you don’t want to die and you want to live long enough to be at your daughter’s wedding, you don’t want or deserve to hear that your health insurance company will not cover the medications that you need to survive and beat cancer. At the same time, she knows that her dedicated husband works
80 hours a week healing and saving people’s lives at the hospital and has insurance that should provide a comprehensive life-saving treatment if she ever needed it. Horribly, Obamacare is denying her basic health insurance coverage to save her life.

On March 10, 2017, she was scheduled by her doctor to begin her fourth chemo cycle at noon. At that time, I was working at Sharp Grossmont Hospital ER when I received a call from my wife and she said, “Oh, I’m here for my chemo therapy but they just told me that the insurance company has not approved my chemo yet.” My mind was racing and my heart had sunk to the bottom of the deepest dark ocean on the planet, but I told her with my best relaxed voice to please stay and make sure she gets her five-hour life-saving chemo infusion and if there is any trouble, I would immediately leave the ER department and drive over there to make sure that she did not leave the cancer center without her treatment. Her chemotherapy continues as I write this story and the outcome is still unknown and we do not know what the future holds…

Unfortunately, Obamacare is “rationed care.” The program emphasized the need to control rising health care spending even though the primary focus of the bill was to expand insurance coverage. Given those two opposing goals, it’s obvious that giving more people access to more insurance and mandating that insurance cover more services will result in more spending, not less. The only way Obamacare can accomplish its goals is through greater efficiencies (i.e., rationing) by increasing profits to health insurance companies, pharmaceutical companies, hospitals, etc - at the cost of reducing adequate delivery of health care or through reductions in access to care or the quality of care to the American people.

The current health care legislation comes closest to success on the issue of expanding the number of Americans with insurance. Obamacare represents an improvement over the status quo on this measure by providing more Americans with insurance cards, but this is a modest achievement. This change has come at the price of increased insurance costs, especially for younger and healthier individuals, and reduced consumer choice. At the same time, Obamacare has applied $2.3 billion in cutbacks for services that the government (not the doctors) believes are overused, such as diagnostic screening and imaging services. This comes at an unacceptable expense of killing tens of thousands of Americans like my wife, the mother of my two young children.
“Working on a New Plan,” La Mesa Courier, May 26, 2017

KNSJ Community Radio interview, May 31, 2017

Concierge Medicine Today, June 2, 2017

Direct Primary Care Journal, June 6, 2017

“Single Payer: Just Another Form of Bureaucratic Control,”
East County Magazine, June 8, 2017

KSEE-24 interview, June 26, 2017

“Regulations Strangling Medical Profession,”
Pomerado News, June 29, 2017

Interview, Brett Winterble Show, KFMB AM760, July 18, 2017

Interview, Real Talk San Diego, July 19, 2017

Interview ABCNews10, July 25, 2017

“Taming Big Pharma,” La Mesa Courier, July 28, 2017
EVENTS

Congressman Duncan Hunter Town Hall Meeting
March 11, 2017 @ 10 am
Ramona Main Stage, 626 Main Street, Ramona

La Jolla Sunrise Rotary
April 27, 2017 @ 7 am
La Jolla Shores Hotel, 8110 Camino Del Oro, La Jolla

San Diego County Taxpayers Association
May 2, 2017 @ 10 am
5575 Ruffin Road, Suite 225, San Diego

Coronado Rotary Binacional
May 22, 2017 @ 12:30 to 2 pm
Coronado Public Library, 640 Orange Avenue, Coronado

Escondido Republican Women Federated
May 24, 2017 @ 11:30 am
Cocina del Charro, 890 W Valley Parkway, Escondido

Rotary Club of San Marcos
May 25, 2017 @ 12 noon
Old Spaghetti Factory, 111 N Twin Oaks Valley Road, San Marcos

Chula Vista Sunset Rotary
June 6, 2017 @ 6:30 to 8:15 pm
First Bank, 2314 Proctor Valley Road #101, Chula Vista
EVENTS

**Encinitas Rotary**
June 14, 2017 @ 12 to 2 pm
Elks Lodge, 1393 Windsor Road, Cardiff-by-the-Sea

**Rotary Club of Kearny Mesa**
June 15, 2017 @ 12 to 1 pm
Hui An Garden Restaurant, 4764 Convoy Street, San Diego

**Torrey Pines Rotary**
July 19, 2017 @ 12 noon
Rock Bottom Brewery, 8980 Villa La Jolla Drive, La Jolla

**Chula Vista Rotary**
July 21, 2017 @ 12 noon
Chula Vista Golf Course, 4475 Bonita Road, Chula Vista

**Vista Hi Noon Rotary**
August 1, 2017 @ 12 noon
Shadowridge Golf Course, 1980 Gateway Drive, Vista

**San Diego Republican Women Federated**
August 19, 2017 @ 6 pm
Rancho Bernardo Courtyard, 16935 W Bernardo Drive, San Diego

**Fallbrook Republican Women Federated**
September 8, 2017 @ 9:30 am
Pala Mesa Resort, 2001 Old Hwy 395, Fallbrook
EVENTS

Escondido Rotary Club
September 12, 2017 @ 12 noon
Escondido Center for the Arts, 340 N Escondido Boulevard, Escondido

Optimist Club of Coronado
September 14, 2017 @ 6:45 am
Coronado Community Center, 1845 Strand Way, Coronado

Pt. Loma Republican Women Federated
September 20, 2017 meeting @ 11 am
Pt. Loma Café, 4865 N Harbor Drive, San Diego

Intermountain Republican Women Federated
September 25, 2017 Fundraiser
TBA

Clairemont Republican Women Federated
September 30, 2017 BBQ @ 11:30 to 3 pm
2112 Galveston Street, Clairemont
Places doctors and patients in charge of health care, not government or insurance companies

Prompt access to a doctor of your choice at truly affordable prices

Low monthly fees, no co-pays

Unlimited office visits, same day appointments, routine care and basic tests at no additional charge

Medications at negotiated or wholesale prices

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Enhances competition, brings health care costs down

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(858) 255-1348 · dr.jamesveltmeyer@yahoo.com
www.VeltmeyerforCongress.com