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The Future of Healthcare in the United States

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Recent reforms in the field of healthcare have sparked an interesting debate amongst a large percentage of the U.S. population, as well as an internal debate within myself. With the presidential election looming large, I feel that it is vital to settle this internal dispute and establish a strong position on the matter. I also feel that diving deep into the source material will be essential for my future career path. As a senior undergraduate in chemistry at the University of Tennessee, I ultimately wish to pursue a medical degree and become a leader of my community as a family doctor. Thus, learning the various intricacies of the healthcare system will certainly be beneficial toward excelling in my future craft in addition to increasing my preparation for medical school interviews. I am hoping that my research on this topic will lead to a better understanding that I can utilize to my advantage not just for getting into medical school but also for making a well-informed vote in this year's election. I finally hope that the reader will find my honor's thesis informative and obtain a better grasp on such an important subject.

In the ever-changing landscape of U.S. healthcare policy, it is important to be prepared for what may be coming next. The health system that is currently in place now may be untouched, tweaked, or completely changed in the near future—one can only speculate on the events that will occur. Currently, however, we are much more preoccupied with adjusting to what we presently face. Healthcare reform has been revitalized under the Obama administration over the course of the last five years with the passing of the Affordable Care Act (colloquially known as “Obamacare”). The future existence of this piece of legislation, though, hinges on the

outcome of this year's presidential race. Republican candidates have denounced the ACA and called for its repeal, while their Democratic counterparts wish to build off of the ACA's components. Thus, as a nation we may be faced with a multitude of contrasting options. Do we scrap the current plan to develop a brand new one? Would we be satisfied with a long-term dedication to the ACA? Or should we explore the possibility of universal healthcare as advocated by Senator Bernie Sanders of the Democratic Party?

My honor's thesis study will investigate these possibilities in order to inform readers who wish to learn more about these matters (including myself) and prompt a thought-provoking discussion for which direction would be best for our country. The majority of this article will focus on describing many of the aspects that come with the Affordable Care Act. Its features and objectives will be outlined, modern statistical data will be presented, and prospective impacts on the involved parties will be explored. The ACA is a vast piece of legislation, thus explaining its inner workings will constitute quite a lengthy portion of my thesis. The final topic of discussion will be devoted to what lies on the horizon in the field of healthcare. The stances of each political party point toward several assumptions on how the health system may proceed, and several possible outcomes will be considered and provided for the reader.

The Affordable Care Act

Before delving straight into “Obamacare”, it is necessary to examine the infrastructure of the healthcare system prior to the Obama administration, most importantly two of its primary components: Medicare and Medicaid. These influential programs have had a longstanding relationship with the American population for decades and have proven to be important building blocks for President Barack Obama’s vision. Medicare is a federally run program that covers people who are either disabled or over 65 years of age and retired, while Medicaid involves the government and state working together to provide healthcare for low-income individuals. Prior to the ACA, though, Medicaid had been limited to several categories of the poor population, such as single parents, children, and pregnant women. Additionally, each state had its own set of rules for who was eligible, including its own poverty threshold that varied from state to state (Hall and Lord, 2014).

Due to Medicaid’s exclusivity, a large portion of the poor population was not covered publicly (through the government), and they were unable to buy private insurance due to its high costs. Those that were actually able to pay for private insurance or obtain it through their workplace might still have been out of luck if they had pre-existing health conditions, though. Private insurance companies held the right to screen potential recipients and decline to provide them insurance services if the individual’s unhealthy history could cost them money in the long run. They could also raise the charges for these individuals in an attempt to recover from losses due to insurance claims. This could then be followed by the dropping of

coverage stemming from the individual's inability to keep up with the payments (Hall and Lord, 2014).

What all of these restrictions amounted to was roughly 50 million (16 percent of the population) uninsured people prior to the beginning of the ACA in 2010 (Hall and Lord, 2014). This shocking statistic, by far the worst of any developed nation, needed to be alleviated in the eyes of President Obama during his tenure in office. His proposal, after several years of restructuring to Congress' liking, eventually came to be known as the Patient Protection and Affordable Care Act (PPACA)—shortened to the Affordable Care Act (ACA) and frequently presented as “Obamacare”. Its overall goal was—and still is—to eliminate the percentage of uninsured individuals in America, and it contained several tenets as to how it would do so.

The ACA's first mode of action was geared toward the insurance companies, disallowing them the right to refuse any applicants based upon their health status. This effectively limited the power that insurance companies originally held and prevented unfortunate individuals from being without much-needed coverage. The ACA's second major objective was to expand Medicaid, which had previously been a somewhat discriminatory program. Medicaid would now provide insurance for everyone near the poverty line regardless of the makeup of the family (i.e. single parent, pregnant mother, etc.). The proposition of this expansion was immediately challenged by several states, however, since a portion of Medicaid's expenses was still expected to be funded by the states. This became a major roadblock to the implementation of Medicaid extension as states had the option to decline President

Obama's plan, an issue that will be explained in more detail later on (Hall and Lord, 2014).

In addition to the two aforementioned goals of the ACA, there are many other features that are involved. For instance, some companies have chosen not to provide insurance for their employees, which places the employees in an unfair position. Thus the government would extend private insurance to these individuals (a process called subsidization)—assuming that their income status was not in line with Medicaid eligibility (Hall and Lord, 2014). In order to maintain a certain level of fairness, each loan was meant to mirror the framework of most group insurance plans (through the workplace) with flexible options and reasonable costs (Hall and Lord, 2014). The flexibility I speak of is exemplified via choices such as the Bronze plan or the Platinum plan, which either involve low premium (payment) costs and high copays (Bronze) or vice versa (Platinum) (Diaz, 2015). Additional subsidies could be extended to particular people who generally could just not afford to pay for insurance due to the loss of a job or other factors of this nature (Hall and Lord, 2014).

For these subsidies to work, though, the recipients had to do their part in the process and buy insurance. This is where another more widely known feature of the ACA comes into play. For those that had the opportunity to enroll in an affordable plan (labeled as single coverage costing less than or equal to 8 percent of the household income) but chose not to, they would be charged a penalty of close to 1 percent of their taxable income with a steady increase in subsequent years. Large businesses of over 50 employees that failed to offer a set of minimum essential

benefits to their workforce would also be charged a monetary penalty for each individual not covered. The existence of these federal mandates soon instigated arguments over its constitutionality. It is important to note that the ACA always includes an element of choice, though, allowing states to opt out of Medicaid expansion or employers and employees to defer purchasing healthcare. Even the imposed mandate was constructed in a way that reflected the personal choice of the individual as opposed to a penalty for violating a law. While some individuals and companies are content with paying the penalty, others may just be unaware on how to obtain insurance. Health insurance marketplaces, or health exchanges, were thus established to service new enrollees by aiding them in purchasing a health plan that works best for them (Hall and Lord, 2014).

Overall, the purpose of the ACA was meant to only affect members of the uninsured population. Naturally, a ripple effect created ramifications for the insurers and physicians, but the ACA's original intentions are undeniable. Those that were insured could keep their current insurance, and the method for which private insurance pays doctors and hospitals would be unchanged. Furthermore, the way in which physicians from all specialties operate would not be affected any more than they already are by outside sources, such as insurers or government agencies (Hall and Lord, 2014). In other words, the normal routine that doctors have become accustomed to would not be different. So, in conclusion, despite the direct impact on the power of the insurance companies to deny patients for fear of cost, eradicating the embarrassing 16 percent uninsured would be accomplished by the ACA. So how successful has it been thus far in doing so?

ACA Statistics*

**All information presented in the statistics section comes from references 2-4 of the works cited page. These references can be viewed for further information on the ACA. Keep in mind that the U.S. population at the beginning of 2015 was estimated to be roughly 320 million.*

A large number of statistical information can be viewed on the Obamacare website (obamacarefacts.com). The reliability of the data presented on this webpage was confirmed through a variety of other sources, so I highly recommend it for finding further information if you feel compelled to do so. Much of this information is intended to show the ACA as a success, however there are still some negatives that can be drawn out of the material. For instance, the data below demonstrates a quick decline in the uninsured percentage after initial reports in 2014, but this trend tapered off to a large extent over the next year. Thus, it is important to remain objective to the following statistics and search for trends to predict the future of the ACA's impact.

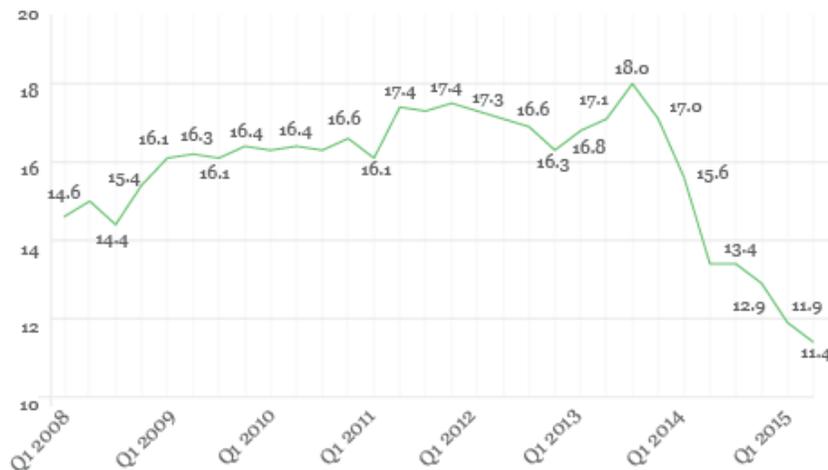


Figure 1. Percentage of uninsured individuals per yearly quarter over the age of 18 as presented by obamacarefacts.com.

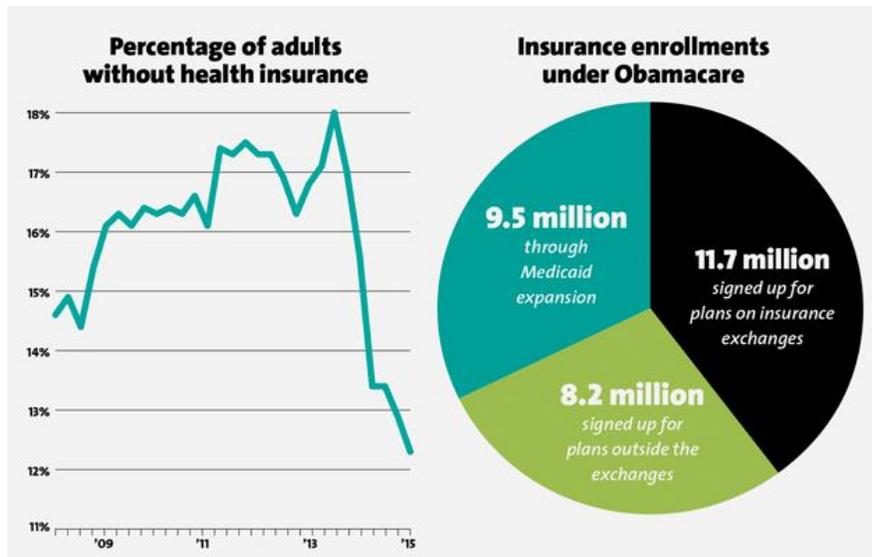


Figure 2. Information on a few general results that pertain to the ACA. Data is obtained from Mother Jones, an investigative news organization that specializes in politics. Sources for this study were taken from ACAsignups.net, a data-intensive tracking system for enrollments, and Gallup, a research-based company.

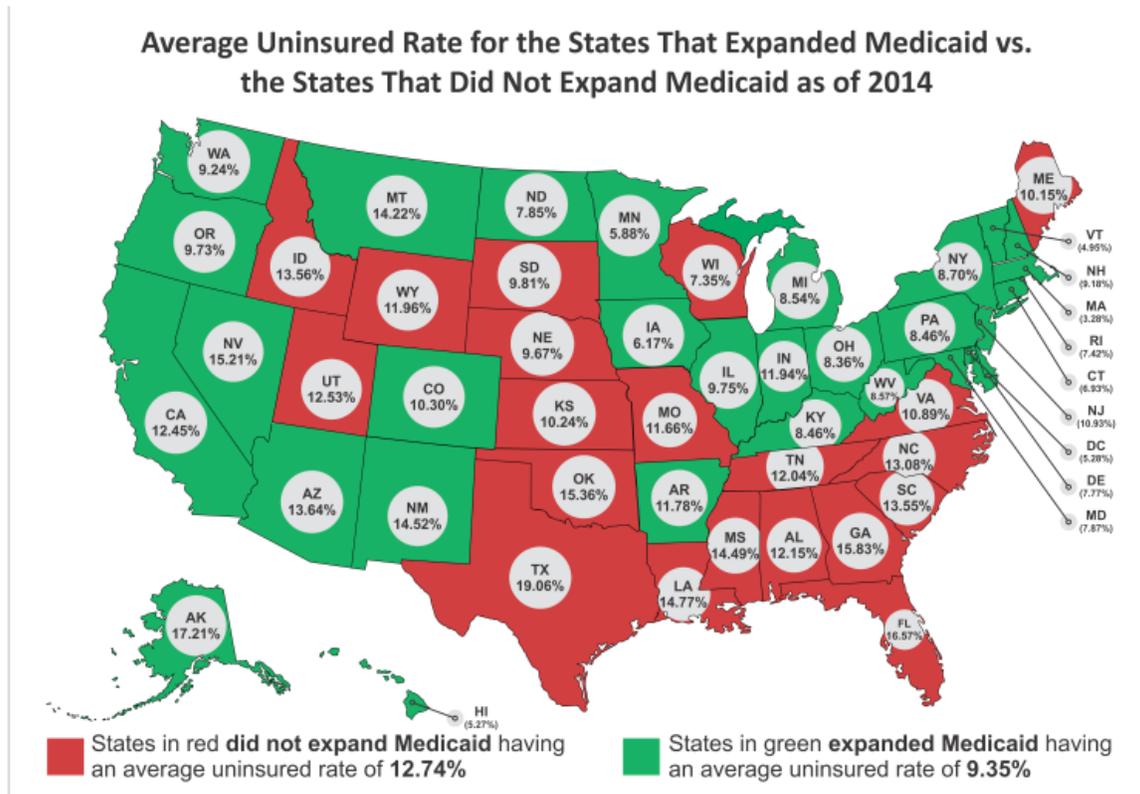


Figure 3. Demographics provided by wallethub.com

Figures 1 and 2 confirm a consistent uninsured percentage of 16 percent in the first few years of the current decade with a spike of 18 percent just prior to the beginning of the ACA in late 2013. The early part of 2014 showed tremendous progress in the amount of uninsured individuals, dipping almost five percent. These numbers have slightly fallen off, however, only decreasing another two percent in the next year to a total of 11.4 percent. This 11.4 percent is certainly not to be taken lightly, though, for it is the lowest it has been since this data was tracked 50 years ago. Figure 2 translates this percentage to a number and splits it up amongst three insurance-obtaining categories. It is clear that the majority of the newly insured population purchased insurance through the provided health insurance exchanges, proving that these agencies did a solid job at helping people find insurance. It is important to note, though, that the pie chart shown in Figure 2 (which corresponds to the first quarter of 2015) is not so different from how it may have looked in 2014. According to the Obamacare central site, 8 million individuals enrolled in the marketplace in early 2014, proving that only 3.7 million enrolled within the next year. Statistics for early 2016 have unfortunately not yet been released, but these aforementioned trends are worth monitoring to determine whether enrolling is on the decline.

Figure 3 is associated with the argument over expanding Medicaid. Overall, a large portion of states experienced a decrease in their uninsured percentages based upon factors mentioned previously, such as purchasing insurance through or without help from the marketplace. While many states that opted into the Medicaid plan were able to drop below double-digit percentages, the same cannot be said for

the states that did not opt in. This was to be expected since a larger area of the poverty line could now be covered, but this nonetheless displays effectiveness of the plan. The average percentage of uninsured in these states (9.35% according to Figure 3) would also be lower if not for the Southwest region, which I assume has issues with illegal immigrants from the Mexican border. The reason for not opting into Obamacare can be traced back to the high levels of funding but also to the traditional political party landscape, as evident in Figure 3 (i.e. southern states typically support the Republican platform, etc.).

Some other notable takeaways from the installment of the ACA are as follows: 2.3 million young adults were able to keep coverage on their parents' plan after the ACA extended the age limit up to age 26 (Ehley, 2015); hospitals have saved 7.4 billion dollars by not having to cover the costs of uninsured patients (Leonard, 2015); and states that did not expand Medicaid caused our nation to lose out on 66 billion dollars of economic output through year 2017 (Leonard, 2015). This latter figure stems from insured individuals being more apt to see more physicians and purchase more medical goods and services.

Conflicting Views on the ACA

So, despite all the seemingly good implications of the Affordable Care Act, why is there so much opposition and disdain? First and foremost, more insured patients equal a higher demand for medical services. This demand exceeded initial projections, and the ACA's goal of reducing medical costs was quickly threatened. To alleviate this pressure, funding for Medicare was reduced as well as the

compensation for physicians and hospitals (Diaz, 2015). In an effort to make up losses and maximize profits, hospitals soon began joining forces, a process termed regionalization (Rudnicki, et. al, 2015). The consolidation of hospitals to bigger cities causes problems for the rural population who are now expected to travel further distances for emergency care (Rudnicki, et. al, 2015). The need for more family doctors has become apparently clear, however the number of patients seeking primary care has piled up faster than the influx of providers from residency programs (Diaz, 2015). All of this has strained the health system, and the physicians are receiving the brunt of it.

A large portion of the general population is uncomfortable with the ACA, too, and it primarily has to deal with the imposed mandate. The mandate has undoubtedly pushed previously unwilling individuals to purchase insurance, but others are still content to pay the penalty given that it is currently less than insurance payments (Diaz, 2015). An additional factor that reinforces this behavior is the eradication of pre-existing conditions. Uninsured people can now wait to buy insurance until a serious medical condition arises, which cannot be declined by insurance companies under ACA law (Diaz, 2015). The penalty that applies to large businesses for not offering health benefits to their employees is also less than the cost of actually providing it. As a result, some companies prefer to pay the penalty, too, which can be detrimental to their employees.

Many people are also unhappy with the health exchange system that provides the subsidies for those in need. In regards to this, I have heard the same question posed in similar fashion by several professional adults: “Why should my

hard-earned money go to lazy, unemployed individuals?" A small group of dissenters from Virginia felt the same way and filed a lawsuit against the government in early 2015. They claimed that only state-run exchanges, as opposed to federal exchanges as well, should be able to issue out subsidies to those that qualified based upon language written in the ACA. The Supreme Court battle, *King v Burwell*, lasted until late June when they decided against the plaintiffs and upheld the federal exchange system. This was a major win for the Obama administration given that only 16 states have state-based marketplaces (Lyon, et. al, 2016). 6.4 million people would have lost their subsidized health coverage and premiums would have risen 287 percent had *King v Burwell* been decided differently (Ehley, 2015). On the other hand, the government would have saved \$1.7 billion a month if the federal marketplace ceased to exist (Ehley, 2015). Thus, federal subsidies can be viewed with positive or negative connotations.

The last major form of opposition to the ACA has come from several states that refuse to expand Medicaid. Protestors believe that an extension of Medicaid makes our citizens more dependent on the government, and their concerns carry some credibility. Studies indicate that under the current system, by 2021 nearly 50 percent of the population will be relying on federally supplied healthcare (Owcharenko, 2013). Many state legislators are uncomfortable with the idea, too, since Medicaid already constitutes the highest portion of their budgets at an average of 23 percent—interestingly just larger than education expenses (Owcharenko, 2013). Asking for a commitment to an increase in this percentage would limit other necessities like education, transportation, and emergency services. The Obama

administration pledged to fund 100% of the costs of any new Medicaid enrollee; however, this provision would change to 90 percent after three years (Owcharenko, 2013). Consequently, states are understandably skeptical. Finally, a 2013 poll showed that one in three doctors were unwilling to care for new Medicaid patients due to the low reimbursement they would receive for their service (Owcharenko, 2013). So even one-third of the actual doctors are unimpressed with the prospect of Medicaid expansion. Despite these drawbacks, there are still many positive ramifications from an enlarged Medicaid program, some of which were outlined in the statistics section of this thesis.

More recently, studies have shown that diagnoses requiring close care like diabetes and heart disease have been increasing (Huston, 2016). This may in fact be a result of our nation's continual struggle to overcome obesity, however it seems more likely that the majority of new-onset diabetics are just Obamacare enrollees that have finally begun to seek treatment since they now have healthcare. Regardless, the magnitude of associated hospital visits has risen to unexpected values and is hinting toward a necessity for larger premiums to cover the medical costs (Huston, 2016). A second cause for concern comes from the health exchange market and one of its primary contributors: UnitedHealthcare. The nation's largest insurance group very recently announced a withdrawal from many of the 36-state marketplaces due to staggering financial losses (Galewitz, 2016). A key aspect toward the idea of state marketplaces was competition, which was supposed to bring down premiums. But now a few states have been reduced to one insurer who can now set their regular payments however they'd like without fear of losing their

customers to other competing sources within the state (Galewitz, 2016). Word of healthcare mergers also poses an issue at the expense of competition as well (Galewitz, 2016). Even though other insurance companies have not commented on potentially following suit, this is still an important occurrence to monitor.

In summary, it is only natural that such a major change to the nation's medical infrastructure has raised so many eyebrows. It has caused many individuals to change their financial habits, having to either allocate more of their income to healthcare-providing federal taxes or prepare for the possibility of increased premiums. And then there are those entities that choose to completely avoid change, whether it be companies or people that prefer to pay the tax penalty. Although a sicker population and instability within the exchange marketplace have crippled the ACA to some degree, it can be said that the biggest roadblock to the success of the ACA is a lack of cooperation. The ACA requires a team effort from the state and federal governments in providing healthcare for the entire country, yet some states refuse to expand Medicaid. Additionally, many individuals and companies don't care about purchasing insurance, further defeating the ACA's purpose. So despite a very admirable and promising improvement to the percentage of uninsured Americans, true and effective change will not occur unless all parties agree to work together.

This viewpoint is my exact opinion on the matter. I believe that the idea behind the Affordable Care Act—providing healthcare to more of the American population—was something that ought to be explored due to such a high uninsured percentage. A primary duty of our commander in chief is to protect the American people, and I find it inspiring that the Obama administration wishes to help us lead

healthier lives and be covered in case of a medical emergency. The ACA has definitely succeeded so far in its main goal; however, I find some of the resulting implications unsettling such as the increased premiums and strain on physicians. I believe that the route we are taking is heading the right direction—we as a nation would not move forward if every act were undone. It is evident, though, that certain changes do need to be made to reduce the ACA's unintended consequences.

What Lies on the Horizon

It is clear that our nation has become more similar to the universal healthcare systems seen in many European countries and Canada, but it is important to note that there are still major differences. First and foremost, universal healthcare implies a single-payer system fully funded only by the federal government. Our current system, as implemented by the Affordable Care Act, is arranged as a shared responsibility between the federal and state levels. While we may be only one step away from this single-payer establishment, the reality of it actually happening soon is unlikely due to the current makeup of our political institutions. For instance, part of the reason why the ACA took so long to proliferate was due to the Republican majority in Congress. Proponents for universal healthcare, most notably Democratic candidate Bernie Sanders, would undoubtedly face the same dilemma in attempting to put their plans into action.

Say, however, that laws employing universal healthcare ended up passing with flying colors—assuming that Sanders was the winner of the 2016 election. What would it look like in America? How would it compare to other countries? Both

questions can simply be answered as “different”. Universal healthcare works so well in other countries like Canada, Great Britain, France, and Germany primarily due to their population size. All four countries fund healthcare through their general revenue, while America does not generate enough revenue to service the entirety of its population (Rashford, 2007). Additionally, America devotes a much larger percentage of its resources to the field of medicine, which translates to a large sum of money required to keep everything running (Rashford, 2007). From this point stems Mr. Sanders’ idea for increasing various forms of taxes (on payroll, income, and on the wealthy) in order to adequately fund the system (Starr, 2016). If indeed this were to work, what is there not to like about the government covering your medical costs?

Well, for one, it is unlikely that absolutely ALL medically related products and services would be covered. For example, Canadian citizens must pay for prescriptions themselves (which we all know can be very expensive at times), and the French government does not pay for dental and eye care (Rashford, 2007). Next, it is unclear whether the patients would actually fully benefit from this plan given that wait times for procedures would have to increase—there are just not enough physicians available to provide prompt care for 300+ million individuals. This could mean weeks to months before arranging an appointment for much-less pressing issues (like a Lasix procedure or even repairing a torn rotator cuff), and it certainly means general difficulty in obtaining a primary doctor visit. The physicians would also take a hit to their salaries as part of the funding process, and they would be

unable to make up for their losses on Medicaid patients by over-charging the privately insured (something they would do at times before) (Starr, 2016).

So maybe universal healthcare isn't exactly the solution. Senator Sanders has a good chance of not even making the Democratic ticket, anyways. So what does former U.S. Secretary of State Hillary Clinton envision? For the most part, she advertises only a tweaking of the Affordable Care Act. She wants to make it harder for insurance companies to merge, allow three visits to a primary physician per year without having to pay a deductible, and create a tax credit for people when their out-of-pocket costs add up to over 5 percent of their income (Kodjak, 2016). She has other ideas as well, but it is clear that she wishes to alleviate the financial strain on insured individuals while keeping the language of the ACA intact.

Business mogul Donald Trump's stance on this issue, however, is far from clear. He was originally very suggestive of a universal healthcare route through statements such as "everybody's got to be covered" and "the government's going to pay for it", which he proclaimed in September 2015 (Diamond, 2016). Since then he has become more anti-Obamacare, wishing to repeal the act and create something new. His recently released plan involves some very promising ideals, however they might be taken lightly due to Trump's ambiguity at times. In order to help those that live in states with only one or two insurance groups in its marketplace, Mr. Trump proposes the sale of insurance across state lines (Diamond, 2016). This would certainly be beneficial to many people in the wake of United Healthcare's exit from several state exchanges. His final main proposals involve making premiums tax deductible and eliminating the federal mandate (Diamond, 2016).

Although all of the possible candidates in this year's presidential election have offered intriguing ideas on healthcare reform, the future course of healthcare in America is still very much up in the air. When conducting this thesis, it was entertaining to try and predict all of the possible directions we as a nation could go. I quickly learned though that it is virtually impossible to judge what may occur given the complexity that encompasses the field of healthcare. Whoever is elected will help create a more transparent picture, but this will only be in regards to the status of the Affordable Care Act—whether it will be built upon or scrapped. Based upon the information I have presented, one can make an educated guess at whose presidential hopeful's plan sounds the most appealing. A politician vying for office only discloses the positives, though, so even the few details I've stated should be read with caution. But when the time comes for changes to be made to our healthcare system, I know that I will understand the material better and be able to formulate an opinion on the matter; and I hope you will, too.

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