Paper 3 Biomedical Ethics
PHI 325 - Dr. Harris

Name: Madison Thompson
Submission Date: May 5, 2026

A Right to Stable Insurance: Data-Driven Incremental Improvements to the American Healthcare System

Word Count: 3884

Previous work has established the American healthcare system as ethically indefensible and critically evaluated the methodology utilized by the Supreme Court to rule against positive healthcare liberties in America. While interesting, such assertions are fundamentally flawed without proposing strategies for redeeming the deconstructed system. This work proposes– based on extensive data analysis of national healthcare expenditures from the Medical Expenditures Panel Survey (MEPS)– a positive liberty to stable healthcare (12-month mandate) as a right for American residents. This right is analyzed from a mathematical, economic, legal, and ethical standpoint. Should it be accepted, it provides the American healthcare system with an ethically defensible component that aligns with existing Congressional law and Supreme Court precedents through the ACA, addressing the concerns of the author's previous work and taking the first step toward incremental improvements to the existing system.

INTRODUCTION

The author's previous work sought to establish that the current American healthcare system is ethically indefensible. Yet, a destructive argument with no proposition for improving the system is no more useful than the system itself. This paper proposes an incrementalistic approach to improving the American healthcare system while functioning within existing social, political, and economic institutions.

Thompson (2026) used convergence frameworks (deontology, utilitarianism, virtue ethics, relational ethics, liberal egalitarianism, justice) and analysis of *Washington v. Glucksberg* to establish that should American residents be compelled to live, there is no ethical defense for existing inequities in the healthcare system. Statistically, these inequities are demonstrated by a 9.9 year difference in life expectancy between high and low-income populations and a 43% natural cause mortality (NCM) difference between urban and rural populations.[1]

While this argument is compelling, it cannot be defended unless it proposes a meaningful change to the system. Further, any change should be responsible, meaning it needs to be congruent with existing healthcare architecture, such that it is genuinely implementable. To find this niche, the author conducted a series of machine learning analyses on data drawn from the Medical Expenditure Panel Survey (MEPS), a nationally representative longitudinal dataset administered by the Agency for Healthcare Research and Quality (AHRQ), spanning 2019-2023 across five annual panels (h216, h224, h233, h243, h251). Individual-level expenditure data across outpatient, emergency, inpatient, and prescription care types were modeled using gradient-boosted regression (XGBoost), with insurance status operationalized as a socioeconomic proxy through an instability variable derived from within-year switching between private coverage, Medicaid, and uninsured status.

Ultimately, it was found that health insurance stability– particularly for the publicly insured– was a key predictor for engaging with healthcare at the model-predicted level.[2] Those with unstable public healthcare or without insurance were classified within lower SES proxy strata, given the relationship between income and insurance status. They are those most likely to negatively experience the aforementioned life-expectancy and NCM differences.

Engaging at the predicted level is generally ideal, given that MEPS is based on expenditures of all individuals in the United States. Overprediction suggests barriers preventing individuals from accessing necessary care, while underprediction suggests crisis-driven acute care. In an ideal society, the model would accurately predict for all social groups, yet there are extreme disparities for those with unstable public insurance (low-income individuals), who were most overpredicted for outpatient and prescription care (preventive care), and most underpredicted for emergency care (acute care), indicating that there exists a significant access barrier for this population.

Based on the data and the ethical necessity of proposing a feasible improvement to the American healthcare system– in a quest to make it ethically defensible– the author proposes a 12-month mandatory insurance guarantee as the first incremental step toward a universally defensible system.

NECESSITY OF INSTITUTIONALLY FEASIBLE INTERVENTIONS

An ethical argument that cannot be implemented is not a solution– it is a preference. The ethical imperative to improve the American healthcare system has long existed, but it has yet to be satisfied by

[1] Madison E. Thompson, "The Ethical Necessity of Rejecting the American Healthcare System," April 2, 2026.
[2] Madison E. Thompson, "Bias Auditing and Correction in MEPS 2019- 2023 Data: A Case Study and Framework for Ethical AI Implementation in Healthcare Settings," May 5, 2026.

critique; it requires proposals that are feasible. In order for a proposal to be feasible, it must be structurally congruent with existing legal, economic, and administrative institutions.

Imagine, if Congress were suddenly to attempt to implement universal healthcare. Pharmaceutical businesses would either be required to go nonprofit or go out of business– leaving what infrastructure? Doctors, nurses, and medical professionals would suddenly have overwhelming case loads and likely experience reduced salaries, resulting in a total collapse of the system. This is not to say that the system does not need to change, or even that universal healthcare is wrong. However, it is to argue that creating change is far from instantaneous, and if that change is drastically distinct from the existing architecture, it will be more destructive than positive, regardless of any intentions held by its facilitators.

As such, there exists a moral obligation for bioethicists who find themselves compelled to argue against the American healthcare system to not only make note of its shortcomings, but to provide clear and actionable improvements that are ethically sound and economically plausible.

The most actionable lever within the existing architecture is the insurance system– the same system the data identifies as the primary site of inequity– and it is here that a right to healthcare can be most immediately and defensibly constructed.

HEALTHCARE AS A RIGHT

The argument of this section is *not* that healthcare is a human right. It is that there should exist, in a healthcare system that is morally defensible, an equal right to healthcare for all members who provide sovereignty to the system via their willing consent. For individuals to give their willing consent, they must do so absent from a state of duress and with knowledge of how they may be affected. This is congruent with Rawls's general conception of justice: "All social values—liberty and opportunity, income and wealth, and the bases of self-respect—are to be distributed equally unless an unequal distribution of any, or all, of these values is to everyone's advantage."[3] Constructing a right– a right to some subset of healthcare in the American system– provides it with an ethically defensible component.

The Content and Design of the Right

The proposed right states that the right-holder is any individual residing in America, the duty-bearer is the federal government via institutional expression of the social contract, and the right is designed to ensure equal access to healthcare regardless of birth, age, race, or socioeconomic status. It seeks to accomplish this via a positive right to 12 months of guaranteed healthcare that cannot be canceled by the government, private insurers (through federal legislation) or individuals. This right protects an individual's access to regular and preventive healthcare– addressing the concerns raised by the MEPS modeling– while preventing excessive government spending on nationally-protected care interventions. The justificatory basis for this right rests on the convergence of benevolent economic design, Rawlsian justice, and the principle of relational autonomy, each developed below.

The Data Argument

Just Train Twice (JTT) is a machine learning algorithm that prioritizes the worst-performing groups of a dataset, retraining machine learning models to prioritize– in the context of healthcare expenditures– the lowest-income, most marginalized populations.[4] This is arguably the data science

[3] John Rawls, "A Theory of Justice," in *Ethics : Essential Readings in Moral Theory* (2012): 393.
[4] Thompson, "Bias Auditing and Correction in MEPS 2019- 2023 Data: A Case Study and Framework for Ethical AI Implementation in Healthcare Settings."

equivalent of Rawls's difference principle, which claims that inequalities in the distribution of social goods are permissible only if they work to the maximum benefit of the worst-off group. As it relates to implementing JTT algorithms to advance the worst-performing groups, without significantly improving outcomes for the well-performing groups, Rawls states: "One is not allowed to justify differences in income or organizational powers on the ground that the disadvantages of those in one position are outweighed by the greater advantages of those in another."[5]

In practice, the baseline model trained on MEPS expenditure data systematically produced the highest prediction error for uninsured and coverage-unstable populations– the least advantaged groups by any Rawlsian measure. Correcting for this required explicitly reweighting training examples from flagged groups, ultimately reducing worst-group RMSE across all care types.[6] The necessity of that correction is itself the ethical finding: a system that requires active intervention to produce equitable predictions is a system that structurally disadvantages its most vulnerable members. The proposed 12-month insurance mandate is a policy action in response to this data– a targeted structural adjustment designed to benefit precisely those the system currently fails, without causing harm upon those it currently benefits.

The Economic Argument

Federal law already mandates coverage of Preventive Health Services under the Patient Protection Affordable Care Act (ACA), including access to vaccinations, annual physicals, and preventive screening.[7] However, this is not federally-funded. Instead, insurers are required to cover preventive services at no cost, meaning the infrastructure for baseline protected care already exists within America's economy. A mandate for equal care opportunity is not novel, but limiting churn to protect both individuals and insurers is.

Every time an individual loses and regains insurance, there are administrative costs, gaps in medication management, and deferrals in care that lead to acute conditions– accounting for emergency expenses, among the most costly per-visit expenditures in MEPS.[8] Further, new insurers are still legally obligated to provide individuals with all rights entitled by the ACA, meaning costs often exceed one suite of preventive services per insured person per year, costing insurance companies more than a stable enrollment model would require.

With the proposed 12-month mandate, individuals are provided with stable and reliable care, greatly benefiting those on public and unstable insurance– the least well-off– per the aforementioned difference principle. Insurers simultaneously receive a more predictable customer base and save money on providing federal services.

This right does not mandate the addition of any new healthcare services or call for excessive spending from existing insurance providers. It simply asks– if we already have a system, and that system has annual requirements– why not ensure they are annually accessible, for everyone? Is that not both following the law as it was intended, while advancing the condition of those in need?

---

[5] Rawls, "A Theory of Justice." 394.
[6] Thompson, "Bias Auditing and Correction in MEPS 2019- 2023 Data: A Case Study and Framework for Ethical AI Implementation in Healthcare Settings."
[7] Patient Protection and Affordable Care Act, Pub. L. Nos. 111–148, 42 U.S.C. (2010): 14.
[8] Thompson, "Bias Auditing and Correction in MEPS 2019- 2023 Data: A Case Study and Framework for Ethical AI Implementation in Healthcare Settings."

LEGAL ANALYSIS

The United States Constitution, as currently interpreted, does not recognize a positive right to healthcare. This is distinct from peer constitutional democracies– Canada, Germany, and the United Kingdom– and the product of judicial interpretation, rather than moral or legal inevitability.

The Due Process Clause of the 14th Amendment currently protects negative liberty– freedom from government interference in medical decisions– not positive entitlement to care. This has been reinforced with aggressive precedent throughout the history of the Supreme Court, most notably in *DeShaney v. Winnebago County* (1989), which established that the state has no obligation under the 14th Amendment to protect individuals from harm to their life, liberty, or property.[9] *Maher v. Roe* (1977) held that states are not required to fund medical services even where a legal right to access them exists.[10] Most recently, *Dobbs v. Jackson Women's Health Organization* (2022) applied the *Washington v. Glucksberg* (1997) standard– requiring that any positive liberty interest be deeply rooted in the nation's history and tradition– to significantly narrow the scope of substantive due process protections for medical procedures.[11]

As established in prior work, the *Glucksberg* traditions test is an insufficient methodology for evaluating novel liberty interests created by modern circumstances.[12] Its application here forecloses judicial recognition of a positive right to healthcare not because such a right is philosophically indefensible, but because the Court's own methodology is not equipped to construct one. This makes legislative action necessary– should a positive liberty right like the one proposed be successful.

The negative and positive rights distinction that underlies this entire framework is not a natural law, it is a design choice that is absent in peer constitutional democracies, including Canada, Germany, and the United Kingdom. Each of these nations recognize positive health rights without systemic collapse, demonstrating that it is possible for the United States to do the same. As it currently exists, the American framework simply has not been legislatively compelled to recognize positive liberties in healthcare, but it is not only feasible, there is international precedent and consensus for doing so.

The Supreme Court and Congress have previously reached some resolution on the issue, namely in *National Federation of Independent Businesses v. Sebelius* (2012), which held that it was within Congressional taxing power to support the ACA through the individual insurance mandate, and fining those who refuse to comply.[13] This ruling demonstrates that both bodies are willing to support implicit legislation related to healthcare, and reasonably determines that while Congress may not compel insurance, it may fiscally encourage it. As such, the ACA's existing mandate that insurers cover preventive services at no cost, the legal infrastructure for a 12-month insurance guarantee already exists within American legislation and is supported by Supreme Court precedent. The proposed right is capable of functioning within an existing constitutional framework, making it architecturally feasible.

---

[9] "DeShaney v. Winnebago Cty. DSS, 489 U.S. 189 (1989)," Justia Law, accessed May 6, 2026, https://supreme.justia.com/cases/federal/us/489/189/.

[10] "Maher v. Roe, 432 U.S. 464 (1977)," Justia Law, accessed May 6, 2026, https://supreme.justia.com/cases/federal/us/432/464/.

[11] "Dobbs v. Jackson Women's Health Organization, 597 U.S. ___ (2022)," Justia Law, accessed May 6, 2026, https://supreme.justia.com/cases/federal/us/597/19-1392/; "Washington v. Glucksberg, 521 U.S. 702 (1997)," Justia Law, accessed April 17, 2026, https://supreme.justia.com/cases/federal/us/521/702/.

[12] Madison E. Thompson, "Insufficient Methodology: Washington v. Glucksberg and the Traditions Test," April 18, 2026.

[13] "National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012)," Justia Law, accessed May 6, 2026, https://supreme.justia.com/cases/federal/us/567/519/.

FOUR-PRINCIPLE ETHICAL ANALYSIS

Beneficence

Beauchamp and Childress define beneficence as a positive moral obligation to act in the interest of others– not merely to avoid harm, but to actively contribute to their welfare. They apply their definition broadly, claiming:

"Many duties in medicine, nursing, public health and research are expressed in terms of a positive obligation to come to the assistance of those in need of treatment or in danger of injury…The range of benefits that might be considered relevant…could even include helping patients find appropriate forms of financial assistance and helping them gain access to health care or research protocols."[14]

Then, is ensuring that all individuals have stable access to healthcare– something that has been statistically proven to promote increasingly positive health outcomes– not a matter of beneficence? Enforcing a 12-month mandate on insurance coverage renders useless Beauchamp and Childress's idea of helping patients find financial assistance by ensuring they gain and maintain access to healthcare.

Subsequently, beneficence is framed as a positive moral obligation, something that individuals are compelled to do for the wellbeing of their peers, even if those peers are already well, with the goal of bettering their condition. This is normatively congruent with the positive liberties that the right to stable insurance– as defined throughout this work– is designed to protect.

Non-Maleficence

Non-maleficence requires that a healthcare system refrain from committing harm upon those it serves. Beauchamp and Childress establish that this principle extends beyond active harm to include the failure to prevent conditions that cause it: "Similar, but more specific prohibitions are found across the literature of biomedical ethics, each grounded in the principle that intentionally or negligently caused harm is a fundamental moral wrong."[15] In its present state, the American healthcare system does not actively deny individuals– particularly those who are low-income– healthcare, but it constructs conditions under which they are unable to reasonably obtain care. A system that knowingly produces systemic gaps in coverage while failing to take action to prevent the harm done upon those in the gaps cannot be considered non-maleficent by Beauchamp and Childress's standards.

Nor is it protected under utilitarianism. While much of this discussion has centered on the rights of the individual, a utilitarian approach extends the argument to the wellbeing of all American residents. Mill argues: "the happiness which forms the utilitarian standard of what is right in conduct is not the agent's own happiness but that of all concerned. As between his own happiness and that of others, utilitarianism requires him to be as strictly impartial as a disinterested and benevolent spectator."[16] By this argument, individual agents have a duty to prevent harm upon their peers just as much as they would prevent harm upon themselves, indicating a moral obligation to uplift the group experiencing any form of disparities in accessing healthcare.

---

[14] Tom L. Beauchamp, "The 'Four Principles' Approach to Health Care Ethics," in *Principles of Health Care Ethics*, 1st ed., ed. Richard E. Ashcroft et al. (Wiley, 2006): 5, https://doi.org/10.1002/9780470510544.ch1.
[15] Beauchamp, "The 'Four Principles' Approach to Health Care Ethics." 5.
[16] John Stuart Mill, "Utilitarianism," in *Ethics : Essential Readings in Moral Theory* (2012): 244.

In the MEPS data, those without insurance (UN_S) represent access suppression, with the lowest utilization of non-emergency healthcare services across any demographic group.[17] This indicates structural exclusion of a low-income group by institutional design. Allowing that exclusion to persist– when a legislative intervention is plausible and supported by precedent– is a harmful policy position that permits ongoing, preventable harm to a specifically vulnerable population. It is morally urgent that some action is taken to end healthcare access suppression for these individuals. A 12-month mandate removes the harm at a societal scale by ensuring no member of the system is structurally excluded from its baseline protections, as is congruent with the broad demands of non-maleficence.

Autonomy

Unstable insurance access prevents individuals from exercising their autonomy, as they cannot reliably choose providers or medications. Stable insurance is arguably a prerequisite for exercising autonomy in a healthcare context, and this right would guarantee such rights upon American residents. This aligns with the liberty interest in the Philosopher's Brief and *Planned Parenthood v. Casey* (1992), which consistently iterates: "It flows from the right of people to make their own decisions about matters 'involving the most intimate and personal choices a person may make in a lifetime.'"[18] Without consistent access to the resources that an individual needs, how are they to make a decision?

They cannot, meaning the American healthcare system as it is currently designed strips those with unstable insurance access of their right to autonomous healthcare decision making. From a data science perspective, this is seen in the bidirectional output of the MEPS data– individuals with unstable access either receive no preventive care, or excessive acute care– reflecting an inability to regulate one's health.[19] The 12-month mandate does not override individual choice, it protects the conditions that allow individuals to make meaningful and free decisions about their healthcare.

Justice

As previously explored in *The Data Argument*, justice requires that the benefits and burdens of healthcare– or any system which a society supports– be distributed equitably. No individual should be denied access to care on the basis of race, income, age, sex, socioeconomic status, or any other demographic factor. Although not explicitly defined by Beauchamp and Childress, they assert that a just society provides its members "according to what is fair, due, and owed."[20]

In MEPS analysis, the current American healthcare system shows statistically significant disparities in access that negatively impact Hispanic, female, and publicly insured unstable populations. The most vulnerable population in a society should not be the ones isolated to statistical disparities.[21]

Rawls's Veil of Ignorance offers a useful test: if individuals were asked to design a healthcare system without knowledge of their race, gender, income, or insurance status, would a rational actor

---

[17] Thompson, "Bias Auditing and Correction in MEPS 2019- 2023 Data: A Case Study and Framework for Ethical AI Implementation in Healthcare Settings."
[18] Ronald Dworkin et al., *Assisted Suicide: The Philosophers' Brief*, 44, no. 5 (1997): 4.
[19] Thompson, "Bias Auditing and Correction in MEPS 2019- 2023 Data: A Case Study and Framework for Ethical AI Implementation in Healthcare Settings."
[20] Beauchamp, "The 'Four Principles' Approach to Health Care Ethics." 6.
[21] Thompson, "Bias Auditing and Correction in MEPS 2019- 2023 Data: A Case Study and Framework for Ethical AI Implementation in Healthcare Settings."

consent to participate in the present American healthcare system?[22] It is difficult to imagine so. What if they were to be born a Hispanic woman?

Then, as a counterexample, what if they were instead promised consistent access to healthcare no matter their demographics. Would that be sufficient? It is fair to assert that it would not, given that adjusting insurance status fails to solve issues of systemic racism, sexism, redlining, and urban/rural divides that negatively impact health. However, it is also unfair to argue it would not be an improvement– that a rational agent would not be *more* compelled to accept a system with marginally increased equality. In this way, the 12-month mandate would slowly drive the American healthcare system toward being more ethically defensible.

DISCUSSION

The 12-month mandate for stable insurance coverage proposed in this work is not designed to argue that healthcare is a human right. It argues that, in order for the American healthcare system to become ethically defensible, it surely must grant some positive liberty to its sovereign participants. And, given the current economic state of the system, granting the right to continued insurance– over a 12-month period– would statistically improve well-being for the most at-risk populations, supporting Rawlsian justice while incrementally improving the system.

This argument is not to claim that the right to stable health insurance will certainly improve healthcare for all vulnerable and minority populations in America. Far from it. It fails to eliminate systemic racism, sexism, classism, and urban/rural divides. However, it provides a step toward equality by following the data to improve outcomes for the groups who are currently being most negatively affected.

The math is not the only convincing argument for mandating stable health insurance access. From a beneficence perspective, it takes action about Beauchamp and Childress's mandate to provide broad positive care, from a non-maleficence perspective, it helps end a system that is complacent in individuals falling in the cracks and suffering as a result, from an autonomy perspective, it gives individuals the time and resources to make their own healthcare decisions, and from a justice perspective, it levels the playing field and elevates the worst-off.

Incrementally assigning positive healthcare rights is working toward a goal that is worthwhile and legally defensible. In Canada, Germany, and the United Kingdom, positive health liberties are key to national law. These societies have not collapsed, and the precedent for enacting similar legislation already exists in the United States. Through Congressional and Supreme Court action to support taxation for the ACA, it is national tradition to allow Congress to rule on the enforcement of healthcare legislation.

This is critical, as healthcare legislation that supports access to preventive care for all Americans already exists in the ACA. Enforcing this right would require new legislation, yes, but nothing that is not already architecturally present and congruent with existing legislation and precedents.

In fact, the infrastructure for this legislation already exists and provides a positive economic case. Some may argue: if individuals have to be insured for a full 12 months, would companies not lose money? To this: many individuals will default on payments– there are systems in place to address this, and the reduction in acute and emergency care utilization that results from stable preventive access will offset those costs. A system in which individuals maintain consistent coverage is a system in which insurers can accurately model risk, reduce administrative churn, and avoid the outsized costs of crisis-driven care by providing individuals with regular access to preventive care that they autonomously

[22] Rawls, "A Theory of Justice." 391.

select. The mandate is not a burden on the economic system, it is a correction to the inefficiencies that instability produces.

Some will argue that mandating insurance participation is paternalistic– particularly given that individuals are not provided the option to opt out once they have selected an annual plan. However, it should be noted that this is 1) not forcing state or federal insurance upon individuals, meaning they can still go private, and 2) that paternalism is for the good of the individual. This mandate corrects a market failure in which individual churn produces systemic harm that no individual actor is capable of independently remedying. The actuarial pool requires stable enrollment to function, when individuals exist and re-enter continuously, the pool cannot price accurately and coverage becomes more expensive for everyone. Further, the data shows that consistent insurance is important for overall health even for individuals with private insurance, indicating that this churning has negative impacts on anyone who changes insurances repeatedly. The effects of unstable insurance are drastic, widely distributed based on demographic data, and beyond what a rational agent beyond the Veil of Ignorance would consent to. As a result, mandating that it become stable is not an act of coercion, but one of enabling autonomy.

CONCLUSION

The author's body of work has found that the American healthcare system is fundamentally flawed, to the point where it can be called ethically indefensible. The methodologies that have been employed– particularly by the Supreme Court– to reach this point, are questionable at best, and prioritize negative liberties over endowing Americans with healthcare protections, unlike peer constitutional democracies.

To make the American healthcare system ethically defensible, drastic measures are needed. However, sudden and novel actions will cause more unrest and harm than engaging in incrementalism using the information that is readily available to us. By running extensive data analysis on healthcare expenditure data, the author concluded that beginning the discussion with not a right to healthcare, but a right within the American healthcare system– the right to have stable health insurance– was not only empirically significant, but normatively critical.

Writing deconstructive philosophy is a challenge to few. Establishing well-founded and plausible solutions to follow said deconstruction is the moral obligation of any philosopher who seeks genuine improvements in society. As such, this work focused on establishing positive liberties using existing legal and normative frameworks. It aims to iteratively work toward redeeming the American healthcare system by constructing ethically defensible components that use the existing system architecture as scaffolding.

References

Beauchamp, Tom L. "The 'Four Principles' Approach to Health Care Ethics." In *Principles of Health Care Ethics*, 1st ed., edited by Richard E. Ashcroft, Angus Dawson, Heather Draper, and John R. McMillan. Wiley, 2006. https://doi.org/10.1002/9780470510544.ch1.

Dworkin, Ronald, Thomas Nagel, Robert Nozick, John Rawls, and Judith Thomson. *Assisted Suicide: The Philosophers' Brief*. 44, no. 5 (1997).

Justia Law. "DeShaney v. Winnebago Cty. DSS, 489 U.S. 189 (1989)." Accessed May 6, 2026. https://supreme.justia.com/cases/federal/us/489/189/.

Justia Law. "Dobbs v. Jackson Women's Health Organization, 597 U.S. ___ (2022)." Accessed May 6, 2026. https://supreme.justia.com/cases/federal/us/597/19-1392/.

Justia Law. "Maher v. Roe, 432 U.S. 464 (1977)." Accessed May 6, 2026. https://supreme.justia.com/cases/federal/us/432/464/.

Justia Law. "National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012)." Accessed May 6, 2026. https://supreme.justia.com/cases/federal/us/567/519/.

Justia Law. "Washington v. Glucksberg, 521 U.S. 702 (1997)." Accessed April 17, 2026. https://supreme.justia.com/cases/federal/us/521/702/.

Mill, John Stuart. "Utilitarianism." In *Ethics : Essential Readings in Moral Theory*. 2012.

Patient Protection and Affordable Care Act, Pub. L. Nos. 111–148, 42 U.S.C. (2010).

Rawls, John. "A Theory of Justice." In *Ethics : Essential Readings in Moral Theory*. 2012.

Thompson, Madison E. Bias Auditing and Correction in MEPS 2019- 2023 Data: A Case Study and Framework for Ethical AI Implementation in Healthcare Settings. May 5, 2026. https://drive.google.com/file/d/1Z0l-cCV8PayHuGdRr9UrfrqyLkt4_51n/view?usp=sharing.

Thompson, Madison E. Insufficient Methodology: Washington v. Glucksberg and the Traditions Test. April 18, 2026. https://docs.google.com/document/d/1qr5PGmgM_MJ1PoKIkH-QsgIabvYWyhfKp4XqvR4HIh4/edit?usp=sharing.

Thompson, Madison E. The Ethical Necessity of Rejecting the American Healthcare System. April 2, 2026. https://docs.google.com/document/d/1UFg92srBg7Pki85QVNYtpDLfczF5Jv6MHB8Rn19y8oA/edit?usp=sharing.