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Abigail Moncrieff, *The Freedom of Health*, 159 *University of Pennsylvania Law Review* 2209 (2011).

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SYMPOSIUM SCHOLAR*

THE FREEDOM OF HEALTH

ABIGAIL R. MONCRIEFF†

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* In the Symposium Scholar Essay Competition, the *Law Review* solicited entries from law school students and recent graduates on a topic related to health care reform. The following piece was selected as the winner.

† Peter Paul Career Development Professor and Associate Professor of Law, Boston University School of Law. Thanks to participants at the Harvard Health Law & Policy Workshop and participants at the University of Pennsylvania Law Review Symposium for helpful questions and comments. Thanks also to Jeff Binkley, Katie Sullivan, Namrata Kotwani, and Kyle Thomson for excellent research assistance.

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INTRODUCTION

What would have happened if the Patient Protection and Affordable Care Act (PPACA)¹ really had authorized government “death panels”² that would decide whether or not an elderly patient could get treatment? Leaving aside the Commerce Clause and other constraints particular to Congress, would that kind of direct health care rationing be a constitutional exercise of governmental power in the United States? I think not. I argue here that an emergent substantive due process constraint would invalidate such an exercise; the phantom death panels would violate a constitutional “freedom of health” that is nascent in Supreme Court precedent. Based on that logic, I argue further that the substantive due process analysis of PPACA’s “individual mandate”—the requirement that all Americans carry health insurance—may be more complicated than most scholars have recognized. The existence of a freedom of health implies that we cannot merely dismiss substantive due process challenges to the mandate on the ground that *Lochner* is dead.³

Particularly since 2006, when a three-judge panel of the D.C. Circuit recognized a fundamental liberty interest in obtaining experi-

¹ Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.).

² See Jim Rutenberg & Jackie Calmes, *Getting to the Source of the ‘Death Panel’ Rumor*, N.Y. TIMES, Aug. 14, 2009, at A1 (detailing the political creation of administrative-euthanasia-panel rumors and their lack of basis in the reform bill itself); see also *A Look at Claims About Health-Care Overhaul—Close Up*, SEATTLE TIMES, Aug. 11, 2009, at A3 (debunking Governor Palin’s and other health care bill critics’ view that the bill would create “death panels”).

³ See *Lochner v. New York*, 198 U.S. 45, 64 (1905) (striking down a state regulation of the hours of bakery employees as an unconstitutional infringement on the substantive due process right to freedom of contract), *abrogated by* *W. Coast Hotel Co. v. Parrish*, 300 U.S. 379 (1937); Mark A. Hall, *The Constitutionality of Mandates to Purchase Health Insurance*, 37 J.L. MED. & ETHICS (SPECIAL SUPPLEMENT S2) 38, 45 (2009) (arguing that the mandate implicates only economic interests and therefore, given the death of the *Lochner* era, implicates no modern substantive due process right).

mental drugs (later overturned en banc),⁴ health law scholars have debated the usefulness and propriety of protecting individuals' liberty in medical decisionmaking.⁵ Unlike the international "human right to health," this American "freedom of health" would operate primarily as a restriction on—rather than as an obligation for—governmental regulation of medical decisionmaking.⁶ That is, in the somewhat disputed parlance of constitutional law, the right would be a negative

⁴ See *Abigail Alliance for Better Access to Developmental Drugs v. Von Eschenbach (Abigail Alliance I)*, 445 F.3d 470, 486 (D.C. Cir. 2006) (holding that a terminally ill, mentally competent patient has a protected liberty interest in accessing potentially life-saving investigational new drugs deemed safe enough for expanded human trial), *rev'd en banc*, 495 F.3d 695 (D.C. Cir. 2007).

⁵ See B. Jessie Hill, *Reproductive Rights as Health Care Rights*, 18 COLUM. J. GENDER & L. 501, 537-39 (2009) [hereinafter Hill, *Reproductive Rights*] (urging reproductive rights advocates to ground the abortion right in a constitutional freedom of health); B. Jessie Hill, *The Constitutional Right to Make Medical Treatment Decisions: A Tale of Two Doctrines*, 86 TEX. L. REV. 277, 324-28 (2007) [hereinafter Hill, *Tale of Two Doctrines*] (outlining the Supreme Court's treatment of the individual freedom of health and the state interest in regulating health as separate doctrines and tracing them through Supreme Court jurisprudence); Elizabeth Weeks Leonard, *The Public's Right to Health: When Patient Rights Threaten the Commons*, 86 WASH. U. L. REV. 1335, 1386-88 (2009) (arguing that there should not be an individual freedom of health on the ground that such a freedom would endanger public health); John A. Robertson, *Controversial Medical Treatment and the Right to Health Care*, HASTINGS CENTER REP., Nov.-Dec. 2006, at 15, 16 [hereinafter Robertson, *Controversial Medical Treatment*] (providing legal and historical foundations for a constitutional freedom of health that could be applied in *Abigail Alliance*); John A. Robertson, *Embryo Culture and the "Culture of Life": Constitutional Issues in the Embryonic Stem Cell Debate*, 2006 U. CHI. LEGAL F. 1, 32-37 [hereinafter Robertson, *Embryo Culture*] (arguing that the constitutional freedom of health should prohibit restrictions on embryonic stem cell research); Eugene Volokh, *Medical Self-Defense, Prohibited Experimental Therapies, and Payment for Organs*, 120 HARV. L. REV. 1813, 1815-17 (2007) (basing the freedom of health in a right of self-defense). At least one scholar considered and elaborated this possibility before *Abigail Alliance* was decided. See Elizabeth G. Patterson, *Health Care Choice and the Constitution: Reconciling Privacy and Public Health*, 42 RUTGERS L. REV. 1, 22-28 (1989) (evaluating Supreme Court precedent on the right to refuse proffered care).

⁶ See Hill, *Reproductive Rights*, *supra* note 5, at 503 (explaining the difference between positive and negative rights and arguing for a "negative right to health" that would "be understood as a right *against* government interference in health care access and medical decisionmaking, rather than a right *to* government-provided medical services"); Hill, *Tale of Two Doctrines*, *supra* note 5, at 330 n.277 (same); Robertson, *Controversial Medical Treatment*, *supra* note 5, at 15 (distinguishing "positive rights to state-funded resources" from the right asserted in *Abigail Alliance* and characterizing the *Abigail Alliance* right as a "negative right to health care" that would protect "the right of a patient and doctor to pursue a course of treatment of their choosing without interference by the government"); Robertson, *Embryo Culture*, *supra* note 5, at 7-8 (arguing for a "negative right against governmental interference with therapy . . . not a positive right to state resources").

one rather than a positive one,⁷ protected alongside other negative liberties under the Fourteenth Amendment's guarantee of substantive due process.⁸

As a handful of scholars have already pointed out, there is support in Supreme Court precedent for this kind of constitutional freedom of health.⁹ Particularly in its forced treatment, right to die, and reproductive rights cases, the Supreme Court has hinted that the constitutional right to bodily integrity includes both a freedom to reject unwanted medical intervention¹⁰ and a freedom to obtain certain health care goods and services.¹¹ In other words, the Supreme Court has hinted that Fourteenth Amendment "liberty" includes individual autonomy in health care decisionmaking.

Both the existence and the strength of the Supreme Court's freedom of health, however, are subject to ongoing debate. We know, at a minimum, that the Supreme Court's hints convinced two D.C. Circuit judges to recognize the health care liberty interest, to treat it as "fundamental," and to apply it to invalidate longstanding administrative processes for drug approval.¹² But we also know that litigants asserting the freedom of health in American courts have not always succeeded.¹³

⁷ See generally ISAAH BERLIN, *Two Concepts of Liberty* (drawing out and discussing the difference between positive and negative rights), in *FOUR ESSAYS ON LIBERTY* 118, 122-34 (1969). For a succinct modern legal discussion of the distinction and its limitations, see Richard A. Posner, *The Cost of Rights: Implications for Central and Eastern Europe—and for the United States*, 32 *TULSA L.J.* 1, 2-3 (1996). For a longer critique of the distinction as it applies to American constitutional doctrine, see David P. Currie, *Positive and Negative Constitutional Rights*, 53 *U. CHI. L. REV.* 864 (1986).

⁸ See generally *Washington v. Glucksberg*, 521 U.S. 702, 755-73 (1997) (Souter, J., concurring) (discussing the general theory and practice of substantive due process rights and providing examples of such rights).

⁹ See Hall, *supra* note 3, at 45 (noting that the Supreme Court has recognized a liberty interest in rejecting care and that there might be a similar interest in obtaining it); Hill, *Reproductive Rights*, *supra* note 5, at 531-37 (tracing the freedom of health through Supreme Court and lower court cases); Hill, *Tale of Two Doctrines*, *supra* note 5, at 329-32 (defending the conclusion that "the Supreme Court has already recognized a substantive-due-process right to make medical treatment decisions without unwarranted government interference"); Patterson, *supra* note 5, at 22-33 (cataloging and discussing Supreme Court precedents that support a freedom of health); Volokh, *supra* note 5, at 1824-28 (deriving a right of medical self-defense from the Supreme Court's abortion jurisprudence).

¹⁰ See *infra* subsection I.A.1.

¹¹ See *infra* subsection I.A.2.

¹² *Abigail Alliance I*, 445 F.3d 470, 486 (D.C. Cir. 2006).

¹³ See *Gonzales v. Carhart*, 550 U.S. 124, 165-68 (2007) (affirming a statute banning certain abortion procedures even though they may be safer in some circumstances); *Glucksberg*, 521 U.S. at 705-06 (holding that statutes criminalizing assisting suicide do not violate the Fourteenth Amendment); *Cruzan v. Dir., Mo. Dep't of Health*,

There are, in fact, more Supreme Court evasions of the freedom of health than there are Supreme Court acknowledgements of it,¹⁴ and the freedom of health has rarely been used at all—and never been used alone—to invalidate state action.

Importantly, though, the rarity of judicial invalidation does not prove that the freedom of health does not or cannot exist. First, like all constitutional freedoms, the freedom of health may be implicitly protected in congressional decisionmaking. Indeed, the difficulties in passing health care reform suggest that political constraints of a constitutional dimension might be in play. Second, like all constitutional freedoms, the freedom of health could not be absolute. Even if given the highest level of constitutional protection—if designated a “fundamental liberty interest”—individuals’ freedom of health would be subject to a state-interest override. In standard doctrinal terms, the individual right could be infringed if the restrictive legislation were “narrowly tailored to serve a compelling state interest.”¹⁵ If situated as a typical Fourteenth Amendment liberty, therefore, the constitutional freedom of health would prohibit the government from burdening autonomous health care decisions without a compelling reason, but it would not prohibit narrowly tailored public-health-justified or other-state-interest-justified infringements. So framed, this constitutional freedom seems already to exist, and the Supreme Court certainly could formalize it without deviating from precedent.

This Article first draws out the freedom of health from Supreme Court precedent and demonstrates that, like other substantive constitutional rights, the freedom of health is a negative liberty that must be balanced against legitimate and compelling regulatory projects. The Article then applies that understanding of the freedom to evaluate some proposed and actual health care regulations that have made headline news in the last decade. I consider the constitutionality of the phantom death panels, the H1N1 vaccine distribution program,

497 U.S. 261, 286-87 (1990) (upholding a state’s ability to decline a parent’s request to withhold nutrition and hydration absent clear and convincing evidence of the incompetent’s wishes); *Buck v. Bell*, 274 U.S. 200, 207-08 (1927) (upholding a state practice of requiring sterilization of the mentally ill); *Jacobson v. Massachusetts*, 197 U.S. 11, 38 (1905) (upholding a mandatory smallpox vaccination policy).

¹⁴ See *infra* Part I (discussing numerous instances in which the Court found state interests compelling enough to override the freedom of health).

¹⁵ *Lawrence v. Texas*, 539 U.S. 558, 593 (2003) (Scalia, J., dissenting). *But cf.* *Patterson*, *supra* note 5, at 48-49 (suggesting that courts should use intermediate scrutiny, rather than strict scrutiny, to enforce the freedom of health and defining the relevant rubric).

the FDA's restrictions on access to experimental drugs, PPACA's obesity and smoking regulations, and, of course, PPACA's individual mandate. Should those programs and regulations be constitutionally permissible under a Fourteenth Amendment freedom of health?

My answer is that the freedom of health, if formalized in its current form, would invalidate some but not all of the proposed interventions. "Death panels" (in the form that Governor Palin understood them to take¹⁶) would be prototypically unconstitutional under the new rubric (though incentives for doctors to gather and enforce advanced directives¹⁷—the would-have-been effect of the since-abandoned provision that sparked the "death panels" debate—certainly would not be). The vaccine distribution program during the 2009 H1N1 flu outbreak could have raised constitutional questions if the states had included criminal or high civil penalties for misdistribution of the vaccine, but in the absence of such penalties, the distribution guidelines did not offend the freedom of health. Restrictions on access to experimental drugs should be constitutionally permissible because they promote a compelling state interest in gathering information about the safety and efficacy of new drugs, but the current regulatory regime may not be sufficiently "narrowly tailored" to the state interest it seeks to promote. Obesity regulations might be unconstitutional, depending on their form, while most anti-smoking regulations should not be. PPACA's wellness initiatives do not raise serious constitutional problems.

Perhaps most interestingly (and certainly most relevantly given present litigation¹⁸), the individual mandate would require a more

¹⁶ See Sarah Palin, *Statement on the Current Health Care Debate*, FACEBOOK (Aug. 7, 2009, 4:26 PM), http://www.facebook.com/note.php?not_id=113851103434 (claiming that the health reform bill would require "my parents or my baby with Down Syndrome . . . to stand in front of [President] Obama's 'death panel' so his bureaucrats can decide, based on a subjective judgment of their 'level of productivity in society,' whether they are worthy of health care").

¹⁷ See America's Affordable Health Choices Act of 2009, H.R. 3200, 111th Cong. § 1233 (authorizing Medicare coverage for "advance care planning consultation," including explanation of advance directives, such as living wills, durable powers of attorney, and health care proxies); see also Toby Harnden, *Obama Retreats on 'End of Life' Plans*, DAILY TELEGRAPH (London), Aug. 15, 2009, at 5 (discussing the political demise of § 1233); Charles Hurt, *Granny Lives! 'End of Life' Out of Health Plan*, N.Y. POST, Aug. 14, 2009, at 10 (same); Clarence Page, Editorial, *'Death Panels' Myth Just Won't Die*, CHI. TRIB., Nov. 1, 2009, at 31 (same).

¹⁸ Compare Florida *ex rel.* Bondi v. U.S. Dep't of Health & Human Servs., No. 10-0091, 2011 WL 285683, at *33 (N.D. Fla. Jan. 31, 2011) (holding that PPACA exceeded Congress's authority under both the Commerce Clause and Necessary and Proper Clause), and Virginia *ex rel.* Cuccinelli v. Sebelius, 728 F. Supp. 2d 768, 788 (E.D. Va.

careful analysis under a freedom of health than scholars and courts have assumed. That said, the state interest in enforcing the mandate seems sufficiently strong to support some infringement of individual liberty, and the actual law supporting the individual mandate imposes a negligible burden on the relevant liberty interest. The individual mandate is a necessary element of health insurance regulation, assuming that universal coverage is a reasonable goal; without a mandate, adverse selection will cause many individuals to be priced out of coverage. PPACA's individual mandate seeks to correct adverse selection through an almost entirely rhetorical set of laws, which impose almost no actual burden on the constitutional liberty interest. As written, no executive official has authority to enforce the mandate against non-compliant individuals. As such, the current "mandate" should pass the strict scrutiny test on the ground that it poses an infinitesimal burden to liberty. If, however, Congress were to bolster the mandate with real enforcement power and heftier fines, the constitutional analysis under the freedom of health should, I think, become harder.¹⁹

This Article proceeds as follows. Part I fleshes out the freedom of health, identifying its foundations in existing American precedent and describing its differences from the "right to health" in international law. Part II considers the controversial proposals and enactments that have made news in recent health care reform debates, using analysis of those issues to develop the framework for enforcing a freedom of health.

I. THE FREEDOM OF HEALTH

As a handful of scholars have pointed out, a constitutional freedom of health already exists at the margins of American law.²⁰ In the forced treatment, reproductive rights, and right-to-die cases, the Su-

2010) (holding that PPACA exceeded Congress's authority under the Commerce Clause and Congress's independent taxation power), *with* *Mead v. Holder*, No. 10-0950, 2010 WL 611139, at *21 (D.D.C. Feb. 22, 2011) (granting the government's motion to dismiss a suit that argued against PPACA's constitutionality and sought declaratory and injunctive relief), *Liberty Univ., Inc. v. Geithner*, No. 10-0015, 2010 WL 4860299, at *16 (W.D. Va. Nov. 30, 2010) (same), *and* *Thomas More Law Ctr. v. Obama*, 720 F. Supp. 2d 882, 895 (E.D. Mich. 2010) (same).

¹⁹ This line of analysis does not, of course, speak to the mandate's validity under the Commerce Clause or under various taxing provisions of the Constitution, which have been scholars' and courts' primary focus so far. *See, e.g.*, Steven J. Willis & Nakku Chung, *Constitutional Decapitation and Healthcare*, 128 TAX NOTES 169, 178-93 (2010) (arguing that the penalty for failure to comply with the individual mandate is unconstitutional under taxing provisions of the Constitution).

²⁰ *See, e.g.*, sources cited *supra* note 9.

preme Court has hinted that Americans hold an important—perhaps fundamental—liberty interest in directing their own health care, which at least includes a right to reject unwanted medical interventions and might include a right to obtain desired medical treatment. Importantly, this constitutional right, like most American constitutional rights, is a so-called “negative” rather than “positive” right. That is, the Supreme Court has never indicated that the national or state governments are required to provide Americans with access to health care—only that they may not encumber that access without justification. This Part will briefly trace the freedom of health through Supreme Court precedent and then draw a rough sketch of the doctrine that emerges, distinguishing the “negative” American freedom of health from the “positive” international human right to health and also offering a “participant-regulator” distinction to flesh out the “positive-negative” distinction between American and international rights.

A. *The Freedom of Health in the Supreme Court*

In 2006, a panel of the D.C. Circuit held that terminally ill patients have a constitutionally protected liberty interest in accessing experimental drugs that might extend their lives.²¹ Further, the court held that the Food and Drug Administration’s prohibitions on the interstate marketing and sale of those experimental drugs impermissibly burdened the patients’ liberty interest and were therefore unconstitutional.²² Although later overturned en banc,²³ the panel decision in *Abigail Alliance* sparked a flurry of scholarship on the question of whether there is or should be a constitutional right to health care.²⁴

Somewhat puzzlingly, much of this scholarship treats the public interest in regulating health as anathema to the individual freedom of health (and, vice versa, the individual freedom as anathema to the public interest in health regulation)—as though the two cannot coexist in constitutional doctrine.²⁵ The purpose of this Section is to dem-

²¹ See *Abigail Alliance I*, 445 F.3d 470, 486 (D.C. Cir. 2006), *rev’d en banc*, 495 F.3d 695 (D.C. Cir. 2007).

²² *Id.*

²³ See *Abigail Alliance for Better Access to Developmental Drugs v. Von Eschenbach (Abigail Alliance II)*, 495 F.3d 695, 713 (D.C. Cir. 2007) (upholding the “FDA’s policy of limiting access to investigational drugs [because it] is rationally related to the legitimate state interest of protecting patients, including the terminally ill, from potentially unsafe drugs with unknown therapeutic effects”).

²⁴ See, e.g., sources cited *supra* note 5.

²⁵ See, e.g., Leonard, *supra* note 5, at 1344 (“Individual rights seem inherently at odds with the collective, population-based perspective central to public health.”). *But*

onstrate that these supposed strands of constitutional health law are actually one coherent doctrine—albeit an underdeveloped, nascent one in Supreme Court jurisprudence. The public interest in regulation—or, as one scholar puts it, the “public’s right to health”²⁶—is simply a “state interest” that sometimes (but not always) overrides the individual liberty interest in health care autonomy, much as the state interests in regulating obscenity, fighting words, and elections sometimes override the individual freedom of speech.²⁷

In this Section, I will trace that single coherent doctrine through two strings of Supreme Court cases: those that imply a freedom to reject medical care and those that imply a freedom to obtain it.

1. Freedom to Reject Care

a. *Origins*

The American freedom of health, as developed by the Supreme Court, got its somewhat inauspicious start in the 1905 case of *Jacobson v. Massachusetts*.²⁸ Challenging a Cambridge Board of Health directive that all resident adults be vaccinated against smallpox, Henning Jacobson argued that the underlying statute and its execution against him violated “the inherent right of every freeman to care for his own body and health in such way as to him seems best.”²⁹ Often cited for the proposition that the individual freedom of health must *not* be a fundamental liberty interest,³⁰ the unanimous opinion upheld the statutory scheme in the face of Jacobson’s challenge.

But reading the *Jacobson* opinion as a whole and rehabilitating it to modern substantive due process analysis, its logic is fully consistent with a constitutional freedom of health.³¹ Writing for the Court, Jus-

see Patterson, *supra* note 5, at 47-49 (using intermediate scrutiny to balance individual and collective interests within a single constitutional doctrine).

²⁶ Leonard, *supra* note 5, at 1335.

²⁷ *See, e.g.*, *Burson v. Freeman*, 504 U.S. 191 (1992) (elections); *Miller v. California*, 413 U.S. 15 (1973) (obscenity); *Chaplinsky v. New Hampshire*, 315 U.S. 568 (1942) (fighting words).

²⁸ 197 U.S. 11 (1905).

²⁹ *Id.* at 26.

³⁰ *See* Hill, *A Tale of Two Doctrines*, *supra* note 5, at 296-99 (discussing the Court’s considerable deference to states’ “broad police power to act in the interest of public health and safety” at the expense of individual liberty); Leonard, *supra* note 5, at 1347 (citing *Jacobson* for the proposition that “[t]here are . . . limits on liberty or bodily integrity rights”).

³¹ Elizabeth Patterson also reads *Jacobson* this way. *See* Patterson, *supra* note 5, at 47 (“The *Jacobson* Court gave substantial credence to the defendant’s claim that a manda-

tice Harlan emphasized the “great dangers” of the smallpox epidemic³² and found it important that the vaccine posed no unique health risk for Jacobson.³³ He then specifically reserved the possibility that an individual with such unique risks could win an as-applied challenge if ordered to take the vaccine.³⁴ In other words, the Court found that the state had a compelling interest in combating infectious disease and that Massachusetts’s forced vaccination law was narrowly tailored to serve that interest—particularly in its application to an individual with no unique risks and because it gave an expert, local board of health authority to determine when vaccination was necessary. Having so concluded, the Court did not need to decide whether Jacobson’s asserted liberty interest in health care autonomy was protectable, much less whether it was fundamental.³⁵ That is, even if the freedom

tory vaccination law effected a substantial invasion of his liberty; however, the Court found that liberty interest outweighed by the public interest in preventing the spread of contagious disease . . .”).

³² *Jacobson*, 197 U.S. at 29.

³³ *See id.* at 30 (noting that Jacobson’s objections to the vaccination were based on “the general theory of those of the medical profession who attach little or no value to vaccination as a means of preventing the spread of smallpox or who think that vaccination causes other diseases of the body,” rather than on any unique threat to his own life or health).

³⁴ *See id.* at 38-39 (noting that the Court’s holding should not be understood to apply in circumstances where vaccination would be “cruel or inhuman”). At least one other scholar highlights this point in reading *Jacobson* as a freedom of health case. *See Hill, Reproductive Rights, supra* note 5, at 535 (acknowledging the *Jacobson* Court’s suggestion “that individuals have a right to protect their health against state-imposed harm from required vaccines”).

³⁵ In its most direct considerations of the asserted liberty interest, the Court gave conflicting signals as to the interest’s constitutional standing. Justice Harlan asserted that “[e]ven liberty itself, the greatest of all rights,” needed to be balanced against the “safety, health, peace, good order and morals of the community,” thereby providing an analysis that resembles modern balancing of interests. *Jacobson*, 197 U.S. at 26-27 (quoting *Crowley v. Christensen*, 137 U.S. 86, 89 (1890)). He also, however, concluded with the following analysis:

While this court should guard with firmness every right appertaining to life, liberty or property as secured to the individual by the Supreme Law of the Land, it is of the last importance that it should not invade the domain of local authority except when it is plainly necessary to do so in order to enforce that law. . . . [W]e do not perceive that this legislation has invaded any right secured by the Federal Constitution.

Id. at 38. That last paragraph may mean only that the law survived constitutional scrutiny (because it was narrowly tailored to serve a compelling state interest) and therefore did not violate Jacobson’s constitutional rights, or it might mean that the legislation did not even implicate those constitutional rights. Given the rest of the opinion and its careful balancing of state and individual interests, the former interpretation seems more compelling. But the latter is certainly possible.

of health existed and garnered the highest level of constitutional protection, the Court found that the Massachusetts law was constitutionally valid. The *Jacobson* opinion, thus, certainly does not preclude—and its analytic mode of balancing individual and collective interests may support—a constitutional freedom of health.

The next assertion of the freedom of health came twenty years later in the first of two forced-sterilization cases, *Buck v. Bell*.³⁶ As it had in the *Jacobson* opinion, the Court rejected the constitutional challenge but did so in a way that is consistent with a modern freedom of health. Carrie Buck brought a somewhat vague, or at least unspecified in the opinion, substantive due process challenge³⁷ to a Virginia statute that authorized mental institutions to sterilize their patients.³⁸ Under the statute, an institution could require sterilization if there was evidence, adduced at a hearing with the patient present, that the underlying reason for the individual's commitment was hereditary. Such evidence existed in Buck's case.³⁹

For an eight-Justice majority,⁴⁰ Justice Holmes wrote a characteristically curt opinion that nevertheless balanced Ms. Buck's individual interests in health and safety⁴¹ against the state's interest in avoiding the social costs of institutionalizing persons with cognitive and mental disabilities.⁴² Although unpersuasive through a modern lens of reproductive rights and mental health advocacy, the Court's conclusion was

³⁶ 274 U.S. 200 (1927).

³⁷ *See id.* at 205 (“The case comes here upon the contention that the statute authorizing the judgment is void under the Fourteenth Amendment as denying to the plaintiff in error due process of law and the equal protection of the laws.”); *id.* at 207 (“The attack is not upon the procedure but upon the substantive law. It seems to be contended that in no circumstances could such an order be justified.”).

³⁸ *See id.* (“An Act of Virginia . . . recites that the health of the patient and the welfare of society may be promoted in certain cases by the sterilization of mental defectives, under careful safeguard . . .”).

³⁹ *See id.* (“Carrie Buck is a feeble minded white woman who . . . is the daughter of a feeble minded mother in the same institution, and the mother of an illegitimate feeble minded child.”).

⁴⁰ Justice Butler dissented without writing a separate opinion. *See id.* at 208.

⁴¹ *See id.* at 205 (“[T]he sterilization may be effected in males by vasectomy and in females by salpingectomy, without serious pain or substantial danger to life . . .”); *id.* at 207 (“Buck . . . may be sexually sterilized without detriment to her general health and that her welfare and that of society will be promoted by her sterilization.” (internal quotation marks omitted)).

⁴² *See id.* at 207 (“We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence.”).

that the state interest in avoiding public support costs for disabled individuals was sufficiently compelling and that the forced sterilization program, with its limited application to institutionalized patients with known hereditary conditions, was narrowly tailored enough to justify the intrusion on liberty.⁴³ As in *Jacobson*, then, the *Buck* Court did not need to decide whether the asserted freedom of health deserved formal constitutional recognition because the majority concluded that the sterilization regime would be constitutionally permissible in any event.

Admittedly, the *Jacobson* and *Buck* opinions do not follow modern “strict scrutiny” or even “intermediate scrutiny” analysis, but neither are they as casual as “rational basis” review would allow. Both cases give credit to the asserted liberty interest and take seriously the plaintiffs’ specific interests in health and autonomy. That is, the opinions do not conclude that any rational reason for forcing vaccination or sterilization would suffice; rather, they conclude that the particular state interests implicated are sufficiently compelling to override the particular individual interests asserted. In their analytic modes, therefore, they support a constitutional freedom of health.

In the second of the two forced-sterilization cases, *Skinner v. Oklahoma*,⁴⁴ the Court invalidated a statute that permitted sexual sterilization of “habitual” criminals,⁴⁵ but it did so on equal protection rather than substantive due process grounds, thereby leaving *Buck v. Bell* intact.⁴⁶ Nevertheless, the *Skinner* majority held that the assertion of an unequal classification—differential treatment of similar criminal categories—required “strict scrutiny” (the first use of that term in Fourteenth Amendment jurisprudence) because it implicated “one of the basic civil rights of man,” namely “[m]arriage and procreation.”⁴⁷ The Court emphasized the irreparable and uncertain effects of sterilization, noting that state-sponsored sterilization “can cause races or types which are inimical to the dominant group to wither and disappear.”⁴⁸ This analysis is not a standard freedom-of-health analysis; the interest that the Court emphasized is not an interest in avoiding surgical intervention or even in avoiding standard health consequences such as ill-

⁴³ See *id.* (“In view of the general declarations of the legislature and the specific findings of the Court, obviously we cannot say as matter of law that the grounds [for sterilization] do not exist, and if they exist they justify the result.”).

⁴⁴ 316 U.S. 535 (1942).

⁴⁵ See *id.* at 536.

⁴⁶ See *id.* at 542 (distinguishing and thereby preserving *Buck*).

⁴⁷ *Id.* at 541.

⁴⁸ *Id.*

ness, pain, disfigurement, or death. But *Skinner's* acknowledgement of a right to marriage and procreation ultimately forms the foundation for the constitutional freedom to obtain medical treatment, which emerges from the reproductive rights cases. It is therefore important to note the case here, even though the opinion is not a strong datum for the freedom to reject care.

b. *Modern Cases*

The strongest data for that freedom, in fact, came nearly half a century after *Skinner*, in a pair of cases considering forced-treatment regimes. In *Washington v. Harper*,⁴⁹ the question before the Court was whether prisoners may refuse administration of antipsychotic medication,⁵⁰ and in *Cruzan v. Director, Missouri Department of Health*,⁵¹ the question was whether a woman in a persistent vegetative state may demand withdrawal of her feeding tubes—and whether, given her incompetence to make such a demand, her parents could do so on her behalf.⁵² The Court concluded in *Harper*⁵³ and strongly implied in *Cruzan*⁵⁴ that patients hold a constitutional liberty interest in rejecting the particular medical interventions at issue, but in both cases, the Court upheld the relevant regulatory regimes on state-interest grounds.⁵⁵

⁴⁹ 494 U.S. 210 (1990).

⁵⁰ See *id.* at 213 (“The central question before us is whether a judicial hearing is required before the State may treat a mentally ill prisoner with antipsychotic drugs against his will.”).

⁵¹ 497 U.S. 261 (1990).

⁵² See *id.* at 280 (noting that the relevant question was whether it was constitutional for Missouri hospitals to have in place “a procedural safeguard to assure that the action of the surrogate” in “electing to have hydration and nutrition withdrawn in such a way as to cause death” represented “the wishes expressed by the patient while competent”).

⁵³ See *Harper*, 494 U.S. at 221-22 (“We have no doubt that . . . respondent possesses a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment.”).

⁵⁴ In *Cruzan*, the Court acknowledged that “under the general holdings of [the Court’s] cases, the forced administration of life-sustaining medical treatment . . . would implicate a competent person’s liberty interest.” 497 U.S. at 279. Without holding that such a liberty interest exists, however, the Court then decided, “for purposes of th[e] case,” to “assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.” *Id.* (emphasis added).

⁵⁵ See *id.* at 282 (“Missouri has permissibly sought to advance these [state] interests [in protecting incompetent patients’ lives and choices] through the adoption of a ‘clear and convincing’ standard of proof.”); *Harper*, 494 U.S. at 227 (“[G]iven the requirements of the prison environment, the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against

In *Harper*, the recognition of the constitutional liberty interest seemed to be a slam dunk for all nine Justices.⁵⁶ Although the majority and dissenting opinions disagreed as to the strength of that interest relative to the state's interest in prison management, both opinions recognized Harper's constitutional right to reject unwanted antipsychotic medication.⁵⁷ *Cruzan* then built on that explicit recognition to hold broadly that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment."⁵⁸ The *Cruzan* majority, however, was hesitant to extend the general right to cover even a competent patient's decision to reject lifesaving treatments, such as nutrition and hydration,⁵⁹ much less a family's decision to do so on behalf of an incompetent patient.⁶⁰ In the end, the majority did not decide whether the general right to reject care would cover such life-and-death decisions.⁶¹

What emerges from *Harper* and *Cruzan*, then, is an explicit constitutional freedom to reject medical interventions, at least so long as those interventions are not necessary to preserve life. Admittedly, the *Cruzan* majority left open the possibility that the general liberty interest is weaker or even nonexistent in the case of lifesaving nutrition and hydration, but the opinion nevertheless recognizes a general constitutional freedom to reject care.

his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest.").

⁵⁶ See *Cruzan*, 494 U.S. at 221-22 (finding for the six-Justice majority that Harper "possesse[d] a significant liberty interest"); *id.* at 237 (Stevens, J., concurring in part and dissenting in part) (criticizing the majority opinion for "undervalu[ing] respondent's liberty interest").

⁵⁷ For the dissent, the particular effects of antipsychotic medication enhanced Harper's liberty interest in avoiding its administration. See *id.* at 239-41 (Stevens, J., concurring in part and dissenting in part) (describing the intended mind-altering effects of the medication, as well as its dangerous unintended side effects).

⁵⁸ 497 U.S. at 278 (citing *Harper* as support for the recognition of this broad right).

⁵⁹ See *id.* at 279 (noting that "the dramatic consequences involved in refusal of such [lifesaving] treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible" and ending with a mere assumption, rather than conclusion, "that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition").

⁶⁰ The Court noted,

The difficulty with petitioners' claim is that in a sense it begs the question: An incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right. Such a "right" must be exercised for her, if at all, by some sort of surrogate.

Id. at 280.

⁶¹ See *id.* at 279 (evaluating and upholding the enforcement regime on an assumption, rather than a holding, that it implicated a constitutional right).

Neither *Harper* nor *Cruzan*, however, clarifies the constitutional stature of that freedom. Although the dissenting opinions in both cases specify that the freedom ought to be a “fundamental” right that triggers strict scrutiny,⁶² the majority opinions do not offer a predefined rubric—a precise level of scrutiny—for analyzing the governmental intrusions. Of course, the cases do make clear that the state interests asserted were sufficient to justify the regulatory regimes at issue, but neither of the majority opinions explicitly labels those interests as “compelling” (for strict scrutiny), “important” (for intermediate scrutiny), or “rational” (for rational basis review). The Supreme Court has thus certainly recognized that the constitutional freedom to reject medical care exists, but the freedom’s precise function is yet to be determined.

2. Freedom to Obtain Care

Unlike the freedom to reject care, the freedom to obtain care does not yet have a life of its own in Supreme Court jurisprudence. Instead, its existence is implicit in and therefore tethered to the Court’s reproductive rights jurisprudence⁶³—although, as I will discuss shortly, it also gained five nonprecedential votes in the assisted-suicide case.⁶⁴ Despite its lack of formal recognition, the right to obtain care has a solid foundation in existing constitutional law, particularly given the difficulty of justifying some reproductive rights holdings without reference to the freedom of health.

Specifically, the rights to contraception and abortion necessarily create a freedom to obtain at least certain kinds of medical care. As the Court has recognized, these reproductive rights would be meaningless without concomitant rights to access birth control mechanisms and abortion surgeries, both of which require physician intervention.⁶⁵

⁶² See *id.* at 304 (Brennan, J., dissenting) (“[I]f a competent person has a liberty interest to be free of unwanted medical treatment, . . . it must be fundamental.”); *Harper*, 494 U.S. at 241 (Stevens, J., concurring in part and dissenting in part) (“There is no doubt . . . that a competent individual’s right to refuse [antipsychotic] medication is a fundamental liberty interest deserving the highest order of protection.”).

⁶³ See generally Hill, *Reproductive Rights*, *supra* note 5, at 530-49 (identifying the freedom-of-health components of abortion jurisprudence and urging reproductive rights advocates to emphasize that basis for preservation of the abortion right).

⁶⁴ See *infra* note 74 (discussing the concurring opinions in *Washington v. Glucksberg*, 502 U.S. 702 (1997)).

⁶⁵ See, e.g., *Gonzales v. Carhart*, 550 U.S. 124, 156-58 (2007) (recognizing that regulation of abortion “would be unconstitutional ‘if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains

Furthermore, the abortion right has a health care dimension insofar as a woman's health or life might hang in the balance as she decides whether to terminate a pregnancy.⁶⁶ Professor Jessie Hill has already traced both of these themes through the Supreme Court's reproductive rights cases; she has demonstrated that *Roe v. Wade*⁶⁷ and its progeny⁶⁸ rest at least in part on a constitutional right to obtain medical care and has highlighted the Supreme Court's insistence—albeit somewhat less pronounced in the most recent partial birth abortion case⁶⁹—that abortion restrictions not endanger maternal health.⁷⁰ I will not reinvent that wheel here.

But the right-to-die case, *Washington v. Glucksberg*,⁷¹ provides another important—and occasionally misunderstood⁷²—datum for the existence of a constitutional freedom to obtain treatment. In *Glucksberg*, three terminally ill patients and their physicians challenged criminal prohibitions on assisted suicide, asserting that competent terminally ill patients should be free to obtain a physician's help in

viability” (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 878-89 (1992)); *Carey v. Population Servs. Int'l*, 431 U.S. 678, 687-89 (1977) (“Limiting the distribution of nonprescription contraceptives to licensed pharmacists clearly imposes a significant burden on the right of individuals to use contraceptives if they choose to do so.” (citing *Eisenstadt v. Baird*, 405 U.S. 438, 461-64 (1972))).

⁶⁶ *Roe v. Wade*, 410 U.S. 113, 153 (1973) (observing that “[s]pecific and direct harm medically diagnosable even in early pregnancy” may result from denying access to abortions altogether); Hill, *Reproductive Rights*, *supra* note 5, at 531-32 (citing “the requirement that abortion regulations must contain an exception to protect against harm to a woman’s health” as an example of a “negative right to health”).

⁶⁷ 410 U.S. 113.

⁶⁸ See, e.g., *Gonzales*, 550 U.S. 124; *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320 (2006); *Stenberg v. Carhart*, 530 U.S. 914 (2000); *Casey*, 502 U.S. 833; *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747 (1986), *overruled in part by Casey*, 505 U.S. 833; *Planned Parenthood Ass’n of Kan. City, Mo. v. Ashcroft*, 462 U.S. 476 (1983); *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416 (1983), *overruled in part by Casey*, 505 U.S. 833.

⁶⁹ See *Gonzales*, 550 U.S. at 155-56 (upholding a partial birth abortion regulation that lacked a health exception); Hill, *Reproductive Rights*, *supra* note 5, at 534 (noting the shift in the Supreme Court’s tone regarding the health exception in *Gonzales*).

⁷⁰ See Hill, *Reproductive Rights*, *supra* note 5, at 506-17 (describing the “medical model of abortion” that the Supreme Court seemed to follow in early abortion decisions); *id.* at 534-37 (deriving a more general “negative right to health” from reproductive rights and other decisions).

⁷¹ 521 U.S. 702 (1997).

⁷² See, e.g., Hill, *Reproductive Rights*, *supra* note 5, at 536-37 (failing to note *Glucksberg*’s odd procedural posture and therefore casting the majority opinion as less supportive of the freedom of health than is actually the case). *But see* Robertson, *Embryo Culture*, *supra* note 5, at 10 (noting that five Justices in *Glucksberg* expressed support for a constitutional right to access palliative care, including death-hastening medical care).

hastening death.⁷³ Because the three patients died before the case reached the Supreme Court, however, the Court treated the challenge as a facial assault on suicide bans—an assertion of a broad right to die for all humans, terminally ill or not. So framed, the challenge did not get a single vote; the Court unanimously rejected the freedom to commit suicide.

Five Justices, however, authored concurring opinions that indicated their support for a narrower constitutional liberty interest in obtaining palliative care from a physician, even when that care might hasten death. Justices O'Connor, Souter, Stevens, Ginsburg, and Breyer all wrote separately to indicate their support for—or at least their interest in preserving the possibility of—a constitutional liberty interest in access to pain management at the end of life and particularly an interest in access to *physician care* in managing pain. Indeed, for at least four of those Justices, that narrower freedom to obtain palliative care seemed to trump the state's interests in preserving life and avoiding euthanasia; for them it appears that the provision of even death-hastening palliation ought not to be criminalized.⁷⁴ Because the challenged statutes did not in fact criminalize death-hastening palliation, all five concurring Justices supported the judgments of the

⁷³ See 521 U.S. at 707-08.

⁷⁴ Only Justice Souter wrote that the state's interests should trump the asserted right to medical assistance. However, he was considering a right to physician-assisted suicide, rather than a right to palliative care. And, even considering the more controversial suicide right, Justice Souter reserved the question of whether that right, if asserted as such (which it apparently was not), could "at some time[] be seen as 'fundamental' to the degree entitled to prevail." *Glucksberg*, 521 U.S. at 781-82 (Souter, J., concurring). He wrote simply that a liberty interest in physician-assisted suicide was not sufficient to trump the state's compelling interest in avoiding a slippery slope to euthanasia. See *id.* (noting that the state's interest in "protecting terminally ill patients from involuntary suicide and euthanasia, both voluntary and nonvoluntary," was "dispositive for [him]" in addressing "the present claim that [Washington's] law is arbitrary or purposeless"). The other four Justices strongly implied that they would have voted differently if the state statutes had criminalized provision of death-hastening palliative care. See *id.* at 737-38 (O'Connor, J., concurring) (noting that although patients may have a "constitutionally cognizable interest in obtaining relief from . . . suffering," the Court did not need to address that possibility in the context of the *Glucksberg* challenge); *id.* at 748-50 (Stevens, J., concurring) (writing separately to note that a ripe as-applied challenge brought by still-living terminally ill patients might succeed); *id.* at 789 (Ginsburg, J., concurring) (joining the logic of Justice O'Connor's concurring opinion); *id.* at 791 (Breyer, J., concurring) (noting that patients might have a fundamental right to avoid pain but that the statutes at issue in *Glucksberg* did not implicate that right).

Court, but they wrote separately to emphasize the importance of the asserted constitutional freedom to obtain health care at the end of life.⁷⁵

Of course, as with the freedom-to-reject-care cases, neither the reproductive rights nor *Glucksberg* opinions—to the extent that they rest on or recognize a freedom to obtain care—could be read to support an absolute freedom. The state interest in protecting fetal life has been an important constraint on women’s abortion rights throughout the *Roe* line of cases⁷⁶—so strong, in fact, that it makes the Court’s scrutiny of abortion restrictions look more like intermediate than strict scrutiny. And the *Glucksberg* concurrences all recognize compelling state interests in preserving life and avoiding euthanasia.⁷⁷ As with the freedom to reject care, then, the freedom to obtain it must be balanced against regulatory interests, and that freedom (if it exists) certainly could be infringed if the restriction were sufficiently justified and tailored.

3. Conclusion

Throughout the Supreme Court’s constitutional health care jurisprudence, the Court has recognized the importance of asserted liberty interests in health care autonomy. As an aspect of general bodily autonomy, the freedom to reject care has gained formal recognition in a handful of cases, and as a necessary element of reproductive rights, the freedom to obtain treatment has been an important, though informal, player in several cases.

Of course, like all American constitutional rights, the freedom of health is subject to limitation when it runs up against legitimate regulatory interests. And, in contrast to core American freedoms like speech and religion, the Supreme Court has been quite willing to recognize state interests in health care regulation, often referring to preservation

⁷⁵ *Id.* at 777-82 (Souter, J., concurring) (grounding the right to physician assistance at the end of life in the general right to bodily autonomy and concluding that “the importance of the individual interest here . . . cannot be gainsaid”).

⁷⁶ *See e.g.*, *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 876 (1992) (“The very notion that the State has a substantial interest in potential life leads to the conclusion that not all regulations must be deemed unwarranted. . . . In our view, the undue burden standard is the appropriate means of reconciling the State’s interest with the woman’s constitutionally protected liberty.”).

⁷⁷ *See generally* Martha Minow, *Which Question? Which Lie? Reflections on the Physician-Assisted Suicide Cases*, 1997 SUP. CT. REV. 1 (discussing the risk of abuse and coercion that might arise if assisted suicide were permitted and concluding that the Supreme Court was right to focus on that risk even though the restrictive regime does not eliminate the practice of assisted suicide).

of health and life as core “police powers” of the states.⁷⁸ In the end, then, the freedom of health seems to be an important constitutional freedom, but it is also one that requires balancing against many legitimate—even compelling—regulatory projects.

B. *The Freedom of Health Versus the Right to Health*

Before applying this freedom of health to current regulatory debates, it is important to flesh out the distinction between the American freedom of health and the international human right to health. The primary difference between the two is that the American freedom restricts regulation while the international right requires participation.⁷⁹ This difference entails two characteristics of substantive freedoms in American law: they are primarily negative rather than positive, and they focus primarily on regulation rather than participation.

Much work has already been done on the positive-negative distinction, both in the health law literature and in the broader constitutional law literature,⁸⁰ so I will summarize those arguments briefly. I will then spend more time identifying and exploring the second (participant-regulator) distinction, which is important to individual substantive rights generally and to the freedom of health particularly.

I will first discuss the positive-negative and participant-regulator distinctions as they apply generally to the Constitution’s individual substantive rights, and I will then use those two distinctions to flesh out the difference between the American freedom of health and the international right to health.

⁷⁸ See *Jacobson v. Massachusetts*, 197 U.S. 11, 27 (1905) (“The good and welfare of the [state], of which the legislature is primarily the judge, is the basis on which the police power rests . . .”); *The Slaughter-House Cases*, 83 U.S. 36, 62 (1873) (discussing the significance of broad police powers to “the life and health of the citizen”).

⁷⁹ International human rights are difficult to enforce, so I hesitate to embrace them as obligations. See generally JACK L. GOLDSMITH & ERIC A. POSNER, *THE LIMITS OF INTERNATIONAL LAW* (2005).

⁸⁰ See, e.g., Elizabeth Weeks Leonard, *State Constitutionalism and the Right to Health Care*, 12 U. PA. J. CONST. L. 1325, 1331-37 (2010) (reviewing the arguments and literature on both sides of the assertion that the Constitution is a “charter of negative rights”).

1. The Positive-Negative and Participant-Regulator Distinctions

a. *Positive-Negative*

In asserting that the U.S. Constitution is a “charter of negative rather than positive liberties,”⁸¹ we typically mean that individual substantive rights limit governmental action rather than requiring it. As Judge Richard Posner famously explained, “The men who wrote the Bill of Rights were not concerned that government might do too little for the people but that it might do too much to them.”⁸² On this understanding, then, the difference between negative and positive rights is simply that negative rights are restrictions while positive rights are obligations. A second, slightly more nuanced aspect of the positive-negative distinction, occasionally identified in the literature, is that negative rights protect individuals against the government itself while positive rights oblige the government to protect individuals against outside influences, such as third-party aggression or natural or economic conditions.⁸³

As many scholars have recognized, this distinction’s explanatory power for American constitutional rights is real but limited. In at least three interrelated respects, constitutional rights create obligations for government action, and some of those are obligations to protect against outside influences. First, many of the Constitution’s procedural rights are positive under this framework, requiring the government to provide (at taxpayer expense) grand juries,⁸⁴ petit juries,⁸⁵ trials,⁸⁶ information to arrestees,⁸⁷ and assistance of counsel;⁸⁸ requiring the government to obtain warrants before seizing property;⁸⁹ and requiring the government to compensate property owners when effecting a taking.⁹⁰ Although many of these rights protect individuals only against governmental attempts to deprive them of liberty or property

⁸¹ Jackson v. City of Joliet, 715 F.2d 1200, 1203 (7th Cir. 1983).

⁸² *Id.*

⁸³ See Currie, *supra* note 7, at 864 (noting that positive rights might obligate government “to protect people against hostile acts of third parties,” or even “to protect them from hunger and disease”).

⁸⁴ U.S. CONST. amend. V.

⁸⁵ See *id.* amend. VI (protecting the right to a jury in criminal trials); *id.* amend. VII (protecting the right to a jury in civil trials at common law).

⁸⁶ *Id.* amend. VI.

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ *Id.* amend. IV.

⁹⁰ *Id.* amend. V.

and might therefore be enforcement elements of standard negative rights,⁹¹ some also protect against private third parties who are, for example, pressing criminal charges or suing at common law.⁹² Furthermore, the requirement that the government provide these services at taxpayer expense rather than on a fee-for-service basis arguably protects the indigent against outside economic conditions, whether or not they are of the government's making. At least insofar as these procedural rights oblige governmental protection against outside influence, they seem to be purely positive under the standard positive-negative rubric, and even those that are merely enforcement elements of negative rights constitute clear obligations for government action and are therefore positive in the broad sense.

Second, the Constitution seems to require the government to enforce negative rights in property, tort, and contract,⁹³ thereby placing an affirmative obligation on the government to act as a creator and enforcer of the common law. This constitutional requirement, if it is indeed a constitutional right, fails both tests for negative rights; it is an affirmative obligation for the government, and it is an obligation to protect against third-party deprivations rather than governmental ones.⁹⁴

Third and finally, as Judge Posner has recognized in his scholarly work,⁹⁵ even the substantive rights that most clearly take a negative-

⁹¹ See Currie, *supra* note 7, at 886-87 (describing the governmental obligations that can arise from enforcement of negative rights).

⁹² In the criminal context, the rights primarily protect individuals against governmental deprivations of a negative right—either liberty itself in cases where conviction results in imprisonment or property in cases where conviction results in a fine. As such, they may be viewed as corollaries to negative rights and also as consistent with the second aspect of the positive-negative distinction, the difference between protection from government and protection from outside influences. But the Seventh Amendment right to a jury in civil suits obligates the government to protect individuals from private third parties. The Seventh Amendment, thus, seems to be a pure positive right according to the standard distinction.

⁹³ See, e.g., *Bronzon v. Kinzie*, 42 U.S. (1 How.) 311, 320 (1843) (“Any such modification of a contract by subsequent legislation, against the consent of one of the parties, unquestionably impairs its obligations, and is prohibited by the Constitution.”); cf. *Ogden v. Saunders*, 25 U.S. (12 Wheat.) 213, 255 (1827) (“[A] State bankrupt law, which impairs the obligation of a contract, is unconstitutional in its application to such contract.”).

⁹⁴ See Cass R. Sunstein, *Why Does the American Constitution Lack Social and Economic Guarantees?*, 56 SYRACUSE L. REV. 1, 6-7 (2005) (arguing that the creation and protection of private property and the market economy require active government assistance).

⁹⁵ See Posner, *supra* note 7, at 3 (noting that every negative liberty entails “a corresponding positive liberty” by requiring “a public machinery of rights protection and enforcement, a machinery that includes police, prosecutors, judges, and even publicly employed or subsidized lawyers”).

rights form—the freedoms of speech, religion, press, and assembly;⁹⁶ the rights to life, liberty, and property;⁹⁷ and the protection of privacy⁹⁸—are all meaningless without a concomitant obligation for the government to enforce them. Even the central “negative rights,” thus, give rise to affirmative obligations for governmental intervention, usually in the form of judicial invalidation of infringing legislative or executive action.⁹⁹

Nevertheless, there is something intuitively appealing and therefore persistently useful about the positive-negative distinction in American constitutional law.¹⁰⁰ Certainly, the U.S. Constitution lacks the broad social and economic guarantees—quintessential “positive rights”—that appear in many other countries’ constitutions and in international charters of rights.¹⁰¹ Unlike many international human rights, our substantive constitutional rights do not require the government to enable individuals to engage in constitutionally protected activities (speech, religion, etc.); they require only that the government leave individuals free to engage in those activities. The U.S. Constitution is therefore a “charter of negative rights” at least in relative terms, compared to international and foreign documents.

b. *Participant-Regulator*

There is a second distinction, though, that seems to have greater—or at least additional—explanatory power for the set of rights that we choose to recognize and for the rights-enforcement scheme that we choose to apply in American constitutional law: the participant-regulator distinction. This distinction arose in Dormant Commerce Clause jurisprudence, with the Supreme Court holding that American

⁹⁶ See U.S. CONST. amend. I.

⁹⁷ See *id.* amend. V (forbidding the national government from depriving individuals of “life, liberty, or property, without due process of law”); *id.* amend. XIV (forbidding state governments from doing the same).

⁹⁸ See generally *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965) (“Various guarantees [in the Bill of Rights] create zones of privacy.”).

⁹⁹ Stephen Holmes and Cass Sunstein have also discussed this point at length. See generally STEPHEN HOLMES & CASS R. SUNSTEIN, *THE COST OF RIGHTS: WHY LIBERTY DEPENDS ON TAXES* (1999).

¹⁰⁰ See, e.g., *supra* note 6 (citing sources that discuss the positive-negative distinction in the context of medical decisionmaking).

¹⁰¹ See generally Sunstein, *supra* note 94 (noting and attempting to explain the absence of social and economic guarantees in the Constitution).

states may discriminate against out-of-state citizens if they are acting as market participants but not if they are acting as market regulators.¹⁰²

The line between proprietary and regulatory action is thin,¹⁰³ but the conceptual difference is relatively clear and descriptively useful: governmental provision or consumption of a good or service at public expense is a participatory action; creation of incentives for private provision of goods or services or for private consumption of goods or services is a regulatory action.¹⁰⁴ Medicare and Medicaid, thus, are participatory actions (public provision of health insurance), while both the individual mandate¹⁰⁵ and the health insurance subsidies¹⁰⁶ are regulatory actions (incentives for individuals to consume private

¹⁰² See *Reeves, Inc. v. Stake*, 447 U.S. 429, 436-37 (1980) (“The basic distinction . . . between States as market participants and States as market regulators makes good sense and sound law . . . [because] the Commerce Clause responds principally to state taxes and regulatory measures impeding free private trade in the national marketplace.”); see also Norman R. Williams & Brannon P. Denning, *The “New Protectionism” and the American Common Market*, 85 NOTRE DAME L. REV. 247, 294-304 (2009) (discussing the role of the market-participant doctrine in Supreme Court jurisprudence with particular focus on a recent case, *Department of Revenue v. Davis*, 553 U.S. 328 (2008)).

¹⁰³ See, e.g., *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 541-42 (1985) (“To say that the distinction between ‘governmental’ and ‘proprietary’ proved to be stable, however, would be something of an overstatement.”); Dan T. Coenen, *The Impact of the Garcia Decision on the Market-Participant Exception to the Dormant Commerce Clause*, 1995 U. ILL. L. REV. 727, 733-34 (discussing arguments that the ruling in *Garcia* undermines the vitality of the Dormant Commerce Clause exception for state proprietary functions); Treg A. Julander, *State Resident Preference Statutes and the Market Participant Exception to the Dormant Commerce Clause*, 24 WHITTIER L. REV. 541, 573 (2002) (acknowledging that “as more levels of governmental action are added, and regulatory and proprietary powers are mixed,” courts could very well arrive at different conclusions with respect to the same conduct (footnote omitted)).

¹⁰⁴ There is some debate as to where exactly tax exemption falls within this framework. In *Department of Revenue v. Davis*, for example, there was disagreement as to whether tax-exempt status for state municipal bonds (and not for similar out-of-state bonds) should be seen as solely participatory or as part regulatory, part participatory. See 553 U.S. at 345 (Souter, J., concurring) (arguing that market regulation is acceptable when it goes “hand in hand” with participation); cf. Dan T. Coenen, *The Supreme Court’s Municipal Bond Decision and the Market-Participant Exception to the Dormant Commerce Clause*, 70 OHIO ST. L.J. 1179, 1184-93 (2009) (arguing that Justice Souter mistakes this dual approach for an either/or designation).

¹⁰⁵ See PPACA § 1501(b), 26 U.S.C.A. § 5000A(a) (West Supp. 1A 2010) (mandating minimum essential coverage).

¹⁰⁶ See generally PPACA, Pub. L. No. 111-148, §§ 1401–1421, 124 Stat. 119, 213-38 (to be codified as amended in scattered sections of 26 and 42 U.S.C.) (providing tax credits for qualified health plans); see also THE HENRY J. KAISER FAMILY FOUND., PUB. NO. 7962-02, EXPLAINING HEALTH CARE REFORM: QUESTIONS ABOUT HEALTH INSURANCE SUBSIDIES (2010), available at <http://www.kff.org/healthreform/upload/7962-02.pdf> (explaining the details and eligibility criteria for the PPACA tax credits).

insurance).¹⁰⁷ In general, regulatory actions use the government's police power, while participatory ones use the power of the purse.¹⁰⁸

Of course, governmental participation in a market skews private activity within that market and therefore has incentive and regulatory effects. The power of the purse cannot be wielded effectively without taxation, which is generally considered a regulatory action, and rules for distribution of and eligibility for publicly provided goods and services are regulatory decisions that, if externally dictated, would influence the government's willingness and ability to participate. Furthermore, the two actions might regularly be substitutes; many governmental goals can be achieved through either participation or regulation. But the point remains that participatory and regulatory actions are conceptually (if not always practically) different.

Furthermore, the distinction seems relevant to theories of constitutional rights, and it helps to clarify the difference between the freedom of health and the right to health. In general, our individual substantive rights focus on the government's regulatory decisions, not its participatory decisions. More specifically, American substantive rights tend to restrict regulation or, occasionally, require regulation; they almost never restrict or require participation. Some examples follow, but bear in mind throughout that no American constitutional right is absolute and that "restrictions" or "constraints" on regulation are therefore different from "bars" or "prohibitions" on regulation:

- The freedom of speech (broadly speaking and eschewing nuance) constrains the government's ability to regulate what we say or how we say it,¹⁰⁹ but it neither obligates the government to provide us with public forums nor constrains the government's ability to pro-

¹⁰⁷ This distinction provides a good example of where the distinction between proprietary and regulatory action becomes more formal than functional: subsidies for private purchase of insurance are regulatory since they are incentives for private action, but the line between subsidizing private insurance and providing Medicare benefits is infinitesimally thin—particularly given that Medicare is largely administered by private contractors.

¹⁰⁸ Other examples include payment of unemployment benefits, which is a participatory action (public provision of wages), compared to the minimum wage law, which is a regulatory action (incentives for private employers to use particular wage rates); and road construction and maintenance (public consumption of construction services), compared to speed limit laws (incentives for private behavior).

¹⁰⁹ See generally C. Edwin Baker, *Scope of the First Amendment Freedom of Speech*, 25 UCLA L. REV. 964 (1978) (developing and evaluating three theories of the scope of speech protection under the First Amendment); Harry H. Wellington, *On Freedom of Expression*, 88 YALE L.J. 1105 (1979) (analyzing why and to what extent free expression deserves governmental immunity).

vide such forums, nor does it obligate nor forbid the government from funding speech directly.¹¹⁰

- The freedom of press (again broadly speaking) constrains the government's ability to regulate media organizations,¹¹¹ but it neither obligates the government to provide us with news nor constrains government's ability to run public news broadcasts.¹¹²
- The right to privacy restricts the government's ability to regulate abortion procedures,¹¹³ but it neither requires the government to include abortion coverage in public health insurance nor prohibits it from doing so.¹¹⁴ Similarly, government is limited in regulating access to contraceptive devices¹¹⁵ but may choose whether to provide public insurance coverage for them; and government is limited

¹¹⁰ See, e.g., *Ark. Educ. Television Comm'n v. Forbes*, 523 U.S. 666, 669 (1998) (rejecting a free speech challenge to the exclusion of a candidate from a debate on a public broadcasting station). See generally Harry Kalven, Jr., *The Concept of the Public Forum: Cox v. Louisiana*, 1965 SUP. CT. REV. 1, 25-27 (discussing time, place, and manner restrictions on the freedom of speech); Geoffrey R. Stone, *Fora Americana: Speech in Public Places*, 1974 SUP. CT. REV. 233, 236-56 (discussing Supreme Court jurisprudence regarding the government's ability to regulate public forums while still respecting the First Amendment).

¹¹¹ See Potter Stewart, "Or of the Press," 26 HASTINGS L.J. 631, 633 (1975) ("The publishing business is, in short, the only organized private business that is given explicit constitutional protection."). Of course, regulations of broadcast media have been more tolerable. See Matthew L. Spitzer, *The Constitutionality of Licensing Broadcasters*, 64 N.Y.U. L. REV. 990, 990 (1989) (noting that, while licensing of newspapers is unconstitutional, licensing of broadcasters is acceptable due to spectrum scarcity); Jonathan Weinberg, *Broadcasting and Speech*, 81 CALIF. L. REV. 1101, 1106 (1993) ("Ordinary First Amendment philosophy strongly disfavors government licensing of speakers; the broadcast regulatory system, by contrast, embraces such licensing." (footnote omitted)).

¹¹² See, e.g., Public Broadcasting Act of 1967, 47 U.S.C. § 396 (2006) (establishing the Corporation for Public Broadcasting and through it, the Public Broadcasting Service and National Public Radio). But see *Red Lion Broad. Co. v. FCC*, 395 U.S. 367, 369, 400-01 (1969) (upholding the FCC "fairness doctrine" requiring that both sides of a controversy receive equal time on broadcast news).

¹¹³ See *supra* notes 65-70 and accompanying text (discussing limitations upon abortion restrictions when a mother's life is at risk).

¹¹⁴ In *Maher v. Roe*, the Court stated that

[t]here is a basic difference between direct state interference with a protected activity and state encouragement of an alternative activity consonant with legislative policy. Constitutional concerns are greatest when the State attempts to impose its will by force of law; the State's power to encourage actions deemed to be in the public interest is necessarily far broader.

432 U.S. 464, 475-76 (1977) (footnote omitted); see also PPACA § 1303(1), 42 U.S.C.A. § 18023 (West Supp. 1B 2010) (detailing abortion-funding rules).

¹¹⁵ See *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965) (declaring a law that forbade use of contraceptives unconstitutional).

in regulating parental decisions¹¹⁶ but may choose whether or not to provide public goods or services to parents, such as public education, child care, or even child protection.¹¹⁷

For the most part, then, constitutional rights restrict regulation rather than participation.¹¹⁸

There is an important caveat to the participant-regulator distinction, though. Substantive constitutional limits apply even when the government is regulating only itself as a market participant—in other words, even when the government is merely setting rules for its own participatory programs. This point is easiest to see in the context of the Equal Protection Clause, which prohibits discriminatory regulations (such as discriminatory distribution and eligibility decisions) with respect to publicly provided goods and services.¹¹⁹

But the point seems to apply broadly, beyond the textually specified equality requirement, to all constitutional constraints on regulation. For example, the Supreme Court invalidated, on free speech

¹¹⁶ See *Pierce v. Soc’y of Sisters*, 268 U.S. 510, 534-35 (1925) (asserting that the government cannot “unreasonably interfere[] with the liberty of parents and guardians to direct the upbringing and education of children under their control”); *Meyer v. Nebraska*, 262 U.S. 390, 403 (1923) (striking down as unconstitutional a state prohibition on teaching children a foreign language).

¹¹⁷ See *DeShaney v. Winnebago Cnty. Dep’t of Soc. Servs.*, 489 U.S. 189, 196-97 (1989) (holding that the state’s failure to remove a child from an abusive father’s home did not violate the Due Process Clause because the Clause did not impose upon the state an affirmative duty to provide the child with adequate protection).

¹¹⁸ Religious freedom, of course, is an exception to this rule. The Establishment Clause restricts governmental participation in religious markets. See Michael W. McConnell, *Religious Freedom at a Crossroads*, 59 U. CHI. L. REV. 115, 117 (1992) (“The Establishment Clause . . . has been interpreted to forbid the government to aid or advance religion.”); see also Jesse H. Choper, *Religion in the Public Schools: A Proposed Constitutional Standard*, 47 MINN. L. REV. 329, 330 (1963) (arguing that public schools violate the Establishment Clause through “solely religious activity” that is likely to compromise or influence a student’s freedom of religious choice or belief). But cf. Michael W. McConnell, *The Origins and Historical Understanding of Free Exercise of Religion*, 103 HARV. L. REV. 1409, 1414-16 (1990) (arguing that the Establishment Clause was meant to prevent Congress from interfering with state establishments of religion that existed at the time of the founding). See generally Kathleen M. Sullivan, *Religion and Liberal Democracy*, 59 U. CHI. L. REV. 195 (1992) (rebutting Michael McConnell’s interpretation of the Establishment Clause); Mark Tushnet, *The Constitution of Religion*, 18 CONN. L. REV. 701 (1986) (examining the seemingly inconsistent outcomes in Establishment Clause cases through the lens of the faded republican tradition).

¹¹⁹ The most famous examples are restrictions on discriminatory admissions policies in publicly funded schools, including both segregation and affirmative action. See, e.g., *Parents Involved in Cmty. Sch. v. Seattle Sch. Dist. No. 1*, 551 U.S. 701 (2007); *Grutter v. Bollinger*, 539 U.S. 306 (2003); *Gratz v. Bollinger*, 539 U.S. 244 (2003); *Regents of the Univ. of Cal. v. Bakke*, 438 U.S. 265 (1978); *Bolling v. Sharpe*, 347 U.S. 497 (1954); *Brown v. Bd. of Educ.*, 347 U.S. 483 (1954).

grounds, a ban on leafleting on public park grounds, roadways, and sidewalks—a regulatory action that applied only to public property.¹²⁰ Importantly, the Court did not hold that the First Amendment obligated public provision of parks, roadways, and sidewalks for speech purposes but rather that the government could not prohibit speech on the public property that it already provided. Similarly, it seems likely that the abortion right would come into play if the government stripped Medicaid eligibility from otherwise-eligible women on the ground that they had obtained privately funded abortions.¹²¹ The Constitution, thus, is not entirely hands-off with respect to government participation in markets. Even when the government participates rather than regulates, its management decisions (unlike those of private participants) must abide by some substantive constitutional limits.

Constitutional rights thus center on regulation rather than participation, but they restrict regulatory actions even within participatory ones. The relevance of the participant-regulator distinction, then, is that American individual rights neither require nor forbid participation itself, but they constrain regulation both within and beyond participatory programs.

2. The Freedom of Health as a Restriction on Regulation and the Right to Health as a Requirement for Participation

The “right to health” in international human rights law purports to require not just regulation but also participation. According to the International Covenant on Economic, Social and Cultural Rights, the international human right to health guarantees all individuals “the enjoyment of the highest attainable standard of physical and mental health.”¹²² That right includes not only the freedom to reject or obtain medical treatment but also an entitlement to a healthy environment and to accessible treatment facilities.¹²³ The right to health, thus, does

¹²⁰ See *Schneider v. State*, 308 U.S. 147, 169-74 (1939) (noting that the ban gave police authorities too much power to decide which citizens were allowed to disseminate information).

¹²¹ See generally GEOFFREY R. STONE ET AL., *CONSTITUTIONAL LAW* 1598-609 (6th ed. 2009) (discussing the doctrine of unconstitutional conditions).

¹²² International Covenant on Economic, Social and Cultural Rights art. 12, Dec. 16, 1966, 993 U.N.T.S. 3; see also OFFICE OF THE UNITED NATIONS HIGH COMM’R FOR HUMAN RIGHTS & WORLD HEALTH ORG., FACT SHEET NO. 31, THE RIGHT TO HEALTH 1 (2008) [hereinafter OHCHR FACT SHEET], available at <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf> (highlighting the “right to health” as a “fundamental part of our human rights”).

¹²³ See OHCHR FACT SHEET, *supra* note 122, at 3-4.

not forbid excessive governmental involvement in private health care decisionmaking; it obligates the government to provide citizens with clean water, air, and streets and with hospitals, drugs, and doctors.¹²⁴

Admittedly, it is possible that a government could fulfill these obligations through mere regulation, offering incentives to expand private markets in environmental quality and health care service. But most advocates of the right to health seem to believe—and it is hard to imagine otherwise—that these obligations would require governmental participation in the relevant markets.¹²⁵ In particular, advocates invoke the right to health when arguing for public health insurance, public provision of hospitals and clinics, publicly funded treatment, public pharmaceutical research and development, public water and sewage system improvements, and so on.¹²⁶

The *right* to health, thus, is undoubtedly a positive right in its formulation, requiring participation rather than just regulation at least in its invocation and also occasionally in its enforcement in foreign courts.¹²⁷

¹²⁴ See *id.* at 22-28.

¹²⁵ See, e.g., Eleanor D. Kinney, *The International Human Right to Health: What Does This Mean for Our Nation and World?*, 34 IND. L. REV. 1457, 1471 (2001) (“[I]f the international right to health is to mean anything at all, it does seem appropriate to impose some implementation obligations on states and also require affirmative action on the part of government”); Wendy K. Mariner, *Law and Public Health: Beyond Emergency Preparedness*, 38 J. HEALTH L. 247, 272-75 (2005) (recognizing that the obligations to protect people from harm and to fulfill their health needs require affirmative government action).

¹²⁶ See, e.g., Erik B. Bluemel, *The Implications of Formulating a Human Right to Water*, 31 ECOLOGY L.Q. 957, 969 (2004) (“The right to water might also be placed as a subordinate right to that of the right to health”); Gary E. Jones, *Regulatory Takings and Emergency Medical Treatment*, 47 SAN DIEGO L. REV. 145, 146 (2010) (analyzing the conflict between the right to health and our country’s fee-for-service health care system); Patti E. Phillips, *Adding Insult to Injury: The Lack of Medically-Appropriate Housing for the Homeless HIV-Infected*, 45 U. MIAMI L. REV. 567, 597-611 (1990-91) (extending the right to health to argue for the provision of housing for indigent people with HIV).

¹²⁷ See, e.g., *Minister of Health v. Treatment Action Campaign 2002* (5) SA 721 (CC) at 728-29 (S. Afr.) (outlining the right to health in a case involving the antiviral drug Nevirapine); see also George J. Annas, *The Right to Health and the Nevirapine Case in South Africa*, 348 NEW ENG. J. MED. 750, 750-51 (2003) (using the Nevirapine case to explore the power of the right to health to obligate government provision of care); Mary Ann Torres, *The Human Right to Health, National Courts, and Access to HIV/AIDS Treatment: A Case Study from Venezuela*, 3 CHI. J. INT’L L. 105, 111-14 (2002) (highlighting the implications of a prominent Venezuela Supreme Court case on the government’s failure to provide antiviral therapies to treat HIV/AIDS); Alicia Ely Yamin, *Not Just a Tragedy: Access to Medications as a Right Under International Law*, 21 B.U. INT’L L.J. 325, 339-41 (2003) (“Costa Rica, India, Venezuela, Columbia, Argentina, and South Africa are among the many countries in which national courts have determined that the state has obligations to provide medications in HIV/AIDS cases and for other diseases.”).

The *freedom* of health, by contrast, is a mostly negative right that only restricts regulation—and, of course, creates a concomitant obligation for enforcement. *Jacobson* limits the government's ability to regulate vaccine consumption but does not oblige the government to provide vaccinations—either through direct provision (i.e., participation) or through subsidization (i.e., regulation). *Buck* and *Skinner* arguably limit the government's ability to regulate fertility but do not oblige the government to provide sterilization or fertility treatment. *Harper* and *Cruzan* limit the government's ability to regulate consumption of medication and medical treatment but do not oblige the government to provide pharmaceuticals or health care. The abortion cases limit the government's ability to regulate the procedure but do not oblige it to include abortion coverage in public insurance or otherwise to provide publicly financed abortions. And *Glucksberg* might limit the government's ability to regulate consumption of palliative care at the end of life but certainly does not oblige the government to provide that care. The freedom of health, thus, does not oblige governmental participation in health care markets.

Of course, it does not forbid that participation either. Several American governments (state and federal) do indeed provide publicly financed vaccines, reproductive technologies, pharmaceuticals, abortion insurance, and hospice care. And, of course, we provide many of our citizens with comprehensive public health insurance through Medicare, Medicaid, the Federal Employees Health Benefits Program, and the State Children's Health Insurance Program, or even with comprehensive public health care through the Military Health System. Public participation in health care is common and uncontroversially constitutional.

C. Conclusion: *The Freedom of Health*

Throughout a long line of precedent, the Supreme Court has taken seriously a principle of individual autonomy in health care decision-making—a constitutional freedom of health. That principle explicitly encompasses a freedom to reject unwanted medical care and implicitly encompasses a freedom to obtain at least certain kinds of medical care.

Although it is true that the Court has never applied a naked freedom of health to invalidate governmental action, two features of substantive constitutional rights might explain the infrequency with which invalidation occurs. First, all such constitutional liberty interests must be balanced against competing regulatory interests. In the case of health care, especially public health, there are many such collective

interests that might outweigh individual autonomy. Second, substantive constitutional rights restrict only regulation, not participation, and the United States has largely relied on participatory rather than regulatory approaches to govern health care decisionmaking. The rarity of invalidation in this case, thus, does not disprove or even much weaken the case for a constitutional freedom of health.

II. RECENT DEBATES

Assuming, then, that a constitutional freedom of health exists, that the individual freedom must be balanced against compelling regulatory interests, and that the constitutional freedom cannot invalidate participatory approaches to health care regulation, what implications does that constitutional rule have for recent hot-button issues in health care regulation? How should we evaluate various autonomy-restricting proposals and regulations, such as the phantom death panels, the 2009 H1N1 vaccine distribution program, the FDA's restrictions on access to experimental drugs, PPACA's antiobesity and anti-smoking regulations, and, most relevantly, PPACA's individual mandate? This Part will address each of those issues in turn, with a hope of fleshing out a framework for the freedom of health.

A. *Death Panels*

Throughout the congressional debates over national health care reform, Alaska Governor Sarah Palin and other conservative commentators warned that the legislative proposals would create death panels, authorizing the government to determine whether sick and elderly patients should be allowed to get treatment.¹²⁸ In her initial account, Governor Palin implied that the death panels would allow the government to block access to all care, including privately funded care;¹²⁹ only later did the conservative commentary refine the story to Medicare-only rationing.¹³⁰ Although never actually proposed in Congress (or any-

¹²⁸ See Palin, *supra* note 16.

¹²⁹ See *id.* (asserting that the health care law would require “my baby with Down Syndrome . . . to stand in front of Obama’s ‘death panel’ so his bureaucrats can decide, based on a subjective judgment of their ‘level of productivity in society,’ whether they are worthy of health care”).

¹³⁰ See, e.g., Robert Longley, *Health Care Reform and ‘Death Panels’—The Facts*, ABOUT.COM, <http://usgovinfo.about.com/od/healthcare/a/deathpanels.htm> (last visited Mar. 15, 2011) (“Across the Internet, blogs and e-mails are claiming that the America’s Affordable Health Choices Act of 2009 (H.R. 3200) requires all Medicare beneficiaries to attend *mandatory* classes once every five years in which they will be in-

where else), the initial account of the phantom death panels—public rationing of privately funded and privately provided care—is a useful starting point in considering the freedom of health and its operation. The kind of direct government rationing that Governor Palin feared is a prototypical example of what the freedom of health ought to forbid.

According to Tea Party mythology, death panels would have authorized the government, presumably through criminal prohibitions or other direct regulatory strategies, to pick and choose which individuals would be allowed access to scarce health care resources.¹³¹ To use Governor Palin's example, the government would have been allowed to decide that her child with Down Syndrome is unworthy of care and that the child should be allowed to die rather than be treated.¹³² Governor Palin thus imagined the death panels as a regulatory, not participatory, strategy to prevent the sick and the elderly from consuming our scarce health care resources. In that form, death panels would have been a direct affront to individual autonomy and a severe constraint on the important liberty interest in health care decision-making. The imagined regulatory structure would have made it significantly harder, if not impossible, for some patients to access health care, even if the patients were willing to use their own money to purchase it.

Could such death panels be upheld as narrowly tailored regulations that serve a compelling state interest? I think not. Although health care inflation is certainly a real problem that needs to be addressed and although we may spend more than we rationally should on care for the sick and the elderly, there are cost-control strategies that would infringe far less on the protected liberty interest than direct public rationing. Furthermore, there is no definite answer on how much we should rationally spend on care for the sick and the elderly, so it is hard to claim conclusively that current spending levels are too high or that spending levels would be more appropriate if we rationed

structed on how to end their lives.”); Domenico Montanaro, *RNC Perpetuates “Death Panels” Rumor*, MSNBC FIRST READ (Aug. 19, 2009, 2:27 PM), http://firstread.msnbc.msn.com/_news/2009/08/19/4430434-rnc-perpetuates-death-panels-rumor (reporting on Republican National Committee Chairman Michael Steele's references to Medicare rationing); Sam Stein, *Grassley Endorses “Death Panel” Rumor: “You Have Every Right to Fear,”* HUFFINGTON POST (Aug. 12, 2009, 1:31 PM), http://www.huffingtonpost.com/2009/08/12/grassley-endorses-death-p_n_257677.html (quoting Iowa Senator Charles Grassley's references to death panels, all of which focused on Medicare beneficiaries' end-of-life decisions).

¹³¹ See Palin, *supra* note 16.

¹³² *Id.*

care through death panels. That is, it is not clear that the savings gained from blocking some patients' access to care would be worth the cost in lost years of life or in increased pain and suffering. The monetization of life years and of pain and suffering is inordinately difficult,¹³³ as is the determination of worthiness to consume care. We therefore lack a precise measure or even a compelling sense of the cost-benefit trade, in the absence of which it would be hard for the government to demonstrate that the regulatory strategy was serving any state interest at all, much less that it was narrowly tailored to serve a compelling one.

What about the Tea Party's revised sense of the death panels? What if, instead of using a direct regulatory strategy like criminalization, Congress amended the Medicare and Medicaid Acts to authorize the same kind of death panels for public health care coverage decisions, allowing the Centers for Medicare and Medicaid Services to deny public insurance coverage to those deemed unworthy? Importantly, unlike Governor Palin's initial conception of the death panels, this approach would leave individuals free to consume health care at their own expense, simply denying some individuals public funding for care. In other words, the approach would be primarily a participatory one rather than a regulatory one. As such, the freedom of health would not apply directly, but it should be incorporated into an equal protection analysis, justifying strict scrutiny of differential treatment among Medicare and Medicaid beneficiaries based on their health status.¹³⁴

In short, direct health care rationing would infringe individuals' fundamental liberty interest in health care autonomy. Because it is almost certainly not the least infringing approach to health care cost control, it ought to be unconstitutional under a freedom-of-health analysis. In their objections to the notion of death panels, thus, Sarah Palin and other members of the Tea Party movement were not completely off-base. Had the government ever proposed and passed such an approach, it would have been an unconstitutional extension of govern-

¹³³ Value of a statistical life (VSL) approximations give us the best estimates for life years and pain and suffering, but those studies are widely divergent and tend to break down when the lives at issue are known rather than statistical. See PETER A. UBEL, *PRICING LIFE* 3 (2000) (providing an anecdotal example of the failure of VSL analysis after introduction of a known life); W. Kip Viscusi & Joseph E. Aldy, *The Value of a Statistical Life: A Critical Review of Market Estimates Throughout the World*, 27 *J. RISK & UNCERTAINTY* 5, 6-7 (2003) (noting that the variability of VSL approximations makes "matching . . . values to the pertinent population at risk . . . problematic").

¹³⁴ Cf. *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942) (referencing the liberty interests in marriage and procreation as a justification for applying strict scrutiny to a sterilization law that discriminated among criminal categories).

mental power. In their regulatory form, the imaginary death panels serve as a prototype for unconstitutional exercises of authority under the freedom of health, and even in a participatory incarnation, they should give rise to strict scrutiny under the Equal Protection Clause.

B. *H1N1 Vaccine Distribution*

The 2009 H1N1 vaccine distribution program presents an interesting case for the freedom of health. In the face of a vaccine shortage and swine flu outbreak, federal and state governments set up a program that effectively prevented some individuals from accessing the vaccine for a period of about two months.¹³⁵ As such, the program hindered some individuals' freedom to consume the vaccine, burdening their liberty interest in health care autonomy. Furthermore, the guidelines for vaccine distribution prioritized certain individuals over others based on risk factors such as age, health, and profession, raising a specter of direct rationing according to "worthiness."¹³⁶ Although it is unclear whether anyone actually faced penalties for distributing the vaccine against the guidelines, the states were authorized to require that only at-risk individuals be vaccinated in the first rounds of allocation, and at least three states provide for civil penalties for misdistribution of vaccines during a shortage.¹³⁷ The vaccine distribution program thus operated somewhat similarly to the feared death panels, allowing the government to decide which people should get limited health care resources and perhaps blocking some people from consuming care that they wanted to purchase with their own money.

¹³⁵ See *Questions & Answers: Vaccine Against 2009 H1N1 Influenza Virus*, CTFS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/H1N1flu/vaccination/public/vaccination_qa_pub.htm (last visited Mar. 15, 2011) (explaining the CDC's recommendation that high-risk groups receive vaccines first); see also Betsy McKay, *Public Faces Long Wait to Get New Flu Vaccine*, WALL ST. J., Oct. 5, 2009, at A1 (describing the allocation of the initially limited vaccine supply); Donald G. McNeil Jr., *Vaccine Supply May Miss Swine Flu Peak*, N.Y. TIMES, Sept. 12, 2009, at A11 (expressing epidemiologists' concern that vaccines would not be available soon enough to adequately protect the population).

¹³⁶ See *2009 H1N1 Vaccination Recommendations*, CTFS. FOR DISEASE CONTROL AND PREVENTION (Oct. 15, 2009, 10:00 AM), <http://www.cdc.gov/h1n1flu/vaccination/acip.htm> (listing vaccine distribution priorities).

¹³⁷ See, e.g., 2004 N.J. Laws 1545-46 (providing for a \$500 civil penalty for willful or knowing violations of a 2004-05 influenza vaccine reallocation plan); OR. REV. STAT. § 433.040 (2009) (providing for a \$500 civil penalty for violations of a health authority vaccination plan in cases of shortage); R.I. GEN. LAWS § 23-76-3 (Supp. 2008) (same). See generally James G. Hodge, Jr. & Jessica P. O'Connell, *The Legal Environment Underlying Influenza Vaccine Allocation and Distribution Strategies*, 12 J. PUB. HEALTH MGMT. PRACTICE 340 (2006) (analyzing state responses to the 2004-05 flu vaccine shortage).

There are two important distinctions, though, between the H1N1 program and the bald rationing of the fictional death panels. First, the program was participatory rather than regulatory. The Centers for Disease Control and Prevention (CDC) had purchased the entire available supply of the vaccine and had distributed it back to providers and patients—at no additional cost—through state governments.¹³⁸ In the vast majority of states, there was no law prohibiting individuals from buying the vaccine through a private supplier; there was simply no private supply available.¹³⁹ Furthermore, the federal government’s distribution guidelines and similar guidelines in most states were purely informational and thus participatory;¹⁴⁰ they were merely government speech. In forty-seven states, there was no penalty for ignoring those guidelines in either the distribution or the consumption of the vaccine.¹⁴¹ Second, even the restrictions that the three penalizing states imposed for misdistribution of the vaccine probably could have passed strict scrutiny. The penalty was a \$500 civil fine for each instance of misdistribution,¹⁴² which would have imposed some burden on individuals’ liberty interest in accessing the vaccine but a lesser burden than criminal sanctions or heftier fines. And in this case, that fine seems justified: First, there was a known and discrete shortage in the vaccine supply. Second, there were clearly identifiable factors that put some individuals at greater risk than others of catching the flu, such as working with small children, or at greater risk of being significantly harmed by the flu, such as being pregnant.¹⁴³ These two concrete factors—supply shortage and individual risk—contrast with the nebulous factors that would justify death panels—overall spending and individual worthiness. There was therefore a concrete need in

¹³⁸ See generally *State & Local Vaccination Guidance: Vaccine Distribution Q&A*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 3, 2009, 4:00 PM), http://www.cdc.gov/H1N1flu/vaccination/statelocal/centralized_distribution_qa.htm (outlining the vaccine distribution system to states).

¹³⁹ See Betsy McKay et al., *Obama Targets Swine-Flu Response*, WALL ST. J., Oct. 26, 2009, at A3 (explaining federal government efforts to purchase and support production of vaccine doses).

¹⁴⁰ See Benjamin E. Berkman, *Incorporating Explicit Ethical Reasoning into Pandemic Influenza Policies*, 26 J. CONTEMP. HEALTH L. & POL’Y 1, 8-9 (2009) (“[P]roviders will . . . not be bound by the guidelines . . . and likely will feel pressured to give vaccine to . . . vaccine seekers who are not at elevated risk of infection or complication.”); Hodge & O’Connell, *supra* note 137, at 342 (noting that CDC guidelines are merely advisory).

¹⁴¹ Cf. *supra* note 137 (noting the three states that did establish penalties for violating vaccine distribution guidelines).

¹⁴² *Id.*

¹⁴³ See 2009 H1N1 Vaccination Recommendations, *supra* note 136.

2009 to steer the limited H1N1 vaccine resources toward certain populations, at least until the supply could catch up to demand, to limit the public health consequences of the swine flu outbreak. Although the distribution program effectively impeded some individuals' freedom to obtain the H1N1 vaccine by socializing the vaccine supply, the CDC's and the states' participatory programs could have passed constitutional muster.

C. *Experimental Drugs*

Another interesting case for the freedom of health is the the subject of the *Abigail Alliance* opinions: the Food and Drug Administration's (FDA) restrictions on access to experimental drugs. In *Abigail Alliance*, a group of patients claimed a fundamental liberty interest in accessing potentially lifesaving drugs.¹⁴⁴ They wanted access only to so-called post-Phase I drugs, which are drugs that have been deemed safe in the first phase of FDA clinical trials and will be tested for effectiveness in Phase II trials.¹⁴⁵ Under current law, drug companies may not advertise or market Phase II drugs at all, and they may sell such drugs only to patients who qualify for a "compassionate-use" exception from the FDA.¹⁴⁶ Even then, drug companies may sell Phase II drugs only at cost, which is not enough to cover liability risks. A patient's best option for obtaining Phase II drugs, therefore, is to apply to be a subject in the clinical trial.¹⁴⁷ But that option is far from a failsafe. The patient might not be accepted to participate if she does not make a good clinical subject for any reason, and even if accepted as a subject, the patient might be given a placebo instead of the active drug. Outside of the trials, patients may wait years for the drug to be approved and marketed.¹⁴⁸

The three-judge panel in *Abigail Alliance* found that these restrictions on access to Phase II drugs violated individuals' liberty interest

¹⁴⁴ See *Abigail Alliance II*, 495 F.3d 695, 701 (D.C. Cir. 2007).

¹⁴⁵ See *id.*

¹⁴⁶ See 21 U.S.C. § 355 (2006) (requiring FDA approval before a drug may be introduced or delivered for introduction into interstate commerce).

¹⁴⁷ See Jerry Menikoff, *Beyond Abigail Alliance: The Reality Behind the Right to Get Experimental Drugs*, 56 U. KAN. L. REV. 1045, 1057-58 (2008).

¹⁴⁸ See *id.* at 1051; cf. Michael D. Greenberg, *AIDS, Experimental Drug Approval, and the FDA New Drug Screening Process*, 3 N.Y.U. J. LEGIS. & PUB. POL'Y 295, 300 (2000) (noting that FDA regulation may be creating a "drug lag" in the United States as compared to drug development in Europe).

in obtaining medical care.¹⁴⁹ The D.C. Circuit, however, reheard the case en banc and overturned the panel's decision, holding that no such constitutional liberty interest exists.¹⁵⁰ Under a freedom-of-health analysis, the panel was obviously right to recognize the liberty interest, though I would argue that the FDA restrictions serve a compelling state interest and are therefore potentially valid.

To establish that drugs provide effective treatment, we need to conduct clinical trials, and those clinical trials need to include control groups that receive placebos instead of active drugs. A rational patient, however, would not choose to participate in a trial—and thereby to risk receiving a placebo—if she could instead access the drug on the market, particularly where the drug has already been proven safe in Phase I trials.¹⁵¹ To preserve the public good of effectiveness studies, therefore, we have a compelling collective interest in restricting individuals' access to Phase II drugs *outside* of the clinical trials.

That said, the plaintiffs in *Abigail Alliance* could have argued that the restrictions are not narrowly tailored to serve the relevant interest. Many patients might apply for the clinical trial and be rejected for various reasons having nothing to do with the drug's likely safety or effectiveness. For example, some patients might have other conditions that would be hard to control for in the study, regardless of whether those conditions were likely to affect the drug's performance. Under current FDA restrictions, even patients who applied to participate in the trials and were rejected are forbidden to access Phase II drugs on the market.¹⁵² The compassionate-use exceptions are administratively burdensome, making access difficult and risky for both patients and doctors.¹⁵³ Given that the relevant state interest is to avoid free-riding—to preserve an incentive for patients to volunteer for the trials—there is no reason to forbid access to patients who were willing but not allowed to participate. Once a patient has applied for the trial

¹⁴⁹ See *Abigail Alliance I*, 445 F.3d 470, 486 (D.C. Cir. 2006).

¹⁵⁰ See *Abigail Alliance II*, 495 F.3d at 712.

¹⁵¹ See Elizabeth Weeks Leonard, *Right to Experimental Treatment: FDA New Drug Approval, Constitutional Rights, and the Public's Health*, 37 J.L. MED. & ETHICS 269, 274 (2009).

¹⁵² See 21 U.S.C. § 355(a) (2006).

¹⁵³ See, e.g., *Clarification of FDA Regulations and Guidance on "Compassionate" and "Humanitarian" Use*, STANFORD U. RES. COMPLIANCE OFF. (Jan. 2006), http://humansubjects.stanford.edu/research/documents/compassionate_humanitarian_use_FDA_GUI01036.pdf (explaining FDA regulations and guidance for the compassionate-use exception); *UCSF Human Research Protection Program Guidelines on Emergency Use and Compassionate Use*, U.C.S.F. HUM. RES. PROTECTION PROGRAM, <http://www.research.ucsf.edu/chr/guide/chrEmerUse.asp#CU> (last visited Mar. 15, 2011) (same).

and been rejected, she should have a constitutional right to access Phase II drugs.

D. *Obesity and Smoking Regulations*

Obesity and smoking regulations provide interesting foils for one another. Under the proposed freedom-of-health analysis, I would argue that direct penalties for eating fatty foods should be unconstitutional while the same direct penalties for smoking might not be. That said, the participatory approaches that the government has used (such as Michelle Obama's "Let's Move" initiative¹⁵⁴) and the nonrestrictive regulatory approaches included in PPACA (such as menu labeling requirements¹⁵⁵ and wellness initiatives¹⁵⁶) should be constitutional with respect to both food and smoking.

To start, I need to make the case that regulations targeting smoking and eating impinge on the liberty interest in controlling one's own health. In doctrinal terms, the claim is that the freedom to reject care should include a freedom to reject preventive care such as diet, exercise, and smoking cessation. In more colloquial terms, the claim is that we should be free to choose a shorter lifespan that includes donuts and cigarettes over a longer lifespan that includes only carrots and exercise. That choice is ultimately a health care choice that falls under the ambit of the freedom of health. As a result, any regulation that punishes people for smoking should raise constitutional questions, as should any regulation that punishes people for choosing fatty foods.

Why, then, are obesity and smoking foils for one another if regulations in both realms implicate the freedom of health? The critical point here is that the collective interest in curbing smoking is much stronger and much more concrete—an interest among nonsmokers in avoiding deleterious effects of second-hand smoke—than the collective interest in curbing obesity. This point, of course, is not new; the second-hand smoke justification for regulating cigarettes is well ac-

¹⁵⁴ See Sheryl Gay Stolberg, *Childhood Obesity Battle Is Taken Up by First Lady*, N.Y. TIMES, Feb. 10, 2010, at A16 (discussing Michelle Obama's program to "revamp" the way American children eat and exercise).

¹⁵⁵ See PPACA § 4205, 21 U.S.C.A. § 343(q)(5)(H) (West Supp. 1 2010) (requiring chain restaurants and retail food establishments to provide nutritional information for regularly offered food items).

¹⁵⁶ See *id.* § 4202, 42 U.S.C.A. § 300u-14 (West Supp. 1A 2010) (offering funding to states "to provide public health community interventions, screenings, and . . . clinical referrals for individuals who are between 55 and 64 years of age"); *id.* § 10408, 42 U.S.C.A. § 2802 note (West Supp. 1B 2010) (offering funding to employers for wellness programs that promote healthy lifestyles and disease self-management).

cepted, and others before me have noted that obesity imposes no similar negative externalities (except to the extent that we choose to subsidize the health care costs of obesity through Medicare and Medicaid).¹⁵⁷ The effects of second hand smoke, thus, provide a compelling state interest for banning public smoking, though perhaps not for banning private smoking (in one's home, for example). The effects of obesity, by contrast, are mostly individual, such that the only state interest in banning unhealthy foods is a paternalistic one. That paternalistic interest should not be cognizable where the relevant liberty interest is an individual freedom to make unhealthy choices free from governmental paternalism—which is what the right to reject care essentially is. If we have a genuine freedom of health, therefore, bans on consumption of unhealthy foods should be unconstitutional in a way that bans on smoking should not be. A few modern regulations might be unconstitutional under this analysis, including bans on trans fats¹⁵⁸ and so-called “fat taxes.”¹⁵⁹

That said, the freedom of health ought not to forbid the government from requiring smokers or obese individuals to pay more for Medicare and Medicaid coverage than nonsmokers and nonobese individuals. Such a system would not penalize the choice to be unhealthy; it would simply require unhealthy individuals to pay for the consequences of their choices or to forego care for their lung cancer or diabetes. Such a system would be no different from requiring people to pay damages for defamation; they are free to speak but must pay for the damage they cause by speaking.

Furthermore, informational campaigns, labeling requirements, and private wellness initiatives should present no constitutional problem under a freedom-of-health analysis. Informational campaigns are merely government speech, participatory actions that individuals remain free to ignore. Labeling requirements are regulatory because they require manufacturers to engage in particular behaviors, but their effect on health care choices is no greater than that of public informational campaigns; they leave individual consumers free to ignore the labels and to continue smoking and eating. Purely informational

¹⁵⁷ See, e.g., Saul Levmore, *Taxing Obesity—Or Perhaps the Opposite*, 53 CLEV. ST. L. REV. 575, 582 (2005–06).

¹⁵⁸ See, e.g., Phila., Pa., Health Code § 6-307 (2011) (prohibiting trans fats in food served at restaurants).

¹⁵⁹ See Jeff Strnard, *Conceptualizing the “Fat Tax”: The Role of Food Taxes in Developed Economies*, 78 S. CAL. L. REV. 1221, 1226 (2005) (discussing food taxes that “explicitly attempt to influence behavior to meet public health goals”).

strategies, thus, should face no constitutional problem. The wellness initiatives are trickier because they effectively punish unhealthy choices by denying benefits to people who refuse to participate in wellness programs.¹⁶⁰ But all such programs currently in existence are privately provided and regulated only to prevent excessive discrimination on the basis of health status. Therefore, under the state action doctrine, these programs are constitutional.

E. *The Individual Mandate*

The most notable controversy regarding the constitutionality of health care regulation today is the debate over the individual mandate. The substantive due process challenge that I consider here, however, has not been a prominent one in that debate. Instead, most scholars and lawyers have focused on structural questions, particularly whether Congress has authority to require individual insurance coverage under either its power to tax or its power to regulate interstate commerce.¹⁶¹ Indeed, even those scholars who argue that the mandate is unconstitutional because it infringes individual liberty do not rely on substantive due process—much less on a freedom of health—to support their claims.¹⁶² Of course, their hesitation is understandable; the claim that we have a substantive due process right *not* to buy health insurance sounds like a *Lochner*-style claim.¹⁶³

Under a freedom of health, though, the substantive due process analysis seems more plausible than most scholars have made it out to be. The mandate requires individuals to carry health insurance cov-

¹⁶⁰ See Cynthia A. Baker, *Bottom Lines and Waist Lines: State Governments Weigh In on Wellness*, 5 IND. HEALTH L. REV. 185, 189 (2008) (“[T]o the extent government supported wellness initiatives ostracize, isolate, and punish . . . unhealthy individuals, those initiatives should be doubly criticized”); Thomas J. Parisi, *The Onus Is on You: Wellness Plans and Other Strategies Being Employed for Patients to Take Ownership of Their Health*, 13 QUINNIPIAC HEALTH L.J. 243, 268-69 (2010) (discussing methods by which employers use wellness programs to penalize nonparticipants).

¹⁶¹ See, e.g., Randy Barnett et al., *Why the Personal Mandate to Buy Health Insurance Is Unprecedented and Unconstitutional*, LEGAL MEMORANDUM (Heritage Found., Washington, D.C.), Dec. 9, 2009, at 1-2 (arguing that the individual mandate exceeds Congress’s power under the Commerce Clause).

¹⁶² See Hall, *supra* note 3, at 41 (discussing possible constitutional challenges to the individual mandate based upon religious freedom, due process, and the Takings Clause); James Taranto, Op-Ed., ‘A Commandeering of the People,’ WALL ST. J., July 24–25, 2010, at A11 (suggesting an argument against the individual mandate premised upon the Tenth Amendment’s preservation of power to the people).

¹⁶³ See Hall, *supra* note 3, at 45 (rejecting the possibility of a substantive due process claim against PPACA because “there is no fundamental right to be uninsured”).

erage throughout the tax year or pay a penalty.¹⁶⁴ At first blush, this requirement does not impinge at all on an individual's freedom either to refuse or to obtain health care. It prohibits individuals from refusing health *insurance*, not any particular health *care*, and individuals with insurance coverage remain free to consume any care they choose. Indeed, insurance might enable individuals to consume some care that they otherwise would not be able to afford, thereby expanding individuals' freedom to make health care choices.

But today's insurance contracts are not mere risk pools, gathering and distributing funds for health care consumption at the discretion of the insured. Instead, today's contracts give insurers variable amounts of discretion under "medical necessity" review to decide whether their insured can buy various kinds of health care with the pool's money.¹⁶⁵ That is, insurance companies today use their contracts to steer individuals towards certain health care consumption decisions, often refusing to cover treatments that they deem ineffective, unnecessary, or even just inordinately costly. As such, an individual's choice among different kinds of insurance contracts—or her choice to enter no such contract at all—will impact her health care consumption. If she is required to buy into such a contract, a patient will give up some degree of freedom and autonomy to choose her own care; at a minimum, she will lose some freedom to direct the care that she purchases with the dollars that she has set aside in insurance. Furthermore, PPACA outlaws the most freedom-preserving kinds of insurance (such as high-deductible sickness and accident insurance), requiring all insurance contracts to provide extensive benefits.¹⁶⁶ Those requirements mean that most health care will be covered, but they also mean that the insurance companies will be allowed to review most consumption decisions for medical necessity.

¹⁶⁴ See PPACA §§ 1501, 16106, 26 U.S.C.A. § 5000A (West Supp. 1A 2010) (setting the penalty scheme for failure to maintain minimal essential coverage); see also STAFF OF J. COMM. ON TAXATION, 111TH CONG., TECHNICAL EXPLANATION OF THE REVENUE PROVISIONS OF THE "RECONCILIATION ACT OF 2010," AS AMENDED, IN COMBINATION WITH THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT" 31-34 (Comm. Print 2010), available at <http://www.jct.gov/publications.html?func=startdown&id=3673> (providing information on the present law and the penalties that PPACA will impose).

¹⁶⁵ See Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1640-41, 1672-73 (1992) (describing the discretion provided insurers to conduct "medical necessity" review in health care contracts).

¹⁶⁶ See PPACA § 1302, 42 U.S.C.A. § 18022 (West Supp. 1B 2010) (setting forth minimal health benefits that qualified health plans must cover).

Of course, even the most restrictive insurance contracts leave their beneficiaries free to pay out of pocket for care that the insurance companies will not cover. The requirement to carry insurance, thus, does not fully strip individuals of the freedom to make alternative consumption decisions. As a result, it is possible to argue that the negative liberty interest is intact; individuals remain free to obtain whatever care they can afford, just as they would be without an insurance contract. But standard constitutional analysis is not usually satisfied with that kind of marginal, retained freedom if a regulatory regime burdens the protected freedom's exercise in a meaningful way. In speech, for example, a regulatory regime that has the real-world effect of chilling speech will be unconstitutional even if the regulation does not fully negate the freedom to speak.¹⁶⁷ Similarly, an abortion regulation might be unconstitutional if it has the real-world effect of making abortion a harder choice, even if women retain the freedom to choose an abortion in the face of the regulatory regime; that real-world effect is the crux of the "undue burden" analysis.¹⁶⁸ In this case, requiring individuals to enter insurance contracts and thereby authorizing insurance companies to perform "medical necessity" review places at least some burden on individuals' freedom to choose their own health care. It will have the real-world effect of swaying health care choices.¹⁶⁹

There seems, therefore, to be a colorable claim that the mandate infringes the freedom of health by requiring individuals to enter discretion-limiting insurance contracts—requiring individuals to give a third-party insurer the power to influence or even to direct their health care spending. The argument is not a bald, *Lochner*-era claim of freedom of contract; it is a claim that these particular contracts make it harder for individuals to exercise an independently protected liberty interest in health care decisionmaking. For an analogy, imagine that some Internet service providers were contractually autho-

¹⁶⁷ See *Lamont v. Postmaster Gen.*, 381 U.S. 301, 305 (1965) (invalidating a regulation that required recipients of mail to authorize deliveries of "communist political propaganda" on the ground that it would have a chilling effect on communist expression).

¹⁶⁸ See *Stenberg v. Carhart*, 530 U.S. 914, 937-38 (2000) (applying the "undue burden" standard to invalidate prohibitions on so-called "partial-birth abortions"); *Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 452-53 (1983) (O'Connor, J., dissenting) (articulating the undue burden standard), *overruled in part* by *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

¹⁶⁹ See, e.g., *Aetna v. Davila*, 542 U.S. 200, 201-02 (2004) (recounting the stories of two plaintiffs who made health care consumption decisions in accordance with their insurance companies' determinations of medical necessity rather than purchasing alternative care out of pocket).

rized to monitor our Internet usage and to block our access to sites that they deemed unnecessary or inappropriate (for example, if they saw that we spent too much time on Facebook during work hours), and imagine that the government required us to buy Internet access through such a contract. I imagine that the freedom of speech would come into play there—at least as a colorable argument, if not as a successful tool—even though the regulation would center on a contract and even if we were free to access the blocked content through other channels, through other media, or through out-of-pocket payment. The freedom-of-health argument against the mandate thus seems colorable and difficult—certainly more viable, I think, than a mere reference to *Lochner* would lead us to believe.

Ultimately, however, even if the freedom of health presents a colorable limitation for the individual mandate, the law as currently written should pass muster under the balancing test. Expanding health insurance coverage and decreasing the cost of insurance on the individual market should count as compelling state interests, but we can neither expand coverage nor control individual market costs as long as insurers fear adverse selection. That is, insurance companies will continue to raise prices on the individual market and will continue to deny coverage as long as they worry that the people seeking insurance are more likely than average to be sick. The mandate addresses that problem by requiring that everyone, sick and healthy alike, enter the insurance pool.

Furthermore, there can be no doubt that the mandate is narrowly tailored. Indeed, it is perhaps *too* narrowly tailored. The mandate claims that it imposes a penalty (or a fine or a tax) of \$695 per year¹⁷⁰ or 2.5% of taxable income (whichever is greater)¹⁷¹ for any individual who refuses to buy insurance. The cost of an individual insurance contract, though, is more than \$695 per year.¹⁷² Many Americans

¹⁷⁰ Health Care and Education Reconciliation Act of 2010 § 1602(a)(2), 26 U.S.C.A. § 5000A(c)(3) (West Supp. 1A 2010).

¹⁷¹ PPACA § 10106(b)(2), 26 U.S.C.A. § 5000A(c)(2).

¹⁷² See Ricardo Alonso-Zaldivar, *Obama Plan to Be Costly for Some Uninsured*, DETROIT FREE PRESS, July 1, 2010, at B5 (acknowledging that new health coverage for previously uninsured individuals may have premiums as high as \$900); Janet Trautwein, Op-Ed., *Why We Need a Strong Individual Mandate*, WALL ST. J., Nov. 11, 2009, at A19 (pointing out that as long as the penalty for failing to purchase insurance is not comparable to the cost of coverage, Americans will continue to avoid procuring insurance).

Median household income in the United States is about \$40,000 per year. See Table of Personal Income for People 25 Years Old and Over with Work Experience in 2009, U.S. CENSUS BUREAU, http://www.census.gov/hhes/www/cpstables/032010/perinc/new03_010.htm (last visited Mar. 15, 2011). The exemption is \$3650, see I.R.S.

might therefore rationally choose to pay the penalty rather than carry insurance, leaving them free to direct their own health care consumption. Furthermore, the penalty itself is extremely difficult for the government to enforce. PPACA did not give the Internal Revenue Service any power to assess the tax or to collect the fine or penalty except by deducting from future income tax refunds.¹⁷³ Individuals thus remain free to ignore the penalty so long as they never pay more tax than they owe, allowing them to remain uninsured without penalty. In short, the law of the individual mandate barely infringes liberty; it seems to be a mere rhetorical or expressive attempt to convince individuals to buy insurance rather than an actual exercise of police power to require universal coverage.

In the end, then, the individual mandate might present a harder case under substantive due process than most commentators have assumed and might present an increasingly difficult case if Congress ever gives the mandate teeth. As written, however, the law ought to pass muster under the state-interest override given that it is minimally infringing.

CONCLUSION

The individual freedom of health has lurked in Supreme Court precedent for several decades, but it has not emerged with a life of its own. Its spectral existence may be due in part to our recognition of many legitimate regulatory interests in health care and public health. Ultimately, however, those regulatory interests can and should be balanced against the individual liberty interest within the constitutional doctrine. We ought, therefore, to recognize the freedom of health and to apply it with a standard state-interest-override potential, through strict or intermediate scrutiny.

Form 1040A, at l. 26 (2010), making median taxable income \$36,350 (\$40,000 - \$3650). Two and one-half percent of that is \$908.75. Using the \$900 estimate for insurance premiums, that leaves most taxpayers' penalty smaller than the cost of insurance (most being defined as everyone below the median). And, of course, the average cost of individual coverage today is significantly higher than \$900 per year; the \$900 figure is a generous estimate of how much costs will go down once the exchanges and regulations are in place.

¹⁷³ See J. Paul Singleton, *Can You Really Have Too Much of a Good Thing?: How Benevolent Tax Policies Have Contributed to the Explosion of Health Care Costs and How New Policies Threaten to Do More of the Same*, 8 DEPAUL BUS. & COM. L.J. 305, 326-28 (2010) (explaining how the IRS's inability to enforce the penalty through use of liens or seizures will decrease the individual mandate's effectiveness).

If we apply that formula to recent hot-button issues in health care regulation, most of what the government has actually accomplished should pass constitutional muster. Both our national and state governments have primarily focused on participatory approaches to health care, and even the regulatory exercises address compelling state interests and present minimal infringements of individual liberty. That said, the restrictions on access to Phase II experimental drugs, the ban on trans fats, and the “fat taxes” on sugary and fatty foods present constitutional problems, and the individual mandate presents a harder case under a freedom of health than most scholars have recognized.