

# If We Can Force People to Purchase Health Insurance, Then Let's Force Them to Be Treated Too

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## I. INTRODUCTION

Proponents of the 2010 Patient Protection and Affordable Care Act (PPACA)<sup>1</sup> justify the Act's mandate that uninsured individuals either purchase a minimally defined health insurance policy ("Maintain Minimum Essential Coverage") or pay a fine,<sup>2</sup> as a necessary and proper exercise of Congress's express constitutional power to regulate interstate and foreign commerce.<sup>3</sup> The United States Supreme Court will decide the correctness of that highly debatable position<sup>4</sup> during its spring 2012 session.<sup>5</sup>

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<sup>1</sup> Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (to be codified primarily in scattered sections of 42 U.S.C.).

<sup>2</sup> PPACA § 1501, 42 U.S.C. § 18091 (2006 & Supp. IV 2011). It is unclear, even to the PPACA's staunchest defenders, whether the penalty, which is enforced through a new section 5001 of the Internal Revenue Code, is more properly characterized as a fine or a tax. *See, e.g.*, Lawrence O. Gostin, *The National Individual Health Insurance Mandate*, 40 HASTINGS CENTER REP. 8, 8 (2010) ("If anything, the tax penalty is too low . . ." (emphasis added)); Vikram David Amar, *Reflections on the Doctrinal and Big-Picture Issues Raised by the Constitutional Challenges to the Patient Protection and Affordable Care Act (Obamacare)* 6 n.33 (UC Davis Legal Studies Research Paper Series, Research Paper No. 278, Oct. 2011), available at <http://ssrn.com/abstract=1936330> (referring to "the tax penalty imposed by the Act . . . . If individuals wish to escape the coverage mandate, conceivably they could refrain from undertaking the economic activity (earning income) that triggers the duty to file a tax return." (emphasis added)).

<sup>3</sup> *See, e.g.*, Mark A. Hall, *Commerce Clause Challenges to Health Care Reform*, 159 U. PA. L. REV. 1825, 1864 (2011); Wilson Huhn, *Constitutionality of the Patient Protection and Affordable Care Act Under the Commerce Clause and the Necessary and Proper Clause*, 32 J. LEGAL MED. 139, 163-64 (2011).

<sup>4</sup> For objections to the PPACA's constitutional legitimacy under the Commerce Clause, *see*, example, Randy E. Barnett, *Commandeering the People: Why the Individual Health Insurance Mandate Is Unconstitutional*, 5 N.Y.U. J.L. & LIBERTY 581 (2010). Other challenges to the PPACA, such as those based on First Amendment Free Exercise and Establishment Clause grounds, *see* Samuel T. Grover, Note, *Religious Conscience Exemptions to the PPACA Health Insurance Mandate*, 37 AM. J.L. & MED. 624 (2011), and on federalism objections to congressionally mandated expansion of the

Assuming, without by any means predicting,<sup>6</sup> that the validity of all parts of the PPACA—including the individual insurance mandate—is upheld, the Court’s (likely multiple) opinions will constitute a major development in the evolution of American constitutional jurisprudence, even if Congress subsequently repeals specific sections of the legislation.<sup>7</sup> Several commentators have expressed concern about the ramifications of a judicially validated PPACA for attempts by the government, especially through the mechanism of Comparative Effectiveness Research (CER),<sup>8</sup> to limit or ration particular forms of potentially beneficial medical care for some or all patients.<sup>9</sup> Others dismiss concern about healthcare rationing as one of “the two [Tea Party] bogeymen [along with socialized medicine] that the freedom of health would be most likely to prohibit.”<sup>10</sup> Thus far, however, little if any attention has been paid to the opposite side of the coin.<sup>11</sup> Does judicial approval of congressional authority to require the purchase of health insurance on interstate commerce grounds necessarily translate into congressional authority to positively affect interstate commerce? Specifically, would such a holding imply judicial approval of federal statutes mandating that individuals submit to receive certain forms of demonstrably cost-effective medical treatment?

This Article addresses the possibility of government-mandated medical treatment as a logical sequel to a judicially sanctioned PPACA. Part II identifies the key issues involved in challenges to the PPACA’s constitutionality, focusing on the manner in which many public health scholars have framed Congress’s rationale for enacting the legislation. Part III assumes that the Supreme Court will endorse the public health rationale undergirding the PPACA. This Part extends that public health rationale to potential federal mandates that individuals undergo particular forms of medical intervention designed to improve their individual health and society’s well-being. Objections to such federal mandates of medical treatment are noted, but

Medicaid program, *see* Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431 (2011), are not discussed in this Article.

<sup>5</sup> *Florida ex rel. Att’y Gen. v. U.S. Dep’t of Health & Human Servs.*, 648 F.3d 1235 (11th Cir. 2011), *cert. granted sub nom. Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 603 (2011) (mem.), *and cert. granted*, 132 S. Ct. 604 (2011) (No. 11-398) (mem.) (argued Mar. 26-27, 2012), *and cert. granted in part*, 132 S. Ct. 604 (2011) (No. 11-400) (mem.) (argued Mar. 28, 2012).

<sup>6</sup> Notwithstanding the cavalier assertions of some commentators, the outcome of litigation challenging the PPACA is hardly an “obvious” or foregone conclusion. *See, e.g.*, Andrew Koppelman, *Bad News for Mail Robbers: The Obvious Constitutionality of Health Care Reform*, 121 YALE L.J. ONLINE 1 (2011), available at <http://yalelawjournal.org/2011/04/26/koppelman.html>.

<sup>7</sup> *See* Eric R. Claeys, *Obamacare and the Limits of Judicial Conservatism*, 8 NAT’L AFFS. 56, 58 (2011) (“In the end, a legislative repeal—signed by a president who supports it—remains the surest way to undo Obamacare.”).

<sup>8</sup> Regarding CER generally, *see* Eleanor D. Kinney, *Comparative Effectiveness Research Under the Patient Protection and Affordable Care Act*, 37 AM. J.L. & MED. 522 (2011).

<sup>9</sup> J. Paul Singleton, *The Good, the Bad, and the Ugly: How the Due Process Clause May Limit Comprehensive Health Care Reform*, 77 TENN. L. REV. 413 (2010); Emily S. Stopa, *Harnessing Comparative Effectiveness Research to Bend the Cost Curve and Achieve Successful Health Reform: An Assessment of Constitutional Barriers to Limiting Health Care Treatment Options*, 13 U. PA. J. CONST. L. 815 (2011); *cf.* Mary Ann Baily, *Futility, Autonomy, and Cost in End-of-Life Care*, 39 J.L. MED. & ETHICS 172 (2011) (arguing that we cannot achieve universal access to quality care at affordable cost without a better public understanding of the moral legitimacy of taking cost into account in healthcare decisions).

<sup>10</sup> Abigail R. Moncrieff, *Safeguarding the Safeguards: The ACA Litigation and the Extension of Structural Protection to Non-Fundamental Liberties*, 64 FLA. L. REV. (forthcoming 2012), available at <http://ssrn.com/abstract=1919272>.

<sup>11</sup> *See, e.g.*, Kinney, *supra* note 8; Singleton, *supra* note 9; Stopa, *supra* note 9; *cf.* Baily, *supra* note 9.

rejected. Part IV consists of a summary concluding that if Americans do not have a constitutional right to refuse to purchase an individual health insurance policy, then they do not have a legally enforceable right to refuse specific medical treatments.

## II. RATIONALES FOR THE INDIVIDUAL INSURANCE MANDATE

The most important legal challenges to the individual health insurance mandate provision of the PPACA are motivated by the challengers' concern about an infringement of Americans' liberty interests, a concern that has been disparaged by a number of PPACA supporters.<sup>12</sup> The challengers' chief argument in the courts, however, has taken the form of a claim that Congress exceeded its express constitutional authority in enacting the individual mandate.<sup>13</sup> More particularly, challengers submit that Congress's power to regulate interstate commerce<sup>14</sup> extends (albeit extremely broadly)<sup>15</sup> only to provisions regarding actions by regulated persons or entities involving goods and services that are traded interstate, and that an individual's unwillingness to purchase health insurance represents a form of inactivity over which Congress has no lawful control.<sup>16</sup> Thus, Congress's "claimed power [in enacting the PPACA under a Commerce Clause rationale] is tantamount to a national police power inasmuch as it lacks principled limits."<sup>17</sup> Critics of the PPACA contend further that the individual mandate provision cannot be justified alternatively on the basis of any other constitutionally enumerated congressional power, including the power to tax to raise revenues for the general welfare.<sup>18</sup>

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<sup>12</sup> See, e.g., Arthur J.R. Baker, *Fundamental Mismatch: The Improper Integration of Individual Liberty Rights into Commerce Clause Analysis of the Patient Protection and Affordable Care Act*, 66 U. MIAMI L. REV. 259, 296 (2011) ("There is a history of efforts to show that congressional legislation enacted pursuant to the Commerce Clause violates some implicit—and typically poorly articulated—liberty right. The Court has rejected these claims in the past and should do so here with respect to the individual mandate." (citations omitted)).

<sup>13</sup> See Abigail R. Moncrieff, *The Freedom of Health*, 159 U. PA. L. REV. 2209, 2247 (2011) ("[M]ost 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. 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." (citations omitted)). Baker objects to this legal strategy, contending that it is "important to address the question [of substantive due process] forthrightly—rather than smuggle it into the analysis under the guise of the Commerce Clause . . ." Baker, *supra* note 12, at 310.

<sup>14</sup> U.S. CONST. art I, § 8, cl. 3 (giving Congress "power to regulate Commerce . . . among the several States").

<sup>15</sup> For example, the Court in *Gonzales v. Raich* held:  
We have never required Congress to legislate with scientific exactitude. When Congress decides that the "total incidence" of a practice poses a threat to a national market, it may regulate the entire class . . . . In this vein, we have reiterated that when "a general regulatory statute bears a substantial relation to commerce, the *de minimis* character of individual instances arising under that statute is of no consequence."  
545 U.S. 1, 17 (2005).

<sup>16</sup> See Kenneth T. Cuccinelli, II, E. Duncan Getchell, Jr. & Wesley G. Russell, Jr., *Why the Debate over the Constitutionality of the Federal Health Care Law Is About More Than Health Care*, 15 TEX. REV. L. & POL. 293, 295 (2011).

<sup>17</sup> *Id.*; see also Ilya Somin, *A Mandate for Mandates: Is the Individual Health Insurance Mandate Case a Slippery Slope?*, 75 LAW & CONTEMP. PROBS. (forthcoming 2012); Editorial, *ObamaCare Goes to Court*, WALL ST. J., Nov. 15, 2011, at A18.

<sup>18</sup> See *Virginia ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768, 786-88 (E.D. Va. 2010), vacated, 656 F.3d 253 (4th Cir. 2011), *petition for cert. filed*, 80 U.S.L.W. 3221 (U.S. Sept. 30, 2011) (No. 11-420) (rejecting the government's attempt to construe the individual mandate as a tax).

Defenders of the PPACA reject the activity/inactivity dichotomy, at least in the healthcare context, as it might purportedly apply to Commerce Clause analysis. Their position, put succinctly, is as follows:

With rare exception, at some point every individual will require health care services. Therefore, the decision of many individuals not to purchase coverage—whether consciously or not—presents a free rider problem. These individuals will generally receive care, whether or not they are able to pay toward that care. For those individuals for whom health coverage is unaffordable, there is a societal obligation to create remedies. On the other hand, for those individuals who could afford to purchase coverage, yet choose not to, it should be clear that “free riding” cannot be sanctioned.<sup>19</sup>

Thus, according to this view, by exposing society to the risk of bearing the financial costs of one’s illness or injury because one has failed to purchase health insurance, that person’s failure to purchase coverage impacts the goods and services traded in interstate commerce.

A number of leading public health law commentators defend the validity of the PPACA as a legitimate exercise of Congress’s Commerce Clause authority by essentially reframing the question, moving beyond a narrowly focused concern about precisely demarcating the blurred line between action and inaction. The public health rationale for the PPACA as constitutionally proper is exemplified by the statement:

In cultural terms, the Court will have to decide whether PPACA is about preserving a fiscally and otherwise healthy collectivity—the nation—or about preserving an individually defined bundle of rights. Perhaps subconsciously, the Justices must frame the relationship between government and individual access to the health care system as primarily either about collective governance or about fostering individual self-governance. Fundamentally, the legitimacy of the individual mandate turns on whether the Court will accept that a sacrifice of individual economic liberty is justified by an obligation to contribute to the common good that accompanies membership in the American political community.<sup>20</sup>

According to this view, the PPACA must be understood as

represent[ing] a determination that a major national problem—access to health care—requires a national solution, and that the solution can work only under conditions in which everyone has health insurance. It further represents a determination that achieving this aim through the market, rather than through a direct government provision of health care, is the best approach.<sup>21</sup>

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<sup>19</sup> Scott A. Berkowitz & Edward D. Miller, *The Individual Mandate and Patient-Centered Care*, 306 JAMA 648, 649 (2011). *But see* Douglas A. Kahn & Jeffrey H. Kahn, *Free Rider: A Justification for Mandatory Medical Insurance Under Health Care Reform?*, 109 MICH. L. REV. 78, 79 (2011) (“[C]onclud[ing] that the free-rider problem, if it exists at all, likely is of minor significance and can hardly be said to justify the adoption of an intrusive and expensive health care program.”).

<sup>20</sup> Nan D. Hunter, *Health Insurance Reform and Intimations of Citizenship*, 159 U. PA. L. REV. 1955, 1977-78 (2011).

<sup>21</sup> Baker, *supra* note 12, at 311-12.

Stated succinctly, “From this perspective, the dispositive constitutional question is not whether Congress’ [sic] interstate commerce power extends to commercial inactivity, but rather whether it authorizes Congress to regulate individual decisions with significant economic ramifications in the interests of protecting and promoting the public’s health.”<sup>22</sup> Put differently, “[t]he activity/inactivity distinction makes no sense for individual choices, like declining health insurance, that have direct and significant economic and health-related costs for the entire population.”<sup>23</sup> In sum, the argument is that, when it comes to Commerce Clause application, “health care is different”<sup>24</sup> and legislation intended to produce social or collective benefits is entitled to special respect.<sup>25</sup>

### III. EXTENDING THE INDIVIDUAL HEALTH INSURANCE MANDATE RATIONALE TO THE MEDICAL TREATMENT CONTEXT

The Supreme Court has been asked to hold that “population-based arguments can be used to justify PPACA’s [individual insurance] mandate” and that the “PPACA’s mandate . . . can be justified by considering the economic consequences of the inaction that is prohibited” because “in terms of the constitutional analysis, the decisions of individuals to forego entry into the insurance market, when aggregated, place a substantial burden on the interstate health care market.”<sup>26</sup> If the Court responds to this argument sympathetically, the same public health logic—healthcare is different—ought to apply *a fortiori* to legitimize future federal laws that would mandate individuals to undergo particular medical treatments, with only narrow exceptions for religious objections<sup>27</sup> or proof of medical contraindications<sup>28</sup> for the specific individual. There are many instances in which patients’ assertions of their right to refuse medical intervention, when aggregated, eventually result in unnecessary expenditures and place a substantial burden on the interstate healthcare market in a way that threatens the government’s aim to maximize the public’s access

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<sup>22</sup> James G. Hodge, Jr. et al., *Congress, Courts, and Commerce: Upholding the Individual Mandate to Protect the Public’s Health*, 39 J.L. MED. & ETHICS 394, 394-95 (2011).

<sup>23</sup> *Id.* at 399.

<sup>24</sup> Cf. Brad Joondeph, *Our Pending National Debate: Is Health Care Reform Constitutional?*, 62 MERCER L. REV. 605, 615 (2011) (challenging proponents of the “health care is different” position to delineate exactly where—if anywhere—they would draw the limits of the Commerce Clause power).

<sup>25</sup> Gostin, *supra* note 2, at 8 (“Opposing a mandate is understandable when viewed from an individual perspective: it interferes with economic freedom and constrains personal choice. In economic terms, it represents a compelled cross-subsidy. However, when viewed from a collective perspective, the [individual health insurance purchase] mandate offers valuable social benefits . . . . [G]overnment is responsible for the well-being of the community, not particular individuals. Even if the decision were primarily self-regarding, its effects—illness and death—can be felt by all.”); see also Brief for Am. Cancer Soc’y et al. as Amicus Curiae in Support of Appellants Urging Reversal, Florida *ex rel.* Att’y Gen. v. U.S. Dep’t of Health & Human Servs., 648 F.3d 1235 (11th Cir. 2011) (Nos. 11-11021, 11-11067), *cert. granted sub nom.* Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 603 (2011) (mem.), and *cert. granted*, 132 S. Ct. 604 (2011) (No. 11-398) (mem.) (argued Mar. 26-27, 2012), and *cert. granted in part*, 132 S. Ct. 604 (2011) (No. 11-400) (mem.) (argued Mar. 28, 2012).

<sup>26</sup> Wendy E. Parmet, *The Individual Mandate: Implications for Public Health Law*, 39 J.L. MED. & ETHICS 401, 406-07 (2011).

<sup>27</sup> See generally Grover, *supra* note 4.

<sup>28</sup> A medical contraindication is “a condition in a recipient that increases the risk for a serious adverse reaction.” See Andrew T. Kroger et al., *Recommendations of the Advisory Committee on Immunization Practices (ACIP)*, 55 MORBIDITY & MORTALITY WKLY. REP. (Ctrs. for Disease Control & Prevention, Atlanta, Ga.), Dec. 1, 2006, at 9, available at <http://www.cdc.gov/mmwr/PDF/rr/rr5515.pdf>.

to health services.<sup>29</sup> If the courts are willing to soften their ordinary Commerce Clause scrutiny in reviewing enactments by a well-meaning Congress because the resulting legal scheme is aimed at the paramount goal of improving the public's health,<sup>30</sup> certainly federal laws targeted at fostering the public's health by compelling individuals to undergo specific forms of medical interventions are entitled to the same judicial deference.<sup>31</sup> "The Government concedes the novelty of the mandate and the lack of any doctrinal limiting principles; indeed, at oral argument defending the PPACA, the Government could not identify any mandate to purchase a product or service in interstate commerce that would be unconstitutional, at least under the Commerce Clause."<sup>32</sup> The American populace, acting through Congress, would no longer be restrained from compelling individuals, whose selfish medical choices harmed the collective good by driving up healthcare costs, to do their civic duty to undergo cost-effective interventions.<sup>33</sup> Society would be empowered to "explore methods to reshape existing therapeutic relationships—and the law and financial arrangements that shape those relationships—to achieve greater sensitivity to values beyond those of the immediate patient . . . ."<sup>34</sup>

#### A. RIPE AREAS FOR FEDERAL MEDICAL TREATMENT MANDATES

A Congress empowered by such a broad reading of the Commerce Clause could identify many possible examples of medical interventions that, if undergone by all clinically eligible individuals, are likely to both reduce future medical expenditures and other economic losses and increase economic productivity for the individual and the collective body.<sup>35</sup> Legally compelling individuals to accept those interventions, thus, would improve the public's health by freeing up scarce resources for more effective redistribution and thereby promote interstate commerce.<sup>36</sup> This Part of the Article makes its point by providing three illustrations of preventive<sup>37</sup> or therapeutic

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<sup>29</sup> There also are important moral arguments for opposing, in some situations, a person's right to refuse treatment. *See, e.g.,* Martin Gunderson, *Being a Burden: Reflections on Refusing Medical Care*, 34 HASTINGS CENTER REP. 37, 37 (2004).

<sup>30</sup> For a criticism of judicial abandonment of constitutional principles in order to promote particular factual results, see ROBERT H. BORK, *THE TEMPTING OF AMERICA: THE POLITICAL SEDUCTION OF THE LAW* 261-65 (1990). *See also* Thomas B. Griffith, *Was Bork Right About Judges?*, 34 HARV. J.L. & PUB. POL'Y 157 (2011).

<sup>31</sup> *See infra* Part III.B.

<sup>32</sup> *Seven-Sky v. Holder*, 661 F.3d 1, 14-15 (D.C. Cir. 2011), *petition for cert. filed*, 80 U.S.L.W. 3359 (U.S. Nov. 30, 2011) (No. 11-679).

<sup>33</sup> Theodore W. Ruger, *Can a Patient-Centered Ethos Be Other-Regarding? Ought It Be?*, 45 WAKE FOREST L. REV. 1513, 1519 (2010) (discussing the problem of selfish patients harming the collective interest by consuming too many non-cost-effective medical services).

<sup>34</sup> *See id.*

<sup>35</sup> *See Hodge et al., supra* note 22, at 399 (concluding that, given the economic and public health ramifications of non-insurance, PPACA's mandate is crucial to improve healthcare access and to ensure future economic success).

<sup>36</sup> *See id.*

<sup>37</sup> *But see* Joshua T. Cohen, Peter J. Neumann, & Milton C. Weinstein, *Does Preventive Care Save Money? Health Economics and the Presidential Candidates*, 358 NEW ENG. J. MED. 661, 661 (2008) ("Sweeping statements about the cost-saving potential of prevention, however, are overreaching."); Katherine Vessely, *Is Preventive Care Really the Answer?*, 20 ANNALS HEALTH L. ADVANCE DIRECTIVE 159 (2010), [http://www.luc.edu/healthlaw/research\\_and\\_pubs/annals/pdfs/Advance%20Directive%20Ar/Online%20Issue%202010.1/Vessely\\_159-166.pdf](http://www.luc.edu/healthlaw/research_and_pubs/annals/pdfs/Advance%20Directive%20Ar/Online%20Issue%202010.1/Vessely_159-166.pdf) (questioning the cost-efficiency of preventive care)

medical treatments for acute or chronic<sup>38</sup> health problems for which legal compulsion has the potential (quite literally) to pay dividends for American society.

One example concerns influenza, an acute illness that, when contracted, can lead to substantial healthcare costs and lost economic productivity.<sup>39</sup> The naturally occurring public health problem of seasonal flu, which leads “to about 200,000 hospitalizations and several thousand deaths in the United States” each year, may be a more realistically significant national threat than potential bioterrorism incidents.<sup>40</sup> Influenza vaccination rates among adults remain well below desired levels, largely because of public ignorance, misunderstanding, and perceptions of inconvenience,<sup>41</sup> despite studies that have quantified clearly the economic value of such vaccination from the societal and payer perspectives.<sup>42</sup> Recognition of the social value of making influenza vaccination more widespread has been reflected in, for example, a proposed rule to add a Medicare/Medicaid condition of participation requiring hospitals, rural health clinics, federally qualified health centers, and end-stage renal disease facilities to offer influenza vaccinations to almost all of their inpatients and outpatients.<sup>43</sup> Laws in at least one state<sup>44</sup> require certain healthcare workers to undergo vaccination for influenza.

Large-scale, voluntary adult influenza vaccination programs in the United States historically have delivered disappointing results.<sup>45</sup> Given the incontrovertible evidence of its potential benefits to interstate commerce due to expected reduced healthcare costs and lessened loss of work productivity, a national program of mandatory influenza vaccination would be consistent with the same public health values undergirding the PPACA's individual health insurance mandate and hence would be a valid exercise of Congress's Commerce Clause authority under any Supreme Court decision upholding the insurance mandate provision.

A second example of compelled treatment that has the potential to contribute positively to interstate commerce by containing healthcare costs and reducing lost

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<sup>38</sup> Regarding the heavy utilization of health services by persons with chronic illnesses and resulting cost implications, see, for example, Jean Yoon et al., *Recent Trends in Veterans Affairs Chronic Conditions Spending*, 14 *POPULATION HEALTH MGMT.* 293 (2011).

<sup>39</sup> Piero L. Lai et al., *Burden of the 1999-2008 Seasonal Influenza Epidemics in Italy: Comparison with the H1N1v (A/California/07/09) Pandemic*, 7 *HUM. VACCINES SUPPL.* 217, 218 (2011); Yiting Xue, Ivar S. Kristiansen, & Birgitte F. de Blasio, *Modeling the Cost of Influenza: The Impact of Missing Costs of Unreported Complications and Sick Leave*, 10 *BMC PUB. HEALTH* 1,1 (2010).

<sup>40</sup> Wil S. Hylton, *How Ready Are We for Bioterrorism?*, *N.Y. TIMES MAG.* (Oct. 26, 2011), [http://www.nytimes.com/2011/10/30/magazine/how-ready-are-we-for-bioterrorism.html?\\_r=1](http://www.nytimes.com/2011/10/30/magazine/how-ready-are-we-for-bioterrorism.html?_r=1).

<sup>41</sup> Bruce Y. Lee et al., *From the Patient Perspective: The Economic Value of Seasonal and H1N1 Influenza Vaccination*, 29 *VACCINE* 2149, 2149 (2011).

<sup>42</sup> See Anthony E. Fiore et al., *Seasonal Influenza Vaccines*, 333 *CURRENT TOPICS MICROBIOLOGY & IMMUNOLOGY* 43, 71 (2009) (describing influenza vaccines as a mainstay of efforts to reduce the substantial health burden from seasonal influenza); see, e.g., Richard H. Beigi et al., *Economic Value of Seasonal and Pandemic Influenza Vaccination During Pregnancy*, 49 *CLINICAL INFECTIOUS DISEASES* 1784 (2009); Patrick Y. Lee et al., *Economic Analysis of Influenza Vaccination and Antiviral Treatment for Healthy Working Adults*, 137 *ANNALS INTERNAL MED.* E225 (2002).

<sup>43</sup> See Medicare & Medicaid Programs: Influenza Vaccination Standard for Certain Participating Providers and Suppliers, 76 *Fed. Reg.* 25,460, 25,460 (May 4, 2011).

<sup>44</sup> N.Y. PUB. HEALTH LAW § 2192 (McKinney 2011) (requiring every long-term care facility in New York to immunize residents and employees against influenza).

<sup>45</sup> E.g., National Swine Flu Immunization Program of 1976, Pub. L. No. 94-380, 90 Stat. 1113 (1976); see also Edward P. Richards et al., *The Smallpox Vaccination Campaign of 2003: Why Did It Fail and What Are the Lessons for Bioterrorism Preparedness?*, 64 *LA. L. REV.* 851 (2004) (analyzing the failure of a civilian smallpox vaccination campaign in the United States).

economic productivity concerns interventions (which could take a variety of pharmacologic<sup>46</sup> and non-pharmacologic forms)<sup>47</sup> for chronic depression.<sup>48</sup> The economic burden of depression in the United States, measured in terms of treatment costs, mortality costs arising from depression-related suicides, and costs associated with depression in the workplace, is enormous.<sup>49</sup> Although much research is yet to be done to improve therapeutic intervention success rates in the depression area,<sup>50</sup> a significant number of patients are able to be restored to a higher level of functional capacity as a result of clinical treatment.<sup>51</sup> Compelled medical treatment for chronically depressed individuals presumably would somewhat increase total direct treatment expenditures, but also would likely substantially reduce mortality costs arising from depression-related suicides and costs associated with depression in the workplace. Those reduced economic costs would impact interstate commerce favorably, and thus constitute a justification for congressional action that is part of a broad scheme intended to improve the nation's health.

A third area ripe for substantial health costs savings that would benefit American society as a whole, and therefore that would be consistent with an ultra-broadly defined goal of the Commerce Clause, relates to treatments intended to reduce the risk of cardiovascular disease. The morbidity and premature mortality associated with cardiovascular disease exert a substantial negative national economic effect, thus burdening interstate commerce.<sup>52</sup> The multiplied risk factor connection between hypertension and elevated lipid levels and the development of cardiovascular disease has been amply documented,<sup>53</sup> as has the cost-effectiveness

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<sup>46</sup> See, e.g., Robert L. Barkin et al., *Recognition and Management of Depression in Primary Care: A Focus on the Elderly. A Pharmacotherapeutic Overview of the Selection Process Among the Traditional and New Antidepressants*, 7 AM. J. THERAPEUTICS 205 (2000).

<sup>47</sup> See, e.g., James A. Blumenthal, *New Frontiers in Cardiovascular Behavioral Medicine: Comparative Effectiveness of Exercise and Medication in Treating Depression*, 78 CLEV. CLINIC J. MED. S35 (2011); Jennifer M. Gierisch et al., *Smoking Cessation Interventions for Patients with Depression: A Systematic Review and Meta-Analysis*, 27 J. GEN. INTERNAL MED. 353 (2011).

<sup>48</sup> Regarding the cost-effectiveness of treating depression, see Stacey A. Tovino, *A Proposal for Comprehensive and Specific Essential Mental Health and Substance Use Disorder Benefits*, 38 AM. J.L. & MED. 472, 502-13 (2012).

<sup>49</sup> See CTRS. FOR DISEASE CONTROL & PREVENTION, DEPRESSION (May 2, 2011), available at [www.cdc.gov/workplacehealthpromotion/implementation/topics/depression.html](http://www.cdc.gov/workplacehealthpromotion/implementation/topics/depression.html) (last visited Mar. 7, 2012); Paul E. Greenberg et al., *The Economic Burden of Depression in the United States: How Did It Change Between 1990 and 2000?*, 64 J. CLINICAL PSYCHIATRY 1465 (2003).

<sup>50</sup> See, e.g., Edward S. Friedman et al., *Baseline Depression Severity as a Predictor of Single and Combination Antidepressant Treatment Outcome: Results from the CO-MED Trial*, 22 EUR. NEUROPSYCHOPHARMACOLOGY 183 (2012).

<sup>51</sup> E.g., AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, CHOOSING ANTIDEPRESSANTS FOR ADULTS: CLINICIAN'S GUIDE (2007), available at <http://www.effectivehealthcare.ahrq.gov/ehc/products/7/9/AntidepressantsClinicianGuide.pdf>; Alex Apler, *Citalopram for Major Depressive Disorder in Adults: A Systematic Review and Meta-Analysis of Published Placebo-Controlled Trials*, BMJ OPEN (Sept. 6, 2011), <http://bmjopen.bmj.com/content/1/2/e000106.full.pdf+html>.

<sup>52</sup> Jeff Herman, *Improving the Treatment & Prevention of Heart Disease*, 4 ST. LOUIS U. J. HEALTH L. & POL'Y 223, 226 (2010) (attributing, in 2009, over \$300 billion in direct and indirect costs in the United States to heart disease); Thomas Thom et al., *Heart Disease and Stroke Statistics—2006 Update: A Report from the American Heart Association Statistics Committee and Stroke Statistics Subcommittee*, 113 CIRCULATION e85, e90 (2006) (estimating national annual costs associated with cardiovascular disease in 2006 as exceeding \$250 billion).

<sup>53</sup> Erik Ingelsson et al., *Clinical Utility of Different Lipid Measures for Prediction of Coronary Heart Disease in Men and Women*, 298 JAMA 776 (2007); Jan A. Staessen et al., *Task Force II: Blood Pressure Measurement and Cardiovascular Outcome*, 6 BLOOD PRESSURE MONITORING 355 (2001).

of preventive pharmacological treatment of persons identified as at high risk because of their blood pressure and cholesterol profiles.<sup>54</sup> Yet, voluntary patient adherence to prescribed medication regimes for these cardiovascular disease risk factors is alarmingly low,<sup>55</sup> a problem that a legal mandate might remedy effectively.

The federal government has a legitimate, arguably even compelling, economic interest in reducing the incidence of cardiovascular disease in the population.<sup>56</sup> The same public health-focused Commerce Clause interpretation that would sustain congressional enactment of the individual health insurance mandate provision in the PPACA surely could serve to undergird a federal requirement that individuals positively contribute to the nation's commerce by adhering to medication instructions designed to reduce the population's risk of developing expensive cardiovascular-disease-related morbidity and premature mortality.

#### B. RESPONSES TO OBJECTIONS TO FEDERAL MEDICAL TREATMENT MANDATES

Objections to federal statutory or regulatory mandates that individuals undergo particular medical treatments, enacted on the predicate that compelled treatment will benefit the public health, are likely to fail for several interrelated reasons. These reasons pertain to the weakness of the individual rights at stake and the strength of the public interest justifying the mandates in question.

First, despite some intimations to the contrary based on considerations of bodily integrity,<sup>57</sup> there does not exist unequivocal, contemporary recognition of a fundamental individual right to refuse medical treatment<sup>58</sup> (at least in a non-research

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<sup>54</sup> ALLHAT Officers & Coordinators for the ALLHAT Collaborative Research Grp., *Major Outcomes in High-Risk Hypertensive Patients Randomized to Angiotensin-Converting Enzyme Inhibitor or Calcium Channel Blocker vs. Diuretic: The Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT)*, 288 JAMA 2981, 2994 (2002); Ruth McDonald, Joseph White & Theodore R. Marmor, *Paying for Performance in Primary Medical Care: Learning About and Learning from "Success" and "Failure" in England and California*, 34 J. HEALTH POL. POL'Y & L. 747, 756 (2009) (commenting on the cost-effectiveness of treating hypertension); Scott D. Ramsey et al., *An Economic Evaluation of Atorvastatin for Primary Prevention of Cardiovascular Events in Type 2 Diabetes*, 26 PHARMACOECONOMICS 329 (2008).

<sup>55</sup> Laura Landro, *Many Pills, Many Not Taken: Tracking Prescriptions with Technology, Personal Touch*, WALL ST. J. (Oct. 11, 2011), <http://online.wsj.com/article/SB10001424052970203388804576616882856318782.html>.

<sup>56</sup> *Heart Disease and Stroke Prevention*, CTRS. FOR DISEASE CONTROL & PREVENTION, [www.cdc.gov/chronicdisease/resources/publications/AAG/dhdsp.htm](http://www.cdc.gov/chronicdisease/resources/publications/AAG/dhdsp.htm) (last updated July 21, 2010).

<sup>57</sup> See Einer Elhauge, *The Broccoli Test*, N.Y. TIMES (Nov. 16, 2011), [available at www.nytimes.com/2011/11/16/opinion/health-insurance-and-the-broccoli-test.html](http://www.nytimes.com/2011/11/16/opinion/health-insurance-and-the-broccoli-test.html) (asserting, without any supporting argument or citation, that "[i]f [Congress] tried to enact a law requiring Americans to eat broccoli, that would be likely to violate bodily integrity and the right to liberty"). The concept of bodily integrity, though, can actually work against protection of autonomous decision-making. When bodily integrity is defined in terms of human dignity,

policies [may] require limiting individual freedom to make "undignified" choices. They coerce individuals in the name of dignity to further social and community values [such as optimizing the use of scarce medical resources so as to make wider access to care available for presently underserved populations]. These decisions express a particular substantive conception of dignity that will often conflict with individual choices . . . .

Neomi Rao, *Three Concepts of Dignity in Constitutional Law*, 86 NOTRE DAME L. REV. 183, 234 (2011).

<sup>58</sup> As Moncrieff notes,

Of course, like all American constitutional rights, the freedom of health [to reject medical treatment] 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

context).<sup>59</sup> “[L]iberties regularly shift in or out of ‘fundamental’ status in response to changing social norms,”<sup>60</sup> and might be afforded less importance when weighed against the societal commitment to contain healthcare costs so as to enhance society’s capacity to assure access to healthcare more universally. “[T]he presumption of individual liberty is a conditional claim that one can rebut. . . . Individuals are not, therefore, meaningfully sovereign—unless that term means only that individuals are subject to legal regulation only when they are in fact subject to legal regulation.”<sup>61</sup> Certainly, federal mandates that intrude on bodily integrity in non-medical situations, such as the requirement that unwilling individuals submit to military service on behalf of the collective good, have consistently been upheld as valid.<sup>62</sup>

Second, the few decisions in which legal mandates of medical treatment have been invalidated have involved individual liberty or privacy interest challenges to the exercise of a state’s police power to promote the general health, safety, welfare, and morals of the community.<sup>63</sup> Never has a court invalidated (nor, for that matter, been asked to invalidate) a medical treatment mandate enacted by Congress under its Commerce Clause authority, nor is a court likely to invalidate such a national law in the face of clear Supreme Court precedent upholding the individual insurance mandate of the PPACA. Indeed, deference to congressional Commerce Clause authority fits nicely with the widely shared position that “[h]ealthcare regulation in the modern age should be a national project entrusted solely to the central government.”<sup>64</sup>

Moreover, protestations that a judicial ruling upholding the PPACA on Commerce Clause grounds would not open the door for Congress to require individuals to buy and eat broccoli<sup>65</sup> are wrong. Fair-minded advocates of the

regulation, often referring to preservation of health and life as core “police powers” of the states. 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.

Moncrieff, *supra* note 13, at 2226-27. *But see* *Cruzan v. Mo. Dep’t of Health*, 497 U.S. 261, 305 (1990) (Brennan, J., dissenting) (“[F]reedom from unwanted medical attention is unquestionably among those principles ‘so rooted in the traditions and conscience of our people’ as to be ranked as fundamental.”).

<sup>59</sup> Regarding an individual’s right to refuse to participate in biomedical and behavioral research, see generally 45 C.F.R. § 46.116 (2011). Even the right to refuse to be a research subject is not absolute. See David Orentlicher, *Making Research a Requirement of Treatment: Why We Should Sometimes Let Doctors Pressure Patients to Participate in Research*, 35 HASTINGS CENTER REP. 20 (2005).

<sup>60</sup> Moncrieff, *supra* note 10 (manuscript at 6).

<sup>61</sup> Patrick M. Brennan, *The Individual Mandate, Sovereignty, and the Ends of Good Government: A Reply to Professor Randy Barnett*, 159 U. PA. L. REV. 1623, 1640-41 (2011).

<sup>62</sup> *Arver v. United States*, 245 U.S. 366, 378 (1918).

<sup>63</sup> See, e.g., *Jacobson v. Massachusetts*, 197 U.S. 11, 26 (1905) (defendant argued his “liberty [was] invaded” by mandatory vaccine).

<sup>64</sup> Abigail R. Moncrieff & Eric Lee, *The Positive Case for Centralization in Health Care Regulation: The Federalism Failures of the ACA*, 20 KAN. J.L. & PUB. POL’Y 266, 266 (2011).

<sup>65</sup> See, e.g., Koppelman, *supra* note 6, at 19-20 (disparaging what he terms the “Broccoli Objection”); Timothy Stoltzfus Jost, *Can Congress Regulate “Inactivity” (and Make Americans Buy Health Insurance)?*, 364 NEW ENG. J. MED. e17(1), e17(2) (2011) (“It is hard to imagine a ‘broccoli mandate’ as essential to the regulation of a commercial market.”). Actually, it is not at all hard to imagine this, given the extra financial resources likely to be devoted to providing medical treatment to persons whose illnesses may be attributed, at least in part, to their unwillingness to eat broccoli. Regarding the long-term benefits of eating broccoli, see Jenna M. Cramer, Margarita Teran-Garcia, & Elizabeth H. Jeffery, *Enhancing Sulforaphane Absorption and Excretion in Healthy Men Through the*

PPACA concede as much, and indeed contend that Congress already has such authority. As observed by David Orentlicher, “[t]he broccoli horse is already out of the barn.”<sup>66</sup> Einer Elhauge suggests that even the narrow interpretation of the Commerce Clause urged by challengers of the individual insurance mandate “would allow Congress to force us to buy broccoli as long as it was careful to phrase the law to say that ‘anyone who has ever engaged in any activity affecting commerce must buy broccoli.’”<sup>67</sup> Other liberal scholars, influenced by the lucid reasoning of one federal district court judge,<sup>68</sup> are not quite ready to commit conclusively to, but do concede the strong possibility of, an affirmative answer to the following query:

Yet if the federal government can require people to buy insurance in order to keep [health insurance] premiums affordable, could it also require people to buy baby aspirin or a gym membership to keep those premiums affordable on the theory that using these products reduces the use of health care services and thus insurance costs?<sup>69</sup>

In this context, government coercion is equally defensible whether we are talking about being forced to buy broccoli or to undergo unwanted medical treatment. To the extent that any individual right to refuse specific medical treatment exists in American jurisprudence, precedent upholding the individual insurance mandate of the PPACA would compel rejection of a right-to-refuse claim that is weighed and balanced<sup>70</sup> against a legitimate federal interest in using the Commerce Clause to promote the public health.

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*Combined Consumption of Fresh Broccoli Sprouts and a Glucoraphanin-Rich Powder*, BRIT. J. NUTRITION FIRSTVIEW 1 (Sept. 13, 2011), <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=8376012&fulltextType=RA&fileId=S0007114511004429>; Subhendu Mukherjee, Hironmoy Gangopadhyay, & Dipak K. Das, *Broccoli: A Unique Vegetable that Protects Mammalian Hearts Through the Redox Cycling of the Thioredoxin Superfamily*, 56 J. AGRIC. FOOD CHEM. 609 (2008); Wei Song et al., *Cellular Antioxidant Activity of Common Vegetables*, 58 J. AGRIC. FOOD CHEM. 6621 (2010); Hannah R. Vasanthi, Subhendu Mukherjee & Dipak K. Das, *Potential Health Benefits of Broccoli—A Chemico-Biological Overview*, 9 MINI-REVS. MED. CHEM. 749 (2009).

<sup>66</sup> David Orentlicher, *Can Congress Make You Buy Broccoli? And Why It Really Doesn't Matter*, 84 S. CAL. L. REV. POSTSCRIPT 9, 12 (2011) [hereinafter Orentlicher, *Can Congress Make You Buy Broccoli?*]; see also David Orentlicher, *Constitutional Challenges to the Health Care Mandate: Based in Politics, Not Law*, 160 U. PA. L. REV. PENNUMBRA 19, 22 (2011) (opining that a broccoli-purchasing and consuming mandate would pass constitutional muster if enacted as part of a larger public health program).

<sup>67</sup> Elhauge, *supra* note 57; see also Einer Elhauge, *The Irrelevance of the Broccoli Argument Against the Insurance Mandate*, NEW ENG. J. MED., e1(1) (Jan. 12, 2012), <http://www.nejm.org/doi/pdf/10.1056/NEJMp1113618>.

<sup>68</sup> Florida *ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, 780 F. Supp. 2d 1256, 1289 (N.D. Fla.), *order clarified*, 780 F. Supp. 2d 1307 (N.D. Fla.), *aff'd in part, rev'd in part*, 648 F.3d 1235 (11th Cir. 2011), *cert. granted sub nom. Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 603 (2011) (mem.), *and cert. granted*, 132 S. Ct. 604 (2011) (No. 11-398) (mem.) (argued Mar. 26-27, 2012), *and cert. granted in part*, 132 S. Ct. 604 (2011) (No. 11-400) (mem.) (argued Mar. 28, 2012) (suggesting that, if the individual health insurance purchase mandate is held constitutional, then Congress would also have the power to “require that people buy *and consume* broccoli at regular intervals, not only because the required purchases will positively impact interstate commerce, but also because people who eat healthier tend to be healthier, and are thus more productive and put less of a strain on the health care system.” (emphasis added)).

<sup>69</sup> Wendy K. Mariner, George J. Annas, & Leonard H. Glantz, *Can Congress Make You Buy Broccoli? And Why That's a Hard Question*, 364 NEW ENG. J. MED. 201, 202 (2011).

<sup>70</sup> Moncrieff, *supra* note 13, at 2237-38 (“[A]ll such [as the freedom to reject unwanted medical treatment] constitutional liberty interests must be balanced against competing regulatory interests. In the case of health care, especially public health, there are many . . . collective interests that might outweigh individual autonomy.”).

As one set of public health law experts reminds us,

[t]he Supreme Court has expressly recognized the governmental interest in protecting the public health, safety, and environment from known or imminent harms under the Commerce Clause. . . . The Supreme Court has consistently upheld federal statutory provisions intended primarily to protect the public's health so long as there was a commerce "hook," principally that the object of regulation has a substantial effect on interstate commerce.<sup>71</sup>

For more than a century, the courts have held that a "sacrifice of liberty could be demanded of the individual by the state in the interest of furthering the social compact, specifically in the context of health."<sup>72</sup> Public health law scholars defending the PPACA even go so far as to warn that judicial invalidation of the PPACA's individual insurance mandate would fatally imperil the federal government's ability to control beneficially individual behavior in future public health emergencies, and they predict a "chilling . . . loss of life that might result from the constitutional precedent that a negative [PP]ACA ruling would set."<sup>73</sup>

Individual medical treatment refusals, just like decisions to decline the purchase of health insurance, have direct and significant economic and health-related costs for the entire population.<sup>74</sup> The federal government may, consistent with public health law precedent and a PPACA individual insurance mandate predicated on an expansive reading of Congress's Commerce Clause authority,

compel an individual to undertake an affirmative action [e.g., submit to medical treatment] to promote the greater good. . . . Laws ordering individuals to engage in actions to promote public health—i.e., public health mandates—certainly have their place in our public health law armamentarium. By responding to complex collective [action] problems to which less coercive legal measures may fall short, mandates can help to alter norms and the social environment in ways that promote health.<sup>75</sup>

#### IV. CONCLUSION

As PPACA defenders remind us, "mandates are a common public health law tool."<sup>76</sup> According to those defenders, the PPACA's individual insurance mandate is simply a logical continuation of that tradition. The PPACA itself, despite its physical girth, still left in its wake many details to be worked out over time through

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<sup>71</sup> Hodge et al., *supra* note 22, at 397 (citing *Hodel v. Va. Surface Min. & Reclamation Ass'n*, 452 U.S. 264, 300 (1981)).

<sup>72</sup> Hunter, *supra* note 20, at 1979.

<sup>73</sup> Mark A. Hall, *Constitutional Morality: Precedential Effects of Striking the Individual Mandate*, 75 LAW & CONTEMP. PROBS. (forthcoming 2012).

<sup>74</sup> David B. Rivkin, Jr. & Lee A. Casey, *ObamaCare and the Limits of Government*, WALL ST. J., Nov. 15, 2011, at A19 ("[I]f Congress can require you to buy health insurance because your lack of insurance may, at some point in the future, impose costs on the wider economy, then on the same theory it can require the purchase (or sale) of virtually any good or service, since the failure to have *or use* the relevant product can always be said to have some economic impact." (emphasis added)).

<sup>75</sup> Parmet, *supra* note 26, at 403, 411.

<sup>76</sup> *Id.* at 405.

subsequent regulatory and enforcement processes.<sup>77</sup> Similarly, a program of congressional mandates requiring that individual Americans submit to particular forms of medical intervention because, on the whole, such a forced treatment program would be beneficial to the public health and therefore to the nation's commerce, would necessitate the working out of numerous substantive and procedural details. But let us put aside the admittedly myriad possible policy and political considerations<sup>78</sup> that certainly would be entailed in designing and implementing a comprehensive public health program centered on various forms of compelled medical treatment.<sup>79</sup> The point of this Article is that there would be no constitutional impediments to Congress to rely upon the tradition of mandates as a public health tool in a post-PPACA-approved world. Such an approach would be fueled by an expansive, public health-oriented interpretation of the Commerce Clause that gives the green light to policymakers to promote the population's good by requiring individuals to submit to specific medical treatments when there are valuable resources to be conserved—and hence commerce and the social compact to be promoted—by so doing. The reading of the Commerce Clause argued for by proponents of the PPACA would set in motion an unstoppable slippery slope, but so what? After all, healthcare is “different.”

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<sup>77</sup> CURTIS W. COPELAND, CONG. RESEARCH SERV., NO. 7-5700, REGULATIONS PURSUANT TO THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PUBLIC LAW 11-148) 2 (2010) (identifying more than forty provisions in the legislation “that require, permit, or contemplate rulemaking by federal agencies to implement the [Act]”).

<sup>78</sup> For example, how would we handle the increased professional manpower needs implicated by recognition of a patient's duty to accept medical treatments that, at present, could be declined under the doctrine of informed consent? See Marshall B. Kapp, *Conscripted Physician Services and the Public's Health*, 39 J.L. MED. & ETHICS 414 (2011). Would individual physicians be able to assert a right of conscience to refuse to participate in forced medical treatment of patients even if such treatment were congressionally authorized?

<sup>79</sup> Some commentators try to assure us that the courts need not worry about the compelled broccoli-eating argument asserted in some challenges to the PPACA's individual health insurance purchase mandate, because political opposition would scuttle any silly bill compelling conduct like broccoli eating. See, e.g., Hall, *supra* note 3, at 1869-70. Hall's unqualified faith in “rational deliberation and democratic electoral constraints,” *id.* at 1870, as effective protections against Congress enacting broccoli-eating-like laws is unjustified, particularly as pressure mounts on politicians to constrain national healthcare expenditures. Similar reliance “on our democratic political process to protect us from unreasonable statutes,” Orentlicher, *Can Congress Make You Buy Broccoli?*, *supra* note 66, at 14, seems excessively optimistic. See, e.g., Jonathan Oberlander, *Health Care Policy in an Age of Austerity*, 365 NEW ENG. J. MED. 1075 (2011) (“The rise of austerity politics has important implications for health policy. The pervasive belief in Washington that deficit reduction is an economic imperative alters normal political rules. In a crisis environment, policymakers are more likely than usual to take on powerful interest groups and contemplate controversial reforms.”). Other attempts to blithely assume away, rather than confront, the possibility of federal laws coercing individual health-promoting behaviors are equally unpersuasive. See, e.g., Huhn, *supra* note 3, at 157 (“The constitutionality of such invasive and apparently arbitrary laws can be dealt with when and if our legislatures ever deign to enact them.”); Elhauge, *supra* note 57 (“[O]ur Constitution has no provision banning stupid laws.”). Evading analysis of the constitutional issues through wishful thinking likely would earn poor grades from any of these commentators if engaged in by one of their law students on a final examination.