

**DEFEATING HEALTH DISPARITIES—A PROPERTY  
INTEREST UNDER THE PATIENT PROTECTION AND  
AFFORDABLE CARE ACT OF 2010**

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*Tonight, after nearly 100 years of talk and frustration, after decades of trying, and a year of sustained effort and debate, the United States Congress finally declared that America’s workers and America’s families and America’s small businesses deserve the security of knowing that here, in this country, neither illness nor accident should endanger the dreams they’ve worked a lifetime to achieve . . . . [W]e proved that we are still a people capable of doing big things and tackling our biggest challenges . . . . We proved that this government—a government of the people and by the people—still works for the people.*<sup>1</sup>

On March 23, 2010, President Barack H. Obama signed the Patient Protection and Affordable Care Act (“the ACA,” “the Act,” or “the Affordable Care Act”)<sup>2</sup> into law, pronouncing an historic triumph. Indeed, the President’s reference to “100 years of talk and frustration,” accurately recalls that the effort to

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<sup>1</sup> Barack H. Obama, President of the United States, Remarks by the President on the House Vote on Health Insurance Reform (Mar. 22, 2010, 11:47 PM), *available at* <http://www.whitehouse.gov/the-press-office/remarks-president-house-vote-health-insurance-reform> [hereinafter Obama Speech].

<sup>2</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

eradicate economic health care disparities in the United States began in 1912, when President Theodore Roosevelt first made mention of providing “universal” access. Likewise, Presidents Franklin D. Roosevelt, Harry S. Truman, Dwight D. Eisenhower, John F. Kennedy, Lyndon B. Johnson, and William J. Clinton all expressly sought to address the discrimination that leads to racial and ethnic disparities in health care access and outcomes. Presidents James E. Carter, Ronald W. Reagan, and George W. Bush also led efforts to bring significant reform to American health care during their terms. But without question, the Affordable Care Act’s comprehensive and far-reaching approach to reforming our nation’s health care is unprecedented in scope and scale. President Obama rightly characterized this law as one that is aimed at “doing big things” and “tackling our biggest challenges.”<sup>3</sup> Among the biggest is the Affordable Care Act’s direct attack on racial and ethnic disparities in our health care system. Yet, while the commitment to eradicate racial and ethnic health care disparities displayed in the ACA is unprecedented, the Act falls short because most of its anti-disparity goals are unenforceable.

This essay argues that, without ensuring the right to non-disparate health care as a legally enforceable interest, even the far-reaching reforms enacted under the ACA will likely remain mere aspirations. My objective here is to outline a novel theory that could work to convert the Act’s lofty goals into a tangibly and demonstrably equitable reality. The basic proposition I advance is that the right to non-disparate health care is a property interest,<sup>4</sup> held in trust by federal and state governments and enforceable under the principles, provisions, and procedures of fiduciary law.

The essay is organized in three parts. First, I describe the ways the Affordable Care Act addresses the three sources of health care disparities at the patient, treatment, and health systems levels. I conclude that the Act’s anti-disparity provisions are admirably comprehensive but not fully enforceable. Next, I introduce the theory that is the core of this essay: the ACA’s provisions are best read to establish a property interest in non-disparate health care. The final section identifies an application for this theory and suggests how it might work to give real meaning to the Affordable Care Act’s disparities provisions. The conclusion identifies issues that remain open for discussion.

## I. THE STATUTORY ATTACK ON DISPARITIES

In 1999, Congress charged the Institute of Medicine (IOM) to study the extent and causes of ethnic and racial health care disparities in the United States. The resulting report, titled *Unequal Treatment: Confronting Racial and Ethnic*

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<sup>3</sup> Obama Speech, *supra* note 1.

<sup>4</sup> See, e.g., Mark Earnest & Dayna Bowen Matthew, *A Property Right to Health Care*, 29 J.L. MED. 65, 65–80 (2008).

*Disparities in Health Care*,<sup>5</sup> documents a sizeable and now familiar body of research demonstrating that Americans who are members of racial and ethnic minorities receive an inferior quality of health care when compared to their white counterparts and that these disparities are not due to differences in patients' clinical needs, individual preferences, insurance, or ability to pay.<sup>6</sup> The IOM Report identified variables at three levels that contribute to these well-documented disparities: "Patient-Level Variables"<sup>7</sup> included factors specific to individual patients that may contribute to health care disparities, such as behavior, attitude, and cultural differences between minority and non-minority patients. "Healthcare Systems-Level Variables" included the organizational and financing features that affect the availability of medical goods and services to minority and non-minority patient populations.<sup>8</sup> Finally, Care-Process or "Treatment-Level Variables" are factors that emanate from provider bias, stereotypes, and prejudice against minority patients.<sup>9</sup> The IOM Report is remarkable for its breadth of study as well as for the range of interventions it recommended to address the identified disparities. Recommendations included general proposals to increase awareness and specific calls for legal and regulatory interventions. The IOM Report also encouraged changes in health delivery systems by proposing increased reliance on evidence-based practice guidelines and improved patient education. Also, the IOM Report made an urgent call for increased and improved data collection and monitoring to better address the prevalent patterns and causes of health disparities.<sup>10</sup> The IOM Report concluded that the evidence that disparities are caused by variables at all levels of the health care continuum calls for broad and systemic interventions to effectively and finally eliminate racial and ethnic health disparities.<sup>11</sup> "Given the role of patient, provider, and contextual factors in shaping the quality of patient care, systemic interventions directed at multiple levels offer promise to modify condi-

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<sup>5</sup> INST. OF MED., NAT'L ACAD., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 30 (Brian D. Smedley, Adrienne Y. Smith & Alan R. Nelson eds., 2003) [hereinafter IOM Report].

<sup>6</sup> *See id.* at 29–79. *But cf.* JONATHAN KLICH & SALLY SATEL, *THE HEALTH DISPARITIES MYTH: DIAGNOSING THE TREATMENT GAP* 4 (2006) (concluding the studies examined by the IOM fail to make a persuasive case that physician bias is a significant cause of disparate care or health status); *see also* Richard A. Epstein, *Disparities and Discrimination in Health Care Coverage: A Critique of the Institute of Medicine Study*, 48 *PERSP. IN BIOLOGY & MED.* §26, §40 (2005) (arguing the IOM study is wrongly backward looking and attacks "the dedicated men and women in the profession who are determined to help people of all backgrounds and races").

<sup>7</sup> The IOM Report defined "Patient Level Variables" as preferences, behaviors, attitudes, and refusal rates and concluded these were factors that do contribute to disparities but are "unlikely explanation[s] for observed disparities in care." IOM Report, *supra* note 5, at 7–8.

<sup>8</sup> *Id.* at 8.

<sup>9</sup> *Id.* at 9.

<sup>10</sup> *Id.* at 20–21.

<sup>11</sup> *Id.*

tions in which health care disparities occur.”<sup>12</sup> In many ways, the Affordable Care Act’s anti-disparity provisions appear to follow the blueprint laid out in the IOM Report. The Act’s ten titles successively answer the challenge to attack racial disparities at multiple levels, enacting tools to address patient, systems, and treatment-level disparities simultaneously.

The Affordable Care Act begins with Title I, which reaffirms unequivocally the reach and force of existing nondiscrimination laws as they apply to health care. The Act declares the continued application of Titles VI and VII of the Civil Rights Act of 1964,<sup>13</sup> Title IX of the Education Amendments of 1972,<sup>14</sup> the Rehabilitation Act of 1973,<sup>15</sup> the Age Discrimination Act of 1975,<sup>16</sup> and any state laws that provide protections against the discrimination these laws prohibit.<sup>17</sup> In addition to authorizing the Secretary of the Department of Health and Human Services to promulgate regulations to give effect to these familiar Civil Rights laws, the Act declares that “individual[s] shall not . . . be subjected to discrimination under[] any health program or activity, any part of which is receiving Federal financial assistance[,] . . . or under any program or activity that is administered by . . . any entity established under this [Act],” and it provides a procedure for enforcing claims that this provision has been violated.<sup>18</sup>

With these broad nondiscrimination provisions as a foundation, Title II of the Affordable Care Act vastly expands the nation’s safety net, increasing coverage for childless adults under the Medicaid Program and allocating the majority of costs associated with this increase to the federal government.<sup>19</sup> In Title III, the Act addresses disparities by reforming health care delivery systems.<sup>20</sup> Title III sets forth a comprehensive “National Strategy to Improve Health Care Quality,” which directs the Secretary of the Department Health and Human Services to designate the goal to “reduce health disparities across . . . populations”<sup>21</sup> as one of its top ten priorities in that national program. In response to recommendations from leading experts in the fight against health disparities, Title IV of the Act mandates that all providers receiving federal support

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<sup>12</sup> *Id.* at 180.

<sup>13</sup> 42 U.S.C. § 2000(d) (2006).

<sup>14</sup> 20 U.S.C. § 1681 (2006).

<sup>15</sup> 29 U.S.C. § 794 (2006).

<sup>16</sup> 42 U.S.C. § 6101 (2006).

<sup>17</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1557, 124 Stat. 119, 378 (2010).

<sup>18</sup> *Id.* § 1557(a).

<sup>19</sup> *See id.* § 2001 (expanding coverage for adults and children up to 133% of the federal poverty level); *id.* § 2001(a) (increasing the federal government’s percentage share of funds to cover newly eligible individuals); *id.* § 2004 (extending Medicaid coverage for children in foster care). Subtitle C simplifies Medicaid and CHIP enrollment. *Id.* §§ 2201–202. Subtitle D extends Medicaid coverage to free standing birth centers, prenatal, and childbirth care. *Id.* § 2301.

<sup>20</sup> *Id.* at Title III, Subtitle A: “Transforming the Health Care Delivery System.”

<sup>21</sup> Patient Protection and Affordable Care Act § 3011.

collect and evaluate data on health disparities and performance “on the basis of race, ethnicity, sex, primary language, and disability status.”<sup>22</sup> This title also requires data collection and sharing to focus on health care disparities in all under-served patients including rural populations.<sup>23</sup> The Act appropriates grant funds for community transformational plans that will “prioritiz[e] strategies to reduce racial and ethnic disparities, including social, economic, and geographic determinants of health.”<sup>24</sup>

Title V introduces work force reforms that will address disparate access to care such as loan repayments and scholarships for students from disadvantaged backgrounds or those seeking to work in medically under-served areas, while also providing funds for culturally competent training programs and curricula to reduce treatment-level factors contributing to health care disparities.<sup>25</sup> The Act provides grant funding for employers and small businesses to establish wellness programs that promote healthy lifestyles and behavior consistent with evidence-based research and best practices in order to address the patient level variables that contribute to health disparities.<sup>26</sup> The ACA reauthorizes the Indian Health Care Improvement Act,<sup>27</sup> making permanent the federal government’s commitment to provide health care to Indians and Alaska Natives across the United States.<sup>28</sup> These patients receive special protections under the Act, including payment protections under qualified health plans<sup>29</sup> and funding for community-based providers through the Indian Health Service.<sup>30</sup> The ACA even heeds the IOM’s call to conduct research in broad subject areas to “provide a better understanding of the contribution of patient, provider, and institutional characteristics on the quality of care for minorities” and re-designates and strengthens the National Institute on Minority Health and Health Disparities with the purpose of funding coordinated interagency research and “improving minority health and the quality of health care minorities receive, and eliminating racial and ethnic disparities.”<sup>31</sup>

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<sup>22</sup> *Id.* § 4302(b)(2).

<sup>23</sup> *See id.* § 4302.

<sup>24</sup> *Id.* § 4201(c)(2).

<sup>25</sup> *See, e.g., id.* §§ 5201, 5307.

<sup>26</sup> *See id.* § 10408.

<sup>27</sup> 25 U.S.C. §§ 1601–1683 (2006).

<sup>28</sup> *See id.* §10221; Craig A. Conway, *Indian Health Care Improvement Act Made Permanent by Health Reform Legislation*, U. HOUS. HEALTH L. & POL’Y INST. HEALTH L. PERSP. (Apr. 7, 2010, 9:50 AM), available at <http://www.law.uh.edu/healthlaw/perspectives/2010/%28CC%29%20IHCI.pdf>.

<sup>29</sup> *See* Patient Protection and Affordable Care Act § 2901.

<sup>30</sup> *See id.* § 10202. Arguably, the Affordable Care Act misses an opportunity to address ethnic and racial disparities that arise within the population of non-citizens in the United States. For example, access to health exchanges and access to premium tax credits and subsidies is limited to citizens and immigrants who are in-status.

<sup>31</sup> *Id.* § 10334.

In these specific sections of the Affordable Care Act and throughout its ten titles, Congress's intent to launch a full-scale attack on the problem of health care disparities is clear. Yet, notwithstanding the Act's comprehensive commitment to addressing racial and ethnic disparities, the Act stops short of guaranteeing a legal entitlement to non-disparate health care. The Act is silent and indeed powerless to provide any enforceable right to the equitable health care to which these several provisions aspire. Arguably, the fact that the law supplies no means of enforcement through which patients, providers, or their advocates can reliably ensure the Act's stated objective, may ultimately undermine the reform's ability to achieve its commitment "to improv[e] minority health . . . and eliminat[e] racial and ethnic disparities."<sup>32</sup> The next section proposes a legal solution that is flexible enough to accommodate the reality that even a firm commitment to health care equality is an open-ended obligation, and this approach offers a well structured array of judicially recognized obligations and penalties that could add the enforceability needed to give the Affordable Care Act "teeth."

## II. FIDUCIARY ENFORCEMENT

The Affordable Care Act expresses Congress's commitment to eradicate racial and ethnic disparities in health care by establishing and funding new organizational structures and procedures to provide increased access to higher quality health care through more health care providers dedicated to and trained to serve disadvantaged communities, while equipping the health care workforce with the information it needs to get the job done. These enactments are significant advancements in the fight against disparities; however, none of these measures provide a mechanism for ensuring or enforcing the Act's stated commitment. Moreover, none of the Act's provisions provide relief for failure to achieve its goal to "reduce health disparities across . . . populations."<sup>33</sup> The Act lacks the legal rules that supply content and a means of enforcement to ensure the legislative purpose Congress has outlined is achieved. To be sure, this omission does not evince any weakness or compromise with respect to the aims of the Act, but rather reflects the difficulty of the problem that enforceability presents. Although the law provides enforceable protections against acts of discrimination in health care, the law has not been able to reasonably prohibit discriminatory health outcomes. My objective here is to propose a legal framework that could serve this end by translating the *goal* of achieving non-disparate health care into a legally cognizable interest in and entitlement to non-disparate health care.

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<sup>32</sup> *Id.* § 10334(a)(1)(A).

<sup>33</sup> *Id.* § 3011.

A. *A Fiduciary Duty to Deliver Non-Disparate Health Care*

The Congressional commitment to eliminate ethnic and racial disparities in health care will best be achieved if courts and legislators recognize the delivery of health care is a fiduciary obligation. The jurisprudential groundwork has been laid for this approach. Courts, with near unanimity, have recognized the interaction between a physician and patient as a fiduciary relationship.<sup>34</sup> For example, in medical malpractice cases, courts have recognized that a provider's fiduciary duty to a patient arises from the trust and confidence the patient invests, believing the physician will operate in good faith and loyalty.<sup>35</sup> Moreover, courts have also held that physicians have a fiduciary duty to disclose information that permits patients to voluntarily and knowingly consent to treatment.<sup>36</sup> By acknowledging the fiduciary nature of the physician-patient relationship, courts have supplied the substantive body of legal rules and procedural avenues for enforcing those rules to protect the interests of both providers and patients. Fiduciary law imposes legally enforceable obligations on experts who occupy a position of authority, superior knowledge, and power, so that their exercise of discretion is directed solely toward serving the best interest of the one who is dependent upon them.<sup>37</sup> Fiduciary law regulates relationships in which a weaker party lacks sufficient information or opportunity to monitor or

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<sup>34</sup> All states except Alabama recognize and enforce the obligations of a fiduciary relationship between physicians and patients. *See* *Gunter v. Huddle*, 724 So. 2d 544, 546 (Ala. Civ. App. 1998) (citing *Mitchell v. Harris*, 246 So. 2d 648, 651–52 (Ala. 1971)).

<sup>35</sup> *See, e.g.,* *Walk v. Ring*, 44 P.3d 990, 999 (Ariz. 2002) (“We long ago held that a patient and a doctor were in a fiduciary relationship ‘calling for frank and truthful information from’ doctor to patient.” (quoting *Action v. Morrison*, 155 P.2d 782, 784 (Ariz. 1945))); *see also* *Moore v. Regents of Univ. of Cal.*, 793 P.2d 479 (Cal. 1990) (asserting a physician’s fiduciary duty to disclose personal financial interest in a procedure); *Stafford v. Shultz*, 270 P.2d 1 (Cal. 1954). *But cf. Gunter*, 724 So. 2d. at 546 (holding physicians are not fiduciaries as a matter of Alabama law).

<sup>36</sup> *See* *Hales v. Pittman*, 576 P.2d 493, 496 (Ariz. 1978) (“If the physician properly informs the patient of the nature and probable results of the operation, as well as alternative methods of treatment, and the patient consents to the operation, then, absent malpractice, the physician is not liable. . . . However, because of the fiduciary relationship between physician and patient, the scope of disclosure required can be expanded by the patient’s instructions to the physician.” (internal citations omitted)); *Demers v. Gerety*, 515 P.2d 645, 650 (N.M. Ct. App. 1973), *rev’d on other grounds* 520 P.2d 869 (N.M. 1974) (“We begin our discussion by noting that the physician-patient relationship is a fiduciary one . . . . The physician is required to exercise the utmost good faith toward the patient throughout the relationship.” (internal citations omitted)); *Moore v. Webb*, 345 S.W.2d 239, 243 (Mo. Ct. App. 1961) (In finding that the provider exceeded the patient’s consent to extract some, not all, teeth, the court said, “A physician occupies a position of trust and confidence as regards his patient—a fiduciary position. It is his duty to act with the utmost good faith. This duty flows from the relationship with his patient and is fixed by law—not by the contract of employment.” (citing *Parkell v. Fitzporter*, 256 S.W. 239 (Mo. 1923))).

<sup>37</sup> *See* RESTATEMENT (THIRD) OF THE LAW OF TRUSTS § 78 at 105–06; *see also* RESTATEMENT (THIRD) OF THE LAW OF AGENCY §§ 8.01–8.04.

directly control the expert on whom he or she relies.<sup>38</sup> The law, therefore, steps in to ensure that the expert fiduciary will conform and align their decisions with the best interest of the one who relies upon them. The fiduciary form of relationship is frequently recognized in business. The legal doctrine protects the values of trust accounts, bank accounts, and corporate shares compelling fairness between employers and employees, directors and shareholders, banks and depositors, and others whom we regard as vulnerable to the superior knowledge and control of another.<sup>39</sup> Similarly, in the physician-patient relationship, superior expertise, knowledge, and skill place doctors in the position of fiduciaries, and the dependent vulnerability of patients in their care are the beneficiaries.<sup>40</sup>

Courts have further extended fiduciary law beyond individual physician providers, to hold that hospitals,<sup>41</sup> nursing homes,<sup>42</sup> and pharmaceutical companies<sup>43</sup> stand in a fiduciary relationship with their patients and therefore owe them the duties of good faith, loyalty, diligence, and care owed by all fiduciaries to their principals. Even in cases involving health benefit plan administrators, the United States Supreme Court has held that insurers occupy a fiduciary role when collecting health benefit premiums and making plan coverage decisions.<sup>44</sup>

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<sup>38</sup> See generally Robert Cooter & Bradley J. Freedman, *The Fiduciary Relationship: Its Economic Character and Legal Consequences*, 66 N.Y.U. L. REV. 1045, 1049–50 (1991) (describing the economic incentives of fiduciary law to deter disloyalty by fiduciary in control and difficult to monitor).

<sup>39</sup> See Tamar Frankel, *Fiduciary Law*, 71 CALIF. L. REV. 795 (1983); see also Deborah DeMott, *Beyond Metaphor: An Analysis of Fiduciary Obligation*, 1988 DUKE L.J. 879, 882 (1988).

<sup>40</sup> PRINCIPALS AND AGENTS: THE STRUCTURE OF BUSINESS 2 (John W. Pratt & Richard J. Zeckhauser eds., 1985) (“Whenever one individual depends on the action of another, an *agency relationship* arises. The individual taking the action is called the *agent*. The affected party is the *principal*. In common parlance, the doctor is the agent, the patient is the principal.”).

<sup>41</sup> See *Jackson v. Okla. Mem’l Hosp.*, 909 P.2d 765 (Okla. 1995) (upholding a *res ipsa loquitur* cause of action on behalf of a patient who received a cautery burn to her lower abdomen during a hysterectomy performed at a state-owned hospital). *But cf.* *Nutty v. Jewish Hospital*, 571 F. Supp. 1050 (S.D. Ill. 1983) (questioning the efficacy of deeming a patient’s relationship to a hospital a fiduciary one).

<sup>42</sup> In *Petre v. Living Centers-East, Inc.*, 935 F. Supp. 808, 812 (E.D. La. 1996), the “[c]ourt concede[d] that fiduciary relationships are most often found in financial dealings,” but it could think of “no relationship which better fits the description of fiduciary duties than that which exists between a nursing home and its residents.”

<sup>43</sup> See, e.g., *Rohlfing v. Manor Care, Inc.*, 172 F.R.D. 330 (N.D. Ill. 1997) (upholding a breach of fiduciary duty action against a nursing home and a related pharmaceutical company to recover excessive fees where the resident reposed confidence in the nursing home and the nursing home was found to be in a position of “superiority and influence” with respect to the resident as a result of this confidence); *Greenfield v. Manor Care Inc.*, 705 So. 2d 926, 931–32 (Fla. Dist. Ct. App. 1997) (holding that a wife “properly alleged a fiduciary duty between [a nursing home] and its residents, which arose out of a special relationship independent of the contract,” which implied a covenant to charge a reasonable fee).

<sup>44</sup> See *Met. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008) (holding an insurer’s denial of long-term disability benefits violated its fiduciary duty to the plaintiff beneficiary).

Applying the fiduciary framework to health care relationships ensures that the policy objectives in the Affordable Care Act will be achieved. Not only does fiduciary law establish a means of enforcement and standardize the rules for achieving equity in health care, but the well-established legal standards set by fiduciary law will enhance the *ex ante* ordering between the many stakeholders in the health care delivery systems. They will know the duties and obligations that arise from their relationships in advance. Parties will be able to choose to conform their conduct and their expectations to the legal rules and enjoy the predictability and certainty that comes from a set of legal rules to govern. Moreover, the legal framework offered here allows parties to modify their duties and obligations by mutual agreement and to privately order solutions to new or unexpected circumstances. The legal framework also performs a distributive justice function by allowing under-represented patients, who are less powerful and influential, the protection of the rules of law that govern health care delivery and financing. The importance of this contribution cannot be overstated.

Acknowledging that the delivery and finance of health care takes place in the context of a fiduciary relationship brings an established body of common law and statutory law to bear on the health care interaction. That fiduciary law can be applied by a court to require a provider to exercise a reasonable degree of care, skill, and caution in the execution of their duties toward a patient. Patients can enforce a provider's fiduciary obligation to act in the best interests of the beneficiary and to disclose any circumstances that are unfair or compromise the beneficiary's interests. Fiduciary law prohibits health care providers from acting in their own best interest; at all times, a fiduciary is held to the standard of "act[ing] for the benefit of the other party as to matters within the scope of the relationship."<sup>45</sup> In fact, courts have recognized two types of fiduciary forms in health care: the agency relationship that arises when a patient entrusts a provider with control and management of his or her health and the trust relationship that arises when a patient entrusts property, not merely personal services, and relies upon the fiduciary to deal with that property for the patient's benefit.<sup>46</sup> The core thesis of this article is that when Congress enacted the Affordable Care Act's provisions aimed at eliminating health care disparities, the government's legislative action implicated the trust form of the fiduciary relationship. However, to fully outline the fiduciary trust at work under the ACA, the remaining work of this section is to explain how the proposed fiduciary trust arises.

In trust law, a trust arises when one party holds property for the benefit of another.<sup>47</sup> Paradigmatically, a trust arises when "A conveys property to B who agrees to deal with the property for the benefit of C. B is the trustee of the

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<sup>45</sup> AUSTIN WAKEMAN SCOTT ET AL., SCOTT AND ASCHER ON TRUSTS 38 (5th ed. 2006).

<sup>46</sup> *Id.* at 36.

<sup>47</sup> *See id.* at 4.

property for *C*.”<sup>48</sup> In the context of the Affordable Care Act, the United States Congress is represented as *B*; it has undertaken to act legislatively for the benefit of the patients, which are represented as *C*. The right to act legislatively is conveyed to Congress under the Constitution, in its most fundamental terms by the American public, and it is designated as *A*. In other words, Congress has acted as a trustee. In fiduciary terms, the American people act as settlor in establishing a trust for the benefit of patient beneficiaries. This analogy reflects the fact that the fiduciary relationship “lies at the heart of democratic government.”<sup>49</sup> Yet the analogy is still incomplete. The important work that remains is to expressly define the property interest that the American public conveys to Congress in establishing the fiduciary trust. The next section explains that this property interest, in short, is the right to non-disparate health care.

*B. A Property Interest in Non-Disparate Health Care*

Dr. Mark Earnest and I have argued elsewhere that equitable access to health care is a property interest in the nature of a public good, sharing qualities with other recognized public goods such as public education, national defense, safe roadways, clean air, and clean water.<sup>50</sup> We concluded that just as the American legal system recognizes the government’s role in providing public education, the availability of fairly distributed health care goods and services represents a non-excludable and non-rivalrous interest that is the product of collective societal investment.<sup>51</sup> Although we acknowledged health care does not represent a pure public (or even merit) good, there is no question that the form of wealth and entitlement to that wealth created when government takes in revenues and in turn dispenses that money to reimburse or directly provide health care, finance biomedical research, fund medical education and training, ensure a safety net for poor and disabled citizens, administer licensing, peer review, and quality controls over providers, franchise the sale of medical devices and pharmaceuticals, the government is managing a property interest on behalf of its citizens.<sup>52</sup>

This section provides further support for the view that health care is a property interest. It offers two additional lenses. Professor Joseph Singer supplies the first lens and replaces the traditional “bundle of sticks” metaphor for property, with a view of property as both an individual entitlement and a social

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<sup>48</sup> See John H. Langbein, *The Contractarian Basis of the Law of Trusts*, 105 YALE L.J. 625 (1995). The creator of a trust, called a “settlor,” can establish the rights of the beneficiaries in any way she chooses, so long as the terms of the trust do not run contrary to public policy. See *id.* at 650.

<sup>49</sup> David S. Law, *A Theory of Judicial Power and Judicial Review*, 97 GEO. L.J. 723, 731 (2009).

<sup>50</sup> See Earnest & Matthew, *supra* note 4.

<sup>51</sup> *Id.* at 78–79.

<sup>52</sup> *Id.*

system.<sup>53</sup> The second lens recalls Professor Charles Reich's "new property" model and proposes fiduciary rules to protect individuals' rights as government emerges as a major source of wealth.<sup>54</sup> Both of these views are apt to describe the interests that Congress framed and advanced when it directed the Secretary of the Department of Health and Human Services to establish a "National Strategy for Quality Improvement in Health Care" that would serve to "reduce health disparities across health disparity populations . . . and geographic areas."<sup>55</sup>

Professor Singer explains at the outset that property establishes minimum terms for social interactions among individuals.<sup>56</sup> The law of property establishes norms and rules that both respond to the shape of social relationships and organize the entitlements and obligations that shape social relationships.<sup>57</sup> Singer explains that "[p]roperty does not come in a preset package. There is no simple definition of property that can be posited without making controversial value judgments about how to choose between conflicting interests."<sup>58</sup> Singer proposes, and I adopt here, an entitlement paradigm to define health care as property, thus replacing the absolutist notions of property that turn individual ownership of tangible and intangible things.<sup>59</sup> This understanding does not take account of rules that merely offer a talisman such as "efficiency" or "liberty" to allocate various shares in the bundle of ownership rights that form traditional notions of property.<sup>60</sup> Instead, Singer's model is useful to describe health care as property because it identifies and orders the conflicting interests of everyone with legitimate claims to rights in health care.<sup>61</sup> These interests are legally and socially protected and yet these interests are not absolute because they necessarily conflict with one another. Thus, property is a distinctly communitarian concept.

The "enduring communitarian perspective" describes property as a construct that operates functionally as a "realm of deeply embedded relationships and community, with a normative focus on the obligations that arise from these interconnections"<sup>62</sup> and underscores the urgency and far-reaching impact of ordering distribution of and access to health care as property. As Professor Davina Cooper explains, property rules form a community's collective identity mediated through the ways in which that community chooses to define the extent to

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<sup>53</sup> See JOSEPH WILLIAM SINGER, ENTITLEMENT: THE PARADOXES OF PROPERTY (2000).

<sup>54</sup> Charles A. Reich, *The New Property*, 73 YALE L.J. 733 (1964).

<sup>55</sup> Patient Protection and Affordable Care Act § 3011.

<sup>56</sup> See SINGER, *supra* note 53, at 1–18.

<sup>57</sup> *Id.*

<sup>58</sup> *Id.* at 7.

<sup>59</sup> *Id.* at 91.

<sup>60</sup> *See id.*

<sup>61</sup> *Id.*

<sup>62</sup> Nestor M. Davidson, *Property and Relative Status*, 107 MICH. L. REV. 757, 771 (2008).

which property belongs to and is part of the whole of the community.<sup>63</sup> The process of fixing boundaries by which a community encodes what it will regard as property, recognizing who will be entitled to the property it defines, and defining which members of the community will have the power and authority to adjudicate breaches to these collective determinations is the way in which a stable and enduring democratic community sustains its identity.<sup>64</sup>

The work of Gregory Alexander and Eduardo Peñalver has been to expand the understanding of community because of the central importance that approaches to allocating property have to the existence of community and the role of individuals within community.<sup>65</sup> They explain,

Property stands . . . squarely at the intersection between the individual and community because systems of property are always the creation of some community. . . . Moreover, systems of property have as their subject matter the allocation among community members of rights and duties with respect to resources that human beings need in order to survive and to flourish. . . . Jeremy Waldron is therefore surely correct when he says that “our interest in property is effectively an interest in the political and economic structure of society.”<sup>66</sup>

Arguing that humans are not self-sufficient but instead require both the interdependency and diversity of community in order to flourish as humans, Alexander and Peñalver conclude that a well-lived life is absolutely impossible apart from community because individuals acting alone are not capable of acquiring or organizing the resources to live. Therefore, the state, itself a community—albeit one subject to unique suspicions—is responsible to promote equal entitlement to these resource as a matter of human dignity.<sup>67</sup>

Applying the communitarian perspective to health care helps to organize the interrelationship between physicians, hospitals, payers, patients, and others engaged in the delivery of health care that necessarily produces conflicts between owners of health care resources and non-owners, providers of health care and patients, consumers of health care and payers, and providers of health care and those who finance the provision of health care. Resolution of these conflicts must, by definition, result in choices that will legitimately harm the interests of others. For example, the decision to increase access to health care in order to reduce racial and ethnic disparities in health outcomes will cause harm

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<sup>63</sup> Davina Cooper, *Opening Up Ownership: Community Belonging, Belongings, and the Productive Life of Property*, 32 *LAW & SOC. INQUIRY* 625, 646–49 (2007).

<sup>64</sup> *Id.*

<sup>65</sup> See Gregory S. Alexander & Eduardo M. Peñalver, *Properties of Community*, 10 *THEORETICAL INQ. L.* 127 (2009).

<sup>66</sup> *Id.* at 128 (quoting JEREMY WALDRON, *THE RIGHT TO PRIVATE PROPERTY* 328 (1988)).

<sup>67</sup> *Id.* at 140–45.

to the liberty interests of those who might otherwise have allocated health care resources without taking the possibility of discriminatory outcomes into account. A choice to encourage the use of preventative care over specialized care may reduce reimbursements to neurosurgeons, cardiac surgeons, and cardiologists, thereby harming their claims to health care resources. Yet these choices may not interfere with patients' legally protected individual interests in or entitlements to non-disparate health care.<sup>68</sup>

Applying Singer's entitlement view of health care as property is justified as a system of defining entitlement rights that establish minimum terms for social interaction among the actors in the health care market. The entitlement view of health care as property creates presumptions about who gets to control particular resources as property "owners" and allocates the burden of persuasion to "non-owners" to justify alternative results. Defining health care as a property interest importantly subjects these entitlements to law that will protect those interests. In this essay, the body of law that I propose to protect health care entitlements is fiduciary law.

The fiduciary rules take into account the effects of self-interest and conflicts of interest that result from alternative entitlement modes that do not impose duties of loyalty, care, competency, good faith, or disclosure. Fiduciary law responds to the social relations between the Congress acting on behalf of the government as trustee. And the fiduciary law framework at once serves to protect the enlightened self-interest of individual patients and patient groups within the health care industry while also describing the terms of social interactions around health care in order to allocate entitlements in ways consistent with the social justice norms of our society.<sup>69</sup>

Professor Charles Reich offered a model of property law to limit the sphere into which government could intrude upon individuals' interests.<sup>70</sup> Property, he proposed, is a legal institution that operates to protect private rights in wealth by drawing a boundary line against an emerging welfare state, under which government might otherwise abuse individual rights in the name of the "public interest."<sup>71</sup> Reich urged the creation of new institutions that could carry on the work of protecting individuals against government largess.<sup>72</sup> The concept of a property "right" was central to Reich's model.<sup>73</sup> The concept of right is most urgently needed where benefits that preserved the self-sufficiency of individuals are at stake. According to Professor Reich, "[o]nly by making such

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<sup>68</sup> See SINGER, *supra* note 53, at 12.

<sup>69</sup> See generally *id.* at 15–16.

<sup>70</sup> Reich, *supra* note 54. But compare the United States Supreme Court decision in *Goldberg v. Kelly*, 397 U.S. 254 (1970), where the Court declined to follow Reich's view of property rules to protect individuals in an emerging welfare state.

<sup>71</sup> Reich, *supra* note 54, at 771.

<sup>72</sup> *Id.*

<sup>73</sup> *Id.* at 786.

benefits into rights can the welfare state achieve its goal of providing a secure minimum basis for individual well-being and dignity in a society where each man cannot be wholly the master of his own destiny.”<sup>74</sup> Applying Professor Reich’s notion of property to the health care context is justified by the unprecedented role that government will now play in ensuring the quality, containing the cost, and increasing access to health care under the Affordable Care Act’s reforms. Under this Act, the government emerges as a major source of the wealth that is health care. Taking in revenue, the government will distribute monetary reimbursements to providers, premium assistance tax credits to individuals, federal matching funds to states expanding their Medicaid populations, and grants to fund comparative effectiveness research. The ACA arguably produces the “breaking down of distinctions between public and private” that inspired Reich to call for a “new property” in 1964.<sup>75</sup>

Applying Reich’s concept to the new landscape for American health care shows that health care is a property right that is protected against violations by the limits that restrain government in all contexts. For example, the new property right to health care may be viewed as an entitlement protected by the Constitution’s Fifth Amendment Due Process limitations as well as the Equal Protection safeguards of the Fourteenth Amendment. Moreover, the new property right to health care may be viewed as subject to the substantive limitations of fiduciary law so that the government must, by law, hold health care in trust for all citizens and act with regard to that property with prudence, diligence, good faith, loyalty, and care.

### III. ENSURING RESULTS

The gravamen of recognizing health care as an entitlement and right not only completes the theoretical justification for applying the law of trusts to define the government’s fiduciary obligations undertaken by the terms of the Affordable Care Act, but it also recognizes a property interest in health care allowing enforcement of the anti-disparity goals Congress has set under the Act as the series of property allocating rules. By these rules, the state must guarantee all members of American society access to health care that is necessary to flourish as a human being. In other words, my proposed interpretation of Singer and Reich’s “new” conceptualizations set property in a communitarian context resulting in a social obligation theory of property law that places an obligation upon society itself, as a principal and fundamental owner of health care as property, to hold government responsible for promoting equal access to health care because health care is essential to enabling individuals within our society to live lives that are “worthy of human dignity.”<sup>76</sup> Thus, the fiduciary law of trusts of-

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<sup>74</sup> *See id.*

<sup>75</sup> *Id.* at 746.

<sup>76</sup> Gregory S. Alexander, *The Social-Obligation Norm in American Property Law*, 94 CORNELL L. REV. 745, 745 (2009).

fers a method of shaping the social relationships among the actors that create, deliver, finance, and use health care in a way that is consistent with our vision of social life in America.

I have set out to point to a collective definition of the interests that result from the interactive agency relationships in health care, to offer a set of legal rules that may be applied to organize health care relationships, and to provide a vision of how the social relationships that result from those rules may serve the core substantive values of American democracy.

Recognizing a property-based understanding of health care delivery and finance is justified by the role the federal and state governments will play in creating health care goods and services—a form of wealth—under the Affordable Care Act. New rules are necessary to organize new social relationships among the newly insured, newly formed organizations for delivery and finance and new levels of government oversight. Fiduciary law will establish the minimum terms for social interaction among providers and new delivery organizations, granting protection to individual patients and patient groups. Fiduciary rules will shape the social relationships between providers, patients, and payers, organizing them in order to accommodate the market-based structure that is foundational to the success of the Affordable Care Act's managed competition approach to health care delivery and finance. Finally, fiduciary rules will provide a set of judicial enforcement provisions and remedies that will constrain the government's choices in administering the newly reformed health care system so that they do not interfere with the protected legal interests of individual and collective beneficiaries—patients—or their entitlement interests. In short, allocating health care as a property interest must occur within a normative framework that serves our society's substantive goals of justice, liberty, equality, and democracy.<sup>77</sup> A hypothetical application is illustrative.

Hispanic Americans constitute more than one-third of all Americans living below 150% of the federal poverty level.<sup>78</sup> Not surprisingly, Hispanics also represent over one-third of the American population that is uninsured.<sup>79</sup> As a consequence, Hispanics represent the largest single ethnic group who report reduced access to medical care, delaying care, avoiding care, or foregoing the purchase of prescription drugs in America.<sup>80</sup> Simply put, poverty leads to disparate health access. And because health outcomes reflect disparities in health access, it is not surprising that Hispanics suffer higher rates of death caused by heart disease, diabetes, cerebrovascular disease, and HIV than any other ethnic group in America, besides non-Hispanic Blacks.<sup>81</sup> This scenario is unlikely to

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<sup>77</sup> SINGER, *supra* note 53, at 12.

<sup>78</sup> U.S. DEP'T OF HEALTH AND HUMAN SERVS. CTRS. FOR DISEASE CONTROL AND PREVENTION, NAT'L CTR FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 2009, WITH SPECIAL FEATURE ON MEDICAL TECHNOLOGY 422 (2010), available at <http://www.cdc.gov/nchs/data/hus/hus09.pdf>.

<sup>79</sup> *Id.*

<sup>80</sup> *Id.* at 312.

<sup>81</sup> *Id.* at 202.

change until the Affordable Care Act is fully implemented in 2014. Indeed after 2014, the Act will prioritize data collection to support research to address these disparities, fund medical education for an increasing number of health care workers to serve the Hispanic population, increase the number of community clinics serving the Hispanic community, and reduce the number of uninsured Hispanic Americans. Yet, without recognizing the property interest in non-disparate health care belonging to Hispanic Americans, these patients will not be able to ensure that the Congressional objective of addressing these health disparities results in an actual reduction in the disparities that prevail today.

However, if the fiduciary rules that regularly protect property interest in fiduciary relationships elsewhere are applied to protect Hispanic Americans, these patients will have a way to adjudicate conflicts among themselves, providers, and payers that will balance their right to share in the access and non-disparate outcomes of health distributed equitably while also protecting the economic interests of the government that reimburses the cost of health care. The fiduciary rules may serve to validate steps the government might take in furtherance of its goals to eradicate health care disparities. And allocations to create infrastructure or processes that protect the entitlement to non-disparate health care might also be understood in the context of serving overall social goals, rather than as only a conflicting individual right. The hope that undergirds the theory laid out here is that the disadvantaged communities, intended as beneficiaries of the Affordable Care Act, will realize tangibly—even dramatically—changed health outcomes as a result of the trust and confidence the Act places in our government to accomplish its stated goals.

#### IV. CONCLUSION

The fiduciary framework presented in this essay is intended to continue a nascent conversation about the property interest I have defined in non-disparate health care. Necessarily, in this brief essay I leave open a number of issues raised by the model. For example, although I have defined an obligation on the part of the state to act as agent to protect interests in health care for all, much remains to be said about how those interests might be enforced. One may posit revisiting Charles Reich's new property regime to create enforceable rights against a welfare state that may operate through a newly articulated series of statutory pronouncements similar to the prudent investor rules. Alternatively, sovereign immunity protections might be extended to limit enforceability of these rights directly against the state itself, but not against government officials who have been held by Congress and by courts to owe fiduciary duties to the public in other instances.<sup>82</sup> It is beyond the scope of this discussion to choose

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<sup>82</sup> See, e.g., *United States v. Sawyer*, 85 F.3d 713, 732 n.16 (1st Cir. 1996) (holding that the obligation to disclose material information inheres in the legislator's general fiduciary duty to the public and citing Congressional enactment of 18 U.S.C. § 1346 (2006) to overrule *McNally v. United States*, 483 U.S. 350 (1987), in which United States Supreme Court ruled to the contrary).

methods and procedures of enforcement. Also, I have said nothing in this discussion about the entitlement to access health care that non-citizens may have. There is much more to say, too, about the conceptualization of health care as property that I have only begun to describe. However, my purpose now in proposing to recognize health care as property is limited to the goal of making two concluding points relevant to the fiduciary role that the government now occupies in combating health disparities. First, American society, whether acting publicly or privately, creates a series of assets entrusted to the fiduciary care of government and collectively, those assets are property called health care. Second, a communitarian understanding of the social relations that comprise this property compels the state to act as society's agent in order to ensure just and equitable access to health care for all Americans.