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# Prepayment Health Care Plan Enabling Acts - Are Their Restrictive Features Constitutional

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## INTRODUCTION

Illness is something which afflicts the rich as well as the poor, the affluent as well as the downtrodden. It does not choose its host according to social position, educational background, or economic status. In this century the medical sciences and the medical professions have minimized the hazards of illness. Yet the costs of preventing or curing illness, and the financial burden placed upon the victim, persists and grows.

To alleviate this financial burden, we have witnessed the passage of Medicare and its benefits. But Medicare is of a limited scope. It is not intended to have a wholesale effect on society. It is not aimed at those individuals and their families who fit into the social rank nebulously characterized as the "Middle Class." These individuals face a financial burden, although not unbearable, in preserving their health.

At this juncture it should be observed that certain health insurance and Blue Cross and Blue Shield plans are available to dilute this burden. Although these plans have existed for sometime and have been helpful in meeting this problem, they have not solved the problem. It is with one of these types of solutions, namely the Blue Shield type, that this paper deals.

Blue Shield plans, more broadly stated, are prepayment health care plans whereby the individual makes a small, periodic payment to a trust, cooperative association, or nonprofit corporation in return for health care services. These services are provided for by a panel or group of health care providers (e.g., physicians, optometrists, dentists), or by the individual's health care provider, who have contracted with the trust, cooperative or nonprofit corporation to provide such services to its subscribing members. The participating health care providers are ordinarily compensated on a salary or per capita basis whenever a panel or group is used, and by a fee-for-service system whenever the individual chooses his own health care provider.[1] The concept of paying for health services by means of small periodic prepayments is an

1. H. HANSEN, LEGAL RIGHTS OF GROUP HEALTH PLANS (1964); *Hansen, Group Health Plans—A Twenty-Year Legal Review*, 42 MINN. L. REV. 527, 528 n.5 (1958).

excellent method of meeting the financial problems attendant to an illness since there is an amortization of the burden.

Most jurisdictions have, however, enacted enabling acts for these prepayment health care plans which restrict the sponsorship and control of the plans to the medical profession. As such, competition among different plans is prevented since, in most instances, only one prepayment health service plan exists within the jurisdiction or within a particular area within the jurisdiction. The medical professions have, in effect, acquired a monopoly over this type of plan. Although the rates charged subscribers under these plans are generally regulated by an insurance commissioner, the lack of competition coupled with the retention of the fee-for-service method of paying professional persons maintains a higher cost to the consumer without any countervailing reason for such a system existing. There is no real or apparent danger in having consumers or lay individuals control the financial aspects of these plans, and nothing can be found to substantiate the reason why the professional personnel or the professional societies should have control over this aspect of the plan. Physicians, dentist, optometrists, etc., are educated and trained to provide health services; they are not educated to deal with financial matters. It is the object of this inquiry to examine the monopolistic control over the financial aspects of these prepayment plans to determine their validity in light of the constitutional standards of due process and the prohibition against delegation of authority to a private body.

## Historical Background

In the 1930's, the need for greater quantitative and qualitative health services for the American people, especially those people in the lower income groups, became a matter of national importance.[2] One of the consequences of this awareness of needed health services was the creation of prepaid health service plans. Among the earliest of these plans were the lay sponsored and lay controlled service plans.[3] The fact that these plans were lay sponsored and lay controlled to a great extent prompted the medical societies to pressure the state legislatures, within whose purview the power to regulate public health is found, for legis-

2. *See generally*, Report of the Committee on the Cost of Medical Care For the American People 172 (1932); Hansen, *Laws Affecting Group Health Plans*, 35 Iowa L. Rev. 209 (1950); Holman and Cooley, *Voluntary Health Insurance in the United States*, 35 Iowa L. Rev. 183 (1950).

3. F. Goldman, Voluntary Medical Care Insurance 148-9 (1948); Serbein, Paying for Medical Care in the United States 157-161, 164, 224 (1953).

lation restricting the sponsorship and control of such prepaid health plans to the medical profession.[4] The initial success of the medical societies was tremendous, and within a short period of time they acquired enabling legislation in a number of states restricting these prepaid health service plans to medical profession sponsorship and control.[5]

It must also be mentioned at this point that the medical societies did not restrict their oppositional tactics to pressuring state legislatures for restrictive enabling legislation. The medical societies also imposed "ethical" sanctions to restrain or prohibit lay controlled plans from acquiring the necessary panels or groups of physicians to service these plans. The primary "ethical" principles used were those principles requiring "free choice of physician" and adherence to the "fee-for-service" system.[6] Although recently the medical societies, particularly the American Medical Association, have reviewed and liberalized their earlier positions,[7] the medical societies have not yet completely accepted the lay controlled health service plan as an ethical program for providing medical services.

The disciplinary actions based on principles of ethics which the medical societies have utilized against physicians participating in these health service plans have not always been accompanied by legal sanction. Two cases of particular importance exemplify this position. In *American Medical Association v. United States,*[8] the United States Supreme Court affirmed the convictions of the American Medical Association and the district medical society for violating Section 3 of the Sherman Act. Section 3 of the Sherman Act prohibits combination or conspiracies in restraint of trade within the District of Columbia. The medical societies were held to have violated this section by coercing physicians not to accept employment from a group health membership corporation providing a prepayment health care plan, by restraining medical association members from consulting with the corporation's physicians and by restraining hospitals in the District of Columbia from affording facilities to the corporation's physicians and patients. The Supreme Court of Washington, in *Group Health Cooperative of*

4. Hansen, *supra* note 2, at 222; Hansen, *supra* note 1, at 531.

5. These plans became known as "Blue Shield" plans, a sequel to the earlier hospital service plans denominated as "Blue Cross" plans. For a listing of the state enabling acts *see*, Hansen, *supra* note 1, at 224 n.52; Hansen, *supra* note 2, at 531-32 n.13.

6. *See, Standards of Acceptance of Medical Care Plans* in AMA, VOLUNTARY PREPAYMENT MEDICAL BENEFIT PLANS, 148-150 (1953).

7. *See generally, Report of the Commission on Medical Care Plans,* J.A.M.A., Jan. 17, 1959 (special issue), often referred to as the *Larson Report.*

8. 317 U.S. 519 (1943), *aff'g* 130 F.2d 233 (D.C. Cir. 1942).

*Puget Sound v. King County Medical Society,*[9] held that the local county medical society's disciplinary actions aimed at physicians operating or desiring to join a certain prepayment health plan had violated the State Constitutional provision prohibiting combination or agreements to fix prices or to limit the production of a commodity, namely, medical services.[10] Notwithstanding these decisions, as well as a report by the American Medical Association warning local medical societies of the legal dangers inherent in such disciplinary actions,[11] there is some evidence that such activities are still being pursued by some local societies, although apparently not to the extent previously undertaken.[12]

While the above mentioned activities proved to be the most formidable obstacles to lay conduct of prepaid health service plans, they were not the only obstacles to such plans. The common law corporate practice rule and the possible application of the state insurance laws also presented difficulties for the operation of such lay sponsored plans.

The common law corporate practice rule prohibits a corporation from practicing as a profession (in this case the healing arts) which requires personal qualifications to be met by the "person" engaged in such a profession.[13] The rule is of significant importance for a health service plan because of the desirability of utilizing the corporate form for liability and tax purposes rather than the unincorporated association form. Although the rule is generally stated without regard to whether the corporation is a profit or nonprofit corporation, it is important to note that no court has yet held a nonprofit corporation operating a health service plan to be in violation of the corporate practice rule. There is, however, at least one jurisdiction in which there is considerable doubt as to whether the problem would be resolved in favor of the use of the nonprofit corporate form.[14]

9. 39 Wash. 2d 586, 237 P.2d 737 (1951).

10. WASH. CONST. art. XII, § 22. For a more extensive discussion of these cases and medical society disciplinary actions *see, The American Medical Association: Power Purpose and Politics in Organized Medicine,* 63 YALE L.J. 938, 988-92 (1954).

11. See *supra* note 7, at 37-42.

12. *See, e.g., New Kensington Group Wins Long Fight to Admit its Physicians to Hospital Staff,* Group Health and Welfare News (Nov. 1967).

13. 1 FLETCHER, CYCLOPEDIA OF THE LAW OF PRIVATE CORPORATIONS, 397 (1963). This is the general rule supported by the weight of authority. For a general discussion of the corporate practice rule *see* Hansen, *supra* note 2, at 211-19; *see also* Note, *Group Health Plans: Some Legal and Economic Aspects,* 53 YALE L.J. 162, 166-71 (1943); Laufer, *Ethical and Legal Restrictions on Contract and Corporate Practice of Medicine,* 6 LAW AND CONTEMP. PROB. 517, 522-27 (1939).

14. 1963 OHIO ATT'Y GEN. REP. No. 82. "It has been well settled in Ohio that a corporation whether organized for profit or *not for profit,* may not engage in the practice of medicine." (Emphasis added).

State insurance laws present another possible obstacle to the operation of a prepayment health service plan since such acts ordinarily require a large reserve fund to be maintained by the insuring group to cover liability contingencies. The weight of authority, however, holds that such plans are not providing insurance, but rather are in the business of providing services, namely, medical care, rather than indemnifying against a loss in the traditional sense of insurance.[15] The distinction is made between the indemnification for services rendered (insurance) and the assurance that the services will be rendered (prepaid health plans).[16]

The matter discussed above was intended to give the reader an historical view of the development of prepaid health care plans and to show the extent of the problems involved in forming and operating such plans. But the corporate practice rule, medical society disciplinary actions, and the possible application of the insurance laws are not the major obstacles today to the formation of consumer sponsored and controlled plans. Restrictive enabling acts are the major obstacle to such plans. A restricting enabling act is an act which restricts the control of the financial aspects of the plan to the health care professions, which in most instances is the medical profession. In effect it means that no one but the health care professions and their members can originate and operate a prepayment health care plan. The constitutional validity of these acts will now be investigated.

## Restrictive Acts

The restrictive acts can be divided into four basic categories as they are found in the enabling acts. There are those acts which contain provisions requiring medical society approval of the articles of incorporation,[17] medical society sponsorship or control over the directors or trustees of the plans,[18] and those acts which require actual medical

15. Group Health Association v. Moor, 24 F. Supp. 445 (D.C. Cir. 1938), *aff'd sub-nom*, Jordon v. Group Health Association, 107 F.2d 239 (D.C. Cir. 1939); Group Health Cooperative of Puget Sound v. King Medical Society, 39 Wash. 2d 586, 237 P.2d 737 (1951); Complete Service Bureau v. San Diego County Medical Society, 43 Cal. 2d 201, 272 P.2d 497 (1954); *cf.*, Cleveland Hospital Service Association v. Ebright, 36 Ohio L. Abs. 600, 45 N.E.2d 157 (Ohio App. 1942), *aff'd*, 142 Ohio St. 51, 49 N.E.2d 929 (1943); *see also*, 167 A.L.R. 323; 29 Am. Jur. Insurance § 12 (1940).

16. Hansen, *Legal Problems in the Organization and Operation of Group Health Plans*, 5 Vand. L. Rev. 14, 22 (1951); Hansen, *supra* note 2 at 219-20; Hansen, 42 Minn. L. Rev. 537 (1958); MacColl, Group Practice and Prepayment of Medical Care, 159-61 (1966).

17. R.I. Gen. Laws Ann. § 27-20-1 *et seq.* (1945).

18. Ga. Code Ann. § 56-1801 *et seq.* (1960); Mich. Stat. Ann. § 550.301 *et seq.* (1957); N.H. Rev. Stat. § 420 (1943); S.C. Code Ann. § 37-1101 *et seq.* (1962).

society control.[19] There are also provisions found in some enabling acts requiring a certain percentage of the physicians in a locality to become members of the plan.[20] Other acts permit all physicians to become participating members of the plan, and require that the corporation or plan itself cannot exclude these physicians if they, the physicians, so desire to join.[21] In many enabling acts of a restrictive nature a basic principle of the American Medical Association Code of Ethics is incorporated as a provision of the act requiring that free choice of physician by a subscriber of the plan be maintained at all times, even though the particular physician chosen by the subscriber is not a participating member of the plan.[22] There are also requirements in some acts which do not necessarily make them restrictive but which have a restrictive nature which require surplus or contingency funds to be maintained by the plan either prior to commencement of business or while business is being conducted and in many instances in both cases.[23] These amounts vary greatly and it is basically the amount required under the act which determines whether the provision is restrictive or not. As to the latter of these restrictive features, it may be noted that there are various valid reasons for requiring such contingency and surplus funds. These plans are closely aligned to insurance, and the insurance laws do require contingency or liability funds to be maintained by insurance companies.

## Recent Developments

In 1963 and 1964, two decisions of great significance concerning restrictive enabling acts were decided in New Jersey. The initial case, *Group Health Insurance of N.J. v. Howell*,[24] decided that section two of the New Jersey Medical Service Corporation Law was unconstitutional. Section 2 stated:

> No person shall be elected a trustee of any medical service corporation unless his nomination has been approved by a recognized medical society or professional medical organization having not less than two thousand members holding licenses to practice medicine and surgery pursuant to Chapter Nine, Title 45, of the Re-

19. The medical society must approve the plan before it can operate in a particular locality. *See*, GA. CODE ANN., § 56-1801 *et seq.* (1960). TENN. CODE ANN., Ch. 29, § 56-2901 *et seq.* (1945).
20. *See, e.g.*, N.H. REV. STAT. Ch. 420 (1943).
21. *See, e.g.*, NEV. REV. STAT. § 696.010 *et seq.* (1963).
22. *See, e.g.*, ALASKA STAT. § 21.20.140 *et seq.* (1966).
23. *Id.*
24. 40 N.J. 436, 193 A.2d 103 (1963).

> vised Statutes, and which has been incorporated for a period of not less than ten years.[25]

It was held that this section constituted a delegation of legislative power to a private organization without adequate legislative standards or safeguards in derogation of Article 4 Section 1 of the New Jersey Constitution,[26] and, further, that the unfairness, arbitrariness, and favoritism of the section was a violation of due process.[27] The court pointed out in its opinion that the medical society was the only organization which met these necessary requirements.[28]

Section 3 of the same act required that 51% of the physicians in any county must be participating physicians before any corporation could be certified to transact business in that county.[29] The constitutionality of this particular section was not decided until the second Group Health Insurance case,[30] decided in 1964. There, the court held that this section was so unreasonable that it constituted an unconstitutional delegation of legislative power or authority to a private organization, as well as being violative of due process.[31] The court stated that the 51% requirement permits the physicians to prohibit any other plan from coming into existence.[32]

Earlier, in 1960, the Illinois Supreme Court decided *Illinois Hospital Service, Inc. v. Gerber*.[33] This case was not concerned with prepaid health services, but rather with prepaid hospital services, commonly known as "Blue Cross" plans. Section 14 of the Illinois "Blue Cross" enabling act prohibited a hospital service plan from operating in any county unless it had contracts with hospitals "which operate not less than thirty per cent (30%) of the total number of general hospital beds which normally serve the residents of said County."[34] The court held the section to be unconstitutional under the Illinois Constitution due process provision.[35] The reasoning was similar to that of the New Jersey court in that the court could find no public purpose in placing

25. N.J. STAT. ANN. § 17:48A-2 (1940).
26. "The legislative power shall be vested in a Senate and General Assembly."
27. 40 N.J. at 444, 193 A.2d at 109 (1963).
28. 40 N.J. at 443, 193 A.2d at 108 (1963).
29. N.J. STAT. ANN. § 17:48A-3 (1940).
30. Group Health Insurance of N.J. v. Howell, 43 N.J. 104, 202 A.2d 689 (1964).
31. *Id.* at 109, 202 A.2d at 693.
32. *Id.*
33. 18 Ill. 2d 531, 165 N.E.2d 279 (1960).
34. ILL. STAT. ANN., Ch. 32, § 562b (1959), repealed by Act of Aug. 24, 1965.
35. ILL. CONST. art. II, § 2.

in the hands of private groups the power of determining whether a hospital service plan should operate in a county.[36] The court also stated that the lack of any standards being placed upon the exercise of this power rendered the section violative of due process.[37] The court further stated:

> If dominion over the economic life of one individual or enterprise is to be given to another, some justification must exist and the conditions upon which control is to be exercised must be stated with at least that degree of precision which is required when comparable authority is given to a public official. . . .[38]

While the reasoning of the court is a helpful analogy to declaring some restrictive provisions of prepaid health service plan enabling acts unconstitutional, the import of the Illinois decision is tempered by the fact that it appears that the court's real reason for declaring the provision unconstitutional was the fact that the Illinois Hospital Association had formulated a policy that only one "Blue Cross" plan should operate in any given area, and that this policy should be carried out by each member hospital having a contract with only one "Blue Cross" plan.[39] The court reached an equitable result, but probably not upon the proper basis.

Nevertheless, the three decisions taken together, and the two New Jersey opinions in particular, constitute a significant development in the area of prepaid health programs because they constitute the initial thrust of court action in piercing the protective shield placed around medical society control of prepaid health services and programs. Before further analysis is pursued on this subject, it is important to reiterate that the opposition to these restrictive enabling acts stems from the medical society control of the financial aspects of the health services, and not with the method or manner of providing these services. It is readily acknowledged that the means and the manner in which the actual health services are provided are and should be solely within the province of the professional personnel qualified to render the services. The consumer is not desirous of controlling the medical aspects of the plans, but rather the economic aspects of the plan.

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36. 18 Ill. 2d 535, 165 N.E.2d 283 (1960).
37. *Id.*
38. *Id.*
39. *Id.* at 534, 165 N.E.2d 282.

## Delegation and Due Process

The two concepts employed by the New Jersey Court to invalidate the restriction provisions of the New Jersey Act, *viz.*, the unlawful delegation of legislative authority to a private body, and the due process requirements of the state and federal constitution will now be analyzed to determine their possible affect on other restrictive enabling acts.

The delegation doctrine is a judicially established concept derived from provisions found in the federal and state constitutions that the legislative power is vested in the legislature. Actually the doctrine is a misnomer today, for it is admitted by most authorities, and some courts, that legislative powers can be delegated to public and private groups;[40] the real reason why such delegations are declared unconstitutional is because the legislature has failed to provide adequate standards or safeguards to accompany the exercise of power delegated.

This reasoning has led some writers to regard the question of delegation as a question of reasonableness, and therefore equivalent to a due process requirement.[41] There appears to be some validity in this statement if one views the cases decided in the two areas by the Supreme Court of the United States and the state courts.

In the earlier part of the Twentieth Century, the Supreme Court of the United States appeared to be laying a patchwork pattern as far as the delegation doctrine and private bodies was concerned. In the period from 1905 to 1917 the Supreme Court decided three cases of significant importance regarding alleged delegation of legislative authority to a private body; all three delegations were found to be constitutional.[42] Yet, during this period the Supreme Court, in *Eubank v. City of Richmond*,[43] held invalid an ordinance delegating to certain neighboring property owners the authority to determine how far buildings should be set back from the street. Then, in 1928, the Court held invalid an ordinance prohibiting an old person's home in an area without the consent of a certain portion of the neighboring persons.[44] In 1936, the now infamous case of *Carter v. Carter Coal Co.*[45] was decided in which

40. U.S. v. Dettra Flag Co., 86 F. Supp. 84 (E.D. Pa. 1949). 1 K. Davis, Administrative Law, §§ 2.14, 2.15 (1958); Jaffe, *Law Making by Private Groups*, 51 Harv. L. Rev. 201 (1937); Note, 67 Harv. L. Rev. 1398 (1954).
41. Jaffe, *supra* note 40, and 67 Harv. L. Rev,. *supra* note 40.
42. Butte City Water Co. v. Baker, 196 U.S. 119 (1905); St. Louis & Iron Mountain Ry. v. Taylor, 210 U.S. 281 (1908); Thomas Cusack Co. v. City of Chicago, 242 U.S. 526 (1917).
43. 226 U.S. 137 (1912).
44. State of Wash. *ex rel.* Seattle Title Trust Co. v. Roberge, 278 U.S. 116 (1928).
45. 298 U.S. 238 (1936).

the Court held invalid the Congressional delegation of authority to a percentage of the employers and employees in the mining industry of the power to fix wages. Since 1936 the Supreme Court has been extremely reluctant to declare any kind of delegation unconstitutional.[46]

With this in mind, it becomes very interesting to note that at approximately the same time the Supreme Court of the United States adopted a new position as to the effect of the due process clause on state legislation regulating business or economic matters.

In 1937, one year after the *Carter* case, the Supreme Court decided *West Coast Hotel v. Parrish*[47] which is considered the watershed for the abandonment of the concept of substantive due process in the area of economic regulations and the adoption of a "hands-off" position by the Supreme Court.[48] Prior to this time the Supreme Court had required that there exist a real and substantial nexus between the means employed by the legislature to control economic measures and the constitutional objectives sought. In effect, the Supreme Court was imposing its own concepts of economic policies upon the legislatures through the due process clause. The new position which began in 1937, and exists today, can best be shown by the Court's own statement in *Ferguson v. Skrupa*[49] which was decided in 1963:

> We refuse to sit as a "superlegislature to weigh the wisdom of legislation," and we emphatically refuse to go back to the time when courts used the Due Process Clause "to strike down state laws, regulation of business and industrial conditions, because they may be unwise, improvident, or out of harmony with a particular school of thought."[50]

From these decisions it is clear that the Supreme Court of the United States has abdicated the field of economic regulation to the state legislatures as far as due process and the delegation doctrine are concerned. Unless there is no rational basis for the legislature's action, it is doubtful that the Supreme Court will invalidate the enactment and consequently it is doubtful that they would act in the area under consideration.

46. For an example of the extent to which the Supreme Court has gone in holding delegations valid *see* Arizona v. California, 373 U.S. 546 (1963), *decree entered*, 376 U.S. 340 (1964), in which a broad delegation of authority was granted to a public official without any guiding standards set by the legislature.

47. 300 U.S. 379 (1937).

48. McCloskey, *Economic Due Process and the Supreme Court: An Exhumation and Reburial*, 1962 S. Ct. Rev. 34.

49. 372 U.S. 726 (1963).

50. *Id.* at 731-2 (footnotes omitted).

However, all state courts did not follow the precedents established by the United States Supreme Court on either the delegation or the due process issue. Many state courts still adhere to the substantive due process concept in the area of economic regulations and require a real and substantial nexus to exist between the restrictions imposed by the statute or ordinance and the objective to be obtained.[51] By these courts retaining the concept of substantive due process they have placed themselves in the position of being the final determinant of state public policy in the area of economic and social regulation and development. It is in these states that it is most likely that a state court would find the restrictive enabling act to be unconstitutional. A court may well feel that the economic or financial control of such plans should not be limited to doctor or medical society control, but rather that others, primarily consumers, should also be able to enter this field and thereby increase competition.

The state court's application of the non-delegation doctrine is conflicting to say the least. Although it is apparent that most state courts still adhere to the doctrine (in name if nothing else) it is unclear as to their reasons for applying it in this area. Perhaps the best statement of the subject is found in *United States v. Dettra Flag Co.*[52] where the court said:

> Many [states] allow delegation of administrative duties to private individuals or corporations when the delegation is under the police power of the state to regulate for the health, safety and welfare of the people. Those statutes which were declared unconstitutional were invalid not necessarily because they involved delegations to private groups, but because they failed to establish definite standards to be followed, because the penalty to be imposed was optional upon private determination, or because the statute permitted arbitrary discrimination among interested parties.[53]

This last reason stated by the court in *Dettra*, the possibility of arbitrary discrimination among interested parties, is the type of pro-

51. *See*, Frecker v. City of Dayton, 153 Ohio St. 14, 90 N.E.2d 851 (1950); City of Scottsbluff v. Winters Creek Canal Co., 155 Neb. 723, 53 N.W.2d 543 (1952); Sperry & Hutchinson Co. v. Hoegh, 246 Iowa 9, 65 N.W.2d 410 (1954); Cott Beverage Corp. v. Horst, 380 Pa. 113, 110 A.2d 405 (1955); Trinka Services, Inc. v. State Board of Mortuary Science, 40 N.J. Super. 238, 122 A.2d 668 (1956). *Cf.*, Anchor Hocking Glass Corp. v. Barber, 118 Vt. 206, 105 A.2d 271 (1954); People v. Ryan, 101 Cal. App. 2d 927, 226 P.2d 376 (1951); Dayton Co. v. Carpet, Linoleum & Resilient Fl. D. Union, 229 Minn. 87, 39 N.W.2d 183 (1949).

52. 86 F. Supp. 84 (E.D. Pa. 1949).

53. *Id.* at 89-90.

vision found in the first New Jersey Group Health case,[54] as well as in *Fink v. Cole*[55] and *Union Trust Co. v. Simmons*,[56] the two principal cases relied upon by the New Jersey Court when invalidating the New Jersey statute.

## Analysis

Regardless of the position that one believes the Court should take in viewing state economic regulations, an act which grants to a private body the power to regulate the economic posture of another, whenever that first party is an interested party to the outcome and is unbridled by legislative standards, safeguards or public responsibility, the delegation should be stricken as being unreasonable and an unconstitutional delegation of power. The legislature is, in effect, transposing the private well being and purposes of the medical professions for the public welfare. Therefore, those restrictive acts which grant to the medical societies the power to approve the plan,[57] or its articles of incorporation,[58] or a majority of its directors or trustees,[59] should be declared invalid.

The other types of restrictive provisions do not present the same type of objections. Those acts requiring a percentage of participating physicians or free choice of physician by a subscriber, or the right of every doctor in the state or locality to join the plan, must be tested on due process requirements rather than on the non-delegation theory.[60] From the foregoing analysis of due process it is extremely doubtful that either the United States Supreme Court or those state courts adhering to the Supreme Court's position on economic due process would hold invalid such acts. It is even doubtful that those state courts espousing the substantive due process concept would hold some of these restrictive provisions invalid because there are valid reasons for requiring a certain quantity of physicians to be associated with the plan since this insures better service. Also, free choice of physician, whether participating or not, theoretically provides the potentiality for better service to the subscriber. Probably the most vulnerable restrictive provisions are

54. 40 N.J. 436, 193 A.2d 103 (1963).
55. 302 N.Y. 216, 97 N.E.2d 873 (1951).
56. 116 Utah 422, 211 P.2d 190 (1949).
57. GA. CODE ANN. § 56-1801 *et seq.* (1960). TENN. CODE ANN., Ch. 29, § 56-2901 *et seq.* (1966).
58. R.I. GEN. LAWS ANN. § 27-20-1 *et seq.* (1945).
59. GA. CODE ANN. § 56-1801 *et seq.* (1960); MICH. STAT. ANN. § 550.301 *et seq.* (1957); N.H. REV. STAT. § 420 (1943); S.C. CODE ANN. § 37-1101 *et seq.* (1962).
60. *See, e.g.*, N.H. REV. STAT. Ch. 420 (1943); NEV. REV. STAT. § 696.010 *et seq.* (1963); ALASKA STAT. § 21.20.140 *et seq.* (1966).

those which require such a high quantity of physicians so as to clearly preclude any other plan (other than a doctor-sponsored plan) from operating in the state, and those acts giving every doctor the right to join the plan since such a requirement appears to be aimed at the benefit of the physician rather than the subscriber or public.

If change is to be effectuated in this area to permit consumer sponsored plans to exist as readily as doctor sponsored plans, the initiative and efforts are probably going to have to be exercised upon the legislatures rather than in the courts, since most of the power of regulation of such activity still remains within the province of the legislature.

## Conclusion

The two New Jersey decisions declaring invalid and unconstitutional the restrictive features of New Jersey's prepaid health service plan enabling act were a forward thrust in penetrating the shield placed around any type of competition in this area. But the lapse of time since these decisions indicates that the courts are not going to be the champion in altering the medical profession's monopolistic hold on prepayment health care plans. Competition is a basic tenet of American society and philosophy. There was and is no valid public purpose in competely thwarting competition in this area. It is unfortunate that the remedy lies within the province of the legislatures, for the chances that the legislatures will act to change these restrictive acts to make them open to consumer sponsorship and control is unlikely. It would be unfortunate to require society to await the massing of opposing pressure groups to counterbalance the influence of the health professions, but such is the only apparent alternative open at this time.

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