You are viewing an archived document from the New Jersey State Library.

THE CAPITOL FORUMS
On Health & Medical Care

THE RELATIONSHIP OF ETHICS & ECONOMICS IN THE EVOLVING HEALTH CARE DELIVERY SYSTEM

Background information for the discussion at the

CAPITOL FORUM
on Wednesday, March 20, 1996
9:00 AM – 1:00 PM
Masonic Temple Library
Trenton, New Jersey

Sponsored by
The League of Women Voters of New Jersey Education Fund

Underwritten by a grant from
THE ROBERT WOOD JOHNSON FOUNDATION

You are viewing an archived document from the New Jersey State Library.

THE RELATIONSHIP OF ETHICS AND ECONOMICS IN THE EVOLVING HEALTH CARE DELIVERY SYSTEM

THE ISSUE: In the absence of an agreed-upon framework of ethics within which to make health and medical care decisions, the health care delivery system becomes vulnerable to decision-making based primarily on economics. Some experts contend that managed care has merged "under one roof" the incompatible principles of business ethics and medical ethics. **Is there a role for the states in monitoring the relationship between ethics (business and medical) and the financing controls present in our evolving health care delivery system? If so, what is that role?**

THE PARAMETERS OF THE DEBATE

The Heisenberg uncertainty principle states that if one part of a system is observed, it is changed and consequently has an affect on other parts of the system; one cannot change one aspect of an integrated system without affecting its other components. This principle applies to everything from atoms to health care. As the health care delivery system continues to evolve, with the proliferation of managed care organizations and the imposition of utilization controls to keep health care costs in check, the health care policy goals of ensuring access and quality are also affected. During this time of transition, there exists a fragile balance between ensuring quality and access, as aggressive steps are being taken on national and state levels to control health care costs.

The utilization and cost controls by which managed care aims to reduce health care spending, such as limiting referrals to specialists, requiring pre-authorization for emergency room services and shortening hospital stays, are coming under scrutiny to ensure that quality and access are not being compromised. At the same time, the issue of medical ethics, so fundamental to sound medical practice, has also emerged as ethical conflicts arise for physicians caring for patients in the managed care system. The business reality of managed care has a direct impact on the physician-patient relationship; it creates a dilemma within which the physician is expected to be simultaneously a patient advocate and a managed care organization advocate, even when those roles present conflicts of interest.

Health policy analysts argue that players in the health care delivery system must develop a set of standards with which to evaluate managed care health plans. By applying such standards, inferior plans that may compromise quality and access in their efforts to reduce costs would be "weeded out" from the system. The questions to be answered are: should these standards be based on principles of economics, policy or ethics; if ethical principles apply, should they be medical ethics or business ethics, or a new hybrid (if at all possible) of the two; and finally, how and by whom should these standards be developed? (Mariner, 1995).

THE MANAGED CARE SYSTEM

There is no single managed care entity; there are different managed care models and various plans, which all may be characterized by the following general definition: "Managed care is a system that, in varying degrees, integrates the financing and delivery of medical care through contracts with selected physicians and hospitals that provide comprehensive health care services to enrolled members for a predetermined monthly premium" (Macklin, 1995). The mix of managed care organizations currently includes: health maintenance organizations (group and staff model HMOs); preferred provider organizations (PPOs), independent provider associations (IPAs) and physician-hospital organizations. (Reference is made to Capitol Forum Issue Briefs: *Managed Care* (February 2, 1994); *Public Oversight of Managed Care* (October 19, 1994) and *Quality Assurance* (June 14, 1995) as background for this Forum discussion.)

The generic term, "managed care organizations" (MCOs) refers to all of these entities. Yet, even the term "managed care" may be evolving in health industry language. Recently, the Group Health Association of America (the national HMO trade association) and the American Managed Care Review Association merged and changed their name to "The American Association of Health Plans." Citing field surveys that found the public had a "negative connotation" associated with the term

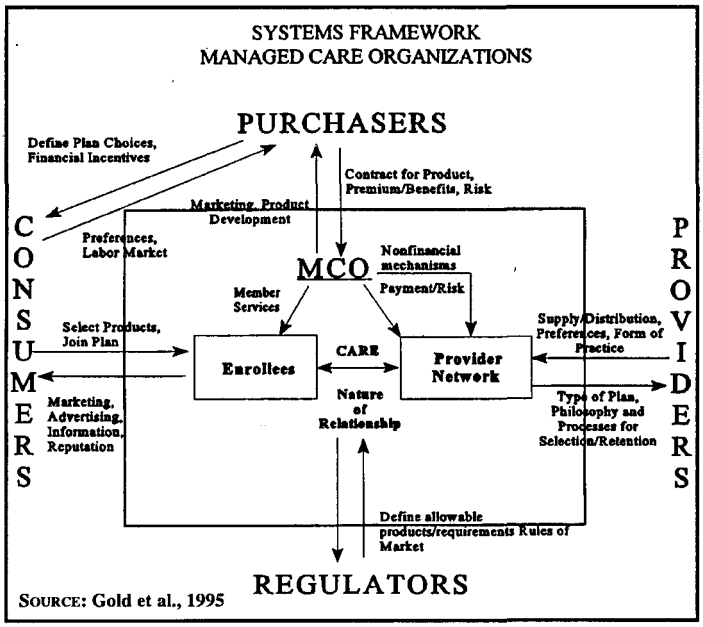
ISSUE BRIEF No. 14

Capitol Forums on Health & Medical Care
League of Women Voters of New Jersey Education Fund
204 West State Street, Trenton, New Jersey 08608 • v (609)683-1533 • f (609) 924-5993•
Writer/Researcher: Joanne T. Fuccello, M.S.W., L.C.S.W.
• Katharine Salter Pinneo, Director • Linda Mather, Associate Director •
©1996 The League of Women Voters of New Jersey Education Fund
Printed on post-consumer recycled paper

You are viewing an archived document from the New Jersey State Library.

"managed care," the group (which represents HMO membership and engages in managed care research and educational activities) chose not to include it within its new name (*Managed Care Week*, Feb. 6, 1996).

The evolving health care system, which currently represents a mix of managed care organizations, traditional indemnity plans based on fee-for-service, and fee-for-service plans with a "managed" component (such as case management or prior authorization), has created new relationships among the four discrete players in the industry. Patients (who want access to affordable health care of high quality); providers (who want medical treatment autonomy and fair compensation for services rendered); payers (who are attempting to control costs and have become a "third" party in the patient-provider relationship); and purchasers [employers and government] (who have a role in overseeing the triad of patient-provider-payer and their interactions with each other), are each "jockeying" for position in this rapidly changing system (Dorken & Pallak, 1995). The critical issue confronting this system is that there has been little collaborative participation by planners representing all four interests (Ibid). Because the system is evolving with such rapidity, and in most states in a relatively unregulated environment, responses to its evolution are for the most part re-active rather than pro-active.



SOURCE: Gold et al., 1995

THE ETHICS OF THE SYSTEM

Ethics in the Health Care Reform Debate

The debate regarding how to control our health care spending (projected to be 17 percent of the Gross Domestic Product [GDP] by the end of the century) has focused on resolving structural and operational problems in the financing and delivery systems. Hence, the emergence of managed care as a viable solution to control escalating health care costs. However, there are deeper issues which underlie the problems in the health care system that involve basic philosophical and existential issues in our society, which are going unanalyzed (for the most part) in the health care reform debate. These issues include: "our societal attitudes towards life and death, the goal of medicine, the meaning of 'health,' suffering versus survival, who shall live and who shall die (and who shall make those decisions)" (Gaylin, 1994). By not addressing these "existential" questions, policy makers will continue to make decisions in a moral vacuum, reforming a health care system potentially driven by economics, rather than by ethics and traditional medical values. Critics of the newly evolving managed care health care system contend that care and treatment decisions are being made for business, economic and efficiency reasons, as opposed to medical and health care reasons.

Evolution of Medical Ethics

The history of ethical standards applied to medicine can be traced back millennia to the Hippocratic tradition of Classical Greece. Under the Hippocratic oath, the physician is required to provide whatever benefit his/her skills could offer, to do no intentional harm and to respect the privacy and confidentiality of the physician-patient relationship (Cloutier, 1995). As the system of health insurance developed during the 20th century, reimbursement policies were designed to enhance and maintain the integrity of the physician-patient relationship. Physicians were reimbursed under a straight fee-for-service to avoid burdening either the patient or physician with the risks associated with the uncertainty in treatment effectiveness (i.e., a given medical procedure may produce different outcomes for people with the same diagnosis). The presumption was that if the system provided incentives that limited access to the full potential range of diagnostic and therapeutic services available, then the quality of care would be compromised.

The emergence of prospective payments for "bundles" of hospital, surgical and supply services, initiated the shift from fee-for-service medical practice, and bargaining power by those outside the physician-patient relationship developed. With the establishment of Diagnostic Related Groups (DRGs), with peer review, pre-authorization for hospitalization and utilization review, the traditional physician-patient relationship was again significantly affected (Cloutier, 1995).

All health care systems have financial incentives that can influence physician behavior. Under the traditional fee-for-service model, physicians are financially rewarded for "over-treating" patients. This system (along with technological advances and public expectations for "more" health care) led to ever-escalating health care costs (Gaylin, 1994). Although the fee-for-service system allowed for more autonomy for providers and freedom of choice for patients, it is quickly being subsumed by managed care organizations which offer cost containment and efficiency mechanisms designed to control the growth of health care. The entire health care system's evolution is further affected by cost-containment measures to quell the

You are viewing an archived document from the New Jersey State Library.

growth of Medicaid and Medicare expenditures. This trend towards enrollment of beneficiaries and recipients in managed care, with its priorities of cost containment and efficiency, raises even higher the challenge of maintaining ethical principles in the administration and operation of these large public programs.

New Ethical Issues Raised by the Emergence of Managed Care

Managed health care was designed to provide quality and accessible health care, while containing costs and monitoring the appropriateness of treatment. Its emergence over the last ten years throughout the country is in response to several complex problems in the health care system; "if resources were unlimited and all care was of the highest quality and appropriateness, managed care would be unnecessary" (LaPuma et al, 1995). The basic philosophical principles of managed care are of a positive nature: they discourage overtreatment, encourage preventive care and promote cost-containment, while maintaining health care quality. An overall benefit of the emergence of managed care is how it has motivated the entire health care industry to coordinate and develop reliable performance and outcome measures to assess quality of care.

However, criticisms of the managed care system are fast emerging which report of patient dissatisfaction, financial conflicts in decision-making, physician discontent with the role of gatekeeper, and legal challenges to the managed care organization's reviewer authority, as well as mixed research results on long-term cost savings and quality effects (Id.) Ethical issues are arising among all players: physicians, patients, payers and policy-makers. Ethical conflicts within managed care organizations are further complicated because of the variation in financing, provider payment and physician autonomy among the various types of MCOs. While all MCOs are presented with the challenge of avoiding undertreatment, some, such as for-profit, group model HMOs, are more challenged than others because of their rigid adherence to capitation, physician controls and administrative costs (Macklin, 1995). Currently, research has shown that the form of managed care that works best to prevent undertreatment is one that is non-profit and has a large salaried physician group that manages the clinical aspects of the provision of health care services (Rodwin, 1995).

Business Ethics and the Financial Implications

Currently, there is great debate regarding the possible consequences of capitation and other financial inducements to physicians to control costs. The most common forms of financial incentives to many managed care organizations are the payment of bonuses from unspent funds and the withholding of portions of income, which may be paid out at the end of the year if certain cost-containment targets are met (Christensen, 1995). Such cost-containment targets may include keeping hospital utilization below a certain rate or the limiting of patient referrals to specialists. The larger the amount of withheld income, the stronger the incentive to remain within these target ranges. Laboratory and radiology costs are frequently deducted from the pooled funds (Ibid).

While the most widely discussed and visible consequence of such incentives is the temptation to withhold needed services from clients, there has been little rigorous study on the issue. The studies which have been conducted have not supported this consequence to be true (Id.) Another potential consequence is the decision not to retain very ill patients in one's health plan, which would limit access to MCOs for individuals with complex or chronic illness. Such consequences must be balanced with the beneficial impacts of managed care incentives, which include the reduction of wasteful treatments, more emphasis on preventive care, the potential for coordinated case management and cost savings as a result of fewer inappropriate or duplicative services. The strongest incentives that exist to balance the temptation for physicians to undertreat in managed care settings are professional ethics, specifically to preserve the patient's well-being, and the importance of peer review and practice guidelines to maintain a high quality of care.

Physicians' Responses to the New Ethics

While physicians may benefit from the structure of the managed care organization, their role in a managed care system presents moral and professional challenges. Administrative controls change doctor-patient relationships to business-person/consumer relationships. While the traditional physician-patient relationship has always been fiduciary in nature, it carried an intrinsic level of loyalty, honesty and trust (Mariner, 1995). Managed care brings a number of third parties into the physician-patient relationship — payers, purchasers, regulators and the courts — and may introduce an atmosphere of mistrust (Id.) Ultimately, the burden is falling on the physician to hold the MCO accountable to maintain its moral responsibility to provide appropriate and quality health care, as he/she is the "front line" player in the medical decision-making process.

The climate of the current health care system is volatile at best. Recently, when offered revised contracts, 50 of 100 Tucson, Arizona, area physicians left the Intergroup of Arizona health plan of which they were member physicians. The reasons included: general practitioners were being pressured to provide specialized care, rather than refer to specialists such as orthopedic surgeon; built-in financial incentives existed to limit care, and the managed care company was negligent in that it was not completely advising patients in advance whether a specific treatment would be covered (*Money Magazine*, December 1995).

In a recent move, the League of Physicians and Surgeons, a New York City-based advocacy group, sued the New York State Department of Health regarding a "gag clause" within a contract the state had approved with ChoiceCare, an HMO filing to operate in the state. The

You are viewing an archived document from the New Jersey State Library.

physicians' group claims that the Department should not have authorized the ChoiceCare contract because it included a physician gag clause, which prohibits physicians from discussing the health plan with patients, and it did not include appeal rights for physicians. The case is pending in the courts (*Managed Care Week*, February 26, 1996).

In an open letter in the *New England Journal of Medicine*, a physician at a major medical center detailed a case in which his patient (a child seeking bone marrow transplantation as treatment for her leukemia) and her family were negatively affected by the restrictions placed on them by their managed care health plan. He concludes his case study by calling on physicians to maintain the sanctity of their roles as patient advocates and to preserve the medical autonomy to do what is best for the patient. He further challenges all players in the evolving health care system to openly collaborate on dealing with these emerging ethical conflicts so that health care and treatment decisions will not be driven by dollars alone (*New England Journal of Medicine*, Feb. 26, 1996).

THE STATES' REACTIONS TO THESE ISSUES

In Other States

All players involved in the evolving health care system acknowledge that changes in the system are occurring at an exponential rate. What type of oversight authority should be implemented by states to ensure that in their efforts to control health care costs do not compromise health care quality or restrict access to health care services? With the failure of a comprehensive national health reform movement, most states are struggling with how to establish standards that will govern a climate in which competitive health care organizations are proliferating.

Throughout the country, states are attempting to protect patient-consumers by promulgating insurance laws which require that employers offer a range of plans to employees allowing for more choice. These laws are in response to the increased number of employers who are offering only restricted plans, such as closed panel HMOs or limited preferred provider organizations (PPOs) (*Managed Care Week*, Jan. 29, 1996). While "any willing provider" laws are becoming less popular, a newly emerging trend is the introduction of laws that mandate that HMOs provide coverage for enrollees seeking out-of-network care. These "Patient Protection Act" bills are emerging throughout the country, and they include requirements that plans disclose financial incentives offered to providers in order to control utilization.

At the present time, the most controversial issue regarding managed care organizations and provision of health care involves the so-called "gag clauses" contained in the contracts between the physicians and the managed care organizations. Such clauses often prevent physicians from giving enrollees information about treatment options that may not be covered under the plan or from referring enrollees to out of network doctors. The American Medical Association and Medical Society members throughout the country find that the gag clauses are unethical and interfere in the physician-patient relationship; they believe such clauses prevent doctors from telling patients about treatment options, payment policies and other health plan provisions (Id.).

In January 1996, Massachusetts was the first state to bar HMOs from enforcing physician gag clauses. The law, effective April 18, 1996, is the first of many such laws being considered around the country, including the states of New York, New Jersey, California, Maine and Illinois. The Massachusetts law stipulates that an insurer may not dismiss or refuse to compensate a provider solely for disclosing plan information "in good faith" (*Managed Care Week*, January 29, 1996). The Massachusetts law enters into the "gray area" in which contract law and statute and administrative law inter-connect. Clearly, the Massachusetts legislature felt that provider protection in this aspect of the health care environment was critical and that contract language was restricting and compromising the tenets of ethical and sound medical practice between physician and patient.

Both the Group Health Association of America and the American Managed Care Review Association (now merged under the name, "The American Association of Health Plans") contend that doctors are inappropriately interpreting the contract language (Id). However, concern is so strong on a national level among legislators and policy makers that a bill has been introduced in Congress by Representative Edward Markey (D-Mass.) which would define allowable "good faith" discussions between physicians and patients so as to include the risks and benefits of treatment.

U.S. Healthcare, one of the country's largest HMOs, under criticism for its questionable "gag" clauses, recently revised its contractual language to clarify physician-patient communication provisions and to encourage open communication with patients. (*Managed Care Week*, February 12, 1996). The revised language was acknowledged by the American Medical Association as a "responsible first step" in resolving the contractual "gag" clause conflict and represents a good example of ways in which the system is trying to "self-correct" (Ibid).

In New Jersey

As the health care system environment continues to evolve in New Jersey, with ever-greater market penetration of managed care organizations, the Department of Health continues to move forward with its revised Health Maintenance Organization (HMO) regulations (N.J.A.C. 8:38). HMO enrollment has increased to close to 1.4 million individuals in the state, with projections of over two million enrollees by the end of 1996 (*The New York Times*,

You are viewing an archived document from the New Jersey State Library.

Nov. 18, 1995). The proposed HMO rules include a disclosure provision, which would require that HMOs disclose the financial incentives they offer participating physicians to hold down medical costs. Under the disclosure rule, patients would know whether or not a physician has any financial incentive to cut back on care and be able to appeal to the state when they believe services have been limited or denied. HMOs would be required to file extensive reports with the Department of Health on services provided and to make public membership satisfaction surveys.

While the rules have been criticized for "singling out" HMOs, and not other managed care entities or fee-for-service plans in the state, the Department feels that the data captured from the reporting requirements would give a clear picture of this large segment of the evolving health care marketplace. The Department of Health does not have the statutory authority to impose similar regulations on the entire health care industry, as it does with HMOs, which have been licensed to operate in the state since 1974.

Under present law, managed care organizations other than HMOs (such as PPOs and IPAs) are regulated under the Department of Insurance through its selective contracting arrangements rules at N.J.A.C. 11:4-37. In their efforts to address this complex issue, members of National Association of Insurance Commissioners (NAIC) are currently debating over how to regulate risk-assuming, unlicensed provider networks, such as Physician-Hospital Organizations (PHOs). While providers believe that these entities are different from HMOs and should not be regulated under the same licensure and solvency requirements, state insurance regulators believe that they are performing the same function and should be subject to the same rules. NAIC plans to have regulatory recommendations by the end of 1996.

In New Jersey's efforts to ensure that quality and access be maintained in the rapidly changing health care environment, State Senator Jack Sinagra (R-18) has introduced the "Health Care Quality Act," which would hold all health insurers more accountable and require them to disclose to enrollees the terms and conditions of the health benefits plans, including treatment policies and restrictions.

In response to growing concerns over the ways in which HMOs and other managed care organizations are changing the health care system in New Jersey, a health-care coalition of 22 groups, including physicians, unions and consumer groups has formed to ensure patient rights (*Trenton Times*, Feb. 8, 1996). A spokesperson for the coalition — the New Jersey Citizen Action Campaign for Patient Rights — stated that there was a critical need for advocacy on behalf of patient rights and stringent monitoring of managed care entities. New Jersey is not alone in having these concerns. New York City Public Advocate Mark Green recently reported that when his staff made more than 500 calls to customer service lines of managed care companies, they often received "vague answers to basic questions and sometimes blatantly inaccurate advice" regarding health plan terms and coverage (*The New York Times*, Jan. 14, 1996). The National Committee for Quality Assurance (NCQA), an accrediting entity, is currently working on a national "report card," which will compare many plans across the country in several areas of performance, such as the quality of the doctors, the access to care, and the availability of preventive tests and immunizations.

The Medical Society of New Jersey, in response to a need for development of ethical standards to meet the challenges of the evolving health care system in New Jersey, has requested that the Commissioner of Health, in the HMO regulations, require that each HMO or managed care organization develop an ethics committee and that an ethics committee be created within the Department to serve as a statewide forum on the issues of biomedical ethics and managed care (*Bioethics Update*, Winter 1996).

THE CONCLUSION

In the current environment in which health care is being delivered in a competitive market, business and medical practices are inextricably entwined. Health care policy experts agree that as we enter the final years of this decade, the trend is going to continue towards managing health care costs through such cost containment mechanisms and utilization controls as pre-authorization, limiting the number of; referrals to specialists, high technology diagnostic tests, and experimental treatments, as well as defining "medical necessity." While medical ethics suggests that every patient is entitled to the best available care, business ethics does not obligate anyone to provide that care if it is not paid for (Mariner, 1995).

The entry into the health care system of managed care organizations, which combine insurance, management and health care delivery, has raised the issue of developing new ethical standards for the health care environment. As the standards of business ethics and medical ethics clash, only through open discussion among consumers, providers, insurers, purchasers, regulators and policy makers can new compatible standards be formulated. The primary remedy at present is to acknowledge that the problem exists and openly discuss solutions on both micro (physician-patient; physician-insurer) and macro (public policy; legislative) levels in an atmosphere of all players' sharing greater personal and professional accountability and a commitment to developing appropriate ethical standards.

You are viewing an archived document from the New Jersey State Library.

QUESTIONS FOR DISCUSSION

- Is it possible to set new ethical standards which combine business and medical ethics to create a health care system committed to patient well-being, quality and access without "over-regulating" the competitive marketplace? How will New Jersey address these complex issues?

- In a recent article in the *Journal of Law, Medicine and Ethics*, a lawyer in the field of health law states that the rapidly developing health care system and integration of health care delivery structures has "outpaced the legal system's ability to regulate or guide the emerging health care market" (Gosfield, 1996). In New Jersey's deregulated health care environment, what is our position regarding increased monitoring and regulation of the industry? Is there a limit below which we will not allow the free market to operate?

- In a recent trend, many HMOs are offering physicians financial incentives in addition to prepayment if the doctors score high in areas like patient satisfaction. By developing and using quality measurement and outcome data, the HMOs are tracking physician performance and offering cash "bonuses" to high-performing physicians, similar to the bonus practice in corporations (*Health & Hospitals Networks*, June 20, 1995). Are such practices reducing medical practice in America to "just another business?" To what extent are these public policy issues or business management issues?

- With each passing month, Medicare and Medicaid enrollment in managed care plans is increasing. Medicare beneficiaries and Medicaid recipients, because of their special health needs as a result of differing degrees of age and disability, are particularly vulnerable patients in the health care system; how will quality and access to health care be assured to these groups in the managed health care system? What entity will advocate for these populations?

- Massachusetts was the first state in the country to bar HMOs from enforcing physician "gag clauses," offering a statutory remedy to what was essentially a provider requirement set forth in the contract with the managed care organization. Where do the boundaries lie between contract law and statutory law and administrative regulation? What steps should be taken when public health concerns are raised when contract mandates may lead to limitations on appropriate care or treatment? What entity decides whether or not a particular treatment or intervention is "medically necessary?"

- Research has shown that the form of managed care organization that works best to prevent undertreatment is one that is non-profit and has a large salaried physician group that manages the clinical aspects of health care services. Are states ethically obligated to promote the development of these types of MCOs over other types in order to protect the public good?

- A recent KPMG Peat Marwick study on close to 12 million patients in 3,700 acute care facilities and hospitals found that although managed care is driving down hospital costs without negatively affecting patient care, hospital costs were flat or starting to increase in many highly penetrated markets (*Managed Care Week*, Feb. 26, 1996). Are such unpredictable cost benefits worth the risk of compromising quality and access? What is New Jersey's commitment to conduct health care research to monitor whether or not expected savings benefits through managed care are achieved?

You are viewing an archived document from the New Jersey State Library.

REFERENCES

Bioethics Update. Winter 1996. A Newsletter of the New Jersey Hospital Association Bioethics Committee.

Christensen, Kate T. "Ethically Important Distinctions Among Managed Care Organizations." Journal of Law, Medicine & Ethics. 23:223-29 (1995).

Cloutier, Mark. "The Evolution of Managed Care." Trends in Health Care, Law & Ethics.v. 10, No. 1-2 (1995).

Dorken, Herbert and M.S. Pallak. "Using Law, Research, Professional Training and Multidisciplinary Collaboration to Optimize Managed Care." Managed Care Quarterly. 2(2): 53-59. 1994.

Employee Benefits Research Institute. Special Report: Financing Health Care Risk. September 1995.

Gaylin, Willard. "Moral and Ethical Decisions Must Be Made for Regulations to Work." In, Health Care in America. Opposing Viewpoints. San Diego, CA. 1994.

Gold, Marsha et al. "Regulating Health Plans and Integrated Delivery Systems: Monitoring Quality." Presentation. Robert Wood Johnson Foundation. State Initiatives in Health Care Reform. Conference for States. November 1995.

Gosfield, Alice G. "The Legal Subtext of the Managed Care Environment: A Practitioner's Perspective." Journal of Law, Medicine & Ethics. 23: 230-35. (1995)

Hospitals and Health Networks. "Cover Story on Physician Incentives." June 20, 1995.

LaPuma, John, D. Schiedermayer and M. Seigler. "Ethical Issues in Managed Care." Trends in Health Care, Law & Ethics. v. 10, No. 1-2. (1995).

Macklin, Ruth. "The Ethics of Managed Care." Trends in Health Care, Law & Ethics. V. 10, No. 1-2 (1995).

Managed Care Week - January 29. 1996; February 12 and 26, 1996.

Mariner, Wendy K. "Business vs. Medical Ethics: Conflicting Standards for Managed Care." Journal of Law, Medicine & Ethics. 23: 236-46 (1995).

Morreim, E. Haavi. "The Ethics of Incentives in Managed Care." Trends in Health Care, Law and Ethics. v.10, No. 1-2 (1995).

The New York Times. "Trenton Wants HMOs to List Financial Incentives for Doctors." November 18, 1995.

Simon, Norma P. "Practitioner Ethics and Managed Care." Managed Care Quarterly. 2(2):43-45.(1994).

Weston, Brent and M. Lauria. "Patient Advocacy in the 1990s." New England Journal of Medicine. v. 334, No. 8. February 22, 1996.