Received 4/15/2019 3:57:38 PM Commonwealth Court of Pennsylvania

Filed 4/15/2019 3:57:00 PM Commonwealth Court of Pennsylvania
334 MD 2014

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA, By JOSH SHAPIRO, Attorney General, et al.; Petitioners, v. UPMC, A Nonprofit Corp., et al.; Respondents.	:	No. 334 M.D. 2014

NOTICE TO PLEAD

To:

Joseph S. Betsko
James A. Donahue, III
Michael T. Foerster
Jonathan S. Goldman
Keli M. Neary
Mark A. Pacella
Jennifer A. Thomson
Heather Vance-Rittman
Tracy Wright-Wertz
Pa. Office of Attorney General
Strawberry Square, 14th Floor
Harrisburg, PA 17120

Daniel I. Booker
Douglas E. Cameron
Kim M. Watterson
Jeffrey M. Weimer
Reed Smith
Reed Smith Centre
225 Fifth Avenue
Pittsburgh, PA 15222

You are hereby notified to file a written response to the enclosed **Answer with New Matter and Counterclaims to Commonwealth's Petition to Modify Consent Decrees** within twenty (20) days from service hereof or a judgment may be entered against you.

COZEN O'CONNOR

Dated: April 15, 2019

/s/ Stephen A. Cozen

Stephen A. Cozen (Pa. 03492)
Stephen A. Miller (Pa. 308590)
Jared D. Bayer (Pa. 201211)
Andrew D. Linz (Pa. 324808)

1650 Market Street, Suite 2800
Philadelphia, PA 19103
Tel.: (215) 665-2000

JONES DAY
Leon F. DeJulius, Jr. (Pa. 90383)
Rebekah B. Kcehowski (Pa. 90219)
Anderson Bailey (Pa. 206485)

500 Grant Street, Suite 4500
Pittsburgh, PA 15219
Tel.: (412) 391-3939

Attorneys for Respondent UPMC

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COMMONWEALTH OF PENNSYLVANIA, By JOSH SHAPIRO, Attorney General, et al.; Petitioners, v. UPMC, A Nonprofit Corp., et al.; Respondents.	: : : : : : : : : : : :	No. 334 M.D. 2014

ANSWER OF RESPONDENT UPMC TO COMMONWEALTH'S PETITION TO MODIFY CONSENT DECREES WITH RESPECT TO COUNT I, NEW MATTER, AND COUNTERCLAIMS[1]

Respondent UPMC, through the undersigned counsel, hereby file its Answer to Commonwealth's Petition to Modify (the "Petition"), New Matter, and Counterclaims, and in support hereof, avers as follows:

A. AS TO "INTRODUCTION"

The Petition's statements in its "Introduction" section are not well-formed averments for a pleading under Pa. R.C.P 1022, and in any case are denied. Contrary to the aspersions the Petition casts on UPMC's conduct, UPMC has acted at all relevant times in accordance with the terms of the Consent Decrees, which were designed and intended by all parties to facilitate the wind-down of its contractual relationship with Highmark. The Attorney General in 2014 embraced the terms of the Consent Decrees, including the wind-down they facilitated, as furthering the public interest. By way of further response, it is admitted only that UPMC signed the Consent Decree and that UPMC declined to agree to Attorney General Josh Shapiro's

[1] Pursuant to the Court's Scheduling Order II, UPMC submits the Answer with respect to Count I of the Petition only. This Answer is made without waiver of the arguments made and relief sought with respect to Counts II-IV of the Petition in UPMC's Motion to Dismiss or Preliminary Objections in the Nature of a Demurrer.

proposal to modify the Consent Decree. The remaining averments in this section are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations therein are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

B. AS TO "UPMC'S STATED CHARITABLE PURPOSES AND REPRESENTATIONS TO THE PUBLIC"

1. Denied. The Petition misquotes UPMC's Amended and Restated Articles of Incorporation. To the contrary, such Articles read:

> The Corporation is incorporated under the Nonprofit Corporation Law of the Commonwealth of the Pennsylvania for the following purpose or purposes: to engage in the development of human and physical resources and organizations appropriate to support the advancement of patient care through clinical and technological innovation, research and education, such activities occurring in the regional, national and international medical communities. The Corporation is organized and will be operated exclusively for charitable, educational and scientific purposes within the meaning of Section 501(c) (3) of the Internal Revenue Code of 1986, as amended (the "Code") by operating for the benefit of, to perform the functions of and to carry out the purposes of the University of Pittsburgh of the Commonwealth System of Higher Education ("University of Pittsburgh"), UPMC Presbyterian Shadyside, and other hospitals, health care organizations and health care systems which are 1) described in Sections 501(c) (3) and 509(a)(1), (2) or (3), 2) are affiliated with the Corporation, University of Pittsburgh and UPMC Presbyterian Shadyside in developing a high quality, cost effective and accessible health care system in advancing medical education and research, and 3) which will have the Corporation serving as their sole member or shareholder. Further, the Corporation provides governance and supervision to a system which consists of a number of subsidiary corporations, including, among others, both tertiary and community hospitals. The Corporation shall guide, direct, develop and support such activities as may be related to the aforedescribed purposes, as well as to the construction, purchase, ownership, maintenance, operation and leasing of one or more hospitals and related service facilities. Solely for the above purposes, and without otherwise limiting its power, the Corporation is empowered to exercise all rights and powers

> conferred by the laws of the Commonwealth of Pennsylvania upon not-for-profit corporations. The Corporation does not contemplate pecuniary gain for profit, incidental or otherwise.

The remaining averments set forth in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial.

2. Admitted in part, denied in part. It is admitted only that UPMC is a Pennsylvania nonprofit corporation, that it operates a number of subsidiary for-profit and nonprofit entities, and that it operates an integrated delivery and finance system. The remaining averments set forth in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

3. Admitted in part, denied in part. It is admitted only that UPMC and a number of its subsidiaries are charitable nonprofit entities. Some UPMC subsidiaries, however, are for-profit entities. The remaining averments set forth in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

4. Admitted in part, denied in part. It is admitted only that UPMC and a number of its subsidiaries are charitable nonprofit entities. Some UPMC subsidiaries, however, are for-profit entities. The remaining averments set forth in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

5. Admitted in part, denied in part. It is admitted only that UPMC has published a Patient Rights Statement and that a version of that Patient Rights Statement has been posted on

UPMC's website. It is specifically denied that UPMC deleted the language referring to "source of payment" from its official Patient Rights Statement. To the contrary, through administrative error, version of the Patient Rights Statement that mistakenly did not include "source of payment" was posted on UPMC's website. The remaining averments set forth in this paragraph and the footnote thereto are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

6. Admitted in part, denied in part. It is admitted only that a webpage exists that includes the quoted text. The remaining averments set forth in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

C. AS TO "PUBLIC FINANCIAL SUPPORT FOR UPMC"

7. Denied. This paragraph does not contain any factual averments to which a response is necessary. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

a) Admitted in part, denied in part. It is admitted that the Hillman Company and Hillman Family Foundations have made donations to, *inter alia*, UPMC Hillman Cancer Center. After reasonable investigation, UPMC is without knowledge or information sufficient to admit or deny the specific amounts, dates, and donees of all such donations, or whether the donors "never intended that their donations would be used to only treat patients with certain types of insurance" as alleged. Accordingly, these averments are denied and strict proof thereof is demanded at the time of trial.

b) Denied. To the contrary, while Highmark provided certain funds to the Children's Hospital of Pittsburgh, the Jameson Health System, which are now known as UPMC Children's Hospital of Pittsburgh and UPMC Jameson, respectively, and St. Francis Health System, the characterization of these funds as "donations" is misleading. In particular, Highmark loaned money to the Children's Hospital of Pittsburgh that has since been repaid. After reasonable investigation, however, UPMC is without knowledge or information sufficient to form a belief as to the truth of the remaining averments set forth in this paragraph. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

i. Denied. To the contrary, while Highmark provided funds to the Children's Hospital of Pittsburgh, the characterization of these funds as "donations" is misleading. By way of further response, Highmark made a combination of grants and loans to the Children's Hospital of Pittsburgh. The loans, which amounted to $163.6 million, have since been repaid.

ii. Denied. To the contrary, while Highmark provided funds to the Jameson Health System, the characterization of these funds as "donations" is misleading. By way of further response, Highmark provided approximately $17 million in the form of grants, loans and/or credit support for the acquisition of St. Francis Hospital of New Castle.

c) Denied. To the contrary, while Highmark has made donations to the Children's Hospital of Pittsburgh Foundation, the figure alleged is inaccurate. After reasonable investigation, UPMC is without knowledge or information sufficient to admit or deny the purpose for which these donations were made. Accordingly, these averments are denied and strict proof thereof is demanded at the time of trial.

8. Admitted in part, denied in part. It is admitted only that UPMC's IRS filings reflect the charitable contributions it has received. UPMC's Form 990 filings, being in writing, speak for themselves; all characterizations of those writings are denied.

9. Admitted in part, denied in part. It is admitted only that, as a charitable non-profit, UPMC and its subsidiaries receive applicable tax-exemptions for which they qualify. The remaining averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

10. Admitted in part, denied in part. It is admitted that UPMC has grown into one of Pennsylvania's largest healthcare providers/insurers. The remaining averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

11. Denied. It is specifically denied that any person is "being shut out of . . . care" as alleged. To the contrary, UPMC provides care to numerous Pennsylvanians, and is the largest provider of charity care in Western Pennsylvania. The remaining averments contained in this

paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

D. AS TO "HISTORY"

12. Denied. To the contrary, this case arises from the Attorney General's improper attempts to "modify" the Consent Decree. By way of further response, UPMC announced in 2011 that it would not extend certain provider contracts with Highmark because of, among other things, Highmark's announced intention to acquire West Penn Allegheny Health System ("WPAHS") and form a directly competing Integrated Delivery and Finance System (IDFS), a business plan that UPMC understood would entail Highmark having to use its insurance monopoly to move tens of thousands of patients away from UPMC into WPAHS.

13. Admitted in part, denied in part. It is admitted only that WPAHS was a competing provider system, that Highmark affiliated with WPAHS to create an IDFS, and that UPMC was already operating an IFDS.

14. Admitted in part, denied in part. It is admitted only that UPMC announced that it would not renew certain provider contracts with Highmark that were set to expire on June 30, 2012 after Highmark announced its affiliation with WPAHS. The remaining averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

15. Admitted in part, denied in part. It is admitted only that UPMC and Highmark agreed to the Mediated Agreement on or about May 1, 2012. The Mediated Agreement, being in writing, speaks for itself; all characterizations of the Mediated Agreement are denied. It is, however, admitted that "[t]he Mediated Agreement was intended to provide members of the public

with additional time, *i.e.*, until December 31, 2014, to transition insurance coverages in include the medical providers of their choice." The remaining averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

16. Denied. To the contrary, Highmark rolled out its Community Blue Health Plan after the Mediated Agreement as a vehicle to tier and steer its subscribers toward WPAHS and away from UPMC. By way of further response, although UPMC warned Highmark prior to open enrollment in 2012 not to mislead potential Community Blue subscribers into believing that they would have any access to UPMC in 2013, Highmark completely disregarded that warning and misled consumers about said access. UPMC repeatedly sought the Attorney General's intervention, as the Community Blue Plan undermined the agreement and protections in the Mediated Agreement. Furthermore, while UPMC generally refused to provide access to Highmark Community Blue subscribers, it had a clinically-led process to make, and did make, exceptions to this practice for patients based on clinical need. The dispute over Community Blue was ultimately settled by the Consent Decrees. The remaining averments contained in this paragraph and the footnote thereto are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

17. Admitted in part, denied in part. It is admitted only that Highmark engaged in aggressive and often misleading marketing campaigns which caused widespread public confusion and uncertainty. It is specifically denied that UPMC did so. To the contrary, any public confusion was caused by Highmark's implementation of the Community Blue Health Plan which was not

subject to the Mediated Agreement. By way of further response, public education about the Highmark/UPMC relationship was specifically addressed in the Consent Decrees, and UPMC paid $2 million to a Consumer Education Fund for the Commonwealth to use to cure any previous inaccuracies. Furthermore, there is no allegation of, and UPMC did not engage in, any inaccurate advertising after the Consent Decrees went into effect. The remaining averments contained in this paragraph and the footnote thereto are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

18. Admitted in part, denied in part. It is admitted only that UPMC and Highmark executed reciprocal Consent Decrees with the Commonwealth (acting through the Office of Attorney General, Pennsylvania Insurance Department, and the Pennsylvania Department of Health) that were entered by the Commonwealth Court on July 1, 2014. The balance of the averments set forth in this paragraph are denied.

19. Denied. To the contrary, since their enactment Highmark consistently ignored the terms of the Consent Decrees, which occasioned multiple enforcement actions. By way of further response, the Attorney General regularly sided with Highmark in these disputes resulting in interpretations of the Consent Decree that narrowed in-network access to UPMC providers for Highmark subscribers. The remaining averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

20. Admitted in part, denied in part. It is admitted only that in December 2017, UPMC

and Highmark entered into what the Attorney General refers to as the Second Mediated Agreement, and that this Agreement was facilitated by the Governor and the Pennsylvania Department of Insurance. The Second Mediated Agreement, being in writing, speaks for itself; all characterizations of the Second Mediated Agreement are denied.

21. Denied. The Second Mediated Agreement, being in writing, speaks for itself; all characterizations of the Second Mediated Agreement are denied.

22. Denied. It is specifically denied that UPMC "failed to ensure" that any "vulnerable member[] of the public" will "have affordable access to their health care providers." To the contrary, UPMC has consistently abided by the terms of the Consent Decree. In contrast, Highmark offered a Medicare Advantage product that did not include UPMC, Community Blue Medicare Advantage HMO, soon after the Consent Decrees were executed. Although the Attorney General sought to prevent this product from being offered to seniors, the Attorney General was denied relief by the Commonwealth Court and opted not to pursue any appeal of that ruling. Furthermore, Highmark, with the approval and support of the Attorney General, has consistently sought to limit its subscribers' in-network access to UPMC providers. The remaining averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

23. Denied. It is specifically denied that UPMC's conduct, which has been consistent with the provisions of the Consent Decrees, is "in direct conflict with UPMC's status as a charitable institution," or that UPMC will eventually "refuse to contract with other health insurers." It is further specifically denied that the expiration of Consent Decrees has any

connection to whether UPMC will "eventually" refuse to contract with other insurers. To the contrary, UPMC's refusal to extend certain provider contracts with Highmark is an outgrowth of circumstances unique to Highmark, namely Highmark's substantial financial imperative to recoup is multi-billion investment in WPAHS and other later acquired provider systems by redirecting tens of thousands of patients in Allegheny County and Erie County from UPMC's charitable assets into Highmark's struggling provider system. Patients will continue to have access to UPMC providers in those counties after the expiration of the Consent Decrees either through the many insurers that offer plans that include UPMC in-network or on an out-of-network basis. General Shapiro seeks to redefine "access" to mean "receipt of healthcare services at in-network rates," which does not mean — and has never meant — access. The averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

E. AS TO "UPMC'S DEPARTURE FROM ITS CHARITABLE PURPOSES"

The Petition's statements at the beginning of this section are not well-formed averments for a pleading under Pa. R.C.P 1022, and in any case are denied. It is specifically denied that UPMC "disfavors" any health plans, as is any implication that it seeks "private, pecuniary gain." To the contrary, UPMC has at all times acted consistent with and in furtherance of its charitable mission and nonprofit status. The remaining averments in this section are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations therein are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

As to "Disputed Payments Concerning Highmark's Out of Network Riders"

24. Denied. It is specifically denied that UPMC has "thwarted" any patients' efforts to

use their insurance. The Consent Decrees, being in writing, speak for themselves; all characterizations of the Consent Decrees are denied. By way of further response, Highmark flouted the terms and spirit of the Consent Decrees and caused all the confusion attendant with the riders, which Highmark developed and sold to customers without any prior discussion with UPMC. By way of further response, Highmark created the riders under which it promised to reimburse to its subscribers the amounts to which UPMC was entitled under the Consent Decrees, rather than pay those amounts to UPMC directly. Thus, these riders were designed to force UPMC to pursue individual patients for payments after care had already been delivered. Rather than acquiesce to that unworkable system, UPMC proposed to bill and receive payments from Highmark directly, but Highmark repeatedly refused. UPMC therefore charged out-of-network Highmark subscribers with riders in advance of care. The remaining averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

a) Denied. The averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

b) Denied. The averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are

deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

c) Denied. The averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

d) Denied. The averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

25. Denied. The averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

a) Denied. To the contrary, this is an example of a patient transitioning care as specifically contemplated by and provided for in the Consent Decree.

b) Denied. To the contrary, per the Attorney General's allegations in this subparagraph, it appears that there was a billing error that was appropriately resolved through normal administrative processes.

26. Denied. To the contrary, UPMC has at all times acted consistent with and in furtherance of its charitable mission, and the Attorney General's unfounded Petition should be

dismissed.

As to "Refusal to Contract and Practices to Increase Revenue"

27. Denied. This paragraph does not state any factual allegations; it simply speculates about the future. By way of further response, UPMC declined to renew provider contracts for Highmark's Medicare Advantage plans for certain UPMC hospitals in Allegheny and Erie Counties, such that in-network access to these hospitals for Highmark Medicare Advantage subscribers will end after June 30, 2019. Those UPMC hospitals outside of Allegheny and Erie Counties allowed their annual evergreen Medicare Advantage contracts to continue through December 31, 2019.

28. Denied. UPMC never represented "that seniors would always have In-Network access to their UPMC physicians," and the Attorney General's allegations are a gross mischaracterization of the October 27, 2014 letter the Attorney General cites. The letter actually says:

> We are writing you today with important information about this year's Medicare Advantage open enrollment.
>
> Highmark has introduced a new Medicare Advantage product called "Community Blue Medicare HMO" that excludes all of UPMC's doctors and hospitals. Choosing this product will prevent you from affordably accessing UPMC's services, ranging from the Hillman Cancer Center, to UPMC's designated National Center of Excellence in Geriatric Medicine, because all of UPMC is out-of-network for Highmark's Community Blue Medicare HMO product. Out-of-network means you could be forced to pay large medical bills to receive care from UPMC doctors and hospitals.
>
> The Commonwealth of Pennsylvania, led by the Attorney General and the Insurance Commissioner, determined that Highmark's Community Blue HMO is a "clear violation" of the Consent Decree that Highmark signed just this past summer and are suing Highmark to stop it. The Consent Decree was created to protect seniors and other patient groups and their access to UPMC.

> In addition, according to the Commonwealth, Highmark is promoting Community Blue Medicare HMO with "misleading" advertisements that will cause "misunderstanding and confusion" for seniors. Insurance brokers have also been told by the Commonwealth that selling Highmark's Community Blue HMO may violate Pennsylvania's Unfair Insurance Practice Act. These concerns are also echoed in a *Pittsburgh Post-Gazette* editorial attached to this letter.
>
> As a UPMC doctor, I appreciate the trust that patients place in us for care. We believe there is a special bond between our older patients and our entire medical staff. That's why UPMC pledged more than, three years ago that the changing relationship between Highmark and UPMC would not affect seniors. We thought that Highmark shared that commitment, but see now that it does not.
>
> During this year's Medicare open enrollment period for Medicare Advantage, you will have many options to choose from, including UPMC *for Life* and Advantra from Health America. These products will provide in-network access to all UPMC doctors and hospitals. Highmark's Community Blue Medicare HMO will not.
>
> We hope that this information is helpful and allows you to make an informed decision, during open enrollment.
>
> If you would like more information, including whether a specific UPMC doctor or hospitals is in the network of a plan you are considering, we are here to help, Please contact our toll-free Senior Info Line at 1-855-946-8762.

29. Denied. To the contrary, now that Highmark's monopolization of the health insurance market in Western Pennsylvania has been broken, there is a competitive, dynamic insurance market that offers consumers a choice of products to suit their needs, and has driven down insurance and healthcare costs. By way of further response, seniors who choose a traditional Medicare product have full in-network access to UPMC. In addition, those seniors can supplement their full in-network access to UPMC by purchasing a Medigap product, including Highmark Medigap products. Seniors opting for a Medicare Advantage product have a range of options for securing full in-network access to UPMC every fall during the Annual Enrollment Period.

30. Denied. This paragraph does not state any factual allegations; it simply speculates

about the future. By way of further response, UPMC will decide with whom to contract and on what terms in the future depending on the particular facts and circumstances of each case.

31. Denied. To the contrary, UPMC's operating practices and rate structures are appropriate; UPMC does not "employ[] practices that increase its revenue without apparent regard for the increase on the costs of the region's health care." By way of further response, the allegations of this paragraph and subparagraphs (a)-(d) were all addressed in and released by the Consent Decree.

a) Denied. To the contrary, medical procedures are performed at appropriate provider facilities.

b) Denied. To the contrary, provider-based billing is expressly allowed by federal law once a provider has undergone the extensive qualification process.

c) Denied. To the contrary, any balance billing that UPMC does is appropriate and a comparison to "actual costs of UPMC's care" for a particular procedure is not an appropriate metric because the rates and reimbursements must be set at a level sufficient to support the system as a whole (including the considerable charity and other unpaid care UPMC provides).

d) Denied. To the contrary, UPMC requires out-of-network patients to pay the estimated cost of non-emergency services in advance of providing treatment. This policy is driven largely by Highmark's refusal to pay UPMC directly for out-of-network care as well as Highmark's record as an unreliable payor.

32. Denied. UPMC does not "disfavor" health plans. To the contrary, UPMC Health Plan offers various insurance plans, and UPMC providers contract with certain health insurers.

33. Denied. The promotional flyer, being in writing, speaks for itself; all characterizations of the promotional flyer are denied.

34. Denied. The promotional flyer, being in writing, speaks for itself; all characterizations of the promotional flyer are denied.

35. Denied. The promotional flyer, being in writing, speaks for itself; all characterizations of the promotional flyer are denied.

36. Denied. It is specifically denied that the UPMC Health Plan offers insurance plans that exclude Pittsburgh UPMC facilities or "exception" facilities. The Consent Decree, being in writing, speaks for itself; all characterizations of the Consent Decree are denied. The remaining averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

As to "Access and Treatment Denials"

37. Denied. It is specifically denied that only people "who carry the right In-Network insurance card . . . get access to UPMC's health care." To the contrary, UPMC providers provide healthcare services to insured and uninsured patients at in-network and out-of-network rates, including substantial amounts of charity and other unpaid care. The remaining averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

As to "Individuals"

a) Denied. To the contrary, this is an example of a patient transitioning care as specifically contemplated by and provided for in the Consent Decree and as specifically intended by her husband's employer.

b) Denied. To the contrary, this is an example of a patient transitioning care as specifically contemplated by and provided for in the Consent Decree.

c) Denied. To the contrary, this is an example of a patient transitioning care as specifically contemplated by and provided for in the Consent Decree. By way of further response, UPMC understands that the patient, who is insured through her husband's insurance, had the option of choosing insurance through UPMC Health Plan or Highmark at comparable cost and benefits level. The patient and her husband chose Highmark.

d) Denied. To the contrary, this is an example of a patient transitioning care as specifically contemplated by and provided for in the Consent Decree.

38. Denied. PMF Industries did not have a healthcare "insurer." PMF Industries did not have any health insurance policy covering its employees or any contract with a health insurance company, nor did it have any agreement with UPMC Susquehanna to pay anything for hospital services. To the contrary, PMF Industries arranged with INDECS, a so-called "repricing company," to handle its bills from Susquehanna Medical Group. UPMC was aware from prior dealings with INDECS and its operator that whatever payment UPMC received would be arbitrary, inconsistent, and unacceptably low. It also had reason to believe INDECS was managed and run by a convicted felon and disbarred lawyer who had spent years in federal prison for embezzlement, including embezzlement from a hospital, and who is barred by law from working in the insurance industry.

a) Denied. The letter cited by the Attorney General, being in writing, speaks for itself; all characterizations of the letter are denied.

b) Denied. The letter cited by the Attorney General, being in writing, speaks for itself; all characterizations of the letter are denied.

c) Denied. The letter cited by the Attorney General, being in writing, speaks for itself; all characterizations of the letter are denied.

d) Denied. The letter cited by the Attorney General, being in writing, speaks for itself; all characterizations of the letter are denied.

e) Denied. The letter cited by the Attorney General, being in writing, speaks for itself; all characterizations of the letter are denied.

f) Denied. The letter cited by the Attorney General, being in writing, speaks for itself; all characterizations of the letter are denied.

g) Denied. The letter cited by the Attorney General, being in writing, speaks for itself; all characterizations of the letter are denied.

39. Denied. PMF Industries did not purchase health insurance for its employees and INDECS did not offer health plans, other insurance products, or "Reference Based Pricing."

40. Denied. It is specifically denied that "reference based pricing" means charging the prices "UPMC says it desires." Neither PMF Industries nor INDECS engaged in "reference based pricing," which generally refers to a consistent price charged or payment made for any specific service based on an available reference or fee schedule. By way of further response, "reference based pricing" is usually designed to significantly underpay hospitals by only offering to pay a small fraction of the hospitals' actual charges.

41. Denied. UPMC does not "reject[] efforts by employers" to use "cost comparison

tools," or "disfavor" any health plans. To the contrary, UPMC rejected an attempt by an unregulated "repricing company," which was run by a convicted felon, to arbitrarily decide what portion of UPMC's charges it would pay for services UPMC Susquehanna had already rendered.

42. Denied. This paragraph does not state any factual allegations; it simply speculates about the future. By way of further response, employers are free to select insurance plans based on the coverages and in-network providers they offer.

As to "Medicare and Older Pennsylvanians"

43. Denied. UPMC declined to renew provider contracts for Highmark's Medicare Advantage plans for certain UPMC hospitals in Allegheny and Erie Counties, such that, consistent with the Consent Decrees, in-network access to these hospitals for Highmark Medicare Advantage subscribers will end after June 30, 2019. UPMC has not decided "to not participate" in Blue Cross Blue Shield plans; to the contrary, Highmark and other members of the Blue Cross Blue Shield Association have illegally acted in concert to prevent UPMC's inclusion in the networks offered by those plans. The averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

44. Denied. This paragraph does not contain any factual averments to which a response is necessary. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

a) Denied. This paragraph does not contain any factual averments to which a response is necessary. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

b) Denied. This paragraph does not contain any factual averments to which a response is necessary. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

c) Denied. This paragraph does not contain any factual averments to which a response is necessary. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

d) Denied. This paragraph does not contain any factual averments to which a response is necessary. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

e) Denied. To the contrary, this is an example of a patient transitioning care as specifically contemplated by and provided for in the Consent Decree.

As to "Emergency"

45. Denied. The allegations of this paragraph are conclusions of law to which no response is required.

46. Admitted in part, denied in part. It is admitted only that health insurance plans are obligated to pay for UPMC emergency services received by their subscribers. After reasonable investigation, UPMC is without knowledge or information sufficient to admit or deny the specific percentage of its patients who are admitted after arriving through an emergency room for each of its hospitals. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

47. Denied. UPMC does not know whether it is "common" for patients to be taken to

emergency rooms at providers who are out of network with their insurance, but it does happen.

48. Denied. Reimbursement for emergency care provided to out of network insureds is determined according to the particular facts and circumstances and the agreements and understandings between the particular provider and insurer.

49. Denied. Reimbursement for emergency care provided to out of network insureds is determined according to the particular facts and circumstances and the agreements and understandings between the particular provider and insurer.

50. Denied. This paragraph consists of speculation and does not contain any factual averments to which a response is necessary. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

51. Denied. The averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

As to "Intent to Require All Out-of-Network Patients to Pay Up-Front and In-Full"

52. Denied. The frequently asked questions sheet upon which the allegations of this paragraph are based, being in writing, speaks for itself; all characterizations of the sheet are denied.

53. Denied. This paragraph consists of speculation and does not contain any factual averments to which a response is necessary. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

54. Denied. This paragraph consists of speculation and does not contain any factual averments to which a response is necessary. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

55. Denied. This paragraph consists of speculation and does not contain any factual

averments to which a response is necessary. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

As to "Assets, Spending and Compensation Practices/UPMC's Current Financial Success Belies Its Need to Deny Care to Anyone"

56. Denied. UPMC's financial statements, being in writing, speak for themselves; all characterizations of the financial statements are denied.

a) Denied. UPMC's financial statements, being in writing, speak for themselves; all characterizations of the financial statements are denied.

b) Denied. UPMC's financial statements, being in writing, speak for themselves; all characterizations of the financial statements are denied.

57. Denied. The averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial. By way of further response, UPMC's financial position is a product of its good stewardship of its charitable assets, and is in spite of Highmark's persistent efforts to harm UPMC. UPMC's charitable assets and ability to pursue its charitable mission are the product of its sound decisionmaking.

58. Denied. The averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial. By way of further response, UPMC incorporates the allegations of paragraph 57 hereof.

59. Denied. The averments contained in this paragraph are denied as scandalous or impertinent matter or conclusions of law to which no response is necessary and strict proof thereof

is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial. By way of further response, UPMC's executives and Board of Directors are faithful stewards of the duties, trusts, and obligations with which they are entrusted. UPMC's ability to pursue its charitable mission, which includes the disbursement of millions of dollars of public benefits through charity and unpaid healthcare services, is a function of their good governance.

60. Denied. The averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

a) Denied. UPMC's tax filings, being in writing, speak for themselves; all characterizations of the financial statements are denied. By way of further response, UPMC's executive compensation decisions take into account the recommendations of neutral, third-party compensation consultants as well as the standard practice established by peer nonprofit entities.

b) Admitted in part, denied in part. It is admitted only that UPMC's corporate offices are located in the U.S. Steel Building in Pittsburgh, PA. The balance of the allegations in this paragraph are denied.

As to "Wasteful Expenditures of Charitable Resources"

61. Denied. UPMC has at all times acted consistent with and in furtherance of its charitable mission and nonprofit status. In particular, UPMC's expansions and investments are consistent with its mission to, *inter alia*, develop human and physical resources and organizations appropriate to support the advancement of patient care through clinical and technological innovation, research, and education and to develop a high-quality, cost-effective and accessible

healthcare system.

a) Denied. This paragraph does not contain any factual averments to which a response is necessary. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

b) Denied. This paragraph does not contain any factual averments to which a response is necessary. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

c) Denied. This paragraph does not contain any factual averments to which a response is necessary. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

62. Denied. The averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

63. Denied. The averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

F. AS TO "UPMC'S EXPANSION"

The Petition's statements at the beginning of this section are not well-formed averments for a pleading under Pa. R.C.P 1022, and in any case are denied. It is specifically denied that

UPMC conduct has "negative impacts" on the public within the greater Pittsburgh area or elsewhere in Pennsylvania. To the contrary, UPMC has at all times acted consistent with and in furtherance of its charitable mission and nonprofit status.

64. Admitted in part, denied in part. It is admitted only that UPMC acquired the hospital systems described, which were in parts of the Commonwealth where UPMC did not previously have a presence. The remaining averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

a) Admitted.

b) Admitted.

c) Admitted.

d) Admitted in part, denied in part. It is admitted only that UPMC Health Plan has a relationship with Tower Health. The remaining averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

e) Admitted.

f) Admitted.

65. Admitted in part, denied in part. It is admitted only that the acquisitions described occurred. The remaining averments contained in this paragraph are denied as conclusions of law

to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

a) Admitted.

b) Admitted.

c) Admitted.

66. Admitted.

67. Denied. The cited website, being in writing, speaks for itself; all characterizations of the website are denied. By way of further response, UPMC's provider system in fact includes more than 40 hospitals, more than 700 doctor offices, and employs more than 4,900 physicians.

68. Denied. The cited website, being in writing, speaks for itself; all characterizations of the website are denied. By way of further response, UPMC's Insurance Services Division in fact covers 3.5 million members.

69. Denied. The cited website, being in writing, speaks for itself; all characterizations of the website are denied. By way of further response, UPMC is the largest non-governmental employer in Pennsylvania with 87,000 employees.

70. Denied. The averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial. By way of further response, UPMC has at all times acted, and will act in the future, consistent with and in furtherance of its charitable mission and nonprofit status. UPMC's expansions extend the reach of the charity care and public benefits it provides. In fact, UPMC's growth has preserved access to care for thousands of Pennsylvanians, including

by affiliating with a struggling community hospital that was likely to close without such assistance. Moreover, many of the transactions that contributed to UPMC's growth were reviewed and tacitly approved by the Attorney General.

G. AS TO "COUNTS"

COUNT I

71. UPMC incorporates all paragraphs of its Answer, New Matter, and Counterclaims as though fully set forth.

72. Denied. The Consent Decrees, being in writing, speak for themselves; all characterizations of the Consent Decrees are denied.

73. After reasonable investigation UPMC is without knowledge or information sufficient to form a belief as to the truth of the averments set forth in this paragraph with regard to notice to "all other parties." To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial. The remaining averments contained in this paragraph are denied as erroneous conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

a) Denied. The averments contained in this paragraph are denied as erroneous conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

b) Denied. The averments contained in this paragraph are denied as erroneous conclusions of law to which no response is necessary and strict

proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

c) Denied. The averments contained in this paragraph are denied as erroneous conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

d) Denied. The averments contained in this paragraph are denied as erroneous conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

74. Denied. The averments contained in this paragraph are denied as erroneous conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

a) Denied. The averments contained in this paragraph are denied as erroneous conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

b) Denied. The averments contained in this paragraph are denied as erroneous conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

c) Denied. The averments contained in this paragraph are denied as erroneous conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

75. Admitted in part, denied in part. It is admitted only that UPMC did not agree to the Proposed Modified Consent Decree, but Highmark apparently did, subject to UPMC's agreement. It is specifically denied that the Proposed Modified Consent Decree is necessary or appropriate, and it is denied that the Attorney General has any authority whatsoever to impose the terms of the Proposed Modified Consent Decree on UPMC.

a) Denied. The Proposed Modified Consent Decree, being in writing, speaks for itself; all characterizations of the Proposed Modified Consent Decree are denied. It is further denied that the Proposed Modified Consent Decree is necessary or appropriate, and it is denied that the Attorney General has any authority whatsoever to impose the terms of the Proposed Modified Consent Decree on UPMC.

b) Denied. The Proposed Modified Consent Decree, being in writing, speaks for itself; all characterizations of the Proposed Modified Consent Decree

are denied. It is further denied that the Proposed Modified Consent Decree is necessary or appropriate, and it is denied that the Attorney General has any authority whatsoever to impose the terms of the Proposed Modified Consent Decree on UPMC.

c) Denied. The Proposed Modified Consent Decree, being in writing, speaks for itself; all characterizations of the Proposed Modified Consent Decree are denied. It is further denied that the Proposed Modified Consent Decree is necessary or appropriate, and it is denied that the Attorney General has any authority whatsoever to impose the terms of the Proposed Modified Consent Decree on UPMC.

d) Denied. The Proposed Modified Consent Decree, being in writing, speaks for itself; all characterizations of the Proposed Modified Consent Decree are denied. It is further denied that the Proposed Modified Consent Decree is necessary or appropriate, and it is denied that the Attorney General has any authority whatsoever to impose the terms of the Proposed Modified Consent Decree on UPMC.

e) Denied. The Proposed Modified Consent Decree, being in writing, speaks for itself; all characterizations of the Proposed Modified Consent Decree are denied. It is further denied that the Proposed Modified Consent Decree is necessary or appropriate, and it is denied that the Attorney General has any authority whatsoever to impose the terms of the Proposed Modified Consent Decree on UPMC.

f) Denied. The Proposed Modified Consent Decree, being in writing, speaks for itself; all characterizations of the Proposed Modified Consent Decree are denied. It is further denied that the Proposed Modified Consent Decree is necessary or appropriate, and it is denied that the Attorney General has any authority whatsoever to impose the terms of the Proposed Modified Consent Decree on UPMC.

g) Denied. The Proposed Modified Consent Decree, being in writing, speaks for itself; all characterizations of the Proposed Modified Consent Decree are denied. It is further denied that the Proposed Modified Consent Decree is necessary or appropriate, and it is denied that the Attorney General has any authority whatsoever to impose the terms of the Proposed Modified Consent Decree on UPMC.

h) Denied. The Proposed Modified Consent Decree, being in writing, speaks for itself; all characterizations of the Proposed Modified Consent Decree are denied. It is further denied that the Proposed Modified Consent Decree is necessary or appropriate, and it is denied that the Attorney General has any authority whatsoever to impose the terms of the Proposed Modified Consent Decree on UPMC.

i) Denied. The Proposed Modified Consent Decree, being in writing, speaks for itself; all characterizations of the Proposed Modified Consent Decree are denied. It is further denied that the Proposed Modified Consent Decree is necessary or appropriate, and it is denied that the Attorney

General has any authority whatsoever to impose the terms of the Proposed Modified Consent Decree on UPMC.

j) Denied. The Proposed Modified Consent Decree, being in writing, speaks for itself; all characterizations of the Proposed Modified Consent Decree are denied. It is further denied that the Proposed Modified Consent Decree is necessary or appropriate, and it is denied that the Attorney General has any authority whatsoever to impose the terms of the Proposed Modified Consent Decree on UPMC.

k) Denied. The Proposed Modified Consent Decree, being in writing, speaks for itself; all characterizations of the Proposed Modified Consent Decree are denied. It is further denied that the Proposed Modified Consent Decree is necessary or appropriate, and it is denied that the Attorney General has any authority whatsoever to impose the terms of the Proposed Modified Consent Decree on UPMC.

l) Denied. The Proposed Modified Consent Decree, being in writing, speaks for itself; all characterizations of the Proposed Modified Consent Decree are denied. It is further denied that the Proposed Modified Consent Decree is necessary or appropriate, and it is denied that the Attorney General has any authority whatsoever to impose the terms of the Proposed Modified Consent Decree on UPMC.

m) Denied. The Proposed Modified Consent Decree, being in writing, speaks for itself; all characterizations of the Proposed Modified Consent Decree are denied. It is further denied that the Proposed Modified Consent

Decree is necessary or appropriate, and it is denied that the Attorney General has any authority whatsoever to impose the terms of the Proposed Modified Consent Decree on UPMC.

n) Denied. The Proposed Modified Consent Decree, being in writing, speaks for itself; all characterizations of the Proposed Modified Consent Decree are denied. It is further denied that the Proposed Modified Consent Decree is necessary or appropriate, and it is denied that the Attorney General has any authority whatsoever to impose the terms of the Proposed Modified Consent Decree on UPMC.

o) Denied. The Proposed Modified Consent Decree, being in writing, speaks for itself; all characterizations of the Proposed Modified Consent Decree are denied. It is further denied that the Proposed Modified Consent Decree is necessary or appropriate, and it is denied that the Attorney General has any authority whatsoever to impose the terms of the Proposed Modified Consent Decree on UPMC.

p) Denied. The Proposed Modified Consent Decree, being in writing, speaks for itself; all characterizations of the Proposed Modified Consent Decree are denied. It is further denied that the Proposed Modified Consent Decree is necessary or appropriate, and it is denied that the Attorney General has any authority whatsoever to impose the terms of the Proposed Modified Consent Decree on UPMC.

q) Denied. The Proposed Modified Consent Decree, being in writing, speaks for itself; all characterizations of the Proposed Modified Consent Decree

are denied. It is further denied that the Proposed Modified Consent Decree is necessary or appropriate, and it is denied that the Attorney General has any authority whatsoever to impose the terms of the Proposed Modified Consent Decree on UPMC.

r) Denied. The Proposed Modified Consent Decree, being in writing, speaks for itself; all characterizations of the Proposed Modified Consent Decree are denied. It is further denied that the Proposed Modified Consent Decree is necessary or appropriate, and it is denied that the Attorney General has any authority whatsoever to impose the terms of the Proposed Modified Consent Decree on UPMC.

76. Denied. The averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial. By way of further response, the terms of the Proposed Modified Consent Decree would impose a radical new, anti-competitive system of healthcare delivery on UPMC and the UPMC Health Plan, which other insurers and providers would readily abuse to their advantage. Among other things, the terms would specifically eliminate UPMC's ability to refuse to contract, would turn over control of its reimbursement rates to General Shapiro's handpicked arbitrators, and would jeopardize UPMC's charitable assets and mission.

77. Denied. The averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial. By way of further response, UPMC incorporates the

allegations of paragraph 76 hereof.

78. Denied. The averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial. By way of further response, UPMC incorporates the allegations of paragraph 76 hereof.

79. Admitted in part, denied in part. It is admitted only that the Office of Attorney General summarized the terms of the Proposed Modified Consent Decree to UPMC at a meeting on or about November 26, 2018, and that the Office of Attorney General sent UPMC the terms of the Proposed Modified Consent Decree on or about December 14, 2018. After reasonable investigation UPMC is without knowledge or information sufficient to form a belief as to the truth of the remaining averments set forth in this paragraph. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

80. After reasonable investigation UPMC is without knowledge or information sufficient to form a belief as to the truth of the averments set forth in this paragraph. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

81. Admitted in part, denied in part. It is admitted only that UPMC did not agree to the Proposed Modified Consent Decree. The remaining averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

82. Denied. The Consent Decree, being in writing, speaks for itself; all characterizations of the Consent Decree are denied.

83. Denied. The Consent Decree, being in writing, speaks for itself; all characterizations of the Consent Decree are denied.

84. Denied. The averments contained in this paragraph are denied as conclusions of law to which no response is necessary and strict proof thereof is demanded at the time of trial. To the extent the allegations are deemed factual in nature, these averments are denied and strict proof thereof is demanded at the time of trial.

WHEREFORE, UPMC respectfully requests judgment in its favor and against the Attorney General, denying the Petition and denying any modification of the Consent Decree, and awarding UPMC such other and further relief as the Court deems just and appropriate.

NEW MATTER AND COUNTERCLAIMS

UPMC hereby states the following New Matter and Counterclaims, and in support thereof, avers as follows:

INTRODUCTION

1. In 2014, UPMC, Highmark and the Commonwealth (represented by the Attorney General, Pennsylvania Department of Health ("DOH"), and Pennsylvania Insurance Department ("PID")) entered into reciprocal Consent Decrees that were designed to manage the wind-down of certain contractual relationships between UPMC and Highmark. The Consent Decrees (collectively, the "Consent Decree") provided a five-year period during which the public would have time to learn and make considered choices about their healthcare in a world where certain Highmark plans no longer included all UPMC providers in-network. Now, as that period is about to come to a close, the Attorney General seeks to transform the Consent Decree into something diametrically opposed to its original purpose, deny UPMC the benefit of its investments, and force it into a contract to which it never agreed, forever.

2. The Office of Attorney General long espoused a view diametrically opposed to the one advanced in General Shapiro's Petition. At the time the Consent Decree was entered, and for years thereafter, the Office of Attorney General maintained that the Commonwealth did not have the power to force UPMC to contract with Highmark. Accordingly, the Consent Decree was the best alternative — a vehicle for a planned transition out of the UPMC/Highmark relationship. The Office of Attorney General repeatedly endorsed the Consent Decree and sued to enforce its terms. At no point in the last five years, including in those prior suits, did it raise the prospect of the modifications General Shapiro now seeks, despite his knowledge of all the predicate facts.

3. General Shapiro's Petition is hopelessly flawed because it relies exclusively on allegations that are legally foreclosed. The prior enforcement actions bar the proposed

modifications as *res judicata*. The Office of Attorney General's prior conduct and statements, both in public and in judicial proceedings, prevent General Shapiro from seeking the proposed modifications by estoppel and in equity. And the Petition rests on claims that were released in the Consent Decree.

4. Even if the allegations in the Petition were viable, the Petition would fail because it seeks impermissible relief. Many of General Shapiro's proposed modifications are preempted by federal law. The proposed modifications are void as against public policy because they would force UPMC to violate antitrust law. And the standard General Shapiro is required to meet — that the proposed modifications are "in the public interest," is both void for vagueness and incapable of judicial determination.

5. General Shapiro's own actions also prevent him from seeking the proposed modifications. He delayed until the very eve of the Consent Decree's expiration to seek modification, despite knowing all the essential facts for years. He seeks a systemwide, in-network contract for Highmark with UPMC, but has failed to ensure Highmark's compliance with the PID's order controlling such a future contract. And most importantly, General Shapiro's actions in filing the instant Petition demonstrate that the representations made to secure UPMC's agreement to the Consent Decree were false, and fraudulent.

FACTUAL ALLEGATIONS

The UPMC-Highmark Relationship

6. UPMC is a world-renowned health care provider and insurer based in Pittsburgh, Pennsylvania that is committed to inventing new models of accountable, cost-effective, patient-centered care.

7. Beginning in late 1990s, UPMC reorganized itself as an integrated delivery and finance system ("IDFS"), a system under which it operates both healthcare providers, including

hospital and other provider systems, and the UPMC Health Plan, a healthcare insurer which offers health insurance plans to employers and individuals.

8. From its inception, UPMC annually invested millions of dollars into the UPMC Health Plain, amounting to over a billion dollars total.

9. UPMC's Insurance Services Division has grown to be the largest medical insurer in western Pennsylvania, has grown to 3.5 million members, and is leading the way with innovative health plans for virtually all segments of society that deliver better quality and lower costs.

10. Highmark is a large insurer headquartered in Pittsburgh, Pennsylvania.

The Mediated Agreement

11. In 2011, Highmark announced a "capital partnership" with West Penn Allegheny Health System ("WPAHS"), a hospital system that competed with UPMC, to create the second IDFS in Western Pennsylvania.

12. As integrated systems that would be in competition with each other, universal contracts between UPMC and Highmark no longer made sense for both parties. Accordingly, UPMC prepared to terminate its systemwide contractual relationship with Highmark.

13. The parties' split grew contentious, however, attracting the involvement of Governor Tom Corbett.

14. Concerned with the impact of an immediate termination on Pennsylvania citizens, Governor Corbett's administration negotiated a so-called "Mediated Agreement" between UPMC and Highmark in May 2012. Among other things, that Mediated Agreement provided that UPMC would continue to provide systemwide in-network access to Highmark Medicare Advantage and commercial health plan subscribers through December 31, 2014.

15. The parties acknowledged that "[t]he contractual extension until the end of 2014 will provide for sufficient and definite time for patients to make appropriate arrangements for their

care and eliminate the need for any possible government intervention under Act 94."

The Highmark-WPAHS Affiliation

16. At the time that Highmark announced its intention to combine with WPAHS, the latter was saddled with ruinous debt.

17. In the course of seeking approval for the transaction from the PID, Highmark submitted financial projections to the PID to demonstrate the future viability of a joint Highmark-WPAHS entity.

18. These financial projections were premised on the future combined entity aggressively competing with UPMC: the projections assumed both that (1) Highmark would not be in a contract with UPMC for systemwide in-network access to UPMC providers after December 31, 2014; and (2) Highmark would be able to successfully attract 41,000 unique patients largely from UPMC hospitals to WPAHS.

19. In addition, Highmark represented that WPAHS could be salvaged only if Highmark did not have contracts with UPMC.

20. Relying on Highmark's financial projections, the PID approved the Highmark/WPAHS affiliation in an Approving Decision and Order on April 29, 2013 (the "UPE Order"), attached hereto as Exhibit A. Indeed, the PID noted that its approval was premised on the continued validity of the assumptions made in Highmark's financial projections. In particular, as a condition of its approval, the PID required Highmark to submit to it detailed financial information about any future contract with UPMC, because of the threat such a contract posed to WPAHS ability to attract patients and, thereby, its future viability.

21. On information and belief, Highmark failed to comply with the conditions imposed in the UPE Order regarding a future Highmark contract with UPMC. In particular, General Shapiro did not verify whether Highmark submitted information to the PID concerning a future

Highmark-UPMC contract before filing the Petition, and to this date Highmark has not done so.

22. UPMC has made multiple efforts to clarify General Shapiro's understanding concerning Highmark's compliance with the UPE Order, including:

a) asking in a January 16, 2019 letter addressed to Executive Deputy Attorney General James A. Donahue, III, whether UPMC was mistaken in its belief that "no . . . analysis [of the impact of a future UPMC-Highmark contract] has been submitted to the Insurance Department—or even performed," which General Shapiro did not answer;

b) asserting UPMC's belief that Highmark had not complied with the UPE Order in UPMC's Motion to Dismiss the Petition, which General Shapiro did not address in his opposition thereto; and

c) requesting, in discovery, that General Shapiro admit that the required information had not been submitted to the PID in advance of filing the Petition, which General Shapiro refused to answer substantively.

23. Because UPMC knew that Highmark would have a substantial financial imperative to recoup what would be a multi-billion investment in the nearly bankrupt WPAHS by redirecting tens of thousands of patients from UPMC's charitable assets, UPMC announced that it would not renew certain of its in-network contracts with Highmark. *See* UPMC Board of Directors Resolution dated June 12, 2013, attached hereto as Exhibit B.

The Consent Decree

24. The Consent Decree arose roughly one year after the PID conditionally approved Highmark's acquisition of WPAHS.

25. As a predicate for negotiating the Consent Decree, three Commonwealth agencies — PID, DOH, and the Office of Attorney General — asserted violations of the Mediated

Agreement by both Highmark and UPMC in a June 2014 "Petition for Review." They also asserted that UPMC's actions constituted violations of the Unfair Trade Practices and Consumer Protection Law and were inconsistent with its charitable purpose. In exchange for settlement of the Petition for Review — and a release of all of the Commonwealth's claims — the Commonwealth agencies sought a further delay in the separation of Highmark and UPMC.

26. The Commonwealth made multiple allegations against UPMC in the Petition for Review, many of which reappear in General Shapiro's instant Petition. Among other things, the Commonwealth contended that:

a) UPMC's alleged failure to timely execute definitive agreements with Highmark for services that would remain in-network after December 31, 2014 had "caused confusion and uncertainty for patients and have denied the public the benefit of the smooth transition the Mediated Agreement intended" and otherwise violated Act 68. Petition for Review, attached hereto as Exhibit C, ¶¶ 52, 77;

b) UPMC's alleged decision to "forego [sic] all future contractual relationships with Highmark after December 31, 2014 violates . . . its representations set forth in its mission statement [and . . . .] its representations set forth in its 'Patients' Rights and Responsibilities that '[a] patient has the right to medical and nursing services without discrimination based upon . . . [the] source of payment[.]'" Exhibit C ¶ 55; and

c) UPMC allegedly violated the Consumer Protection Law by engaging in "unfair methods of competition and unfair or deceptive acts or practices," "willfully engag[ing] in unfair and unconscionable acts or practices . . . by

> pursuing a strategy of subjecting consumers to unfair and substantially higher 'out-of-network' charges under circumstances beyond the consumers' control. Exhibit C at 16-17.

27. Highmark and UPMC agreed to resolve the Petition for Review, but only on terms — like those in the 2012 Mediated Agreement and as acknowledged in the 2014 Petition for Review — that were again subject to a fixed expiration date, namely, June 30, 2019.

28. On June 27, 2014, UPMC and the three Commonwealth parties (the Office of Attorney General, PID, and DOH) signed the Consent Decree as a settlement of the allegations and matters at issue in the Petition for Review.

29. The parties agreed that the Consent Decree should be "interpreted consistently with" the 2013 Approving Order and the Mediated Agreement, and that "[t]he Consent Decree is not a contract extension and shall not be characterized as such." Exhibit B to the Petition at 1.

30. The Consent Decree was designed as a vehicle to resolve various disputes between and among the Commonwealth parties, Highmark and UPMC, to facilitate the end of their relationship, and to provide an unambiguous end date, after which UPMC would no longer be obligated to provide in-network access to Highmark subscribers in certain hospitals.

31. Pursuant to that end, the Consent Decree provided for a fixed termination date five years after its date of entry — June 30, 2019.

32. In exchange for UPMC's willingness to provide transitional in-network services such as continuity of care, oncology, emergency services, and otherwise unique care to Highmark subscribers for another five years, the three Commonwealth parties agreed to:

> release any and all claims [they] brought or could have brought against UPMC for violations of any laws or regulations within their respective jurisdictions including claims under laws governing non-profit corporations and charitable trusts, consumer protection laws,

> insurance laws and health laws relating to the facts alleged in the Petition for Review or encompassed with this Consent Decree for the period of July 1, 2012 to the date of filing.

Exhibit B to Petition at 14.

33. UPMC's agreement to the Consent Decree was secured by the Office of Attorney General's explicit or implicit representation that the Consent Decree: (a) would terminate, (b) was not a contract extension, (c) would not be used to force a contract extension with Highmark, and (d) was intended to facilitate the termination of UPMC's provider contracts with Highmark.

34. The Office of Attorney General proceeded to defend the Consent Decree in public testimony.

35. A few months after the Consent Decree was executed, Executive Deputy Attorney General James A. Donahue, III, who negotiated and signed the Consent Decree, testified before the Democratic Policy Committee of the Pennsylvania House of Representatives. In that testimony, Mr. Donahue defended the Commonwealth's strategy in securing the Consent Decrees with UPMC and Highmark by explaining that the Commonwealth could not force UPMC to contract with Highmark or anyone else:

> UPMC's announcement in 2011 that it would no longer contract with Highmark for a full range of services raised tremendous concern in Western Pennsylvania. The simple question we faced was could we force UPMC and Highmark to contract with each other? We concluded that we could not for several reasons. First, there is no statutory basis to make UPMC and Highmark contract with each other. There is an act, Act 94, which limits certain special corporations, health, hospital plan corporations from terminating hospital contracts; but ultimately those contracts can expire.

36. Mr. Donahue also testified that, while "price is at the heart of the dispute between Highmark and UPMC," there "is no mechanism in Pennsylvania for resolving this price dispute."

The Attorney General's Efforts to Enforce the Consent Decree

37. The Attorney General sued to enforce the Consent Decree on three occasions since 2014.

38. By filing each of these actions, the Office of Attorney General repeatedly endorsed and sought to enforce the terms of the Consent Decree as they currently exist, including its fixed termination on June 30, 2019 and UPMC's freedom not to contract with Highmark thereafter.

39. First, soon after the Decree went into effect, the Attorney General sued Highmark over its refusal to include UPMC in its Community Blue Medicare Advantage program. *See Commonwealth ex rel. Kane v. UPMC*, 129 A.3d 441, 451 (Pa. 2015). The Attorney General lost this action in the Commonwealth Court and declined to appeal it.

40. Then, in 2016, the Pennsylvania Supreme Court held that certain actions by Highmark did not trigger provisions of the Consent Decree allowing UPMC to terminate immediately its Medicare Advantage contracts with Highmark. *See Kane*, 129 A.3d at 463.

41. Finally, on November 20, 2017, General Shapiro filed an enforcement action against UPMC over the termination of Medicare Advantage contracts in 2019 (the "2018 Action"). *See Commonwealth ex rel. Shapiro v. UPMC*, 188 A.3d 1122, 1124 (Pa. 2018).

42. In 2018 Action, General Shapiro tried to force UPMC to remain in Medicare Advantage contracts with Highmark after the Consent Decree expired. General Shapiro sought to extend UPMC's obligation to remain in-network for Highmark's Medicare Advantage products beyond the June 30, 2019 end date of the Consent Decree to January 1, 2020.

43. The 2018 Action was initiated in the Pennsylvania Commonwealth Court before Judge Dan Pellegrini.

44. During the litigation before the Commonwealth Court in the 2018 Action, Judge Pellegrini held a conference with the parties in chambers. Among those in attendance were James

Donahue and Mark Pacella for the Office of Attorney General, Daniel Booker representing Highmark, Leon DeJulius, Jr. and Anderson Bailey representing UPMC, and Amy Daubert representing the Pennsylvania Department of Insurance.

45. In the course of this untranscribed conference, Judge Pellegrini questioned whether the Commonwealth intended to seek to extend the expiration date of the Consent Decree through its modification provision.

46. Counsel for the Office of Attorney General stated that it might eventually seek such a modification.

47. The Court instructed the Office of Attorney General to produce any witnesses it had in support of modification then if ever, explaining that the parties "can't come back later" to seek extension of the Consent Decree by modification.

48. General Shapiro did not produce any such witnesses or seek modification at that time.

49. The Pennsylvania Supreme Court ultimately rejected General Shapiro's attempt to extend the Consent Decree. *See Shapiro*, 188 A.3d at 1124. The Court confirmed that the Consent Decree expired on June 30, 2019, and that the Consent Decree only required UPMC to remain in its Medicare Advantage contracts with Highmark through that date. *See id.* The Court expressly rejected the Commonwealth's effort to compel UPMC's participation in the Consent Decree beyond that date. *See id.* at 1134 (finding "no basis upon which to alter [the Expiration Date], to which the parties agreed[.]").

50. All the factual allegations in the Petition involve actions or events that either took place *before* that 2018 Action or consist of UPMC's efforts to implement the June 30, 2019 termination of Medicare Advantage contracts that the Pennsylvania Supreme Court upheld in the

2018 Action.

51. The Office of Attorney General was aware of the various acts alleged in the Petition supposedly showing that UPMC failed to comply with its charitable mission or made misleading statements. UPMC's expansion and expenditures were also known to the Office of Attorney General.

52. General Shapiro could have asserted his claims based on those allegations that predated the 2018 Action when he was before the Court in the 2018 Action.

53. In particular, General Shapiro was well aware of the existence of the Consent Decree's modification provision during the 2018 Action, in which he sought the same relief he now seeks here — to extend UPMC's contract with Highmark beyond the expiration of the Consent Decree. Indeed, Judge Pellegrini specifically raised the issue of modification and told General Shapiro that he needed to proceed with a modification theory then, if ever.

The Petition to Modify Consent Decrees

54. General Shapiro filed his Petition to Modify UPMC's Consent Decree on February 7, 2019, less than five months before the Consent Decree expires, despite being aware of all the predicate facts for the Petition since at least November 20, 2017.

55. Neither PID nor DOH, who were parties to the Consent Decree, joined General Shapiro's Petition.

56. The Petition seeks, through the guise of modification, to radically rewrite the Consent Decree by, among other things, forcing UPMC to contract with Highmark or any other willing insurer at rates set by arbitrators General Shapiro selects, interfering with UPMC's ability to set the terms of its agreements by prohibiting a host of contractual terms, and binding UPMC to these unforeseen rule forever.

57. These proposed modifications are ill-conceived, unwarranted, improper, and

violate both state and federal law.

The Proposed Modifications Improperly Interfere with Medicare Advantage

58. General Shapiro's proposed modifications directly conflict with the federal Medicare Advantage ("MA") program in multiple ways. The Medicare Act, enacted as Title XVIII of the Social Security Act and codified at 42 U.S.C. §§ 1395 – 1395lll, creates a federally funded health insurance program for elderly and disabled individuals. Part C of the Act, 42 U.S.C. §§ 1395w-21 – 1395w-28, creates the MA program, through which beneficiaries may receive Medicare benefits through plans provided by private entities called MA organizations ("MAOs"). *See* 42 C.F.R. § 422.2.

59. The MA program is the subject of comprehensive federal statutory and regulatory authority. *See, e.g.*, 42 U.S.C. §§ 1395w-21 – 1395w-28; *see also* 42 C.F.R. § 422 *et seq.*

60. Congress has made clear that federal standards shall exclusively govern the MA program and preempt all state law requirements. Part C contains an express preemption clause, which states: "The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part." 42 U.S.C. § 1395w-26(b)(3).

61. The Centers for Medicare & Medicaid Services ("CMS"), the federal agency that oversees the MA program, has confirmed the broad scope of federal preemption: "[A]ll State standards, including those established through case law, are preempted to the extent that they specifically would regulate MA plans, with exceptions of State licensing and solvency laws." 70 Fed. Reg. 4665.

62. Federal law for the MA program preempts the proposed modifications in at least the following ways.

63. *First*, General Shapiro's proposed modifications would wrongly impose forced

contracting and rate structures on UPMC. *See* Exhibit G to the Petition ¶¶ 3.2–3.3.

64. In the interest of fostering competition as an integral part of the MA program, Congress enacted a "noninterference" provision, which states:

> Noninterference. In order to promote competition under this part and part D of this subchapter and in carrying out such parts, the Secretary may not require any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services under this subchapter or require a particular price structure for payment under such a contract to the extent consistent with the Secretary's authority under this part.

42 U.S.C. § 1395w-24(a)(6)(B)(iii); see also 42 C.F.R. § 422.256(a)(2).

65. Nonprofit MAOs and healthcare providers thus have the freedom to negotiate their own price structures, decide not to enter a particular payer-provider contract at all, or decide to terminate a payer-provider contract.

66. General Shapiro's proposed modifications would violate these rights. They would force UPMC, as a nonprofit provider and insurer to enter into involuntary MA contracts.

67. And, where the parties cannot agree on rates, General Shapiro's proposed modifications would force UPMC to adopt a specific price structure in the form of rates set according to specified arbitration procedures.

68. General Shapiro is also wrongly imposing a particular price structure on UPMC by prohibiting "provider-based billing." *See* Exhibit G to the Petition ¶ 3.4.5.

69. Provider-based billing generally refers to the exercise of a right under federal regulations that permit providers that meet specific criteria to bill a facility fee for services to MA enrollees. *See generally* 42 C.F.R. § 413.65. This kind of facility fee is common throughout the healthcare industry and represents, for instance, a hospital's cost of providing the facilities and equipment when a patient sees a doctor in a location owned by the hospital.

70. General Shapiro's proposed modifications would bar UPMC's nonprofit providers

from charging this fee, regardless of whether the provider meets the federally mandated criteria. In effect, General Shapiro would prevent UPMC from recovering the full cost of providing MA services, notwithstanding federal law that allows it to do so.

71. Section 413.65 and the noninterference provision's prohibition on imposing a particular price structure bar General Shapiro from precluding provider-based billing among Pennsylvania nonprofit healthcare providers.

72. *Second*, General Shapiro's proposed modifications would wrongly impose specific rates on services to out-of-network MA patients. *See* Exhibit G to the Petition ¶ 3.5.

73. Congress has established the amount to be accepted as payment in full for authorized services and emergency services to out-of-network MA patients. That amount is the reimbursement that would be available if the patient were enrolled in traditional Medicare. *See* 42 U.S.C. § 1395w-22(k)(1). No state court or actor, including General Shapiro, can supplant those determinations with its own assessment of what the public interest requires.

74. Federal law preempts General Shapiro from imposing a different amount for services to out-of-network MA enrollees.

75. *Third*, General Shapiro's proposed modifications would interfere with CMS's exclusive purview to regulate advertising for MA plans. *See* Exhibit G to the Petition ¶ 3.10.

76. Nonprofit MAOs that offer MA plans must submit proposed advertising to CMS for the agency's review. Under 42 U.S.C. §1395w-21(h)(2), any marketing material which is "materially inaccurate or misleading or otherwise makes a material misrepresentation" shall be disapproved by CMS.

77. Courts have broadly held that this review process and the MA program's express preemption provision bar states from imposing their own standards on the accuracy of advertising

for MA plans. *See, e.g.*, *Commonwealth v. UPMC*, No. 334 MD 2014 (Oct. 30, 2014); *see also Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134, 1152, 1157 (9th Cir. 2010); *Morrison v. Health Plan of Nev.*, 328 P.3d 1165, 1170 (Nev. 2014).

78. General Shapiro is preempted from regulating the accuracy of advertising for MA plans.

The Proposed Modifications Discriminate Between Insurers Operating on ACA Exchanges

79. The Affordable Care Act ("ACA") also preempts General Shapiro's proposed modifications.

80. The ACA contains an express preemption clause, pursuant to which any state regulatory actions "that 'hinder or impede' the implementation of the ACA run afoul of the Supremacy Clause." *St. Louis Effort for AIDS v. Huff*, 782 F.3d 1016, 1022 (8th Cir. 2015) (applying 42 U.S.C. § 18041(d)).

81. Among other things, the ACA created health insurance exchanges in all 50 states. These exchanges are thoroughly regulated, largely online marketplaces, where individuals and small businesses can purchase private insurance plans. The exchange in Pennsylvania is administered by the federal government.

82. The ACA requires health plans to prove each year that they meet a detailed set of requirements, including but not limited to requirements with respect to benefits, network adequacy and rating. The ACA's requirements ensure that the plans all meet the same standards, and to protect the consistency of those standards, the ACA prohibits states from imposing regulations on some health plans that it does not impose on others. 42 U.S.C. § 18012 requires that any state "standard or requirement" for health plans offering insurance products "shall be applied uniformly to all health plans in each insurance market to which the standard and requirements apply."

83. General Shapiro's proposed modifications would violate Section 18012 — and are preempted pursuant to Section 18041(d) — because they would impose different regulatory requirements for some health plans than for others.

84. Specifically, under General Shapiro's proposed modifications, the UPMC Health Plan would incur the cost and harm associated with compulsory provider contracting and transfer of ultimate control over rates from the plan and its actuaries to a private arbitration panel. For-profit competitors offering substantially similar plans, however, are exempt from General Shapiro's new rules and free to manage their networks and establish rates as they see fit.

85. The ACA intended a level playing field for all insurers when designing and setting premiums for health plans to be offered on the exchanges. Section 18012 preempts General Shapiro's proposed disparate treatment of nonprofit insurers offering products in the ACA marketplaces.

The Proposed Modifications Interfere with Employer-Sponsored Health Plans Regulated by ERISA

86. The Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, is a comprehensive federal statutory and regulatory scheme that governs, inter alia, the administration of "self-insured" health plans, i.e., health plans that are administered by insurers but in which an employer assumes the financial risk of providing health care benefits to its employees.

87. Congress has made clear that the federal standards of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." 29 U.S.C. § 1144(a).

88. "State law" includes "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State." *Id.* § 1144(c)(1). The definition of "State" includes "a

State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans . . . ." *Id.* § 1144(c)(2).

89. General Shapiro's assertion of control over UPMC extends to employee benefit plans and constitutes regulation of the benefit structure and administration of self-insured plans. Specifically, his proposed modifications would force UPMC Health Plan to contract with all willing providers; submit to an arbitration process to establish rates in the event that rates cannot be privately determined; and forgo specific contract terms.

90. General Shapiro's proposed modifications do not carve out any exceptions for self-insured benefit plans. That is, there is no indication that employers or third-party administrators can preclude certain providers from their networks and thus structure benefit plans around preferred provider arrangements. General Shapiro's proposed modifications are therefore preempted. *See, e.g.*, *Kentucky Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 366 (6th Cir. 2000) (finding that all willing provider laws cannot be enforced "against the employer who has a self-insured ERISA plan nor against the administrator of such a plan").

91. General Shapiro's interference would also impose a significant and detrimental economic impact on these plans, which is another basis to find that his rules are preempted under ERISA.

92. General Shapiro's proposed modifications would further violate ERISA by disrupting the uniformity that Congress, through ERISA, sought to achieve across states related to employee benefit plans and employer conduct. UPMC Benefit Management Services, Inc., a part of UPMC's insurance arm, administers self-insured health plans in multiple states, including Pennsylvania. General Shapiro's Pennsylvania-specific regulatory requirements would require

UPMC Benefit Management Services, Inc. to tailor its plans to the peculiarities of each jurisdiction, in contravention of the letter and intent of ERISA.

93. ERISA preempts General Shapiro's interference with administration of self-insured health plans. ERISA's "savings clause" does not exempt General Shapiro from preemption. That clause does not apply, both on its face and pursuant to ERISA's "deemer clause," 29 U.S. Code § 1142(b)(2)(b).

The Proposed Modifications Deny UPMC the Benefit of Its Investments

94. The U.S. and Pennsylvania Constitutions both prohibit the Commonwealth's seizure of private property without compensation.

95. The federal Constitution provides that "[n]o person shall be . . . deprived of . . . property, without due process of law; nor shall private property be taken for public use, without just compensation." U.S. Const. amend. V.

96. Similarly, the Pennsylvania Constitution commands that "private property [shall not] be taken or applied to public use, without authority of law and without just compensation being first made or secured." Pa. Const. art. I, § 10.

97. While the classic example of an unconstitutional taking involves the direct, physical seizure of property, the government also runs afoul of the Takings Clauses when it "goes too far" in regulating private property. *Lingle v. Chevron U.S.A. Inc.*, 544 U.S. 528, 537 (2005) (quoting *Pa. Coal Co. v. Mahon*, 260 U.S. 393, 415 (1922)). These regulatory takings are equally "compensable under the Fifth Amendment," and are equally subject to constitutional scrutiny. *Id.*

98. UPMC structured its business affairs and contractual relationships against the background of the competitive American healthcare system. Its business model, which is premised upon that competitive, market-based system, is the product of decades of investment in the highest level of medical, research, and administrative talent.

99. UPMC's investment in its business, the contractual agreements that create and regulate its integrated healthcare network, and its investment in opening and maintaining federally compliant facilities all constitute protected property interests.

100. These property interests are protected by the Fifth Amendment and its Pennsylvania counterpart.

101. All of these property interests would be compromised by the proposed modifications General Shapiro seeks to impose.

102. In addition to its extensive healthcare provider network, UPMC made a substantial investment in creating the UPMC Health Plan. The UPMC Health Plan is a health insurance option for consumers separate and distinct from UPMC's provider business.

103. Like any health insurance plan, the Plan charges premiums, pools and distributes the health risks of its beneficiaries, and pays for the covered health services incurred by its beneficiaries.

104. Since the late 1990s, UPMC has invested over a billion dollars in the creation of the UPMC Health Plan and other components of the insurance side of its IDFS.

105. These investments create constitutionally protected property interests that would be subject to regulatory takings if General Shapiro imposes his proposed modifications.

106. The UPMC Health Plan and UPMC's provider systems work together to achieve efficiencies, compete more effectively with other plans and provider networks, and create increased value for both businesses.

107. General Shapiro's proposed modifications would greatly impair this value by imposing a radical new anti-competitive system on both UPMC's provider side and the UPMC Health Plan, thereby denying UPMC the valuable use of its property.

108. General Shapiro's proposed modifications would also prohibit provider-based billing.

109. UPMC has also made significant investments in opening and maintaining its facilities — the buildings, equipment, and physical infrastructure necessary to provide healthcare services to patients — in compliance with federal standards for provider-based billing. Under federal regulations, healthcare providers with facilities that comply with extensive enumerated criteria can charge facility fees for services to patients on Medicare Advantage plans. *See, e.g.*, 42 C.F.R. § 413.65 (listing criteria for provider-based status and permitting provider-based billing).

110. These fees serve to offset the substantial costs a provider must incur to establish and maintain the infrastructure to provide healthcare services effectively.

111. Not only would General Shapiro's proposed modifications interfere with UPMC's valuable use of its real estate, fixtures, and personal property, they would also interfere with its property rights in the fees to which UPMC is entitled under federal law and its contracts with Medicare Advantage plans. General Shapiro's proposed modifications would prohibit provider-based billing in contracts with commercial plans as well.

112. General Shapiro's proposed modifications are also an attack on UPMC's property interest in the Consent Decree currently in effect.

113. The U.S. Supreme Court has long held that valid contracts are, themselves, property. *See Lynch v. United States*, 292 U.S. 571, 579 (1934); *see also Corman*, 74 A.3d at 1168 (Pa. Commw. Ct. 2013) (endorsing this settled proposition). In particular, a consent decree is the property of its parties because it "is 'in essence a contract binding the parties thereto.'" *Corman*, 74 A.3d at 1168 (quoting *Commonwealth v. U.S. Steel Corp.*, 325 A.2d 324, 328 (Pa. Commw. Ct. 1974).

114. Consequently, UPMC "owns" the protections of the Consent Decree through June 30, 2019.

115. The terms of General Shapiro's proposed modifications would compromise each of these property interests.

116. The proposed modifications would reduce the value UPMC could realize from the UPMC Health Plan, in which UPMC has invested over a billion dollars.

117. General Shapiro's proposed modifications would also prohibit the collection of facility fees through provider-based billing.

118. Finally, imposition of the terms of the proposed modifications would so radically alter the existing Consent Decree as to almost completely destroy it.

119. UPMC relied on the existing Consent Decree to order its affairs for almost five years. The sudden conversion of that existing Consent Decree into a perpetual mandate to be the only socialized healthcare provider in the Commonwealth is an improper seizure of UPMC's property interest in the Consent Decree through June 30, 2019.

The Proposed Modifications Force UPMC to Violate Antitrust Law

120. The terms of General Shapiro's proposed modifications would require UPMC to engage in anticompetitive behavior and restraints of trade in violation of antitrust law.

121. General Shapiro's proposed modifications would force UPMC to participate in violations of antitrust law because the forced contracts it would have to enter, at privately arbitrated rates, would create anticompetitive restraints of trade.

122. Section 1 of the federal Sherman Act forbids unreasonable restraints of trade injurious to competition. *See, e.g.*, *In re Ins. Brokerage Antitrust Litig.*, 618 F.3d 300, 314-15 (3d Cir. 2010).

123. Agreements that facilitate coordination, which include the compelled contracts

General Shapiro would impose on UPMC, violate the antitrust laws as injurious to competition. *See, e.g.*, *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1087-88 (N.D. Ill. 2012) (holding that coordination among market participants "is an example of the dangers of collusion that the antitrust laws seek to prevent" and rejecting transaction due to increased risk of "coordinated conduct in the relevant market," especially once "communication becomes easier and more effective"); *FTC v. CCC Holdings*, 605 F. Supp. 2d 26, 65-67 (D.D.C. 2009) (finding structural factors, including transparent pricing throughout the industry, facilitated possibility of coordinated interaction); *United States v. H & R Block, Inc.*, 833 F. Supp. 2d 36, 77-78 (D.D.C. 2011) (increased coordination reduces innovative pricing and products).

124. General Shapiro's proposed modifications would *require* that the private arbitration panel follow coordinated pricing when forcing contracts between insurers and providers. *See* Exhibit G to Petition §§ 4.3.4.1, 4.3.4.2, 4.3.4.6 (requiring arbitration panel to consider, *inter alia*, the "existing contract or contracts . . . between [the p]arties," "prices paid for comparable services by other Health Plans and/or accepted by other Health care Providers of similar size and clinical complexity within the community," and the "weighted average rates of other area hospitals of similar size and clinical complexity . . . .").

125. General Shapiro's proposed modifications would demand that all market prices be publicly known, that proposals should be in line with others' pricing strategies, and that a contract *must* result from such proposals. *See* Exhibit G to Petition § 3.4.2 (prohibiting any "Gag Clause, practice, term or condition"). This guarantees, by design, that UPMC will be forced to participate in the same problematic anticompetitive effects that can occur in the merger context. *See OSF*, 852 F. Supp. 2d at 1087-88; *CCC*, 605 F. Supp. 2d at 65-67; *H&R Block*, 833 F. Supp. 2d at 77-78.

126. Under the new "system" created by General Shapiro's proposed modifications, healthcare contractors would be incentivized to offer coordinated pricing or other terms free from competitive pressure, which is precisely what the antitrust law condemns as harmful to competition and consumers.

127. Moreover, the conduct compelled by General Shapiro's proposed modifications would not be immune from antitrust liability on the basis of state action because they depend on a system of privately selected arbitrators forcing contracts.

128. The proposed modifications would also force UPMC to enter into agreements with insurers that they would have been unable to secure on the open market, guaranteeing its participation in a plethora of anticompetitive effects and harms to competition.

129. Requiring private parties to be in a position in which they would not have found themselves on the open market is bad economics, bad policy, and violates the law prohibiting such unreasonable restraints of trade. *See* Phillip E. Areeda & Herbert Hovenkamp, Antitrust Law ¶¶ 100 (3d and 4th Eds. 2018) ("[T]he principal objective of antitrust policy is to maximize consumer welfare by encouraging firms to behave competitively while yet permitting them to take advantage of every available economy that comes from internal or jointly created production efficiencies, or from innovation producing new processes or new or improved products.").

130. In fact, the Third Circuit Court of Appeals articulated these concepts in a case that involved some of the parties to the Petition. Before it was acquired by Highmark, WPAHS attacked the reimbursement contracts between UPMC and Highmark as unreasonable restraints of trade that injured WPAHS, because of allegedly lower reimbursement rates to WPAHS. *West Penn Allegheny Health Sys., Inc. v. UPMC, et al.*, 627 F.3d 85, 101-05 (3d Cir. 2010). In finding that such agreements between UPMC and Highmark alleged an unreasonable restraint of trade, the

Third Circuit held:

> [U]nlike independent action, concerted activity inherently is fraught with anticompetitive risk insofar as it deprives the marketplace of independent centers of decisionmaking that competition assumes and demands. . . . Such shortchanging poses competitive threats similar to those posed by conspiracies among buyers to fix prices, . . . and other restraints that result in artificially depressed payments to suppliers — namely, suboptimal output, reduced quality, allocative inefficiencies, and (given the reductions in output) higher prices for consumers in the long run.

Id. at 103-04.

131. The forced contracting demanded by General Shapiro would guarantee the "suboptimal output, reduced quality, allocative inefficiencies, and . . . higher prices for consumers in the long run" that were merely alleged in the *West Penn* case. *Id.* at 104.

132. The Petition seeks to compel UPMC to break the law because General Shapiro's proposed modifications would require it to operate in restraint of trade and violate antitrust law. The Court cannot impose such a contract.

133. To do would be to force UPMC into a contract "which cannot be performed without violation of . . . a provision [of a statute]," which would therefore be "illegal and void." *Dev. Fin. Corp. v. Alpha Hous. & Health Care, Inc.*, 54 F.3d 156, 163 (3d Cir. 1995) (quoting *Am. Ass'n of Meat Processors v. Casualty Reciprocal Exch.*, 588 A.2d 491, 495 (Pa. 1991)).

134. Thus, even if the modifications were imposed, General Shapiro could not enforce them.

General Shapiro Filed Allegations Devoid of Evidentiary Support, Without Basis in Existing Law, and for an Improper Purpose

135. General Shapiro's claim for modification of the Consent Decree rests on allegations that have no evidentiary support whatsoever and an assertion of his authority that has no basis in law.

136. *First*, General Shapiro is aware that he is without authority to force UPMC to contract against its will through modification or any other method, because members of his Office previously admitted that the Attorney General has no such authority.

137. The basic premise of the Petition and the proposed modifications it seeks to impose is to force UPMC hospitals to enter into contracts with Highmark (and every other willing payor) and to force the UPMC Health Plan to enter into contracts with any willing provider at rates and on terms determined by outside arbitrators, or to impose this regime by requiring UPMC to provide healthcare services to everyone, regardless of whether there is a provider contract, at in-network rates.

138. However, the Office of Attorney General has specifically admitted that it has no legal authority to force UPMC to contract with Highmark. That lack of authority was the basis for negotiating the Consent Decree in the first instance.

139. The Office of Attorney General specifically confirmed this lack of authority in testimony before the Democratic Policy Committee of the Pennsylvania House of Representatives on October 10, 2014.

140. In that testimony, the Office of Attorney General defended the Commonwealth's strategy in securing the Consent Decrees with UPMC and Highmark by explaining that the Commonwealth could not force UPMC to contract with Highmark or anyone else. Executive Deputy Attorney General James A. Donahue, III testified that the Office of Attorney General evaluated whether it could "force UPMC and Highmark to contract with each other," and "concluded that we could not" because "there is no statutory basis to make UPMC and Highmark contract with each other."

141. UPMC called this testimony to General Shapiro's attention on January 31, 2019, a

week before he filed the Petition.

142. General Shapiro did not respond to UPMC's notice regarding this testimony before filing the Petition.

143. *Second*, General Shapiro is aware that the core allegations in the Petition were released in the Consent Decree.

144. As noted above, the Consent Decree comprehensively addressed the wind-down and eventual termination of the UPMC/Highmark relationship, and "release[d] any and all claims the [Attorney General], PID or DOH brought or could have brought against UPMC for violations of any laws or regulations within their respective jurisdictions, including claims under laws governing non-profit corporations and charitable trusts, consumer protection laws, insurance laws and health laws relating to the facts alleged in the Petition for Review or encompassed within this Consent Decree for the period of July 1, 2012 to the date of filing." Exhibit B to the Petition, § IV.C.5.

145. The Petition nonetheless rests almost entirely on a recitation of clearly released allegations, including:

a) Allegedly misleading marketing campaigns regarding access to UPMC physicians for Highmark subscribers, which occurred in the course of the Community Blue dispute. *See* Petition ¶ 17. The Consent Decree expressly resolved and addressed this by requiring UPMC and Highmark to jointly pay into a Consumer Education Fund for the Commonwealth to inform consumers about the end of the UPMC/Highmark relationship. Exhibit B to Petition § IV.B.

b) The compensation of UPMC's executives and location of its headquarters, both of which were in place long before the Consent Decree went into effect on July 1, 2014. *See* Petition ¶ 60.

c) Various, allegedly revenue-increasing practices — including transferring procedures to specialty providers, charging provider-based fees, and charging Out-of-Network patients for the unreimbursed balance of the services they receive — all of which predated, and were specifically addressed by, the Consent Decree. *See* Petition ¶ 31; Exhibit B to Petition §§ IV.A.8 (regulating transfer of patients), IV.A.3 & IV.A.4 (regulating balance billing), & IV.C.1 (setting a schedule of billing rates in the absence of a negotiated rate).

d) Most importantly, UPMC's refusal to contract with Highmark to provide In-Network access to Highmark subscribers. *See* Petition ¶¶ 27-29, 106, 107, 117, 119.c. The Consent Decree and the Mediated Agreement that predated it were occasioned by UPMC's decision to terminate its relationship with Highmark. The Consent Decree was put in place to implement the separation over time — UPMC's efforts to initiate that separation necessarily preceded and were covered in the Consent Decree.

146. The Petition fails to mention or account for the release provision in the Consent Decree.

147. *Third*, General Shapiro is aware that the allegations in the Petition surrounding UPMC Susquehanna have no evidentiary basis.

148. The Petition alleges a sequence of events involving UPMC Susquehanna, PMF

Industries (also referred to as "a Williamsport area manufacturing business"), and PMF's unnamed "insurer." Petition ¶ 38.

149. It proceeds to allege that PMF "purchase[s] health insurance" for its employees from this "insurer," which in turn tries to contract with providers for "Reference Based Pricing."

150. In fact, as General Shapiro is aware, PMF's "insurer," INDECS, is not an insurer at all, but rather a self-styled "third-party administrator" that does not engage in reference-based pricing. It instead arbitrarily decides on an ad hoc basis how much to pay for a service already rendered to a patient without any reference to the hospital's charge, Medicare/Medicaid rates, or any other published rate schedule. It is moreover operated by a convicted felon and has been sanctioned for misconduct in both New Jersey and New York.

151. *Fourth*, General Shapiro is aware that the allegations regarding out-of-area Blue Cross Blue Shield companies are not true.

152. The Petition alleges that UPMC "deci[ded] to not participate" in the networks of out-of-area Blue Cross Blue Shield companies.

153. As General Shapiro knows, this allegation is false.

154. In fact, UPMC has repeatedly offered to enter into full in-network provider contracts with these out-of-area Blue Cross Blue Shield companies, but they have refused to contract with UPMC because of the Blue Cross Blue Shield Association's illegal and anticompetitive market allocation rules for its affiliated companies, which are enforced in Western Pennsylvania by Highmark. These rules preclude out-of-area Blue Cross Blue Shield companies from contracting with UPMC.

155. UPMC is currently seeking an injunction in the U.S. District Court for the Northern District of Alabama against enforcement of those rules, which have been declared *per se* violations

of the Sherman Act.

156. General Shapiro is aware of the Alabama litigation.

157. *Fifth*, the Office of Attorney General reviewed and did not object to transactions that contributed to UPMC's expansion, which General Shapiro now claims will allegedly harm patients.

158. The Petition alleges that "[t]he effects on the public of UPMC's conduct were previously limited to the greater Pittsburgh area[, but] with its expansion across the Commonwealth, even more patients will experience these negative impacts," Petition at 35, and that "its potential to deny care or increase costs will impact thousands more Pennsylvanians," Petition ¶ 70.

159. As General Shapiro knows, however, the refusal of certain UPMC hospitals to contract with Highmark is and always has been limited to Allegheny and Erie Counties, where Highmark owns and operates a competing hospital system, and thus does not extend to hospitals outside of those areas.

160. Moreover, the Office of Attorney General reviewed each of these transactions (up to and including the transaction with Somerset Hospital, which closed on February 1, 2019) for compliance with both charitable trust law and antitrust law and, with the exception of Jameson Health System, made no objection. In the case of UPMC Jameson, the Office of Attorney General litigated its objections and lost.

NEW MATTER AFFIRMATIVE DEFENSES

161. UPMC incorporates all paragraphs of this Answer, New Matter, and Counterclaims as though fully set forth herein.

162. The Petition fails to state a claim upon which relief can be granted.

163. The modifications sought in Count I of the Petition are preempted by federal law,

including the Medicare Act, 42 U.S.C. § 1395 *et seq.*, the Affordable Care Act, 42 U.S.C. § 18012, the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.*, and controlling federal regulations.

164. General Shapiro is judicially estopped from seeking the modifications sought in Count I of the Petition.

165. General Shapiro is equitably estopped from seeking the modifications sought in Count I of the Petition.

166. General Shapiro is barred by *res judicata* from seeking the modifications sought in Count I of the Petition.

167. General Shapiro is barred by claim preclusion from seeking the modifications sought in Count I of the Petition.

168. General Shapiro is barred by issue preclusion from seeking the modifications sought in Count I of the Petition.

169. General Shapiro is barred by law of the case from seeking the modifications sought in Count I of the Petition.

170. General Shapiro is barred by the release provision of the Consent Decrees from seeking the modifications sought in Count I of the Petition.

171. General Shapiro failed to join indispensable parties in bringing the Petition.

172. The modifications sought in Count I of the Petition would be unenforceable for illegality, as they would force UPMC to violate state and federal antitrust law.

173. General Shapiro is barred by laches from seeking the modifications sought in Count I of the Petition.

174. General Shapiro is barred by unclean hands from seeking the modifications sought

in Count I of the Petition.

175. The modifications sought in Count I of the Petition are barred by failure of a condition precedent, in particular, the failure to comply with the conditions imposed by the UPE Order, including but not limited to ¶ 22 thereof.

176. The modifications sought in Count I of the Petition are barred by fraud.

177. General Shapiro is barred by his acquiescence in the termination of the Consent Decree from seeking the modifications sought in Count I of the Petition.

178. Whether the modifications sought in Count I of the Petition are "in the public interest" is a political and/or legislative question not suitable for judicial determination.

179. The modification clause of the Consent Decree is unenforceable and void for vagueness.

WHEREFORE, UPMC respectfully requests judgment in its favor and against the Attorney General, denying the Petition and denying any modification of the Consent Decree, and awarding UPMC such other and further relief as the Court deems just and appropriate.

COUNTERCLAIMS

COUNTERCLAIM COUNT I – FRAUD IN THE INDUCEMENT

180. UPMC incorporates all paragraphs of this Answer, New Matter, and Counterclaims as though fully set forth herein.

181. The central purpose of the Consent Decree was to facilitate the unwinding of UPMC's contractual relationship with Highmark.

182. The intent and understanding of the parties at the time the Consent Decree was negotiated was to achieve that central purpose.

183. The Office of Attorney General made the following explicit or implicit representations concerning the Consent Decree before or during the negotiations:

a) the Consent Decree would terminate;

b) the Consent Decree was not a contract extension;

c) the Consent Decree would not be used to force a contract extension with Highmark;

d) the Consent Decree released the Attorney General's claims against UPMC related to its decision not to extend provider contracts with Highmark; and/or

e) the Consent Decree was intended to facilitate the termination of UPMC's provider contracts with Highmark.

184. These representations were material to the negotiation of the Consent Decree, to UPMC's understanding of the scope of the modification provision thereto, and to UPMC's agreement to be bound by the Decree.

185. These representations were false, as exemplified by the relief General Shapiro seeks in his proposed modifications.

186. On information and belief, the Office of Attorney General knew these representations to be false or made the representations with reckless disregard for their truth or falsity.

187. On information and belief, the Office of Attorney General intended these representations to induce UPMC's reliance, and knew that UPMC would not have agreed to the Consent Decree if it had known the Decree would be used to subject it to a permanent contract with Highmark or any other interested insurer.

188. UPMC justifiably relied on these false representations in agreeing to be bound by the Consent Decree and, in particular, the modification clause thereof.

189. UPMC's agreement to the Consent Decree and its modification clause, which were secured by the Office of Attorney General's false representations, caused its injury in that it is now exposed to, and must defend the instant litigation. Moreover, that litigation seeks to impose proposed "modifications" that would be ruinous to UPMC's business and would compromise its freedom not to contract, forever.

WHEREFORE, UPMC respectfully requests judgment in its favor and against the Attorney General, denying any modification of the Consent Decree, granting rescission of the Consent Decree as fraudulently obtained, awarding UPMC restitution of all funds UPMC paid in the course of entering and performing under the Consent Decree, included but not limited to the $2,000,000 UPMC contributed to the Consumer Education Fund, awarding UPMC compensatory damages, and awarding UPMC such other and further relief as the Court deems just and appropriate.

COUNTERCLAIM COUNT II – DECLARATORY JUDGMENT/ UNCONSTITUTIONAL TAKING

190. UPMC incorporates all paragraphs of this Answer, New Matter, and Counterclaims as though fully set forth herein.

191. This is a claim for declaratory relief pursuant to 42 Pa. C.S.A. § 7531, *et seq.* and Pa. R.C.P. 1601.

192. UPMC has protected property interests in its provider business, the UPMC Health Plan and its associated insurer business, the contractual agreements that create and regulate its integrated healthcare network, its investment in opening and maintaining federally compliant facilities, and the confidential business information it generates and relies upon to operate that network all constitute protected property interests.

193. UPMC also has a protected property interest in the existing Consent Decree,

including the termination provision that caused the Decree to expire on June 30, 2019.

194. The proposed modifications sought in Count I of the Petition would have a significant detrimental economic impact on UPMC by denying it the valuable use of those property interests.

195. The proposed modifications would also significantly interfere with UPMC's investment-backed expectations concerning the rules under which it operates.

196. In particular, the proposed modifications would (a) prohibit the sharing of confidential business information between the provider and insurance arms of UPMC's IDFS, (b) prohibit UPMC from charging provider- or facility-based fees to which it is entitled under federal law, (c) reduce the value UPMC could realize from the UPMC Health Plan, (d) remove all UPMC's control over the rates at which it is reimbursed for healthcare services, and (e) "modify" the Consent Decree out of existence.

197. The proposed modifications do not provide any compensation to UPMC for these injuries to UPMC's property interests.

198. Consequently, if imposed, General Shapiro's proposed modifications would be an unconstitutional regulatory taking without just compensation in violation of the Fifth Amendment to the U.S. Constitution and Article I, Section 10 of the Pennsylvania Constitution.

WHEREFORE, UPMC respectfully requests judgment in its favor and against the Attorney General, declaring that the Proposed Modified Consent Decree, if imposed by this Court, would effectuate an unconstitutional taking without compensation, and awarding UPMC such other and further relief as the Court deems just and appropriate.

Dated: April 15, 2019

Respectfully submitted,

COZEN O'CONNOR

/s/ Stephen A. Cozen

Stephen A. Cozen (Pa. 03492)
Stephen A. Miller (Pa. 308590)
Jared D. Bayer (Pa. 201211)
Andrew D. Linz (Pa. 324808)

1650 Market Street, Suite 2800
Philadelphia, PA 19103
Tel.: (215) 665-2000

JONES DAY
Leon F. DeJulius, Jr. (Pa. 90383)
Rebekah B. Kcehowski (Pa. 90219)
Anderson Bailey (Pa. 206485)

500 Grant Street, Suite 4500
Pittsburgh, PA 15219
Tel.: (412) 391-3939

Attorneys for Respondent UPMC

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA, By JOSH SHAPIRO, Attorney General, et al.; Petitioners, v. UPMC, A Nonprofit Corp., et al.; Respondents.	: : : : : : : : : : : :	No. 334 M.D. 2014

CERTIFICATE OF SERVICE

I hereby certify that on this 15th day of April, 2019, I submitted the foregoing Answer with New Matter and Counterclaims to Commonwealth's Petition to Modify Consent Decrees for electronic service via the Court's electronic filing system on the following:

James A. Donahue, III
Executive Deputy Attorney General
Public Protection Division
Pennsylvania Office of Attorney General
jdonahue@attorneygeneral.gov

Mark A. Pacella
Pennsylvania Office of Attorney General
mpacella@attorneygeneral.gov

Jennifer A. Thomson
Senior Deputy Attorney General
Pennsylvania Office of the Attorney General
jthomson@attorneygeneral.gov

Tracy Wright Wertz
Pennsylvania Office of the Attorney General
twertz@attorneygeneral.gov

Joseph S. Betsko
Pennsylvania Office of Attorney General
jbetsko@attorneygeneral.gov

Michael T. Foerster
Pennsylvania Office of Attorney General
mfoerster@attorneygeneral.gov

Heather Vance-Rittman
Pennsylvania Office of Attorney General
hvance_rittman@attorneygeneral.gov

Jonathan S. Goldman
Pennsylvania Office of Attorney General
jgoldman@attorneygeneral.gov

Keli M. Neary
Pennsylvania Office of Attorney General
kneary@attorneygeneral.gov

Douglas E. Cameron
Reed Smith
dcameron@reedsmith.com

Daniel I. Booker
Reed Smith
dbooker@reedsmith.com

Kim M. Watterson
Reed Smith
kwatterson@reedsmith.com

Jeffrey M. Weimer
Reed Smith
jweimer@reedsmith.com

/s/ Stephen A. Cozen

Stephen A. Cozen

EXHIBIT A

BEFORE THE INSURANCE DEPARTMENT
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:

Application of UPE for Approval of the Request by UPE to Acquire Control of Highmark Inc.; First Priority Life Insurance Company, Inc.; Gateway Health Plan, Inc.; Highmark Casualty Insurance Company; Highmark Senior Resources Inc.; HM Casualty Insurance Company; HM Health Insurance Company, d/b/a Highmark Health Insurance Company; HM Life Insurance Company; HMO of Northeastern Pennsylvania, Inc., d/b/a First Priority Health; Inter-County Health Plan, Inc.; Inter-County Hospitalization Plan, Inc.; Keystone Health Plan West, Inc.; United Concordia Companies, Inc.; United Concordia Dental Plans of Pennsylvania, Inc.; and United Concordia Life and Health Insurance Company	:	Pursuant to Sections 1401, 1402 and 1403 of the Insurance Holding Companies Act, Article XIV of the Insurance Company Law of 1921, Act of May 17, 1921, P.L. 682, as amended, 40 P.S. §§ 991.1401 - 991.1403; 40 Pa.C.S. Chapter 61 (relating to hospital plan corporations); 40 Pa.C.S. Chapter 63 (relating to professional health services plan corporations); and Chapter 25 of Title 31 of The Pennsylvania Code, 31 Pa. Code §§ 25.1-25.23 Order No. ID-RC-13-06

APPROVING DETERMINATION AND ORDER

Upon consideration of the information, presentations, reports, documents and comments received, as well as other inquiries, investigations, materials, and studies permitted by law,[1] the application (the "Application") of UPE (the "Applicant") to acquire control (the "Change of Control") of Highmark Inc.; First Priority Life Insurance Company, Inc.; Gateway Health Plan, Inc.; Highmark Casualty Insurance Company; Highmark Senior Resources Inc.; HM Casualty Insurance Company; HM Health Insurance Company, d/b/a Highmark Health Insurance Company; HM Life Insurance Company; HMO of Northeastern Pennsylvania, Inc., d/b/a First

[1] These materials include, but are not limited to, information submitted to the Department by UPE and members of the public, and the reports prepared for the Department by The Blackstone Group, L.P. (the "Blackstone Report") and Margaret E. Guerin-Calvert, Senior Consultant, Compass Lexecon (the "Guerin-Calvert Report"). All of the publicly available materials submitted to the Department are available on the Department's website at: http://www.portal.state.pa.us/portal/server.pt/community/industry_activity/9276/highmark_west_penn_allegheny_health_system/982185

Priority Health; Inter-County Health Plan, Inc.; Inter-County Hospitalization Plan, Inc.; Keystone Health Plan West, Inc.; United Concordia Companies, Inc.; United Concordia Dental Plans of Pennsylvania, Inc.; and United Concordia Life and Health Insurance Company (the "Highmark Insurance Companies") and all other transactions included in the Form A which are subject to the Department's jurisdiction and require approval of the Department are hereby approved, subject to the conditions set forth below (collectively the "Conditions").

Section 1402 of the Insurance Holding Companies Act requires the Department to approve an application for a change in control unless the Department has found that:

(i) After the Change of Control, the Highmark Insurance Companies would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which they are presently licensed;

(ii) The effect of the Change of Control would be to substantially lessen competition in insurance in this Commonwealth or tend to create a monopoly therein;

(iii) The financial condition of the Applicant is such as might jeopardize the financial stability of a one or more of the Highmark Insurance Companies or prejudice the interests of any policyholders;

(iv) The Change of Control, including but not limited to any material change in the business or corporate structure or management of the Applicant or the Highmark Insurance Companies as described in the Application is unfair and unreasonable to policyholders of the Highmark Insurance Companies and not in the public interest;

(v) The competence, experience and integrity of those Persons who would control the operation of any of the Highmark Insurance Companies are such that it would not be in the interest of the policyholders of the Highmark Insurance Companies and the public to permit the Change of Control;

(vi) The Change of Control is likely to be hazardous or prejudicial to the insurance buying public; and

(vii) The Change of Control is not in compliance with laws of the Commonwealth.

The burden is on the Department to show a violation of the standards. The standards are phrased in the negative and the Department is required to approve a transaction unless it finds that any of the standards are met.

The Department finds that, with the imposition of the Conditions set forth below to preserve and promote competition in insurance in the Commonwealth of Pennsylvania, to protect the public interest, and to protect the financial stability of the Highmark Insurance Companies, the Change of Control (and all other transactions included in the Application which are subject to the Department's jurisdiction and require approval of the Department) do not violate Section 1402 of the Insurance Holding Companies Act.

The form of the Second Amended and Restated Bylaws of Highmark Inc., as submitted to the Department in connection with the Application, meet the statutory standards of 40 Pa.C.S. § 6328(b).

This Approving Determination and Order shall be subject to the following Conditions, all of which must be complied with in order for the approval of the Application to be valid. This Approving Determination and Order is effective immediately.[2] The Department will issue further full written findings and conclusions on or before May 31, 2013 that substantially reflect the factual conclusions reached in the Blackstone Report and the Guerin-Calvert Report.

Competitive Conditions

Preamble: Both the WPAHS Entities and the Domestic Insurers engage in confidential and competitively sensitive contract negotiations with each other's rivals that involve price and non-price terms and product design. Common ownership of the Domestic Insurers and the WPAHS Entities provides the opportunity for each to obtain and make use of Competitively Sensitive Information from rivals that could be used to the potential detriment of consumers and competition. The ability of rival insurers in the Western Pennsylvania area to develop and obtain the benefits of innovative products and pricing depend on their ability to contract with UPE-affiliated providers without risk of disclosure to the Domestic Insurers. A risk to competition exists if a Domestic Insurer can adversely affect any rival's price and non-price contract terms or deter innovation or access or limit gains to innovation by obtaining and acting upon any rival's Competitively Sensitive Information. A risk to competition also exists if Health Care Insurers or Health Care Providers enter into contractual arrangements, including but not limited to arrangements (known as "most-favored nation" arrangements) that guarantee receipt of the best payment rate and/or terms

[2] The captions, headings and preambles in this Approving Determination and Order are for convenience and general reference only and shall not be construed to describe, define or limit the scope, intent or meaning of any of the terms or conditions of this Approving Determination and Order.

offered to any other Health Care Insurer or Health Care Provider. The following Competitive Conditions are designed to mitigate potential adverse competitive effects on competition and on rivals contracting with the Domestic Insurers and/or the WPAHS Entities when under common ownership and to maximize market-based access opportunities of unrelated providers and community hospitals to the IDN and insurers to UPE Health Care Providers.

Prohibition On Exclusive Contracting

1. No Domestic Insurer shall enter into a contract or arrangement with any UPE Health Care Provider which contract or arrangement requires the UPE Health Care Provider to exclusively contract with one or more Health Care Insurers with respect to any Health Care Service.

2. No UPE Entity shall, directly or indirectly, prohibit or limit the authority of any other UPE Entity that is a Health Care Provider from entering into any contract or arrangement with any Health Care Insurer. Exclusive contracts with specialized providers, such as anesthesiologists or emergency room physicians, may be entered into by a UPE Entity that is a Health Care Insurer with at least thirty (30) days' prior written notice to the Department, so long as the Department does not advise the requesting Health Care Insurer that the Department either disapproves the request for approval or requests any further information or explanation regarding the request for approval within such thirty (30) day period.

Provider/Insurer Payment Contract Length Limitation

3. No Domestic Insurer shall enter into any contract or arrangement with any Health Care Provider where the length of the contract (including but not limited to the initial term and all renewal terms) is in excess of five (5) years, without the prior Approval of the Department. No UPE Entity that is a Health Care Insurer domiciled in Pennsylvania shall enter into any contract or arrangement with any Health Care Provider where the length of the contract (including but not limited to the initial term together with all renewal terms) is in excess of five (5) years, without the Approval of the Department.

Termination Of Current Health Care Insurer Contracts Other Than For Cause

4. Until December 31, 2015, no UPE Entity that is a Health Care Provider shall terminate a Health Care Service reimbursement contract with any Health Care Insurer for a reason other than for cause.

Prohibition On Most Favored Nation Contracts Or Arrangements

5. No Domestic Insurer shall enter into any contract or arrangement with any Health Care Provider on terms which include a "most favored nation" or similar clause that guarantees or provides that a Domestic Insurer will receive the best payment rate and/or terms that such Health Care Provider gives any other purchaser or payor of the same or substantially the same product or service.

6. No UPE Entity that is a Health Care Provider shall enter into any contract or arrangement with any Health Care Insurer which includes a "most favored nation" or similar clause that guarantees or provides that the Health Care Insurer will receive the best payment rate and/or terms that such UPE Entity gives any other purchaser or payor of the same or substantially the same product or service.

Firewall Policy

7. UPE shall develop, implement, monitor the operation of and enforce strict compliance with a Firewall Policy for UPE, UPE Provider Sub, and each UPE Entity that is a Health Care Provider or a Health Care Insurer (and for such other UPE Entities as the Department may require). The Firewall Policy shall be in a form and substance acceptable to the Department. Within thirty (30) days after the issuance of this Approving Determination and Order, UPE shall file with the Department, for the review and Approval of the Department, a comprehensive Firewall Policy that includes but is not limited to the elements set forth in Appendix 2 (Firewall Policy), which is attached hereto and is incorporated herein by reference. Different Firewall Policies may be submitted for separate UPE Entities or types of UPE Entities, provided that each such separate policy shall substantially include all of the elements set forth in Appendix 2 (Firewall Policy) and be accompanied by an explanation that describes the need for a separate policy. Once Approved by the Department, each Firewall Policy ("Approved Firewall Policy") shall be made publicly available in accordance with the requirements of the Department. After Approval of the Department of the Approved Firewall Policy, UPE shall cause each applicable UPE Entity to maintain in full force the applicable Approved Firewall Policy. No UPE Entity may make any material amendment, waive enforcement of or terminate any material provision of its Approved Firewall Policy without the Approval of the Department. Each UPE Entity required to have and to maintain an Approved Firewall Policy shall give prompt notice to the Department of any other amendment, waiver or termination of its Approved Firewall Policy.

8. On or before May 1 of each year, UPE shall file with the Department a report executed by UPE's President and its Chief Privacy Officer. The report shall be a public record, shall be in a form and substance satisfactory to the Department and shall include the following certification to the best of the President's and Chief Privacy Officer's information, knowledge and belief: (i) at all times during the immediately preceding calendar year, each UPE Entity subject to Condition 7 was governed by and operated in accordance with a Department Approved Firewall Policy; (ii) at all times in the prior calendar year each Approved Firewall Policy was fully implemented, monitored and enforced in accordance with its terms, except as fully described in subsection (vi) below; (iii) mandatory training of employees with access to any Competitively Sensitive Information (including both current employees and all new hires) has occurred in accordance with the terms of the applicable Approved Firewall Policy; (iv) each UPE Entity that is subject to Condition 7 has obtained recertification biannually of each of its employees with access to any Competitively Sensitive Information stating that the employee has received a copy of the Approved Firewall Policy, understands the Approved Firewall Policy and agrees to abide by the Firewall Policy; (v) no individual with management oversight over all or part of both UPE's provider and insurer business

segments has used Competitively Sensitive Information obtained as part of his or her oversight function to competitively disadvantage a rival Health Care Provider or Health Care Insurer; (vi) each UPE Entity that is subject to Condition 7 has undertaken an annual good faith review of the UPE Entity's Approved Firewall Policy compliance for the prior calendar year and that either (a) there were no violations or other breaches of the applicable Approved Firewall Policy other than those for which the UPE Entity had previously provided notice to the Department in accordance with the Approved Firewall Policy, or (b) the Department has been provided with the non-reported breaches report and corrective action plan required in Condition 9; and (vii) such other information as the Department shall require.

9. UPE, UPE Provider Sub, and each UPE Entity that is a Health Care Provider or a Health Care Insurer shall provide the Department with such information regarding its Approved Firewall Policy and its implementation and enforcement as the Department shall from time to time request. In addition to other information to be provided to the Department, a report of non-reported breaches of the applicable Approved Firewall Policy, which shall not be a public record, shall accompany the annual certification along with a corrective action plan (which shall be satisfactory in form and substance to the Department) to assure the Department of future, timely compliance with the Approved Firewall Policy and to provide an explanation as to why prior notice of such breach had not been provided to the Department. Approved Firewall Policy implementation and enforcement shall be subject to review and/or examination by the Department, or consultants retained by the Department at the expense of the UPE Entity, to the extent that the Department believes that such review and/or examination is in the public interest.

Financial Conditions

Preamble: The following financial conditions are intended to: (i) limit the amount of policyholder funds that may be transferred to any Domestic Insurer's new parent entity or other Affiliates of the parent; (ii) establish an enhanced standard of review and assessment that is required to be undertaken prior to any Domestic Insurer entering into additional material financial commitments; (iii) implement ongoing reporting and monitoring requirements related to a Domestic Insurer's investments into the WPAHS Entities; (iv) establish criteria for a plan of corrective action to be prepared by UPE if the turnaround of WPAHS falls short of certain targets; and (v) enhance the level of transparency and accountability with respect to Highmark's stated goal of deriving tangible policyholder benefits, in the form of relative premium and cost of care savings, related to financial commitments made in connection with the Transaction.

Limitations On Donations

10. Without the Approval of the Department, no Domestic Insurer shall make, or agree to make, directly or indirectly, any Donation, which together with all other Donations made or agreed to be made by that Domestic Insurer within the twelve (12) consecutive months immediately preceding such Donation equals or exceeds the lesser of: (i) 3% of the Domestic Insurer's surplus as regards policyholders, as shown on its latest annual statement on file with the Department; or (ii) 25% of the Domestic Insurer's net income as shown on its latest annual statement; provided, however, if UPE has filed pursuant to Condition 15 a WPAHS Corrective Action Plan, any Donation made or agreed to be made by any Domestic Insurer to any UPE Entity shall be restricted solely for use in connection with implementing the Financial Commitments under and to the extent provided in the WPAHS Corrective Action Plan, until such time as all Financial Commitments related to the WPAHS Corrective Action Plan are satisfied. A Domestic Insurer may not make or agree to make a Donation which is part of a plan or series of like Donations and/or other transactions with other UPE Entities, the purpose, design or intent of which is, or could reasonably be construed to be, to evade the threshold amount set forth in this Condition and thus avoid the review that would occur otherwise. Notwithstanding the foregoing, and in addition to the requirements of (i) and (ii) of this Condition 10, in no event shall Highmark have any right, directly or indirectly, to make any Donation under this Condition if the RBC Rating of Highmark is, or as a result of the Donation is likely to be, 525% or below. This Condition 10 shall not apply to a Donation made from a Domestic Insurer that is a direct or indirect subsidiary of Highmark to Highmark or any subsidiary of Highmark. No Approval of the Department shall be required under this Condition if Department approval for the Financial Commitment has been obtained under 40 P.S. § 991.1405.

Financial Commitment Limitations

11. Any Financial Commitment made or agreed to be made to or for any Person by any of the UPE Entities designated in this Condition, directly or indirectly, shall satisfy the following requirements:

A. **Due Diligence Standard.** For all Financial Commitments: (i) the UPE Entity making or agreeing to make any Financial Commitment shall conduct a Commercially Reasonable Process to evaluate and assess the benefits and risks to policyholders, subscribers or other stakeholders, as applicable, and whether the Financial Commitment furthers and is consistent with the UPE Entity's nonprofit mission, if the UPE Entity is exempt from Federal taxation pursuant to Section 501(c)(3) of the Internal Revenue Code); and (ii) the terms of any Financial Commitment shall satisfy the provisions of 40 P.S. § 991.1405, as if the Financial Commitment transaction were made or agreed to be made between or among members of the holding company system.

B. **Transactions Requiring Only Notice.** If the amount of any Financial Commitment made or agreed to be made by one or more of the Domestic Insurers equals or exceeds $100,000,000 in the aggregate (or if such Financial

Commitment, together with all other Financial Commitments made by one or more of the Domestic Insurers, directly or indirectly, within twelve (12) consecutive months immediately preceding the making of the Financial Commitment causes the total to exceed $100,000,000), the Domestic Insurer(s) making or agreeing to make such Financial Commitment shall deliver to the Department written notice 30 days in advance of making or agreeing to make such Financial Commitment (the "Financial Commitment Notice"). The Financial Commitment Notice shall describe such Financial Commitment, and provide such information as is required by 31 Pa. Code § 27.3 relating to material transactions, together with such other information as the Department shall request. No notice is required under this Condition if notice of the Financial Commitment is provided to the Department pursuant to 40 P.S. § 991.1405.

C. **Transactions Requiring Department Approval.** Without the Approval of the Department, no Domestic Insurer shall make or agree, directly or indirectly, to make any Financial Commitment if: (i) the amount thereof, together with all other Financial Commitments made or agreed to be made directly or indirectly by all of the Domestic Insurers within the immediately preceding consecutive twelve (12) months, equals or exceeds $250,000,000; (ii) the amount thereof is made in connection with a Financial Commitment made or agreed to be made to a Person (including but not limited to any Affiliates), together with all other Financial Commitments between or among one or more of the UPE Entities, on the one hand, and such Person (including but not limited to any Affiliates), on the other hand, aggregate $250,000,000 or more; or (iii) the RBC Rating of Highmark is, or as a result of the Financial Commitment is likely to be, 525% or below.

D. **No Circumvention Mechanism.** No Domestic Insurer may undertake any action to delay any Financial Commitment or perform or agree to perform any Financial Commitment in stages or steps, or take any other action with respect to any Financial Commitment, the purpose, design or intent of which is, or could reasonably be construed to be, to evade any of the foregoing requirements.

Disclosure Of Financial Commitments And Financial And Operational Information

12. On or before May 1 of each year, UPE shall file with the Department a report setting forth: (i) all Financial Commitments made or agreed to be made by any UPE Entity within the immediately preceding calendar year; and (ii) specifying the section of this Condition pursuant to which such Financial Commitments were permitted to be made or agreed to be made. UPE shall promptly and fully respond to questions or requests of the Department for information in connection with such report.

13. Each year, no later than the date on which the financial statements are required to be filed for the holding company system under Form B or otherwise filed pursuant to 40 P.S. § 991.1404 (a), UPE shall file with the Department, as a public record, audited financial statements (including but not limited to all footnotes) of UPE prepared in accordance with GAAP, for the immediately preceding calendar year. In addition, UPE shall file with

the Department any letters from auditor(s) to management and any other information requested by the Department.

14. UPE shall file with the Department a report setting forth the below listed financial and operational information for the WPAHS Entities (the "Required WPAHS Financial and Operational Information"). The Required WPAHS Financial and Operational Information shall be filed quarterly for each quarter through the period ended June 30, 2015 (within 30 days after the end of the quarter) and thereafter annually on July 1 of each year.

A. The Required WPAHS Financial and Operational Information shall be presented on the same basis as the information was presented for the immediately preceding three (3) month period through the quarter ended June 30, 2015, or for each annual report on the same basis the information was presented for the preceding four (4) quarters of each year for which the annual report is required to be delivered. For each quarterly report, the information shall be compared to the WPAHS budget or forecast for such quarter and for each annual report, the information shall be compared to the WPAHS budget or forecast for such year and the Base Case financial projections. UPE shall make members of its management team available to the Department on a timely basis for purposes of reviewing the Required WPAHS Financial and Operational Information with the Department and any consultants retained by the Department.

B. The Required WPAHS Financial and Operational Information shall include for the WPAHS Entities:

(1) An income statement displaying a level of detail consistent with the Base Case Financial Projections for the WPAHS Entities as submitted by UPE to the Department as part of UPE's Form A filings (the "Base Case Financial Projections"). To the extent that the income statement submitted to the Department pursuant to this Condition differs from GAAP, a reconciliation shall be submitted as well.

(2) A cash flow statement displaying a level of detail consistent with the Base Case Financial Projections for the WPAHS Entities submitted by UPE to the Department as part of UPE's Form A. To the extent that the income statement and cash flow statements submitted to the Department pursuant to this Condition differ from GAAP, a reconciliation shall be submitted as well.

(3) A calculation of the WPAHS Entities' Days Cash on Hand as defined in the Master Trust Indenture (the "DCOH"), which shall present a level of detail sufficient to reconcile the components of the calculation to the income statement and balance sheets submitted as part of this Condition.

(4) A calculation of WPAHS Entities' Debt Service Coverage Ratio, as defined in the Master Trust Indenture, which shall present a level of detail

sufficient to reconcile the components of the calculation to the income statement and balance sheets submitted as part of this Condition.

(5) A schedule of capital expenditures for all WPAHS Entities, and for each WPAHS Entity for which information is requested by the Department, during the applicable calendar quarter in question and grouped by significant project categories.

(6) A schedule of inpatient and outpatient discharge volume for the WPAHS Entities in total and for each primary WPAHS Entity facility.

(7) A schedule of occupancy rates for the WPAHS Entities in total and for each primary WPAHS facility.

(8) A schedule of salaried and non-salaried employees, including but not limited to physicians, on an FTE basis for the WPAHS Entities in total and for each primary WPAHS Entity operating segment (hospitals, physician organization, etc.).

(9) A schedule of occupied beds by each primary WPAHS Entity facility.

(10) A schedule of FTEs per occupied bed by each primary WPAHS Entity facility.

(11) Audited financial statements (including but not limited to all footnotes) of WPAHS and WPAHS Affiliates specified by the Department prepared in accordance with GAAP, for the immediately preceding calendar year along with any letters from auditors to management.

(12) If WPAHS files consolidated financial statements with any UPE Entity other than WPAHS Affiliates specified by the Department, then UPE shall deliver WPAHS' consolidating financial statements showing its financial position, results of operations, changes in cash flow and related footnotes thereto of WPAHS and such specified WPAHS Affiliates on a standalone basis.

(13) Such other financial and operational information related to WPAHS and the IDN Strategy as may be requested, from time to time, by the Department.

WPAHS Corrective Action Plan

15. UPE shall prepare and produce to the Department a plan of financial and operational corrective action for WPAHS (the "WPAHS Corrective Action Plan") if either:

A. (i) From the date hereof through June 30, 2015, the aggregate amount of Financial Commitments made or agreed to be made directly or indirectly by all UPE Entities to the WPAHS Entities equals or exceeds $100,000,000 and (ii) the

WPAHS Entities have issuer ratings from two (2) of the Credit Rating Agencies of less than investment grade; or

B. As of the quarter ended June 30, 2015, either (i) the WPAHS Entities' net income, as determined in accordance with GAAP ("Net Income"), has not been greater than $0.00 after adjusting for any material non-recurring or unusual income, including but not limited to all payments received from any UPE Entity outside of the normal course of business and any Financial Commitments to the extent included in such Net Income, for two (2) out of the previous four (4) consecutive quarters; or (ii) DCOH, after adjusting for any material non-recurring or unusual cash receipts and Financial Commitments, including but not limited to all payments received from any UPE Entity outside of the normal course of business, has not been equal to or greater than a value of sixty-five (65) days for two (2) of the previous four (4) consecutive quarters.

16. If a WPAHS Corrective Action Plan is required to be prepared and produced to the Department pursuant to Condition 15A or 15B, it shall be produced promptly upon request or order of the Department to UPE and all such information when produced shall be treated as confidential pursuant to an examination process or proceeding under 40 PS § 991.1406.

17. The WPAHS Corrective Action Plan shall specify, in reasonable detail, UPE's intended actions to be taken over the subsequent twelve to twenty-four (12–24) months that are designed and anticipated to: (i) facilitate repayment or refinancing of the bond obligations of the WPAHS Entities payable to Highmark (or any UPE Entity) and on terms that would not require any Credit Enhancement Device from Highmark or other UPE Entities; (ii) generate DCOH of at least sixty-five (65) days within eighteen (18) months and for the foreseeable future thereafter; and (iii) generate net income of no less than $0 within eighteen (18) months and for the foreseeable future thereafter.

A. In addition, the WPAHS Corrective Action Plan shall specify the intended corrective actions that are proposed to be implemented, including but not limited to the following potential actions that were referenced in UPE's Form A filing: (i) efficiency improvements and revenue opportunities; (ii) changes in employment, including but not limited to in the number of employed physicians; (iii) modifications to capital expenditure plans; (iv) reductions in unfunded research; (v) non-core asset sales; (vi) restructuring of compensation and benefits; and (vii) outsourcing.

B. The WPAHS Corrective Action Plan shall include but not be limited to: (i) an estimate of total cost to adopt, implement and consummate the WPAHS Corrective Action Plan—including but not limited to write-downs, one-time or ongoing restructuring costs, anticipated litigation, consulting, legal and other advisory fees and any future capital commitments—specifying UPE's estimated value for any WPAHS Entity-related investments held by Highmark or any other UPE Entity, including but not limited to loans or bonds receivable, at the time of the WPAHS Corrective Action Plan's implementation and without consideration

of potential contingency actions; and (ii) the amount of any funding needed by the WPAHS Entities to fully pay for and carry out the WPAHS Corrective Action Plan (the "WPAHS Required Funding") and an acknowledgement that any Donations made pursuant to Condition 10 will be restricted for use in paying the WPAHS Required Funding to the extent of the amount of the WPAHS Required Funding.

C. Prior to submission, UPE shall have the WPAHS Corrective Action Plan reviewed at its sole expense by an external financial expert, who shall conclude as to the reasonableness of the plan and the sufficiency of the WPAHS Required Funding and UPE's stated actions for the purposes of limiting future WPAHS, Highmark and/or UPE losses and/or the need for additional Financial Commitments. The financial expert also shall assess the specific level of benefits and costs to be borne by Highmark's policyholders, as distinct from any franchise benefits accruing to Highmark in the form of higher enrollment, revenue and market share, and shall conclude as to the reasonableness of the value assigned by UPE to Highmark's investments in WPAHS.

Executive Compensation

18. UPE and Highmark shall ensure and maintain in effect a policy that any senior executives of any UPE Entity who have been responsible for designing, recommending and/or implementing the IDN Strategy have a meaningful portion of their long-term compensation tied to the achievement of quantifiable and tangible benefits to policyholders, if any, or to the charitable nonprofit entity, if the UPE Entity is exempt from Federal taxation pursuant to Section 501(c)(3) of the Internal Revenue Code (the "IDN Compensation Policy"). Within ninety (90) days after the date hereof, UPE shall deliver to the Department a copy of the IDN Compensation Policy which satisfies the foregoing requirements in a form and substance acceptable to the Department. Any amendments to the IDN Compensation Policy shall be submitted to the Department accompanied by a certification by the President of UPE that, to the best of his or her information, knowledge and belief, the amendment to the IDN Compensation Policy satisfies the requirements of this Condition. UPE shall report annually by May 1 of each year the amount of the compensation paid to such senior executives and describe the manner in which such compensation is consistent with the IDN Compensation Policy.

Meeting IDN Savings Benchmarks

19. On or before May 1 of each year, UPE shall file with the Department a report describing in detail whether each Benchmark contained in Appendix 3 (Benchmarks), which Appendix 3 is attached hereto and incorporated herein by reference, has been met or what progress has been made toward meeting each Benchmark. The report shall include but not be limited to a statement of savings achieved through implementation of the IDN Strategy (the "IDN Savings") during (i) the preceding calendar year; and (ii) in total since consummation of the Affiliation Agreement. Each annual report shall quantify: (i) the total savings realized by policyholders across all products and consumers compared to the estimate of the cost of care that would have been incurred by policyholders if the

Affiliation Agreement had not been consummated (the "Total IDN Savings"); (ii) the relative savings realized by consumers on a per-member-per-month claims basis (the "PMPM IDN Savings"); (iii) a comparison of the Total IDN Savings and PMPM IDN Savings to the relevant projections provided in the Form A filing and shall provide a detailed description of variances between the projections and actual savings achieved; (iv) the annual and cumulative savings actually achieved by policyholders in the eight categories for which projected savings were provided to the Department in the Form A, which categories are set forth in Attachment 4 (Total IDN Savings Categories) or such other categories as the Department may approve. UPE shall have the quantification of savings and related explanations of variances reviewed by an external actuarial consulting firm, which shall conclude as to the reasonableness of the methodologies used for quantifying the savings. Within ninety (90) days of closing of the Affiliation Agreement, UPE shall submit to the Department a detailed plan for the measurement and reporting methodologies to be followed for compliance with this Condition. If the Benchmark has not been met or if satisfactory progress has not been made toward achievement of the Benchmark, the report shall specify what corrective actions will be taken in order to assure that the Benchmark is met in a timely fashion. Specifically, if, as of December 31, 2016, either the Total IDN Savings or the PMPM IDN Savings are less than the amounts projected as part of the Form A filing, then, by April 1, 2017, UPE shall file with the Department a detailed corrective action plan to maximize IDN Savings in the future or otherwise generate tangible policyholder benefits in amounts sufficient to justify the continued investment of policyholder funds in the IDN Strategy.

Public Interest/Policyholder Protection Conditions

Consumer Choice Initiatives

Preamble: Consumer choice and other member cost-sharing initiatives, including but not limited to tiered network products based upon transparent, objective criteria that include quality and cost, are procompetitive. These initiatives are consistent with efforts to provide consumers with informed healthcare choices and to incentivize consumers to consider the costs of healthcare and quality of outcomes in choosing providers. The following consumer choice initiative Condition is designed to prohibit provider and insurer contracts that would prohibit or limit the ability of Health Care Insurers to implement such consumer choice initiatives.

20. After the issuance of this Approving Determination and Order, no Domestic Insurer shall enter into a contract or arrangement with a Health Care Provider that prohibits and/or limits the ability of any Domestic Insurer to implement Consumer Choice Initiatives, without the prior Approval of the Department. After the issuance of this Approving Determination and Order, no UPE Entity that is a Health Care Provider shall enter into a contract or arrangement with a Health Care Insurer that prohibits and/or limits the ability of the UPE Entity to implement Consumer Choice Initiatives, without the prior Approval of the Department. This Condition does not prohibit a Domestic Insurer or a UPE Entity that is a Health Care Provider from entering into a contract that provides volume

discounts, provided that such volume discounts are not conditioned upon or related to commitments not to implement Consumer Choice Initiatives.

Affiliation And IDN Impact On Community Hospitals

Preamble: UPE indicates in its filings that vibrant and financially healthy community hospitals are a key component of the IDN Strategy. Community hospitals are viewed as high quality, lower cost alternatives for healthcare delivery; and, thus, are projected to be key partners. UPE acknowledges that its efforts to reinvigorate the WPAHS Entities may result in some draw of inpatients away from community hospitals to the WPAHS Entities, but states that the IDN Strategy and UPE's "Accountable Care Alliance" strategy overall will increase inpatient admissions at community hospitals, thereby resulting in a net increase in community hospital inpatient admissions. To address concerns that the Affiliation Agreement will adversely impact inpatient admissions at community hospitals and risk the financial viability of these community assets, the Department imposes Conditions that require the monitoring and reporting of Affiliation Agreement and IDN Strategy implementation impacts on community hospital discharges, and Conditions requiring UPE to report any financial commitments and other efforts to deliver more cost-effective healthcare at community hospitals to further healthcare choices in the Western Pennsylvania area.

21. On or before May 1 of each year, UPE shall submit a document (the "IDN-Community Hospital Report"), which IDN-Community Hospital Report shall describe in detail for the immediately preceding calendar year: (a) the number of discharges for each Domestic Insurer at each hospital in the WPA service area, as such area is defined in connection with the Form A (the "WPA Service Area"); (b) the number of discharges for each Domestic Insurer at each hospital in its WPA Service Area for calendar year ended 2012 ("Base Year Discharge Data"); (c) a comparison of the discharge information in the current IDN Certification against: (i) the discharge information provided by UPE under the IDN Certification for the immediately preceding year, if any was required to be provided; and (ii) the Base Year Discharge Data; (d) an analysis of whether and to what extent Highmark's affiliation with WPAHS and the implementation of the IDN Strategy resulted in a net decrease in the Domestic Insurers' discharges at its WPA Service Area community hospitals; and (e) the amount and nature of any Financial Commitments by any and all UPE Entities in community-based facilities and service in community hospitals that any such UPE Entities have undertaken with each hospital (excluding any hospitals of WPAHS and UPMC or their respective subsidiaries), including but not limited to efforts to identify opportunities to deliver more cost-effective healthcare to ensure a robust and vibrant network with meaningful choice in key service lines.

A. Within sixty (60) days after the date of an IDN-Community Hospital Report, the Domestic Insurers shall submit to the Department a plan of operational corrective action ("IDN Corrective Action Plan") if the analysis set forth in the IDN-Community Hospital Report for the year in question reflects a net decrease of

10% or more in all of the Domestic Insurers' discharges at their WPA Service Area community hospitals with which they have a contract or arrangement. The IDN Corrective Action Plan shall specify, in reasonable detail, the Domestic Insurers' intended commercially reasonable actions to be taken over the subsequent twelve (12) months that are designed and anticipated to address the reasons for the decrease in discharges relating to the Affiliation Agreement and the IDN Strategy. The IDN Corrective Action Plan shall include but not be limited to an estimate of total cost to adopt, implement and consummate the IDN Corrective Action Plan.

B. The Domestic Insurers shall use commercially reasonable efforts to implement the IDN Strategy in a manner that utilizes and enhances the role of community hospitals in their respective WPA Service Areas to provide continued services to the communities they serve.

Transition Plan Regarding UPMC Contract

Preamble: The Department recognizes that Highmark's contract with UPMC is scheduled to terminate on December 31, 2014, and new or extended provider contracts may or may not be entered into between the parties. The Department also recognizes that the Application's Base Case is premised on a non-continuation of the UPMC Contract and that continuation of such contract may, based on the Applicant's projections, delay WPAHS' financial recovery. The potential termination of these provider contracts may be disruptive to the Domestic Insurers' enrollees and consumers of UPMC healthcare services as that termination date is reached. In the event of a contract termination and to minimize any adverse impact on healthcare consumers and protect the public interest, the Department imposes a transition plan condition on all Domestic Insurers that have contract(s) with UPMC. The Condition focuses on issues such as continuation of care and access options available to the Domestic Insurers' enrollees; adequacy of the Domestic Insurers' remaining provider networks; and appropriate communications, as necessary, to inform healthcare consumers of any issues with continued access to certain UPMC facilities and practice areas.

22. With respect to the possibility of a contract between or among one or more of the Domestic Insurers and UPMC after December 31, 2014, the following shall apply:

A. If a Domestic Insurer secures UPMC's assent to a new contract, combination, affiliation, or arrangement (or an extension of the current contract that expires on December 31, 2014) ("New UPMC Contract"), UPE shall notify the Department in advance of the execution of the New UPMC Contract and provide the Department with updated information, based on reasonable assumptions and credible projections, on the impact of the terms of any New UPMC Contract on the financial performance of WPAHS, as well as an independent analysis of an expert on the impact of the New UPMC Contract on both the insurance and

provider markets in the region including but not limited to any effects on competition.

B. If, however, one or more of the Domestic Insurers and UPMC do not enter into a New UPMC Contract by July 1, 2014, then UPE shall file with the Department and with the Pennsylvania Department of Health: (i) an update of the status of negotiations between UPMC and such Domestic Insurer(s), including but not limited to reasons that the parties have been unable to enter into a New UPMC Contract; and (ii) a formal transition plan (the "UPMC Contract Transition Plan") no later than July 31, 2014 that sets forth such information as shall be required by the Department and the Department of Health and which addresses such issues as continuation of care; options available to subscribers to access Health Care Providers; appropriate communication, as necessary, to subscribers, providers and others regarding adequacy and changes in cost or scope of coverage. The UPE Entities shall fully cooperate with the Department and the Department of Health in coordinating with UPMC for the further development and, if necessary, implementation of the UPMC Contract Transition Plan with the goal of minimizing any disruption to consumers and the marketplace and ensuring that such consumers continue to have access to quality healthcare in a competitive marketplace.

Community Health Reinvestment

Preamble: Preamble: This Condition requires Highmark to continue its commitment to non-profit activities directed to the betterment of overall community healthcare by fixing and expressly making permanent a percentage of Highmark's direct written premiums that will be dedicated to Community Health Reinvestment endeavors.

23. Commencing with calendar year 2014, Highmark shall annually dedicate to and pay for Community Health Reinvestment Activities ("CHR") an amount equal to 1.25% of all of Highmark's aggregate direct written premiums, as reported in the annual statement filed by Highmark pursuant to Condition 23B (the "Annual CHR Payment Obligation") for the immediately preceding year.

A. The Annual CHR Payment Obligation shall be calculated on a calendar year basis. Notwithstanding the foregoing, (i) Highmark's minimum Annual CHR Payment Obligation (the "Minimum Annual CHR Payment Obligation") shall be equal to 1.25% of all of Highmark's aggregate direct written premiums for the 2013 calendar year; and (ii) Highmark shall not be required to fund or commit to fund Community Health Reinvestment Activities for 2014 in an amount in excess of 105% of the Minimum Annual CHR Payment Obligation, and thereafter in an amount in excess of 105% of the actual CHR Payment made (but in no event less than the Minimum Annual CHR Payment Obligation) for the immediately preceding calendar year. Highmark shall not be required to fund or commit to fund any Community Health Reinvestment Activities to the extent that, at the time of such funding or commitment, or after giving effect thereto, its RBC

Rating level is, or is reasonably expected to be, less than 525%. If Highmark fails to meet its Annual CHR Payment Obligation in any calendar year, the deficiency in such payment obligation shall be paid by Highmark by May 1 of the following calendar year into the Insurance Restructuring Restricted Receipt Account.

B. On or before March 31 of each calendar year, Highmark shall provide to the Department a report, in form and substance acceptable to the Department, of Highmark's Community Health Reinvestment Activities for the prior calendar year.

C. The provisions of this Condition supersede and replace in their entirety any obligation by Highmark pursuant to Condition 4 of the Department's Decision and Order dated November 27, 1996 (Docket No. MS96-04-098) (the "1996 Department Order").

Miscellaneous Conditions

Modification Of Prior Orders

24. Except as expressly provided in this Approving Determination and Order, nothing in this Approving Determination and Order shall be construed to modify or repeal any term or condition of any prior order or approval of the Department, including, but not limited to, the 1996 Department Order.

25. The Department shall determine whether and to what extent any conflict or inconsistency exists between or among this Approving Determination and Order and any term or condition in any prior order(s) or approval(s) of the Department, and the Department shall have the authority to determine what term or condition controls.

Department Costs And Expenses

26. The Department may retain at the reasonable expense of the UPE Entities, as determined by the Department, any attorneys, actuaries, accountants and other experts not otherwise part of the Department's staff as, in the judgment of the Department, may be necessary to assist the Department, regardless whether retained before, on or after the date of this Approving Determination and Order, in or with respect to: (i) evaluation and assessment of any certifications, reports submissions, or notices given or required to be given in connection with this Approving Determination and Order; (ii) compliance by any of the UPE Entities with this Approving Determination and Order; (iii) the enforcement, or any challenge or contest to enforcement or validity, of the Conditions or otherwise of this Approving Determination and Order, including, but not limited to, reviewing and analyzing any certifications, reports, submissions or notices by or for any UPE Entity or auditing and reviewing any books and records of any UPE Entity to determine compliance with any of the Conditions; (iv) litigation, threatened litigation or inquiries or investigations regarding, arising from or related to the Form A filing, the process surrounding the approval of the Form A filing and/or this Approving Determination and Order; and/or (v) the defense of any request or action to require public disclosure of

information that UPE or the Department deems confidential. The obligations of the UPE Entities to the Department for all such costs and expenses shall be joint and several obligations.

Modification Of Approving Determination And Order

27. Upon written request by a UPE Entity setting forth: (a) the specific Condition(s) for which such UPE Entity seeks relief; (b) the reason for which such relief is necessary and (c) an undertaking by such UPE Entity to provide all such further information as the Department shall require to evaluate the request, the Department may evaluate and, after evaluation of the request, the Commissioner, in the Commissioner's sole discretion, may grant relief, in whole or in part, from one or more of the Conditions as the Commissioner may be deem appropriate.

28. The Commissioner reserves the right to impose additional conditions upon the approval of the Transaction or modify the Conditions in this Approving Determination and Order if, in his reasonable judgment (i) the consolidated financial position or results of operation of the WPAHS Entities suffer or incur, or are reasonably likely to suffer or incur, a material deterioration or material adverse change and the Commissioner finds that such material deterioration or material adverse change might jeopardize the financial stability of a Domestic Insurer or prejudice the interest of the policyholders of a Domestic Insurer; (ii) the Commissioner finds that actions taken or proposed to be taken by any UPE Entity might jeopardize the financial stability of a Domestic Insurer or prejudice the interest of policyholders of a Domestic Insurer; and/or (iii) the Commissioner finds that actions taken or proposed to be taken by any UPE Entity would substantially lessen competition in insurance in this Commonwealth or tend to create a monopoly therein.

Settlement Of Litigation

29. Without the prior approval of the Commissioner, UPE and each UPE Entity agrees that it will not settle, enter into a settlement agreement or otherwise consent to terminate litigation where the result of such settlement or termination of litigation will be to affect or impair in any way the objective or purpose sought by the Department in imposing or establishing any Condition in this Approving Determination and Order.

Modification Of Affiliation Agreement

30. No UPE Entity which is a party to the Affiliation Agreement may amend, waive enforcement of, modify, or enter into any other agreement or arrangement having the effect of terminating, waiving or modifying, in any material respect, the terms or conditions of the Affiliation Agreement, without the prior approval by the Commissioner.

Sunset Of Conditions

31. The Conditions contained in this Approving Determination and Order shall expire as follows:

A. The following Conditions shall not expire: Conditions 1 and 2 (Prohibition on Exclusive Contracting); 3 (Provider/Insurer Contract Length); 5 and 6 (Prohibition on Most Favored Nation Contracts or Arrangements); 7, 8, and 9 (Firewall Policy); 10 (Donations); 11 (Financial Commitment Limitations); 13 (one of the Public Disclosure of Financial Commitments and Financial and Operational Information Conditions); 20 (Consumer Choice Initiatives); 23 (Community Health Reinvestment); 26 (Department Cost and Expenses); 27 and 28 (Modification of Approving Determination and Order); 29 (Settlement of Litigation); 32 (Required Record Retention); 33, 34, and 35 (Enforcement); and 36 (Post Closing Obligations).

B. Unless a Condition is listed in Condition 31A or contains a specific expiration date, the Condition shall expire on December 31, 2018, provided that the Department may extend any of these Conditions for up to an additional five (5) years if, in the judgment of the Department, such an extension is in the public interest, and further provided that any expiration of any Condition shall not affect or limit the obligations arising under such Condition prior to its expiration.

Required Record Retention

32. The books, accounts and records of each UPE Entity shall be so maintained and be accessible to the Department as to clearly and accurately disclose the precise nature and details of the transactions between and/or among any UPE Entity and/or other Person, and to permit the Department to establish compliance with the Conditions or otherwise of this Approving Determination and Order, including, but not limited to, such accounting information as is necessary to support the reasonableness of any charges or fees to a Person.

Enforcement

33. Each of the UPE Entities shall be subject to the jurisdiction of the Department for the purpose of enforcing the terms or the Conditions or otherwise of this Approving Determination and Order. Nothing in this Approving Determination and Order is intended to create or enlarge the right of any Person to enforce, seek enforcement of, and/or seek compliance by the UPE Entities with the terms and conditions of this Approving Determination and Order.

34. To the maximum extent provided by law, a violation of any Condition shall constitute a violation of 40 Pa.C.S. § 6105 (relating to penalties), which provides that any person who violates a Department order made pursuant to 40 Pa.C.S. Chapter 61 (relating to hospital plan corporations) or hinders or prevents the Department in the discharge of its duties under that statute shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine of not more than $ 3,000 or to be imprisoned for not more than six months, or both, in the discretion of the court. This statute also provides that any act or default by any corporation, association, or common law trust who violates a Department order made pursuant to 40 Pa.C.S. Chapter 61 (relating to hospital plan corporations)

shall be deemed to be the act or default of the officers or directors who participated in authorizing or effecting such act or default or who knowingly permitted it.

35. In addition to its powers otherwise available under applicable law, the Department may apply to the Commonwealth Court for an order enjoining any UPE Entity or any director, officer, employee or agent thereof from violating or continuing to violate any term or condition of this Approving Determination and Order and for such other equitable relief as the nature of the case and the interest of any Domestic Insurer's policyholders, creditors, shareholders, members or the public may require.

Post Closing Obligations Of UPE

36. If UPE proceeds with closing the Transaction and implements the Change of Control as contemplated by Form A, UPE shall have been deemed to have agreed expressly to fully and promptly comply with each Condition set forth in this Approving Determination and Order. UPE shall have the obligation and responsibility to cause all UPE Entities to comply with their respective obligations under this Approving Determination and Order, including but not limited to the Conditions.

37. Highmark shall provide to the Department a list of closing documents for the Affiliation Agreement and the JRMC Affiliation Agreement within five (5) days after consummation of the Transaction and shall maintain the listed documents and make them available to the Department for a period of not less than five (5) years from the date of this Approval Determination and Order.

This Approving Determination and Order is effective immediately. The Department will issue further full written findings and conclusions on or before May 31, 2013 that substantially reflect the factual conclusions reached in the Blackstone Report and the Guerin-Calvert Report.

Michael F. Consedine
Insurance Commissioner
Commonwealth of Pennsylvania

Date: April 29, 2013

Appendix 1 (Definitions)

In addition to the words or terms otherwise defined in the Approving Determination and Order, as used in this Approving Determination and Order and the appendices thereto, the following terms have the following meanings:

"1996 Department Order" shall have the meaning set forth in Condition 23C.

"Addendum 1" means Addendum No. 1 to Amendment No. 1 to Form A dated August 24, 2012.

"Affiliate" means any present Person or any Future Person that, directly or indirectly through one or more intermediaries, Controls, is Controlled by, or is under Common Control with any other UPE Entity and their successors and assigns. "Affiliate" includes but is not limited to all Persons in which any UPE Entity, directly or indirectly, has a membership interest.

"Affiliation Agreement" means the contract entered into between UPE, UPE Provider Sub, Highmark, WPAHS and certain subsidiaries of WPAHS as specified therein dated October 31, 2011, as amended by that certain Amendment No. 1 to Affiliation Agreement entered into as of January 22, 2013, relating to the affiliation between or among the parties thereto.

"Annual CHR Payment Obligation" shall have the meaning set forth in Condition 23A.

"Approval of the Department" or "Approved by the Department" means, except as otherwise provided in this definition: either (1) the Department expressly grants its written approval to a written request by the applicable requesting party for Department approval; or (2) within thirty (30) days after the receipt by the Department of the written request for approval, the Department does not advise the requesting party that the Department either disapproves the request for approval or requests any further information or explanation regarding the request for approval. With respect to Condition 3 (Provider/Insurer Payment Contract Length Limitation), Condition 7 (Firewall Policy) and Condition 21 (Consumer Choice Initiatives), "Approval of the Department" means when the Department expressly grants its written approval to a written request by the applicable requesting party for Department approval.

"Approved Firewall Policy" shall have the meaning set forth in Condition 7.

"Base Case Financial Projections" means the WPAHS financial projections for fiscal years 2013–2017 as prepared by Highmark, dated January 16, 2013 and submitted by UPE to the Department as Exhibit K to Amendment No. 2 to Form A.

"Base Year Discharge Data" shall have the meaning set forth in Condition 21.

"Benchmark" shall have the meaning set forth in Appendix 3 (Benchmarks).

"Commercially Reasonable Process" means such due diligence and evaluative process that would be customarily performed by parties to an arm's length transaction in the geographic

area in which the Financial Commitment is to be made in order to assess the merits and risks of a Financial Commitment and the financial, operational and policy effects to the involved UPE Entity. This includes but is not limited to obtaining, where commercially appropriate and reasonable or to the extent required by law, of a third party fairness opinion or fair market value analysis of such Financial Commitment or other financial analysis and/or stakeholder cost-benefit assessment as may be customarily or reasonably expected to be performed in connection with such a transaction.

"Competitively Sensitive Information" means any information that is not available publicly that could potentially affect competitive innovation and/or pricing between or among one or more UPE Entities and the rivals of such UPE Entities at the provider and/or insurer levels. At a minimum, "Competitively Sensitive Information" includes but is not limited to: (i) present and future reimbursement rates by payor; (ii) payor-provider reimbursement contracts; (iii) terms and conditions included in agreements or arrangements between payors and providers, including but not limited to discounts in reimbursements in agreements; (iv) reimbursement methodologies including but not limited to provisions relating to performance, pay for performance, pay for value, tiering of providers; and (v) specific cost and member information, and revenue or discharge information specific to the payor.

"Community Health Reinvestment Activity" means community health services and projects that improve health care or make health care more accessible. The term includes funding, subsidization or provision of the following: (i) health care coverage for persons who are determined by recognized standards as determined by the Department to be unable to pay for coverage; (ii) health care services for persons who are determined by recognized standards to be uninsured and unable to pay for services; (iii) programs for the prevention and treatment of disease or injury, including but not limited to mental retardation, mental disorders, mental health counseling or the promotion of health or wellness; and (iv) such other services or programs as the Department may approve, including but not limited to health or mental health services for veterans, and the prevention of other conditions, behaviors or activities that are adverse to good health as well as donations to or for the benefit of health care providers in furtherance of any of the foregoing purposes. "Community Health Reinvestment Activity" does not include expenditures for advertising, public relations, sponsorships, bad debt, administrative costs associated with any Domestic Insurer, programs provided as an employee benefit, use of facilities for meetings held by community groups, or expenses for in-service training, continuing education, orientation or mentoring of employees.

"Consumer Choice Initiatives" mean tools and methods that assist consumers in making informed healthcare decisions that reflect differences in the price, cost and quality of care provided. These initiatives may include but are not limited to tools that enable consumers to compare quality and cost-efficiency of medical treatments, healthcare goods and services and providers, and incentives such as tiered network health plan benefit designs that reward patients who choose to use healthcare resources more efficiently. The term "Consumer Choice Initiatives" specifically includes but is not limited to products that include Tiering and Steering as part of their product design.

"Control," "Controlling," "Controlled by" or "under Common Control with" have the meaning given to those terms in 40 P.S. § 991.1401.

"Credit Enhancement Device" means any letter of credit, guaranty, line of credit, insurance or any other device, arrangement or method, financial or otherwise, given or provided as security or assurance for the payment of the principal of, premium, if any, or interest on, the applicable debt.

"Department" means the Insurance Department of the Commonwealth of Pennsylvania.

"Domestic Insurers" means the following Pennsylvania domestic insurers to which the Form A applies: Highmark Inc.; Highmark Casualty Insurance Company, a Pennsylvania stock insurance company; Highmark Senior Resources Inc., a Pennsylvania stock insurance company; HM Casualty Insurance Company, a Pennsylvania stock insurance company; HM Health Insurance Company, d/b/a Highmark Health Insurance Company, a Pennsylvania stock insurance company; HM Life Insurance Company, a Pennsylvania stock insurance company; Keystone Health Plan West, Inc., a Pennsylvania business corporation and licensed health maintenance organization; United Concordia Companies, Inc., a Pennsylvania stock insurance company; United Concordia Dental Plans of Pennsylvania, Inc., a Pennsylvania business corporation and licensed risk-assuming PPO; and United Concordia Life And Health Insurance Company, a Pennsylvania stock insurance company. "Domestic Insurers" also includes but is not limited to any Health Care Insurer hereafter formed, acquired or organized directly or indirectly by or for any of the foregoing or by any other UPE Entity. The term "Domestic Insurers" shall not include First Priority Life Insurance Company, Inc.; Gateway Health Plan, Inc.; HMO of Northeastern Pennsylvania, Inc., d/b/a First Priority Health; Inter-County Health Plan, Inc.; or Inter-County Hospitalization Plan, Inc. to the extent that those entities are not used, directly or indirectly, to circumvent, affect or impair the purpose or intent of any Condition.

"Domestic Insurer Competitively Sensitive Information" means Competitively Sensitive Information originated by, received and/or held, directly or indirectly, in any form by or for any Domestic Insurer.

"Donation" means any contribution, grant, donation, distributions under 40 P.S. § 991.1405 or other transfer or payment of funds, property or services (or a commitment to make a Donation), whether made directly or indirectly, in cash or in kind, by any UPE Entity to any other UPE Entity or to any other Person; provided, however, that "Donation" shall not include any transfer or payment made in exchange for the fair value of goods or services received by the transferring or paying Person. An expenditure made for a Community Health Reinvestment Activity is not a "Donation", so long as the expenditures are for the direct provision of community health services and direct funding of projects that improve health care or make health care more accessible. Donations that are in furtherance of the Affiliation Agreement, the JRMC Affiliation Agreement and any affiliation agreement with SVHS; and/or are capital expenditures related to the IDN or the IDN Strategy are not to be considered as Community Health Reinvestment Activity for the purposes of this definition of "Donation."

"Financial Commitment" means any direct or indirect payment or transfer of any cash or other property, any Donation, provision of services, encumbrance upon or granting of any security interest in or to any assets or properties, or the direct or indirect guaranty or incurrence of any contractual obligation or liability. The term "Financial Commitment" includes, but is not limited to, the acquisition of any assets or properties of or interests in, the merger, consolidation or affiliation with, or the entering into of any financial or contractual relationship with, any Person, except for: (i) any Financial Commitment made in the ordinary and usual course of the UPE Entity's business; or (ii) any amounts expressly required to be paid without any further consent of any Person and pursuant to the current provisions of the Affiliation Agreement, JRMC Affiliation Agreement and/or any affiliation agreement between Highmark and SVHS acceptable to the Department. Without limiting the generality of the foregoing, (i) until June 30, 2017, a Financial Commitment shall include but is not limited to (A) any advance payment by a Domestic Insurer to a WPAHS Entity pursuant to or in connection with a contract or arrangement for the payment or reimbursement for Health Care Services; or (B) an increase in contractual rates pursuant to or in connection with a contract or arrangement for the payment or reimbursement for Health Care Services between or among any Domestic Insurer and any WPAHS Entity in excess of the level of increase set forth in the Base Case Financial Projections; and (ii) in no event shall any Financial Commitment relating to the acquisition of any assets or properties of or interests in, the merger, consolidation or affiliation with, or any Donation to or investment in, any Person in connection with the IDN Strategy, as it may be renamed, modified or replaced, be considered to be in the ordinary course of business.

"Financial Commitment Notice" shall have the meaning set forth in Condition 11B.

"Firewall Policy" means a written course of action that governs the use, disclosure, release, dissemination or sharing of Competitively Sensitive Information between and/or among each UPE Entity and the employees, contractors, officers, directors, managers or other personnel of other UPE Entities. Without limiting the scope of any Firewall Policy, a Firewall Policy shall restrict each Domestic Insurer's and its directors', officers', employees' and agents' knowledge and ability to influence, directly or indirectly, the negotiations of other UPE Entities with rival insurers, and, conversely, shall restrict other UPE Entities' and their directors', officers', employees' and agents' knowledge and ability to influence, directly or indirectly, any Domestic Insurer's negotiations with rival Health Care Providers.

"Form A" means the Form A filed by UPE, as applicant, with the Department on November 7, 2011, as amended and supplemented by filings made by UPE with the Department.

"GAAP" means generally accepted accounting principles, consistently applied.

"Health Care Insurer" means the Highmark Insurance Companies or any other related or unrelated insurance company, health plan corporation, professional health services plan corporation, health maintenance organization, preferred provider organization or other Person in the business of insurance that finances or pays for health care goods and/or services.

"Health Care Provider" means a Person licensed, certified or otherwise authorized or permitted by the laws of the Commonwealth of Pennsylvania or any other state to provide or

perform a Health Care Service in the ordinary course of business or practice of a profession and any other Person who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to a physician, dentist, hospital, nursing home, assisted living provider, home health agency or any other Person that would constitute a "health care provider" pursuant to Federal HIPAA privacy laws (45 C.F.R. § 160.103).

"Health Care Service" means any medical or health care service including but not limited to the treatment or care of an individual or administration of any medical service or medical goods or supplies or dispensing of any medical goods or supplies.

"Highmark" means Highmark Inc., a Pennsylvania nonprofit corporation licensed to operate a hospital plan and a professional health services plan and its successors and assigns.

"Highmark Affiliates" means all Affiliates of Highmark. The term includes but is not limited to all of the Domestic Insurers (other than Highmark).

"Highmark Entities" or "Highmark Entity" means, individually and/or collectively, Highmark and Highmark Affiliates.

"Highmark Insurance Companies" shall have the meaning as set forth in the first paragraph of this Approving Determination and Order.

"IDN" means all aspects of and all Persons involved or to be involved with the integrated delivery network proposed by UPE referred to in Addendum 1 and which is referenced on page 1 of Addendum 1 (wherein UPE states that ". . . UPE proposed the change in control as part of a strategy to implement an integrated delivery network (IDN)"). The IDN is further described throughout the Form A and elsewhere in documents filed by UPE. The IDN includes but it's not limited to the Affiliation Agreement, the JRMC Affiliation Agreement, and proposed affiliation agreement with SVHS, the expansion of the provider network (physicians, community hospitals and medical malls), infrastructure development (including but not limited to the acquisition, expansion, development, improvement or construction of Health Care Services, Health Care Providers, facilities, physician practice management companies and group purchasing organizations), other relationships with individuals or Persons included in the Provider Group and any other activity that has been, is being or is expected to be included in the IDN when the IDN is fully implemented.

"IDN Compensation Policy" shall have the meaning set forth in Condition 18.

"IDN Savings" shall have the meaning set forth in Condition 19.

"IDN Strategy" refers to UPE's strategy to implement the IDN.

"Insurance Restructuring Restricted Receipt Account" means the restricted receipt account in the Pennsylvania State Treasury established by Section 7 of Act 62, 40 P.S. § 991.1403b.

"JRMC" means Jefferson Regional Medical Center, its successors and assigns.

"JRMC Affiliates" means all Affiliates of JRMC.

"JRMC Affiliation Agreement" means that certain affiliation agreement by, between and among UPE, UPE Provider Sub, Highmark, JRMC, the subsidiaries of JRMC and Jefferson Regional Medical Center Foundation dated as of August 13, 2012.

"Master Trust Indenture" shall have the meaning set forth in the Affiliation Agreement.

"Minimum Annual CHR Payments Obligation" shall have the meaning set forth in Condition 23A.

"Net Income" shall have the meaning set forth in Condition 15B.

"New UPMC Contract" shall have the meaning set forth in Condition 22A.

"Person" means any individual, corporation, partnership, limited liability company, trust, association, employee pension plan or stock trust or other entity or organization, including but not limited to any governmental or political subdivision or any agency or instrumentality thereof.

"PMPM IDN Savings" shall have the meaning set forth in Condition 19.

"Provider Group" refers to the Persons included or to be included in the "Provider Group" shown on the Proposed Corporate Structure after Tab N to Addendum 1.

"RBC Rating" means the risk-based capital level of a Health Care Insurer determined in accordance with the insurance laws and requirements of the Commonwealth of Pennsylvania as amended from time to time and in a manner acceptable to the Department.

"Required WPAHS Financial and Operational Information" shall have the meaning set forth in Condition 14.

"Steering" means any practice, process or arrangement the effect of which is directly or indirectly to encourage, direct or maneuver a Person into a course of action, e.g., choice of healthcare, by offering structured economic incentives that vary by their value to the consumer or other Person.

"SVHS" means Saint Vincent Health System, a Pennsylvania nonprofit corporation, its successors and assigns.

"SVHS Affiliates" means all Affiliates of SVHS.

"SVHS Entities" or "SVHS Entity" means SVHS and all SVHS Affiliates, collectively and individually.

"Tiering" means a method or design of a health care plan in which a Health Care Providers are assigned to different benefit tiers based on the Health Care Insurer's application of criteria to Health Care Providers' relative costs and/or quality, and in which enrollees pay the cost-sharing (co-payment, co-insurance or deductible) associated with a Health Care Provider's assigned benefit tier(s).

"Total IDN Savings" shall have the meaning set forth in Condition 19.

"Transaction" means the proposed Change of Control relating to the Highmark Insurance Companies as reflected in the Form A, together with all other related transactions and all aspects of the IDN Strategy, including but not limited to the Affiliation Agreement, the JRMC Affiliation Agreement, the expansion of the provider network (physicians, community hospitals and medical malls), the development of infrastructure (physician practice management companies and group purchasing organizations), formation of other relationships with individuals or entities included in the Provider Group, and any other activity that has been, is being or is expected to be included in the IDN when the IDN Strategy is fully implemented.

"UPE" means the Pennsylvania nonprofit corporation of that name formed on October 20, 2011, being the ultimate parent entity, and its successors and assigns.

"UPE Entity" or "UPE Entities" means individually and/or collectively UPE and Affiliates of UPE, including, but not limited to, UPE Provider Sub, Highmark, all Highmark Affiliates, WPAHS, and all WPAHS Affiliates, JRMC, and all of JRMC Affiliates, SVHS and all SVHS Affiliates, any entity Controlled by any of the foregoing, and their respective successors and assigns.

"UPE Health Care Provider Competitively Sensitive Information" means Competitively Sensitive Information originated by and/or held in any form by each business unit, e.g., each hospital (including, but not limited to, WPAHS and JRMC), each physician group, and other UPE Entities on the IDN side of UPE's business.

"UPE Provider Sub" means the Pennsylvania nonprofit corporation of that name formed on October 20, 2011 as referenced on page 7 of the Form A, its successors and assigns.

"UPMC" means University of Pittsburgh Medical Center and/or any and/or all of its Affiliates, its successors and assigns.

"UPMC Contract Transition Plan" shall have the meaning set forth in Condition 22B.

"WPA Service Area" shall have the meaning set forth in Condition 21.

"WPAHS" means West Penn Allegheny Health System, Inc., a Pennsylvania nonprofit corporation, its successors and assigns.

"WPAHS Affiliates" means all Affiliates of WPAHS.

"WPAHS Corrective Action Plan" shall have the meaning set forth in Condition 15.

"WPAHS Due Diligence Information" shall have the meaning set forth in the Affiliation Agreement.

"WPAHS Entities" or "WPAHS Entity" means, individually and/or collectively, WPAHS and all WPAHS Affiliates.

"WPAHS Tax-Exempt Bonds" shall have the meaning set forth in the Affiliation Agreement.

Appendix 2 (Firewall Policy)

Firewalls are a class of provisions that govern both the dissemination and/or sharing of Competitively Sensitive Information between and/or among the formerly independent operations of each UPE Entity and the personnel from each such entity that can be involved in decision-making and engaged with its rivals (who are suppliers or customers) at other UPE Entities. The purpose of developing and implementing a firewall policy is to avoid the inadvertent or intentional disclosure of Competitively Sensitive Information that could potentially reduce substantially competitive innovation or pricing between and/or among the vertically integrated entities and their rivals at the provider and insurer levels.

With respect to each UPE Entity, it is also imperative from a competitive perspective to establish firewalls that prevent persons with influence over managed care contracts and related reimbursements on the health plan side from obtaining information on rival managed contracts and related reimbursements on the provider side.

With this Condition, each UPE Entity shall develop and submit a firewall policy to the Department for approval. Different Firewall Policies may be submitted for separate UPE Entities or types of UPE Entities.

At a minimum, the Firewall Policy shall incorporate each of the following factors:

- UPE, UPE Provider Sub, Highmark, WPAHS, JRMC, and SVHS senior management involvement and support;
- Corporate firewall compliance policies and procedures;
- Mandatory training and education of current and new employees;
- Monitoring, auditing and reporting mechanisms;
- Consistent disciplinary procedures for violation of the Firewall Policy and incentives to ensure compliance; and
- A recusal policy to reduce the risk of senior management's involvement in the review and approval of contracts or arrangements containing Competitively Sensitive Information to which they should otherwise not have access.

From a competitive perspective, the following principles shall guide the development and implementation of an effective Firewall Policy among the UPE Entities' vertically integrated hospitals/providers and its insurers relating to personnel and decision-making:

- Separate managed care contracting information and activity of the hospital and of the insurer segments, including but not limited to the personnel who engage in decision-making and contracting with suppliers (customers);

- Firewall mechanisms that prevent sharing of Competitively Sensitive Information among persons at the hospital and insurer entities, with clear definition of what constitutes Competitively Sensitive Information; and

- Clear confidentiality policies, procedures and protocols that describe the specific persons and positions that can have access to Competitively Sensitive Information with clear policies and procedures for monitoring or auditing compliance with established firewalls, reporting of violations, and remedial actions taken in the event of a violation of the firewall.

Firewalls to prevent the dissemination of competitively sensitive information are common among vertically integrated firms, particularly integrated hospitals and insurance entities. At a minimum, each UPE Entity's Firewall Policy shall prohibit the exchange of Competitively Sensitive Information, including but not limited to:

- Present and future reimbursement rates by payor;

- Payor-provider reimbursement contracts;

- Terms and conditions included in agreements or contracts between payors and providers including but not limited to discounts in reimbursements in agreements;

- Reimbursement methodologies including but not limited to provisions relating to performance, pay for performance, pay for value, tiering of providers; and

- Specific cost and member information and revenue or discharge information specific to the payor.

Each UPE Entity's Firewall Policy shall incorporate monitoring, auditing and reporting mechanisms and provide consistent disciplinary procedures for violation of the Firewall Policy and incentives to ensure compliance, including but not limited to acknowledgement and certification by each employee or independent contractor with access to Competitively Sensitive Information of the employee's or independent contractor's responsibility to report actual or potential violations with the understanding that such reporting will not result in retribution. Employees also shall be required to affirmatively acknowledge that failure to report such information may subject the employee to disciplinary action and independent contractors shall be required to acknowledge that failure to report such information shall constitute cause for termination of such independent contractor's contract.

UPE's Firewall Policy shall include but not be limited to a whistleblower protection/anti-retaliation policy acceptable to the Department that specifically includes but is not limited to reports of Firewall Policy violations. The Firewall Policy may reference a whistleblower protection/anti-retaliation policy of UPE or another UPE Entity so long as that whistleblower/anti-retaliation policy is acceptable to the Department.

Appendix 3 (Benchmarks)

The following are the benchmarks (the "Benchmarks") referred to in Condition 19:

- $3,000 lower yearly premiums for a family of four by Fiscal Year 2016 relative to a "no transaction scenario" as described in the Form A.
- 10% cost savings on inpatient spend on enrollees that remain with the Domestic Insurers that are Health Care Insurers.
- 10% cost savings on outpatient spend on enrollees that remain with the Domestic Insurers that are Health Care Insurers.
- Achieve estimated IDN cost savings relative to a "no transaction scenario" as described in the Form A in the following amounts:

Period	With UPMC at Non-Par after 12/31/2014			With UPMC at Par after 12/31/2014		
	TOTAL	Utilization Shift	IDN Implementation	TOTAL	Utilization Shift	IDN Implementation
*CY14	$12M	$80M	($68M)	($91M)	$33M	($215M)
*CY15	($233M)	$4M	($238M)	($298M)	($15M)	($283M)
*CY16	($261M)	$14M	($275M)	($447M)	($15M)	($432M)

* "CY" means calendar year

Attachment 4 (Total IDN Savings Categories)

1) Oncology Shift
2) Utilization Shift
3) Reimbursement
4) Healthier Population
5) Right Setting
6) Right Treatment
7) Cost/Quality
8) Other

EXHIBIT B

UPMC LIFE CHANGING MEDICINE

BACKGROUND STATEMENT

June 12, 2013

UPMC's Mission is **to serve our communities by providing outstanding patient care and to shape tomorrow's health system through clinical and technological innovation, research, and education**. Within the comparatively short life of UPMC, this critical Mission has been advanced with levels of effectiveness and impact that probably are unsurpassed in the history of modern American medicine. Today, UPMC is widely recognized as one of the top academic medical centers in the world. The beneficiaries of UPMC's success include the patients we serve, the communities in which we work and the health of human kind. Consider the following:

- The hospitals, physicians and other health care professionals of UPMC now meet the needs of millions of patients annually. By any measure, UPMC has become the clear provider-of-choice for those living in the communities it serves. UPMC also has made Western Pennsylvania a destination-of-choice for patients from other locations around the world who seek medical care for complex conditions.
- In partnership with the University of Pittsburgh, UPMC has pioneered new approaches to transplantation, heart disease, cancer, neurological diseases and injuries, orthopedic conditions, psychiatric disorders and other life-threatening conditions. This unique and critical partnership also has provided education and training for most of the region's physicians, nurses and other healthcare professionals.
- Nearly 60,000 people earn their livelihoods at UPMC, making it Pennsylvania's largest non-governmental employer, and the spending by UPMC and its employees has been a critical factor in restoring and preserving the region's economic health. The system's total economic impact on the region is estimated to be nearly $22 billion annually, making it the principal driver of Western Pennsylvania's new "meds and eds" economy. After the decline of the smokestack industries and the more recent Great Recession, UPMC buoyed the local economy and helped the region to avoid the devastating consequences suffered by other cities.
- In the past fiscal year alone, UPMC also provided more than $622 million in community benefits, including charity care, uncompensated care from government programs for the poor, community health improvement programs and donations, funding for medical research, and education for tomorrow's health care professionals. The vast majority of the care for the region's underserved and economically disadvantaged population is provided by UPMC, while its $100 million commitment to The Pittsburgh Promise stands as an unprecedented example of philanthropic re-investment in the people of the City that has long been its principal home.

The fiduciary responsibility to pursue and protect that Mission is ultimately entrusted to UPMC's Board of Directors, twenty-four unpaid volunteers representing a broad cross-section of the communities and constituencies it serves. Its Board

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has ensured that UPMC provides innovative, high-quality, and cost-effective healthcare to the residents of Western Pennsylvania. It is a Board that also has been consistently attentive to risk – being mindful, in particular, of lessons from the recent history of healthcare in Western Pennsylvania, lessons that are telling but that, at least for some, seem to have been quickly, and perhaps conveniently, forgotten:

- As the original Allegheny General Hospital, a highly respected Pittsburgh institution with a long and proud history, became the Allegheny Health Education and Research Foundation, its operations were jeopardized by a flawed business strategy, poor management decisions, and questionable oversight. The result was the largest bankruptcy in American healthcare history, a series of criminal prosecutions, the loss of tens of millions of Western Pennsylvania dollars and thousands of Western Pennsylvania jobs, and permanent damage to what had been the Allegheny General Hospital.
- When the Board and management of the Western Pennsylvania Hospital assumed the role of "white knight" in saving what was left of the Allegheny General Hospital, their intentions almost certainly were noble. However, an objective look at the financial circumstances of these two institutions strongly suggested that West Penn lacked the strength to assume that responsibility and that the weight of Allegheny General inevitably would quickly pull West Penn, another institution with a long and proud history, into financial jeopardy, which it did.
- Meanwhile Highmark repeatedly tried to support and subsidize the new West Penn Allegheny Health System, over time infusing hundreds of millions of dollars into it. As now is absolutely clear, these subsidies did not rescue West Penn Allegheny from the financial difficulties that were the product of its own management decisions. However, by distorting the competitive environment, those subsidies caused lasting damage to other regional hospitals. St. Francis Hospital, which had been in operation since 1861 and which had particularly distinguished itself as a provider of compassionate psychiatric care and mental health services, did not survive. Mercy Hospital, the city's only remaining Catholic hospital, no longer could sustain itself and asked to become a part of UPMC under an arrangement that helped preserve its distinctive Catholic mission.

Throughout these tumultuous times, though regularly targeted by both Highmark and West Penn Allegheny, UPMC held fast to its mission, which the Board pursued with focus and foresight. A prime example of the Board's stewardship was the creation, fifteen years ago, of the UPMC Health Plan, which over the years has transformed UPMC into an integrated health system. By design, integrated health systems create provider networks that compete on quality, cost and member satisfaction when compared to traditional insurers that instead offer broad networks less attuned to clinical innovation, service, and cost. At its founding, moreover, the UPMC Health Plan emerged as the first real insurance competitor in a market historically dominated by Highmark.

When the UPMC Health Plan was formed, numerous critics, including Highmark, publicly contended that this integrated model could not and would not work—that UPMC was destined to be "another AHERF." But the Board's integrated strategy has been repeatedly confirmed as UPMC has thrived while other respected medical

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institutions in this region have struggled and sometimes failed. Indeed, nationally recognized experts today encourage providers to create financing arms, take on financial risk, and align internal incentives up and down their organizations — actions already taken by UPMC. These experts, supported by the new health reform legislation, now further promote vertical integration and vigorous competition as ways to limit the cost of healthcare and enhance value.

Given these trends, it was perhaps not surprising that two years ago Highmark reversed its longstanding condemnation of UPMC's integrated model and announced its own plan to become an integrated health system by acquiring the financially troubled West Penn Allegheny Health System. Highmark's expressed intention was, and has remained, to resurrect West Penn Allegheny as a competitor to UPMC and to put the full weight of its insurance monopoly behind this new competitor.

UPMC, consistent with its responsibilities to its patients and to the broader community, immediately advised the public of the impending expiration of the contracts allowing Highmark to include UPMC facilities and physicians in its network and specified that a renewal of those contracts would not be possible were Highmark to acquire West Penn Allegheny and reposition itself as a competing provider, both because it would put UPMC at risk and because it would undermine the very competition that should benefit the region, as a driver of even higher levels of quality and of lower cost. Then, as now, UPMC recognized the potential to move Western Pennsylvania from among the least competitive healthcare markets, with a dominant insurer and a dominant provider, to one of the most competitive, with two integrated health systems competing on the basis of quality, service, and cost, and at least three national insurers offering in-network access to both systems.

By mid-2012, with the end of the Highmark/UPMC contracts looming, Highmark and West Penn Allegheny had still not completed their proposed combination. At the Governor's behest, UPMC and Highmark therefore entered into a Mediated Agreement that extended the contracts between them until December 31, 2014, specifically to "provide for sufficient and definite time for patients to make appropriate arrangements for their care and eliminate the need for governmental intervention" when the contracts expired. As one part of that agreement and consistent with its commitments to patients and community, UPMC agreed that after 2014 Highmark subscribers would continue to have in-network access to various unique facilities and services at UPMC, including Children's Hospital, Western Psychiatric Institute and Clinic, certain oncology services not available at West Penn Allegheny, and two facilities that are essentially the sole providers of hospital services in their communities, UPMC Northwest Hospital and UPMC Bedford Memorial Hospital.

The Pennsylvania Insurance Department ultimately approved Highmark's proposal to acquire West Penn Allegheny on April 29, 2013, **an approval built on a Highmark plan that assumed no further contract extension with UPMC**. Highmark and West Penn Allegheny closed their transaction that same day.

As Highmark, UPMC, and the community in general approach this newly competitive market for what is perhaps the most personal, sensitive, and important service of all—health care—no one can afford to ignore demographic or medical reality. Southwestern Pennsylvania, where all of West Penn Allegheny's

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facilities are located, has a significant surplus of hospital beds, the product of a stable or declining population combined with advances in medical care that have reduced the need for acute admissions. As a result, any effort to increase patient admissions at one hospital will succeed only at the expense of other hospitals—a reality the consultants retained by the Pennsylvania Insurance Department described as a "zero sum game."

In the face of that reality, Highmark has put forward a business plan that requires it to increase admissions at West Penn Allegheny's hospitals by 41,000 patients per year. As the St. Francis and Mercy experiences suggest, some of those patients could come from community hospitals. In dealing with that large number, however, Highmark has made no secret of where it intends to get the vast majority of those admissions: UPMC.

As to how it would shift tens of thousands of patients per year from the UPMC doctors and hospitals that have been historically—and overwhelmingly—preferred to West Penn Allegheny's offerings, Highmark has presented two alternative plans. Highmark's "Base Case," as proposed to the Pennsylvania Insurance Department, assumes that it will have no contracts—commercial or Medicare—with UPMC after 2014 and that its subscribers will therefore not have the option of going to UPMC hospitals or physicians in network. According to Highmark, the vast majority of the "contestable volume" of patients in that Base Case will switch to West Penn Allegheny providers rather than change their insurer to keep UPMC in network. Whether or not Highmark's Base Case assumptions are sound can only be determined in the competitive marketplace. However, it is important to note that this Base Case with no UPMC contract was accepted by the Insurance Department—with extensive conditions and monitoring to assure that Highmark meets the expectations it has created. Among those conditions is one requiring Highmark to seek Insurance Department approval before signing any contract that it might offer UPMC, to ensure that, should UPMC ever agree to such a contract, it would not impair the recovery of West Penn Allegheny or otherwise lessen competition among either insurers or providers.

In fact, Highmark's alternative business plan assumes that any new contract with UPMC would, unlike the current contracts, permit Highmark to use economic incentives to "tier and steer" Highmark's subscribers away from UPMC and into the West Penn Allegheny Health System. Highmark has given these contractual provisions the appealing, but misleading, name "consumer choice initiatives," because as Highmark has already demonstrated any "choice" it might provide to its subscribers would be illusory.

In what would amount to a classic bait and switch, Highmark would lure employers and subscribers into new contracts or contract renewals with the illusion of in-network access to UPMC only to use tiers, co-pays, co-insurance, deductibles and the like to steer those subscribers over to West Penn Allegheny. While Highmark has said that it would tier and steer based on differences in "cost and quality," even those pressures would undermine patient choice. Nor could UPMC ever rely on Highmark to gauge "cost and quality" fairly and objectively, particularly where Highmark's announced intention is to drive an additional 41,000 patients every year away from UPMC and into West Penn Allegheny.

Highmark simply has no option but to force its subscribers toward West Penn Allegheny; over the

Continued

last decade, those subscribers have overwhelmingly chosen UPMC when given an unfettered choice. That is why Highmark has outlined only two business plans supporting a rescue of West Penn Allegheny: its base plan in which its subscribers would have no in-network access to UPMC and therefore would have to use West Penn Allegheny, and its alternative plan, where its subscribers would be offered the illusion of access to UPMC only to be steered to West Penn Allegheny.

Clearly UPMC could not responsibly sign contracts giving Highmark the free use of anti-competitive weapons to harm UPMC. The diversion of 41,000 patients per year from UPMC's system would be the equivalent, for example, of closing both UPMC Mercy and UPMC Shadyside, with the attendant loss of approximately 11,000 jobs. Nor could UPMC, as a committed healthcare provider, willingly allow Highmark to discourage patients from using the hospitals and physicians they overwhelmingly prefer. Indeed, Compass-Lexecon, the consultants retained by the Insurance Department, recognized that it would be "unreasonable" to assume that UPMC would enter into the contracts proposed by Highmark.

Were Highmark to divert tens of thousands of patients away from UPMC and into West Penn Allegheny, UPMC would be greatly diminished. It could no longer invest more than $250 million in annual support of cutting edge research, education and training at the University of Pittsburgh. Nor could it make commitments to initiatives like the Pittsburgh Promise, which is investing $100 million of UPMC funds in an unprecedented opportunity for economically challenged families to send their children to college and as an incentive for families to remain in Pittsburgh. It could no longer invest more than $500 million per year in capital projects creating facilities and jobs in Pittsburgh. It could no longer provide care to the vast majority of the underprivileged and underserved. If Highmark wants to inflict that kind of damage on one of the world's best health systems and on the constituents and communities that it serves, it should have to do that by competing, integrated health system to integrated health system, without seeking to create yet another uncompetitive market by handicapping its chief competitor.

UPMC's Board owes a fiduciary obligation to preserve and protect the charitable assets that have been entrusted to it and to ensure that those charitable assets are managed and deployed in pursuit of UPMC's Mission. Highmark's announced plan to steer tens of thousands of admissions away from UPMC's hospitals in Southwestern Pennsylvania poses a direct, substantial threat to UPMC's charitable assets, to its clinical and academic mission, to its role as the economic driver of the region, and to its ability to provide future benefits to the community. Highmark's opportunity to deliver on that devastating plan would be greatly enhanced were it to secure contracts capturing UPMC's hospitals and its physicians within its network after December 31, 2014, particularly if any such contracts allowed Highmark to impede its subscriber's access to UPMC's hospitals and steer them instead into its newly formed health network.

Any concerns, moreover, about continued access to the unique community assets managed by UPMC have already been addressed in the Mediated Agreement, which provides for Highmark subscribers to have in-network access to certain UPMC specialty hospitals, certain unique oncology services, certain "sole-provider" hospitals, certain services at non-UPMC facilities under joint ventures, and certain services provided by UPMC physicians

Continued

at non-UPMC locations or facilities, even after the existing commercial contracts expire on December 31, 2014.

Meanwhile, enhanced competition in both the insurance market and the provider market positions Western Pennsylvania to maintain high quality and affordable healthcare. There will be at least five choices of insurance sponsors available to consumers and businesses, including the UPMC Health Plan, rated as having the highest quality and consumer satisfaction of commercial plans in western Pennsylvania and having at its core UPMC's world class providers. Highmark, meanwhile, will offer plans centered on West Penn Allegheny and designed to entice patients away from UPMC. National insurers, including Aetna, Cigna, and United Healthcare, and others, already are offering and will continue to offer access to both UPMC providers and Highmark providers. Although the Pittsburgh market had long been a competitive outlier without either vibrant national carriers or consumers accustomed to shopping for less costly insurance alternatives, the region's employers and consumers have more recently been the beneficiaries of a price war that will save them tens of millions of dollars on health insurance premiums.

Finally, eighteen months is a reasonable amount of time for Highmark and UPMC to negotiate and implement a transition plan that would allow everyone affected by this development to adapt to and make informed decisions about that transition. Numerous employers are already offering their employees insurance options that will include full, in-network access to UPMC after 2014; others will follow suit once it becomes clear that the current contracts will, in fact, expire. No further time should be wasted, however, in making that expiration clear and in moving forward with the appropriate transition.

SYS409129 JAB/LY 06-13-13

UPMC LIFE CHANGING MEDICINE

RESOLUTION

UPMC Board of Directors
June 12, 2013

It is therefore resolved as follows:

- UPMC cannot, in keeping with its central clinical and academic mission, its duty to protect and preserve its charitable assets, and its obligations to the communities it serves, enter into any extension of the existing commercial contracts, or any new commercial contracts, providing Highmark with in-network access to any current UPMC hospitals or physicians in Southwestern Pennsylvania beyond Children's Hospital of Pittsburgh of UPMC, Western Psychiatric Institute and Clinic, UPMC Northwest, UPMC Bedford Memorial and certain other services (including certain unique oncology services) as specified in the Mediated Agreement of July 1, 2012, and therefore will not do so;
- Management shall continue to enter into, or extend, commercially reasonable contracts with health insurers that do not own or control provider services that compete with UPMC's hospitals or physicians; and
- Management shall immediately attempt to engage Highmark in discussions regarding the transition that will take place between the date of this resolution and December 31, 2014, with the purposes of (1) providing all subscribers, patients, physicians, and employers with adequate, timely and accurate information on which to base the choices they will have; (2) ensure for the smooth and safe transfer of insurance coverage and patient care; and (3) provide for enhanced competition in the market for health insurance and the market for health services.

EXHIBIT C

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA, By KATHLEEN G. KANE, Attorney General; PENNSYLVANIA DEPARTMENT OF INSURANCE, By MICHAEL CONSEDINE, Insurance Commissioner and PENNSYLVANIA DEPARTMENT OF HEALTH, By MICHAEL WOLF, Secretary of Health, Petitioners, v. UPMC, A Nonprofit Corp.; UPE, a/k/a, HIGHMARK HEALTH, A Nonprofit Corp. and HIGHMARK, INC., A Nonprofit Corp.; Respondents.	:	No. 334 M.D. 2014

PETITION FOR REVIEW

The Commonwealth of Pennsylvania acting as *parens patriae* through its Attorney General, Kathleen G. Kane, its Insurance Commissioner, Michael F. Consedine, and its Secretary of Health, Michael Wolf, by and through the Office of General Counsel, bring this action to redress violations of the Unfair Trade Practices and Consumer Protection Law (Consumer Protection Law), 73 P.S. §§201-1—201-9.3, the Insurance Companies Law of 1921, 40 P.S. §§991.2101-991.2193 (Act 68), and breach of a third party beneficiary contract.

JURISDICTION

1. This Court has original jurisdiction over this action pursuant to Section 761(a)(2) of the Judicial Code, 42 Pa.C.S. § 761(a)(2), which gives this Court jurisdiction over actions initiated by the Commonwealth.

PARTIES

2. Petitioner, the Commonwealth of Pennsylvania is acting as *parens patriae* through its Attorney General, Kathleen G. Kane (Commonwealth), with her office located on the 14TH Floor of Strawberry Square, in Harrisburg, Pennsylvania 17120.

3. Petitioner, the Pennsylvania Insurance Department through its Insurance Commissioner, Michael F. Consedine, is located on the 13TH Floor of Strawberry Square, in Harrisburg, Pennsylvania 17120.

4. Petitioner, the Pennsylvania Department of Health through its Secretary of Health, Michael Wolf, is located in the 8TH Floor of the Health and Welfare Building, West 625 Forster Street, Harrisburg, PA 17120.

5. Respondent, UPMC is a domestic, nonprofit corporation incorporated on June 10, 1982, on a non-stock, non-membership basis, with its registered office located at U.S. Steel Building, 200 Lothrop Street, Pittsburgh, Pennsylvania 15213. Unless otherwise specified, all references to "UPMC" include all of its controlled nonprofit and for-profit subsidiaries, partnerships, trusts, foundations, associations or other entities however styled.

6. Respondent, UPE, also known as Highmark Health, was incorporated on October 20, 2011, on a non-stock, non-membership basis, with its registered office located at Fifth

Avenue Place, 120 Fifth Avenue, in Pittsburgh, Pennsylvania 15222. UPE serves as the sole controlling member of Highmark, Inc.

7. Respondent, Highmark, Inc., is a domestic, nonprofit corporation incorporated on December 6, 1996, with its registered office located at Fifth Avenue Place, 120 Fifth Avenue, in Pittsburgh, Pennsylvania 15222. Unless otherwise specified, all references to "Highmark" include UPE and all of its controlled nonprofit and for-profit subsidiaries, partnerships, trusts, foundations, associations or other entities however styled.

FACTS

8. Paragraphs 1 through 7 are incorporated as if fully set forth.

9. At all times relevant and material, UPMC has operated as the parent corporation and controlling member of a nonprofit academic medical center and integrated health care delivery system supporting the health care, research and educational services of its constituent hospitals and providers.

10. UPMC controls more than 20 academic, community and specialty hospitals, more than 400 clinical locations, and employs more than 3,300 physicians.

11. UPMC's website at www.upmc.com describes UPMC's mission, vision and values as follows:

Our Mission:

> **UPMC's mission is to serve our community by providing outstanding patient care** . . . .

Our Vision:

> **Putting our patients at the center of everything we do** and creating a model that assures **that every patient gets the right care, in the right way, at the right time, every time.**

Our Values:

> **Our patients and members are our first priority and we strive to be responsive to their needs as well as those of the thousands of family members, visitors and community residents who walk through our doors, email, text or call us every day.**

http://www.upmc.com/why-upmc/mission/pages/default.aspx (emphasis added).

12. UPMC's "Patients' Rights and Responsibilities," posted in various offices of its subsidiaries and published on its web site provides in pertinent part:

> At UPMC, **service to our patients is our top priority**. . . . .
>
> . . .
>
> 13. **A patient has the right to medical and nursing services without discrimination based upon** race, color, age, ethnicity, religion, sex, sexual orientation, national origin, **source of payment**, or marital, veteran, or handicapped status.
>
> . . .

See, http://www.upmc.com/patients-visitors/patient-info/pages/patient-rights-responsibilities.aspx (emphasis added).

13. UPMC is the dominant provider of health care services throughout western Pennsylvania accounting for approximately 60% of the medical-surgical market share in Allegheny County and 35.7% of the medical-surgical market share in the 29 county region of western Pennsylvania.

14. UPMC is also the ultimate controlling person of an insurance holding company system that includes, *inter alia*, three domestic stock insurance companies, two domestic risk-assuming preferred providers and three domestic health maintenance organizations (collectively UPMC Insurance Subsidiaries), including the UPMC Health Plan, covering approximately 2 million members throughout western Pennsylvania in competition with other health plans.

15. UPMC and the UPMC Insurance Subsidiaries are engaged in the business of insurance in the Commonwealth of Pennsylvania.

16. Highmark Health is the ultimate controlling person of an insurance holding company system that includes, *inter alia*, domestic hospital plan corporations and professional health services plan corporations, domestic stock insurance companies, domestic health maintenance organizations and a domestic risk-assuming preferred provider organization (collectively Highmark Health Insurance Subsidiaries).

17. Highmark Health and the Highmark Health Insurance Subsidiaries are engaged in the business of insurance in the Commonwealth of Pennsylvania.

18. Highmark's Blue Cross Blue Shield subsidiaries are independent licensees of the Blue Cross Blue Shield Association, and operate respectively as a certified hospital plan corporation (Blue Cross) and a certified professional health service corporation (Blue Shield) pursuant to Sections 6103 and 6307 of the Hospital Plan Corporations Act and the Professional Health Services Plan Corporation Act, respectively. 40 Pa.C.S. §§ 6103 and 6307.

19. Highmark is the largest health plan throughout UPMC's service area in western Pennsylvania, accounting for more than 60% of the region's health plan market.

20. Historically, UPMC has always contracted with Highmark for its commercial insurance products.

21. In the spring of 2011, UPMC announced that it would not agree to renew or renegotiate its provider agreement with Highmark, which was due to expire on December 31, 2012.

22. UPMC justified its refusal to renew its contractual relationship with Highmark in the spring of 2011 because of Highmark's proposal to affiliate with the West Penn Allegheny

Health System, another nonprofit health care provider, which would create the region's second charitable integrated health care delivery system in competition with UPMC. An integrated health care delivery system includes physicians, hospitals, ancillary care and a health insurer all under the control of one entity. UPMC was then western Pennsylvania's only integrated health care delivery system.

23. The expiration of the UPMC/Highmark provider agreement would have subjected all of Highmark's health insurance members to UPMC's significantly higher out-of-network charges for their health care needs unless they either switched their health care provider away from UPMC or their health plan away from Highmark to one of the health insurers with which UPMC had contracted, albeit at higher prices.

24. UPMC's announcement resulted in legislative hearings and an agreement with Highmark negotiated through the Governor's office, dated May 1, 2012 (Mediated Agreement).

25. Under the terms of the Mediated Agreement, UPMC and Highmark agreed to provide in-network access to all UPMC hospitals and physicians for Highmark commercial and Medicare Advantage members through December 31, 2014. Highmark and UPMC agreed to the contract extension until the end of 2014 to provide substantial and definite time for patients to make appropriate arrangements for care and eliminate the need for any possible governmental intervention under Act 94, 40 Pa.C.S. § 6124 (d), which deals with the termination of provider contracts by hospital plan corporations.

26. Under the terms of the Mediated Agreement, Highmark and UPMC also agreed to negotiate rates and terms for continued Highmark member access to certain UPMC services on an in-network basis beginning in 2015, including Western Psychiatric Institute and Clinic, certain oncological services, UPMC Bedford Memorial, and UPMC

Venango (Northwest). Highmark members in a continuing course of treatment at UPMC would also continue to have in-network access to UPMC hospital and physician services. UPMC-Highmark arrangements with UPMC Mercy and Children's Hospital of Pittsburgh of UPMC would remain in effect, with existing arrangements regarding UPMC Hamot extended until December 31, 2014.

27. The Mediated Agreement provided that, "The agreement, in principle, is binding and will be implemented through formal agreements to be completed by June 30, 2012."

28. On May 2, 2012, Highmark and UPMC issued a Joint Statement announcing the Mediated Agreement to the public as providing in-network access to all UPMC hospitals and physicians for Highmark commercial and Medicare Advantage members until December 31, 2014. A true and correct copy of the May 2, 2012 Joint Statement by Highmark and UPMC is attached as Exhibit "A".

29. On or about April 23, 2013, the Pennsylvania Insurance Department (PID) approved Highmark's affiliation with the West Penn Allegheny Health System and they now operate under a newly formed charitable, nonprofit parent, UPE, doing business as "Highmark Health."

30. Highmark's filing and supporting materials submitted to the PID contemplated a "base case" scenario where Highmark would not have a continued contractual relationship with UPMC. The PID's approval was largely premised on acceptance of Highmark's base case scenario.

31. Highmark Health serves as the sole controlling member of the system's health plan and provider subsidiaries; the health plan subsidiary continues to operate under the name, "Highmark" while another newly formed provider subsidiary operates under the name,

"Allegheny Health Network," which serves as the sole controlling member of the West Penn Allegheny Health System, the Jefferson Regional Health System, and the St. Vincent's Health System.

32. In approving the Highmark/West Penn affiliation described above, the PID prohibited Highmark from agreeing to any future provider contracts containing anti-tiering and anti-steering provisions, which are contract provisions UPMC has traditionally insisted upon.

33. On June 12, 2013, UPMC's Board of Directors allegedly resolved, *inter alia,* to forego "any extension of the existing commercial contracts, or any new commercial contracts, providing Highmark with in-network access to any current UPMC hospitals or physicians in Southwestern Pennsylvania beyond Children's Hospital of Pittsburgh of UPMC, Western Psychiatric Institute and Clinic, UPMC Northwest, UPMC Bedford Memorial and certain other services . . . as specified in the Mediated Agreement . . . ."

34. UPMC purports to have taken these actions because Highmark is now a competitor in the health care provider market and will be "tiering and steering" its health plan customers to move patients from UPMC into Highmark's new system. "Tiering" is the practice of having "tiers" of providers in a network. If members seek care from providers in preferred tiers, they typically pay lower co-pays or co-insurance (the percentage of the bill the consumer pays). If members seek care at non-preferred providers in the network, they pay higher co-pays and co-insurance. "Steering" is the practice of offering some incentive to members to use one provider over another.

35. UPMC contends that such "tiering and steering" practices by Highmark would have a deleterious financial impact on UPMC.

36. The UPMC Health Plan, however, offers tiered products providing UPMC's members lower cost-sharing amounts if they use UPMC's providers.

37. UPMC has used its UPMC Health Plan to "tier and steer" members to UPMC providers and has openly competed against Highmark in the insurance market for more than a decade without Highmark similarly refusing to contract with UPMC as one of its competitors.

38. Many people obtain their health plans through their employers and will not be able to change their insurance to avoid UPMC's higher out-of-network charges unless their employers change or add another health plan to their employee benefit plans. Moreover, UPMC's contracts with other health plans are at higher rates than Highmark's contracts and prohibit steering and tiering, thereby putting those firms at a disadvantage to Highmark and the UPMC Health Plan.

39. Pursuant to the Emergency Medical Treatment and Labor Act (EMTALA,), 42 U.S.C. § 1395dd, a hospital is required to treat all persons who come to an emergency room when in an emergency medical condition or in labor.

40. UPMC's hospitals get more than 50% of admissions from their emergency rooms. When a patient is treated for an emergency condition or admitted for an emergency, the patient's health plan is obligated to pay for the patient's care.

41. Since patients in an emergency medical condition often have no control over which emergency room they are taken to when their emergency occurs, it is common for patients to be taken to emergency rooms of hospitals which are outside the networks of their health plans.

42. In such circumstances, the health plan pays the bill of the hospital at rates negotiated on an ad hoc basis.

43. UPMC tenders bills to the health plans at full charges, their highest prices, and each bill is individually negotiated.

44. If Highmark does not have a contract with UPMC, its members will, nonetheless still arrive at UPMC emergency rooms. Highmark and UPMC will negotiate each bill and Highmark will pay significantly higher prices for the treatment of consumers in emergency medical conditions than it does currently. These high costs will be borne immediately by all area employers who are self-insured. Employers who are fully insured will pay higher insurance rates in the future as the higher costs are incorporated in their rate base.

45. The ongoing contractual disputes between UPMC and Highmark have escalated to the point that both entities have engaged in extensive and costly lobbying, advertising campaigns, and litigation which have further contributed to the public's confusion and misunderstanding.

COUNT I

UPMC'S AND HIGHMARK'S BREACH OF MEDIATED AGREEMENT, LIABILITY TO PUBLIC AS THIRD-PARTY BENEFICIARY

46. Paragraphs 1 through 45 are incorporated as if fully set forth.

47. Under the Mediated Agreement, Highmark's members were intended to have access to all of UPMC's providers through at least December 31, 2014 to smooth the public's transition in the changing relationship between UPMC and Highmark, making the public-at-large a third-party beneficiary of the Mediated Agreement.

48. In recognition of special community needs and certain unique services provided by Western Psychiatric Institute, UPMC Northwest, and UPMC Bedford Memorial, Highmark and UPMC agreed to negotiate terms and conditions for continued in-network access to those entities.

49. UPMC and Highmark agreed to negotiate terms and conditions for continued in-network access to certain UPMC oncological services.

50. Highmark and UPMC agreed that Highmark members in a continuing course of treatment would have in-network access to UPMC hospitals and providers.

51. More than two years after executing the Mediated Agreement on May 1, 2012, UPMC and Highmark have yet to reach definitive agreements for:

a. continued in-network access to Western Psychiatric Institute, UPMC Northwest, and UPMC Bedford Memorial;

b. continued in-network access to certain UPMC oncological services and are now arbitrating the appropriate rates for those services as well as their respective abilities to change the rates or fee schedules;

c. continued in-network access for Highmark members in a continuing course of treatment at UPMC hospitals and providers;

d. continued in-network access to other UPMC hospitals and providers serving special local community needs or providing unique services, including, but not limited to, UPMC Altoona, UPMC Hamot, UPMC Horizon, and Kane Community Hospital;

e. access to other UPMC providers serving non-UPMC locations or facilities under joint ventures, service agreements, or otherwise;

f. continuity of care services to be provided by UPMC to Highmark members beginning January 1, 2015 – nor have they settled upon the rates for continuity of care services; and

g. the terms and conditions under which Highmark will pay for services rendered through referrals to out-of-network UPMC facilities by in-network UPMC providers.

52. The lack of the definitive agreements complained of have caused confusion and uncertainty for patients and have denied the public the benefit of the smooth transition the Mediated Agreement intended.

WHEREFORE, the Commonwealth respectfully requests that this Honorable Court find Highmark and UPMC to be liable to the Commonwealth on behalf of the public as a third-party beneficiary to the Mediated Agreement and:

a. Require respondents to reach an agreement for hospital, physician and follow-up care services to Highmark members at Western Psychiatric Institute and Clinic, and for certain oncological, trauma and behavioral health services to Highmark members at any UPMC facility within 30 days of this Court's order and, failing such agreement, impose last best offer arbitration;

b. Require respondents to reach an agreement concerning UPMC hospitals and providers that serve special local community needs or provide unique services, including, but not limited to Western Psychiatric Institute and Clinic, UPMC Bedford Memorial, UPMC Venango (Northwest), UPMC Hamot, UPMC Altoona, UPMC Horizon, and Kane Community Hospital within 30 days of this Court's order and, failing such an agreement, impose last best offer arbitration;

c. For the emergency room services EMTALA requires UPMC to provide to Highmark members, require respondents to reach an agreement for hospital, physician and follow-up care services at all UPMC hospitals within 30 days of this Court's order and, failing such an agreement, impose last best offer arbitration;

d. Require that respondents reach an agreement for hospital, physician and follow-up services for Highmark members who are part of vulnerable populations, including, but not limited to, consumers age 65 and older who are eligible or covered by Medicare/Medicare Advantage/MediGap health plans; and consumers who are eligible or covered by CHIP, Medicaid fee-for-service and Medicaid managed care health plans within 30 days of this Court's order and, failing such an agreement, impose last best offer arbitration; and

e. Order any other relief that the Court deems appropriate.

COUNT II

UPMC'S VIOLATIONS OF THE CONSUMER PROTECTION LAW, ENGAGING IN UNFAIR CONDUCT CAUSING SUBSTANTIAL INJURY TO CONSUMERS WHO CANNOT AVOID THE RESPONDENT'S SUBSTANTIALLY HIGHER "OUT-OF-NETWORK" COSTS FOR ITS HEALTH CARE SERVICES.

53. Paragraphs 1 through 52 are incorporated as fully set forth.

54. At all times relevant and material, UPMC engaged in and continues to engage in trade or commerce within Pennsylvania by advertising, marketing, promoting, soliciting, and selling an array of medical products and services, including acute inpatient hospital care, outpatient care, physician services and the UPMC Health Plan insurance products and

services directly and indirectly to consumers, within the meaning of Section 2 of the Consumer Protection Law, 73 P.S. § 201-2.

55. UPMC's decision to forego all future contractual relationships with Highmark after December 31, 2014, violates:

a. its representations set forth in its mission statement on its web site that, "[o]ur patients and members are our first priority and we strive to be responsive to their needs . . . ."; and

b. its representations set forth in its "Patients' Rights and Responsibilities" that, "[a] patient has the right to medical and nursing services without discrimination based upon . . . [the] source of payment . . . ."

56. Sections 2(4)(iii), (v), (viii) and (xxi) of the Consumer Protection Law define "unfair or deceptive acts or practices" as follows:

. . .

(iii) Causing likelihood of confusion or of misunderstanding as to affiliation, connection or association with, or certification by, another;

. . .

(v) Representing that goods or services have sponsorship, approval, characteristics, ingredients, uses, benefits or quantities that they do not have or that a person has a sponsorship, approval, status, affiliation or connection that he does not have;

. . .

(viii) Disparaging the goods or services or business of another by false or misleading representation of fact;

. . .

(xxi) Engaging in any other fraudulent or deceptive conduct which creates a likelihood of confusion or of misunderstanding.

73 P.S. §201-2(4)(iii), (v), (viii) and(xxi).

57. Section 3 of the Consumer Protection Law, 73 P.S. §201-3, declares unfair and deceptive acts or practices to be unlawful.

58. Section 4 of the Consumer Protection Law, 73 P.S. §201-4, empowers the Attorney General to bring actions in the name of the Commonwealth to restrain persons by temporary and permanent injunction from using any act or practice declared to be unlawful by Section 3 of the Consumer Protection Law, 73 P.S. §201-3.

59. Section 4.1 of the Consumer Protection Law, 73 P.S. §201-4.1, provides that, "whenever any court issues a permanent injunction to restrain and prevent violations of this act . . . the court may in its discretion direct that the defendant or defendants restore to any person in interest any moneys or property . . . which may have been acquired by means of any violations of this act . . . ."

60. Section 8(b) of the Consumer Protection Law provides:

> In any action brought under section 4 of this act, if the court finds that a person, firm or corporation is willfully using or has willfully used a method, act or practice declared unlawful by section 3 of the act, the Attorney General . . . may recover, on behalf of the Commonwealth of Pennsylvania, a civil penalty of not exceeding one thousand dollars ($1,000) per violation, which civil penalty shall be in addition to other relief which may be granted under sections 4 and 4.1 of this act. Where the victim of the willful use of a method, act or practice declared unlawful by section 3 of this act is sixty years of age or older, the civil penalty shall not exceed three thousand dollars ($3,000) per violation, which penalty shall

be in addition to other relief which may be granted under section 2 and 4.1 of this act.

73 P.S. §201-8(b).

61. UPMC has represented to the public generally, and to its patients in particular, that UPMC's vision is "Putting our patients at the center of everything we do and creating a model that assures that every patient gets the right care, in the right way, at the right time, every time."

62. UPMC has described it values to the public generally, and to its patients in particular, that "Our patients and members are our first priority and we strive to be responsive to their needs . . . ."

63. UPMC's decision to forego all future commercial contractual relationships with Highmark after December 31, 2014, beyond those provided for in the Mediated Agreement, however, will inevitably result in thousands of unintended "out-of-network" medical procedures per year.

64. As alleged, many of those "out-of-network" procedures will be due to circumstances beyond the consumers' control.

65. As such, UPMC's discriminatory conduct subjects consumers to suffer unfair and substantially higher "out-of-network" charges for its health care services and is at odds with UPMC's representations to the public.

WHEREFORE, the Commonwealth respectfully requests that this Honorable Court:

a. Find that UPMC has engaged in unfair methods of competition and unfair or deceptive acts or practices within the meaning of Section 201-4 of the Consumer Protection Law;

b. Find that UPMC has willfully engaged in unfair and unconscionable acts or practices in violation of Section 201-3 of the Consumer Protection Law by pursuing a strategy of subjecting consumers to unfair and substantially higher "out-of-network" charges under circumstances beyond the consumers' control;

c. Pursuant to Section 201-4 of the Consumer Protection Law, enjoin UPMC its agents, representatives, servants, employees, successors, and assigns from imposing unfair and substantially higher "out-of-network" charges for its health care services by limiting UPMC's charges to no more than a reasonable price consistent with UPMC's charitable mission;

d. Award the Commonwealth its costs of investigation and attorneys' fees in this action pursuant to Section 201-4.1 of the Consumer Protection Law; and

e. Order any other relief the Court deems appropriate. .

COUNT III

UPMC AND HIGHMARK'S VIOLATIONS OF THE INSURANCE COMPANY LAW OF 1921

66. Paragraphs 1 through 63 are incorporated as if fully set forth.

67. Act 68 empowers the Pennsylvania Insurance Department and the Pennsylvania Department of Health to bring actions in the name of the Commonwealth to enjoin any action in violation of Act 68, 40 P.S. §991.2182(c).

68. In the Mediated Agreement, Highmark and UPMC agreed, in recognition of special local community needs and certain unique services provided by UPMC, to negotiate terms and

conditions for continued in-network access to Western Psychiatric Institute, UPMC Northwest, and UPMC Bedford.

69. In the Mediated Agreement, Highmark and UPMC agreed, in recognition of special local community needs and certain unique services provided by UPMC, to negotiate terms and conditions for continued in-network access to certain oncological services.

70. In the Mediated Agreement, Highmark and UPMC agreed that Highmark members in a continuing course of treatment would have in-network access to UPMC hospitals and providers.

71. UPMC and Highmark have negotiated a Term Sheet for in-network services at Western Psychiatric Institute, UPMC Northwest and UPMC Bedford Memorial. However, UPMC and Highmark have not reached a definitive agreement.

72. UPMC and Highmark have not agreed on a contract for other UPMC hospitals and providers that serve special local community needs or provide unique services, including, but not limited to, UPMC Hamot, UPMC Horizon, and Kane Community Hospital.

73. UPMC and Highmark have not agreed on a contract for other UPMC providers that service non-UPMC locations or facilities under joint ventures, services agreement, or otherwise.

74. UPMC and Highmark are currently engaged in a dispute concerning the appropriate rate of payment for oncological services and the parties' ability to change rate or fee schedules.

75. UPMC and Highmark have not agreed on the continuity of care services to be provided by UPMC to Highmark members beginning January 1, 2015 or the rates for such services.

76. UPMC and Highmark have not agreed on the terms and conditions under which Highmark will pay for services rendered upon referral to an out-of-network UPMC facility by an in-network UPMC provider.

77. The ongoing contractual dispute threatens the adequacy of Highmark's network and the access of Highmark members to emergency care at reasonable cost.

WHEREFORE, the Commonwealth respectfully requests that this Honorable Court:

a. Find that UPMC's and Highmark's ongoing contractual dispute has threatened and continues to threaten the adequacy of Highmark's network in violation of Act 68, 40 P.S.§ §991.2111(1) and 2111(4);

b. Require that respondents reach an agreement for hospital, physician and follow-up care services to Highmark members at Western Psychiatric Institute and Clinic, and for certain oncological, trauma and behavioral health services to Highmark members at any UPMC facility within 30 days of this Court's order and, failing such agreement, impose last best offer arbitration;

c. Require that respondents reach an agreement concerning UPMC hospitals and providers that serve special local community needs or provide unique services, including, but not limited to Western Psychiatric Institute and Clinic, UPMC Bedford Memorial, UPMC Altoona, UPMC Venango (Northwest), UPMC Hamot, UPMC Altoona, UPMC Horizon, and Kane Community Hospital within 30 days of this Court's order and, failing such an agreement, impose last best offer arbitration;

d. For the emergency room services EMTALA requires UPMC to provide to Highmark members, require that respondents reach an agreement for hospital,

physician and follow-up care services at all UPMC hospitals within 30 days of this Court's order and, failing such an agreement, impose last best offer arbitration ;

e. Require that respondents reach an agreement for hospital, physician and follow-up services for Highmark members who are part of vulnerable populations, including, but not limited to consumers age 65 and older who are eligible or covered by Medicare/Medicare Advantage/MediGap health plans; and consumers who are eligible or covered by CHIP, Medicaid fee-for-service and Medicaid managed care health plans within 30 days of this Court's order and, failing such an agreement, impose last best offer arbitration; and

f. Order any other relief that the Court deems appropriate.

Respectfully submitted,

KATHLEEN G. KANE,
Attorney General

By: _____
James A. Donahue, III
Executive Deputy Attorney General
PA Office of Attorney General
Public Protection Division
14TH Floor, Strawberry Square
Harrisburg, P A 17120
Telephone: (717) 787-9716
PA Bar No: 42624

JAMES D. SCHULTZ,
General Counsel, On Behalf Of

MICHAEL F. CONSEDINE
Insurance Commissioner

MICHAEL WOLF
Secretary of Health

By: _____
Yen T. Lucas
Chief Counsel
Pennsylvania Insurance Department
Governor's Office of General Counsel
13TH Floor, Strawberry Square
Harrisburg, PA 17120
Telephone: (717) 783-1975
PA Bar No 203588

UPMC LIFE CHANGING MEDICINE

NEWS RELEASE SEARCH

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UPMC/University of Pittsburgh Schools of the Health Sciences

UPMC LIFE CHANGING MEDICINE

Joint Statement by Highmark and UPMC

For Journalists

Paul Wood
Vice President & Chief Communications Officer, Public Relations
Telephone: 412-647-6647

Other Inquiries
Contact Us

PITTSBURGH, May 2 – Highmark and UPMC are pleased to announce that they have reached an agreement in principle to provide for in-network access to all UPMC hospitals and physicians for Highmark Commercial and Medicare Advantage members until December 31, 2014.

In addition, in recognition of special local community needs and certain unique services offered by UPMC, and to minimize access to care and rate disputes, Highmark and UPMC have agreed to negotiate rates and terms for continued Highmark member access to certain UPMC services on an in-network basis starting in 2015, including Western Psychiatric Institute and Clinic, certain oncological services, UPMC Bedford, and UPMC Northwest. Highmark members in a continuing course of treatment at UPMC will also continue to have in-network access to UPMC hospital and physician services.

Current Highmark-UPMC arrangements regarding UPMC Mercy and Children's Hospital are unaffected by this agreement and will remain in effect. The current Highmark-UPMC arrangements regarding UPMC Hamot, which expire on June 30, 2013 with an additional one-year run-out period, will be extended by six months to December 31, 2014.

As part of its community benefit mission, UPMC will also continue to provide in-network hospital and physician services at preferred rates for certain Highmark plans which serve vulnerable populations, specifically Special Care, pa fair care, CHIP and Guaranteed Issue plans, for such time as these plans continue to be offered by Highmark.

The contractual extension until the end of 2014 will provide for sufficient and definite time for patients to make appropriate arrangements for their care and eliminate the need for any possible governmental intervention under Act 94. Highmark has agreed not to seek or support such intervention in return for UPMC's agreement to the extension.

This agreement was reached with the assistance of a mediator designated by Governor Corbett and the support of interested legislators. The agreement in principle is binding and will be implemented through formal agreements to be completed by June 30, 2012.

Exhibit "A"

medical questions that you have. Further, UPMC.com is not a tool to be used in the case of an emergency. If an emergency arises, you should seek appropriate emergency medical services.

For UPMC Mercy Patients: As a Catholic hospital, UPMC Mercy abides by the Ethical and Religious Directives for Catholic Health Care Services, as determined by the United States Conference of Catholic Bishops. As such, UPMC Mercy neither endorses nor provides medical practices and/or procedures that contradict the moral teachings of the Roman Catholic Church.

Pittsburgh, PA, USA UPMC.com

VERIFICATION

I, GARY A. SHADE, being duly sworn according to law, hereby state that I am authorized to make this verification on behalf of the plaintiff, and that the allegations in the foregoing Petition for Review are true and correct to the best of my knowledge, information and belief.

Gary A. Shade

SWORN AND SUBSCRIBED TO

before me this 27th day of June 2014

Melissa M Ritzman
Notary Public

My commission expires 4/29/2016

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
MELISSA M RITZMAN, Notary Public
Dauphin County, City of Harrisburg
My Commission Expires April 29, 2016

VERIFICATION

I, W. Thomas McGough, Jr., state that I am Executive Vice President and Chief Legal Officer of UPMC, and I am authorized to verify the foregoing **Answer with New Matter and Counterclaims to Commonwealth's Petition to Modify Consent Decrees** and state that the information contained in it is true and correct to the best of my personal knowledge, information, and belief. This Verification is made subject to the penalties of 18 Pa. C.S.A. § 4904 relating to unsworn falsification to authorities.

Dated: April 15, 2019