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334 MD 2014

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA, ET AL., *Petitioners,* v. UPMC, ET AL., *Respondents.*	:	No. 334 MD 2014

APPLICATION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF BY SENATE PRESIDENT PRO TEMPORE JOSEPH B. SCARNATI, III

Proposed *amicus curiae* Senate President Pro Tempore Joseph B. Scarnati, III submits this application for leave to file *amicus curiae* brief in support of UPMC's Motion to Dismiss the Petition to Modify Consent Decrees. The proposed brief, attached hereto as Exhibit 1, is necessary to address several issues of core constitutional concern for Senator Scarnati; chiefly, the encroachment upon the General Assembly's sole authority to legislate under Article II of the Pennsylvania Constitution. While this proposed *amicus curiae* brief is submitted after UPMC's Motion and the Attorney General's response, given the importance of the issues presented, and the fundamental constitutional issues implicated by the pending Petition, Senator

Scarnati requests that the Court accept the brief as if it were timely filed.

Accordingly, Senator Scarnati respectfully requests that, in disposing of the Attorney General's pending Petition to Modify Consent Decrees, the Court grant this application and consider the brief attached hereto.

Respectfully submitted,

Dated: March 15, 2019

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Exhibit 1

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

No. 334 MD 2014

COMMONWEALTH OF PENNSYLVANIA, ET AL.,

Petitioners,

v.

UPMC, ET AL.,

Respondents.

BRIEF FOR *AMICUS CURIAE* SENATE PRESIDENT PRO TEMPORE JOSEPH B. SCARNATI, III

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I. INTRODUCTION

In our tripartite system of government, courts must be vigilant against efforts to blur the lines between legislative, executive, and judicial functions. As it concerns the legislative function in particular, the Supreme Court has observed that protecting its integrity from erosion through even limited accession to other branches is "vital to the preservation of liberty." *Protz v. Workers' Compensation Appeal Board*, 161 A.3d 827, 833 (Pa. 2017). The Attorney General's Petition to Modify Consent Decrees, if fully granted, presents just the type of legislative usurpation that is so often blocked by courts of the Commonwealth in the interests of preserving representative government. *See, e.g.*, *id.* Accordingly, to protect constitutional boundaries, Senate President Pro Tempore Joseph B. Scarnati, III asks the Court to deny, at least in part, the Petition.

II. STATEMENT OF INTEREST

Senator Scarnati is the duly elected Pennsylvania Senator representing Senate District 25, which covers Cameron, Clearfield (part), Clinton, Elk, Jefferson, McKean, Potter, and Tioga Counties. Senator Scarnati is also the elected Senate President Pro

Tempore, as set forth in Article II, Section 9 of the Pennsylvania Constitution. As Senate President Pro Tempore, Senator Scarnati has various constitutional and statutory responsibilities, which include directing bills to the appropriate committee within the Senate so that they can be properly considered and debated. *See* Senate Resolution 3, Regular Session 2019-2020, at Rule 5 (Jan. 1, 2019).[1] Further, as a constitutional officer in the legislative branch of government, Senator Scarnati has an inherent interest in ensuring that the legislative function conferred on the General Assembly by Article II of the Pennsylvania Constitution is protected. This includes an interest in ensuring that policy-making decisions constitutionally committed to the General Assembly are not made by non-legislative officials.

This *amicus curiae* brief is submitted to protect the foregoing interests. No person or entity other than Senator Scarnati or his counsel paid in whole or in part for this brief, nor authored it in whole or in part. *See* Pa.R.A.P. 531(b)(2).

[1] Available at: http://www.pasen.gov/rules.cfm.

III. ARGUMENT

The central "problem" posed by the Attorney General in his pending Petition—that UPMC has failed to act in ways that the Attorney General would prefer—is one that is quintessentially a legislative one. Indeed, this "problem," at its core, is a policy question: How should non-profit healthcare providers act, contract, and get paid? As a policy question, the "solution" is not the implementation of various choices selected by the Attorney General or this Court, *see, e.g.*, Petition ¶ 75(a)-(r), but instead reasoned legislative action; or even, perhaps, a constitutional mandate. *See infra* footnote 2. Were the Court to act as requested, however, appropriate democratic action could not occur or would occur in the wrong branch of government, resulting in a violation of Article II of the Pennsylvania Constitution.

To further illuminate the foregoing, two basic propositions set the stage and the context.

One, the General Assembly, and the General Assembly alone, is vested with the power to legislate and set statutory policy. *See* Pa. Const. Art. II, § 1; *Protz*, 161 A.3d at 833. Efforts by other branches of government to intrude upon this policy-making authority are

prohibited, as, indeed, are the General Assembly's own voluntary acts to give the power away. *See id.* at 833-35.

Two, the Attorney General, according to the Supreme Court and this Court, *can only* exercise those powers that have been specifically conferred upon him by the General Assembly. *See Com. v. Carsia*, 517 A.2d 956, 958 (Pa. 1986) (interpreting Pa. Const. Art. IV, § 4.1 to mean the powers of the Attorney General are "strictly a matter of legislative designation and enumeration"); *Golden Triangle News, Inc. v. Corbett*, 700 A.2d 1056, 1061 (Pa. Cmwlth. 1997) ("*Carsia* demonstrates that the Attorney General's authority is that which is established by legislation."). A particular power that has never been conferred upon the Attorney General—chiefly because it is constitutionally forbidden—is the ability to set policy. Indeed, in drafting and recommending the Commonwealth Attorneys Act to the General Assembly in 1978, the Joint State Government Commission Task Force on the Office of the Elected Attorney General stated that one of the core concepts of the Task Force on which there was "substantial consensus" was that "[t]he elected Attorney General is not to function as a policymaker. Instead, the Attorney General's role is intended to encompass only the

traditional role of lawyers in society[.]" *See* Joint State Gov't Comm'n, *Office of Elected Attorney General—Final Report*, at 4, 5 (Sept. 1, 1978) (favorably cited in *Carsia*, 517 A.2d at 513).[2]

Against the foregoing, the insurmountable flaws in some of the relief requested by the Attorney General can be laid bare. To begin, parts of what the Attorney General asks this Court to do is plainly policymaking, which, if endeavored, would violate Article II. The best evidence that policy-making is afoot is to look at recent and forthcoming actions in the General Assembly. For instance, on January 23, 2019, so-called "any willing provider" (AWP) legislation was introduced in the Pennsylvania House. *See* HB 602 (PN 648), Regular Session 2019-2020 (Exhibit A). This AWP bill provides that a "health care payer shall be required to contract with and to accept as a health care benefit plan participant any willing provider of health care services." *See* HB 602 at 2, lines 27-29. The current AWP bill was likewise introduced in the last two sessions. *See* HB 345 (PN 334), Regular Session 2017-2018 (Exhibit B); HB 294 (PN 293), Regular Session 2015-2016 (Exhibit C). Also introduced in a prior legislative session was so-called "any willing

[2] Available at: http://jsg.legis.state.pa.us/resources/documents/ftp/publications/1978-09-01%201978%20Office%20of%20Elected%20Attorney%20General%20Final.pdf.

insurer" (AWI) legislation, which provided that "hospitals operating as part of an integrated delivery network or any entity directly or indirectly owned, operated or controlled as part of these entities shall contract with any health insurance carrier that is willing to enter into a contract." *See* HB 1621 (PN 2483), Regular Session 2013-2014, at 3, lines 12-16 (Exhibit D). Another version of AWI legislation is also reportedly forthcoming in the current session. *See* Steve Twedt, *Pa. lawmaker seeks co-sponsors for 'any willing insurer' legislation to push Highmark, UPMC together*, Pittsburgh Post-Gazette (Feb. 6, 2019) (Exhibit E) ("Senate Minority Leader Jay Costa, D-Forest Hills, is seeking co-sponsors on legislation which "would require UPMC and Highmark to either contract with each other for services or enter mandatory arbitration," according to a release circulated Wednesday.").[3]

These AWP and AWI bills look remarkably similar to the relief the Attorney General asks the Court to impose upon UPMC in the

[3] Further, a recent press release states that a proposed constitutional amendment, to cover the exact relief sought in the Petition, will soon be introduced. Indeed, Representative Frank Dermody has announced that he is "proposing a state constitutional amendment requiring tax-exempt hospital systems to accept reasonable reimbursement payments from uninsured patients and patients covered by other health insurance plans." *See* Rep. Frank Dermody, *Dermody seeks constitutional fix to health care crisis*, www.pahouse.com (Feb. 7, 2019) (Exhibit F).

pending Petition. *See* Petition ¶ 75(b)-(c);[4] *see also* Petition ¶ 97(f); ¶ 110(f). That is, the relief the Attorney General is seeking by Court order is precisely the type of policy the General Assembly is now, or will soon be, debating. Stated more bluntly still: the Attorney General is asking this Court to *legislate*, which is power only held by the General Assembly under Article II of the Pennsylvania Constitution.

Finally, the Attorney General, as noted, is an office of limited power—limited by that which the General Assembly confers. *See Golden Triangle News*, 700 A.2d at 1061. Here, the Attorney General has relied on a constellation of statutes to insist this Court can enter an order requiring certain contracting choices he has made. But none of these statutes gives the Attorney General, or this Court, the ability to set such choices. *Cf.* 10 P.S. § 162.19(a); 15 Pa.C.S. § 5712; 15 Pa.C.S.

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[4] Petition at paragraph 75:
Consequently, the Commonwealth sought the following modifications to the Consent Decrees. Highmark agreed to these modifications, UPMC did not. Those terms included:
....
b. Imposing upon the respondents' health care provider subsidiaries a "Duty to Negotiate" with any health care insurer seeking a services contract and submit to single, last best offer arbitration after 90 days to determine all unresolved contract issues;
c. Imposing upon the respondents' health care insurance subsidiaries a "Duty to Negotiate" with any credentialed health care provider seeking a services contract and submit to single, last best offer arbitration after 90 days to determine all unresolved contract issues[.]

§ 5547; 20 Pa.C.S. § 7781; 73 P.S. § 201-4 (cited in Petition at ¶¶ 97, 99-102, 114). At most, these statutes outline limited recourse the Attorney General can take, and limited equitable remedies a court can enter, to achieve certain public-protection or consumer-protection choices made by the General Assembly.

To step beyond the limited authority and remedies provided in these laws, however, achieves a headlong leap into a non-delegation violation. *See generally Protz*, 161 A.3d at 833-35. Indeed, the Attorney General, and this Court, must be able to point to specific statutory parameters in the cited statutes that "guide and restrain" the Attorney General's and this Court's discretion, *see id.* at 834; and Senator Scarnati submits such guidance and restraints cannot be identified because they were never conferred. That is, in none of the statues invoked by the Attorney General did the General Assembly intend for him to have the power to force non-profit healthcare providers to contract and act in the all of the ways requested in the Petition, nor did the General Assembly intend for this Court to have the power to bring the Attorney General's unilateral policy wishes to fruition.

IV. CONCLUSION

Much of what the Attorney General hopes to achieve with the pending Petition is the making of legislative policy with this Court's blessing. This outcome is prohibited by Article II of the Pennsylvania Constitution, which vests the General Assembly alone with such law-making authority. Accordingly, those parts of the pending Petition that seek legislative remedies by Court order should be denied.

Respectfully submitted,

Dated: March 15, 2019

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WORD COUNT CERTIFICATION

I hereby certify that the above principal brief complies with the word count limits of Pa.R.A.P. 531(b)(3). Based on the word count feature of the word processing system used to prepare this brief, this document contains 1677 words, exclusive of the cover page, tables, and the signature block.

Dated: March 15, 2019

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Exhibit A

PRINTER'S NO. 648

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 602 Session of 2019

INTRODUCED BY DeLUCA, A. DAVIS, HILL-EVANS, MILLARD, FREEMAN, MURT, DEASY AND READSHAW, MARCH 1, 2019

REFERRED TO COMMITTEE ON INSURANCE, MARCH 1, 2019

AN ACT

Amending Title 40 (Insurance) of the Pennsylvania Consolidated Statutes, in special provisions relating to particular classes of insurers, providing for nondiscrimination by payers in health care benefit plans.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Part III of Title 40 of the Pennsylvania Consolidated Statutes is amended by adding an article to read:

ARTICLE C

MISCELLANEOUS PROVISIONS

Chapter

69. Nondiscrimination by Payers in Health Care Benefit Plans

CHAPTER 69

NONDISCRIMINATION BY PAYERS

IN HEALTH CARE BENEFIT PLANS

Sec.

§ 6901. Definitions.

The following words and phrases when used in this chapter shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Health care benefit plan." An insurance policy, contract or plan that provides health care to participants or beneficiaries directly or through insurance, reimbursement or otherwise.

"Health care payer." An individual or entity that is responsible for providing or paying for all or part of the cost of health care services covered by a health care benefit plan. The term includes, but is not limited to, an entity subject to:

(1) Chapter 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

(2) The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, including:

(i) a preferred provider organization subject to section 630 of The Insurance Company Law of 1921; or

(ii) a fraternal benefit society subject to Article XXIV of The Insurance Company Law of 1921.

(3) The act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

(4) An agreement by a self-insured employer or self-insured multiple employer trust to provide health care benefits to employees and their dependents.

§ 6902. Discrimination against willing providers prohibited.

A health care payer shall be required to contract with and to accept as a health care benefit plan participant any willing provider of health care services. A health care payer may not discriminate against a provider of health care services which:

(1) Agrees to accept the health care payer's standard payment levels.

(2) Meets and agrees to adhere to quality standards established by the health care payer.

§ 6903. Construction and application of chapter.

(a) Construction.--This chapter may not be construed to prohibit a health care payer from negotiating and paying rates higher than the health care payer's standard payment levels to one or more providers.

(b) Application.--This chapter:

(1) Shall apply to all health care benefit plans that compensate providers on a fee-for-service basis, per diem or other nonrisk basis.

(2) May not be applied to health care benefit plans regarding products that compensate providers on a capitated basis or under which providers accept significant financial risk in a formal arrangement approved by Federal or State authorities.

Section 2. This act shall take effect in 60 days.

Exhibit B

PRINTER'S NO. 334

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 345 Session of 2017

INTRODUCED BY DeLUCA, O'BRIEN, READSHAW, ROZZI, D. MILLER, MURT, GODSHALL, D. COSTA, MILLARD, THOMAS, FREEMAN, FRANKEL AND BIZZARRO, FEBRUARY 3, 2017

REFERRED TO COMMITTEE ON INSURANCE, FEBRUARY 3, 2017

AN ACT

Amending Title 40 (Insurance) of the Pennsylvania Consolidated Statutes, in special provisions relating to particular classes of insurers, providing for nondiscrimination by payers in health care benefit plans.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Part III of Title 40 of the Pennsylvania Consolidated Statutes is amended by adding an article to read:

ARTICLE C

MISCELLANEOUS PROVISIONS

Chapter

69. Nondiscrimination by Payers in Health Care Benefit Plans

CHAPTER 69

NONDISCRIMINATION BY PAYERS

IN HEALTH CARE BENEFIT PLANS

Sec.

6901. Definitions.

6902. Discrimination against willing providers prohibited.

6903. Construction and application of chapter.

§ 6901. Definitions.

The following words and phrases when used in this chapter shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Health care benefit plan." An insurance policy, contract or plan that provides health care to participants or beneficiaries directly or through insurance, reimbursement or otherwise.

"Health care payer." An individual or entity that is responsible for providing or paying for all or part of the cost of health care services covered by a health care benefit plan. The term includes, but is not limited to, an entity subject to:

(1) Chapter 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations);

(2) the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, including:

(i) a preferred provider organization subject to section 630 of The Insurance Company Law of 1921; or

(ii) a fraternal benefit society subject to Article XXIV of The Insurance Company Law of 1921;

(3) the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act;

(4) an agreement by a self-insured employer or self-insured multiple employer trust to provide health care benefits to employees and their dependents.

§ 6902. Discrimination against willing providers prohibited.

A health care payer shall be required to contract with and to accept as a health care benefit plan participant any willing provider of health care services. A health care payer may not

discriminate against a provider of health care services who:

(1) agrees to accept the health care payer's standard payment levels; and

(2) meets and agrees to adhere to quality standards established by the health care payer.

§ 6903. Construction and application of chapter.

(a) Construction.--This chapter may not be construed to prohibit a health care payer from negotiating and paying rates higher than the health care payer's standard payment levels to one or more providers.

(b) Application.--This chapter:

(1) shall apply to all health care benefit plans that compensate providers on a fee-for-service basis, per diem or other nonrisk basis; and

(2) may not be applied to health care benefit plans regarding products that compensate providers on a capitated basis or under which providers accept significant financial risk in a formal arrangement approved by Federal or State authorities.

Section 2. The provisions of this act are severable. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity may not affect other provisions or applications of this act that can be given effect without the invalid provision or application.

Section 3. This act shall take effect in 60 days.

Exhibit C

PRINTER'S NO. 293

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 294 Session of 2015

INTRODUCED BY DeLUCA, DAVIS, THOMAS, DEASY, KORTZ, MURT, BARRAR, D. MILLER, COHEN, D. COSTA, READSHAW AND HARHAI, FEBRUARY 2, 2015

REFERRED TO COMMITTEE ON INSURANCE, FEBRUARY 2, 2015

AN ACT

Amending Title 40 (Insurance) of the Pennsylvania Consolidated Statutes, providing for nondiscrimination by payers in health care benefit plans.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Part III of Title 40 of the Pennsylvania Consolidated Statutes is amended by adding an article to read:

ARTICLE M

MISCELLANEOUS PROVISIONS

Chapter

91. Nondiscrimination by Payers in Health Care Benefit Plans

CHAPTER 91

NONDISCRIMINATION BY PAYERS

IN HEALTH CARE BENEFIT PLANS

Sec.

§ 9101. Definitions.

The following words and phrases when used in this chapter shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Health care benefit plan." An insurance policy, contract or plan that provides health care to participants or beneficiaries directly or through insurance, reimbursement or otherwise.

"Health care payer." An individual or entity that is responsible for providing or paying for all or part of the cost of health care services covered by a health care benefit plan. The term includes, but is not limited to, an entity subject to:

(1) Chapter 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations);

(2) the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, including:

(i) a preferred provider organization subject to section 630 of The Insurance Company Law of 1921; or

(ii) a fraternal benefit society subject to Article XXIV of The Insurance Company Law of 1921;

(3) the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act;

(4) an agreement by a self-insured employer or self-insured multiple employer trust to provide health care benefits to employees and their dependents.

§ 9102. Discrimination against willing providers prohibited.

A health care payer shall be required to contract with and to accept as a health care benefit plan participant any willing provider of health care services. A health care payer may not discriminate against a provider of health care services who:

(1) agrees to accept the health care payer's standard payment levels; and

(2) meets and agrees to adhere to quality standards established by the health care payer.

§ 9103. Construction and application of chapter.

(a) Construction.--This chapter may not be construed to prohibit a health care payer from negotiating and paying rates higher than the health care payer's standard payment levels to one or more providers.

(b) Application.--This chapter:

(1) shall apply to all health care benefit plans that compensate providers on a fee-for-service basis, per diem or other nonrisk basis; and

(2) may not be applied to health care benefit plans regarding products that compensate providers on a capitated basis or under which providers accept significant financial risk in a formal arrangement approved by Federal or State authorities.

Section 2. The provisions of this act are severable. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity may not affect other provisions or applications of this act that can be given effect without the invalid provision or application.

Section 3. This act shall take effect in 60 days.

Exhibit D

PRINTER'S NO. 2483

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1621 Session of 2013

INTRODUCED BY CHRISTIANA, FRANKEL, V. BROWN, GRELL, M. K. KELLER, FLECK, GINGRICH, GALLOWAY, YOUNGBLOOD, KORTZ, SNYDER, TOOHIL, MOLCHANY, BARBIN, BENNINGHOFF, READSHAW, WHEATLEY, DERMODY, D. MILLER, PARKER, MCGINNIS, GODSHALL, P. DALEY, CALTAGIRONE, MICCARELLI AND C. HARRIS, OCTOBER 15, 2013

REFERRED TO COMMITTEE ON HEALTH, OCTOBER 15, 2013

AN ACT

Amending the act of July 19, 1979 (P.L.130, No.48), entitled "An act relating to health care; prescribing the powers and duties of the Department of Health; establishing and providing the powers and duties of the State Health Coordinating Council, health systems agencies and Health Care Policy Board in the Department of Health, and State Health Facility Hearing Board in the Department of Justice; providing for certification of need of health care providers and prescribing penalties," further providing for definitions, for licensure and for issuance of license; and providing for confidentiality.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Section 802.1 of the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, is amended by adding definitions to read:

Section 802.1. Definitions.

The following words and phrases when used in this chapter shall have, unless the context clearly indicates otherwise, the meanings given them in this section:

* * *

"Default provider agreement." An agreement between a hospital that is part of an integrated delivery network and a willing health insurance carrier to provide health care services, which agreement is imposed upon the parties in the event that they fail to enter into a mutually agreeable contract.

* * *

"Health insurance carrier." An entity licensed in this Commonwealth to issue health insurance, subscriber contracts, certifications or plans that provide medical or health care coverage by a health care facility or licensed health care provider that is offered or governed under this act or any of the following:

(1) The act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."

(2) The act of May 18, 1976 (P.L.123, No.54), known as the "Individual Accident and Sickness Insurance Minimum Standards Act."

(3) 40 Pa.C.S. Chs. 61 (relating to hospital plan corporations) and 63 (relating to professional health services plan corporations).

* * *

"Integrated delivery network." One or more entities with common ownership, operation or control, which include both of the following:

(1) One or more hospitals, one or more physician practices and/or one or more health care providers offering health care services.

(2) One or more entities operating as a health insurance

carrier offering health insurance, administering health benefits, operating a health maintenance organization and/or offering other health care benefits and coverage to employers and/or individuals in this Commonwealth.

Section 2. Section 806 of the act is amended by adding a subsection to read:

Section 806. Licensure.

* * *

(j) Hospitals operating as part of an integrated delivery network.--

(1) In addition to complying with the standards and regulations promulgated under this section, hospitals operating as part of an integrated delivery network or any entity directly or indirectly owned, operated or controlled as part of these entities shall contract with any health insurance carrier that is willing to enter into a contract.

(2) When contracting with health insurance carriers, hospitals operating as part of an integrated delivery network shall be:

(i) prohibited from using contractual provisions and engaging in business practices that impede the availability of health care and that restrict access to facilities based solely on the type of insurance coverage offered by a health insurance carrier;

(ii) prohibited from incorporating contractual provisions that limit or preclude the use of tiered networks by health insurance carriers;

(iii) prohibited from using any portion of the reimbursement rate to subsidize a health insurance carrier operating as part of the same integrated delivery

network;

(iv) prohibited from incorporating a termination provision with a health insurance carrier for reasons other than a willful breach of contract; and

(v) permitted to contract for its services at reimbursement rates that are based upon sound actuarial data.

(3) Failure of any hospital operating as part of an integrated delivery network and a willing health insurance carrier to maintain a mutually agreeable contract shall result in the parties entering into a default provider agreement while they submit to mandatory binding arbitration. The default provider agreement shall set forth payment terms, while all other contractual terms of the previously executed contract shall remain in effect until the arbitration process is completed. The arbitrator shall set all terms of the new contract.

(4) Failure of any newly affiliated hospital with an existing integrated delivery network or failure of any hospital operating as part of a newly formed integrated delivery network and a willing health insurance carrier to enter into a mutually agreeable contract within 90 days of the affiliation or formation shall result in the parties submitting to mandatory binding arbitration to establish a contract. The arbitrator shall set all terms of the new contract.

(5) A mutually agreeable arbitrator shall be chosen by the parties from the American Arbitration Association's National Healthcare Panel of arbitrators experienced in handling payor-provider disputes.

(6) All costs associated with the arbitration shall be split equally between the parties.

(7) The arbitrator shall conduct the arbitration pursuant to the American Arbitration Association's Healthcare Payor Provider Arbitration Rules.

(8) Contract terms and conditions shall be established as follows:

(i) Each party shall submit best and final contract terms to the arbitrator.

(ii) The arbitrator may request the production of documents, data and other information.

(iii) Payment terms and all other contractual provisions shall be set by the arbitrator.

(9) The default provider agreement shall remain in effect until the hospital operating as part of an integrated delivery network and a willing health insurance carrier complete the arbitration process.

(10) Payment terms under the default provider agreement will be set according to an amount equal to the greatest of the following three possible amounts:

(i) The amount the health insurance carrier negotiated with other in-network hospitals for the same service.

(ii) The amount calculated by the same method the health insurance carrier uses to determine payments for out-of-network services, such as the usual, customary and reasonable charge.

(iii) The amount that would be paid under Medicare for the same services.

(11) Copies of all contracts between hospitals operating

as part of an integrated delivery network and all health insurance carriers shall be provided to the department and the Insurance Department.

Section 3. Section 808(a) of the act, amended December 22, 2011 (P.L.563, No.122), is amended and the section is amended by adding subsections to read:

Section 808. Issuance of license.

(a) Standards.--The department shall issue a license to a health care provider when it is satisfied that the following standards have been met:

(1) that the health care provider is a responsible person;

(2) that the place to be used as a health care facility is adequately constructed, equipped, maintained and operated to safely and efficiently render the services offered;

(3) that the health care facility provides safe and efficient services which are adequate for the care, treatment and comfort of the patients or residents of such facility;

(4) that there is substantial compliance with the rules and regulations adopted by the department pursuant to this act;

(5) that a certificate of need has been issued if one is necessary; [and]

(6) that, in the case of abortion facilities, such facility is in compliance with the requirements of 18 Pa.C.S. Ch. 32 (relating to abortion) and such regulations promulgated thereunder[.]; and

(7) that, in the case of a hospital operating as part of an integrated delivery network, such facility:

(i) has contracts with all willing health insurance

carriers;

(ii) does not place restrictive covenants in its employment contracts that restrain any health care practitioner from engaging in his lawful profession; and

(iii) has submitted an attestation statement to the department and the Insurance Department certifying that no portion of any reimbursement rate with a health insurance carrier is subsidizing the health insurance carrier operating as part of the same integrated delivery network.

* * *

(d) Methodology records.--Every hospital submitting an attestation statement in accordance with this section must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its methodology for developing reimbursement rates for every health insurance carrier in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify that no portion of any reimbursement rate is subsidizing the health insurance carrier operating as part of the same integrated delivery network.

(e) Survey.--The department or any of its surveyors may conduct a survey under this section of any hospital operating as part of an integrated delivery network as often as the secretary, in his sole discretion, deems appropriate.

(f) Survey expenses.--When conducting a survey under this section, the department may retain attorneys, independent actuaries, independent certified public accountants or other professionals and specialists as surveyors. All expenses

incurred in and about the survey of any hospital, including compensation of department or Insurance Department employees assisting in the survey and any other professionals or specialists retained in accordance with this section shall be charged to and paid by the hospital surveyed in such a manner as the secretary shall by regulation provide.

Section 4. The act is amended by adding a section to read:

Section 902.2. Confidentiality.

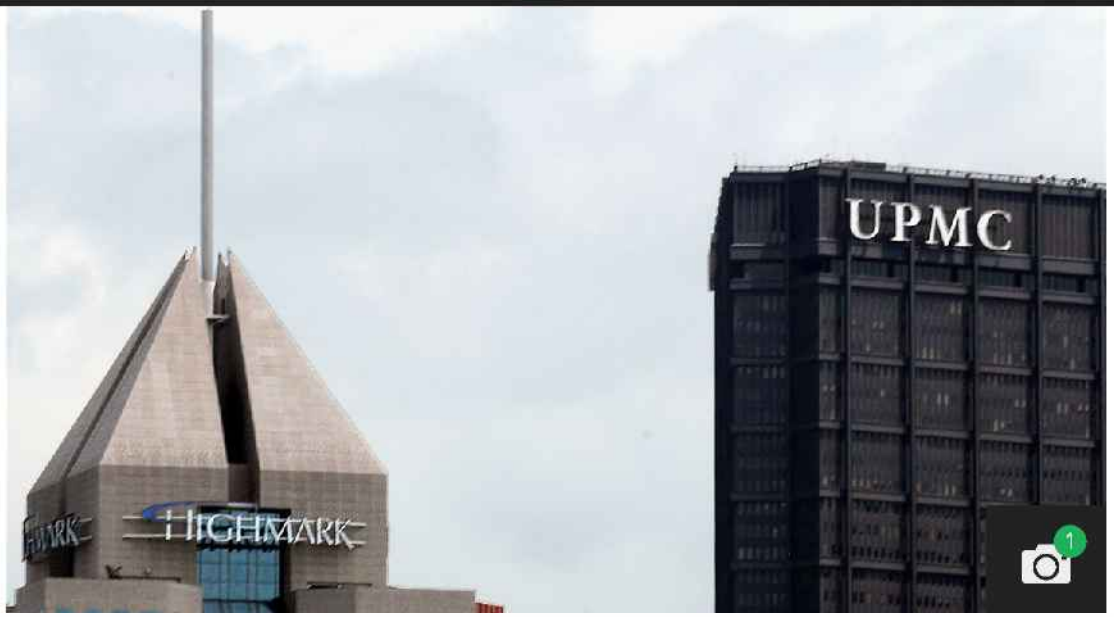
(a) Received materials.--Any insurance contracts, documents, materials or information received by the department or Insurance Department from a hospital for the purpose of compliance with this act and any regulations developed pursuant to this act shall be confidential.

(b) Access.--The department may use the information under section 806 and any regulations developed pursuant to this act for the sole purpose of a licensure or corrective action against a health care facility.

(c) Right-to-know requests.--Any insurance contracts, documents, materials or information made confidential under this act shall not be subject to requests under the act of February 14, 2008 (P.L.6, No.3), known as the "Right-to-Know Law."

Section 5. This act shall take effect in 90 days.

Exhibit E



Pa. lawmaker seeks co-sponsors for 'any willing insurer' legislation to push Highmark, UPMC together

STEVE TWEDT
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FEB 6, 2019 2:45 PM

Senate Minority Leader Jay Costa, D-Forest Hills, is seeking co-sponsors on legislation which "would require UPMC and Highmark to either contract with each other for services or enter mandatory arbitration," according to a release circulated Wednesday.

While not even in bill form yet, the move is another sign of growing interest from Harrisburg as the Pittsburgh region moves into the final months of a five-year agreement that has allowed some Highmark Medicare Advantage members and others continued in-network access to UPMC hospitals.

Mr. Costa's proposed legislation would apply to all statewide integrated delivery networks -– entities such as Highmark and UPMC that provide both care and sell health insurance -– that would require those hospitals and physicians to contract with all insurers.

Kris B. Mamula
Pa. attorney general targets access, cost issues related to Highmark-UPMC divorce

The release notes, "This issue is particularly problematic in southwestern Pennsylvania given the ongoing dispute between UPMC and Highmark."

If enacted, "Consumers will not be denied care, or worse abandoned mid-treatment, simply because they hold one type of insurance over another."

The legislation also intends to block any dominant health system "from demanding unreasonable rates for services from insurers, and in turn raising the overall cost of health care because they are in the 'must have' system in that area."

Similar legislation proposed in 2013 easily passed in the House but died in the Senate.

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Steve Twedt and Kris B. Mamula

Exhibit F

Dermody seeks constitutional fix to health care crisis

Rep. Frank Dermody *February 7, 2019 | 2:17 PM*

HARRISBURG, Feb. 7 – As Pennsylvania Attorney General Josh Shapiro pursues a legal remedy to the years-long struggle between UPMC and its customers who have Highmark insurance, House Democratic Leader Frank Dermody will seek a legislative solution.

Dermody is proposing a state constitutional amendment requiring tax-exempt hospital systems to accept reasonable reimbursement payments from uninsured patients and patients covered by other health insurance plans.

"Imagine riding in an ambulance with lights flashing and sirens blaring as your spouse or child is rushed to the nearest emergency room. Then imagine being handed a large bill because that hospital has its own health insurance plan and won't accept your insurance," Dermody said. "This is not hypothetical. It's happening to people every day.

"We are lucky to have these world-class institutions in Pennsylvania and, with generous support from taxpayers, they provide some of the best care and treatment available anywhere in the world," he said.

"It's time to make sure tax-exempt hospital systems live up to their charitable missions, and that includes UPMC. These giants of health care provide life-saving care," Dermody said, "and we are blessed to have them. But these entities must learn to get along with each other and put their patients first. For too long they have not.

"We need to make sure that nobody faces bankruptcy because an ambulance took them to the wrong hospital, and we have to preserve people's access to care by their own doctors," Dermody said.

Dermody is gathering more co-sponsors in the House before introducing his proposal to change the state constitution to protect people's access to affordable health care.

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