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IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

MEMORANDUM IN SUPPORT OF RESPONDENT UPMC'S MOTION TO DISMISS THE PETITION TO MODIFY CONSENT DECREES, OR PRELIMINARY OBJECTIONS IN THE NATURE OF A DEMURRER

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MEMORANDUM IN SUPPORT OF RESPONDENT UPMC'S MOTION TO DISMISS THE PETITION TO MODIFY CONSENT DECREES, OR PRELIMINARY OBJECTIONS IN THE NATURE OF A DEMURRER

The Attorney General's Petition to Modify Consent Decrees (the "Petition") is actually an attempt to undo and reverse those decrees. It asks this Court to force Respondent UPMC to remove a majority of its Board of Directors, to return its contractual obligations with Highmark Inc. to what they were before the Consent Decrees were entered, to maintain those obligations *forever*, and, going further, to force UPMC to contract with *any* insurance carrier or third-party administrator without limitation, also forever.

This "modification" would be unprecedented and unwarranted. More than just trampling over several legal protections, as detailed below, Attorney General Shapiro's Petition guts the very Consent Decree that he seeks to "modify." Indeed, less than one year ago, the Pennsylvania Supreme Court held in this case regarding this Consent Decree that a court cannot "alter[] an unambiguous and material term of the Consent Decree — the June 30, 2019 end date" (*Commonwealth ex rel. Shapiro v. UPMC*, 188 A.3d 1122, 1131 (Pa. 2018) ("*Shapiro*")) — yet

General Shapiro asks for that same relief again. The Petition exceeds General Shapiro's authority, and it should be dismissed in its entirety.

BACKGROUND

The Consent Decree[1] was always rooted in the Commonwealth's effort to provide an orderly termination of contractual relationships between UPMC and Highmark. The background to this termination, however, began long before 2014, and the involvement of various Commonwealth agencies provides important context for General Shapiro's Petition.

Mediated Agreement and Highmark-WPAHS Litigation

In 2011, UPMC prepared to terminate its contractual relationship with Highmark after the latter announced its plan to acquire UPMC's top competitor. *See* Petition for Review, *Commonwealth ex rel. Kane v. UPMC*, No. 334 M.D. 2014 (Pa. Commw. Ct. June 27, 2014), attached hereto as Exhibit A, ¶ 21. The acquisition of this competitor, the struggling West Penn Allegheny Health System ("WPAHS"), set the stage for a new era in which Highmark would become an integrated delivery and finance system ("IDFS"), like UPMC. *Id.* ¶ 22. As integrated systems in competition with each other, universal contracts no longer made sense for both parties.

The parties' split grew contentious, however, attracting the involvement of Governor Tom Corbett. 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. *Id.* ¶ 24; *see also* Highmark – UPMC Agreement (the "Mediated Agreement"), attached hereto as Exhibit B. Among other things, that Mediated

[1] The Commonwealth — represented by the Office of Attorney General, the Insurance Department, and the Department of Health — entered into separate, nearly identical Consent Decrees with both Highmark and UPMC on or about June 27, 2014 (collectively referred to herein as the "Consent Decree").

Agreement provided that UPMC would continue to extend full in-network access to Highmark Medicare Advantage and commercial health plan subscribers through December 31, 2014. 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." Exhibit B at 1; s*ee also* Exhibit A ¶ 25.

Around this time, the Attorney General publicly endorsed the importance of competition between the two integrated systems, UPMC and Highmark. Highmark's decision to extend its full in-network relationship with UPMC through the end of 2014 — and the attendant delay in Highmark shifting admissions away from UPMC and into WPAHS — prompted WPAHS to announce a termination of its Highmark affiliation. In late 2012, Highmark sued WPAHS to enjoin WPAHS's termination, and the Attorney General intervened in support of Highmark's request for relief. *See* Commonwealth's Findings of Fact and Memorandum of Law, *Highmark, Inc. v. W. Penn Allegheny Health Sys., Inc.*, Case No. GD-12-18361 (Ct. Common Pleas, Allegheny County Nov. 7, 2012), attached hereto as Exhibit C. In that litigation, the Attorney General emphasized that, if the affiliation failed, "[t]he competitive benefits to the community of a second integrated health care financing and delivery system [in addition to UPMC] will be lost indefinitely." *Id.* at 11.

Highmark Acquisition of WPAHS

To secure the Pennsylvania Insurance Department's ("PID") approval for the WPAHS acquisition, Highmark made several important representations. Most specifically, Highmark conceded that WPAHS — which was saddled with ruinous financial losses[2] — could only be

[2] *See* Exhibit C at ¶ 5 (noting that WPAHS stated that "its deteriorating financial position" was so dire that, when the Highmark acquisition was stalled, it needed to "move as quickly as possible to secure

salvaged if Highmark did not have global contracts with UPMC. *See* Pennsylvania Insurance Department's UPE Order in the Highmark/West Penn Allegheny Health System Matter, *In re Application of UPE*, No. ID-RC-13-06 (Pa. Ins. Dept. April 29, 2013) ("Approving Order"), attached hereto as Exhibit D, at 15 (recognizing that Highmark's financial projections are "premised on a non-continuation of the UPMC Contract and that continuation of such contract may, based on [Highmark's] projections, delay WPAHS' financial recovery"); *see also* PID Findings of Fact and Conclusion of Law, *In re Application of UPE*, No. ID-RC-13-06 (Pa. Ins. Dept. April 29, 2013), attached hereto as Exhibit E, at ¶ 146(e) (noting that "the assumed termination of Highmark's provider contract with UPMC" is a "critical assumption[] on which Highmark's projections rely"). As explained in the Commonwealth's original Petition for Review:

> 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.**

Exhibit A ¶ 30 (emphasis added).

This representation about the viability of WPAHS was important. Highmark's financial projections for WPAHS would dramatically change if Highmark remained in contract with UPMC — thereby placing Highmark's reserves at risk. *See* Allegheny Health Network Strategic and Financial Plan 2017-2020, No. ID-RC-13-06, filed on March 17, 2017 by Highmark Health, available at https://www.insurance.pa.gov/Companies/IndustryActivity/CorporateTransactionsofPublicInterest/HighmarkWestPennAlleghenyHealthSystem/Documents/

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another strategic partner in order to preserve its charitable health care mission"); ¶ 10 (stating that the deterioration in WPAHS's financial condition "negative[ly] affects the quality and future viability of its health care services in the community").

HH_AHN%20Public%20Strategic%20and%20Financial%20Plan%202017-2020.pdf, attached hereto as Exhibit F.[3] For that reason, the PID's Approving Order required Highmark to provide the Insurance Department "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 Contract on both the insurance and provider markets in the region including but not limited to any effects on competition." Exhibit D ¶ 22A (emphasis added).

Proceedings Leading to the Consent Decree

The Consent Decrees arose roughly one year after the PID conditionally approved Highmark's acquisition of WPAHS. As a predicate for negotiating the Consent Decrees, three Commonwealth agencies — the PID, the Department of Health ("DOH"), and the Attorney General — asserted violations of the Mediated Agreement by both Highmark and UPMC in a June 2014 "Petition for Review." In its Petition for Review, the Commonwealth repeatedly acknowledged that the Mediated Agreement was intended only to be a temporary measure that expired on December 31, 2014. *See, e.g.*, Exhibit A ¶ 25; *see also, e.g.*, *id.* ¶ 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[.]").[4] Nonetheless, in exchange for settlement of the

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[3] Under Pa. R.E. 201, courts may take judicial notice of facts that can be "accurately and readily determined from sources whose accuracy cannot reasonably be questioned." *See also, e.g., Drake Mfg. Co., Inc. v. Polyflow, Inc.*, 109 A.3d 250, 264 (Pa. Super. Ct. 2015) ("[T]he court can take judicial notice of public documents.").

[4] *See also* Exhibit A ¶ 52 (alleging that Highmark and UPMC's failure to contract has "caused confusion and uncertainty for patients and ha[s] denied the public the benefit of the *smooth transition the Mediated Agreement intended*.") (emphasis added).

Petition for Review — and a release of all of its claims — the Commonwealth agencies obtained a further delay in the separation of Highmark and UPMC.

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

- 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. *Id.* ¶¶ 52, 77;

- UPMC's alleged decision to "forego [*sic*] all future contractual relationships with Highmark after December 31, 2014 violate[d] . . . 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[.]'" *Id.* ¶ 55; and

- 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. *Id.* at 16-17.

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 (June 30, 2019) and a release.

The Consent Decree

On June 27, 2014, UPMC and the three Commonwealth parties (the Attorney General, the PID, and DOH) signed the Consent Decree as a settlement of the Petition for Review, "the allegations of which [were] incorporated" and released in the Consent Decree. Exhibit B to Petition, (the "Consent Decree") at 1. 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." *Id.* at 2. Indeed, under the Consent Decree, UPMC starting in 2015 largely would be out-of-network for Highmark subscribers in the Greater Pittsburgh Area. There, UPMC agreed to provide only transitional in-network services such as continuity of care, oncology, emergency services, and otherwise unique care to Highmark subscribers for another five years. *Id.* § IV.A.

In exchange for UPMC's agreement to provide these services, 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." *Id.* at 14. The parties also agreed that, even though UPMC would not be providing full in-network care to all Highmark subscribers during the ensuing five years, "the terms and agreements encompassed within [the] Consent Decree do not conflict with UPMC's obligations under the laws governing non-profit corporations and charitable trusts, consumer protection laws, antitrust laws, insurance laws and health laws." *Id.*

The Attorney General's Office defended the Consent Decree in public testimony. 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 . . . ." James A. Donahue, III, Video of Testimony before Pa. House Democratic Policy Committee, Oct. 10, 2014, available at https://wdrv.it/39aa0b6df, attached hereto as Exhibit G.

The Attorney General's Efforts to Enforce the Consent Decree

The Attorney General sued to enforce the Consent Decrees on three occasions. First, soon after the Decrees 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) ("*Kane*"). 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. Finally, on November 20, 2017, the General Shapiro filed an enforcement action against UPMC over the termination of Medicare Advantage contracts in 2019. *See Shapiro*, 188 A.3d at 1125.

In this most recent enforcement 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 for a year beyond the June 30, 2019 end date of the Consent Decree to June 30, 2020.[5]

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[5] In support of his petition, General Shapiro alleged, among things, that UPMC's decision to terminate Medicare Advantage contracts contradicted a October 27, 2014 mailer to seniors in which it promised to continue serving seniors with Highmark Medicare Advantage plans. Brief in Support of Petition to Enforce, *Commonwealth ex rel. Shapiro v. UPMC*, No. 334 M.D. 2014 (Pa. Commw. Ct. Nov. 20, 2017), attached hereto as Exhibit H, at 5. This allegation re-appears in the instant Petition at ¶ 120.

The Pennsylvania Supreme Court unanimously rejected General Shapiro's attempt to extend the Consent Decree. *See Shapiro*, 188 A.3d at 1135. 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. As the Court recognized, there was "no basis upon which to alter [the Expiration Date], to which the parties agreed[.]" *See id.* at 1134.

The Commonwealth Prepared For the Expiration of the Consent Decrees

In 2017 and 2018, the PID continued to prepare for the end of the Consent Decrees. The PID continued to monitor Highmark's progress in developing WPAHS, now known as Allegheny Health Network ("AHN"), as an IDFS competitor to UPMC. Although the requirement in the PID's Approving Order that Highmark provide updated information on the impact of any new UPMC contract on AHN, as well as the insurance and provider markets, was set to expire on December 31, 2018, the PID opted to extend that protection. In late July 2017, the PID modified its Approving Order to extend that protection through December 31, 2020. *See* Letter from Teresa D. Miller to Jack M. Stover dated July 28, 2017, attached hereto as Exhibit I, at 31 (modifying Approving Order sunset provision to December 31, 2020).[6]

In 2018, while General Shapiro fought his losing battle in court, the PID secured UPMC's support in preparing Pennsylvania citizens for the expiration of the Consent Decree. In particular, the PID, which (along with DOH) expressly declined to join General Shapiro's 2018

[6] Available at https://www.insurance.pa.gov/Companies/IndustryActivity/CorporateTransactionsofPublicInterest/HighmarkWestPennAlleghenyHealthSystem/Documents/Approval%20Letter%20-%20Highmark%20Health%20Request%20for%20Modification%20to%202013%20Order%20-%20FINAL%20-%20July%2028%202017.pdf.

enforcement action,[7] and — with the Governor's Office — brokered an agreement between UPMC and Highmark to extend in-network commercial contracts for UPMC specialty and sole provider community hospitals for two to five years. *See* Petition ¶¶ 20-21; *see also* Press Release, "Governor Wolf Announces Landmark UPMC and Highmark Agreement to Access Critical Care Services," Jan. 4, 2018, available at https://www.governor.pa.gov/ governor-wolf-announces-landmark-upmc-highmark-agreement-access-critical-health-care-services/, attached hereto as Exhibit K, at 2 ("Consumers who live in communities where a choice of providers, facilities, and services is available will have to make a choice when the consent decrees expire at the end of June 2019."). In late 2018, the PID posted Frequently Asked Questions ("FAQs") online to provide guidance to patients about this new agreement and to assist patients with transition issues attendant with the end of the Consent Decrees. *See* Pennsylvania Insurance Department, "FAQs for End of Consent Decree Between Highmark and UPMC," available at https://www.insurance.pa.gov/Companies/Documents/FAQ%20for%20End%20of%20Consent%20Decree%20Final.pdf, attached hereto as Exhibit L. The PID explained that the Commonwealth was "allowing this to happen" because "[t]he Commonwealth cannot force an insurance company and a provider contract at in-network rates with each other," the same conclusion detailed in Mr. Donahue's October 2014 testimony. *Id.*

In the FAQs, the PID explained that the end of the Consent Decree would "primarily impact current Highmark insureds in the Greater Pittsburgh and Erie areas who: (a) are in a continuing course of treatment with a UPMC provider; or (b) who are currently in or will seek oncology treatment from a UPMC provider; and/or (c) have Medicare Advantage plans." *Id.*

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[7] *See* Letter from Kenneth L. Joel to Pennsylvania Supreme Court, *Shapiro*, 188 A.3d 1122 (Pa. Mar. 30, 2018), attached hereto as Exhibit J, at 2 (explaining that the PID and DOH "took no position before Commonwealth Court and, accordingly, submit that by taking no position in this appeal, we will be better able to protect consumers and patients moving forward").

Those insureds would "now need to decide" to "keep their Highmark insurance and start seeing a new in-network doctor," "to continue seeing their UPMC doctor and change their insurance plan to one where UPMC providers are in-network," or "continue seeing their UPMPC doctor and consider options for paying out-of-network provider costs." *Id.*

The Petition to Modify

General Shapiro filed the instant Petition against the backdrop of this extensive history. He moved forward in litigation without the participation of the PID or DOH, which had concluded that the Commonwealth had no authority to compel continued UPMC-Highmark contracts and were working to facilitate patient transitions under the Consent Decree. *See id.* He moved forward even though the Pennsylvania Supreme Court had held only months earlier that he could not extend UPMC's obligations beyond June 30, 2019. And he moved forward by recycling allegations from his failed 2017 Petition to Enforce, the 2014 Petition for Review, as well as allegations regarding conduct predating the Consent Decree — conduct that was released by the Attorney General pursuant to the Consent Decree.

Relying on these old allegations, General Shapiro seeks to rewrite the Consent Decree entirely and impose radical new obligations on UPMC beyond June 30, 2019. These unprecedented requirements go well beyond the original purpose of the Consent Decree or the alleged harm the 2012 Mediated Agreement sought to remedy. Among other things, the terms of General Shapiro's demands include the following, all of which he seeks to impose on UPMC in perpetuity:

(a) By January 1, 2020, UPMC must replace a majority of its board members who were on its boards as of April 1, 2013, with new board members who have not had any relationship with UPMC for the past five years, and make certain other unspecified changes to its executive management;

(b) UPMC providers must contract with any insurer that wants a commercial or MA contract with that provider;

(c) the UPMC Health Plan must contract with any healthcare provider that seeks an MA or commercial contract;

(d) the parties to these forced contracts must submit to binding arbitration if they cannot agree on the rates to be paid for healthcare services;

(e) UPMC is prohibited from utilizing Provider-Based Billing, defined to mean "charging a fee for the use of the . . . building or facility at which a patient is seen," (Exhibit G to Petition § 2.25);

(f) UPMC is prohibited from including six other types of non-rate provisions in any of its contracts, including a provision that limits the dissemination of cost information;

(g) UPMC must accept rates for out-of-network emergency services at rates established by General Shapiro;

(h) UPMC is prohibited from engaging in any public advertising that General Shapiro determines is unclear or misleading in fact or by implication; and

(i) UPMC is barred from exercising any right to terminate a contract without cause.

See Petition ¶ 75. In the alternative to the items listed above, General Shapiro seeks to limit UPMC's reimbursements for all Out-of-Network services to the average of its In-Network rates. *See* Petition at 45. In addition, he seeks other relief for alleged violations of the Charities Act, Nonprofit Corporation Law ("NCL"), and Unfair Trade Practices and Consumer Protection Law ("UTPCPL"), including: forcing UPMC to substantiate the reasonableness of its executives' compensation, provide an accounting of charitable contributions it received for over a decade, and pay an undefined amount in penalties, reimbursement and restitution, as well as enjoining UPMC from denying access and treatment to Highmark subscribers. *See* Petition at 50, 57-58, 67-69.

These mandates are not limited to UPMC's relationship with Highmark and have nothing to do with providing Highmark subscribers a transition period to prepare for the end of the UPMC/Highmark provider contracts. And notwithstanding the Supreme Court's recent ruling confirming that the Consent Decree ends June 30, 2019 and is not subject to involuntary extension, General Shapiro seeks to impose each of these new requirements and conditions in perpetuity through a "modification" of the Consent Decree.

ARGUMENT

I. The Petition's Claims Are Barred as a Matter of Law.

The allegations in General Shapiro's Petition are either released, forfeited, or unripe and should be summarily dismissed by this Court. The 2014 Consent Decree irrevocably released claims arising from most of the allegations in the Petition, and they cannot be resurrected. The Attorney General forfeited other claims by failing to bring them in any of the earlier enforcement actions in this case, as the Consent Decree and claim-preclusion principles require. The remainder of the "facts" in the Petition rests on speculative predictions about future harms that are neither ripe (nor accurate) nor adequate to state a claim for relief. Taken together, these procedural flaws bar the relief sought by the Petition.

A. Claims Released by the Consent Decree Cannot Support General Shapiro's Petition.

A consent decree is a contract controlled by ordinary principles of contract interpretation. *See, e.g.*, *Shapiro*, 188 A.3d at 1131 (recognizing that the Consent Decree in this case is "a judicially sanctioned contract that is interpreted in accordance with the principles governing all contracts"). A release or settlement agreement contained in a contract will be enforced "if all its material terms have been agreed upon by the parties." *Pennsbury Vill. Assocs., LLC v. McIntyre*, 11 A.3d 906, 914 (Pa. 2011); *see, e.g.*, *Roth v. Old Guard Ins. Co.*, 850 A.2d 651, 653 (Pa.

Super. Ct. 2004) ("In the absence of fraud or mutual mistake a general release is enforceable according to its terms.").

UPMC's decision to terminate a full contractual relationship with Highmark formed the core of the allegations at issue in the Petition for Review and encompassed in the Consent Decree. Petition ¶¶ 52, 55, 77. The Consent Decree was intended as a five-year transition from UPMC's global relationship with Highmark to a more limited one. *See* Consent Decree § IV.C.9. An essential part of the Consent Decree was the Commonwealth's release of *any and all claims* arising out of a series of UPMC actions. Specifically, the Consent Decree:

> **release[d] any and all claims** the [Attorney General's Office], 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.

Consent Decree § IV.C.5 (emphasis added). All claims in the instant Petition that are based on allegations that predate the Decree are accordingly released.

In an attempt to persuade this Court that intervention is needed, however, General Shapiro dredges up these released factual allegations and tries to use them broadly to impose forced contracting with all providers and insurers. Among others, General Shapiro relies on the following fully released claims:

- the dispute over Highmark Community Blue plan, which occurred during 2013, *see* Petition ¶¶ 16-18, 96, 103, 107, 118;
- the compensation of UPMC's executives and location of its headquarters, both of which were in place long before the Consent Decree, *id.* at ¶¶ 61–63;
- 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 id.* ¶ 31; Consent Decree §§ 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); and

- most importantly, UPMC's refusal to contract with Highmark to provide In-Network access to Highmark enrollees, *see* Petition ¶¶ 12-19, 27-29, 37, 106, 107, 117, 119.c.

General Shapiro now, after having enjoyed the benefit of UPMC's agreement to abide by the Decree for nearly five years, cannot renege on the release that secured the agreement. All of the allegations in the Petition that predate the Consent Decree are released and cannot be considered, as a matter of law, in General Shapiro's Petition.

B. Claim Preclusion Bars Re-litigation of General Shapiro's Claims.

General Shapiro forfeited the instant claims under principles of claim preclusion. Claim preclusion, also known as *res judicata*, bars re-litigation by the same parties of the same claim *and* all other claims that should have been litigated in the prior action — or here, multiple enforcement actions. *See, e.g.*, *Balent v. City of Wilkes-Barre*, 669 A.2d 309, 313 (Pa. 1995); *see also Gregory v. Chehi*, 843 F.2d 111, 116 (3d Cir. 1988) ("Claim preclusion prevents a party from prevailing on issues he might have but did not assert in the first action.") (citations omitted). The doctrine of claim preclusion looks beyond "the technical differences between the two actions, take[s] a broad view of the subject, and bear[s] in mind the actual purpose to be attained." *Gregory*, 843 F.2d at 117 (citing *Helmig v. Rockwell Mfg. Co.*, 131 A.2d 622, 626-27 (Pa. 1957)).

In 2017, General Shapiro brought the most recent enforcement action in an attempt to extend UPMC's contract for Highmark's Medicare Advantage plans beyond the June 30, 2019 expiration of the Consent Decree. *See Shapiro*, 188 A.3d at 1132. The case was ultimately resolved by the Pennsylvania Supreme Court, which held that the Consent Decree expires on

June 30, 2019 and could not be extended. *See id.* ("There is also no dispute that the Consent Decree, by its terms, expires on June 30, 2019."). The Supreme Court held that the "June 30, 2019 end date" is "an unambiguous and material term of the Consent Decree" and that it had "no basis upon which to alter this unambiguous date, to which the parties agreed[.]" *Id.* at 1132, 1134.

General Shapiro could and should have asserted the Petition's claims in his 2017 enforcement action. All the factual allegations in the Petition allegedly took place before that enforcement action.[8] General Shapiro was aware of these 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 General Shapiro. General Shapiro could have asserted his claims based on those allegations the last time he was before the Court in this case. He chose not to do so, and the final judgment of the Pennsylvania Supreme Court precludes General Shapiro from resurrecting them now. *See Shapiro*, 188 A.3d at 1132.

Moreover, the Petition openly announces that General Shapiro's "actual purpose" has not changed since last year's litigation in this case — namely, to extend UPMC's contracts with Highmark beyond the expiration of the Consent Decree. The 2017 enforcement action likewise sought to force UPMC to extend its relationship with Highmark for a year beyond the end of the Consent Decree. *See id.* at 1125-26. After failing to convince the Supreme Court to grant that extension, General Shapiro is now doubling down and trying to extend that relationship *forever*. If any of the grounds now asserted in the Petition support such an extension, they necessarily should have been asserted to support the extension sought last year. For example, General

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[8] As the Attorney General's Petition demonstrates, the allegations that post-date that enforcement action consist of UPMC's efforts to implement the June 30, 2019 termination of the Medicare Advantage contracts — the termination that the Supreme Court held was permitted under the Consent Decrees. *See, e.g.*, Petition ¶ 37, 117.

Shapiro now maintains that the public interest requires the Consent Decree to be modified to continue the contract between UPMC and Highmark indefinitely. But last year, when he was trying to extend that very contract, General Shapiro did not seek a modification on that ground.

C. Claims Rest on Legally Deficient Speculation About Future Conduct.

The Petition is also based on speculative future actions. General Shapiro contends that modification is necessary because *if* UPMC were to refuse to contract with insurers other than Highmark — a hypothetical for which there is no support — "[s]uch refusal will result in more patients seeking access . . . to UPMC on a cost-prohibitive Out-of-Network basis." Petition ¶ 23; *see also, e.g.*, *id.* ¶¶ 23, 30, 52-54, 105-107.b, 117, 119.c, 121. General Shapiro assumes without basis that UPMC will be Out-of-Network for non-Highmark insurers, and that subscribers of non-Highmark insurance companies will therefore be burdened at some future time. *See id.* ¶ 42.

A party, however, may not invoke a court's jurisdiction "to determine rights in anticipation of events which may never occur." *DeNaples v. Pa. Gaming Control Bd.*, 150 A.3d 1034, 1040 (Pa. Commw. Ct. 2016) (quotation omitted). "An issue that may arise in the future is not considered "ripe" for judicial interpretation." *Id.* (internal quotation omitted); *see also, e.g.*, *Phila. Entm't & Dev. Partners, L.P. v. City of Phila.*, 937 A.2d 385, 392-93 (Pa. 2007) (finding that challenge to city ordinance that had yet to be enforced was not ripe for adjudication where the only harm asserted was based on what challenger "anticipate[d]" to occur). These allegations are predicated on predictions about future UPMC conduct for which there is no present indication that they will ever occur. UPMC has never said it will not contract with non-Highmark insurers. Nor has General Shapiro alleged any such facts to assert that is the case. There is, accordingly, none of the antagonism in the parties' respective positions that ripeness requires, because UPMC has not taken any position and is not alleged to have taken any position. As the Pennsylvania Supreme Court recognized in this case, "while there may be a colorable

belief that the loss of UPMC as a provider for Highmark plans may be disruptive, *conjecture of this nature* is insufficient to alter the unambiguous termination date of the Consent Decree." *Shapiro*, 188 A.3d at 1133 (emphasis added). The Petition's claims that rely on these empty predictions are inadequate as a matter of law.

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Taken as a whole, each and every claim in the Petition is barred as a matter of law, and the Petition should be dismissed.

II. The Petition Seeks an Invalid Modification.

General Shapiro's Petition should also be dismissed as an improper "modification" of the Consent Decree. In reality, General Shapiro asks the Court to obliterate material terms of the existing Consent Decree and impose a new, sweeping, inconsistent injunction with no expiration date — all under the guise of "modification." Pennsylvania law does not permit such an action.

A. General Shapiro Cannot Annul The Central Purpose Of The Consent Decree Through "Modification."

General Shapiro's proposed "modification" is a misnomer as it repudiates the central terms of the Consent Decree — including the parties' express termination date and the lack of full in-network contracts between UPMC and Highmark. General Shapiro cannot "modify" an agreement in a way that binds UPMC and Highmark, forever, in a way contrary to the original purpose of the Consent Decree.

As discussed above, the Consent Decree is a contract controlled by ordinary principles of contract interpretation. *See Shapiro*, 188 A.3d at 1131. Accordingly, it should be read holistically to give effect to all of its provisions and to render them consistent with each other. *See, e.g.*, *Guy M. Cooper, Inc. v. East Penn Sch. Dist.*, 903 A.2d 608, 616 (Pa. Commw. Ct. 2006). Fundamentally, the plain language of the Consent Decree controls its scope. *See, e.g.*,

Jacob Siegel Co. v. Philadelphia Record Co., 35 A.2d 408, 409 (Pa. 1944). "Where the language used is plain and unambiguous, the rights of the parties must be determined by the provisions of the instruments wherein they committed their agreement to writing." *Musselman v. Sharswood Bldg. & Loan Ass'n*, 187 A. 419, 421 (Pa. 1936). Similarly, courts have consistently refused to interpret one provision of a contract in a way that annuls another provision. *See, e.g.*, *Shehadi v. Ne. Nat'l Bank*, 378 A.2d 304, 306 (Pa. 1977) (reversing the lower court's decision to isolate and disregard a material provision of an agreement).

There is no dispute that the Consent Decree expires on June 30, 2019. The Consent Decree states it expressly, see Consent Decree, § IV.C.9 ("**Termination** — This Consent Decree shall expire five (5) years from the date of entry"), and the Supreme Court of Pennsylvania expressly held that the Consent Decree terminates on that date, see *Shapiro*, 188 A.3d at 1132. The Supreme Court further held that the expiration date of the Consent Decree was a material provision of the parties' agreement and that the courts cannot "alter[] an unambiguous and material term of the Consent Decree — the June 30, 2019 end date." *Id.*

The Supreme Court's decision in *Shapiro* is more than merely illustrative; it is the law of the case that is binding on this Court and preclusive of General Shapiro's attempt to relitigate the issue. *See, e.g.*, *Zappala v. James Lewis Grp.*, 982 A.2d 512, 519 n.6 (Pa. Super. Ct. 2009) (noting that the law of the case doctrine commands that a lower court "may not alter a legal question decided by an appellate court in the matter") (citing *Commonwealth v. Starr*, 664 A.2d 1326, 1331 (Pa. 1995)); *Robinson v. Fye*, 192 A.3d 1225, 1231-32 (Pa. Commw. Ct. 2018) (collateral estoppel bars relitigation by a party to an earlier action of the same issue that was actually litigated and necessary to a prior judgment). General Shapiro cannot now make another

attempt to "alter the unambiguous termination date of the Consent Decree" because he already litigated that before the Pennsylvania Supreme Court and lost. *Shapiro*, 188 A.3d at 1133.

It is also clear that the Consent Decree did not extend existing provider agreements or prohibit their termination. The Consent Decree emphasizes plainly in its introductory paragraph that it "is not a contract extension and shall not be characterized as such." Consent Decree, ¶ I.A. The *Shapiro* Court — citing its prior decision in *Kane*, 129 A.3d 441 — stated that "the Consent Decree 'forecloses the automatic renewal' of the [UPMC / Highmark provider agreements]." 188 A.3d at 1128.

In spite of, and in response to, that decision, General Shapiro now asks the Court to "modify" the Consent Decree in a manner that vitiates the "consent" that gives animating force and legal authority to the Consent Decree. This Court cannot "modify" the Consent Decree in a manner that directly contradicts its most material term. General Shapiro has alleged no fraud, accident or mistake that might justify a modification of the material terms of the Consent Decree, let alone a wholesale rewriting of the agreement. *See, e.g.*, *Universal Builders Supply v. Shaler Highlands Corp.*, 175 A.2d 58, 61 (Pa. 1961) (citing *Buffington v. Buffington*, 106 A.2d 229 (Pa. 1954)).

Moreover, any "modification" to the Decree could only have effect during the period that the Consent Decree remains operative — namely, until June 30, 2019. The imposition of obligations beyond that date is not a "modification;" it would require, as an essential prerequisite, UPMC's consent for a new decree that extended past that date. Otherwise, there is no "consent" authorizing any modifications to a "Consent" Decree. What General Shapiro seeks to do here is plainly not a "modification," because any genuine modification would expire along with the rest of the Consent Decree. Instead, he seeks to unilaterally impose some brand new

and different agreement under the guise of a modification. General Shapiro's coercive effort to extend the Consent Decree beyond its express, material terms must fail. *See Dravosburg Hous. Ass'n v. Borough of Dravosburg*, 454 A.2d 1158, 1161 (Pa. Commw. Ct. 1983) (citing *Commonwealth ex rel. Creamer v. Rozman*, 309 A.2d 197 (Pa. 1973)) ("[A] consent decree is an agreement binding upon the parties thereto who cannot be allowed to repudiate that to which they agreed for purposes of their own and for their own benefit.").

In a similar, uncommon instance where the plaintiff, rather than a defendant, sought to modify the consent decree, the D.C. Circuit held any "fortification of [an] injunction's terms must be in service of the consent decree's original 'intended result." *Salazar v. District of Columbia,* 896 F.3d 489, 498 (D.C. Cir. 2018) (citation omitted). "There is a critical difference between a [trial] court's power to modify an ongoing consent decree and its authority to impose a new injunction." *Id.* at 497. The court continued:

> When a plaintiff seeks to enhance a consent decree's terms, courts must be careful to ensure that the new injunctive terms give effect to and enforce the operative terms of the original consent decree. **Courts may not, under the guise of modification, impose entirely new injunctive relief.** That practice would end run the demanding standards for obtaining injunctive relief in the first instance, would deny the enjoined party the contractual bargain it struck in agreeing to the consent decree at the time of its entry, and would destroy the predictability and stability that final judgments are meant to provide.

Id. at 498 (emphasis added).

The same equitable principles that drove the *Salazar* court to reject the plaintiff's use of a modification provision should also compel this Court's rejection of the Petition. The Consent Decree, consistent with the relief sought in the Petition for Review, provided a definite transition period to avoid disruption to Highmark subscribers. The instant Petition seeks injunctive relief in perpetuity, is not limited to UPMC's contractual relationship with Highmark, imposes new contractual terms on all UPMC provider and health plan contracts, requires changes to UPMC's

Board of Directors and imposes a firewall requirement. These requests for injunctive relief are indisputably entirely "new" injunctive relief, would deny UPMC the benefit of the bargain it struck with the Commonwealth in the form of the Consent Decree, and would destroy the predictability and sustainability that the Consent Decree, entered as a final judgment, was meant to provide. This Court should apply the principles enunciated in *Salazar* and reject General Shapiro's proposed modifications.

B. The Attorney General Agreed that UPMC's Performance Under the Consent Decree, Including No Global In-Network Contract With Highmark, Complied with the Law.

Modification is also improper because the Consent Decree itself established that the central elements of General Shapiro's current Petition are lawful. The Petition repeatedly asks the Court to compel UPMC into a judicially imposed contract with Highmark and, going even further, with any insurer or provider that wishes to contract with UPMC. General Shapiro urges that, by not contracting with Highmark, "UPMC is operating in violation of . . . the Solicitation of Funds for Charitable Purposes Act, the Nonprofit Corporation Law of 1988, and the Unfair Trade Practices and Consumer Protection Law." Petition ¶ 4 (internal citations omitted). The Attorney General, however, explicitly "agree[d] that the terms and agreements encompassed within this Consent Decree" — including no contract extension with Highmark and only temporary transition protections for Highmark subscribers — "*do not conflict with UPMC's obligations under the laws governing non-profit corporations and charitable trusts, consumer protection laws*, antitrust laws and health laws." *See* Consent Decree, IV.C.6 (emphasis added).

The Court cannot modify the Consent Decree based on alleged violations of law where the Attorney General already has *conceded no such violations exist*. That would violate the unambiguous and enforceable terms of the Consent Decree. *See Shapiro*, 188 A.3d at 1131. Equitable estoppel and judicial estoppel further foreclose such an about-face by General Shapiro.

See Commc'ns Network Int'l, Ltd. v. Mullineaux, 187 A.3d 951, 963 (Pa. Super. Ct. 2018) (describing the equitable estoppel doctrine, including "acts, representations, or admissions, or by [one's] silence when [one] ought to speak out") (citation omitted); *see also Westinghouse Elec. Corp./CBS v. Workers Comp. Appeal Bd. (Korach)*, 883 A.2d 579, 586 (Pa. 2005) (laying out the same list); *Trowbridge v. Scranton Artificial Limb Co.*, 747 A.2d 862, 864 (Pa. 2000) (parties may not "assum[e] a position inconsistent with his or her assertion in a previous action, if his or her contention was successfully maintained"); *Gross v. City of Pittsburgh*, 686 A.2d 864, 867 (Pa. Commw. Ct. 1996) ("[T]he doctrine of judicial estoppel . . . prevent[s] parties from abusing the judicial process by changing positions as the moment requires.").

C. The Petition Fails to Allege How the Proposed "Modification" Promotes the Public Interest.

Modification is also improper because General Shapiro failed to plead facts essential to demonstrate how the requested "modification" would promote the public interest. Petitioners must plead sufficient facts to support a claim. Only well-pled facts are entitled to the presumption of truth, and the Court should disregard "conclusions of law, unwarranted inferences from facts, argumentative allegations or expressions of opinion." *Scrip v. Seneca*, 191 A.3d 917, 923 (Pa. Commw. Ct. 2018).

Here, the Petition's statements concerning the public interest are merely conclusory. *Id.* The Petition asserts that the Commonwealth "belie[ves] that modification of the Consent Decrees is needed to protect the public's interests," but alleges nothing to substantiate this "belief." Petition ¶ 73. The Petition takes pains to recite the history of this case and catalog UPMC's alleged bad acts, but it never explains how the proposed modifications would address those wrongs, why they are necessary, or what effect the terms would have on the public if they were

implemented. The list of proposed modifications has almost no connection to either the facts alleged or the Petition's unsupported rhetoric about the public interest.[9]

If the Petition's empty statements about the public interest were enough to support this request for modification, they would be sufficient to request any modification under the sun. It simply cannot be enough for General Shapiro to allege that some, unspecified modification would serve the public interest, and then attach a laundry list of unconnected demands. And yet that is all General Shapiro has done here. The Petition fails to offer any factual allegations supporting its conclusory assertions that modification would actually serve the public interest. Its request for modification, therefore, must be dismissed as legally deficient.

This is not an academic exercise. During the pendency of the Consent Decree, the Attorney General, in fact, has expressly contended that the ability for an insurer or provider *not* to contract is necessary for low prices and high quality care. As recently as 2016, the Attorney General sought to enjoin the proposed merger between UPMC Pinnacle (then called PinnacleHealth System, or "PinnacleHealth") and Penn State Hershey Medical Center ("Hershey"), another hospital system operating in the same geographic area. *See* Complaint, *FTC v. Penn State Hershey Med. Ctr.*, No. 1:15-cv-2362 (M.D. Pa. Apr. 8, 2016), attached hereto as Exhibit M. In opposing the merger, the Attorney General argued that the rivalry between Hershey and Pinnacle benefited patients with "lower healthcare costs and increased quality of care." *See id.* at 3. Critical to the Attorney General's argument was that the merger

[9] With the exception of the mandatory contract term, which would, presumably, serve to force UPMC to remain in contract with Highmark forever, it is unclear how General Shapiro arrived at the list of terms he now demands. For instance, one proposed modification would prohibit sharing of competitively sensitive information. Petition ¶ 75.a. The word "information," however, appears nowhere in the Petition before General Shapiro requests this prohibition in Count I. It is therefore impossible to tell why General Shapiro believes this term is even necessary, much less whether and how it would serve the public interest.

would have eliminated leverage for health insurers seeking to contract with the merged health system. That is, insurers would be forced to accept higher prices from the merged health system because they would have no ability to walk away from negotiations. Indeed, on appeal to the Third Circuit, the Attorney General argued:

> **Competition between hospitals leads to both lower prices (as described immediately below) and to improvements in quality of care and service to patients**. . . . Prices are negotiated between each hospital and health insurance company. Like any business deal, both sides have some amount of bargaining power, or "leverage," and the agreement reached depends on the relative strengths of that leverage. ***Leverage ultimately is a function of a party's ability to walk away from the negotiation and refuse to do business with its negotiating partner***. Thus, in bargaining over hospital prices, if the hospital demands too high a price and the insurer abandons the negotiation, the hospital will lose access to most of that insurer's members. . . . Conversely, if the insurer insists on an unacceptably low price and the hospital walks away, the insurer will be unable to include the hospital in its network and must offer a policy that does not cover the hospital. A hospital's leverage thus depends on how important it is to the insurer's network, which reflects both patient preferences for the hospital and the availability of desirable alternative substitute hospitals.

Brief of the Federal Trade Commission and the Commonwealth of Pennsylvania, *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327 (3d Cir. 2016) (No. 16-2365), attached hereto as Exhibit N, at 6-7 (emphases added). The Attorney General was ultimately successful in that litigation, and the merger failed. In what can only be described as a complete reversal of position, General Shapiro now alleges that it is both unlawful and against the public interest for nonprofit insurers or providers to walk away from negotiations.

Senior representatives from the Attorney General's Office have also made similar statements before the Pennsylvania House of Representatives, even in the context of contract disputes between UPMC and Highmark and, more specifically, about the Consent Decree. In October 2014, James A. Donahue, III, the Executive Deputy Attorney General of the Public

Protection Division — and one of the principal authors of the current Petition before this Court — publicly testified as follows:

> *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. . . . Second, the disputes that we see here that exist between Highmark and UPMC are similar to although less publicly known than disputes between health plans and hospitals around the country. These disputes over how, what the terms of contracts are go on every day and there are very vigorous and acrimonious disputes going on with many hospital systems and many health plans throughout the Commonwealth. If we forced a resolution in this case we really could not avoid trying to force a similar resolution in all those other situations and that is just simply an unworkable method of dealing with these problems. Third, *the contracting process involves two parties willingly coming to an agreement. By us trying to force the parties to enter into an agreement we would be putting our finger on the scale so to speak and having effects that we aren't quite sure what those effects would be. And in particular we wouldn't be sure about what the price effects that we would impose would be. In contract negotiations one of the key things is that each party has the ability to walk away from the negotiations. That ability to walk away forces each side to be reasonable in most circumstances, putting our finger on the scale in favor of one side or the other changes that dynamic in ways that are unpredictable.* And one of the key things here in most contract negotiations is price, and price is at the heart of the dispute between Highmark and UPMC, and *there is no mechanism in Pennsylvania for resolving this price dispute.*

Exhibit G (emphasis added). The Attorney General has taken irreconcilably inconsistent positions when it comes to the public interest. He should not be allowed to rest on mere conclusions here.

III. The Petition Lacks Required Party-Specific Allegations.

The Court additionally should deny the Petition because General Shapiro failed to plead critical prerequisites to the extreme asserted enforcement authority. His request to bind all facets of the UPMC system to a sweeping new healthcare regime encroaches on the jurisdiction of the Commonwealth agencies actually charged with overseeing that regime, and disregards the limits on his oversight of nonprofit corporations.

First, General Shapiro is proceeding (for the second time in two years) without even alleging any assent, authorization, or input from either of the two other Petitioners in this matter, the PID and the DOH. The PID is "charged with the execution of the laws of this Commonwealth in relation to insurance." 40 P.S. § 41; *see also Foster v. Mut. Fire, Marine & Inland Ins. Co.*, 614 A.2d 1086, 1091 (Pa. 1992) ("The General Assembly, in recognition of the specialized complexities involved in insurance generally, and in the regulation of this industry in particular, assigned the task of overseeing the management of that industry, in this Commonwealth, to the Insurance Department, the agency having expertise in that field. The Insurance Commissioner . . . is, therefore, afforded broad supervisory powers to regulate the insurance business in this Commonwealth, including the power to protect 'the interests of insureds, creditors, and the public generally.'") (quoting 40 P.S. § 221.1(c)). Similarly, DOH has authority over licensed healthcare facilities in the Commonwealth, including responsibility for, inter alia, investigating complaints that a facility is seeking direct payment from a patient. *See, e.g.*, 35 P.S. §§ 448.803, 449.95; *SEIU Healthcare Pa. v. Commonwealth*, 104 A.3d 495, 498 (Pa. 2014) ("To carry out its statutory duty to protect the health of Pennsylvania citizens and determine and employ the most efficient and practical means for the prevention and suppression of disease, [DOH] oversees the administration of public health services to residents of Pennsylvania's sixty-seven counties.") (citing 71 P.S. §§ 532(a) and 1403(a)).

These agencies have the subject-matter expertise — and statutory authority — unique to the regulation of health and insurance. And yet, General Shapiro now seeks to impose on millions of Pennsylvanians sweeping healthcare reform without alleging even that the PID or DOH has reviewed his proposal, much less has agreed with its underlying policy. Indeed, there is reason to believe that they do not. As detailed above, rather than pursue any of the relief

General Shapiro now seeks, the PID has worked diligently to prepare western Pennsylvanians for the end of the Consent Decree and to help them with the transition. *See supra* at 9-11. As a general matter, the Court should not consider General Shapiro's request for relief without making sure that the regulators responsible for administering that relief agree with each of the principles on which the request is based.

That is particularly important under the terms of the specific modification provision at issue here. Any ability to modify the parties current Consent Decree "shall be interpreted consistently with the Insurance Department's UPE Order in the Highmark/West Penn Allegheny Health System matter, In Re Application of UPE, No. ID-RC-13-06 (Pa. Insur. Dept. 2013) [the 'Approving Order']." Consent Decree § I.A. The PID's 2013 Approving Order authorized Highmark's acquisition of the former WPAHS hospital system but imposed certain conditions on the deal. As the Attorney General has admitted, the PID's approval order "was largely premised" on the assumption that Highmark "would not have a continued contractual relationship with UPMC." Exhibit A ¶ 30 (emphasis added). As a means of protecting the public interest and Highmark's financial stability from the undue stress of WPAHS's (and now AHN's) flagging finances, the PID thus required that Highmark submit additional financial data for that agency's review prior to any new contract with UPMC.[10] Exhibit D at ¶ 22. General Shapiro's new requirements for forced contracting and mandatory in-network access for all thus are directly contrary to the PID's own efforts to assure healthy, competitive healthcare markets.

[10] The Petition did not allege that Highmark complied with this requirement. Indeed, the Attorney General's Office conspicuously refused to answer UPMC's direct question whether Highmark had complied with this requirement prior to filing the Petition to Modify. *See* Letter from W. Thomas McGough, Jr. to James A. Donahue, III, Jan. 16, 2019, attached hereto as Exhibit O, at 2. Because of this omission, General Shapiro failed to satisfy a condition precedent to filing the instant Petition.

The Attorney General's Office should not be allowed to supplant its sister agencies' expertise and judgment in health and insurance while the PID and DOH sit on the sidelines.[11]

Second, the Petition ignores fundamental matters of corporate form. As an alternative to the Consent Decree's modification provision, for instance, General Shapiro relies on "the Commonwealth's responsibility to ensure that UPMC . . . fulfills its charitable responsibilities," and enforce "the respondents' charitable missions." Petition ¶ 2. On that basis, he alleges violations of the Pennsylvania charities law (Count II) and asks the Court to re-set all of UPMC's reimbursement to rates of General Shapiro's liking (Count II). He likewise alleges violations of "UPMC's" alleged fiduciary duties (Count III) and "UPMC's" duties under the UTPCPL (Count IV). Based on these allegations, General Shapiro seeks to bind all of UPMC's subsidiaries to the terms of his new proposed consent decree.

Pennsylvania law does not permit blurring corporate distinctions that easily. Courts must instead "start from the general rule that the corporate entity should be recognized and upheld[.]" *Wedner v. Unemployment Compensation Bd. of Review*, 296 A.2d 792, 795 (Pa. 1972). UPMC is the nonprofit parent corporation of over a hundred corporate entities — some for-profit, some nonprofit. In his attempt to force "UPMC" to enter into a "contract" with "Highmark" because it is a "charity," General Shapiro conflates not only all those subsidiaries but also the different factual circumstances and legal regimes that are unique to each of these entities. Significantly, the vast majority of UPMC's hospitals have commercial and Medicare Advantage contracts with Highmark *and will continue to have those contracts after June 30.*[12] *See* Petition ¶ 20. No relief

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[11] It makes no difference that the Consent Decree's modification provision permits any party to seek modification. Here, the requested modification is contrary to bedrock principles set forth in the two documents with which the Consent Decree must be harmonized. That kind of "modification" should not go forward without the unanimous consent of all concerned, including UPMC, the PID, and DOH.

[12] UPMC Altoona, UPMC Bedford, UPMC Horizon, UPMC Jameson, UPMC Kane, UPMC Northwest, UPMC Western Psychiatric Institute and Clinic, UPMC Children's Hospital of Pittsburgh, all

can be entered as to them. Nor are all UPMC subsidiaries nonprofits. Notwithstanding the extraordinarily broad authority asserted by General Shapiro, there is no conceivable basis to impose relief against for-profit companies.

And though all Pennsylvania nonprofit corporations are governed by the Nonprofit Corporation Law (NCL), 15 Pa. C.S.A. § 5101 *et seq.*, not all nonprofit corporations share the same status. For example, not every nonprofit corporation qualifies as a section 501(c)(3) organization, a status which is governed by federal law, administered by the IRS and qualifies the organization for exemption from federal income tax. And not every nonprofit corporation is an Institution of Purely Public Charity ("IPPC") under Pennsylvania law nor subject to General Shapiro's authority over charitable trusts and bequests. *See Hosp. Utilization Project v. Commonwealth*, 487 A.2d 1306, 1317 (Pa. 1985) ("*HUP*") (interpreting "Institution of Purely Public Charity" under Article VIII, § 2(a)(v) of the Pennsylvania Constitution); 71 P.S. § 732-204(c) (providing the "Attorney General . . . may intervene in any other action, including those involving charitable bequests and trusts . . . ."). IPPC status entitles qualifying nonprofit corporations to be exempt from certain taxes and is governed by Act 55 and the *HUP* test. *See* 10 P.S. § 375; *HUP*, 487 A.2d at 1317. To the extent General Shapiro purports to challenge "UPMC" exemptions from real estate taxes — the Petition is hopelessly unclear in this regard — it is the titled owner of a real estate parcel that must satisfy Act 55 and *HUP*, which is generally the UPMC hospital that sits on the land. *See* Pa. Const., Art. VIII, § 2(a)(v) (establishing special rule for real property tax exemptions). Some UPMC entities are section 501(c)(3) organizations, but not IPPCs under state law, and vice versa. In fact, some are neither and others are not even

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UPMC Pinnacle hospitals, and all UPMC Susquehanna hospitals currently contract with Highmark and will continue to do so beyond June 30, 2019. *See* Exhibit L.

nonprofit corporations. Although all of these different corporations exist within the UPMC system, General Shapiro's Petition accounts for none of these distinctions.

General Shapiro cannot obtain relief against one entity based on the alleged violation by a different entity. The Petition contains none of the allegations necessary to disregard corporate form or specify which UPMC subsidiaries are susceptible to what enforcement authority. Absent particularized allegations specific to the corporate form and contracting status of each UPMC subsidiary, General Shapiro cannot state a claim as to any. For precisely this reason, the Allegheny Court of Common Pleas dismissed a similar lawsuit brought by the City of Pittsburgh. *See City of Pittsburgh v. UPMC*, No. GD-13-05115 (Ct. Common Pleas, Allegheny County June 25, 2014), attached hereto as Exhibit P. The same result is required here.

IV. General Shapiro Has No Legal Authority To Require That UPMC Entities Enter Into Contracts With Any Willing Insurer or Provider, Including Highmark.

While the Petition alleges all manner of purported misconduct, the principal relief it seeks to compel is universal, evergreen contracts between UPMC entities and Highmark (and every other willing insurer or provider) at rates and on terms determined by outside arbitrators. Alternatively, the Petition seeks to limit reimbursements to UPMC providers for Out-of-Network services to UPMC's "average In-Network rates" — as if contracts existed between UPMC providers and insurers. *See* Petition at ¶¶ 75(b)-(c), 97(f), 110(f). General Shapiro cited no legal authority to support this requested relief, and both the Attorney General's Office and the PID have previously admitted — unambiguously — that the Commonwealth lacks any such authority.

A. *Parens Patriae* Authority Does Not Permit General Shapiro to Second-Guess UPMC's Charitable Mission, Including Its Contracting Decisions.

Parens patriae authority over charities is limited. It does not permit General Shapiro to control the actions and decisions of a nonprofit made in the ordinary course of business, such as

dictating the terms of the nonprofit's commercial contracts. Instead, General Shapiro's *parens patriae* authority is appropriately exercised only when a charity engages in an extraordinary transaction, such as the disposition of assets committed to charity, a change of charitable purposes, or some other fundamental corporate transaction, or when the charity's officers or directors have engaged in a gross breach of fiduciary duty or criminal conduct.[13] The Attorney General's Office has acknowledged that its *parens patriae* power typically involves the review of specific, major transactions "effecting a fundamental corporate change." *See* Office of the Attorney General, "Review Protocol for Fundamental Change Transactions Affecting Health Care Nonprofits," Mar. 14, 2011, attached hereto as Exhibit R, at 1. But as commentators have explained, "[n]othing in the Attorney General's *parens patriae* status or powers gives the Attorney General the authority to substitute his judgment for that of the board or trustees of a nonprofit corporation acting in good faith." Marc S. Cornblatt & Bruce P. Merenstein, *Charities & the Orphans' Court*, 46 Duq. L. Rev. 583, 588 (2008).

None of the Pennsylvania cases sanctioning the Attorney General's use of *parens patriae* authority involved intervention into a non-profit entity's ordinary course business affairs. As Judge Pellegrini correctly stated in *In re Milton Hershey School Trust*, "[t]here is no basis in the law, either statutory or case, giving the Attorney General a right to become 'fully involved' in the decision-making of the Trust; he is neither a co-manager nor co-Trustee of the Trust."

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[13] *See, e.g.*, *In re Milton Hershey Sch. Tr.*, 807 A.2d 324, 338-39 (Pa. Commw. Ct. 2002) (proposed sale of a controlling interest in Hershey Corporation, the principal asset of the trust); *In re Coleman's Estate*, 317 A.2d 631, 632 (Pa. 1974) (qualifications of trustees); *Commonwealth v. Citizens Alliance for Better Neighborhoods, Inc.*, 983 A.2d 1274 (Pa. Commw. Ct. 2009) (breach of fiduciary duties and diversion of charitable assets to personal use); 15 Pa. C.S.A. § 5547 (prohibiting disposition of property committed to charitable purposes without court approval); Marc S. Cornblatt & Bruce P. Merenstein, *Charities & the Orphans' Court*, 46 Duq. L. Rev. 583, 588 (2008), attached hereto as Exhibit Q.

Milton Hershey Sch., 807 A.2d at 338-39 (Pellegrini, J., dissenting).[14] Rather, a Pennsylvania nonprofit's normal operations and procedures are left to its fiduciaries, governed by the Pennsylvania Nonprofit Corporation Law ("NCL"), 15 Pa. C.S.A. §§ 5101-6162, and the nonprofit's Articles of Incorporation. *See Zampogna v. Law Enf't Health Benefits, Inc.*, 151 A.3d 1003, 1004 (Pa. 2016).

General Shapiro bears a heavy burden in exercising his *parens patriae* authority to allege that a non-profit's actions or decisions violate the Charities Law, the NCL, or its own articles of incorporation. In *Zampogna*, the Pennsylvania Supreme Court reviewed the standards used in evaluating whether a nonprofit corporation's actions could be enjoined under the NCL as inconsistent with its corporate purpose. In rejecting a challenge to a charity's use of funds to send political postcards to its members, the court held that "the interplay between a nonprofit corporation's corporate purpose and that corporation's authority to take corporate action must be construed in the least restrictive way possible, limiting the amount of court interference and second-guessing[.]" *Id.* at 1013. Thus, the Court held, "a nonprofit corporation's action is authorized when: 1) the action is not prohibited by the NCL or the corporation's articles; and 2) the action is not clearly unrelated to the corporation's stated purpose." *Id.*

This is an intentionally difficult standard, because "courts should not act as super-boards second guessing decisions of corporate directors, as courts are 'ill-equipped' to become

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[14] This part of Judge Pellegrini's dissent is consistent with the majority opinion. Judge Pellegrini took exception to the Attorney General's intervention in the proposed sale of a charity's principal asset (Hershey Corporation) before the charity's governing board made a firm decision to sell the asset. *See id.* The majority disagreed, finding that the Attorney General had standing to intervene at an earlier time given its "responsibility for public supervision of charitable trusts" and the fact that the Hershey business was "essentially the sole asset of the corpus of the School Trust" at the time of Mr. Hershey's death. *Id.* at 330-31. Notwithstanding the disagreement on when the Attorney General's *parens patriae* authority was triggered, there is nothing in the majority's opinion that would sanction General Shapiro's intervention in the day-to-day business affairs of a charity.

'enmeshed in complex corporate decision-making.'" *Id.* at 1014 (internal citation omitted); *see also Commonwealth ex rel. Kane v. New Founds., Inc.*, 182 A.3d 1059, 1067-68 (Pa. Commw. Ct. 2018) (noting, in case where Attorney General alleged mismanagement of charitable nonprofit corporation, that "the adoption of the business judgment rule 'reflects a policy of judicial noninterference with business decisions of corporate managers, presuming that they pursue the best interest of their corporations, insulating such managers form second-guessing or liability for their business decisions in the absence of fraud or self-dealing or other misconduct or malfeasance'") (quoting *Cuker v. Mikalauskas*, 692 A.2d 1042, 1046 (Pa. 1997))).

General Shapiro alleged no facts that UPMC's refusal to enter into universal contracts with Highmark is prohibited by the NCL or UPMC's articles of incorporation, or that this decision is "clearly unrelated" to UPMC's stated purpose. General Shapiro points to nothing in UPMC's articles of incorporation or the NCL that prohibits UPMC from deciding not to contract with a particular payor. That is because neither contains any such prohibition. Nor does Pennsylvania law require UPMC to provide access to its healthcare system to everyone at a particular price. Accordingly, UPMC's decision not to do so violates no law or any charitable purpose.

In sum, *parens patriae* is a limited power that permits General Shapiro to intervene in court proceedings concerning the affairs of a non-profit entity regarding divestiture of assets or fundamental change of charitable purposes and in extreme cases of fraud or abuse. It does not transform General Shapiro into the "CEO" of any non-profit entity of his choosing, and it does not enable General Shapiro to insert himself into the ordinary course of business decision-making of UPMC and other non-profits in matters such as its commercial contracting.

B. The Commonwealth Has Admitted That It Cannot Force UPMC Entities To Enter Into Contracts With Highmark And All Other Willing Insurers and Providers.

Not only does General Shapiro lack general power under his *parens patriae* authority to intervene in UPMC's operations and business affairs, it is beyond dispute that he has no legal basis under Pennsylvania law to compel the principal relief seeks here: forced contracts between UPMC entities and Highmark (or any other willing insurer or provider). *See* Petition at ¶¶ 75(b)-(c), 97(f), 110(f).

The Pennsylvania General Assembly has specifically rejected the same "any willing provider" ("AWP") and "any willing insurer" regime General Shapiro seeks to establish through the Petition. Despite considering the issue many times, the Pennsylvania General Assembly has refused to enact AWP legislation. Most recently, in February 2017, AWP legislation was re-introduced to the Pennsylvania Committee on Insurance and did not receive a vote.[15] Pennsylvania has also considered a counterpart to AWP legislation, a so-called Any Willing Insurer law, and likewise rejected it.[16] General Shapiro's attempt to mandate and impose terms of contracts between healthcare insurers and providers outside of the legislative process subverts both the free market and democratic systems that define the American healthcare system. Whether a healthcare provider or healthcare payer must contract is not a decision for General Shapiro, but for the Pennsylvania General Assembly.

The Executive Branch of the Commonwealth has explicitly admitted that it cannot force UPMC — or any other nonprofit healthcare provider or insurer for that matter — to enter into contracts against its will. In a statement following the Supreme Court's 2018 ruling that the

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15 Pennsylvania General Assembly, House Bill 345, Regular Session 2017-2018, February 3, 2017.

16 Pennsylvania General Assembly, House Bill 1621, Regular Session 2017-2018, June 26, 2017.

Consent Decree unambiguously expires on June 30, 2019, the PID provided the following question-and-answer guidance on its website:

3. Why is the Commonwealth allowing this to happen?

The Commonwealth cannot force an insurance company and a provider to contract at in-network rates with each other.

Governor Wolf has dedicated significant efforts and will continue to diligently work to protect consumers by overseeing the implementation of the Consent Decree and through the consummation of the January 2018 agreement, to ensure access for Highmark's commercial insureds who require critical, unique services.

See Exhibit L, at 1. *The same guidance remains on the PID's website today.*

Moreover, the Executive Deputy Attorney General *who signed the Consent Decree and this Petition* made exactly the same point when the Consent Decree went into effect. In testimony before the Democratic Policy Committee of the Pennsylvania House of Representatives on October 10, 2014, Executive Deputy Attorney General James A. Donahue, III 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. Specifically, Mr. Donahue testified that the Attorney General's Office 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."[17] Exhibit G.

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[17] These statements by Mr. Donahue are also relevant for equitable estoppel. The Attorney General's Office induced UPMC's justifiable reliance by taking this position in public testimony that was specifically describing the scope of the Attorney General's authority over UPMC's contractual relations. *See Natiello v. Dept. of Envtl. Prot.*, 990 A.2d 1196, 1203 (Pa. Commw. Ct. 2010) ("The doctrine of equitable estoppel applies when a Commonwealth agency has (1) intentionally or negligently misrepresented a material fact; (2) knowing or having reason to know that another person would justifiably rely on that misrepresentation; (3) or where the other person has been induced to act to his detriment because he justifiably relied on the misrepresentation."). UPMC signed the Consent Decree and spent the last five years ordering its business arrangements and investments in reliance on the terms of the Consent Decree, including, most importantly, its termination.

Accordingly, the Court should, at a minimum, rule that UPMC entities cannot be forced to enter into universal, evergreen contracts between UPMC entities and Highmark (or any other willing insurer or provider). The Court should likewise rule that it has no authority to afford General Shapiro's alternative relief: limiting UPMC providers' reimbursements for Out-of-Network services to UPMC's "average In-Network rates," which effectively seeks the same relief as forcing UPMC into universal contracts against its will.

C. The Pennsylvania General Assembly Delegated Exclusive Regulatory Authority to Other Commonwealth Agencies, Not General Shapiro.

General Shapiro's proposed modifications also fail as a matter of law because they intrude on a regulatory field that the Pennsylvania General Assembly *exclusively* delegated to DOH and the PID. The requirements he asks this Court to impose fly in the face of the considered judgments of the Pennsylvania General Assembly.

The proposed modifications conflict with the carefully crafted regulatory scheme governing managed care plans in the Commonwealth. As defined in 40 P.S. § 991.2102, managed care plans include HMOs, hospital plan corporations (*i.e.*, Blue Cross plans) and professional health services plan corporations (*i.e.*, Blue Shield plans). The General Assembly delegated the power to regulate these health plans exclusively to the DOH and the PID. *See* 40 P.S. § 991.2181(d),(e) (empowering these agencies to ensure compliance of managed care plans to statutes and regulations and to make regulations). This statutory authority includes ensuring that managed care plans "assure availability of adequate health care providers in a timely manner, which enables enrollees to have access to quality care and continuity of health care services." 40 P.S. § 991.2111(1).

Under this authority, in order to ensure adequate provider networks, the DOH has adopted network access requirements in 28 Pa. Code § 9.679 that plans must meet. The DOH

has also established regulations that, among other things, require its approval of provider networks that are limited to select participating providers — so-called narrow networks — to likewise ensure that enrollees continue to have adequate access even with a more limited network. *See* 28 Pa. Code § 9.653 (listing requirements). Thus, the DOH requires that every managed care plan meet provider network access requirements and to obtain express department approval to offer health plans with so-called narrow networks. *Id.* In short, UPMC Health Plan only offers provider networks for its health plans that the Commonwealth, acting through the DOH, deems adequate.

General Shapiro, however, seeks to run roughshod over the DOH and impose his own assessment of an adequate provider network for a health plan. In effect, General Shapiro's proposal would deem all UPMC Health Plan networks inadequate, regardless of DOH approval; instead the only adequate provider network for its health plans would be one that includes every provider interested in joining. This sweeping arrogation of power would gut the DOH's rules and oversight process and commandeer the authority the General Assembly chose to give it.

Network adequacy is not the only area where General Shapiro would supplant applicable regulatory authority. For example, DOH regulations mandate the required provisions that must be included in managed care plan contracts with network providers. *See* 28 Pa. Code § 9.722 (requiring plans to submit and obtain approval of healthcare provider contracts from DOH, and enumerating certain "consumer protection provisions" that must be included). One such required provision expressly allows a plan and provider to include in their contract the ability to terminate without cause, so long as the notice of termination period is no less than 60 days. *See id.* § 9.722(e). Yet General Shapiro's proposed modifications would preclude UPMC from terminating any provider agreements without cause. Petition ¶ 75.l.

General Shapiro would even interfere in areas the General Assembly reserved for itself rather than defer to administrative regulation. The General Assembly, for instance, enacted legislation concerning the provision of emergency services, and did not delegate additional regulatory power to establish rates for such services. The General Assembly mandated that managed care plans "[e]nsure that emergency services are provided twenty-four (24) hours a day, seven (7) days a week and provide reasonable payment or reimbursement for emergency services." 40 P.S. § 991.2111(4). More specifically, in a provision entitled "Emergency Services," the General Assembly directed that managed care plans "shall pay all reasonably necessary costs associated with the emergency services provided during a period of emergency." 40 P.S. § 991.2116. These statutes apply to emergency services, whether provided by in-network or out-of-network providers. *See id.* Thus, the General Assembly has spoken with respect to the reimbursement of emergency services and has not delegated authority to regulate further. In spite of these legislative choices, General Shapiro seeks to exercise power he does not have to establish a cap limiting UPMC's charges for out-of-network emergency services to its average in-network rates. Petition ¶ 75.k.

Because General Shapiro's proposed modifications contradict the settled regulatory delegations of the General Assembly, he lacks authority to impose those modifications.

V. Counts II-IV Were Improperly Commenced and, In Any Event, the Attorney General Fails to State a Claim for Violation of the Charities Law, the Nonprofit Corporation Law, or the Unfair Trade Practices and Consumer Protection Law.

Finally, General Shapiro has not stated a claim in Counts II, III, or IV for violation of the Charities Law, NCL, or UTPCPL.

A. Counts II-IV Are Procedurally Improper.

As an initial matter, General Shapiro's Petition is the wrong mechanism to bring a new action alleging statutory claims against UPMC under Counts II-IV.[18] General Shapiro is not immune from the procedural requirements necessary to institute legal claims for relief. Under the Pennsylvania Rules of Civil Procedure, "[a]n action may be commenced by filing with the prothonotary (1) a praecipe for a writ of summons, or (2) a complaint." Pa. R.C.P. 1007. *See Commonwealth ex rel. Creamer v. Rozman*, 309 A.2d 197, 199 (Pa. Commw. Ct. 1973) ("Rozmans correctly contend that an action under the [UTPCPL] Act may not be commenced by a consent petition providing for a permanent injunction."); *In re Correction of Official Records with Civil Action*, 404 A.2d 741, 742 (Pa. Commw. Ct. 1979) ("Our practice generally does not provide for the commencement of an action by petition and rule.").

Here, General Shapiro has filed neither a praecipe nor a complaint. Instead, he attempts to bring entirely new legal claims through a "Petition to Modify Consent Decrees." He cannot, under the guise of such a "modification" petition, effectively amend the initial petition that led to the Consent Decree, bypass discovery, motions practice, and all other pretrial procedures, and fast-forward straight to a judicial determination that UPMC violated the Charities Act, NCL, and UTPCPL. If General Shapiro believed that UPMC violated the Consent Decree, then he should have availed himself of the enforcement mechanism prescribed in Section IV.C.4 of the

[18] Through these claims, General Shapiro asks the Court to, among other things, force UPMC to substantiate the reasonableness of its executives' compensation, enjoin UPMC from conducting any further charitable solicitations, provide an accounting of charitable contributions it received for over a decade, and pay an undefined amount in penalties, reimbursement and restitution, as well as enjoining UPMC from denying access and treatment to Highmark subscribers. Petition at 50, 57-59, 67-69.

Decree.[19] But he cannot smuggle entirely new claims through a petition to "modify" a consent decree.

B. As A Matter Of Law, UPMC Did Not Violate Either the Charities Law or the Nonprofit Corporation Law.

General Shapiro's misuse of the Charities Law and the NCL fails as a matter of law. Put simply, both claims rest on a single false premise — namely, that UPMC commits to providing high-quality accessible healthcare, but UPMC has decided "to deny access" to some people by not providing care to *everyone* at in-network rates. *See* Petition ¶¶ 94, 96, 103-107.

This simplistic contention fundamentally misstates UPMC's charitable mission statement and the meaning of "access" to healthcare. Importantly, UPMC's charitable mission nowhere says that it is to provide high-quality accessible healthcare *to everyone at in-network rates*. *See* Exhibit A to Petition. That is a straw-man invented by General Shapiro.[20] Rather, the mission is, *inter alia*, to 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. Specifically:

> 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**

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[19] The Consent Decree designated the procedure to pursue claims that arose before June 30, 2019. Specifically, it empowered the Commonwealth to "seek enforcement of the Consent Decree in the Commonwealth Court" for violations of the terms of the Decree, after notice and an opportunity to cure. Consent Decree § IV.C.4. Enforcement actions were also the designated method to resolve claims that arise from complaints by "[a]ny person who believes they have been aggrieved by violation of [the] Consent Decree." *Id.*

[20] Indeed, General Shapiro inaccurately quotes UPMC's operative articles and statement of charitable mission, which is, *inter alia*, to 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, not to provide healthcare to everyone at in-network rates. *See* Exhibit A to Petition.

> **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.

Exhibit A to Petition (emphasis added).

There is no dispute that UPMC is doing just that. Indeed, General Shapiro affirmatively alleges that "[t]he public's support [of UPMC] has not gone unrewarded in that UPMC has grown into one of Pennsylvania's largest health care providers and health care insurers." Petition ¶ 10.[21]

[21] It is unpersuasive, on its face, to claim that UPMC's operations are out of line with its charitable mission or in the public interest. UPMC is the largest non-governmental employer in the Commonwealth, employing over 84,000 people in Pennsylvania. It provides more than $900 million dollars a year in benefits through its communities, including free and reduced-price medical care. It operates a world-renowned medical research center that is considered one of the best research hospitals in the country.

Nor does "accessible" healthcare or "access" to healthcare mean "access to UPMC *at in-network rates*." In *Highmark, Inc. v. UPMC Health Plan, Inc.*, for example, a federal court found that "access" to a healthcare provider means exactly that — the ability to access care at the provider, without regard to whether the access was at in-network or out-of-network rates, *i.e.*, the cost to the subscriber. *See* 276 F.3d 160, 172 (3d. Cir. 2001) (discussing the district court's ruling as to the meaning of "access" and declining to decide that issue on appeal). UPMC does provide high-quality accessible healthcare; there is no dispute that it does, and General Shapiro in fact acknowledges that UPMC provides access to out-of-network patients. It just requires that they pay in advance for the services, which it is permitted to do. *See* 42 U.S.C. § 1395(a) (Medicare); 42 U.S.C. § 1396a(a)(23) (Medicaid) (entitling, through federal legislation that occupies the field, recipients of Medicare and Medicaid to obtain health services from a provider only "if such institution, agency or person undertakes to provide him such services").[22]

That UPMC does not provide healthcare to everyone at in-network rates is not, as a matter of law, contrary to its charitable purpose or in violation of the Charities Act or the NCL.

C. The Petition Fails to State a Claim Under the UTPCPL.

Likewise, General Shapiro cannot impose his new healthcare model through the UTPCPL. He alleges that UPMC has engaged in unfair and deceptive acts or practices in violation of the UTPCPL based upon unsupported allegations relating to UPMC's unwillingness to provide services to certain patients and its unwillingness to contract with Highmark.[23]

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[22] The Attorney General has known for years that UPMC has required prepayment from patients seeking out-of-network care under the Consent Decree. The Attorney General has never contended that UPMC's request for prepayment violated the Consent Decree. Nor is it clear that General Shapiro even contends that today. Regardless, and as detailed above, General Shapiro is now precluded from asserting any claim for modifying the Consent Decree based on that assertion. *See supra* at 15-16.

[23] Those claims are legally barred, in any event, as discussed *supra* at 13-18.

The UTPCPL, however, only regulates the conduct of sellers in consumer transactions (*i.e.*, transactions in which a seller is selling goods or services to a consumer buyer). It proscribes "[u]nfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce as defined by [the UTPCPL]." 73 P.S. § 201-3. To be unlawful, an act or practice must be done "in the conduct of any trade or commerce," which the law enumerates as four types of commercial activities: "***the advertising, offering for sale, sale or distribution*** of any services and any property, tangible or intangible, real, personal or mixed and any other article, commodity, or thing of value wherever situate, and includes any trade or commerce directly or indirectly affecting the people of this Commonwealth." *Id.* § 201-2(3) (emphasis added).

None of the conduct alleged in support of General Shapiro's UTPCPL claim falls within these four commercial activities. UPMC's negotiating (or refusing to negotiate) with a prospective third-party payor does not involve the "advertising, offering for sale, sale or distribution" of any covered product or service. *See* Petition ¶ 118-19, 121; *see, e.g.*, *Anderson v. Nationwide Ins. Enter.*, 187 F. Supp. 2d 447, 461 (W.D. Pa. 2002) (holding that insurers' alleged refusal to honor contractual obligations did not qualify as "advertising, offering for sale, sale or distribution of any services and any property" under the UTPCPL). Similarly, UPMC's notifications concerning the termination of its Highmark commercial and Medicare Advantage contracts are not covered by the statute. *See* Petition ¶ 117-18, 120.

Moreover, the UTPCPL only regulates the conduct of sellers vis-à-vis consumers; it does not apply to private contracts between commercial entities under which healthcare providers agree to provide services to members/beneficiaries of healthcare plans in exchange for the health plans' reimbursement for those services. Commercial contracting between healthcare providers

and payors is not within the scope of "trade and commerce" under the UTPCPL.[24] Therefore, because General Shapiro does not have authority under the UTPCPL to regulate more than the conduct of sellers in consumer transactions, Count IV provides no basis whatsoever for the relief it seeks.

CONCLUSION

For the foregoing reasons, Respondent UPMC respectfully requests that this Court reject General Shapiro's Petition to Modify Consent Decrees; deny the relief sought in the Petition; and dismiss the claims therein as a matter of law.

Dated: February 21, 2019

Respectfully submitted,

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[24] Even if the UTPCPL did cover the conduct alleged in the Petition — and it does not — General Shapiro has not adequately pled any violation of the statute. As set forth *supra* 13-16, each of the allegedly "unfair" and "deceptive" acts alleged in Count IV either preceded the Consent Decree (and, accordingly, were settled and released), *see, e.g.*, Petition ¶ 118, or should have been addressed in an enforcement actions, *see, e.g.*, Petition ¶ 117, 119-20.

CERTIFICATE OF SERVICE

I hereby certify that on this 21st day of February, 2019, I submitted the foregoing Memorandum in Support of Respondent UPMC's Motion to Dismiss the Petition to Modify Consent Decrees, or Preliminary Objections in the Nature of a Demurrer for electronic service via the Court's electronic filing system on Petitioner, The Office of Attorney General, on the following:

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EXHIBIT A

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

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UPMC LIFE CHANGING MEDICINE

NEWS RELEASE SEARCH

GO

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

EXHIBIT B

Final

CONFIDENTIAL: Subject to Mediation Agreement

Highmark - UPMC Agreement

1. Elements of agreement for public disclosure in a Joint Statement by Highmark and UPMC:

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. No run out.

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, certain oncological services, UPMC Bedford, and UPMC Venango. 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.

2. Elements of agreement not for public disclosure:

[redacted]

[redacted]

So agreed:

Deborah L Price
for Highmark

_____
for UPMC

EXHIBIT C

IN THE COURT OF COMMON PLEAS OF ALLEGHENY COUNTY, PENNSYLVANIA

HIGHMARK, INC., Plaintiff, v. WEST PENN ALLEGHENY HEALTH SYSTEM, INC., CANONSBURG GENERAL HOSPITAL, ALLE-KISKI MEDICAL CENTER, ALLEGHENY MEDICAL PRACTICE NETWORK, ALLEGHENY-SINGER RESEARCH INSTITUTE, ALLEGHENY SPECIALTY PRACTICE NETWORK, ALLE-KISKI MEDICAL CENTER TRUST, CANONSBURG GENERAL HOSPITAL AMBULANCE SERVICE, FORBES HEALTH FOUNDATION, SUBURBAN HEALTH FOUNDATION, THE WESTERN PENNSYLVANIA HOSPITAL FOUNDATION, WEST PENN ALLEGHENY FOUNDATION, L.L.C., WEST PENN ALLEGHENY ONCOLOGY NETWORK, and WEST PENN PHYSICIAN PRACTICE NETWORK, Defendants.	:	CIVIL DIVISION Case No. GD12-18361 **COMMONWEALTH'S FINDINGS OF FACT AND MEMORANDUM OF LAW**

COMMONWEALTH OF PENNSYLVANIA,
By: LINDA L. KELLY, Attorney General,

Counsel of Record for this Party:

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IN THE COURT OF COMMON PLEAS OF ALLEGHENY COUNTY, PENNSYLVANIA

HIGHMARK INC.,	:	CIVIL DIVISION
Plaintiff,	:	
v.	:	
	:	
WEST PENN ALLEGHENY HEALTH SYSTEM, INC., CANONSBURG GENERAL HOSPITAL, ALLE-KISKI MEDICAL CENTER, ALLEGHENY MEDICAL PRACTICE NETWORK, ALLEGHENY-SINGER RESEARCH INSTITUTE, ALLEGHENY SPECIALTY PRACTICE NETWORK, ALLE-KISKI MEDICAL CENTER TRUST, CANONSBURG GENERAL HOSPITAL AMBULANCE SERVICE, FORBES HEALTH FOUNDATION, SUBURBAN HEALTH FOUNDATION, THE WESTERN PENNSYLVANIA HOSPITAL FOUNDATION, WEST PENN ALLEGHENY FOUNDATION, L.L.C., WEST PENN ALLEGHENY ONCOLOGY NETWORK, and WEST PENN PHYSICIAN PRACTICE NETWORK,	:	Case No. GD12-18361
Defendants.	:	

COMMONWEALTH'S FINDINGS OF FACT AND MEMORANDUM OF LAW

The Commonwealth of Pennsylvania, Intervener in the above-captioned matter, acting in its capacity as *parens patriae* through its Attorney General, Linda L. Kelly, respectfully files its Findings of Fact and Memorandum of Law, as follows:

INTRODUCTION

The critical importance to the public of the implementation of the proposed affiliation of the original Plaintiff, Highmark, Inc. ("Highmark"), and the fourteen named original Defendants related to the West Penn Allegheny Health System (collectively, "West Penn") cannot be overstated. The pleadings of the parties, as well as the testimony of witnesses for both sides, are replete with statements that, if the Affiliation fails, the public will be irreparably harmed by the loss of the benefit of a second integrated health care financing and delivery system; through the loss of physicians and employees; the displacement of patients and the disruption of treatment; the reduction of medical research; as well as the loss of hundreds of millions of dollars of charitable assets that have already been committed to the affiliation. The relief requested by the Commonwealth, which would temporarily suspend the litigation while the parties cooperate on Highmark's submittal to the Pennsylvania Insurance Department, is necessary to protect the mutual interests of the parties and to prevent irreparable harm from befalling the public.

PROPOSED FINDINGS OF FACT

1. The original Plaintiff, Highmark, and all but one of the fourteen named West Penn defendants are domestic nonprofit corporations formed for the charitable purposes set forth in their respective articles. See Highmark's Verified Complaint for Special, Preliminary and Permanent Injunctive Relief, Specific Performance and For Damages ("Highmark's Complaint"), paragraphs 7 through 21; Defendants' Verified Answer and New Matter ("West Penn's Answers").

2. Together, Highmark and West Penn hold billions of dollars in assets, which are held in trust for the benefit of the public. See Pruner Estate, 390 Pa. 529, 136 A. 2d 107 (1957).

3. The October 31, 2011 Affiliation Agreement between Highmark and West Penn ("Agreement"), as contemplated, places all of the parties under the common control of a nonprofit Ultimate Parent Entity ("UPE"), formed for the charitable purposes of operating as a vertically integrated health care financing and delivery system to serve the Western Pennsylvania community. (Highmark Complaint, para. 1, and Exhibit A; West Penn Answer, para. 1; Transcript, p. 26, 1. 24, Exhibit 1.)

4. Highmark's action, however, alleges that West Penn has breached the parties' Agreement and seeks injunctive relief to preserve the transaction while also seeking damages against West Penn. (Highmark Complaint, paras. 2 – 6.)

5. Conversely, West Penn denies the allegations contending Highmark has breached the Agreement and that its deteriorating financial position requires that it move as quickly as possible to secure another strategic partner in order to preserve its charitable health care mission. (West Penn Answer, paras. 2 – 6; West Penn Counterclaims, paras. 121 – 187.)

6. In light of the Commonwealth's oversight responsibilities over charitable organizations and their assets as set forth above, the parties submitted their Agreement to the Commonwealth for its review and approval as a prerequisite to the transaction's closing. (Exhibit 1, para. 8.4; Transcript, p. 190.)

7. The Agreement, as submitted to the Commonwealth, did not contemplate a restructuring of West Penn's indebtedness and the Commonwealth tentatively approved the

proposed transaction on that basis subject to the parties completing an appropriate record before the Orphans' Court Division of this Court. (Exhibit 1, para. 6.3(k); Transcript, p. 529.)

8. Subsequent to the Agreement's submission to the Commonwealth, Highmark concluded that a restructuring of West Penn's indebtedness may be required to secure the approval of the Pennsylvania Insurance Department ("PID"), which is also a prerequisite to the transaction's closing. (Transcript, pp. 124 – 130.)

9. Highmark's and West Penn's refusal to cooperate in exploring debt restructuring and ensuing breach of contract claims are now causing unreasonable delays and consuming scarce charitable resources on the substantial costs and expenses of litigation as well as damage to the reputations and goodwill of both parties within the medical community, financial markets, and public-at-large. (Transcript, pp. 21 – 24.)

10. West Penn's financial condition continues to deteriorate during the delay in approval of the Affiliation by the PID, which negative affects the quality and future viability of its health care services in the community. (Transcript, p. 866.)

11. If the PID approval is further delayed, West Penn's finances will quickly reach the point where bankruptcy is the system's only option and the quality of its charitable health care mission will be irretrievably lost to the community. (Transcript, pp. 615, 866.)

12. If West Penn is permitted to secure another strategic partner, the hundreds of millions of dollars in charitable assets Highmark has already advanced to West Penn, including,

but not limited to, the third-party contracts and other obligations Highmark has assumed in reliance on their transaction going forward will be lost. (Transcript, p. 22.)

13. Should West Penn's only alternative be to partner with a commercial entity all of Highmark prior loans and contributions to West Penn of at least $200M will inure to the benefit of private investors. (Transcript, p. 22.)

THE COMMONWEALTH'S INTEREST AND ENTITLEMENT TO INJUNCTIVE RELIEF

I. THE COMMONWEALTH, ACTING AS *PARENS PATRIAE*, HAS THE LEGAL STANDING AND OBLIGATION TO INQUIRE INTO THE FUNCTIONING OF THE PARTIES IN THAT, AS A PUBLIC CHARITIES, THEY HOLD THEIR ASSETS IN TRUST FOR THE BENEFIT OF THE PUBLIC-AT-LARGE.

Pennsylvania's case law makes clear the role and authority of the Commonwealth when acting through its attorney general in cases involving public charities and, indeed, all property committed to charitable purposes:

> The beneficiary of charitable trusts is the general public to whom the social and economic advantages of the trusts accrue. But because the public is the object of the settlors' benefactions, private parties have insufficient financial interest in charitable trusts to oversee their enforcement. Consequently, *the Commonwealth itself must perform this function if charitable trusts are to be properly supervised. The responsibility for public supervision traditionally has been delegated to the attorney general to be performed as an exercise of his* parens patriae *powers.* . . . These are the ancient powers of guardianship over persons under disability and of protectorship of the public interest which originally were held by the Crown of England as the 'father of the country,' . . . and which as part of the common law devolved upon the states and federal government. . . . *Specifically, these powers permitted the sovereign, wherever necessary, to see to the proper establishment of charities through his officer, the attorney general, and to exercise supervisory jurisdiction over all charitable trusts.*

Pruner Estate, 390 Pa. 529, 531-32, 136 A.2d 107, 109 (1957) (citations and footnotes omitted, emphasis added).

Only several years later our Supreme Court went on to rule that the scope of this oversight authority over charitable trusts encompasses all public charities in general. Commonwealth v. Barnes Foundation, 398 Pa. 458, 159 A.2d 500 (1960). In Barnes, the Attorney General filed a petition for citation against a public charity in control of an art gallery that refused to open to the public. The Attorney General also sought an accounting of the foundation's income and expenditures. Reversing the lower court, the Supreme Court denied the foundation's preliminary objections averring that the petition failed to state a cause of action. The Court held that the Attorney General, as *parens patriae*, is authorized to inquire into the status, activities and functioning of public charities reasoning that:

> It cannot be questioned that Attorney General Alpern, by virtue of the powers of her office, is authorized to inquire into the status, activities and functioning of public charities. This authority was recognized at common law:
>
> 'It is the duty of the King as *parens patriae* to protect property devoted to charitable uses; and that duty is executed by the officer who represents the Crown for all forensic purposes. On this foundation rests the right of the Attorney General in such cases to obtain by information the interposition of the court of equity.' . . . .
>
> This Court has affirmed the common law in holding that where litigation involves charitable trusts, the Attorney General is obliged to participate as a necessary party. . . . It would be an inadequate form of government which would allow organizations to declare themselves charitable trusts without requiring them to submit to supervision and inspection. Without such supervision and control, trustees of alleged public charities could engage in business for profit. It is because of the temptation which such lack of supervision would offer, that a Congressional committee observed:
>
> 'Foundations should not only operate in a goldfish bowl, they should operate with glass pockets.' H.R. Report 2514, 82d Congress.

> ...
>
> The lower Court held that the petition did not allege a cause of action. But what more formidable cause of action could exist than the assertion that the trustees of a charitable trust are failing to carry out the mandates of the indenture under which they operate?
> ...

Id. at 467-68, 159 A.2d at 505. The court also stated that the Attorney General had "not only the authority but the duty to ascertain" the factual circumstances surrounding the foundation to determine whether it deserved its tax-exempt status. *Id.* at 465, 159 A.2d at 504. As the court noted in its reasoning, "Every dollar a public institution saves in tax levy becomes an extra stone in the heavy sack the Commonwealth piles on every taxpayer's back." *Id.*

On remand to the Orphan's Court, the president judge granted wide latitude to the Attorney General in authorizing the Commonwealth's request that the foundation be ordered to produce, among other things, an inventory of all the art along with appraised values, an itemized list of the foundation's total assets, the foundation's annual income since the founder's death, and an itemized account of the foundation's expenditures during the same period. Commonwealth v Barnes Foundation (No. 2), 11 Fiduc. Rep. 29 (O.C. Montg. 1961). In its analysis of the scope of inspection and discovery to be afforded the Commonwealth, the court found "[t]hat such powers, *parens patriae*, are broad and sweeping powers there can be no dispute. For it is of the essence of a public charity that it be subject to the visitorial powers of the sovereign." *Id.* at 31. It added that the "broad investigatory and visitorial powers of the Commonwealth" being asserted "should not be lightly regarded" nor restricted on technical procedural grounds. *Id.*[1]

[1] These common law principles have been codified and carried over into Section 204(c) of the Commonwealth Attorneys Act, 71 P.S. §732-204(c), which states in pertinent part that, "[t]he Attorney General shall represent the Commonwealth ... in any action brought by or against the Commonwealth ... and may intervene in any other action, including those involving charitable bequests and trusts...."

> [I]n the case of public charities the securities are not held by the trustees "in his, her, their, or its own right," and . . . "The trusts mentioned are not trusts for particular persons, but for particular objects. It may be that in the administration of the trusts for these charitable and religious objects some person may be incidentally benefited, but he is not a person entitled by law to 'the use, benefit, or advantage' of the trust, or who has by law any beneficial interest or ownership in it whatever. The funds are not held in trust for any person whomsoever, but to be applied to the particular charities and religious purposes mentioned, in the discretion of the trustees, so that no person or individual can possibly be said to have any legal right or interest in it whatever..."

In re Buhl's estate, 300 Pa. 29, 34, 150 A. 86, 87 (1930) (citation omitted). *See also,* Cain's Estate, 16 Pa. D. & C. 3d 50 (O.C. Del. 1980) (attorney general's interest, as *parens patriae,* is in all charitable organizations, not merely charitable trusts).

A prominent example of the Commonwealth's exercise of its *parens patriae* authority over nonprofit charitable corporations occurred In re Allegheny Health, Education and Research Foundation (AHERF), 252 B.R. 309 (W.D. Pa. 1999) (emergency stay granted); 252 B.R. 332 (W.D. Pa. 1999) (order of Bankruptcy Court reversed). AHERF involved the partial bankruptcy of a state-wide health care system in which the Commonwealth took action to void AHERF's status as the controlling member of its non-debtor affilatiates to preserve their ongoing charitable missions. Although initially enjoined by the Bankruptcy Court pursuant to the automatic stay provisions of the Bankruptcy Code, the U.S. District Court for the Western District of Pennsylvania held that the police power exception to the automatic stay under the federal Bankruptcy Code includes the Commonwealth's exercise of its "*parens patriae* powers to protect the assets and/or charitable mission of a charitable trust or other non-profit charitable corporation." 252 B.R. 309, 327.

Moreover, as a nonprofit corporation formed for charitable purposes, each of the parties is deemed to hold their assets in trust to further their charitable purposes. Section 5103 of the Nonprofit Corporation Law, defines charitable purposes as, "[t]he relief of poverty, the

advancement of education, the advancement of religion, the promotion of health, governmental or municipal purposes, and other purposes the accomplishment of which is beneficial to the community." 15 Pa.C.S. § 5103.

Section 5547(a) of the Nonprofit Corporation Law provides, "(a) General rule.—Every nonprofit corporation incorporated for a charitable purpose or purposes may take, receive and hold such real and personal property as may be given, devised to, *or otherwise vested in such corporation, in trust*, for the purpose or purposes set forth in its articles." 15 Pa.C.S.A. §5547(a) (emphasis added). This statutory provision has been expressly interpreted to encompass all of the assets of a nonprofit corporation formed for charitable purposes, not only assets that have been expressly donated.

In Re Roxborough Memorial Hospital, 17 Fiduc.Rep.2d 412 (O.C. Phila. 1997), the hospital sought the orphans' court's approval of the sale of substantially all of its physical and operating assets in order to confirm that the sale would not result in a diversion of such assets from their charitable purposes. After citing the above provisions of Section 5547(a), the orphans' court determined that:

> The Hospital has generated revenues from the services provided. Such revenues like the assets used to generate them are to be used for the charitable purposes as set forth in the Hospital's articles of incorporation. A nonprofit corporation that charges fees is permitted to make an incidental profit. However, "[a]ll such incidental profit shall be applied to the maintenance and operation of the lawful activities of the corporation, and in no case shall be divided or distributed in any manner whatsoever among the members, directors or officers of the corporation:" 15 Pa.C.S.A. §5545. **Accordingly, all property held by a nonprofit corporation is held in trust to carry out its charitable purposes. All property held by a charitable nonprofit including the operating revenues, grants, donations, bequests, etc. generated therefrom, constitute property committed to charitable purposes.**

In Re Roxborough Memorial Hospital, *supra*, 17 Fid. Rep.2d at 422, 423 (emphasis added). *See also,* In re HealthEast, Inc., 10 Fiduc. Rep. 2d 285 (O.C. Lehigh, 1992) (Audit of all hospital assets to confirm proper functioning as charitable institution).

"The Commonwealth has *parens patriae* standing whenever it asserts quasi-sovereign interests, which are interests that the Commonwealth has in the well-being of its populace." Commonwealth v. Citizens Alliance for Better Neighborhoods, Inc., et al., 983 A.2d 1274, 1277 (Cmwlth. Ct. 2009).

II. THE COMMONWEALTH IS CLEARLY ENTITLED TO THE REQUESTED INJUNCTIVE RELIEF.

To obtain a preliminary injunction, the Commonwealth must establish: (1) that the injunctive relief is necessary to prevent irreparable harm that cannot be adequately compensated by money damages; (2) that greater injury will occur from refusing to grant the injunction than from granting it; (3) that the injunction will restore the parties to their status quo as it existed before the alleged wrongful conduct; (4) that the Commonwealth is likely to prevail on the merits; (5) that the injunction is reasonably suited to abate the offending activity; and (6) that the public interest will not be harmed if the injunction is granted. Brayman Construction Corporation v. Commonwealth Department of Transportation, 608 Pa. 584, 13 A. 3d 925 (2011) (short synopsis of the case).

A. The Commonwealth's Requested Injunctive Relief Is Necessary To Prevent Irreparable Harm That Cannot Be Adequately Compensated By Money Damages.

If the parties abandon their affiliation the members of the community will suffer irreparable harm. The viability and quality of West Penn's charitable health care mission will

continue to deteriorate and be lost to the community indefinitely. The competitive benefits to the community of a second integrated health care financing and delivery system will be lost indefinitely. Hundreds of millions of dollars of charitable assets already committed to the transaction will never be recovered. The community, through the Commonwealth, has no adequate remedy at law to restore any of the losses and non-monetary damages at issue.

B. Greater Injury Will Occur From Refusing To Grant The Commonwealth's Injunction Than From Granting It.

If the Commonwealth's injunctive relief is denied, the public will most assuredly suffer one of two disastrous consequences:

1. Should Highmark prevail, West Penn will suffer additional operational losses while Highmark attempts to restructure the hospital system's debt hoping to secure the approval of the Pennsylvania Department of Insurance ("PID"). West Penn's ongoing operational losses will continue to weaken the quality of its services and, should the PID ultimately disapprove the transaction, West Penn will be left with bankruptcy as its only practical option; or

2. Should West Penn prevail, the health care system will accrue additional operational losses while it seeks out an alternative strategic partner(s). Given that the systems' current cash reserves are expected to be exhausted within the next several months, its ongoing operational losses will compel it to pursue bankruptcy relief to salvage as much of its existing services as possible.

In either of the above circumstances, the quality of West Penn's services will continue to deteriorate through the loss of physicians and employees, the displacement of patients, disrupted treatment, and diminished medical research--all at the ultimate expense of public.

As such, this Court cannot grant the relief requested by Highmark, without further protecting the continued viability of West Penn and protecting the public's interest as requested by the Commonwealth. See Allegheny Anesthesiology Associates, Inc. v. Allegheny General Hospital, 826 A. 2d 886 (Pa. Super. 2003) (a preliminary injunction would not be granted to

employer seeking to enjoin employees from violating restrictive employment covenant where there would be a serious and detrimental impact on patient service, the work of other physicians and the general public welfare.) See also McMullan v. Wohlgemuth, 444 Pa. 563, 281 A. 2d 836 (1971) (a preliminary injunction will not be granted to a newspaper to publish the names of welfare recipient in advance of the trial on the merits of the right-to-know lawsuit because of the adverse effect on the public interest).

On the other hand, if the Commonwealth's injunctive relief is granted, the litigation will be suspended while the parties work cooperatively to provide Highmark with the opportunity to restructure West Penn's debt and complete the insurer's submission to the PID. Throughout the balance of the proposed transaction's regulatory review, Highmark will be obliged to reimburse West Penn's operational losses. If the transaction is approved by the PID, West Penn's operating losses are rendered moot since, under the Agreement, those losses have always been expected to be absorbed by the new UPE. If the proposed transaction is disapproved, however, Highmark's reimbursements will serve to maintain the status quo in West Penn's finances since it will need to pursue an alternative strategic partner(s).

Accordingly, denying the Commonwealth's injunctive relief will clearly result in greater harm than granting it.

C. Granting The Commonwealth's Injunction Will Restore The Parties To Their Status Quo As It Existed Before The Alleged Wrongful Conduct.

As mentioned above, the Commonwealth has respectfully requested that this Honorable Court issue an injunction that suspends the subject litigation without prejudice to any party to pursue their pecuniary claims and defenses in the event their affiliation does not go forward. The Commonwealth's injunction establishes a timetable of no longer than ninety (90) days within

which the parties must work cooperatively to complete Highmark's submission to the PID and seek the PID's approval of the transaction.

Hence, the position and interests of all parties will be restored to immediately prior to the wrongful breaches of contract alleged.

D. The Commonwealth Is Likely To Prevail On The Merits.

Neither Highmark nor West Penn are seeking relief requests that adequately protect the interests of the community. On the contrary, Highmark and West Penn each seek relief that unreasonably and ultimately harms the public.

Highmark's requested relief does not address the probability that further regulatory delays will likely force West Penn out of business, the loss of which to the public far exceeds the harm that Highmark has alleged.

West Penn's requested relief asks this Court to disregard the hundreds of millions of dollars in charitable assets that have already been committed to achieving the strategic goals of the Agreement. Depending upon the identity of any alternate strategic partner, all of those assets as well as whatever equity may exist in West Penn's assets may be lost to private investors, in addition to the likely continued loss of physicians, employees and patients.

Under the circumstances at hand, only the Commonwealth's requested relief preserves the interests of the general public as much as practically possible and, in that regard, is the only party likely to prevail on the merits presented.

E. The Commonwealth's Injunction Is Reasonably Suited To Abate The Offending Activity.

The passage of time, during which the proposed transaction remains in limbo and West Penn's finances continue to deteriorate, is the greatest threat to the interests of all parties

concerned, especially the public. The injunctive relief requested by the Commonwealth directly addresses that issue while preserving the interests of all parties to the fullest extent possible.

F. The Public Interest Will Not Be Harmed If The Commonwealth's Injunction Is Granted.

The injunctive relief as outlined above will equitably address the interests of all parties, including those of the community which are inextricably entwined in the current controversy. West Penn will be afforded the degree of certainty it needs to go forward with the parties' Agreement or to pursue an alternate strategic plan in the event the Agreement is disapproved. Highmark will be afforded the opportunity to restructure West Penn's debts with West Penn's cooperation and enjoy material control over the time required to perfect its submission to the PID, thus limiting its financial exposure in the event that the transaction is disallowed.

Additionally, the general public will be afforded the security of having the parties exhaust the regulatory process before losing the Agreement's potential benefits to the community, while salvaging as much of West Penn's existing health care services as practically possible. The relief requested by the Commonwealth will also preserve the monetary claims of the parties to the fullest extent possible in the event the need arises to pursue them; and all parties will have recourse to the Court through its continuing oversight and jurisdiction should any violations or enforcement issues arise.

CONCLUSION

For all of the foregoing reasons, the Commonwealth respectfully requests that this Honorable Court grant the injunctive relief requested, as well as any other relief deemed appropriate.

Respectfully submitted,

COMMONWEALTH OF PENNSYLVANIA
LINDA L. KELLY
Attorney General

By: Mark A Pacella

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November 7, 2012

CERTIFICATE OF SERVICE

I, Gene J. Herne, hereby state that I am an Attorney for the Commonwealth of Pennsylvania in this matter and hereby certify that I served a true and correct copy of the ***Commonwealth's Findings of Fact and Memorandum of Law*** via electronic and first class mail on November 7, 2012, to the following:

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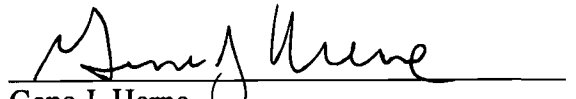

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November 7, 2012

EXHIBIT D

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 E

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW

WHEREAS, on November 7, 2011, UPE (the "Applicant") filed an application on Form A, Statement Regarding The Acquisition of Control of or Merger With Domestic Insurers (the "Initial Form A Application") to acquire control (the "Change of Control") of Highmark Inc., ("Highmark") [1], and of various subsidiaries thereof as identified in the Initial Form A Application and set forth above; and

[1] On May 2, 2013, UPE filed with the Department of State to change its name to Highmark, and Highmark Inc simultaneously filed with the Department of State to change its name to Highmark Health Services. For purposes of these Findings of Fact and Conclusions of Law "UPE" will continue to be referred to as "UPE" and "Highmark, Inc." will continue to be referred to as "Highmark".

WHEREAS, the Applicant filed Amendment No. 1 to the Initial Form A Application dated July 13, 2012 ("Amendment No. 1"); and

WHEREAS, the Applicant filed Addendum No. 1 to Amendment No. 1 to the Initial Form A Application dated August 24, 2012 ("Amendment No. 1 – Addendum")

WHEREAS, the Applicant filed Amendment No. 2 to the Initial Form A Application, dated January 18, 2013 (Amendment No. 2"); and

WHEREAS, the Applicant filed Addendum No. 1 to Amendment No. 2 to the Initial Form A Application dated January 18, 2013 ("Addendum 1"); and

WHEREAS, the Applicant filed Addendum No. 2 to Amendment No. 2 to the Initial Form A Application dated January 23, 2013 ("Addendum 2"); and

WHEREAS, the Applicant filed Addendum No. 3 to Amendment No. 2 to the Initial Form A Application dated February 12, 2013 ("Addendum 3"); and

WHEREAS, the Applicant filed Addendum No. 4 to Amendment No. 2 to the Initial Form A Application dated March 8, 2013 ("Addendum 4"); and

WHEREAS, the Applicant filed Addendum No. 5 to Amendment No. 2 to the Initial Form A Application dated March 27, 2013 ("Addendum 5," and together with the Initial Form A Application, Amendment No. 1, Amendment No. 1 – Addendum, Amendment No. 2, Addendum 1, Addendum 2, Addendum 3, Addendum 4, thereto, collectively, the "Form A"); and

WHEREAS, the Department issued multiple, specific information requests to which UPE responded; and

WHEREAS, the comprehensive record developed in the course of the Department's review of the Form A included more than 64,000 pages of reports and analytical data, more than 10,000 pages of public comments and more than six hours of public testimony; and

WHEREAS, in determining whether to approve the Form A, the Department considered materials submitted by UPE, other information, presentations, reports, documents, public comments, and other inquiries, investigations, materials, and studies permitted by law; and

WHEREAS, the Department specifically considered reports prepared for the Department by The Blackstone Group, L.P. (the "Blackstone Report") and Margaret E. Guerin-Calvert, Senior Consultant, Compass Lexecon, LLC (the "Guerin-Calvert Report"); and

WHEREAS, on the basis of all of the information listed above, on April 29, 2013, the Department issued an Approving Determination and Order, a copy of which is attached hereto as Exhibit A and incorporated herein by reference (the "Approving Determination and Order") which approved the Change of Control and all other transactions included in the Form A which are subject to the Department's jurisdiction and require the approval of the Department, subject to the Conditions set forth in the Approving Determination and Order; and

WHEREAS, on the basis of all of the information listed above, on April 29, 2013, the Department found in the Approving Determination and Order that, with the imposition of the Conditions as set forth in the Approving Determination and Order 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 Form A which are subject to the Department's jurisdiction and require approval of the Department, did not violate Section 1402 of the Insurance Holding Companies Act, 40 P.S. § 991.1402 ("Section 1402"); and

WHEREAS, on April 29, 2013, Highmark consummated the Affiliation Agreement with West Penn Allegheny Health System, Inc. ("West Penn") and the purchase of certain tax-exempt bonds of West Penn; and

WHEREAS, the Approving Determination and Order provided that the Department would subsequently issue on or before May 31, 2013 further full findings of fact and conclusions of law that substantially reflect the factual conclusions reached in the Blackstone Report and the Guerin-Calvert Report; and

WHEREAS, the Approving Determination and Order defines certain terms as used therein and any capitalized terms not defined in these full findings of fact and conclusions of law have the meaning ascribed to them in Appendix 1 (Definitions) to the Approving Determination and Order.

NOW, THEREFORE, this 31st day of May, 2013, the Department makes the following further findings of fact and conclusions of law in further support of the Approving Determination and Order.

INTRODUCTION

The Form A that was before the Department ultimately originated from a plan Highmark announced in 2011 to create an integrated delivery network (or "IDN") for healthcare services in the western Pennsylvania area (the "WPA" or the "Western Pennsylvania Region"). An IDN usually includes an insurer or other payor and a system of healthcare providers – including physicians, hospitals, and/or health plans – operating within the same network, often under the same parent company. Among the perceived benefits of IDNs are that participants are incentivized to use better patient care strategies, such as coordination of care to secure better and more efficient patient outcomes, and are better equipped to benefit from economies of scale.

As part of its IDN Strategy, Highmark sought to formally affiliate with the West Penn which is referred to in the Form A, the Guerin-Calvert Report, and the Blackstone Report as "WPAHS". As part of this plan as set forth in the Form A, Highmark and West Penn would be

placed under the same parent company, the Applicant. Because these changes involved a change of control of Highmark and certain insurer subsidiaries thereof, the Applicant requested the Department's approval of certain elements thereof pursuant to the Insurance Holding Companies Act, and the Department was required to approve the Change of Control unless it found that one of the standards set forth in Section 1402 existed.

Upon its review of the Form A, the Department concluded that with the imposition of the Conditions the Change of Control and the transactions related thereto as noted in the Guerin-Calvert Report and the Blackstone Report do not violate Section 1402.

The foregoing Recitals and Introduction are deemed incorporated into the Findings of Fact and Conclusions of Law as if set forth therein.

FINDINGS OF FACT

I. Identity of Entities Involved.

A. UPE.

1. UPE is a Pennsylvania nonprofit corporation, exempt from federal income taxation pursuant to Section 501(c)(3) of the Internal Revenue Code, with its principal place of business in Pittsburgh, Pennsylvania.

2. UPE was formed on October 20, 2011, in anticipation of the Transaction set forth in the Form A.

3. Upon the closing of the Transaction contemplated by the Form A, the members of Highmark consist of two classes: (i) UPE; and (ii) the persons constituting the Board of Directors of Highmark, with UPE having the authority as the corporate member to elect Highmark's Board.

4. UPE is also the sole member of UPE Provider Sub, a Pennsylvania nonprofit corporation exempt from federal income taxation pursuant to Section 501(c)(3) of the Internal Revenue Code and that, after issuance of the Approving Determination and Order, changed its name to Allegheny Health Network ("UPE Provider Sub"). UPE Provider Sub is the direct or indirect parent corporation of West Penn, Jefferson Regional Medical Center, HMPG, Inc. and their subsidiaries.

5. UPE has certain reserved powers as it relates to Highmark and West Penn.

6. All of UPE's initial directors were selected from among Highmark's directors.

7. UPE has certain reserved powers as it relates to UPE Provider Sub, such as electing its Board of Directors and officers, and approving its strategic plans and annual budgets.

8. UPE's bylaws provide for the following as it relates to its Board and management:

a) The Board of Directors shall consist of at least three members, and the directors shall be divided into three classes so that 1/3 of the aggregate number of directors may be chosen each year.

b) The principal officers of UPE shall be a Chief Executive Officer responsible for the general and active management of the business; a Chief Financial Officer responsible for financial accounting and reporting for the business and such other duties as may be assigned by the Chief Executive Officer or the Board of Directors; a Treasurer responsible for all funds and securities of the business; and a Secretary who shall keep the minutes of the meetings of the Board of Directors and its committees and run elections and notices in accordance with the Bylaws.

c) Other officers include one or more President(s) responsible for the direct administration, supervision, and control of such activities in the management of the business as may be assigned by the Chief Executive Officer or the Board of Directors; and Vice Presidents responsible for duties assigned by the Chief Executive Officer or the Board of Directors.

9. The directors of UPE prior to the issuance of the Approving Determination and Order were William Winkenwerder, Jr., MD; J. Robert Baum, Ph.D.; David A. Blandino, M.D.; David J. Malone; David M. Matter; and Victor A. Roque.

10. The senior officers of UPE prior to the issuance of the Approving Determination and Order were William Winkenwerder, Jr. MD (President and CEO); Thomas L. VanKirk (Secretary); and Nanette P. DeTurk (Treasurer).

B. Highmark.

11. Highmark is a Pennsylvania nonprofit corporation with its registered address in Camp Hill, Pennsylvania. In July 2012, William Winkenwerder, Jr., M.D. was hired as Highmark's President and CEO to fill the vacancy created by the termination of the employment of Kenneth R. Melani, M.D. The office of CEO is currently vacant. The senior officers of Highmark currently are: Deborah L. Rice-Johnson (President, Highmark Health Plan); David L. Holmberg (President, Diversified Services); Nanette P. DeTurk (Treasurer); and Thomas L. VanKirk (Secretary).

12. Highmark was created through the consolidation in 1996 of Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield. It is an independent licensee of the Blue Cross Blue Shield Association. Highmark operates as Highmark Blue Cross Blue Shield in the twenty-nine western-most counties of Pennsylvania, and as Highmark Blue Shield in the remaining counties of the Commonwealth. Highmark provides traditional "fee for service" coverage to groups and individuals in Pennsylvania. In addition, Highmark also offers health insurance coverage in 49 of Pennsylvania's 67 counties through a preferred provider

organization, or "PPO" program. Highmark is also an administrative services only, or "ASO," provider for certain self-insured groups.

13. As a party to a joint operating agreement, Highmark provides professional health services coverage in conjunction with hospital coverage provided by Blue Cross of Northeastern Pennsylvania and by Independence Blue Cross ("IBC"). Highmark has several subsidiaries and affiliates that are engaged in offering health insurance, dental insurance, vision services, workers' compensation insurance, stop-loss insurance, real estate management services, and other administrative services. On a combined entity basis, Highmark and its subsidiaries have approximately 32 million members, of which approximately 4.7 million are health plan members.

14. Highmark has several subsidiaries that provide insurance products in numerous states, including HMO coverage; group and individual Medicare products; and vision, dental, and stop loss coverage.

15. First Priority Life Insurance Company, Inc. is a Pennsylvania stock insurance company with its principal address in Wilkes-Barre, Pennsylvania. Highmark owns 40.1% of the outstanding stock of First Priority Life Insurance.

16. Gateway Health Plan, Inc. is a Pennsylvania business corporation and licensed health maintenance organization with its principal address in Pittsburgh, Pennsylvania. Gateway Health Plan, Inc. is wholly owned by Gateway Health Plan, LP, in which Highmark has a 49% limited partnership interest and a 1% general partnership interest (through Highmark Ventures, Inc., a wholly-owned subsidiary of Highmark).

17. Highmark Casualty Insurance Company is a Pennsylvania stock insurance company with its principal address in Pittsburgh, Pennsylvania. It is a wholly-owned subsidiary of HM Insurance Group, Inc., which is a wholly-owned subsidiary of Highmark.

18. Highmark Senior Resources, Inc. is a Pennsylvania stock insurance company with its principal address in Pittsburgh, Pennsylvania. It is a wholly-owned subsidiary of Highmark.

19. HM Casualty Insurance Company is a Pennsylvania stock insurance company with its principal address in Pittsburgh, Pennsylvania. It is a wholly-owned subsidiary of HM Insurance Group, Inc., which is a wholly-owned subsidiary of Highmark.

20. HM Health Insurance Company, d/b/a Highmark Health Insurance Company, is a Pennsylvania stock insurance company with its principal address in Pittsburgh, Pennsylvania. It is a wholly-owned subsidiary of Highmark.

21. HM Life Insurance Company is a Pennsylvania stock insurance company with its principal address in Pittsburgh, Pennsylvania. It is a wholly-owned subsidiary of HM Insurance Group, Inc., which is a wholly-owned subsidiary of Highmark.

22. HMO of Northeastern Pennsylvania, Inc., d/b/a/ First Priority Health, is a Pennsylvania nonprofit corporation and licensed health maintenance organization with its principal address in Wilkes-Barre, Pennsylvania. Highmark owns a 40% interest in HMO of Northeastern Pennsylvania, Inc.

23. Inter-County Health Plan, Inc. is a Pennsylvania nonprofit corporation licensed to operate a professional health services plan, with its principal address in Horsham, Pennsylvania. Highmark owns a 50% interest in Inter-County Health Plan, Inc.

24. Inter-County Hospitalization Plan, Inc. is a Pennsylvania nonprofit corporation licensed to operate a hospital plan, with its principal address in Horsham, Pennsylvania. Highmark owns a 50% interest in Inter-County Hospitalization Plan, Inc.

25. Keystone Health Plan West, Inc. is a Pennsylvania business corporation and licensed health maintenance organization with its principal address in Pittsburgh, Pennsylvania. It is a wholly-owned subsidiary of Highmark.

26. United Concordia Companies, Inc. is a Pennsylvania stock insurance company with its principal address in Harrisburg, Pennsylvania. It is a wholly-owned subsidiary of Highmark.

27. United Concordia Dental Plans of Pennsylvania, Inc. is a Pennsylvania business corporation and licensed risk-assuming PPO with its principal address in Harrisburg, Pennsylvania. It is a wholly-owned subsidiary of United Concordia Companies, Inc., which is a wholly-owned subsidiary of Highmark.

28. United Concordia Life and Health Insurance Company is a Pennsylvania stock insurance company with its principal address in Harrisburg, Pennsylvania. It is a wholly-owned subsidiary of United Concordia Companies, Inc., which is a wholly-owned subsidiary of Highmark.

29. Highmark; 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; HM Life Insurance Company; HMO of Northeastern Pennsylvania, Inc.; 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 are collectively referred to herein as the "Highmark Insurance Companies."

C. West Penn.

30. West Penn is a Pennsylvania nonprofit corporation, exempt from federal income taxation pursuant to Section 501(c)(3) of the Internal Revenue Code.

31. West Penn owns and operates hospitals and primary and specialty care practice sites throughout Allegheny, Armstrong, Butler, Beaver, Washington, and Westmoreland Counties in the Western Pennsylvania Region.

32. West Penn owns or controls directly or indirectly the following five acute care hospitals:

a) Allegheny General Hospital ("AGH") in Pittsburgh, Pennsylvania;

b) Alle-Kiski Medical Center, d/b/a Allegheny Valley Hospital ("AVH"), in northeast Pittsburgh, Pennsylvania;

c) Canonsburg General Hospital ("CGH") in northern Washington County, Pennsylvania;

d) The Western Pennsylvania Hospital-Forbes Regional campus, d/b/a Forbes Regional Hospital ("FRH"), in Monroeville, Pennsylvania; and

e) Western Pennsylvania Hospital ("WPH") in Pittsburgh, Pennsylvania.

33. West Penn is the second-largest healthcare provider in the Greater Pittsburgh market. Among its five hospitals, West Penn operates approximately 1,600 inpatient beds. It employs approximately 11,500 employees, and has over 1,700 physicians (employed and private practice) on staff at its hospitals.

34. At the time the Form A was filed, West Penn had approximately an 18% inpatient market share in the Greater Pittsburgh market, compared to a 40% market share of the largest health care provider in the Greater Pittsburgh market, UPMC.

D. Jefferson Regional Medical Center.

35. Jefferson Regional Medical Center ("JRMC") is a Pennsylvania nonprofit corporation, exempt from federal income taxation pursuant to Section 501(c)(3) of the Internal Revenue Code. JRMC provides a range of comprehensive health care services on an 83-acre campus in southern Allegheny County, Pennsylvania. The major subsidiaries of JRMC at the time the JRMC Affiliation Agreement was entered into were the following:

a) Jefferson Regional Medical Center Foundation, a nonprofit corporation that conducts fundraising, donation management, and fund management activities to support the charitable, educational, and scientific purposes of JRMC;

b) JRMC - Diagnostic Services LLC, a Pennsylvania nonprofit, single-member limited liability company that provides professional billing services;

c) Health System Service Corporation, a Pennsylvania for-profit corporation that provides health-related programs and services for patients and healthcare providers;

d) The Park Cardiothoracic and Vascular Institute, a Pennsylvania nonprofit, taxable corporation that is a cardiothoracic and vascular surgical practice consisting of four cardiothoracic surgeons providing services to patients living in central and southwestern Pennsylvania, eastern Ohio, and northern West Virginia;

e) JRMC Specialty Group Practice, a Pennsylvania nonprofit, taxable corporation that employs physicians in various specialties to provide services to patients in JRMC's service area; and

f) JRMC Physician Services Corporation, a Pennsylvania nonprofit, taxable corporation that houses the billing services for professional house physician and physician assistant services to patients of JRMC.

36. On March 1, 2013, JRMC became a wholly-owned subsidiary of UPE Provider Sub.

E. Saint Vincent Health.

37. Saint Vincent Health System ("SVHS") is a Pennsylvania nonprofit corporation exempt from federal income taxation pursuant to Section 501(c)(3) of the Internal Revenue Code., with Sisters of St. Joseph of Northwestern Pennsylvania ("SSJ") as its sole member. It is the parent company of the controlled affiliates Westfield Memorial Hospital ("WMH"), Clinical Services, Inc. ("CSI"), Saint Vincent Medical Education and Research Institute, Inc. d/b/a Saint Vincent Medical Group, and Saint Vincent Affiliated Physicians.

38. Saint Vincent Health Center ("SVHC") is a Pennsylvania nonprofit corporation with SSJ as its sole member. It owns and operates an acute care and two major outpatient centers separately licensed by the Pennsylvania Department of Health: Saint Vincent Surgery Center and Saint Vincent Endoscopy Center.

F. History Between Highmark and West Penn.

39. Highmark and West Penn have had a relationship that long predates the parties' present affiliation.

40. In 1996, Highmark executed indemnity hospital agreements with AGH, FRH, AVH, CGH, and WPH, which were at the time owned by the Allegheny Health, Education and Research Foundation ("AHERF").

41. In 1997, Highmark executed managed care hospital agreements with these hospitals.

42. In 1998 AHERF declared bankruptcy.

43. In 2000, these five hospitals formed West Penn.

44. Since that time, West Penn has experienced financial difficulties, particularly in recent years. West Penn suffered annual operating losses of $19 million in 2010, $52 million in 2011, and $113 million in 2012.

45. In April 2011, Highmark's Board of Directors was advised that West Penn needed a $25 million cash advance on claim payments prior to April 11, 2011, in order to give West Penn working capital, which was advanced to West Penn .

46. Despite the cash advances to West Penn by Highmark, West Penn continued to experience operational and financial difficulties.

G. The Affiliation Agreement.

47. In June 2011, Highmark and West Penn announced an agreement in principle to formally affiliate, and on or about June 28, 2011, the parties entered into a term sheet (the "Term Sheet").

48. As of October 31, 2011, UPE, UPE Provider Sub, Highmark, West Penn and certain subsidiaries of West Penn entered into the Affiliation Agreement (the "Original Affiliation Agreement") which was later amended by that certain Amendment No. 1 to Affiliation Agreement entered into as of January 22, 2013 (the "Affiliation Agreement Amendment," and together with the Original Affiliation Agreement, collectively, the "Affiliation Agreement"), pursuant to which Highmark and West Penn agreed to affiliate and establish the IDN.

49. Highmark stated that the affiliation with West Penn would be the "cornerstone. . .of an integrated health system" that would allow the achievement of a "more affordable, more efficient, more satisfying and higher quality" healthcare experience for its policyholders and subscribers.

50. Highmark has expressed the belief that the affiliation with West Penn would: (i) provide more choice and access to providers; (ii) reduce anticipated increases of healthcare costs and premiums; (iii) improve quality of care; (iv) improve subscriber experience; and (v) preserve a community asset, West Penn.

51. As described in the Form A, UPE would become the direct parent of Highmark (and an indirect parent of Highmark's subsidiaries, including subsidiaries that write insurance), and the indirect parent of West Penn. UPE would not be authorized to write any health insurance.

52. The contemplated Transaction also proposed the creation of an additional new subsidiary of UPE, UPE Provider Sub, that would be the sole member of West Penn.

53. Pursuant to the transaction contemplated by the Affiliation Agreement: (i) Highmark would continue to be a Pennsylvania nonprofit corporation, but be subject to control by UPE; (ii) West Penn would retain all of its existing assets, liabilities, and operations, but would be subject to governance and certain oversight by UPE and UPE Provider Sub as provided in the West Penn Bylaws; (iii) Highmark would continue to operate a nonprofit hospital plan and nonprofit professional health services plan; (iv) Highmark would continue to participate in Blue Cross and Blue Shield Association programs; and (v) Highmark did not assume the debts or obligations of West Penn.

54. The Affiliation Agreement provided for UPE to become the sole corporate member within a new class of membership that would be established in Highmark. UPE was to hold all right in this new class of corporate membership in Highmark, with the other class of members consisting of the existing members of Highmark's Board of Directors.

55. The Affiliation Agreement also provided that UPE would be the sole member of UPE Provider Sub. UPE Provider Sub in turn would become the sole member of West Penn, which in turn would remain the parent company of the various hospital and healthcare provider entities in the West Penn health system.

56. The Affiliation Agreement provided that UPE would have certain reserved powers in West Penn. Effective upon the consummation of the Affiliation Agreement, Section 3.3(a) of West Penn's Amended and Restated Bylaws ("West Penn Bylaws") provides for the right of UPE Provider Sub to make recommendations to UPE with respect to actions by UPE on matters reserved to UPE under Section 3.3(b). That section gives UPE the following reserved powers over West Penn, subject to limitations as provided in Section 3.3(b) of the West Penn Bylaws:

a) to determine the number of directors that will comprise the Board of Directors of West Penn;

b) to elect the directors of West Penn;

c) to remove any of the directors of West Penn to replace any such director for the unexpired portion of his or her term;

d) to approve the election, re-election, and removal of all officers including the Chief Executive Officer of West Penn, and its subsidiaries in accordance with the Article V of the West Penn Bylaws;

e) to amend, revise or restate West Penn's and the subsidiaries' Articles of Incorporation and Bylaws, subject to limitations;

f) to adopt or change the mission, purpose, philosophy or objectives of West Penn or its subsidiaries;

g) to change the general structure of West Penn or any of its subsidiaries as a voluntary, nonprofit corporation;

h) to (1) dissolve, divide, convert or liquidate West Penn or its subsidiaries, (2) consolidate or merge West Penn or its subsidiaries with another corporation or entity, (3) sell or acquire assets, whether in a single transaction or series of transactions, where the consideration exceeds 1% of West Penn's consolidated total assets;

i) to approve the annual consolidated capital and operating plan and budget of West Penn and its subsidiaries, and any amendments thereto or significant variances therefrom;

j) to approve the incurrence of debt by West Penn and its subsidiaries or the making of capital expenditures by West Penn and its subsidiaries during any fiscal year of West Penn, in either case in excess of one quarter of 1% of the consolidated annual operating budget of West Penn for such fiscal year, if such debt or capital expenditures are not included in West Penn's or its subsidiaries' approved budgets, whether in a single transaction or a series of related transactions;

k) to approve any donation or any other transfer of West Penn's or its subsidiaries' assets, other than to its member or to West Penn by its subsidiaries in excess of $10,000.00, unless specifically authorized in West Penn's or the subsidiaries' approved budgets;

l) to approve strategic plans and mission statements of West Penn and its subsidiaries;

m) to approve investment policies of West Penn and its subsidiaries;

n) to approve the closure or relocation of a licensed healthcare facility of West Penn and its subsidiaries;

o) to approve the formation of subsidiary corporations, partnerships and joint ventures or to make investments in existing subsidiary corporations, partnerships and joint ventures, if the new investments of West Penn and its subsidiaries in such subsidiary corporations, partnerships and joint ventures during any fiscal year would, in the aggregate, exceed 1% of West Penn's consolidated total assets at the end of the prior fiscal year of West Penn;

p) to approve the dissolution of subsidiary corporations, partnerships and joint ventures of West Penn and its subsidiaries, if the aggregate value of

the ownership interests of West Penn and its subsidiaries in such subsidiary corporations, partnerships and joint ventures so dissolved in any fiscal year would exceed 1% of West Penn's consolidated total assets at the end of the prior fiscal year;

q) to establish and manage West Penn's program for compliance with all legal requirements applicable to West Penn and the hospitals operated by West Penn, all accreditation and licensing requirements and the conditions of participation in all governmental payor programs applicable to West Penn or West Penn's hospitals;

r) to select and appoint auditors and to designate the fiscal year of West Penn and its subsidiaries; and

s) to give such other approvals and take such other actions as are specifically reserved to members of Pennsylvania nonprofit corporations under the Nonprofit Corporation Law.

57. The West Penn Bylaws provide that no more than 75% of the Board of Directors of West Penn can be appointed by UPE, with the balance being selected by a self-perpetuating arrangement described in Section 4.2 (b) of the West Penn Bylaws.

58. The Original Affiliation Agreement provided for a series of funding commitments from Highmark to West Penn of up to $400 million as follows:

a) an unrestricted payment of $50 million funded on June 28, 2011 (upon execution of the Term Sheet) to West Penn to be used as determined by a joint committee as provided in the Original Affiliation Agreement for among other purposes, to make capital improvements and fund operations; and

b) an unrestricted payment of $100 million which was paid upon signing the Original Affiliation Agreement in October 2011, of which $50 million was advanced as a loan; and

c) a loan of $50 million funded 180 days after the execution of the Original Affiliation Agreement (April 2012); and

d) two additional loans of $100 million each to be advanced on the later of the closing or April 1, 2013, and April 1, 2014, respectively, to be reduced by any positive cash flow of the West Penn-affiliated organizations.

These payments were subject to limitations as provided in the Original Affiliation Agreement.

59. In addition to the Highmark funding commitments of up to $400 million as provided above, (i) the Original Affiliation Agreement provided for Highmark to make an additional $75 million charitable contribution at the time of closing to provide scholarships for medical students and pre-medical and health-related science studies and other health-related professional education; and (ii) in April 2012, Highmark authorized an unrestricted contribution of up to $8 million to West Penn to pay for management consultants of West Penn.

60. In July 2012, Hammond Hanlon Camp LLC ("H2C"), an independent investment banking and financial advisory firm that had been retained by Highmark, reported to Highmark's Board concerning the financial situation of West Penn and various strategic options available to it, including West Penn bond debt restructuring.

61. In August 2012, Highmark and West Penn began regular meetings to discuss a potential restructuring of the Bonds.

62. On September 28, 2012, West Penn claimed that Highmark had anticipatorily breached the Original Affiliation Agreement by Highmark: (i) announcing it would not consummate the affiliation even if the Department approved it; and (ii) insisting that West Penn restructure through bankruptcy. Accordingly, West Penn announced that it no longer considered itself bound by the Original Affiliation Agreement.

63. On October 1, 2012, Highmark sued West Penn in the Allegheny County Court of Common Pleas, seeking an order that West Penn's attempted anticipatory repudiation of the Original Affiliation Agreement was improper and of no effect, that Highmark had not

anticipatorily breached the Original Affiliation Agreement, and that West Penn was forbidden from negotiating an affiliation with any other organization.

64. On November 9, 2012, the court granted Highmark's motion for a preliminary injunction, ruling that the Original Affiliation Agreement remained in place, that Highmark was not in breach, and that West Penn was not permitted to negotiate an affiliation with any other party (the "2012 Court Ruling").

65. The obligations of the parties under the Original Affiliation Agreement were subject to various conditions precedent that needed to be satisfied or waived as a condition to closing of the Original Affiliation Agreement.

H. The Amendment to the Original Affiliation Agreement.

66. After the 2012 Court Ruling, Highmark and West Penn began new negotiations concerning the parties' relationship going forward and possibilities to address West Penn's financial condition. On January 22, 2013, the parties agreed to the Affiliation Agreement Amendment.

67. The Affiliation Agreement Amendment did not change the organizational structure of UPE, UPE Provider Sub, Highmark, or West Penn, or change UPE's reserved powers in West Penn as described above.

68. The Affiliation Agreement Amendment increased the obligation of Highmark to make aggregate funding commitments from $400 million to $475 million and revised the terms by:

a) eliminating Highmark's obligation to make the charitable contribution of $75 million at closing and replacing it with an obligation to make at closing an unrestricted and unconditional grant payment of up to $75 million, subject to deduction for any advances against such amount up to $33.6 million to pay certain West Penn obligations coming due prior to closing; and

b) revising the terms of the Fourth Funding Commitment to provide for the payment of $50 million into escrow upon the execution of a certain Bond Tender, Consent and Forbearance Agreement among the bond holders of the West Penn Series 2007A Bonds (the "Bonds") covering not less than 73.5% of the aggregate outstanding principal amount of the Bonds and that upon the closing of the Affiliation Agreement, the $50 million in escrow would be released to West Penn and an additional $50 million funded by Highmark to West Penn, the aggregate of which continuing to be in the form of loans from Highmark and if the closing did not occur by April 30, 2013, or an agreed extension to that date, the $50 million would have been paid to West Penn; and

c) revising the extent of any security that would be available for the repayment of the loans.

69. In addition to the obligations of Highmark to West Penn as provided in the Affiliation Agreement, the Affiliation Agreement Amendment provided for Highmark to make a tender offer to purchase the Bonds, provided that a sufficient number of bondholders agreed to tender. Specifically, launching the tender offer was conditioned upon the holders of at least 73.5% of the aggregate outstanding principal amount of the Bonds agreeing to tender their Bonds. The tender offer was an all cash offer at $0.875 per $1.00 of principal plus accrued interest, with an approximate $65 million to $89 million discount.

70. In January 2013, Highmark's Board approved the proposed tender offer transaction for the Bonds and Highmark's Board was advised of the expectation that the Bonds acquired in the tender offer transaction would be refinanced with the proceeds of a subsequent tax-exempt bond issue.

71. The Affiliation Agreement Amendment added an express covenant that West Penn would continue to provide charitable care consistent with past practices for at least four years following closing.

72. The Affiliation Agreement Amendment also provided that West Penn would not pursue any comparable transaction or affiliation while the Affiliation Agreement was pending and that neither party would make any material change to West Penn's operations inconsistent with its federal income tax-exempt status for a period of four years. Furthermore, the pending litigation between Highmark and West Penn relating to West Penn's asserted default by Highmark under the Original Affiliation Agreement would be dismissed when the Affiliation Agreement closed.

73. By an order dated February 12, 2013, the Orphans' Court Division of the Court of Common Pleas of Allegheny County approved UPE's proposed organization and structure with UPE Provider Sub as the sole member of West Penn conditioned upon the receipt by the Highmark Entities of approval from the Department for the creation of UPE as the parent of Highmark.

I. Affiliation with Jefferson Regional Medical Center.

74. As part of its IDN Strategy, Highmark pursued other hospital affiliations as well, but the West Penn affiliation remained at the core of its strategy.

75. On August 13, 2012, UPE, UPE Provider Sub, and Highmark entered into an Affiliation Agreement (the "JRMC Affiliation Agreement") with JRMC and its subsidiaries (including but not limited to JRMC - Diagnostic Services LLC, Health System Service Corporation, the Park Cardiothoracic and Vascular Institute, the JRMC Specialty Group Practice,

and the JRMC Physician Services Corporation) and Jefferson Regional Medical Center Foundation.

76. The JRMC Affiliation Agreement provided that at closing, UPE Provider Sub would become the sole member of JRMC.

77. To facilitate the closing of the JRMC Affiliation Agreement prior to the approval of the Form A by the Department, Highmark and JRMC then slightly modified the structure of the transaction from what is described in the JRMC Affiliation Agreement. UPE Provider Sub would become the sole member of JRMC at Closing and Highmark would become an "other body" as defined in Section 5103 of the Pennsylvania Non Profit Corporation Law of 1988 (the "Other Body") of UPE having the reserved power to appoint the UPE Board of Directors. JRMC's Bylaws provide that UPE and JRMC shall each have authority to appoint members to the JRMC Board provided that at all times the approximate number of aggregate board votes authorized to be cast by JRMC Board members appointed by UPE is as close as possible to seventy-five percent (75%) but not eighty percent (80%) or more.

78. Upon the Department's approval of the Form A, UPE's Bylaws were amended to remove the authority of Highmark as the Other Body.

79. Highmark agreed to make available to JRMC grants in the aggregate of up to $100 million to finance certain capital projects. Highmark further agreed to guarantee the payment of debt, pension, and all other liabilities of JRMC on the books as of March 31, 2012. Highmark also committed to make a monetary contribution in the amount of $75 million to the JRMC Foundation, to be made in installments by January 1, 2014.

80. In addition, JRMC staffing levels would be maintained, JRMC's employees would be retained, JRMC's existing charity care policy and level of support for education and community programs would not change for at least 5 years after closing, and JRMC would not pursue any comparable affiliation or transaction while the JRMC Affiliation Agreement was pending.

81. By an order dated February 12, 2013, the Orphans' Court for the Court of Common Pleas of Allegheny County approved the transactions described in and contemplated by the JRMC Affiliation as provided therein.

82. On March 1, 2013, Highmark and JRMC announced the consummation of the JRMC Affiliation Agreement.

J. Affiliation with Saint Vincent.

83. On March 28, 2013, Highmark, UPE, UPE Provider Sub and SVHS, SVHC, the Saint Vincent Foundation for Health and Human Services ("SVH"), Clinical Services, Inc. and SSJ entered into an Affiliation Agreement (the "SVHC Affiliation Agreement") pursuant to which UPE Provider Sub would become at the closing thereunder the sole corporate member of SVHS, SVHC and SVH, and SSJ would relinquish its reserved powers over SVHS, SVHC and SVH.

84. Pursuant to the SVHC Affiliation Agreement, Highmark, UPE or UPE Provider Sub agrees to: (a) transfer to SVHC grants in the aggregate amount of $25 million to be used as provided therein and (b) make a contribution of $10 million to SSJ.

85. Upon a closing of the SVHC Affiliation Agreement, the SVHS/SVHC Boards would be structured so that the directors entitled to exercise approximately 75% of the voting power of the Boards would be elected by UPE. The other approximate 25% would be elected by SVHS/SVHC as provided in the SVHC Affiliation Agreement. SVHS and SVHC agreed that they will not pursue any comparable transaction or affiliation while the parties proceed with a proposed transaction.

86. The SVHC Affiliation Agreement has not closed.

K. Distributions.

87. UPE represented that it had no plans to declare any extraordinary dividend, liquidate any of the Domestic Insurers, sell their assets to or merge them with any person or persons, or to make any other material change in their business operations or corporate structure or management except as provided in the Form A, including as follows:

a) The business of Highmark Senior Resources Inc. ("HSR") would be novated to HM Health Insurance Company ("HHIC"). HSR planned to distribute approximately $40 million to Highmark in the first quarter of 2013, leaving approximately $3 million in surplus in order to maintain certain licenses.

b) Highmark would terminate its reinsurance agreement with HHIC as of January 1, 2013. HHIC planned to distribute approximately $450 million to Highmark in the first quarter of 2013. No additional contributions or dividends were projected for 2012 through 2016.

c) Highmark's vision subsidiary HVHC Inc. had developed an accelerated growth strategy that involves opening new retail stores from 2013 through 2018. Highmark management proposed to fund a portion of HVHC's growth strategy with capital contributions to HVHC of $40 million in 2013 and $25 million in 2014, which would be funded out of Highmark's surplus.

L. The Public File.

88. A public file has been maintained by the Department that includes all documents filed with the Department by UPE and its representatives, Highmark and its representatives, and West Penn and its representatives, except those documents which were designated as confidential by UPE, Highmark or West Penn.

89. The public file also contains all comments and documents received by the Department from interested persons, responses to those comments received by the Department from UPE, Highmark, or West Penn, non-confidential versions of the Blackstone Report and the Guerin-Calvert Report, non-confidential correspondence between the Department and UPE, Highmark, or West Penn, and the transcript of the public informational hearing that was conducted.

90. The public file has been maintained by the Department at its Harrisburg office and has been available to any interested person for inspection and copying in accordance with rules of the Department.

91. The public file has also been made available online at http://www.portal.state.pa.us/portal/server.pt/community/industry_activity/9276/highmark___west_penn_cumulative_log/1036250.

92. All materials in the public file have been indexed in a composite document, in part to aid interested persons who wish to obtain copies of any of the public documents. The index was posted on the Department's website and was routinely updated as new documents became available for public inspection.

93. The Department at various times sent emails to interested persons who had previously requested documents from the public file, or who attended the public informational hearing discussed below, to advise them that additional documents had been received by the Department and were available.

94. As of April 19, 2013, the comprehensive record developed in the course of the Department's review of the Form A included more than 64,000 pages of reports and analytical data, more than 10,000 pages of public comments and more than six hours of public testimony.

M. The Department's Retention of Consultants and Advisors.

95. Section 1402 provides that the Commissioner of the Department (the "Commissioner") may retain, at the acquiring person's expense, any attorneys, actuaries, accountants and other experts not otherwise a part of the Department's staff as may be reasonably necessary to assist the Department in reviewing the proposed acquisition of control.

96. The Department retained Blank Rome LLP ("Blank Rome") to act as its legal advisor in connection with matters relating to the Department's examination of UPE's proposed acquisition of control of the Highmark Insurance Companies.

97. On December 9, 2011, Blank Rome engaged Blackstone Advisory Partners L.P. ("Blackstone") as a financial advisor to assist in its review of the Application (the "Blackstone Engagement Letter").

98. In the Blackstone Engagement Letter, Blank Rome requested that Blackstone serve as financial consultant and potential expert witness to the Department in connection with the matters relating to the Department's examination of the Change of Control transaction.

99. On March 27, 2012, Blank Rome engaged Compass Lexecon LLC and its affiliates ("CL") as an economic advisor to assist in its review of the Application (the "CL Engagement Letter").

100. In the CL Engagement Letter, Blank Rome requested that CL perform economic analysis, expert witness and other services as described in such letter in connection with the Change of Control transaction.

N. Public Informational Hearing.

101. Section 1402 provides that the Commissioner shall conduct a hearing if either the acquiring party or the party to be acquired requests a hearing within ten days of the filing of the Application. A hearing may also be held if the Commissioner, in his discretion, elects to conduct a hearing as part of his review and analysis of a Form A filing.

102. Neither UPE nor the Highmark Insurance Companies requested a hearing on the Application.

103. Because the parties to the Application did not request a hearing, the decision whether to conduct a hearing was within the Commissioner's discretion under Section 1402.

104. The Commissioner exercised his discretion to hold a public informational hearing on the Application.

105. The Commissioner's decision to hold a public informational hearing was an appropriate exercise of his discretion under Section 1402.

106. On March 3, 2012, the Department published notice in the *Pennsylvania Bulletin* announcing that a public informational hearing would be held in Pittsburgh on April 17, 2012, with regard to the Application.

107. The published notice advised that the public informational hearing would provide an opportunity for interested persons to present oral comments relevant to the Application. The notice also stated that, in the alternative, written comments could be mailed to the Department or sent via email.

108. The notice was also posted on the Department's website.

109. On March 14, 2012, the Department issued an eblast announcing the public informational hearing.

110. On April 10, 2012, the Department issued a press release announcing the public informational hearing, including an announcement that the hearing could be viewed live via the internet.

111. Included within the *Pennsylvania Bulletin* notice and press release were instructions for interested persons to pre-register to present oral comments.

112. Approximately 150 persons attended all or part of the public informational hearing, including representatives of the Department, UPE, Highmark, West Penn and other interested persons.

113. The Commissioner presided over the public informational hearing and received oral comments.

114. During the public informational hearing, among other things, the Department described its review process.

115. Highmark and West Penn representatives provided an overview of the Change of Control and the affiliation with West Penn, discussing how the Change of Control of Highmark and the Highmark Insurance Companies in conjunction with Highmark's proposed affiliation with the West Penn is good for the Western Pennsylvania Region.

116. Blackstone and CL representatives described the services that they were retained to perform as consultants to the Department.

117. During the public informational hearing, a number of interested persons presented their positions, and, in some cases, responded to questions posed by the Commissioner.

118. The public informational hearing was transcribed by a stenographer. The transcript of the public informational hearing is available on the Department's website.

119. At the request of the Department, the webcast of the hearing was archived and made available for viewing by accessing the Department's website.

O. Notice and Comments.

120. On November 7, 2011, the Department issued a press release (the " Form A Press Release") announcing that the Initial Form A Application had been received.

121. The Form A Press Release invited interested persons to submit comments to the Department regarding the Application beginning November 9, 2011.

122. Notice of the filing of the Form A was also published in the Pennsylvania Bulletin on November 19, 2011. 41 Pa.B. 6310.

123. As described above, the Department held the public informational hearing with regard to the Application as provided for in Section 1402.

124. At the conclusion of the public informational hearing on April 10, 2012, the Department announced that the public comment period would remain open until June 1, 2012. The Department also announced that it would reopen the public comment period once again for a brief period once the Department's consultants had issued their reports. Notice of the June 1, 2012, closing of the public comment period was published in the Pennsylvania Bulletin on April 28, 2012. 42 Pa.B. 2352.

125. The public comment period was reopened for an indefinite period of time on July 28, 2012, after receipt of Amendment No. 1. 42 Pa.B. 4831.

126. The public comment period ended on April 19, 2013.

127. If any of the below conclusions of law are determined to be findings of fact, they shall be deemed incorporated in the Findings of Fact as if fully set forth therein. If any of the above Findings of Fact are determined to be conclusions of law, they shall be deemed incorporated in the Conclusions of Law as if fully set forth therein.

CONCLUSIONS OF LAW

128. Under Section 1402, the Department has jurisdiction to review and approve the Change of Control.

129. Section 1402 requires the Department to approve an application for a change in control unless the Department has found one or more of the following:

a) 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; or

b) 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; or

c) The financial condition of the Applicant is such as might jeopardize the financial stability of one or more of the Highmark Insurance Companies or prejudices the interests of any policyholders; or

d) 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 Form A is unfair and unreasonable and fails to confer a benefit on policyholders of the Highmark Insurance Companies and not in the public interest; or

e) 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 of the public to permit the Change of Control; or

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

g) The Change of Control is not in compliance with the laws of this Commonwealth.

130. The burden is on the Department to show a violation of these 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.

131. Under Section 1402, the Department has not found that any of the above conditions are present with respect to the Change in Control.

132. The Department finds that, with the imposition of the Conditions set forth in the Approving Determination and Order 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 Form A which are subject to the Department's jurisdiction and require approval of the Department do not violate Section 1402.

II. Standard 1: Condition Not Present – That The Highmark Insurance Companies Would Not Be Able To Satisfy The Requirements For The Issuance Of A License To Write Lines of Insurance.

133. When analyzing an application for a change in control under Section 1402, the Department reviews the requirements for continued licensure of the domestic insurer(s) subject to the change in control.

134. Specifically, the Department reviews whether the acquirer would be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed after the acquisition. 40 P.S. § 991.1402(f)(1)(i).

135. The classes of insurance for which an insurance company may be incorporated and become licensed to write are set out in Section 202 of the Insurance Company Law, 40 P.S. § 386.

136. Based on their year-end 2012 capital, surplus, and net worth balances, Highmark and the other Highmark Insurance Companies would be able to satisfy the requirements for the issuance of a license to write the lines of insurance for which they are presently licensed upon completion of the Change of Control .

137. In order to satisfy requirements of a license to write the relevant lines of insurance, the Highmark Insurance Companies must meet certain statutory minimum capital balance requirements.

138. These requirements are met for each of the Highmark Insurance Companies:

	Capital Balance			Surplus Balance			Net Worth Balance		
($ in thousands)	Q4 2012	Requirement	Satisfy	Q4 2012	Requirement	Satisfy	Q4 2012	Requirement	Satisfy
Highmark Inc.	–	–	Yes	–	–	Yes	$4,138,085	$25	Yes
HMO of Northeastern Pennsylvania, Inc.	432	–	Yes	49,500	–	Yes	64,035	1,500	Yes
First Priority Life Insurance Company, Inc.	1,837	1,100	Yes	118,757	550	Yes	145,141	1,650	Yes
Gateway Health Plan, Inc.	1	–	Yes	114,329	–	Yes	197,604	1,500	Yes
Highmark Casualty Insurance Company	2,500	850	Yes	21,250	425	Yes	148,453	1,275	Yes
Highmark Senior Resources Inc.	2,000	1,100	Yes	72,000	550	Yes	38,568	1,650	Yes
HM Casualty Insurance Company	1,000	850	Yes	1,000	425	Yes	5,464	1,275	Yes
HM Health Insurance Company	2,500	1,100	Yes	491,438	550	Yes	641,252	1,650	Yes
HM Life Insurance Company	3,000	1,100	Yes	174,338	550	Yes	246,981	1,650	Yes
Inter-County Health Plan, Inc.	–	–	Yes	2,295	–	Yes	2,400	25	Yes
Inter-County Hospitalization Plan	–	–	Yes	2,655	–	Yes	4,692	–	Yes
Keystone Health Plan West, Inc.	150	–	Yes	120,850	–	Yes	407,207	1,500	Yes
United Concordia Companies, Inc.	1,100	1,100	Yes	72,650	550	Yes	399,943	1,650	Yes
United Concordia Dental Plans of Pennsylvania, Inc.	1	–	Yes	3,972	–	Yes	1,546	100	Yes
United Concordia Life and Health Insurance Company	1,500	1,100	Yes	10,444	550	Yes	213,357	1,650	Yes

139. Highmark does not anticipate any changes to the December 31, 2012, relevant capital balances of Highmark or the other Highmark Insurance Companies resulting from the Change of Control that would cause Highmark or any of the Highmark Insurance Companies to fail to meet the relevant statutory capital balance requirements, and the Department does not find that any such changes are likely.

III. Standard 2: Condition Not Present – That 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.

140. The Change of Control of the Highmark Insurance Companies is subject to review and analysis under Section 1402(f)(1)(ii) and the applicable parts of Section 1403 of the

Insurance Holding Companies Act to determine whether the effect of the Change of Control would be to substantially lessen competition or tend to create a monopoly in the Commonwealth. 40 P.S. § 991.1402(f)(1)(ii) (the "Competitive Standard").

141. In applying the Competitive Standard, the informational requirements of Section 1403(c)(2) and the standards of Section 1403(d)(2) of the Insurance Holding Companies Act, 40 P.S. § 991.1403 ("Section 1403"), are applicable.

142. Pursuant to Section 1403(d), the Department may enter an order under Section 1403(e)(1) with respect to a change of control if there is substantial evidence that the effect of the change of control may be substantially to lessen competition in any line of insurance in the Commonwealth or tend to create a monopoly therein or if the insurer fails to file adequate information in compliance with Section 1403(c).

143. Any acquisition covered under Section 1403 involving two or more insurers competing in the same market is prima facie evidence of violation of the competitive standards of Section 1403 if the involved insurers possess certain market shares and any acquisition, merger or consolidation covered under Section 1403 involving two or more insurers competing in the same market is prima facie evidence of violation of the competitive standard in Section 1403 if: (A) there is a significant trend toward increased concentration in the market; (B) one of the insurers involved is one of the insurers in a grouping of such large insurers showing the requisite increase in the market share; and (C) another involved insurer's market is two per centum (2%) or more.

144. Section 1403(d)(2)(iv) further provides that even though an acquisition is not prima facie violative of the competitive standard under Section 1403(d)(2)(i) and (ii) as

described above, the Department may establish the requisite anticompetitive effect based upon other substantial evidence and may consider relevant factors, such as, but not limited to, the following: market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry and ease of entry and exit into the market.

145. While the Transaction is not a prima facie violation of the competitive standard of Section 1403(b), the Department requested from the Applicant additional material and information to determine whether the Change of Control, if consummated, would violate the competitive standard of Section 1403(d) and Department through its consultant undertook a review of relevant factors relating to competition.

146. Based upon such review, the Guerin-Calvert Report concluded, and the Department so finds, that:

a) The Transaction contemplated by the Form A does not raise any direct horizontal competitive concerns in the relevant markets for healthcare insurance, hospital services, or physician services in the 29-county Western Pennsylvania Region.

b) Highmark's share in the market for commercial insurance products in the WPA is approximately 60%. This share has been stable for at least the past five years. Based on these shares of other market participants, the market is "highly concentrated" as measured by the Herfindahl-Hirschman Index. There is not a significant prior history of other insurers being able to compete away enrollees from Highmark, although some rivals to Highmark have recently made unquantifiable and preliminary inroads based on the inclusion of UPMC-network hospitals as in-network hospitals.

c) Based on market conditions and other limitations on competitors to Highmark in ease of entry and/or expansion into the market, it cannot be rejected that Highmark has market power in the insurance sector such that competing insurers could not provide competitive discipline were there to be a concern about Highmark's ability to exercise market power post-Transaction.

d) The affiliation between Highmark and West Penn creates competitive risks that Highmark and West Penn will be able to change the terms of contracting with rival insurers, and the opportunity to make use of competitively-sensitive information from rivals to the detriment of competition. This is particularly important here, where market conditions limit the options available to rivals, and because the ability of rival insurers to provide effective competition to Highmark is an important constraint to keep Highmark's incentives aligned with the public interest.

e) The IDN as proposed by Highmark, with West Penn at its core, has the characteristics of a successful IDN, making it more likely to achieve improved clinical and fiscal outcomes for some portion of the WPA. The capital costs of implementing the IDN are at least $1 billion, and almost $1.6 billion when the potential costs of addressing West Penn's debts are considered. Highmark has set forth a reasonable economic case to support the conclusion that the affiliation between Highmark and West Penn will benefit policyholders, and is in the public interest. But there is some uncertainty about whether Highmark will be able to shift large volumes of inpatients to West Penn, some of the economic assumptions underlying Highmark's projected IDN cost savings, and the assumed termination of Highmark's provider contract with UPMC as of December 31, 2014 – all critical assumptions on which Highmark's projections rely. These three factors are significant economic risks that must be considered.

f) The West Penn "downside case" (*see infra* at paragraphs 186-187) that the Department requested Highmark prepare, in which Highmark is able to attain only 50% of the incremental discharges it projects in its West Penn base case scenario (submitted by UPE to the Department as Exhibit K to Amendment No. 2), is a plausible economic scenario. There is not sufficient detail at this point to conclude whether Highmark will be able to restore West Penn to a competitively-viable hospital system absent the projected inpatient volume shifts outlined in the base case scenario.

g) Highmark makes a well-reasoned case as to why affiliation with West Penn may better and more immediately ensure West Penn's ability to achieve the inpatient volumes, financial changes, and cost reductions necessary for a more efficient health care delivery system instead of affiliating with another third party. Any third-party acquirer of West Penn would need to deal anew with West Penn's debt issues, would need to invest substantial capital resources in West Penn, and negotiate new provider contracts with Highmark and others.

147. But with the imposition of the Conditions to preserve and promote competition in insurance in the Commonwealth, the Change of Control and the transactions described in the Form A do not violate Section 1402. The Conditions permit the substantive benefits

contemplated by the Change of Control and the associated transactions while limiting the risks of adverse competitive effects.

Specific Factual Conclusions

148. Highmark has a substantial market share in the market for health care insurance coverage in the 29-county WPA and any other relevant geographic area.

149. For a relevant product market that includes HMO, PPO, POS, and traditional indemnity insurance, Highmark's commercial enrollment as of December 2011 accounts for approximately 59.6% of the population in the WPA that has commercial health care insurance, or 1.39 million persons out of a total insured pool of 2.33 million.

150. If the product market were to focus just on certain types of commercial insurance coverage, e.g., small group coverage, Highmark's market share would likely be even higher.

151. For a relevant product market for Medicare that includes Highmark's Medicare and Medicare Advantage enrollment as of December 2011, Highmark's share accounted for a small to significant percentage of Medicare eligible persons residing in the WPA, depending on the specific area in question.

152. Focusing only on a market that included Medicare Advantage plans in the WPA, Highmark's share totaled 56%, twice the share of the next largest healthcare insurer, UPMC.

153. Highmark competes with several other healthcare insurance providers in the WPA, including HealthAmerica, Aetna, UnitedHealthCare, Cigna, and the UPMC health plans.

154. As measured by admissions to West Penn hospitals under commercial plans in the first half of 2012, and as measured by revenue received by West Penn by insurer over the same period, Highmark's market share was consistent with its overall market share as stated in paragraph 149, and the market shares for the other insurers were significantly less.

155. As measured by other methods, such as estimates of the entire WPA market, and/or as measured by plan type (direct versus group), Highmark has consistently been found to have at least a 60% market share over the past several years.

156. In sum, available data submitted to the Commonwealth by the Applicant and other insurers indicate that few insurers have experienced substantial market share growth over the past several years, although UPMC has experienced the most substantial growth. Volume and market share estimates are the most skewed at the local level – i.e., the Western Pennsylvania Region, suggesting that rivals to Highmark and UPMC are even weaker in the local Pittsburgh area.

157. Although Highmark suggests that the existence of significant competitors and large, national health insurers such as UnitedHealthCare, Aetna, and Cigna, in the market indicate the existence of vigorous competition, the Department has not found reliable information to suggest that any competitor other than UPMC is capable of attracting a large number of enrollees away from Highmark. Win/loss data and other information show Highmark's largest loss of enrollees was in 2011-2012, with most of those consumers switching to UPMC.

158. In summary, the data suggests that, based upon historical experience, it is unlikely competing insurers would be able to expand readily and effectively to attract substantial numbers of members away from Highmark.

159. By contrast, West Penn has a significant, but nowhere near dominant, market share in the market for inpatient acute care services.

160. The relevant geographic market includes a large number of hospital competitors (suppliers), and is determined by a so-called "90 percent service area" test, which determines the fewest number of zip codes from which the combined West Penn hospitals derive 90% of their inpatients.

161. In that area, UPMC has approximately a 47% market share, West Penn has an approximate 16% market share, and six other hospitals have market shares between 3% and 7%.[2]

162. Community hospitals in the Pittsburgh area generally have, on average, occupancy rates in the 60% range. The West Penn or UPE-affiliated hospitals have utilization rates that vary above or below that 60% figure.

163. These figures suggest that Highmark, or other insurer rivals, with appropriately configured and priced products, such as tiered or limited health care networks, could draw inpatients away from UPMC.

164. The affiliation between Highmark and West Penn will not lead to any significant concerns due to any horizontal overlaps in the relevant geographic market for hospital services,

[2] One of these is JRMC which, if included with West Penn, would give the hospitals controlled by UPE Provider Sub 19.5% share.

even when the affiliation with JRMC is included because JRMC's share of discharges is so small (3%-4%).

165. There is some overlap, however, between Highmark and West Penn in the market for physician services due to employment and affiliation agreements between Highmark, West Penn, and Pittsburgh-area physicians. But Highmark employs relatively few physicians, and even when there are overlaps in specialties between Highmark and West Penn, there are substantial competitive alternatives.

166. Even though the affiliation between Highmark and West Penn will increase overall UPE physician enrollment in the relevant geographic market, there is no material change anticipated in any share in any group that reflects competitive concerns.

167. The affiliation between Highmark and West Penn is a "vertical" transaction, because it involves a combination between entities at different levels of the production and distribution chain. Vertical combinations are often viewed as pro-competitive, rather than anticompetitive, although there is a risk that a vertical combination can have anticompetitive effects on horizontal competition at one or more levels at which the relevant entities compete.

168. In a combination such as the affiliation between Highmark and West Penn, there could be an incentive to increase input prices at the hospital level, or to change contract terms with rival insurers to achieve higher premium prices.

169. As noted above, Highmark has a high and stable market share in the healthcare insurance market in the WPA, with rivals other than UPMC having lower shares with few

changes in recent years. (Part of this is due to Highmark's 10-year low reimbursement rate contracts with both West Penn and UPMC.)

170. But mitigating against Highmark's relatively high and stable market share are new contracts between several rival insurers and UPMC, which are now offering a broader in-network portfolio of hospitals comparable to Highmark. Accordingly, rivals now appear to be more robust competitors.

171. Overall, however, the Guerin-Calvert Report could not reject the likelihood that Highmark has sufficient market power, or that Highmark/West Penn has changed incentives after the Transaction, to engage in competitively adverse conduct.

172. The Guerin-Calvert Report analyzed the profitability to an integrated Highmark-West Penn of a hypothetical price increase to rival national insurers, and concluded that it would have a direct effect on West Penn's admissions, revenues, and profits, and an indirect effect on Highmark's enrollment, revenues, and profits.

173. West Penn (including its Affiliates) and the Domestic Insurers including Highmark 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, West Penn and its Affiliates provide 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 affiliation also causes a potential concern that Highmark would be able to exercise control over contracting with the potential to include contracting provisions that would tend to disadvantage competitors.

174. The risk that competitors' confidential information could be put to an improper use increases significantly because of the affiliation. This may include present and future reimbursement rates, payor-provider reimbursement contracts, reimbursement methodologies, including pay for performance, pay for value, and consumer choice initiatives (e.g., tiering of providers).

175. The ability of rival insurers in the Western Pennsylvania Region 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.

176. But these problems are remediable through "firewall" provisions of the type included in the Conditions incorporated into the Approving Determination and Order, including: (i) separate managed care contracting information and activity of the hospital and of the insurer, including personnel who are involved in the decision-making; (ii) mechanisms that prevent sharing of competitively-sensitive information among persons at the hospital and at the insurer; and (iii) clear confidentiality policies that describe what persons can access what information, and provide for monitoring of compliance and remedial actions if violations occur. In connection with the implementation of a proper firewall policy, the President and Chief Privacy Officer of UPE should provide annually a certification regarding compliance by the UPE Entities with such firewall policy.

177. As it pertains to contracting, there is a risk that the UPE entities would have the incentive and power to implement strategies that could constrain rival firms' ability to provide a competitive constraint on Highmark. This could include, for example, terminating payor

contracts, as the UPE entities could make up for patient losses on the insurance side of the business.

178. Further, 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 offered to any other Health Care Insurer or Health Care Provider.

179. In addition to the use of most favored nations clauses, competition can be adversely affected by use of exclusivity provisions which if imposed could facilitate anticompetitive effects by preventing a competitor from contracting with such entities.

180. In addition, contracts that substantially exceed normal and customary lengths (usually 2-5 years) have the potential to limit the ability of rival hospitals/insurers to respond to changes in the market place and may inhibit competitive change; moreover, there does not appear to be any pro-competitive or business justification for substantially longer contracts that have been raised in the record here.

181. The U.S. Department of Justice, Antitrust Division (the "DOJ"), has recognized that the length of contract is a consideration in the evaluation of competition in WPA. The DOJ has stated "*Long-term contracts between dominant hospitals and insurers can dull their incentives to compete, leading to higher prices and fewer services. If a dominant hospital is guaranteed a predictable revenue stream for many years from a dominant insurer, then the*

hospital may be less likely to promote the growth of new insurers by offering them competitive rates. Similarly, if a dominant health insurer is guaranteed rates from a dominant hospital for an extended period, then the insurer may be less likely to promote competition in the hospital market by investing in more affordable hospitals." Statement of the Department of Justice's Antitrust Division on Its Decision to Close Its Investigation of Highmark's Affiliation Agreement With West Penn Allegheny Health System.

182. Moreover, Highmark's affiliation with West Penn presents the risk that a health care provider affiliated with UPE could exercise control to prohibit or limit the ability of Health Care Insurers to implement 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.

183. Again, these contracting-related risks are minimized through the Conditions included in the Approving Determination and Order.

The Effect of and Risks Associated With Highmark's IDN Strategy

184. Highmark posits that it needs to be commonly-owned with West Penn, rather than simply contracting with it, to implement its IDN Strategy so as to align West Penn's incentives completely with Highmark's and to achieve high quality, lower cost healthcare in the Western Pennsylvania Region.

185. Reinvigorating West Penn as a viable and vigorous competitor to UPMC is an important component of Highmark's strategy to reduce healthcare costs for its members, and a source of public benefit flowing from the Transaction. By attracting more enrollee admissions to West Penn and other changes associated with the IDN Strategy, Highmark expects to lower the

premium rates paid by Highmark's enrollees below that which enrollees would have paid had the affiliation not occurred and make Highmark more competitive in the insurance marketplace.

186. This strategy will potentially create a more viable West Penn system that may incentivize providers and patients to choose West Penn for hospital services, presumably at a lower cost and for a full range of services, instead of opting for UPMC or other higher-cost hospitals. And this aligns with Highmark's incentives to attract more patients from other, higher-cost facilities.

187. Based on projections prepared by Highmark, including alternative scenarios requested by the Department, even in the scenario identified by Highmark as a West Penn "downside case"[3] scenario, in which West Penn generates only half as many incremental discharges as Highmark projects in the Form A that by 2017, West Penn still would enjoy significantly more discharges than presently projected, and it would reverse the consistent declining trend in discharges that has characterized West Penn since 2007.

188. In order for Highmark's IDN Strategy to work, it must: (i) incentivize patients to select West Penn and other aligned hospitals instead of UPMC; and (ii) incentivize physicians to use West Penn and other aligned hospitals instead of UPMC. Unless those two goals are met, it is unlikely that Highmark can attract sufficient numbers of patients to West Penn to make the affiliation successful in terms of: (i) stabilizing West Penn; (ii) lowering the cost of care for Highmark members; (iii) lowering Highmark's risk exposure to possible financial failure by West Penn; and (iv) providing improved competitive healthcare delivery to the Western Pennsylvania Region.

[3] The "downside case" is referred to sometimes as the "worse case" in the Guerin-Calvert Report.

189. Highmark's goal of creating an IDN to provide access to affordable healthcare could result in substantial benefits to consumers in the Western Pennsylvania Region, including reduced costs for both insurance and healthcare services, improved quality of care, and improved patient outcomes. Because the IDN is intrinsically related to the affiliation with West Penn, it is appropriate to consider the IDN's costs and benefits as part of the evaluation of affiliation and whether Highmark's members, and the public, will benefit therefrom.

190. Highmark estimates that its IDN Strategy will result in substantial aggregate cost savings beginning in 2014 -- $91 million in 2014, $298 million in 2015, and $447 million in 2016, with similar amounts to follow in successive years. As stated in the Blackstone Report, the cost of implementing the IDN strategy is approximately $1.8 billion in the aggregate.

191. If Highmark's projections concerning the increase in patient discharges at West Penn are correct, then West Penn should benefit substantially from its affiliation with Highmark. Among other items, West Penn is expected to: (i) receive critical financial support; (ii) participate in innovative patient care delivery models; (iii) enjoy enhanced clinical protocols and advanced technology; (iv) be able to advance the level of care at West Penn, including sustaining the emergency department; (v) establish a trauma program at FRH; and (vi) be able to increase capabilities at CGH.

192. Highmark estimates that premiums for its enrollees would be 8% greater than they would otherwise have been if the IDN were not implemented.

193. The Department and its expert, however, conclude that Highmark's "base case" projections of discharge volume increases through 2017 and other underlying assumptions are

not supported by the economic evidence presented, and rely on assumptions of patient, physician, and competitor behavior that are uncertain.

194. Accordingly, the Department through its advisors requested the Applicant to provide projections that assumed West Penn would be able to attain only 50% of the incremental discharges Highmark projected in its "base case." The Guerin-Calvert Report concluded that this scenario is as plausible as the "base case" scenario. Under this scenario, however, West Penn would be unable to achieve breakeven income.

195. Highmark has proposed a number of "Contingency Actions" if it could not attain at least 50% of the incremental discharges. These would involve significant changes in the operation of West Penn that could include selling off non-core assets and reducing capital expenditures. Even under this "downside case" scenario, those contingency actions would tend to hold healthcare costs down rather than increase upward price pressure.

196. There are also risks associated with the affiliation with West Penn. A sufficient volume of patients may not be attracted to West Penn. A sufficient number of physicians may not be able to be convinced or incentivized to refer patients to West Penn. Providers (other than UPMC, whose exit from the system is assumed by the Applicant after 2014) may pull out of the network, leaving members without their preferred physicians.

197. Highmark projects that if the affiliation were not to occur, it could result in higher costs, greater consolidation in the provider market, and a shutdown of further services at the West Penn facilities. This would lead to a strengthening of UPMC's market share and an increase in costs and premiums throughout the market.

198. Highmark also contends that if it did not affiliate with West Penn, it would be forced to renew its provider contract with UPMC at a higher cost, and would be forced to pass those costs on to subscribers, accepting a reduced margin, or some combination of the two.

199. For its part, West Penn has not provided significant information on what it would do if the Affiliation were not approved. It would likely have to seek out another financial partner, one that may not allow West Penn to continue its charitable mission, an important part of West Penn's decision to affiliate with Highmark.

200. Furthermore, if West Penn were to continue to shrink the services it provides, or were forced to close certain facilities altogether, it would leave UPMC in a stronger competitive position and better able to exercise dominant market power. In the greater Pittsburgh market, only UPMC and West Penn provide the full range of acute care services. For example, there are six major service groupings in which UPMC and West Penn has a combined share of at least 75% of patient discharges – spine, neurosurgery, neonatology, other OB, surgical tracheostomy, and HIV. And for some services, UPMC and West Penn are the only two providers in the area.

201. Although there is substantial uncertainty concerning whether large numbers of patients will be shifted successfully to West Penn, as the Applicant projects, or whether certain of the economic assumptions made in the Form A are sound, the Applicant's strategy appears to be reasonable, and could provide significant benefits to Highmark's members and to the Western Pennsylvania Region as a whole.

202. As the Applicant's strategy is reasonable and could provide significant benefits to its members and to the Western Pennsylvania Region as a whole, provided the Conditions set forth in the Approving Determination are adhered to, the Department has not found that 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.

IV. Standard 3: Condition Not Present – That The Financial Condition Of The Applicant Is Such That It Might Jeopardize The Financial Stability Of Highmark Or Prejudice The Interests of Policyholders.

203. When analyzing an application for a change of control under Section 1402, the Department reviews the financial condition of the acquiring person(s) as of the consummation of the Change of Control.

204. The Applicant is the acquiring person under Section 1402 and is a nonprofit corporation separate from the Highmark Insurance Companies.

205. The Form A does not disclose any agreement by any of the Highmark Insurance Companies or any Affiliate to assume any debts or obligations of the Applicant.

206. The Department has reviewed the financial statement submitted by the Applicant – essentially a newly-formed entity – as of February 28, 2013.

207. The Department notes that the Applicant reports that it has or projects to have $327.3 million of total assets, and reserves of approximately $80.1 million at closing. Such amounts primarily relate to the assets and reserves of JRMC, which consummated an affiliation with UPE on March 1, 2013.

208. Based upon the information provided by the Applicant that it has or projects to have reserves of approximately $80.1 million at closing, the Department does not find that the financial condition of the Applicant is such that it might jeopardize the financial stability of the

Highmark Insurance Companies or prejudice the interests of policyholders as of the consummation of the Change of Control.

209. The financial condition of the Applicant does not pose any impediment to the Change in Control, nor jeopardize the financial condition of Highmark as of the consummation of the Transaction.

V. Standard 4: Condition Not Present – That The Change of Control, Including Any Material Change In The Business Or Corporate Structure Or Management Of The Applicant Or The Highmark Insurance Companies Is Unfair Or Unreasonable and Fails To Confer Benefit On Policyholders And Are Not In The Public Interest.

210. With the assistance of Blackstone and the Blackstone Report, the Department has carefully considered the impact the Transaction could have on the Highmark Insurance Companies.

211. Blackstone's financial analysis focused on the following aspects of the Transaction: (i) the financial impact on Highmark; (ii) the potential cost and benefits to Highmark's policyholders; and (iii) implications for competition and the insurance-buying public.

212. Blackstone performed a number of analyses in connection with its review of the impact of the Change of Control and the associated transactions, including: (i) an overview of Highmark's current financial position; (ii) an assessment of Highmark's total financial commitments related to its IDN Strategy; (iii) an assessment of the capital commitments implied by Highmark's IDN Strategy that are contingent on approval of the Form A, as compared to those that have already been funded or will be funded regardless of the approval of the Form A;

(iv) an assessment of the potential impact of the Transaction on Highmark's net liquid assets, investment portfolio, credit profile, and Risk Based Capital Ratio ("RBC");[4] (v) an assessment of Highmark's RBC stress test; (vi) a review of Highmark's "base case" financial projections for West Penn and assessed potential vulnerabilities in Highmark's assumptions; (vii) a review of "downside case" financial projections prepared by Highmark for West Penn and the related impact on Highmark, based on an assumed lower level of inpatient volume than in the base case; and (viii) a review of Highmark's analysis of the financial impact to it of completing no affiliation with West Penn whatsoever (the "no transaction" case) and its underlying assumptions.

213. As of December 31, 2011, Highmark's combined enterprise GAAP balance sheet showed cash and investments of approximately $6.2 billion and total reserves of $5 billion, which averaged 5.7% annual growth since 2007.

214. The circumstances in which Highmark found itself in 2012, namely: (i) its deteriorating contract dispute with UPMC; (ii) the rapid decline of West Penn's financial condition; (iii) the potential for accelerated physician departures from West Penn; and (iv) the possibility that Highmark could find itself without *either* a UPMC contract or relationship with West Penn to serve as the foundation of its IDN Strategy were circumstances that led Highmark to conclude that it was essential to proceed quickly, and these circumstances may have contributed to Highmark securing a transaction that was more expensive, or bore more risk, than was originally anticipated.

[4] The RBC is a measure of an insurer's liquidity and capital adequacy. It is monitored by the Department and measured against Department-established benchmarks.

215. In exchange for financial terms that were deemed by West Penn's financial advisors to be favorable to West Penn, Highmark received limited contractual flexibility in the Affiliation Agreement to respond to certain changes in West Penn's financial profile, including covenant defaults, between signing and closing of the Transaction.

216. In order to expedite execution of the Original Affiliation Agreement and maximize control of West Penn, Highmark chose not to restructure West Penn's debts prior to signing, and thus appears to have ceded leverage to West Penn bondholders in subsequent West Penn restructuring negotiations, and, as a consequence, the $233 million injected into West Penn by Highmark prior to the closing of the Affiliation Agreement supported the value of the Bonds that Highmark was seeking to purchase, amounting to a transfer of value from Highmark to the bondholders for which Highmark may receive an uncertain return.

217. Although Highmark stated that it expects to spend $1 billion in total capital in its IDN strategy, including commitments to West Penn, its total capital commitment is actually in excess of $1.8 billion, when accounting for: (i) Highmark's acquisition of and/or potential need to repay the Bonds; (ii) advances Highmark made to West Penn outside of the Affiliation Agreement; (iii) the maximum potential grants Highmark may be obligated to make to JRMC; and (iv) credit enhancement that may potentially be provided by Highmark in support of borrowing by IDN-related entities.

218. In the absence of the Change of Control, various elements of the IDN Strategy would have been, or already have been, implemented directly by Highmark, and absent the Department's approval of the Form A, Highmark stated that a UPE change-of-control would be sought without West Penn.

219. Approximately $382 million of the total planned IDN budget was expended or invested as of December 31, 2012 (including the aforementioned $233 million expended or invested at West Penn), and Highmark informed the Department of its plans to make $806 million of additional expenditures and investments related to the IDN Strategy irrespective of the Department's decision with respect to the Form A, resulting in $1.188 billion of expenditures and investments that were not contingent on approval of the Form A.

220. Of the $1.188 billion of expenditures that was not contingent on the Department's decision with respect to the Form A, $639 million relates to unrestricted payments that Highmark characterizes as business expenses subject to limited review by the Department, even though a significant portion of the payments were (or will be) made in exchange for obtaining governance rights in, and/or enhanced business alignment with, recipient organizations.

221. In total, the Transaction could reduce Highmark's net liquid assets, calculated as total liquid assets minus total debts and liabilities, by approximately $1.5 billion, a decrease of nearly 49% based on its December 31, 2012 balance sheet.

222. Highmark projects approximately $1.2 billion of cumulative net income from 2013 to 2017 on a combined enterprise basis, but net income of only $106 million in 2013 due to IDN expenditures and the costs of health care reform.

223. Following the acquisition of the Bonds, 20% of Highmark's fixed income investment portfolio will be comprised of speculative grade securities, compared to 11% prior to the Transaction.

224. Highmark's RBC has been deemed to fall within a range of "sufficient" as determined in accordance with the applicable standards of the Department for each of the last five years.

225. Highmark subjected its "base case" RBC calculation to a "stress test." Highmark also ran a revised "stress test" using inputs provided by Blackstone. Although the specific details of these models are confidential, they demonstrate substantial risk associated with a potential downturn in the financial markets, and a risk associated with the value of West Penn being insufficient to support the carrying value of the Bonds, forcing a potential Highmark write-off of approximately $400 million in 2016, as but one example.

226. But when Highmark's projected "base case" (which assumes approval of the Form A and the closing of the Affiliation Agreement) is measured against the hypothetical "no transaction" case, in which the Affiliation Agreement did not close and Highmark instead executed a new contract with UPMC beginning in 2015, it is apparent that, by many measures, Highmark would fare better having the Transaction contemplated by the Form A close than not. For example, its net income, measured as a percentage of revenue, is estimated to be higher in each of 2013 through 2016 with the "base case" as opposed to the "no transaction" case.

227. Again, the details of this analysis are confidential, but the Department has reviewed the unredacted details in reaching this conclusion.

228. There is also some uncertainty concerning whether Highmark has reasonably assessed the likelihood that West Penn will be able to lure large numbers of inpatients away from UPMC, including whether consumers will be attracted to West Penn's offerings and whether

competing providers would be able to dynamically compete with attempts by West Penn to gain market share.

229. As a result, the Department requested that Highmark run a "downside case" scenario that reflected a 50% decrease in projected incremental patient volume at West Penn.

230. The "downside case" projects considerably less patient volume and weaker financial performance by West Penn. This is also a reasonable potential alternative outcome for the affiliation with West Penn, and indicates that there is substantial doubt as to the likelihood that Highmark will fully recover its investment.

231. Again, the details of this analysis are confidential, but the Department has reviewed the unredacted details in reaching this conclusion.

232. On the whole, Blackstone concluded, and the Department agrees, that Highmark's IDN strategy: (i) may underestimate the amount of capital required – $1.8 billion instead of $1 billion; and (ii) the $1.8 billion commitment will result in a material change to Highmark's financial profile, because a significant portion of Highmark's current balance of net liquid assets will be converted into illiquid, highly concentrated and, in the case of West Penn, high-risk investments.

233. Taken as a whole, the IDN strategy will materially decrease Highmark's liquidity and will reduce the quality of its investment portfolio. Its long-term IDN-related commitments, coupled with uncertainties in the future as identified in the Blackstone Report, are such that the Department cannot conclude that these IDN commitments will not, in the long term, potentially jeopardize the financial stability of Highmark, absent the imposition of certain safeguards.

234. As a result, the Approving Determination and Order included substantial financial Conditions that will affect the Highmark Insurance Companies going forward, and on which the Department's approval of the Form A was expressly conditioned.

235. The 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 West Penn and its Affiliates; (iv) establish criteria for a plan of corrective action to be prepared by UPE if the turnaround of West Penn and its Affiliates fall 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. When properly implemented, they should sufficiently ameliorate the risk the affiliation poses to the Highmark Insurance Companies and their policyholders.

236. Blackstone also considered the costs and benefits to Highmark policyholders as a result of the affiliation. To assess the affiliation's costs and benefits to policyholders, Blackstone: (i) reviewed Highmark's financial exposure to West Penn, on a contingent and non-contingent basis; (ii) assessed the total potential value available to repay Highmark's anticipated loan and bond investments in West Penn under different operating scenarios, at different points in time; (iii) compared Highmark's total financial exposure to West Penn to the amount Highmark could potentially recover on its investment in West Penn under different scenarios and at different

points in time, yielding a range of potential implied net losses to Highmark (the "West Penn Value Gap") on a basis contingent and not contingent on Form A approval; (iv) reviewed Highmark's exposure to non-West Penn elements of its IDN Strategy; (v) measured the potential financial value to Highmark in exchange for its investments into non-West Penn elements of the IDN Strategy; (vi) compared Highmark's total financial exposure to non-West Penn elements of the IDN Strategy with the potential value to Highmark for its investments in the non-West Penn elements of its Plan, resulting in a range of potential implied net losses to Highmark (the "IDN Value Gap"), on both a contingent and non-contingent basis; (vii) reviewed Highmark's plans to secure financial benefits for its policyholders through reduced cost of care and reduced premiums, and the likelihood that those savings would be secured given the varying levels of future discharge volume at West Penn; and (viii) compared the potential total Value Gap to the potential savings.

237. An analysis of the value received by Highmark in exchange for its capital commitment to West Penn indicates potential investment losses for Highmark ranging from $208 million to $679 million in total on a basis not contingent on Form A approval, and potential investment losses for Highmark ranging from ($9) million to $362 million based on amounts that are contingent on the approval of the Form A.

238. Based on this analysis, Blackstone concluded that the value of the tangible financial assets received in return for Highmark's investment may be substantially less than the potential $1.8 billion investment Highmark is making in its IDN Strategy. Blackstone also recognized that because there is little precedent for the IDN Strategy proposed by Highmark and

the savings that may result therefrom, the projected savings for policyholders ($1.147 billion from 2013 through 2017) could be materially overstated.

239. In sum, there is a potential maximum estimated gap between Highmark's capital commitments and the value of tangible financial assets Highmark will receive as a result of the affiliation with West Penn which could total $1.037 billion or more ($362 million of which may be contingent on approval of the Form A), depending on the financial performance of West Penn and the potential for West Penn's unsecured creditors to pursue UPE in the event West Penn is later forced to restructure.

240. Highmark's projected IDN savings to policyholders are feasible, but have little precedent. It is possible, however, that the value received by policyholders through the IDN savings will cover the gap between Highmark's total Transaction-contingent capital commitments related to the IDN Strategy and the value of actual tangible financial assets received by Highmark.

241. But the potential benefits to policyholders are less certain than either the IDN Strategy-related investments or expenditures that are to be funded through policyholder reserves, or the potential franchise benefits (e.g., increased enrollment, market share, and revenue) that may accrue to Highmark.

242. Because the potential benefits of the affiliation are uncertain, 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"). UPE shall be required to 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.

243. In addition to the risks associated with the affiliation, 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.[5] The Department also recognizes that Highmark'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 West Penn's financial recovery. The potential termination of these provider contracts may be disruptive to the Highmark Insurance Companies enrollees and consumers of UPMC health care 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 determined that it was necessary to impose a transition plan condition on all Domestic Insurers that have contract(s) with UPMC.

244. Moreover, in order to assure benefits to the public from the Transaction ,the Department determined that it was necessary to impose a condition that 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.

[5] No conclusion has been made in these Findings of Fact and Conclusions of Law with respect to whether a new or extended provider contract should or should not be entered into between Highmark and UPMC.

245. In connection with the analysis of costs and benefits to policyholders, however, the Conditions set forth in the Approving Determination and Order sufficiently ameliorate the risk the affiliation poses to policyholders.

246. The analysis stated in Paragraphs 146 to 201 above are incorporated herein, to the extent they address Highmark's assumptions and the likelihood of Highmark's projections being fulfilled or falling short.

VI. Standard 5: Condition Not Present – That The Competence, Experience, And Integrity Of Those Persons Who Would Control The Operation Of Highmark Are Such That It Would Not Be In The Interest Of The Policyholders And The Public To Permit The Change Of Control.

247. When analyzing an application for a change of control under Section 1402, the Department reviews the competence, experience, and integrity of the persons who will control the operations of the acquired insurer.

248. Biographical affidavits for all directors and executive officers of UPE and West Penn were reviewed by the Department.

249. The Department is satisfied that the persons who would control the operations of UPE and West Penn have such competence, experience, and integrity that the interests of policyholders and the public would not be jeopardized.

VII. Standard 6: Condition Not Present – That The Change Of Control Is Likely To Be Hazardous Or Prejudicial To The Insurance Buying Public.

250. When analyzing an application for a change of control involving a domestic insurer under Section 1402(f)(1)(vi) of the Insurance Holding Companies Act, the Department

evaluates whether the merger, consolidation or other acquisition of control is likely to be hazardous or prejudicial to the insurance buying public.

251. As it relates to Highmark enrollees and other policyholders, the discussion at Paragraphs 210 through 246 above are incorporated herein. Provided the financial Conditions are complied with, the affiliation does not pose a material risk to Highmark policyholders.

252. As it relates to the public at large, the Department, Blackstone, and CL reviewed public comments received concerning the Form A, and conducted private meetings with various market participants. Based upon its review, the Department concludes that the imposition of the Conditions is sufficient to make it not likely that the affiliation would be hazardous or prejudicial to the insurance buying public.

VIII. Standard 7: Condition Not Present – That The Change Of Control Is Not In Compliance With The Laws Of The Commonwealth.

253. When analyzing an application for a change of control involving a domestic insurer under Section 1402, the Department reviews the Transaction to determine whether the merger, consolidation, or other acquisition of control is not in compliance with the laws of this Commonwealth, including Article VIII-A, Insurance Company Mutual-to-Stock Conversion Act.

254. The Department has evaluated the Transaction as set forth by the Form A as to whether it is in compliance with the laws of Pennsylvania.

255. The Department has not identified any provision of Pennsylvania law that the Change of Control would violate.

IX. Bylaw Amendments.

256. Pursuant to 40 Pa.C.S. Chapter 63 (relating to professional health services plan corporations), Highmark is required to submit to the Department for approval any changes to its bylaws.

257. In connection with the Form A, Highmark submitted to the Department a form of the Second Amended and Restated Bylaws of Highmark, Inc. (the "Highmark Bylaws").

258. Having reviewed the Highmark Bylaws, the Department finds the Highmark Bylaws as submitted to the Department in connection with the Form A meet the statutory standards of 40 Pa.C.S. § 6328(b).

X. Miscellaneous.

259. Section 1402(f)(2) does not require that the Department conduct a hearing in review of a change of control unless the persons or insurers involved in the filing so request, or the Department, in its discretion, elects to hold a hearing.

260. The Department's decision to conduct a public informational hearing under Section 1402 , even though the persons or insurers involved in the Form A did not request a hearing, was a proper exercise of the Department's discretionary authority.

261. The process by which public comments were solicited, the process afforded at the public informational hearing, and the process by which the Form A was approved, all satisfied due process.

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The foregoing Findings of Fact and Conclusions of Law are approved and issued this 31st day of May, 2013

Michael F. Consedine
Insurance Commissioner
Commonwealth of Pennsylvania

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 F

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March 27, 2017

VIA HAND DELIVERY

Joseph DiMemmo, CPA
Deputy Insurance Commissioner
Office of Corporate and Financial Regulation
Pennsylvania Insurance Department
1345 Strawberry Square
Harrisburg, PA 17120

Re: *Order No. ID-RC-13-06*

Dear Deputy Commissioner DiMemmo:

Please find attached a document titled Allegheny Health Network Strategic and Financial Plan 2017-2020 filed by Highmark Health.

Thank you for your consideration.

Very truly yours,

Jack M. Stover

JMS/gmt
Enclosure
cc: Lawrence J. Beaser, Esquire (via email)
Patrick T. DeLacey (via Email)

ALLEGHENY HEALTH NETWORK STRATEGIC AND FINANCIAL PLAN

2017-2020

Positioning AHN as a thriving competitor in a dynamic regional health care landscape and delivering on its mission to provide low cost, high quality health care

EXECUTIVE SUMMARY

Almost four years ago, Highmark Inc. (HM) enabled the formation of Allegheny Health Network (AHN) to ensure that HM customers and the Western Pennsylvania (WPA) community would retain access to a competitive high quality health care system that would help control premium costs for all health care consumers. Since that time, Highmark and AHN have worked together and have made significant progress to reinforce their financial strength and stability and have continued to build the core operational and technology platforms needed to support their long-term strategy. This strategy has been focused on redesigning the delivery of care and re-investing in the community network (both AHN and independent community providers) to advance their stated goals and preserve a future for community health care delivery in a time of great turbulence for the healthcare industry. In the process, HM, AHN, and its community partners have established Pennsylvania (PA) as a hub for healthcare transformation and investment and offered PA employers/policyholders a true value-based alternative to the traditional system of fee-for-service (FFS) driven care.

With the turnaround phase behind them, Highmark Health (HH), HM and AHN now are focused on the future and are preparing for and executing against the fundamental changes which are taking place in the healthcare marketplace – including market consolidation, potential vertical integration, and the approaching end of the Consent Decree(s) to which HM and UPMC are parties and which govern the termination of their contractual relationships (Consent Decrees(s)). The time has come for HH, HM and AHN to make final preparations to ensure that AHN has all of the competitive capabilities and HM has the competitive access each needs to effectively serve their respective constituencies, not just in WPA but across the Commonwealth.

To effectively compete and ultimately succeed in this intense, dynamic and highly competitive environment, HH, HM and AHN need a level playing field with their primary WPA competitor, UPMC -- especially given the aggressive moves being made by UPMC and others in PA to consolidate assets. Being able to effectively compete includes the need to have the flexibility to make timely, strategic investments as required to execute on the HH strategy; to build out the remaining services and care models needed to provide patients with a full set of value-based service; and to mitigate what otherwise would be a health care market that would restrict choice and access, and allow care costs and insurance prices to increase without constraint.

It is in this context that HH, AHN and HM have prepared this strategic and financial plan (the Plan). The following pages provide additional detail on the significant progress HH, HM and AHN have made since the formation of AHN, where the integrated delivery and financing system (IDFS) is today, where it is going and how it plans to execute.

HH's success in implementing its strategy will enable it to stay on track in its transformational journey to re-configure a new, integrated health coverage and care model that redefines the

consumer experience, is focused on value-based delivery, and that HH, HM and AHN believe will work better for everyone. It will also continue to ensure that HM customers and the WPA community retain access to a competitive, high quality health care system that would help control premium costs for all health care consumers.

The Original Promise of the HM-AHN affiliation and progress to date

At the time of AHN's formation, the WPA market was facing the potential of having only one true system option for comprehensive care, which had the potential of increasing costs for the WPA community and reducing the availability of services particularly in the outlying communities. HM intervened to assure that its WPA employers/members had another option, one that would be dedicated to the premise that health care buyers/consumers deserved care in their communities at an affordable cost and with a high degree of service. Realizing that goal required substantive investment to recapitalize AHN, sustain community care (for both AHN and independent facilities and individual practitioners), and transition the delivery of care to the new model. Succeeding in that goal would require nothing short of a transformation in how clinicians, healthcare professionals, insurers, and members/patients worked together.

Four years into that journey, HH, HM, AHN, and their community partners have made substantial progress. With HM's help, AHN has made necessary infrastructure investments in all of its hospitals, re-opened the West Penn Hospital (WPH) Emergency Department, opened four Health and Wellness Pavilions, placed critical services back into the local communities (including oncology and women's health services, as well as urgently needed services in the community of Braddock), partnered with the majority of independent hospitals in the community to provide necessary specialty support in the community, created a clinically-integrated network (CIN) led by AHN and community physicians, and implemented a market leading information technology platform. The collective investment has created a viable alternative in the market that delivers a lower-cost, better-quality option, with an emphasis on empathy and caring for the patient.

2016 was a year of acceleration for the value-based delivery system. AHN created a new standard for access by launching same-day appointments in a market that was averaging 19 days wait time for a primary care physician appointment and 38 days for a specialist appointment. A "Living Proof" marketing campaign highlighted the high degree of patient touch and caring that AHN provides for its patients. AHN, its community hospital partners, and now the CIN have worked and are working together to create a lower-cost network for the market and collaboration on new care models that promise continued cost reduction.

The success of these efforts can be seen in the growth in volume at both the community hospitals and AHN and the dramatic increase in AHN earnings before interest, taxes, depreciation and amortization (EBITDA) from ($24 million) in 2013 to $116 million in 2016. AHN revenue has grown 30% over that time frame.

The current strategic context

The environment in which HM, AHN, and their independent community partners operate is more dynamic than ever. The fundamental trends affecting healthcare – rising costs, patient dissatisfaction, and lack of coordination – continue to plague the industry. The changes in the regulatory environment suggested by the new administration in Washington have created increased uncertainty and will likely force another fundamental adjustment to market conduct, coverage, and reimbursement. The individual consumer/patient faces the prospect of losing affordable coverage and/or access to services. All of this is intensified by the impending end of the Consent Decree(s).

In reaction, payors and providers are seemingly following one of two strategies. The first is to attempt to preserve the current system through structural and service consolidation, and a re-investment in the assets, systems, and services that create economic value under a FFS model. The second is to embrace the transition to value, where the need for lower total cost drives pushing care into lower cost settings in the community, redesigning care delivery models around the patient, coordinating care across providers, improving access, simplicity, and transparency, and investing in lower-cost assets.

With the speed of change and the level of uncertainty at a peak, HH, AHN and HM have put together a strategy to move to value-based care at scale as fast as possible. HH, HM and AHN – and many of the community independents – believe that this position will be the right answer under any regulatory or reimbursement structure that is put in place and will also most fully align with the collective missions of the organizations.

The 2020 strategy for HH//AHN/HM

HH, AHN and HM have a two-step vision for the future – reinvent the model of healthcare at scale in WPA and use that platform as a means to advance HH's mission going forward. This aligns with AHN's mission to deliver lower-cost, high-quality health care to the residents of WPA. HH has a 5-part strategy for delivering that vision that includes building unique offerings for consumers/patients, growing sustainably by focusing on customers who want to buy on value, putting clinicians in charge of developing the new models of clinical practice that make sense to them and to their patients, and building partnerships across PA to enable the delivery of these new models in the community. As shown above, the strong foundation in place is reason to believe these bold goals can be accomplished.

That said, HH's strategies require additional investment over the next five years with a particular focus on building out services to close any remaining perceived or real gaps in service for AHN and its community partners and in pushing forward clinical transformation quickly across the population. While HH believes this value-based model of care will be the preferred model of the majority of customers in the market, it is critical to invest now given the pending end of the Consent Decree(s) so that the services can be put in place and the market has time to understand

the value of these services before they make choices based on a new paradigm. In this fast changing market environment, and given how central HM is to both AHN's and its community partners' efforts to put this model in place, HM's current lack of flexibility to invest in a more timely way puts HM and AHN at a competitive disadvantage and ultimately jeopardizes the sustainability of community-based, value-based care in WPA (and likely beyond).

Value for the PA community of a successful AHN/HM

The success of HH's 2020 strategy will provide great benefit to the PA community at large. First, the employers/patients/members in the community will be able to access a system of healthcare that is built for and around the individual. The goal of value-based healthcare – high quality, great experience, and great outcomes at an affordable cost – has been elusive but is for the first time on the cusp of being realized in WPA if HM, AHN, and their community partners can continue their transition. If AHN and HM fail, the alternative is likely a highly consolidated, high-cost healthcare system which removes service from the community. Second, the success of the 2020 strategy will ensure PA as a hub for healthcare innovation, which will in turn attract research and investment dollars and generate high-paying jobs for the region. Third, the success of HH in turn ensures the continued viability of community providers who can be given the resources, services, and integrated relationships to survive and transition as needed to a more sustainable model. Finally, the success of the HH strategy will ensure that employers/patients/members have choice and competition and all the market benefits which come therein.

Financial Forecast

The financial forecasts of AHN are most materially impacted by the levels of investment necessary in the system to prepare for the transition of volume leading up to and as a result of the expiration of the Consent Decree(s). The transition of volume is expected to occur moderately over the next two years. When the Consent Decree(s) end in 2019, the volume is projected to transition more rapidly to AHN.

In anticipation of the impending termination of access for HM members to UPMC at the end of the Consent Decree(s) in June 2019, in 2017 and 2018, AHN will be focused on a variety of investments, including, most importantly, in service lines and service areas expected to experience the greatest disruption from the termination of the Consent Decree(s) –and the most volume transitioning to AHN and the independent community providers. Management will also focus on the ongoing effort to increase employer and consumer perceptions of the system and to make accretive operational adjustments through ongoing capital spend on existing facilities. Lastly, AHN will continue to evolve how it is delivering care to both prepare the AHN system to compete in a value-based world over the longer term, and to enable the leveraging of those learnings across the HH footprint beyond WPA.

The Plan assumes HM will provide funds to HH/AHN of up to $850 million over the period 2017-2018 for the investments contemplated at AHN. HM also will forgive loans previously provided to HH/AHN of approximately $720 million, a significant portion of which has been already accounted for in the primary metric of HM financial strength (i.e., risk based capital (RBC)). The financial transactions between HM and HH/AHN will be made in accordance with applicable regulatory requirements, which will assure that HM maintains an appropriate level of financial strength. These transactions will allow HM to deliver on its mission of making affordable health care available, which requires that it have access to high quality providers at a reasonable cost. HM will provide such funding via capital contributions that will be sourced from existing cash and investment balances, projected annual operating cash flow and the expected gains and earnings available from HM investments. AHN will provide the remaining funding necessary through either cash flows or outside financing.

The financial forecasts for AHN also contemplate a repositioning of its balance sheet to place it on a firm footing for growth. In the current state, the balance sheet carries debt that originated pre-affiliation with HM and through the various affiliation agreement terms. It is critical for the future growth and expansion of AHN to better position the balance sheet.

Following these investments, both AHN and HM are projected to be strong. Both organizations and the subset of the business within them that represent the IDFS project positive operating performance in all years, with an increase from 2017 to 2020. These WPA IDFS financial results provide adequate earnings to support HM's RBC level. Additionally, AHN is projected to generate sufficient cash flow to fund all of its liabilities and ongoing costs in 2019 and 2020, and the WPA IDFS is projected to generate returns sufficient to support the business.

HH management has considered the impact of a less favorable market scenario to both HM and AHN. Even in this scenario, the cash flows from the WPA IDFS are projected to be at levels enabling HM to provide annual funding to AHN to support capital expenditures.

Management of HM, AHN, and HH recognize that under the Approving Determination and Order issued by the Pennsylvania Insurance Department (PID) in connection with Highmark's initial affiliation with the West Penn Allegheny Health System (WPAHS), certain actions by the PID may be necessary to enable the Plan. Accordingly, built into the Plan is the assumption that such actions are taken. Almost four years ago, the PID took the bold action to enable the formation of AHN, to save 17,000 jobs, and to ensure that the WPA community would have access to a competitive health care environment. HM, AHN, and HH have executed on the plan to provide that competitive health care environment while also delivering financial value to the community, AHN patients and HM customers through health care costs that are lower than they would have been but for the affiliation. HH as an enterprise has made remarkable progress in the almost four years since the initial affiliation and has a well thought-out strategy that will translate

into the realization of the vision of a transformed health care system – one that is focused on value not volume, for the benefit of the members of the WPA community and beyond.

THE ORIGINAL PROMISE OF THE HM-AHN AFFILIATION AND PROGRESS TO DATE

At the time of AHN's creation, the WPA region was facing the potential loss of viable competition for high-end healthcare. WPAHS was in financial trouble and facing a potentially crippling second bankruptcy. WPAHS was one of two systems in the market that offered high-end quaternary and tertiary care, and in fact in the past had been considered the pre-eminent medical facility in the region with a heritage of innovation and quality. At the same time, HM and UPMC were in a contract negotiation that threatened the affordability of care in the community and/or the access for community members to all services.

The HM-AHN affiliation was consummated with the primary goal of preserving for the WPA community access to affordable, high quality health care. HM and AHN believed that preserving competition in the market would stabilize costs, promote innovation, and ensure choice for customers. At the time of the affiliation, HM and AHN committed to making investments that would recapitalize AHN, turn around its financial performance, and improve the services being delivered. Secondarily, preservation of competition would also ensure that independent providers – both physicians and hospitals – would have a partner in preserving their viability.

The key to delivering on the promise of the HM-AHN affiliation was the creation of a model of healthcare that truly offered value to customers, in the form of better experience (simplicity and transparency), better access, and better outcomes, all at an affordable cost. Understanding that this was so far unachieved in the industry, HM and AHN set out on their bold vision supported by the common cultures of the organizations, their mission-driven focus, the combined strength of their financial resources and management talent, and the strong partnerships and connections they had to both community members/institutions and organizations across the country. Delivery of the goal required large investment to recapitalize AHN (which had missed a generation of infrastructure investments due to its financial history), build out a broader network across the full spectrum of care, invest in community partners to preserve their services, financial viability, and independence, and upgrade clinical capabilities.

The investments made over the last four years have been substantial. Among the various investments are the following:

- New ambulatory care/surgery center, hybrid operating room, cardiac magnetic resonance imaging, and cardiac unit at Allegheny General Hospital

- Reversing the decision to close West Penn Hospital; reopening of emergency department; and opening of new catheterization labs, expansion and enhancement of intensive care, emergency and obstetrics facilities and neonatal intensive care unit at the hospital
- Creation of a new cancer institute, women's center, neurosurgery, gastro-intestinal, and liver/kidney disease services at Jefferson Hospital
- Enhancement and expansion of intensive care unit and opening of a new Level II trauma center at Forbes Hospital
- Enhancement of inpatient units at Saint Vincent Hospital
- Opening of new outpatient centers in the communities of Wexford, Peters Township, Bethel Park, Monroeville, and Millcreek Township in Erie County
- Enhancing/replacing critical infrastructure across the AHN system
- Growing the employed physician staff by over 500 physicians
- Implementation of the Epic medical records technology across all the ambulatory centers and four hospitals
- Build out of a home services company – Healthcare@Home
- Acquisition of Premier Medical Associates, a major high performing multi-specialty practice
- Addition of clinical service support at over 28 community hospitals

2016 was a particularly significant year for the system as it made major strides in delivering on the promise of value based care, including:

- Same-day appointments for primary care physicians and specialists were launched to great acclaim and satisfaction by the market
- The piloting of multiple new care models in the market including major innovations in cancer, diabetes, women's health, chronic obstructive pulmonary disease, and congestive heart failure
- The launch of the AHN CIN with support of independent physicians across the market
- The launch of the "Living Proof" marketing campaign, which showcased for the public the compassionate, human-centered care that AHN was delivering
- New partnerships with community hospitals supported by new reimbursement programs from HM supporting high-quality, clinically integrated car

The results across the HH system in 2016 show the extent to which these accomplishments and investments have delivered on the promise of turning around AHN. AHN EBITDA reached $116 million in 2016 from a starting point of ($24 million) in 2013. The earnings margin of 4+% was achieved despite taking actions in conjunction with HM to reduce overall utilization and to largely forego hospital-based billing, a common industry practice that raises rates for services that can be provided in a lower-cost setting. The latter decision costs AHN multiple earnings margin points each year but was made to preserve the affordability of care in the community. Revenues at AHN grew 30%+ over the same period as employers and community

members embraced AHN's capabilities and value-based offerings. At the same time, community hospital volumes remained largely stable despite the general market decline thanks to partnerships with AHN and HM that maintained services in the community. HM also benefitted by retaining 96%+ of its commercial membership and 94% of its overall membership, and experienced a $680 million turnaround in financial results for 2016 thanks in part to the cost savings driven from the partnership with providers and the growing percentage of its members that prefer to use the lower-cost AHN/community hospital network. HH believes these results not only position the organization for future success but also substantiate the premise of the affiliation.

CURRENT STRATEGIC CONTEXT

Industry Trends

There currently exists an underlying disconnect between what the health care industry is delivering and what health care customers want. The normal market mechanisms that would ensure the connection between price, value delivery, and supply and demand do not work very well in the semi-regulated health care system present in the United States today. Costs have been escalating at an unsustainable rate to the point that many customers can no longer afford the health care they want. Access to care is challenged throughout the industry – that includes specific physician specialties and basic primary care. Patient desires for an easy to use, transparent system are not met, and even basic quality is hard to understand. The current incentives and payment system are not well aligned to promote provider care delivery change. Consumers are paying more (often more than they can afford) while becoming increasingly dissatisfied with their experience, thereby creating an environment highly susceptible to disruption.

Perhaps as a result, the predicted evolution of the industry from a volume-driven FFS construct toward one that is more consumer-conscious and "value-based" appears to have accelerated and perhaps reached a tipping point in the most recent years. The accelerated pace of change is being driven by a set of factors including the breakdown in the industry's cross-subsidization model, a new degree of consumer activism in demanding value for care, and the pace of innovation threatening to upset the traditional industry norms.

It is the government's broader intervention in health care with the passing of the Affordable Care Act (ACA) that has been the biggest catalyst for the industry in recent years. Since its passage, the Centers for Medicare & Medicaid Services (CMS) and several states have shown a willingness to make broad, highly complex changes to the health care financing system in an effort to re-align payment to value. While catalyzing and effective in decreasing the uninsured, there is much ambiguity still as to the effectiveness of the changes in either bending the long-

term cost trend or in promoting fundamental transformation of care delivery at the front-line practice level. The rapid pace of change has introduced a great deal more complexity and strategic uncertainty into the environment by putting pressure on traditional margins, creating volatility in risk pools and payor market segments, and promoting new forms of consolidation for scale and capability-building.

The passage of the Medicare Access and CHIP Reauthorization Act (MACRA) has added another element of government-mandated change into the provider community. While waiting for the final rules for MACRA to be clarified, AHN also has had to contemplate which funding path it will seek to follow to prepare the organization for the impact of the new payment models under the Merit-based Incentive Payment System (MIPS) or the Advanced Alternative Payment Models (APMs).

The most recent developments in industry regulation suggested by the initial draft of the American Health Care Act (AHCA) will add another level of uncertainty into the market payment environment. As the debate and structure of the AHCA bill takes place, all players in the industry will need to be flexible and ready to adapt to the changes it creates.

In the face of these industry changes, payers and providers have adopted a wide range of strategies, each seeking to protect core business and enable organizational flexibility and/or survivability in the long-run. These have included horizontal and vertical integration, new business investment and/or business diversification, renewed forms of cost reduction, and non-traditional business partnerships. Many of these moves have also created a need for each health care company to re-examine its basic philosophy on the value of scale and what the core competencies of each player in the value chain should be.

That said, two basic paths have emerged that industry players are following. One is a recommitment to the preservation and extension of the current FFS model as long as possible. Players committed to this path have been pursuing in full force the strategies that have been in place for years: consolidation to create economies of scale and better negotiating power in the markets, consolidation of services in higher-cost settings, expansion of services that are profitable in a FFS environment (e.g., higher-end surgeries), re-investment in traditional structures. This has been a preferred strategy of many players in the industry for years, in the hopes of preserving economics until changes in the market forced a change.

Increasingly, a second path is emerging – the one which HM and AHN are embracing with full force. That path is a full commitment to building a value-based system, which requires a full-scale cultural change in the way that clinical services are sold and delivered. This involves moving care to lower-cost settings, redesigning care models to promote integration and clinical standardization and passing those benefits along to employers and members, re-aligning payment to quality and cost performance, and embracing novel forms of integration and partnership. This second path is beginning to offer an alternative to the traditional model of medicine and holds the

promise of correcting some of the more fundamental issues with the system today. The transition to that model, however, requires substantial investment to build the capabilities and new processes to support the necessary type of care. The divergence in these two paths is likely to shape the healthcare competitive landscape for years to come.

In the local PA market, these dynamics are playing out at an increasing pace. Adding to the dynamics in WPA is the impending end of the Consent Decree(s), which is forcing reinvestment by players across the system to move into one of the two models. Providers are increasingly looking to commit to one of the two models. The competitive dynamics have spread across the state and re-alignment is beginning to occur. In this context, HH needs to move even faster to secure the capabilities and positioning needed for its value-based delivery system to compete on equal footing and to respond to the moves being made by other players, not just in WPA but across the state.

Overall, the competitive environment in WPA is shaping up by 2019 to be one of the industry's clearest pure examples of an integrated system dedicated to FFS health care (and the high-end costs and services that come with it) competing directly with an integrated system dedicated to value-based delivery. As stated above, HH believes fully that the long-term market choices will fall in favor of HH and AHN, but as the market fully digests these tradeoffs it is anticipated that there will be a curve of adoption/readiness that will muddy the transition for the next few years.

HM-AHN 2020 STRATEGY

HH is pursuing a five part strategy that it believes will re-center healthcare around the patient with models created and led by the clinicians who serve them. The strategy has a number of facets including:

- *Customer Value Creation* – Building products and services that are aligned to patients' demands for value – namely, access, experience, and quality at an affordable cost

- *Sustainable Growth* - Focusing on businesses and customers where HM-AHN's commitment to customer value most resonates. That includes building on HH's history of investing in diversified healthcare businesses that can add jobs and value to the community

- *Clinician-led Care Delivery Transformation* – Creating care models underlying products and services that are oriented around reducing waste in the healthcare system by putting clinicians in the driver's seat

- *Core business performance* – Improving the core systems that are required for delivering insurance and care (e.g., billing platform, Epic)

- *Unparalleled Execution* – Building the right leaders, systems, and processes to ensure transformational execution

Against that overall strategy, AHN has set high-level goals that are supportive of the AHN mission. First, AHN will deliver on its value proposition – superior access and experience scores (as measured by traditional industry metrics and likely more customer-oriented metrics developed over the timeframe) at a lower total per member per month cost to its end customers (the customers of its payers or the individual policyholders) with better than or equal to quality relative to today. Second, AHN will further its competitive position with improved market positioning and brand recognition across WPA. Third, AHN will achieve its financial targets as laid out in the Plan. Fourth, AHN will contribute (as projected) to the strength of the overall HH system.

Over the next two years, the HH-AHN strategy will focus on the transitional period to occur after the expiration of the Consent Decree(s). This will include closing service gaps and building out the competitive cost and value proposition that will ensure that HM members have affordable access to virtually all of the clinical services they will need. Community providers – both physicians and hospitals – will be integral partners (and ultimately beneficiaries) of the strategy as HM works to ensure that access points and services will be available in all communities and that long-standing community providers will be able to transition as appropriate to the value-based model.

More specifically, AHN will be putting investment into the community to bolster the provision of specific services – namely, cancer, women's health, and emergency services. In each case, HM and AHN believe that the community-based model that they have today in concert with their community partners is a superior model in terms of cost, quality, and experience for patients in that they get to stay closer to home for care. The community partners are essential to delivery of these services, and HM and AHN will seek to partner with them to ensure patients stay in the community for care and are not driven to higher-cost, urban settings. HM and AHN believe that their model is already winning over the population (as evidenced by growing volumes and reputation at AHN in each service), but that more needs to be done to overcome the historical marketing campaigns that have influenced the community. In addition to these services, HM and AHN (with funding provided by HM) will be investing in the Erie market (as recently announced) to ensure that HM customers have access to all services they need in that market and in the clinical care models needed to drive to a lower-cost network. All of this investment will bring the community better care in lower cost settings.

VALUE FOR THE PA COMMUNITY OF A SUCCESSFUL HH-AHN-HM STRATEGY

There is much at stake over the next few years for not just AHN and HM but also the PA community at large. The success of the HH-AHN-HM strategy benefits the community in four substantial ways.

First, as originally intended, the creation of the value-based healthcare system led by AHN and HM and inclusive of the community partners will preserve for community residents access to high-quality clinical services at an affordable cost. As the progress to date shows, the community has responded to the new value-based offerings. The next few years are critical for AHN and HM as the last building blocks to a fully competitive and strategically differentiated network are put in place. Additional investments are required to close perceived service gaps in the market, as well as new clinical models that will deliver value-based care, and new community investments that will bolster access and service in the community. Some of these gaps are real but others are only a function of the acceptance curve that comes with the introduction of a transformative product to an industry. With the right promotion and investment, AHN and HM believe they will showcase to the market the value of the new model and ensure that community members can make the best choice for themselves. Failure to make these investments may result alternatively in a lack of understanding on behalf of the market and a potential decline at HM that would put policyholders and potentially the whole value-based model at risk. Hence, the need for HM and AHN to invest boldly and swiftly.

Second, the success of the new value-based model will cement PA as a hub of clinical innovation for the nation. The entire health care industry is looking at the competitive dynamics in WPA to see how the market reacts to the growing divergence between the FFS providers and the value-based providers like HM, AHN, and its community partners. HH has already established innovative partnerships with many industry leaders including Johns Hopkins University for clinical research, Carnegie Mellon University for technology innovation and incubation, Google for new device experimentation, numerous technology companies for clinical research, and other strategic investors and vendors looking to prove out their value-based offerings on the HM-AHN canvas. HM's role as one of the leading Blue Cross/Blue Shield plans and the first to invest in provider assets at scale has drawn attention from sister plans and may lead to the establishment of research hubs here in PA. All of these partnerships and affiliations serve the community by bringing in the state-of-the-art practices and technologies for care while creating jobs for the region.

Third, the success of the AHN-HM model preserves the community hospital/provider model. HM and AHN both need the community providers to exist and, in fact, to thrive in order to

deliver on their model of care. They have invested heavily over the years in service support and reimbursement to these providers so that they have the resources not only just to survive financially but to transition their model to one that best serves their community and is sustainable over time. HH acknowledges the importance of these community providers and is committed to preserving the localized care they provide. The preservation of the community provider system not only allows for better healthcare, but it preserves jobs in many smaller markets around the region.

Finally, the preservation of the community hospital model and AHN as a quaternary/tertiary hub serves the explicit purpose of preserving choice and access for community members. Consumers do not want to be forced into only one model or provider for care. They want choice and they want the ability to stay with the health plan they have enjoyed in many cases for many years. They want to be assured that they can still get the services they need – the success of the HH-AHN-HM strategy will do that and limit disruption to membership.

FINANCIAL FORECAST

This financial forecast includes and is based upon assumptions, estimates and other information that is considered to be forward-looking. Although this financial forecast is predicated on AHN's detailed strategic plans and represents management's best estimates and expectations, it is subject to future events, risks, uncertainties and market conditions that may cause actual results to differ materially from those set forth in this financial forecast.

Overview

In 2017 and 2018, AHN continues its steady progress of recapitalizing the core of its business, strengthening its core operations, and making focused operating and capital investments that are important for long term success in the market place. With modest but continuing volume increases in 2017, the operating loss narrows to $27 million and AHN projects a $14 million operating gain in 2018.

In 2019 and 2020 as the Consent Decree(s) end, AHN benefits from substantially increased volumes coming from HM and from the strategic capital reinvestment program. In 2019 and 2020, as a result of an anticipated increase in volume, operating income rises to $151 million and $175 million, respectively.

in millions	2016	2017	2018	2019	2020
Total Operating Revenue	$ 2,898	$ 3,077	$ 3,227	$ 3,705	$ 3,851
Total Operating Expense	2,936	3,104	3,213	3,554	3,676
Operating Income (Loss)	$ (38)	$ (27)	$ 14	$ 151	$ 175
Operating Margin	*(1.3%)*	*(0.9%)*	*0.4%*	*4.1%*	*4.5%*
Net Income (Loss)	$ (49)	$ (29)	$ (17)	$ 136	$ 167
Net Margin	*(1.7%)*	*(0.9%)*	*(0.5%)*	*3.7%*	*4.3%*
EBITDA	$ 101	$ 137	$ 187	$ 350	$ 381
EBITDA Margin	*3.5%*	*4.5%*	*5.8%*	*9.4%*	*9.9%*
DCOH	73	75	79	78	89
Debt to Capital	85.6%	48.3%	41.9%	38.4%	36.3%
Total Discharges	86,457	88,538	91,132	100,927	104,517
Outpatient Registrations	1,294,198	1,309,468	1,361,605	1,540,080	1,560,576

EBITDA is positive in all periods and rises faster than net income during the projection period. EBITDA is a non-GAAP measure of operating earnings that excludes interest, taxes, and depreciation and amortization costs and is a widely used proxy measure for operating cash flow generation. AHN EBITDA is $137 million and $187 million during 2017 and 2018 respectively. EBITDA increases to $350 million and $381 million respectively for 2019 and 2020. In order to apply an additional level of conservatism to the projected volumes and cost control measures in the later years, reductions of EBITDA in 2019 and 2020 were applied to the projections in the Plan in a combination of revenue and expense factors.

EBITDA levels in 2017 and 2018 are projected to be positive and growing. In order to maintain adequate levels of liquidity throughout 2017 and 2018, HM intends to fund the ongoing capital expenditures at AHN to the extent that AHN cash flows are not sufficient to fund them. Also during the projection period, HH funds certain strategic initiatives at AHN. Financing options are planned that are sufficient to maintain the overall liquidity levels at AHN and to substantially maintain its financial position until 2019 when earnings and related cash flows rise sufficiently. By 2020, the improved earnings and cash flows of AHN, along with the return of capital expenditures to more normalized levels, allow AHN to maintain sufficient cash flow.

During this timeframe, AHN continues to expand its employed physician staff. Physicians added during this period will be targeted to service line and service area coverage.

AHN will transition, deleverage and consolidate its capital debt structure, including by refinancing its existing bank debt, to achieve long term capital stability and provide more extensive liquidity within AHN itself as it begins to operate under one consolidated obligated

group structure. The projected growth at AHN supports recapitalizing AHN's debt structure, providing AHN with the financial flexibility needed to invest in capital infrastructure and strategic imperatives.

For the last four years, AHN has substantially reduced the ongoing operating loss and commenced a period of internal investment that has nearly doubled since 2014 compared to historical averages. The robust capital expenditure investment and revitalization of AHN will continue at elevated investment levels throughout the 2017-2020 time-frames in order for AHN to remain a highly competitive health system. Those investments will substantially address the remaining AHN infrastructure needs, a process that began at the inception of AHN almost four years ago.

In summary, the AHN financial projections for 2017-2020 highlight volume growth and the generation of improved operating margin levels with significant ramp up in 2019 that leverages a strong health system footprint and stabilized cost base. During the early years of the financial projections, AHN, with HM's support, continues to make focused investments in the access, patient experience, service lines and other growth initiatives to position the health system to accommodate the projected rotation of HM customers into the AHN health system upon the expiration of the Consent Decree(s). The ramping financial benefits of these strategic investments are a significant driver in the operating margin improvements reflected within the financial projections.

This financial forecast supports the continued steps necessary to achieve a vibrant AHN and to contribute to the overall stability and success of the IDFS during a period of significant transition. AHN's net revenue, net income and EBITDA are projected to improve each year driven by steady to strong volume increases, revenue growth, better expense containment and overall operating performance. The capital structure is reset and rationalized for long term financial funding support. The earnings improvements along with the debt level reductions result in significant de-levering of AHN by 2020. Operating cash flows improve and capital expenditure levels return to normal levels.

Key Financial Indicators

	2016	2017		2018		2019		2020	
Volumes									
Discharges	86,457	88,538	2.4%	91,132	2.9%	100,927	10.7%	104,517	3.6%
Adjusted Discharges	178,304	181,454	1.8%	188,001	3.6%	212,263	12.9%	218,639	3.0%
Emergency Department Visits	297,868	296,992	-0.3%	302,619	1.9%	320,853	6.0%	322,289	0.4%
Outpatient Registrations	1,294,198	1,309,468	1.2%	1,361,605	4.0%	1,540,080	13.1%	1,560,576	1.3%
Physician Office Visits	2,756,386	2,895,669	5.0%	3,004,338	3.8%	3,342,652	11.3%	3,385,004	1.3%
Operating Results (in millions)									
Total Revenue	2,898	3,077		3,227		3,705		3,851	
Total Operating Expenses	2,936	3,104		3,213		3,554		3,676	
Operating Margin	(38)	(27)		14		151		175	
Total Non-Operating Income/Expense	$ (11)	$ (2)		$ (31)		$ (15)		$ (8)	
Net Income	$ (49)	$ (29)		$ (17)		$ 136		$ 167	
Financial Metrics									
FTE's	18,708	17,502	4.8%	17,746	1.4%	19,175	8.1%	19,344	0.9%
EBITDA (in millions)	$ 101	$ 137		$ 187		$ 350		$ 381	
Operating Margin %	-1.3%	-0.9%		0.4%		4.1%		4.5%	
Net Income %	-1.7%	-0.9%		-0.5%		3.7%		4.3%	
EBITDA %	3.5%	4.5%		5.8%		9.4%		9.9%	
Days Cash on Hand	73	75		79		78		89	
Days in A/R	41.8	40.8		39.4		39.5		39.5	
Total Debt (in millions)	$ 1,417	$ 907		$ 920		$ 920		$ 920	
Debt to Unrestricted Equity	(31.2)	1.3		0.9		0.8		0.7	
Debt to EBITDA	14.0	6.6		4.9		2.6		2.4	

VOLUMES

AHN is expecting modest volume growth in 2017 and 2018 ramping up growth in 2019 corresponding with the expiration of the Consent Decree(s). Per the table above, overall, total AHN inpatient volumes are projected to increase by approximately 2.4% in 2017 and 2.9% in 2018, ramping to 10.7% in 2019 and 3.6% in 2020. Outpatient registrations are projected to increase 1.2% in 2017, and then increase 4.0% in 2018, 13.1% in 2019, and 1.3% in 2020. AHN's volume forecast takes into account the impact of HM health plan enrollment changes, including the impact of the expiration of the Consent Decree(s).

Over the next two years through 2018, AHN will be focused on organic, programmatic growth in clinical service lines to improve its market position in the competitive WPA environment. Planned programmatic changes for 2017 are supported by the employment of new physicians, ramp up of recently added physician practices, as well as program expansion across most major hospital facilities.

There are several key strategic investments that have been layered into AHN's baseline financial forecast. These investments will allow AHN to deliver high quality care within the region at critical access points and are projected to generate incremental patient volumes for AHN, primarily through improved access for HM customers post-Consent Decree(s).

REVENUE

AHN's revenue improvement over the forecast period is primarily driven by the higher projected volumes, near-term improvement in revenue cycle operations, and contracted annual increases from commercial and government payers, and reflect the optimization of quality incentive payments and fee schedule reimbursements. Net patient service revenue (NPSR) improves by 6.8% in 2017 and 5.1% in 2018, with an increase of 14.6% seen in 2019 correlating to the increase in inpatient discharges (10.7% growth) and outpatient registrations (13.1% growth) seen in 2019. In 2020, the NPSR levels off at a 4% increase in line with 2020 volume projections.

Payer rates and inflationary adjustments have been modeled in the financial forecast. Government payer rates reflect anticipated rate changes to the Medicare program resulting from coding and a two-midnight rule adjustment. Revenue enhancements from improved revenue cycle operations have been built into the financial forecast.

AHN recognizes that a change in the way Medicare reimbursements are calculated will occur through MACRA, but at this point is not positioned to forecast these impacts given the uncertainty of the legislation's implementation guidance.

EXPENSES

AHN's operating expenses are held to minimal per unit growth levels throughout the forecast period in order to leverage the established physician base and fixed cost structure. Overall, operating expense increases 5.7% in 2017 and 3.5% in 2018, largely correlating with patient volume growth. An operating expense increase of 10.6% is projected in 2019 to account for the ramp up in projected patient volumes. As incremental volumes transition to AHN in 2019, AHN projects to maintain the same fixed cost structure, lowering the cost per case. In 2020, operating expense levels out with a 3.4% increase in line with volume projections.

DIVERSIFIED BUSINESSES

Diversified businesses continue to be an important part of AHN's longer term growth strategy which includes growth in diversified revenue streams from related business platforms. Currently, AHN diversified businesses include durable medical equipment, home health and hospice, infusion therapy and rehabilitation businesses and its group purchasing organization. AHN expects to increase market share for patients requiring these services as the focus on the continuum increases its emphasis on post-acute care services. At the same time, AHN expects to realize efficiencies in the diversified business operating structure which it expects will contribute to improved operating margins. AHN continues to evaluate opportunities to diversify its business operations. In some cases, these diversified businesses are structured as joint ventures and the minority interest is recorded as a non-operating expense.

NON-OPERATING ACTIVITIES

Non-operating activities primarily include interest expense, investment income and other income or expenses associated with AHN's joint venture investments.

Interest expense increases as a result of projected rising interest rates. Investment results are projected to increase slightly each year over the projection period as a result of the expected increase in interest rates and accompanying improvement in liquidity and investment balances.

Balance Sheet and Assumptions

(Dollars in Millions)	Dec-16	Dec-17	Dec-18	Dec-19	Dec-20
ASSETS					
Cash & Investments	$ 498	$ 560	$ 586	$ 665	$ 797
Receivables	364	378	384	434	450
PPE, Net	1,099	1,211	1,393	1,453	1,423
Goodwill and other intangible assets, net	115	113	110	108	106
Other Assets	590	587	650	655	658
TOTAL ASSETS	**$ 2,666**	**$ 2,849**	**$ 3,123**	**$ 3,315**	**$ 3,434**
LIABILITIES & NET ASSETS					
Debt	$ 1,417	$ 907	$ 920	$ 920	$ 920
Other Liabilities	1,010	972	925	922	897
Total Liabilities	2,427	1,879	1,845	1,842	1,817
Total Net Assets	239	970	1,278	1,473	1,617
TOTAL LIABILITIES & NET ASSETS	**$ 2,666**	**$ 2,849**	**$ 3,123**	**$ 3,315**	**$ 3,434**

Capital Expenditures. Projected capital spend has been estimated by facility by year projected at $942 million through 2020. These capital needs were estimated based on a clinical and operational assessment of asset age and condition during 2016 within the context of strategic investment priorities. The timing of the projected capital spend by year could be impacted by changes in operational priorities and by various constraints, including but not limited to regulatory, vendor/procurement timeframes or other capacity-related constraints.

Debt. Projected debt declines from 2016 to 2017 due to the forgiveness of debt from HM as previously discussed.

Additional balance sheet indicators were reflected previously in the Plan.

Cash Flow Statement and Assumptions

A condensed summary of the projected 2016-2020 cash flow statements and key assumptions follow:

In millions	2016	2017	2018	2019	2020
Cash Flow from Operating Activities:	64	28	77	194	239
Cash Flow from Investing Activities:	(147)	(282)	(387)	(262)	(236)
Cash Flow from Financing Activities:	111	260	316	87	4
Net Increase in Cash and Cash Equivalents	28	6	5	19	7
Beginning Cash and Cash Equivalents	138	166	172	177	196
Ending Cash and Cash Equivalents	166	172	177	196	203

Cash flow from operations is projected to increase each year in the projection period 2017-2020, as noted above, based on projected improvement in operating results, EBITDA and volumes across AHN, particularly in 2019 and 2020 following the expiration of the Consent Decree(s).

Cash flow from investing activities represents a significant outflow each year of the projection period based on the significant level of capital investment being made in the system in both core capital infrastructure as well as strategic investments in key service lines and service areas.

Cash flow from financing activities is higher in 2017 and 2018 due primarily to projected capital transfers from both HM and HH to provide support for the ongoing capital infrastructure and strategic initiatives as AHN continues its turnaround. The level of capital transfers declines in 2019 with no capital transfers required in 2020.

KEY OPPORTUNITIES, RISKS, AND MITIGATION STRATEGIES

AHN assessed potential opportunities and risks to the financial forecast, and looked at factors that could have a material effect on the forecast and also contemplated a number of mitigation strategies, including the development of investment and action scenarios for different levels of volume and providing for flexibility in the investment structures.

CONCLUSION

In summary, as described in this Plan, HH, AHN and HM have made steady and significant progress since the formation of AHN to stabilize and strengthen the AHN system and to deliver on their collective promise to create a customer-focused, value-based IDFS that works for everyone – that ensures that the residents of WPA, including the many HM customers in the region, will continue to have access to a competitive, innovative, high quality health care system that provides a choice of providers and delivers care affordably. As demonstrated by this Plan, HH, AHN and HM have the leadership, the roadmap to the future, and the financial strength and stability to execute on their shared vision, and they remain firmly committed to re-configuring the health care model to one that delivers differentiated value across the full spectrum of health care needs – a model that, put simply, is focused on *getting health care right* – and they intend to do just that.

EXHIBIT G

This video exhibit is accessible at:
https://wdrv.it/39aa0b6df

EXHIBIT H

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IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA, By KATHLEEN G. KANE, Attorney General; PENNSYLVANIA INSURANCE DEPARTMENT; and PENNSYLVANIA DEPARTMENT 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

Brief in Support of the Commonwealth's Petition to Enforce Consent Decrees

On July 1, 2015, the Court approved two separate Consent Decrees between the Commonwealth and Highmark and the Commonwealth and UPMC. The acrimony that led to the entry of the two-separate Consent Decrees and the need for Consent Decrees at all has been discussed in previous hearings. That acrimony continues and is at the core of the current dispute.

The Consent Decrees require that:

> "Vulnerable Populations – UPMC and Highmark mutually agree that vulnerable populations include (i) consumers age 65 or older who are eligible to be covered by Medicare, Medicare Advantage … with respect to Highmark vulnerable populations, UPMC shall continue to contract with Highmark at in-network rates for all of its hospital, physician and continuity of care services …" Consent Decree at ¶ IV A2.

> "In-Network" means where a Health Care Provider has contracted with a Health Plan to provide specified services for reimbursement at a negotiated rate to treat the Health Plan's members. The member shall be charged no more than the co-pay, co-insurance or deductible charged by his or her Health Plan, the member shall not be refused treatment for the specified services in the contract based on his or her Health Plan and the negotiated rate paid under the contract by the Health Plan and the member shall be payment in full for the specified services. Consent Decrees at ¶ 11 J.

The Consent Decrees expire five years after their entry, Consent Decrees at ¶ IV C (9). Thus, the plain meaning of the Consent Decrees is that Highmark and UPMC must be in contract with each other for Highmark's Medicare Advantage Plans[1] through June 30, 2019, five years from the date of entry of the decrees.

Two factors complicate what should otherwise be a simple proposition. First, the federal Centers for Medicaid and Medicare Services ("CMS") mandate that Medicare Advantage plans provide coverage for a full calendar year. For most Medicare eligible consumers, these plans are chosen during the period of October 15 through December 7. The plans chosen during that time cover the period of January 1 to December 31 of the following year.

[1] This Court earlier ruled that Highmark could offer some Medicare Advantage Plans that did not include UPMC. See Court's October 30, 2014, Order.

The second complicating factor is UPMC and Highmark's Medicare Advantage contract. That contract also has a one-year renewal period and there is not a provision for a six-month renewal period.[2]

I. THE CONSENT DECREES DEFINE IN-NETWORK AS "WHERE A HEALTH CARE PROVIDER HAS CONTRACTED WITH A HEALTH PLAN …"

A plain reading of the Consent Decrees is that for the term of the Decrees, Highmark and UPMC must have a contract for Medicare Advantage products. UPMC would like to terminate its Highmark Medicare Advantage Contract (represented by Exhibit 1, original 1999 contract and Exhibit 2, 2002 Amendment) effective December 31, 2018. UPMC sees no problem here because its contract with Highmark has a "run out" clause, which takes effect for six months after the contract is terminated. That clause states that the Provider shall provide service and it shall accept the rates applicable on the dates of termination.

The actual contract between UPMC and Highmark lists 24 obligations of UPMC as a provider, some of which are beyond the scope of providing services and

[2] There is a six-month "run out" clause which states: In the event of termination of this Agreement for any reason other than default by Provider, the Provider shall be obligated to continue to comply with the terms and conditions of this Agreement and continue to provide services to Health Plan's Members for six (6) months after the date on which the termination becomes effective. For services rendered during this six (6) month period, Provider shall accept Health Plan's payment rates in effect on the termination date. ¶ 16.3. Amendment to Medicare Acute Care Provider Agreement dated January 4, 2002. Attached as Exhibit 2.

accepting payment. See Exhibit 1. ¶ 3.1.1 – 3.3, p. 5. Highmark's obligations to UPMC are similarly detailed. Given the parties past history, the Commonwealth does not accept the "run out" clause and a contract are the same thing.

II. THE SIMPLE SOLUTION IS FOR THE COURT TO ORDER HIGHMARK AND UPMC TO AGREE TO A CONTRACT

UPMC and Highmark need to have a contract for the first six months of 2019. There are two routes to achieving that goal. One route is to order the parties to negotiate a six-month contract and failing their ability to do that, the parties would utilize the contract resolution provision of the Consent Decree. See Consent Decree ¶ IV(C) (1). The alternative is to use the existing contract and extend the contract for a year. This latter route is less confusing to consumers, but UPMC objects because of the potential that Highmark will use the extension to remain in-network until June 30, 2020. UPMC's concern is that Highmark would use the same "run out" clause that Highmark now says does not represent a contract to represent a contract for the first half of 2020.[3]

Both UPMC and Highmark changed positons throughout the life of the Consent Decrees. For Example, having a Medicare Advantage Contract with UPMC was very

[3] UPMC and Highmark having a contract for Medicare Advantage or any other product is not illegal, adverse to the public interest, or inconsistent with their respective charitable missions. So UPMC's concern about the contract being extended is purely an issue of self-interest.

important to Highmark. Medicare Advantage is referenced in the Vulnerable Populations definition of the Decrees. ¶IV A. 2. Then within a couple months of entry of the decree, Highmark created a Medicare Advantage plan without UPMC in its network.

UPMC has also maintained in a letter dated October 27, 2014, mailed to seniors that it would serve seniors with Highmark Medicare Advantage plans. See Exhibit 3. Now UPMC states that it will not contract with Highmark at all after June 30, 2019.

More recently, Highmark and UPMC were unable, without the intervention of the Office of Attorney General, to arrange for payment for a patient needing lung surgery, even though Highmark agreed to cover the surgery and UPMC agreed to accept payment. See Affidavit of Carrie Wilson.

These instances suggest that a contract, which is terminated, but running out will not be free of controversy. The Court should take into account the prior conduct of the parties and order the parties to have a contract.

Past conduct is probative of how the parties will behave in the future and may be a basis for an injunction. See, Commonwealth v. Percadani, 844 A.2d 35, 45-46 (Pa. Commw. 2004) (Past conduct can form a basis for future injunction.)

This Court's May 27, 2015 Order reflects the need to insure that the parties actually comply with the Consent Decree.

III. CMS REGULATIONS DO NOT RESOLVE THE ISSUES PRESENTED BY THE COMMONWEALTH'S PETITION

CMS regulates Medicare Advantage Plans in a number of ways. The ones relevant here deal with the scope of Highmark's network if UPMC is not in its network and the representations that Medicare Advantage Plans make to consumers. As noted in the Commonwealth's Petition, CMS requires a Medicare Advantage Organization to have enough providers to meet Medicare's geo-access requirements and if it loses providers mid-year, it may be required to add new providers to its network.

The geo-access requirements set forth in Medicare Advantage Network Adequacy Criteria Guidance (last updated January 10, 2017) available at https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf.

In general, CMS requires Medicare Advantage Organizations to meet network adequacy requirements for 35 medical specialties and 27 types of facilities. Id. at Appendices D & E. The network adequacy requirements vary by county type and specialty. See Id. At pp. 6-12. CMS does not provide advisory or hypothetical opinions.

The Commonwealth cannot answer the question of what CMS would do in the event of a termination of the Highmark/UPMC contract in the middle of the 2019 calendar year.

As the Commonwealth notes in its petition, almost 700,000 seniors live in Western Pennsylvania, half a million of them choose Medicare Advantage plans, and Highmark is the largest MAO with more than 170,000 members. Also the rate at which seniors switch plans is very low. Petition at ¶¶ 27 to 31.

Seniors are likely to face significant harm in the form of out-of-network charges if UPMC and Highmark do not comply with the Consent Decrees.

Given UPMC's and Highmark's history with each other, the Commonwealth requests that the Court enter an Order that: UPMC not terminate the existing contract for the calendar year 2019 and also prohibit Highmark from representing that UPMC is in-network for any part of 2020 based on the "run out clause" ¶ 16.3 of UPMC's and Highmark's Amended Medicare Advantage contract; or UPMC and Highmark negotiate a contract for the period of January 1, 2019 to June 30, 2019.

For these reason, the Commonwealth's Petition should be granted.

Respectfully Submitted

COMMONWEALTH OF PENNSYLVANIA

JOSH SHAPIRO
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Date: November 20, 2017 By: /s/James A. Donahue, III

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EXHIBIT I

pennsylvania
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Suite 500
Harrisburg, PA 17101-1357

Re: Request for Modification of Certain Conditions of the Pennsylvania Insurance Department's Approving Determination and Order dated April 29, 2013 (Order No. ID-RC-13-06) (the "2013 Order")[1]

Dear Mr. Stover:

On March 27, 2017, Highmark Health ("Highmark Health") filed with the Pennsylvania Insurance Department (the "Department") a Request for Modification seeking, *inter alia*, certain changes to Conditions 10 and 11 of the 2013 Order (the "Request for Modification").

Having reviewed the Request for Modification, the information provided by or on behalf of Highmark Health in response to questions from the Department and its consultants, as well as the comments from the public and others, the Pennsylvania Insurance Commissioner (the "Commissioner") pursuant to Section 27 of the 2013 Order hereby grants relief to Highmark Inc. ("Highmark") by agreeing to modify Conditions 10 and 11, and certain other Conditions and provisions of the 2013 Order, as provided herein. This decision of the Commissioner is being made in reliance upon Highmark Health's assurances that the information provided by or on behalf of Highmark Health in connection with the Request for Modification is true, accurate and complete.

SECTION I. BACKGROUND

On April 29, 2013, the Commissioner approved the application of UPE (now known as Highmark Health), which was submitted to the Department to acquire control of Highmark and various subsidiaries thereof as identified in the Form A relating thereto (the "Change of Control"), subject to certain conditions as set forth in the 2013 Order (the "Conditions"). The Department found that with the imposition of the Conditions, the Change of Control would not violate Section 1402 of the Insurance Holding Company Act.

[1] Any capitalized terms not defined in this letter shall have the same meaning ascribed to them in both the 2013 Order and Appendix 1 (Definitions) to the 2013 Order.

A. Pertinent Provisions of the 2013 Order Regarding Donations (Condition 10) or Financial Commitments (Condition 11).

Among other things, the 2013 Order imposes Conditions on Highmark and its other Domestic Insurers to notify or seek approval from the Department before Highmark or any other Domestic Insurer makes certain Donations or Financial Commitments. Specifically, Condition 10 currently states:

> 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.

As to Financial Commitments, Condition 11 currently states:

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.

B. Pertinent Definitions Set Forth in the 2013 Order.

The term "Donation" is defined in Appendix 1 (Definitions) of the 2013 Order, as follows:

"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 [Highmark Health] Entity to any other UPE [Highmark Health] 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."

The term Financial Commitment is defined in Appendix 1 (Definitions) of the 2013 Order as follows:

> "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 [Highmark Health] 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.

C. <u>The Department's June 19, 2015 Approval of $175 million Financial Commitment.</u>

On June 19, 2015, the Department approved a Financial Commitment in the form of a grant or grants up to a total of $175 million pursuant to Conditions 10 and 11(C) of the 2013

Order (the "June 19, 2015 Approval Letter"). Condition F of the June 19, 2015 Approval Letter ("Condition F") states:

> F. Simultaneously with the submission to the Department pursuant to the 2013 Order of any notice or request to approve any future Financial Commitment which, individually or in a series of one or more related transactions, exceeds $100 million, Highmark shall provide to the Department, in addition to all other information required or requested by the Department, a calculation of the affect or impact of the proposed Financial Commitment on the RBC of Highmark and any other Domestic Insurers proposing to make the Financial Commitment and a "downside" or "stress" analysis of such effect on the RBC of Highmark and such other Domestic Insurers. Highmark shall provide such calculations for the current calendar year in the manner requested by the Department based upon commercially reasonable assumptions. Highmark shall promptly and fully respond to questions or requests of the Department for information in connection with such notice and shall promptly update such projections, if any of the projected effects differ in any material respect.

SECTION II. SUMMARY OF THE REQUEST FOR MODIFICATION

A. Highmark Health's Requested Modifications to Conditions 10 and 11.

Pursuant to the Request for Modification, Highmark Health requests approval of the Commissioner to amend Condition 10, such that Condition 10 would be deleted in its entirety. Regarding Condition 11, Highmark Health seeks to: (i) re-number Condition 11 so it would be titled "Condition 10/11"; (ii) provide that the Domestic Insurer proposing to make a Financial Commitment would have no obligation to deliver advance notice to the Department of any Financial Commitment; (iii) add to Condition 11(C) the current exclusion contained in Condition 10 providing that no Approval of the Department is required under Condition 11 if Department approval for the Financial Commitment has been obtained under 40 P.S. § 991.1405; and (iv) provide that the only requirement for Department Approval of a Financial Commitment would be if Highmark's RBC Rating is, or as a result of the Financial Commitment is likely to be, 525% or below.

Specifically, in the Request for Modification, Highmark Health proposes that Condition 11 be modified to read in its entirety as follows:

> 10/11. 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 Department Approval.** Without the Approval of the Department, no Domestic Insurer shall make or agree, directly or indirectly, to make any Financial Commitment if the RBC Rating of Highmark is, or as a result of the Financial Commitment is likely to be, 525% or below. This Condition 10/1 1(B) shall not apply to a Donation made by a Domestic Insurer that is a direct or indirect subsidiary of Highmark to Highmark or any other 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.

C. **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.

Lastly, the Request for Modification asks that Condition F of the June 19, 2015 Approval Letter be deleted.

B. Highmark Health's Stated Bases for the Request for Modification.

Highmark Health asserts that it is filing the Request for Modification in response to significant market changes; and, also, against the backdrop of substantial progress which has been made over the past four years in the development of Allegheny Health Network ("AHN")

and Highmark Health's integrated delivery and financing system (the "IDFS"), as set forth in more detail in the Allegheny Health Network Strategic and Financial Plan, 2017-2020 (the "AHN Strategic and Financial Plan").

In the Request for Modification, Highmark Health acknowledges that, when the Department issued its Order in 2013, it imposed certain conditions that were designed 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. However, Highmark asserts that Conditions 10 and 11, which were ". . .imposed when the IDFS was new and untested - will have precisely the opposite effects in the current competitive environment if they continue in place unmodified." Highmark then asserts that "[w]ith the rapid pace of change in the industry and the Consent Decree(s)[2] coming to an end, and as new and unpredictable events shape competition in other parts of the Highmark Health footprint, Highmark Health, Highmark and AHN need to be relieved of constraints which unnecessarily inhibit or burden their ability to freely compete." Request for Modification at 9.[3]

The Request for Modification does not describe any specific transactions or opportunities which Conditions 10 and 11 have prevented Highmark Health or its affiliates from pursuing.

SECTION III. THE DEPARTMENT'S REVIEW OF THE REQUEST FOR MODIFICATION

Upon receipt of the Request for Modification, the Department requested its consultants, including Raymond James & Associates, Inc. ("Raymond James") and Compass Lexecon ("Compass Lexecon"), to undertake a detailed review of the relief sought by Highmark Health. As the Department's financial consultant, Raymond James focused on the financial status and progress of AHN and more generally, Highmark Health, over the past four years. Compass Lexecon was asked to conduct an updated review of the state of competition in the Western Pennsylvania insurance market and the progress that has been made over the past four years in the development of AHN and the IDFS.

In evaluating the Request for Modification, the Department considers the effect of the Request for Modification on the underlying purposes of the 2013 Order, namely "to preserve and

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[2] "Consent Decrees" refers to the two *(2)* Consent Decrees entered on June 27, 2014, one of which is between the Commonwealth and UPMC and the other of which is between the Commonwealth and Highmark, in Case No. 334 M.D. 2014 before the Commonwealth Court of Pennsylvania. As a result, UPMC and Highmark agreed that the UPMC/Highmark contracts for the following UPMC hospitals will expire on December 31, 2019: UPMC Altoona, UPMC Bedford, UPMC Hamot and its affiliate, Kane Community Hospital, UPMC Horizon and UPMC Northwest; that the contract for Hillman Cancer Center will expire on June 27, 2019; that the contract for UPMC Mercy will expire on June 30, 2019; and that the contract for Children's Hospital of Pittsburgh of UPMC will expire on June 30, 2022.

[3] The Department acknowledges that this is the asserted position of Highmark Health and does not constitute conclusions of the Department.

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. . . ."

A. Analysis of Competitive Conditions in the Western Pennsylvania Health Care Market.

As mentioned above, at the request of the Department, Compass Lexecon undertook a review of the changes in the competitive conditions in the Western Pennsylvania health care market which consists of the following twenty-nine (29) counties: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Centre, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington, and Westmoreland (collectively the "WPA Area" or "WPA"). *See* "Assessment of Healthcare Competition Following Highmark Inc.'s Affiliation with West Penn Allegheny Health System, Inc. and other Healthcare Providers" prepared by Compass Lexecon for the Department, dated July 2017 (the "Compass Lexecon July 2017 Competitive Assessment").[4]

Among other things, Compass Lexecon concluded that:

1. Since the issuance of the 2013 Order, Highmark has made strategic investments in AHN's infrastructure and operations to improve quality of care and expand access of the care delivered. *See* Compass Lexecon's July 2017 Competitive Assessment at p. 46. Due to these investments, AHN hospitals and outpatient facilities have improved their ability to compete and attract patients, thus making AHN a more effective competitor in delivering healthcare services to residents of the WPA Area. *Id.* at 26. Furthermore, Compass Lexecon's analysis indicates that patients now view AHN as a more effective substitute to competitor hospitals now as compared to 2012. *Id.* at 49.

2. "Highmark has been able to compete successfully in maintaining and attracting new members with its narrow network products. . ." and Highmark "appears to be developing new and innovative network products to use in competing for members." July 2017 Competitive Assessment at p. 54.

3. "Our analysis of actual discharges and outpatient visits by Highmark members during this transition period indicates that the Transition Plan has achieved its purpose in minimizing disruption to consumers and ensuring quality access to care for Highmark members. Our analysis finds a decreasing reliance over time on Highmark members accessing UPMC facilities and a shift to in-network options at AHN and in-network community partners. Table 15 shows that as of the first three quarters of 2016, non-UPMC hospitals captured 73% of Highmark member discharges in the WPA. By comparison, only 33% of UPMC enrollees were

[4] Compass Lexecon prepared both a public and confidential version of its July 2017 Competitive Assessment. The public version of the report is available on the Department's website at http://www.insurance.pa.gov/Companies/IndustryActivity/CorporateTransactionsofPublicInterest/HighmarkWestPennAlleghenyHealthSystem/Documents/Compass%20Lexecon%20Public%20Assessment%20of%20Healthcare%20Competition%20in%20WPA%20July%202017.pdf

discharged from a non-UPMC hospital." *See* Compass Lexecon's July 2017 Competitive Assessment at p. 36.

4. "As a result of its affiliation with Highmark, AHN is now a more effective competitor in delivering healthcare services to residents of Western Pennsylvania. AHN has made significant investment in AHN's infrastructure and operations to improve quality of care and the efficiencies of its operations. In addition, because of AHN's long-troubled financial situation, the capital investments that Highmark has funded not only have improved facilities relative to what otherwise had been the case, but also have expanded both access to care and the quality of care delivered." Compass Lexecon's July 2017 Competitive Assessment at pp. 46-47.

5. Despite the progress that AHN has made since the affiliation with Highmark, while the Conditions of the 2013 Order have not significantly impacted Highmark's ability to compete as an insurer in the WPA market, "Highmark has had a net loss of membership to its competitors" since implementation of the 2013 Order. Compass Lexecon's July 2017 Competitive Assessment at p. at 45.

6. In addition to observing that Highmark has suffered a loss of membership, Compass Lexecon acknowledges that, in certain instances, Highmark and AHN may not have had the benefit of a level playing field because such Conditions are not placed on its competitors. Specifically, Compass Lexecon concluded:

> Highmark has been subject to the 2013 Order's competitive conditions for over three years. Our competitive assessment indicates that these competitive conditions have not placed Highmark at a competitive disadvantage. In our view, Highmark legitimately asserts that, *imposing these conditions on Highmark and AHN without also imposing the same competitive and consumer choice conditions on its rivals does not ensure a level playing field in competing for insureds or patients.*
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> Compass Lexecon's July 2017 Competitive Assessment at p. 53 (emphasis added).

B. Public Notice and Comment Period.

In addition to the review of the Request for Modification by its consultants, the Department sought comments from the public and others. On April 8, 2017, the Department published in the Pennsylvania Bulletin, 47 Pa.B. 2161, a public notice that Highmark Health had filed the Request for Modification (the "Public Notice") as permitted by Condition 27 of the 2013 Order and the AHN Strategic Plan under Condition H of the June 19 Approval.

In the Public Notice, the Department advised that the Request for Modification and AHN Strategic Plan materials were filed with the Department on March 27, 2017, and were available on the Department's web site at www.insurance.pa.gov. Persons wishing to comment

on the Request for Modification, on the grounds of public or private interest, were invited to submit a written statement to the Department on or before April 24, 2017 and direct their comments to Joseph DiMemmo, Deputy, Office of Corporate and Financial Regulation, Insurance Department, 1345 Strawberry Square, Harrisburg, PA 17120, fax (717) 787-8557.

The public comment period closed on May 8, 2017. Comments were received from residents of the WPA Area and other interested parties including the Insurance Federation of Pennsylvania and the United Steelworkers Union. The overwhelming majority of comments received by the Department were in support of the Request for Modification. Specifically, a total of twenty-three (23) written comments were submitted, of which twenty-one (21) were in favor of the Request for Modification and only two (2) comments opposed or otherwise did not support the proposed modifications.

C. Conclusions of the Commissioner.

Pursuant to Condition 27, the Commissioner has the authority to modify the 2013 Order in whole or in part upon written request of a Highmark Health Entity. Specifically, Condition 27 provides as follows:

> 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 deem appropriate.

In considering whether to exercise her sole discretion to grant relief under Condition 27, the Commissioner has considered a number of factors, including:

1. The Commissioner has taken into consideration the conclusion of Compass Lexecon, as highlighted in its report, that, "[a]s a result of its affiliation with Highmark, AHN is now a more effective competitor in delivering healthcare services to residents of Western Pennsylvania." See Compass Lexecon's July 2017 Competitive Assessment at p. 46.

2. By being "a more effective competitor," AHN has expanded both access to care and the quality of care delivered. Compass Lexecon's July 2017 Competitive Assessment at p. 46. AHN's expansion of access to quality care is consistent with one of the objectives of the 2013 Order "to maximize market-based access opportunities."

3. Compass Lexecon observes that ". . .imposing these conditions on Highmark and AHN without also imposing the same competitive and consumer choice conditions on its rivals does not ensure a level playing field in competing for insureds or

patients." See Compass Lexecon's July 2017 Competitive Assessment at p. 53.

4. The Commissioner also consider the perceived need to have a "level playing field" referred to on p. 53 of Compass Lexecon's July 2017 Competitive Assessment and in various public comments that addressed Highmark's treatment as compared to its competitors. The benchmark for appropriate regulation, generally, must be whether Highmark is held to the same standard as other health insurance companies that are similarly situated in terms of corporate structure.

5. However, the health insurance market is dynamic and continues to change especially in light of the fact that the Consent Decrees are scheduled to come to an end. This and other circumstances will present, as Highmark Health observes, "new and unpredictable events" for Highmark and Highmark must continue to be able to respond to an ever-changing insurance and healthcare market as well as unforeseen challenges that may present themselves following the expiration of the Consent Decrees.

6. Also considered by the Commissioner was the strong public support in favor of the Request for Modification and the objectives of the 2013 Order, which include the preservation and promotion of competition in the Commonwealth of Pennsylvania and the protection of the public interest.

Based on the consideration of these factors, the Department's review of the Request for Modification, the information provided by or on behalf of Highmark Health in response to questions of the Department and its consultants, and the comments of the public, the Department's consultants and others, the Commissioner pursuant to Condition 27 of the 2013 Order hereby grants partial relief to Highmark by agreeing to modify Conditions 10 and 11 as set forth below. In addition, in order to grant relief with respect to Conditions 10 and 11, the Commissioner finds that it is necessary to modify certain other Conditions and provisions of the 2013 Order as set forth below.

Effective as of July 28, 2017 (the "Effective Date"), each of the following Conditions and definitions of the 2013 Order is modified as follows:

A. Technical modification to entity names throughout the 2013 Order.

1. Every place in the 2013 Order where the entity "UPE" is mentioned, that reference is hereby modified to read "Highmark Health."

2. Every place in the 2013 Order where the entity "UPE Provider Sub" is mentioned, that reference is hereby modified to read "Allegheny Health Network" or "AHN".

B. Modifications to Condition 10 (Limitations on Donations) and Condition 11(Financial Commitment Limitations) and definitions of "Donation" and "Financial Commitment" in Appendix I (Definitions) of the 2013 Order.

Conditions 10 and 11 are amended and restated to read as follows:

Limitations on Donations

10. Effective as of July 28, 2017, Condition 10 is deleted; provided that the Commissioner reserves the right, in the Commissioner's sole discretion, to reinstate Condition 10, in whole or in part, with respect to one or more Domestic Insurers, upon written notice to Highmark.

Financial Commitment Limitations

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

    A. Due Diligence Standard. For all Financial Commitments: (i) the Highmark Health 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 Highmark Health Entity's nonprofit mission, if the Highmark Health 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. Each Highmark Health Entity making or agreeing to make any Financial Commitment shall reasonably document the Commercially Reasonable Process undertaken pursuant to this Condition 11.A., shall provide to the Department upon any filing with the Department pursuant to this Condition 11, or whenever requested by the Department, a summary of the documentation supporting the performance of such Commercially Reasonable Process and shall provide such further information as requested by Department.

Documentation evidencing such Commercially Reasonable Process shall be retained by the Highmark Health Entity for five (5) years after making the Financial Commitment to which the Commercially Reasonable Process relates.

B. Transactions to or with Highmark Health Entities. Without the Approval of the Department, no Domestic Insurer shall, directly or indirectly, make or agree to make: (i) any Financial Commitment to or with any Highmark Health Entity if in the calendar year commencing January 1, 2017, or in any subsequent calendar year after December 31, 2017, either (A) the amount thereof, together with all other Financial Commitments made or agreed to be made directly or indirectly by all of the Domestic Insurers to or with any Highmark Health Entity in such calendar year, equals or exceeds ten percent (10%) of Highmark's surplus as regards to policyholders as shown on its last annual statement on file with the Department; or (B) the RBC Rating of Highmark is, or as a result of the Financial Commitment is likely to be, 525% or below; or (ii) any Financial Commitment in the form or substance of a Loan to any Highmark Health Entity (other than Highmark or any direct or indirect subsidiary of Highmark) if at any time on or after January 1, 2017 the amount thereof, together with all other Financial Commitments in the form or substance of a Loan made or agreed to be made directly or indirectly by all of the Domestic Insurers to or with any Highmark Health Entity (other than Highmark or any direct or indirect subsidiary of Highmark) from or after January 1, 2017, reduced by any amount of principal repayments made with respect to such Loans, exceeds an aggregate amount of $200,000,000 or more. The calculation of the RBC Rating of Highmark for the purposes of this Condition 11.B. shall be made as provided in Condition 11.E. The calculation of the amount of the Financial Commitment shall be made as provided in Condition 11.F.

C. Transactions to or with any Person other than Highmark Health Entities. Without the Approval of the Department, no Domestic Insurer, directly or indirectly, shall make or agree to make any Financial Commitment to or with any Person other than a Highmark Health Entity in the calendar year commencing January 1, 2017, or any subsequent calendar year after December 31, 2017, if the RBC Rating of Highmark is, or as a result of the Financial Commitment is likely to be, 525% or below. The calculation of the RBC Rating of Highmark for the purposes of this Condition 11.C. shall be made as provided in Condition 11.E. The calculation of the amount of the Financial Commitment shall be made as provided in Condition 11.F.

D. Calculation of Financial Commitment Limitations. If a Financial Commitment is made by a Domestic Insurer to a Highmark Health Entity and such Highmark Health Entity further makes a Financial Commitment to a Person other than a Highmark Health Entity, the Financial Commitment made by the Domestic Insurer to the Highmark Health Entity and by the Highmark Health Entity to the Person other than a Highmark Health Entity shall not be aggregated, but for the purposes of this Condition 11, such Financial Commitment made to the Highmark Health Entity shall be subject to the requirements of Condition 11.B.

E. RBC Rating Calculation; Reports to the Department.

(1) The calculation of the RBC Rating of Highmark to determine if the RBC Rating of Highmark is, or as a result of a Financial Commitment is likely to be, 525% or below shall be based upon the last annual statement of Highmark on file with the Department, adjusted for the impact of the proposed Financial Commitment and the most recently available information or data as shown in the latest

Quarterly RBC Report filed pursuant to Condition 11.E.(3).

(2) Simultaneously with the submission to the Department of any request to approve any Financial Commitment pursuant this Condition 11, Highmark shall provide to the Department, in addition to all other information required or requested by the Department: (i) a calculation of the effect or impact of the proposed Financial Commitment on the RBC Rating of Highmark (determined as provided in Condition 11.E.(1)); (ii) a "downside" or "stress" analysis of such effect on the RBC Rating of Highmark; and (iii) a calculation of the effect or impact of the proposed Financial Commitment on the RBC Rating of Highmark based upon the last annual statement of Highmark on file with the Department prior to the applicable Financial Commitment.

(3) Highmark shall provide to the Department on a quarterly basis a report (the "Quarterly RBC Report"), in form and substance acceptable to the Department, that includes calculations of the RBC Rating of Highmark (i) based upon the last annual statement of Highmark on file with the Department, adjusted for the most recently available information or data as of the end of the quarter to which such Quarterly RBC Report relates; and (ii) based upon the last annual statement of Highmark on file with the Department. Along with the Quarterly RBC Report, Highmark shall provide the Department with all supporting documentation used to arrive at its estimates of the RBC Rating of Highmark, including but not limited to, any models, analyses or other supporting documentation used in estimating the effect of a potential transaction on the RBC Rating of Highmark.

F. Financial Commitment Calculation.

(1) In determining the amount of a Financial Commitment in any applicable calendar year, the Financial Commitment shall be deemed to occur upon the date on which the Financial Commitment (or the portion thereof) is required be reflected in the financial statements of the Domestic Insurer in accordance with statutory accounting principles.

(2) The amount of the Financial Commitment for an applicable calendar year shall be all or that portion of the Financial Commitment that meets the test provided in Condition 11.F.(1) above; provided that if less than the entire amount of the Financial Commitment satisfies the test in Condition 11.F.(1) above, the remaining portion of the Financial Commitment shall be deemed to be a Financial Commitment once such remaining portion is required to be reflected in the financial statements of the Domestic Insurer in accordance with statutory accounting principles.

(3) Notwithstanding any other provision of this Approving Determination and Order, with respect to any Financial Commitment relating to any guaranty or surety arrangement, the amount of the Financial Commitment for a calendar year with respect to that guaranty or surety arrangement shall be equal to the maximum amount of the guaranty or surety as set forth in or determined by the applicable instrument or agreement of guaranty or surety (or any other documents relating thereto), if the obligations under such guaranty or surety at issuance or any time thereafter are collateralized, or required (whether immediately or upon the occurrence of any events or conditions) to be collateralized,

directly or indirectly, by any assets or properties of any Domestic Insurer; provided that the foregoing shall not apply to any existing guaranty of a Domestic Insurer or to any extension of such guaranty hereafter entered into or agreed upon, if any such extension arrangement is acceptable to the Department in form and substance.

G. Application to Certain Transactions.

(1) Condition 11.B. shall not apply to Highmark's forgiveness of any indebtedness owed to it as of July 31, 2017 by Highmark Health and/or AHN and/or subsidiaries of Highmark Health or any alternative repayment method of such indebtedness acceptable to the Department in form and substance. This indebtedness, as of July 31, 2017, is estimated to be approximately $500,000,000 owed by AHN to Highmark and the $200,000,000 owed by Highmark Health to Highmark (collectively the "$700,000,000 Debt").

(2) No later than thirty (30) days after the RBC Rating of Highmark exceeds 650% as reflected in a Quarterly RBC Report required to be submitted to the Department pursuant to Condition 11.E.(3), Highmark shall forgive for statutory accounting purposes (or finalize an alternative repayment method acceptable to the Department in form and substance with respect to) the $700,000,000 Debt. Any time after November 30, 2019, the Department may require Highmark to forgive for statutory accounting purposes (or finalize an alternative repayment method satisfactory to the Department with respect to) the $700,000,000 Debt.

(3) Condition 11.B. shall not apply to: (i) the extension of Highmark's existing guarantee of

the WPAHS term loan dated May 22, 2014 by and between WPAHS and certain lenders; and/or (ii) a successor guarantee by Highmark of such loan, if such extension or successor guaranty is acceptable to the Department in form and substance.

(4) Condition 11.B. shall not apply to a Financial Commitment that is: (i) otherwise in compliance with applicable Pennsylvania law, including but not limited to the Insurance Holding Company Act, which act shall at all times apply to Financial Commitments of Highmark and each direct or indirect subsidiary of Highmark and (ii) either (A) from Highmark to a direct or indirect subsidiary of Highmark; or (B) from a direct or indirect subsidiary of Highmark to Highmark or another direct or indirect subsidiary of Highmark; provided that any Financial Commitment made by a direct or indirect subsidiary of Highmark to any Person other than to Highmark or any other direct or indirect subsidiary of Highmark shall be treated for the purpose of this Condition 11 as if it were a Financial Commitment of Highmark on the date of such Financial Commitment by such direct or indirect subsidiary of Highmark.

H. **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 or any Approval of the Department which otherwise would have been required.

I. **No Limitation on Other Obligations.** Nothing contained in this Approving Determination and Order shall limit or affect the obligations of each Highmark

> Health Entity to comply with applicable law, including without limitation the Insurance Holding Company Act. No Approval of the Department shall be required under this Condition 11 if Department approval for the Financial Commitment has been obtained under 40 P.S. § 991.1405.

The definitions of "Donation" and "Financial Commitment in Appendix I (Definitions) of the 2013 Order are amended and restated to read as follows and a new definition of the word "Loan" is added to the 2013 Order to read as follows:

> "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 Highmark Health Entity to any other Highmark Health 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." For the avoidance of doubt, the term "Donation" shall also include: (i) any dividends, howsoever denominated; and/or (ii) any distribution made to (A) AHN; (B) any direct or indirect subsidiary of AHN; and/or (C) any direct or indirect subsidiary of Highmark Health that is not a wholly-owned direct or indirect subsidiary of Highmark.
>
> * * *
>
> "Financial Commitment" means any direct or indirect payment or transfer of any cash or other property, any Donation as defined herein, 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: (a) any Financial Commitment made in the ordinary and usual course of the Highmark Health Entity's business; or (b) 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 December 31, 2020, a Financial Commitment shall include but is not

limited to (A) any advance payment by a Domestic Insurer to a AHN 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 AHN Entity in excess of amounts to be determined on the basis of a method of calculation to be submitted to the Department by Highmark by September 15, 2017, which method of calculation shall be acceptable to the Department in form and substance; 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.

* * *

"Loan" means any loan, advance or other transfer or conveyance of cash or property from a Person to another Person in which the Person so receiving (or to receive) such cash or property promises to repay all or portion of the amount so received, regardless of whether such amount to be repaid is secured or unsecured, provides for interest or no interest or is evidenced by any agreement, writing, note or other evidence of indebtedness. In determining the amount of the Loan, the amount of the Loan shall equal the principal amount of the Loan plus the aggregate interest that would accrue on the outstanding amount of the Loan over the term thereof in excess of the commercially reasonable rate of interest that would be charged to a similarly situated borrower which is not affiliated with the Person making the Loan.

* * *

The Department is granting this relief based on assurances by Highmark that it is committed to forgiving for statutory accounting purposes (or to finalizing an alternative repayment method satisfactory to the Department with respect to) the approximately $700 million in loans Highmark provided to Highmark Health and AHN.

C. Modifications to Condition 3 (Provider/Insurer Payment Contract Length Limitation).

Condition 3 of the 2013 Order is modified to read as follows:[5]

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

[5] Additions are **underlined in bold;** Deletions are **[~~in brackets, in bold and with strikeout~~]**

all renewal terms) is in excess of five (5) years, without the prior Approval of the Department. No **[~~UPE~~]** **Highmark Health** Entity that is a Health Care **[~~Insurer domiciled in Pennsylvania~~]** **Provider** shall enter into any contract or arrangement with any Health Care **[~~Provider~~]** **Insurer** 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.

D. Modification to Condition 13 (Financial Statements).

Condition 13 of the 2013 Order is modified to include the *de facto* change to Condition 13 by Condition E of the June 19, 2015 Approval Letter, as follows:[6]

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~~]** **Highmark Health** shall file with the Department, as a public record, audited financial statements (including but not limited to all footnotes) of **[~~UPE~~]** **Highmark Health** prepared in accordance with GAAP, for the immediately preceding calendar year. In addition, **[~~UPE~~]** **Highmark Health** shall file with the Department any letters from auditor(s) to management and any other information requested by the Department. **The audited financial statements of Highmark Health that are required to be filed annually pursuant to Condition 13 as a public record shall include a footnote (or disclosure in another manner as required by GAAP) that discloses the balance sheets and income statements of Highmark, AHN and Highmark Health (Parent Only) separately and shall provide consolidating adjustments totaling to the audited consolidated balance sheet and income statement of Highmark Health.**

E. Modification to Condition 14 (WPAHS (now AHN) financial and operational information) of the 2013 Order.

Condition 14 of the 2013 Order is modified by adding a new Condition 14.C., which replaces the *de facto* change to Condition 14 of the 2013 Order by

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[6] Additions are **underlined in bold;** Deletions are **[~~in brackets, in bold and with strikeout~~]**.

Condition D of the June 19, 2015 Approval Letter, as of the Effective Date, to read as follows:[7]

C. Highmark Health shall continue to file quarterly with the Department the Required AHN Financial and Operational Information pursuant to this Condition 14 for each quarter through the period ended December 31, 2020 and thereafter annually on July 1 of each year; provided that the Department may extend the requirement to file the Required AHN Financial and Operational Information quarterly for up to an additional five (5) years if, in the judgment of the Department, such an extension is in the public interest. Highmark Health shall benchmark (the "Benchmark Report") the actual results for each such quarter and annually thereafter against the projections contained in the "Allegheny Health Network Strategic and Financial Plan (2017-2020)" ("AHN Strategic and Financial Plan"), as filed with the Department and as such plan may be updated or extended, if required by the Department pursuant to Condition 15. A public version of the AHN Financial and Operational Information and the Benchmark Report also shall be filed with the Department at the same time as these reports are filed with the Department.

F. Modification to Condition 15 (Relating to the WPAHS Corrective Action Plan) of the 2013 Order.

1. Condition 15 of the 2013 Order was modified by the *de facto* changes in Condition H of the June 19, 2015 Approval Letter ("Condition H"). In response to Condition H, Highmark Health submitted a Preliminary AHN Corrective Action Plan and the Final AHN Corrective Action Plan. Subsequently, the Department permitted Highmark Health to submit the AHN Strategic and Financial Plan[8] as a substitute for the Final AHN Corrective Action Plan.

2. Condition 15 of the 2013 Order is amended to add to the 2013 Order the requirements of Condition H of the June 19, 2015 letter approving grants up to $175 million pursuant to Conditions 10 and 11(C) of the 2013 Order (Condition "H"), so that the text of all changes to Condition 15 will be in one document. However, this change shall not be interpreted to require any additional filing by Highmark Health or AHN under Condition 15 or Condition H, unless the Department imposes on Highmark Health an obligation to update, or extend the period

[7] In this letter, language that is listed as being in entirely new subsections or in amended and restated provisions is not underlined or otherwise noted as new language.

[8] *See* the public version of the AHN Strategic and Financial Plan.
http://www.insurance.pa.gov/Companies/IndustryActivity/CorporateTransactionsofPublicInterest/HighmarkWestPennAlleghenyHealthSystem/Documents/HH_AHN%20Public%20Strategic%20and%20Financial%20Plan%202017-2020.pdf

covered by, the Final AHN Corrective Action Plan or the AHN Strategic and Financial Plan as permitted by Condition 15.C. as set forth below (and as previously permitted by Condition H.(4) with respect to the AHN Corrective Action Plan).

3. Pursuant to the foregoing, Condition 15 of the 2013 Order is modified by adding a new Condition 15.C., which replaces the *de facto* change to Condition 15 by Condition H, as of the Effective Date, to read as follows:

> * * *
>
> C. Highmark Health shall submit to the Department a corrective action plan for AHN and its Affiliates setting forth the information required by this Condition 15.C., together with such information necessary to make such plan full, accurate and complete (the "AHN Corrective Action Plan"). The AHN Corrective Action Plan submitted may be in the form of (i) a confidential and a non-confidential (public) version of the AHN Corrective Action Plan; or (ii) one AHN Corrective Action Plan with appropriate redactions of confidential information; provided, however, that all information so redacted shall be provided to the Department. A preliminary version of the required AHN Corrective Action Plan (the "Preliminary AHN Corrective Action Plan") shall be filed with the Department no later than July 15, 2015 and the final and complete AHN Corrective Action Plan (the "Final AHN Corrective Action Plan")[9] shall be filed with the Department no later than September 30, 2015.
>
> (1) The AHN Corrective Action Plan shall provide, among other items:
>
> (a) A description of the specific steps and investment of funds and changes to AHN and the AHN Entities that have already been taken to carry out or implement the IDN Strategy since the close of the Affiliation Agreement; specifically including: (A) a description of the category of the IDN program changes, projects or investments that have been incurred or implemented (the "Changes Implemented"); (B) the cost thereof; (C) the specific locations at which the Changes Implemented were made; (D) the reason(s) why such changes or investments were required or advisable;

[9] See the public version of the AHN Strategic and Financial Plan.
http://www.insurance.pa.gov/Companies/IndustryActivity/CorporateTransactionsofPublicInterest/HighmarkWestPennAlleghenyHealthSystem/Documents/HH_AHN%20Public%20Strategic%20and%20Financial%20Plan%202017-2020.pdf

(b) The specific results or benefits/cost savings sought to be obtained by the Changes Implemented, including a quantification of value, if available, and comparison of the actual benefits/cost savings obtained to date in comparison to those anticipated as of the date that such Changes Implemented were incurred or implemented;

(c) A description of any steps, initiatives or plans that were proposed, but not implemented, and the reasons for not implementing such plans or proposals;

(d) The specific objectives or goals of all strategies, plans and actions comprising the AHN Corrective Action Plan, including the timeline for the accomplishment of these objections (the "Plan Objectives"); and

(e) Detailed operating and financial projections on a quarterly basis for the period of July 1, 2015 through December 31, 2017 and the following operating and financial projections, together with a description of the assumptions underlying such projections which must be reasonable and likely attainable:

(i) Projected inpatient discharges and outpatient registration volume for each AHN Entity, along with projected occupancy rates and in connection therewith:

(A) Provide written commentary explaining why the Board of Directors of Highmark Health (the "Highmark Health Board") and the Board of Directors of AHN and their management believe these volumes to be achievable.

(B) Discuss the impact of the current University of Pittsburgh Medical Center Consent Decree upon these projections.

(ii) Projected income statements, displaying a level of detail consistent with the Base Case Financial Projections for the AHN Entities submitted by Highmark in connection with the 2013 Order.

(iii) Projected balance sheets, displaying a level of detail consistent with the Base Case Financial Projections for the AHN Entities.

(iv) Projected cash flow statements, displaying a level of detail consistent with the Base Case Financial Projections for the AHN Entities.

(v) A detailed schedule of anticipated capital expenditures for all of the AHN Entities' facilities, including:

(A) For each AHN facility, a specific list of significant projects and the timing of these projects, including each Specific Scheduled Use;

(B) A list of strategic initiatives, including potential acquisitions of other businesses or entities, including, hospitals, physician groups, laboratories or other enterprises; and

(C) A schedule of anticipated future spending by AHN or any AHN Entity for its or their affiliated community hospitals and the strategic rationale for such spending.

(vi) A schedule of projected salaried and non-salaried employees on a full-time equivalent basis for the AHN Entities in total and for each primary AHN Entity operating segment or component, together with an explanation of how each primary operating segment or component is defined.

(vii) A description of any plans to downsize, close or repurpose, in whole or in part, any facility or operation owned or operated by any AHN Entity and provide a schedule of the timing and cost/benefit analysis associated with these plans.

(viii) A schedule of any anticipated future Financial Commitments from any Domestic Insurer to any direct or indirect AHN Entity along with the purpose of such Financial Commitments.

(ix) A calculation of AHN's projected Days Cash on Hand (the "DCOH") as defined in the Master Trust Indenture dated May 1, 2007, as amended, relating to the West Penn 2007A Series Bonds (the "Trust Indenture") for each quarter through December 31, 2017.

(x) A calculation of AHN's projected Debt Service Coverage Ratio as defined in the Trust Indenture for each quarter through December 31, 2017.

(xi) Provide functional excel backup to each set of financial projections requested in items C.(1)(e)(i) – (x) above.

(xii) A list of any projected future changes in Specific Scheduled Uses of the Financial Commitment of AHN.

(2) As part of the AHN Corrective Action Plan, Highmark Health shall provide a description of the diligence process that the Highmark Health Board pursued in order to ultimately approve the AHN Corrective Action Plan, including a description of the following:

(a) The manner in which the AHN Corrective Action Plan was prepared and how the projections were assessed or made at each facility;

(b) The material issues or concerns that the Highmark Health Board or management expressed with regard to earlier drafts of the AHN Corrective Action Plan; and

(c) The changes that were made to the AHN Corrective Action Plan in order to ultimately obtain approval by the Highmark Health Board.

(3) Prior to submission of the Final AHN Corrective Action Plan to the Department, Highmark Health shall have the Final AHN Corrective Action Plan reviewed at its sole cost and expense by an independent external financial expert experienced in these matters who was not involved with, and who did not otherwise participate in the preparation of or provide any analysis for, the Preliminary AHN Corrective Action Plan or the Final AHN Corrective Action Plan (the "Financial Commitment Reviewer"). The Financial Commitment Reviewer shall provide an opinion as to the reasonableness of the Final AHN Corrective Action Plan, the sufficiency of the Final AHN Corrective Action Plan to accomplish the Plan Objectives and 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 an opinion as to the reasonableness of the value assigned by Highmark Health and/or Highmark to Highmark's investments in AHN. A copy of such report shall be submitted to the Department as part of the Final AHN Corrective Action Plan and a public version of such report also shall be submitted to the Department.

(4) Highmark Health shall respond to all questions from the Department and its advisors relating to the Final AHN Corrective Action Plan and/or the AHN Strategic and Financial Plan, as such plans may be updated or extended from time to time, within the timeframe requested by the Department. The Department may impose, upon notice to Highmark Health, an obligation to update the Final AHN Corrective Action Plan or the AHN Strategic and Financial Plan or extend the period covered by the Final AHN Corrective Action Plan or the AHN Strategic and Financial Plan.

(5) The Final AHN Corrective Action Plan shall specifically identify any Financial Commitments (including Donations) contemplated by the Final AHN Corrective Action Plan. A review by the Department of the Preliminary AHN Corrective Action Plan and/or the Final AHN Corrective Action Plan shall not constitute an approval of any such Financial Commitments (including Donations, if any) unless: (i) Highmark specifically shall request approval of such Financial Commitments (including Donations, if any) and provide the information relating thereto to fully describe the nature and purposes for such Financial Commitment (including Donations, if any) and (ii) the Department shall specifically grant approval of such Financial Commitments (including Donations, if any) pursuant to the approval requirements of the this Approving Determination and Order.

G. Modifications to Condition 18 (Executive Compensation) of the 2013 Order.

Condition 18 is modified to read as follows:[10]

18. **[~~UPE~~]** **Highmark Health** and Highmark shall ensure and maintain in effect a policy that any senior executives of any **[~~UPE~~]** **Highmark Health** Entity who have been responsible for designing, recommending and/or implementing the IDN Strategy **and/or the AHN Strategic and Financial Plan, as filed with the Department and as such plan may be updated or extended, if required by the Department pursuant to Condition 15,** 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~~]** **Highmark**

[10] Additions are **underlined in bold**; Deletions are **[~~in brackets, in bold and with strikeout~~]**

Health 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~~]** **By October 15, 2017 Highmark Health** 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~~]** **Highmark Health** 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~~]** **Highmark Health** 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.

H. Modifications to Condition 21 (Affiliation and IDN Impact On Community Hospitals.

Condition 21 of the 2013 Order is modified to read as follows:[11]

21. On or before May 1 of each year, **[~~UPE~~]** **Highmark Health** 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~~]** **IDN-Community Hospital Report** against: (i) the discharge information provided by **[~~UPE~~]** **Highmark Health** under the **[~~IDN Certification~~]** **IDN-Community Hospital Report** for the immediately preceding year**[~~, if any was required to be provided~~]**; and (ii) the Base Year Discharge Data; (d) an

[11] Additions are **underlined in bold;** Deletions are **[~~in brackets, in bold and with strikeout~~]**

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]~~ Highmark Health** Entities in community-based facilities and service in community hospitals that any such **~~[UPE]~~ Highmark Health** 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.

* * *

I. Modifications to Condition 31 (Sunset of Conditions) of the 2013 Order.

Condition 31 of the 2013 Order is amended and restated as follows:

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); 12 and 13 (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); 31 (Sunset of Conditions); 32 (Required Record Retention); 33, 34, and 35 (Enforcement); and 36 (Post Closing Obligations).

B. Condition 19 (Meeting IDN Savings Benchmarks) and Condition 37 (Post-Closing Obligations of Highmark Health regarding closing documents) shall expire on

December 31, 2017, 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.

C. Unless a Condition is listed in Condition 31.A. or 31.B. or contains a specific expiration date, the Condition shall expire on December 31, 2020, 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.

J. Modification to the definition of "Domestic Insurer."

The definition of "Domestic Insurer" in Appendix 1 (Definitions) the 2013 Order is amended by adding the changes to this definition made by Condition G of the June 19, 2015 Approval Letter to read as follows:[12]

"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**; First Priority Life Insurance Company, Inc.; HMO of Northeastern Pennsyvlania, Inc., d/b/a First Priority Health; Highmark**

[12] Additions are **underlined in bold**; Deletions are **[~~in brackets, in bold and with strikeout~~]**

Benefits Group Inc.; Highmark Coverage Advantage Inc. and Highmark Senior Health 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~~] Highmark Health** 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.

SECTION IV. CONCLUSION

Other than as expressly set forth in this Letter, the terms and conditions of the 2013 Order and the June 19 Approval Letter are unchanged and remain in full force and effect. This Letter is effective as of the Effective Date and does not amend, alter, or affect the 2013 Order or the June 19, 2015 Approval Letter prior to the Effective Date.

Sincerely,

Teresa D. Miller
Insurance Commissioner
Commonwealth of Pennsylvania

EXHIBIT J

Received 3/30/2018 2:21:33 PM Supreme Court Middle District

Filed 3/30/2018 2:21:00 PM Supreme Court Middle District
5 MAP 2018

COMMONWEALTH OF PENNSYLVANIA
GOVERNOR'S OFFICE OF GENERAL COUNSEL

March 30, 2018

VIA PACFile

Amy Dreibelbis, Esquire
Deputy Prothonotary
Supreme Court of Pennsylvania
Pennsylvania Judicial Center
601 Commonwealth Avenue, Suite 4500
Harrisburg, PA 17106-9185

Re: Commonwealth of Pennsylvania, et al v. UPMC, et al
Docket No. 5 MAP 2018

Dear Ms. Dreibelbis:

On behalf of our clients—the Pennsylvania Insurance Department and Pennsylvania Department of Health—we submit this position letter to the Pennsylvania Supreme Court in the above-referenced matter. We submit this letter in lieu of a brief on the matter now pending before this Honorable Court.

On November 20, 2017, the Office of Attorney General filed a Petition to Enforce Consent Decrees along with a supporting brief. Pennsylvania Insurance Department ("PID") and Pennsylvania Department of Health ("DOH") (collectively, "Executive Petitioners") took no position on this Petition.

On January 29, 2018, Commonwealth Court—through Judge Dan Pellegrini—issued an Opinion and entered the following Order: "AND NOW, this 29th day of January, 2018, following a hearing, the Commonwealth's Petition to Enforce is granted. It is ordered that the Medicare Acute Care Provider Agreement and its amendments shall remain in effect until December 30, 2019. Highmark Health and Highmark, Inc. are ordered not to represent in any manner that UPMC is in-network for any part of 2020." UPMC appealed Judge Pellegrini's Order.

Executive Petitioners regulate both UPMC and Highmark and do so with the ultimate goal of protecting consumers, patients, and the public. To achieve this goal, Executive Petitioners must be able to interact with all members of the regulated community including UPMC and Highmark. For example, in its brief to this Court, UPMC noted that Executive Petitioners, in conjunction with Governor Wolf's office, brokered a post-Consent Decree agreement with UPMC and Highmark. *See* UPMC Brief at 16, n.4.

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There remain open issues between UPMC and Highmark—such as negotiating and reaching an agreement between Highmark and UPMC establishing reasonable rates for out-of-network access, without balance billing, for emergency room visits at each other's hospitals by Highmark and UPMC enrollees and Blue Card members when the Consent Decree ends. Executive Petitioners continue to encourage (and expect) Highmark and UPMC to work together to reach a new agreement on this critical issue, as well as others. Because of the role of Executive Petitioners—which differs from the role of the OAG—we took no position before Commonwealth Court and, accordingly, submit that by taking no position in this appeal, we will be better able to protect consumers and patients moving forward. Finally, Executive Petitioners submit that a prompt resolution of UPMC's appeal is critically important as it will establish certainty in the marketplace and, by so doing, protect consumers.

Respectfully submitted,

DENISE J. SMYLER
General Counsel

By: */s/ Kenneth L. Joel*
Kenneth L. Joel
Deputy General Counsel

Counsel for Pennsylvania Department of Health and Pennsylvania Insurance Department

cc: All Counsel of Record

EXHIBIT K

Governor Wolf Announces Landmark UPMC and Highmark Agreement to Access Critical Health Care Services

January 04, 2018

HEALTHCARE, HUMAN SERVICES, PRESS RELEASE, PUBLIC HEALTH

Pittsburgh, PA – In anticipation of the conclusion of the consent decrees that guide the relationship between UPMC and Highmark, Governor Tom Wolf today announced a landmark agreement between UPMC and Highmark that creates terms to provide access to critical, unique services and to certain hospitals in the commonwealth.

“My commitment has always been to put the patients and communities served by UPMC and Highmark first, and make sure consumers who need vital, at times life-saving health care, can get it,” Governor Wolf said. “I want to thank both companies for sharing this commitment, and for working together to reach this agreement for the benefit of so many people in western Pennsylvania.”

UPMC and Highmark have been working under consent decrees signed in 2014 that provide continued, in-network access to care for customers of both companies. However, these agreements will expire at the end of June 2019, at which time, without today’s terms, commercial customers of Highmark would be denied in-network access to these community and specialty UPMC providers and facilities.

"This landmark agreement means consumers of both companies will have in-network access to facilities that provide one-of-a-kind services," Governor Wolf said. "This is medical care that simply is not available anywhere else in the region, and denying affordable access to this vital care is just not acceptable. I am pleased that with this agreement access will continue."

The agreement ensures in-network access for customers of both companies to facilities that provide one-of-a-kind services. These include:

- Western Psychiatric Institute
- UPMC Center for Assistive Technology
- UPMC Center for Excellence for treatment of Cystic Fibrosis
- Certain highly specialized transplant services only available through UPMC
- Selected UPMC Joint Ventures with community facilities, including oncology

Highmark enrollees will also have continued access to the Children's Hospital of Pittsburgh under the terms of an existing agreement.

"Allowing Highmark insurance customers to seek the unique care provided at these facilities at in-network prices will allow consumers continued access to these important services," Acting Insurance Commissioner Jessica Altman said.

The agreement also provides in-network access to certain UPMC hospitals in the commonwealth. These include:

- UPMC Altoona
- UPMA Bedford
- UPMC Northwest
- UPMC Kane
- Carlisle Regional
- Lancaster Regional
- Heart of Lancaster
- Memorial Hospital of York
- Hanover
- Certain UPMC Susquehanna Hospitals

"Similar to the unique services available regionally only at one facility, in these communities basic health care is not available anywhere but at the UPMC hospitals. Keeping in-network access for Highmark customers means they will continue to have access to nearby critical health care," Altman said.

"With the end of the Consent Decree in 2019, this agreement provides clarity regarding the unique and highly desirable medical services only available at UPMC's world-class facilities," said David Farner, executive vice president, UPMC, and chief strategy and transformation officer.

"We thank the Governor and the Insurance Department for their efforts to support our commercial members," said Deb Rice-Johnson, president of Highmark Inc. "Our network of hospitals and physicians is one of the largest in the state. Access to these community hospitals reinforces the value of having choice in health care options for keeping care close to home for our members and community-based."

Consumers who live in communities where a choice of providers, facilities, and services is available will have to make a choice when the consent decrees expire at the end of June 2019.

"The bottom line is this agreement means all health care consumers in western Pennsylvania will continue to have access to vital health care, and the uncertainty that has plagued so many people for several years can now end," Governor Wolf said.

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EXHIBIT L

FAQs for End of Consent Decree Between Highmark and UPMC:

1. **What is the Highmark/UPMC Consent Decree?**

   In 2012, UPMC announced it would no longer continue to contract with Highmark following Highmark's proposed affiliation with health care provider Allegheny Health Network (AHN). In 2014, Highmark and UPMC each entered into a Consent Decree with the Office of Attorney General, the Insurance Department and the Department of Health to provide clarity and certainty for consumers concerning in-network access for Highmark members to UPMC providers. The Consent Decree allowed for access to certain unique or exception UPMC hospitals and providers and for certain groups of people (such as seniors) to continue receiving in-network treatment until the expiration of the Decrees on **June 30, 2019**.

2. **Who does the ending of the Consent Decree impact?**

   The ending of the Consent Decree will primarily impact current Highmark insureds in the Greater Pittsburgh and Erie areas who: (a) are in a continuing course of treatment with a UPMC provider; or (b) who are currently in or will seek oncology treatment from a UPMC provider; and/or (c) have Medicare Advantage plans.

   These insureds will now need to decide to either:

   - keep their Highmark insurance and start seeing a new in-network doctor,
   - to continue seeing their UPMC doctor and change their insurance plan to one where UPMC providers are in-network
   - or continue seeing their UPMC doctor and consider options for paying out-of-network provider costs.

   Insureds do not necessarily have to choose between in-network access to AHN and in-network access to UPMC. Both commercial and Medicare Advantage plans that provide in-network access to both AHN and UPMC are offered by several national insurance companies.

3. **Why is the Commonwealth allowing this to happen?**

   The Commonwealth cannot force an insurance company and a provider to contract at in-network rates with each other.

   Governor Wolf has dedicated significant efforts and will continue to diligently work to protect consumers by overseeing the implementation of the Consent Decree and through the consummation of the January 2018 agreement, to ensure access for Highmark's commercial insureds who require critical, unique services.

4. **What is in-network access, and why is it important?**

   In-network access is when an insurance company has a contract with a health care provider to provide services to enrollees for a negotiated rate. The health care provider agrees to accept the negotiated rate, together with any cost sharing by the enrollee (such as a copayment, coinsurance or deductible), as payment in full. Consequently, the patient does not receive a bill for the charges that exceed the insurers' payment. For many patients, it is often significantly less expensive for an insured to seek treatment from an in-network provider. However, each plan is different.

   Some health insurance plans only pay for services when an enrollee visits an in-network provider unless it is an emergency (such as exclusive provider organizations (EPOs) and health maintenance organizations (HMOs)). If you have a traditional HMO and choose to seek non-emergency care from an out-of-network provider, you will pay the entire cost. Other health insurance plans will pay at least some of the costs even if the member visits an out-of-network provider (point of service (POS) and preferred provider organizations (PPOs)). However, if you receive care from an out-of-network provider you will pay more of the cost than if you saw an in-network provider, and your provider may ask you to pay the difference between the actual cost of the service and the amount paid by your insurance company. This is called balance billing. Note that balance billing is up to the providers' discretion and prohibited for Medicare beneficiaries.

5. **How can I find out if the doctors and hospitals I want to use are in-network for a health plan I am considering?**

   The best way to find out if a provider you would like to visit is in-network would be to consult the website of the health plan in which you are considering enrollment. Additionally, you can reach out to the provider directly to confirm their network status with the health plan you are considering.

6. **Is there a transition period for care if my hospital/provider is not in-network?**

   Yes, the transition period is through **June 30, 2019**. Highmark insureds in the Greater Pittsburgh region and Erie will not have in-network access to any UPMC facility beyond this date, except for the exceptions clarified in Question 9.

7. **What is the impact to me if I am a Highmark member and I receive care from an out-of-network UPMC provider for non-emergency services?**

   With respect to in-network access to UPMC providers for Highmark members, the Consent Decree allows certain populations to take until June 30, 2019, to transition to a provider who is in-network with Highmark, explore out-of-network benefits, or change their health insurance coverage during the open enrollment period.

The end of the Consent Decree is almost here. If you have marketplace coverage or are enrolled in a Medicare Advantage plan, you will need to make decisions about your 2019 insurance coverage during open enrollment season. Since the Consent Decree ends mid-year 2019, the plan you select may or may not have access to most UPMC hospitals and/or physicians for the entire 2019 year.

People in the Greater Pittsburgh and Erie area who are planning on enrolling in a Highmark insurance plan must take into account which providers are in-network with Highmark insurance. Their UPMC provider may not be on that list for the entire year (there are a few exceptions listed in later questions), and so if they plan on staying with their Highmark insurance they may choose to switch providers. If they enroll in a Highmark insurance plan and try to continue seeing their UPMC provider, they will be required to pay higher out-of-pocket costs and may be subject to balance billing (if they are not a Medicare beneficiary).

It is important to understand your insurance plan's out-of-network coverage, if applicable. Your financial responsibility may be impacted by utilizing an out-of-network provider.

8. **I have group coverage from a Blue Cross Blue Shield (BCBS) company other than Highmark, am I affected by this?**

   Yes, if you have a plan that utilizes a network of providers and seek treatment in Highmark's service area the rules for in-network access will be the same as outlined in question 7. The BlueCard program is a national program that enables members of one Blue Cross and Blue Shield (BCBS) Plan to obtain health care services while travelling or living in another BCBS Plan's service area. If you have group coverage from a BCBS company other than Highmark and seek treatment in Highmark's service area, you will be able to access providers that are in-network with Highmark. If you choose to see an out-of-network provider and your plan has an out-of-network benefit, you will be required to follow the provider and insurance plan's out-of-network process.

9. **Are there any specific UPMC services or hospitals that are still in-network if I have Highmark commercial insurance?**

   Yes, there are UPMC hospitals that will remain in-network in 2019 for Highmark insurance plans.

   In January of this year, Highmark and UPMC announced an agreement to continue access to UPMC providers for Highmark members with commercial coverage needing access to critical, unique services, including certain transplant services. This agreement also affects cancer patients and areas where there are not many other feasible options for access to non-UPMC providers. These exceptions are listed below.

Please be aware that these exceptions may not apply to certain "no UPMC" Highmark insurance plans, such as My Direct Blue and Community Blue Medicare HMO/PPO, which are designed to be out-of-network for all UPMC providers (although My Direct Blue is in-network at UPMC Children's Hospital of Pittsburgh). You should check with Highmark to see if your coverage is a "no UPMC" plan in which you would not have in-network access under these exceptions.

The following specialty services by UPMC will remain in-network for Highmark insureds after June 30, 2019, even if the hospitals would otherwise be considered out-of-Network: UPMC Center for Assistive Technology, UPMC Center of Excellence for Treatment of Cystic Fibrosis, and services unique to UPMC in the region, such as living-donor liver transplants, lung transplants, heart-lung transplants and small bowel transplants. These specialty transplants are also in-network services for other Blue Cross and Blue Shield members accessing UPMC through the Blue Card program in accordance with Blue Card rules and the members specific benefit plan design.

As always, it is best to check with your insurer on the status of a provider from which you wish to receive care prior to obtaining services from the provider.

Pursuant to a term sheet agreed to by the parties to allow access following the Consent Decree expiration, Highmark's commercial enrollees have the following access to UPMC facilities:

UPMC hospitals in the greater Pittsburgh area continuing to contract with Highmark insurance at in-network rates:

Greater Pittsburgh Area Hospitals	In-Network	Out-of-Network
UPMC Children's Hospital of Pittsburgh	✔	
UPMC Magee-Womens Hospital		✘
UPMC East		✘
UPMC McKeesport		✘
UPMC Mercy		✘
UPMC Montefiore		✘
UPMC Passavant (both campuses)		✘
UPMC Presbyterian		✘
UPMC St. Margaret		✘
UPMC Shadyside		✘
UPMC Hillman Cancer Center at UPMC Shadyside		✘
UPMC Western Psychiatric Hospital	✔	

In Western PA, UPMC hospitals continuing to contract with Highmark insurance at in-network rates:

Western PA Hospitals	In-Network	Out-of-Network
UPMC Altoona	✔	
UPMC Bedford	✔	
UPMC Hamot		✖
UPMC Horizon (both campuses)	✔	
UPMC Jameson	✔	
UPMC Kane	✔	
UPMC Northwest	✔	

In Central and Eastern PA, UPMC hospitals continuing to contract with Highmark insurance at In-network rates:

Central and Eastern PA Hospitals (After 6/30/19)	In-Network	Out-of-Network
UPMC Cole	✔	
UPMC Pinnacle Carlisle	✔	
UPMC Pinnacle Community Osteopathic in Harrisburg	✔	
UPMC Pinnacle Hanover	✔	
UPMC Pinnacle Harrisburg	✔	
UPMC Pinnacle Lancaster	✔	
UPMC Pinnacle Lititz	✔	
UPMC Pinnacle Memorial in York	✔	
UPMC Pinnacle West Shore in Mechanicsburg	✔	
UPMC Susquehanna Divine Providence in Williamsport	✔	
UPMC Susquehanna Lock Haven	✔	
UPMC Susquehanna Muncy Valley	✔	
UPMC Susquehanna Soldiers & Sailors in Wellsboro	✔	
UPMC Susquehanna Sunbury	✔	
UPMC Susquehanna Williamsport Regional	✔	
UPMC Chautauqua WCA in Jamestown, NY (via Blue Card program)	✔	

In the Greater Pittsburgh Area, UPMC Cancer and Radiation Centers continuing to contract with Highmark at In-network rates until 2021:

CANCER CENTERS	CENTER TYPE
UPMC Cancer Center Medical Oncology, Beaver	Medical Oncology Center
UPMC Cancer Center Medical Oncology, Washington	Medical Oncology Center
Excela Arnold Palmer Medical Oncology, Mt. Pleasant	Medical Oncology Center

Excela Arnold Palmer Medical Oncology, North Huntingdon	Medical Oncology Center
UPMC Cancer Center Medical Oncology, Sewickley	Medical Oncology Center
Heritage Valley Radiation Oncology at UPMC West	Radiation Oncology Center
UPMC/St. Clair Hospital Cancer Center	Radiation Oncology Center
Heritage Valley Radiation Oncology Beaver	Radiation Oncology Center
Washington Health System Radiation Oncology	Radiation Oncology Center
Butler Health System Medical and Radiation Oncology	Medical & Radiation Oncology Centers
Excela Arnold Palmer Cancer Center	Medical & Radiation Oncology Centers

In Western PA outside of the Greater Pittsburgh Area, UPMC Cancer and Radiation Centers continuing to contract with Highmark insurance at In-network rates until 2021:

The Regional Cancer Center, Erie	Radiation Oncology Centers

In Western PA outside of the Greater Pittsburgh Area, UPMC Cancer and Radiation Centers continuing to contract with Highmark insurance at In-network rates until 2024:

CANCER CENTERS	CENTER TYPE
UPMC Cancer Center Medical Oncology, Johnstown	Medical Oncology Center
UPMC Cancer Center Medical Oncology, Uniontown	Medical Oncology Center
Grove City Medical Oncology (limited Med Oncology services)	Medical Oncology Center
UPMC Cancer Center Medical Oncology, Greenville	Medical Oncology Center
UPMC Cancer Center Medical Oncology, Windber	Medical Oncology Center
John P. Murtha Regional Cancer Center	Radiation Oncology Center
Uniontown Hospital Radiation Oncology, Robert E. Eberly Pavilion	Radiation Oncology Center
Jameson Radiation Oncology	Radiation Oncology Center
UPMC Cancer Center at UPMC Altoona	Medical & Radiation Oncology Centers
UPMC Cancer Center at UPMC Horizon	Medical & Radiation Oncology Centers

10. Are there any specific Allegheny Health Network (AHN) services or hospitals that are still in-network if I have UPMC insurance?

The Consent Decree specifically involves Highmark insurance and UPMC providers. Although the Consent Decrees do not speak to the UPMC Health Plan and access to AHN, that is still something consumers should consider during open enrollment. Therefore, if you have UPMC Health Plan, you should go to the UPMC Health Plan's website and look to see which providers are listed as in-network. Provider directories are subject to change, so it is important to check the health plan's website periodically for the most up-to-date information.

11. What facilities are considered in-network with each plan?

Insurance companies and providers negotiate contracts that determine network access for individual insurance plans. For the most up-to-date information on which facilities are considered in-network for each health plan, the consumer should go to the insurance company's website and check the provider directory, as they are subject to change.

12. I like my Primary Care Physician (PCP), can I just self-pay and continue to see him/her?

Yes, if you choose to keep both your PCP and your health insurance plan, you may continue to see your UPMC provider on an out-of-network basis. However, you should consider in advance your financial costs. If you choose to self-pay for your office visit you will likely also be personally responsible for any additional costs as a result of that visit, such as lab tests or procedures recommended by your provider.

13. What about providers (PCPs, specialists)? Both UPMC and Highmark's websites suggest contacting the provider directly. Can we trust that the in-network provider listing is correct on the plan's website?

It is the responsibility of the insurance company to have the most accurate information on its website, and that includes the listing of in-network providers.

If you notice incorrect listings on the company's website, please reach out to the Pennsylvania Insurance Department's Bureau of Consumer Services. Its contact information can be found below:

Toll-free: 1-877-881-6388
Fax: (717) 787-8585
TTY/TDD: (717) 783-3898

File a complaint by visiting this website: https://www.insurance.pa.gov/Consumers/File%20a%20Complaint/Pages/default.aspx

It is always best to check with your insurer on the status of a provider from which you wish to receive care prior to obtaining services from that provider. Should you have questions after reviewing their website, please contact the customer service number on the back on your insurance card.

14. **What if I have a Highmark PPO product, or a Highmark Medicare Advantage PPO product (such as Freedom Blue), or a Highmark HMO POS product (such as Security Blue) can I still go to an out-of-network facility?**

Yes, if you have a Highmark commercial PPO plan, a Highmark Freedom Blue or Security Blue plan, you may still go to an out-of-network provider; you should refer to your plan's benefits for in and out-of-network coverage.

For commercial plans, you may be accountable for the difference between UPMC's charge and the insurance plan's allowed amount payment, after your cost sharing. Please see Question 4 for more information on balance bills.

For some services in Medicare plans, like physician visits, there may be no difference in cost-sharing for in or out-of-network. For other services, you may pay less for using a provider in Highmark's network. Medicare providers cannot require members to pay a copay or cost-sharing amount that exceeds the in or out-of-network payment stipulated by their plan. Note that emergent and urgent care is always covered as in-network coverage per federal regulations.

UPMC has stated that after June 30, 2019, it intends to require patients with out-of-network insurance products to pay in advance for all nonemergent services. For more information regarding this pre-pay policy, call Highmark at the number on the back of your ID card or UPMC at 1-800-533-8762.

Information specific to traditional Medicare, Medicare Supplement, and Medicare Advantage Enrollees

15. **If I have traditional Medicare along with Medicare supplemental insurance, am I affected by this?**

Consumers with Medicare supplemental insurance (also called Medigap) have access to all providers who accept Medicare, including UPMC.

Currently, most Medicare supplemental policies do not have networks. Therefore, there is no concept of in-network or out-of-network associated with those Medicare supplemental policies.

You should always review your providers' network status and your plan's network benefits before purchasing a plan.

16. If I have Medicare Advantage, am I affected by this?

There are certain UPMC services and hospitals that will continue to be in-network, as described further below. You should always check with your insurance company and/or your doctor before scheduling a visit to confirm their network status with your insurance.

17. What if Highmark Medicare Advantage subscribers find out that their provider is not in-network after all enrollment periods have ended? Will they have a Special Enrollment Period?

A Special Enrollment Period (SEP) is granted only on an exception basis and on terms set by the federal Centers for Medicare and Medicaid Services.

18. Are there any specific UPMC services or hospitals that are still in-network if I have a Highmark Medicare Advantage plan?

Most UPMC providers and hospitals in Greater Pittsburgh and Erie will be out-of-network for Highmark Medicare Advantage members after June 30, 2019. However, there are certain UPMC services and hospitals that will continue to be in-network, as described further below.

Please be aware that these exceptions may not apply to certain "no UPMC" Highmark insurance plans, such as My Direct Blue and Community Blue Medicare HMO/PPO, which are designed to be out-of-network for all UPMC providers (although My Direct Blue is in-network at UPMC Children's Hospital of Pittsburgh). You should check with Highmark to see if your coverage is a "no UPMC" plan, in which case you would not have in-network access under these exceptions.

As always, it is best to check with your provider and with your insurer on the status of a provider in which you wish to receive care prior to obtaining services from that provider.

For further questions about Medicare Advantage products, please contact the Medicare Services Center at 1-800-MEDICARE. For Pennsylvanians seeking assistance with Medicare coverage, you can contact the toll-free APPRISE helpline at 1-800-783-7067.

Pursuant to ongoing contracts between the parties, Highmark's Medicare Advantage enrollees have the following access to UPMC facilities:

UPMC hospitals in the greater Pittsburgh area continuing to contract with Highmark insurance at in-network rates:

Greater Pittsburgh Area Hospitals	In-Network	Out-of-Network
UPMC Children's Hospital of Pittsburgh	✔	
UPMC Magee-Womens Hospital		✘
UPMC East		✘
UPMC McKeesport		✘
UPMC Mercy		✘
UPMC Montefiore		✘
UPMC Passavant (both campuses)		✘
UPMC Presbyterian		✘
UPMC St. Margaret		✘
UPMC Shadyside		✘
UPMC Hillman Cancer Center at UPMC Shadyside		✘
UPMC Western Psychiatric Hospital	✔	

In Western PA, UPMC hospitals continuing to contract with Highmark insurance at in-network rates:

Western PA Hospitals	In-Network	Out-of-Network
UPMC Altoona	✔	
UPMC Bedford	✔	
UPMC Hamot		✘
UPMC Horizon (both campuses)	✔	
UPMC Jameson	✔	
UPMC Kane	✔	
UPMC Northwest	✔	

In Central and Eastern PA, UPMC hospitals continuing to contract with Highmark insurance at In-network rates:

Central and Eastern PA Hospitals (After 6/30/19)	In-Network	Out-of-Network
UPMC Cole	✔	
UPMC Pinnacle Carlisle	✔	
UPMC Pinnacle Community Osteopathic in Harrisburg	✔	
UPMC Pinnacle Hanover	✔	
UPMC Pinnacle Harrisburg	✔	
UPMC Pinnacle Lancaster	✔	

UPMC Pinnacle Lititz	✔	
UPMC Pinnacle Memorial in York	✔	
UPMC Pinnacle West Shore in Mechanicsburg	✔	
UPMC Susquehanna Divine Providence in Williamsport	✔	
UPMC Susquehanna Lock Haven	✔	
UPMC Susquehanna Muncy Valley	✔	
UPMC Susquehanna Soldiers & Sailors in Wellsboro	✔	
UPMC Susquehanna Sunbury	✔	
UPMC Susquehanna Williamsport Regional	✔	

In the Greater Pittsburgh Area, UPMC Cancer and Radiation Centers continuing to contract with Highmark at In-network rates until 2021:

CANCER CENTERS	CENTER TYPE
Excela Arnold Palmer Medical Oncology, Mt. Pleasant	Medical Oncology Center
Excela Arnold Palmer Medical Oncology, North Huntingdon	Medical Oncology Center
Heritage Valley Radiation Oncology at UPMC West	Radiation Oncology Center
UPMC/St. Clair Hospital Cancer Center	Radiation Oncology Center
Heritage Valley Radiation Oncology Beaver	Radiation Oncology Center
Washington Health System Radiation Oncology	Radiation Oncology Center
Butler Health System Medical and Radiation Oncology	Medical & Radiation Oncology Centers
Excela Arnold Palmer Cancer Center	Medical & Radiation Oncology Centers

In Western PA outside of the Greater Pittsburgh Area, UPMC Cancer and Radiation Centers continuing to contract with Highmark insurance at In-network rates until 2021:

The Regional Cancer Center, Erie	Radiation Oncology Centers

In Western PA outside of the Greater Pittsburgh Area, UPMC Cancer and Radiation Centers continuing to contract with Highmark insurance at In-network rates until 2024:

CANCER CENTERS	CENTER TYPE
UPMC Cancer Center Medical Oncology, Johnstown	Medical Oncology Center

Grove City Medical Oncology (limited Med Oncology services)	Medical Oncology Center
UPMC Cancer Center Medical Oncology, Greenville	Medical Oncology Center
UPMC Cancer Center Medical Oncology, Windber	Medical Oncology Center
John P. Murtha Regional Cancer Center	Radiation Oncology Center
Uniontown Hospital Radiation Oncology, Robert E. Eberly Pavilion	Radiation Oncology Center
Jameson Radiation Oncology	Radiation Oncology Center
UPMC Cancer Center at UPMC Altoona	Medical & Radiation Oncology Centers
UPMC Cancer Center at UPMC Horizon	Medical & Radiation Oncology Centers
UPMC Cancer Center at UPMC Northwest	Medical & Radiation Oncology Centers

19. Where can I ask more questions or file a complaint?

If you have questions or wish to file a complaint, there are various options for you to obtain assistance.

- If you are a Highmark health plan member with questions about your coverage, call the Member Service phone number on the back of your insurance card.
- Speak to your provider.
- If you wish to file a complaint, you can contact the Pennsylvania Insurance Department at the following:

  1209 Strawberry Square
  Harrisburg, PA 17120
  Toll-free: 1-877-881-6388
  Fax: (717) 787-8585
  tty/tdd: (717) 783-3898
  A complaint form can be accessed from the Insurance Department's website: www.insurance.pa.gov

Please note that the answers to these FAQs describe the current status as of the time of this posting. The Pennsylvania Insurance Department will update the information when and if new information becomes available.

EXHIBIT M

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

FEDERAL TRADE COMMISSION

and

COMMONWEALTH OF PENNSYLVANIA,

Plaintiffs,

vs.

PENN STATE HERSHEY MEDICAL CENTER

and

PINNACLEHEALTH SYSTEM,

Defendants.

Civil Action No.: 1:15-CV-2362

~~FILED UNDER SEAL~~

COMPLAINT FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

Plaintiffs, the Federal Trade Commission ("FTC" or "Commission"), by its undersigned attorneys, and the Commonwealth of Pennsylvania, acting by and through its Office of Attorney General, petition this Court, pursuant to Section 13(b) of the Federal Trade Commission Act ("FTC Act"), 15 U.S.C. § 53(b), and Section 16 of the Clayton Act, 15 U.S.C. § 26, for a temporary restraining order

and preliminary injunction enjoining Penn State Hershey Medical Center ("Hershey") from consummating its proposed merger (the "Merger") with PinnacleHealth System ("Pinnacle"). Absent such provisional relief, Hershey and Pinnacle (collectively, "Defendants") would be free to consummate the Merger on 12:01 a.m. on December 10, 2015.

Plaintiffs require the aid of this Court to maintain the *status quo* during the pendency of an administrative proceeding on the merits scheduled to begin on May 17, 2016, which the Commission already has initiated pursuant to Sections 7 and 11 of the Clayton Act, 15 U.S.C. §§ 18, 21, and Section 5 of the FTC Act, 15 U.S.C. § 45. That administrative proceeding will determine the legality of the Merger, subject to judicial review by a federal Court of Appeals, and will provide the parties to this proceeding a full opportunity to conduct discovery and present testimony and other evidence regarding the likely competitive effects of the Merger.

NATURE OF THE CASE

1. This is an action to temporarily restrain and preliminarily enjoin the consummation of the merger between Hershey and Pinnacle, the two largest health systems in the greater Harrisburg, Pennsylvania area. If allowed to proceed, the Merger would create a dominant provider of general acute care ("GAC") inpatient

hospital services in the Harrisburg area. The Merger is likely to substantially lessen competition for healthcare services in Harrisburg, Pennsylvania, and its surrounding communities, leading to increased healthcare costs and reduced quality of care for over 500,000 local residents and patients.

2. Today, Hershey owns and operates one GAC hospital in the Harrisburg area, while Pinnacle operates three GAC hospitals. Hershey and Pinnacle operate the only three hospitals located in Dauphin County. Both Hershey and Pinnacle are high-quality health systems that, with limited exceptions, offer an overlapping range of GAC inpatient hospital services ("GAC services"), including primary, secondary, tertiary, and quaternary services.

3. Hershey and Pinnacle are close competitors for GAC services in the Harrisburg area. Hershey and Pinnacle vigorously compete on price, quality of care, and services provided, both for inclusion in commercial health plan networks and to attract patients from one another. The rivalry between Hershey and Pinnacle has benefited local patients with lower healthcare costs and increased quality of care. The Merger would eliminate this significant head-to-head competition between Hershey and Pinnacle and its related benefits.

4. The Merger would substantially lessen competition in the market for GAC services sold to commercial health plans in an area roughly equivalent to a

four-county region comprised of the Harrisburg Metropolitan Statistical Area (Dauphin, Cumberland, and Perry Counties) plus Lebanon County (the "Harrisburg Area").

5. The only significant competitor of the Defendants in the Harrisburg Area is Holy Spirit Hospital ("Holy Spirit"), which is a smaller community hospital located in eastern Cumberland County that offers a more limited range of services than Hershey or Pinnacle. There are two other hospitals located on the outskirts of the Harrisburg Area. They are even smaller community hospitals that offer a more limited range of services than Holy Spirit and a much more limited range of services than the Defendants. Neither of these hospitals meaningfully constrains Hershey or Pinnacle.

6. Post-Merger, the combined entity will account for approximately 64% of all GAC services in the Harrisburg Area. Using the Herfindahl-Hirschman Index ("HHI") to measure market concentration, the post-Merger HHI would be approximately 4,500 with an increase of approximately 2,000 points. This high market share and corresponding high concentration level render the Merger presumptively unlawful under the relevant case law and likely to increase market power—by a wide margin—under the 2010 U.S. Department of Justice and Federal Trade Commission Horizontal Merger Guidelines ("Merger Guidelines").

7. The Merger would substantially increase the combined entity's bargaining leverage in negotiations with commercial health plans. The combined entity would be able to exercise market power by raising prices and reducing quality and services, ultimately harming Harrisburg Area residents and patients.

8. Entry or expansion by other providers of the relevant services is unlikely to occur, much less in a manner that is timely, likely or sufficient to deter or mitigate the loss of price and non-price competition in the near future.

9. Finally, the Defendants' efficiency claims are overstated, speculative, unverifiable, not merger-specific, or result from an anticompetitive reduction in output, quality, or services, and are largely non-cognizable. Any cognizable efficiency claims are insufficient to offset the substantial competitive harm the Merger is likely to cause.

10. On December 7, 2015, by a 4-0 vote, the Commission found reason to believe that the Merger would violate Section 7 of the Clayton Act and Section 5 of the FTC Act.

11. A temporary restraining order enjoining the Merger is necessary to preserve the Court's ability to afford full and effective relief after considering the Commission's application for a preliminary injunction. Preliminary injunctive relief is imperative to preserve the *status quo* and protect competition during the

Commission's ongoing administrative proceeding. Allowing the Merger to proceed would harm consumers and undermine the Commission's ability to remedy the anticompetitive effects of the Merger if it is ultimately found unlawful after a full trial on the merits and any subsequent appeals.

JURISDICTION AND VENUE

12. This Court's jurisdiction arises under Section 13(b) of the FTC Act, 15 U.S.C. § 53(b); Section 16 of the Clayton Act, 15 U.S.C. § 26; and 28 U.S.C. §§ 1331, 1337, and 1345. This is a civil action arising under Acts of Congress protecting trade and commerce against restraints and monopolies, and is brought by an agency of the United States authorized by an Act of Congress to bring this action.

13. Section 13(b) of the FTC Act, 15 U.S.C. § 53(b), provides in pertinent part:

> Whenever the Commission has reason to believe –
>
> (1) that any person, partnership, or corporation is violating, or is about to violate, any provision of law enforced by the Federal Trade Commission, and
>
> (2) that the enjoining thereof pending the issuance of a complaint by the Commission and until such complaint is dismissed by the Commission or set aside by the court on review, or until the order of the Commission made thereon has become final, would be in the interest of the public – the Commission by any of its attorneys designated by it for such purpose may bring suit in a district court of the United States to enjoin any such

> act or practice. *Upon a proper showing that weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest*, and after notice to the defendant, a temporary restraining order or a preliminary injunction may be granted without bond . . . , (emphasis added).

14. In conjunction with the Commission, the Commonwealth of Pennsylvania brings this action for a preliminary injunction under Section 16 of the Clayton Act, 15 U.S.C. § 26, to prevent and restrain Hershey and Pinnacle from violating Section 7 of the Clayton Act, 15 U S C § 18, pending the Commission's administrative proceeding. The Commonwealth of Pennsylvania has the requisite standing to bring this action because the Merger would cause antitrust injury in the market for GAC services sold to customers within its state.

15. Defendants are, and at all relevant times have been, engaged in activities in or affecting "commerce" as defined in Section 4 of the FTC Act, 15 U.S.C. § 44, and Section 1 of the Clayton Act, 15 U.S.C. § 12. Defendants also are, and at all relevant times have been, engaged in commerce in the Commonwealth of Pennsylvania.

16. Defendants transact substantial business in this district and the Commonwealth of Pennsylvania and are subject to personal jurisdiction therein. Venue, therefore, is proper in this district under 28 U.S.C. § 1391(b) and (c) and 15 U.S.C. § 53(b).

17. The Merger constitutes a transaction subject to Section 7 of the Clayton Act, 15 U.S.C. § 18.

THE PARTIES AND THE PROPOSED MERGER

18. Defendant Hershey is a not-for-profit healthcare system headquartered in Hershey, Pennsylvania in Dauphin County. The system includes the Milton S. Hershey Medical Center ("Hershey Medical Center"), a GAC academic medical center affiliated with the Penn State College of Medicine, and the Penn State Hershey Children's Hospital (located on the Hershey Medical Center campus and the only children's hospital in the Harrisburg Area).

19. The Hershey Medical Center has 551 licensed beds (125 of which are located at the Children's Hospital). It employs approximately 804 physicians. Hershey offers a full range of GAC services, from primary care to quaternary services. It offers quaternary services such as heart transplants and operates a state-designated Level I Trauma Center for pediatrics and adults. In fiscal year 2014, on a system-wide basis, Hershey generated approximately $1.4 billion in revenue and had approximately 29,000 inpatient discharges.

20. Defendant Pinnacle is a not-for-profit healthcare system headquartered in Harrisburg, Pennsylvania. Pinnacle operates three GAC hospitals in the Harrisburg Area. Pinnacle's Harrisburg Hospital and Community General

Osteopathic Hospital are located in Dauphin County and Pinnacle's West Shore Hospital, which opened in May 2014, is located in eastern Cumberland County.

21. Pinnacle's combined system has 662 licensed beds, which are divided among its three GAC hospitals. Pinnacle offers a full range of GAC services, from primary care to quaternary services, excluding only a limited number of quaternary services. Harrisburg Hospital, which is Pinnacle's flagship teaching hospital, has a Level III neonatal intensive care unit and performs high-level services such as kidney transplants. Pinnacle's CardioVascular Institute is considered one of the leading cardiology programs in Pennsylvania. In 2014, Pinnacle generated approximately $850 million in revenue and had more than 35,000 inpatient discharges.

22. In June 2014, Hershey and Pinnacle signed a letter of intent pursuant to which they agreed to explore the possibility of combining their assets. In March 2015, the Defendants' boards approved moving forward with the transaction. Although the final merger documents have not yet been signed, pursuant to the letter of intent, the transaction would be structured as a membership substitution by which the new entity would become the sole member of both Hershey and Pinnacle, and Hershey and Pinnacle will have equal representation on the new entity's board of directors.

THE RELEVANT SERVICE MARKET

23. The relevant service market in which to analyze the effects of the Merger is GAC inpatient hospital services sold to commercial health plans and their members. This service market encompasses a broad cluster of medical and surgical diagnostic and treatment services offered by both Hershey and Pinnacle that require an overnight hospital stay.

24. Although the Merger's likely effect on competition could be analyzed separately for each of the hundreds of affected medical procedures and treatments, it is appropriate to evaluate the Merger's likely effects across this cluster of services because the services are offered to Harrisburg Area patients under similar competitive conditions, by similar market participants. There are no practical substitutes for this cluster of GAC services.

THE RELEVANT GEOGRAPHIC MARKET

25. The relevant geographic market in which to analyze the effects of the Merger is the Harrisburg Area, which is an area roughly equivalent to the Harrisburg Metropolitan Statistical Area (Dauphin, Cumberland, and Perry Counties) and Lebanon County.

26. The appropriate geographic market in which to analyze the Merger is the area in which consumers can practicably find alternative providers of the

service. The test from the Merger Guidelines used to determine the boundaries of the geographic market is whether a hypothetical monopolist of the relevant services within that geographic area could profitably negotiate a small but significant and non-transitory increase in price (here, reimbursement rates for GAC services). If so, the boundaries of that geographic area are an appropriate geographic market.

27. In general, patients choose to seek care close to their homes or workplaces for their own convenience and that of their families because it takes less time to travel to a hospital that is nearby and it is easier to arrange for transportation and visitation. Residents of the Harrisburg Area strongly prefer to, and do, obtain GAC services locally. Moreover, residents of the Harrisburg Area who require emergency hospital services seek such services within the Harrisburg Area. They would not travel outside of the Harrisburg Area for such emergency services without jeopardizing their health and well-being.

28. Evidence from multiple sources shows that an overwhelming percentage of commercially insured residents of the Harrisburg Area seek GAC services within the Harrisburg Area.

29. Hospitals outside the Harrisburg Area, such as those in York and Lancaster Counties, do not consider themselves as, and are not, meaningful

competitors of Hershey, Pinnacle, or other hospitals in the Harrisburg Area for the provision of GAC services to residents of the Harrisburg Area because they draw very few patients from the Harrisburg Area.

30. Health plans that offer health care networks in the Harrisburg Area do not consider hospitals outside of the Harrisburg Area to be viable substitutes for Harrisburg Area hospitals. Very few of their members leave the Harrisburg Area to obtain GAC services, even for tertiary and quaternary care.

31. Because residents of the Harrisburg Area strongly prefer to obtain GAC services in the Harrisburg Area, a health plan that did not have Harrisburg Area hospitals in its network would be very difficult to successfully market a network to employers and consumers in the area. Accordingly, a health plan would not exclude from its network a hypothetical monopolist of hospital services in the Harrisburg Area in response to a small but significant price increase.

MARKET STRUCTURE AND THE MERGER'S PRESUMPTIVE ILLEGALITY

32. Hershey currently accounts for approximately 26% of the relevant market. Pinnacle currently accounts for approximately 38% of the market. A combined Hershey/Pinnacle would own by far the largest GAC hospital system within the Harrisburg Area. Defendants' post-Merger market share would be overwhelming at approximately 64% of the relevant market.

33. Of the three other hospitals that provide GAC services to residents in the Harrisburg Area, only one – Holy Spirit Hospital – is of any competitive significance. Holy Spirit currently accounts for approximately 15% of the relevant market. The remaining two hospitals are Carlisle Regional Medical Center (in central Cumberland County), which accounts for approximately 5% of the market, and WellSpan Good Samaritan Hospital (in central Lebanon County), which accounts for approximately 6% of the market. These two hospitals are small community hospitals with limited service offerings and little appeal to residents of the Harrisburg Area. They do not compete to any significant degree with the Defendants. No other hospital accounts for more than 3% of the relevant market. Accordingly, the proposed Merger would reduce the number of meaningful competitors in the Harrisburg Area from three to two.

34. Under the relevant case law, including U.S. Supreme Court precedent and recent litigated hospital merger cases, the Merger is presumptively unlawful by a wide margin, as it would significantly increase concentration in an already highly concentrated market.

35. The Herfindahl-Hirschman Index ("HHI") is used to measure market concentration under the Merger Guidelines. A merger or acquisition is presumed likely to create or enhance market power under the Merger Guidelines, and thus, is

presumed illegal under relevant case law, when the post-merger HHI exceeds 2,500 points and the merger or acquisition increases the HHI by more than 200 points.

36. Here, the market concentration levels far exceed those HHI thresholds. The post-Merger HHI in the GAC services market will be over 4,400, an increase of approximately 2,000 points. The approximate HHI figures and market shares for the GAC services market in the Harrisburg Area are summarized in the table below.

GENERAL ACUTE CARE INPATIENT HOSPITAL SERVICES		
Hospital System	**Pre-Merger Market Share**	**Post-Merger Market Share**
Penn State Hershey Medical Center	26%	64%
PinnacleHealth System	38%	
Holy Spirit Health System – A Geisinger Affiliate (Cumberland County)	15%	15%
WellSpan Good Samaritan Hospital (Lebanon County)	6%	6%
Carlisle Regional Medical Center (Cumberland County)	5%	5%
Other (<3% share each)	10%	10%
HHI	**2,500**	**4,500**
Change in HHI	**+2,000**	

ANTICOMPETITIVE EFFECTS

A.

Hospital Competition Yields Lower Prices and Higher Quality

37. Competition between hospitals occurs in two distinct but related dimensions. First, hospitals compete to be selected as in-network providers for commercial health plans' members. Second, hospitals compete with each other on the basis of non-price features (*e.g.*, quality, amenities, etc.) to attract patients, including health plan members, to their facilities.

38. In the first dimension of hospital competition, hospitals compete to be included in health plan networks. To become an in-network provider, a hospital negotiates with a health plan and, if mutually agreeable terms can be reached, enters into a contract. Reimbursement rates (*i.e.*, prices), which the hospital charges to a health plan for services rendered to a health plan's members, are the primary contractual terms negotiated.

39. In-network status benefits the hospital by giving it preferential access to the health plan's members. Health plan members typically pay far less to access in-network hospitals than out-of-network hospitals. Thus, all else being equal, an in-network hospital will attract more patients from a particular health plan than an out-of-network hospital. This dynamic motivates hospitals to offer lower rates to

health plans to win inclusion in their networks.

40. From the health plan's perspective, having hospitals in-network is beneficial because it enables the health plan to create a healthcare provider network in a particular geographic area that is attractive to current and prospective members, typically local employers and their employees.

41. A critical determinant of the relative bargaining positions of a hospital and a health plan during negotiations is whether other, nearby comparable hospitals are available to the health plan and its members as alternatives in the event of a negotiating impasse. The presence of alternative hospitals limits a hospital's bargaining leverage and thus constrains its ability to obtain higher reimbursement rates from health plans. The more attractive these alternative hospitals are to a health plan's members in a local area, the greater the constraint on that hospital's bargaining leverage. Where there are few or no meaningful alternatives, a hospital will have greater bargaining leverage to demand and obtain higher reimbursement rates.

42. A merger between hospitals that are close substitutes from the perspective of health plans and their members therefore tends to produce increased bargaining leverage for the merged entity and, as a result, higher negotiated rates, because it eliminates a competitive alternative for health plans.

43. Increases in the reimbursement rates negotiated between a hospital and a health plan significantly impact the health plan's members. "Self-insured" employers rely on a health plan for access to its provider network and negotiated rates. These employers pay the cost of their employees' health care claims directly and thus bear the full and immediate burden of any rate increases in the healthcare services used by their employees. "Fully-insured" employers pay premiums to health plans—and employees pay premiums, co-pays, co-insurance and/or deductibles—in exchange for the health plan assuming financial responsibility for paying hospital costs generated by the employees' use of hospital services. When hospital rates increase, health plans pass on these increases to their fully-insured customers in the form of higher premiums, co-pays, co-insurance and/or deductibles.

44. In the second dimension of hospital competition, hospitals compete to attract patients to their facilities by offering higher quality care, amenities, convenience, and patient satisfaction than their competitors. This competition can be significant because health plan members often have a choice of in-network hospitals where they face similar out-of-pocket costs. Hospitals also compete on these non-price dimensions to attract patients covered by Medicare and Medicaid, as well as other patients without commercial insurance. A merger of competing

hospitals eliminates that non-price competition and reduces their incentive to improve and maintain quality.

B.

The Merger Would Eliminate
Close Competition between Hershey and Pinnacle

45. Hershey and Pinnacle are vigorous competitors in the relevant market due to the similarity in services that they both offer and their geographic proximity. The Merger would eliminate direct and substantial competition between the Defendants and create a dominant health system that could increase reimbursement rates and/or reduce service levels for GAC inpatient services. Close competition in the relevant market is evident from a wide variety of evidence, including econometric analysis of the Defendants' patient draw data, ordinary-course documents, testimony, and information from health plans.

46. A standard economic analysis of the closeness of competition known as diversion analysis, which is based on data about where patients receive hospital services, confirms that Hershey and Pinnacle are very close competitors. More specifically, Pinnacle is the only significant competitor of Hershey and Hershey is the only significant competitor of Pinnacle other than Holy Spirit Hospital. Diversion analyses show that if Hershey were no longer available, over 40% of its patients would seek GAC services at Pinnacle. Similarly, if Pinnacle were no

longer available to patients, over 30% of its patients would seek GAC services at Hershey. The diversions between the Defendants are higher than those present in recent hospital merger cases where courts have found that the transaction at issue would substantially lessen competition and, therefore, violated the Clayton Act.

47. Hershey and Pinnacle offer a wide range of overlapping GAC inpatient service lines, from primary to higher-end tertiary and quaternary care, with the limited exceptions of major organ transplants and high-end trauma care, which are provided by Hershey but not by Pinnacle. Data show that the services offered by each of the Defendants substantially overlap with one another. Diagnosis-related groups ("DRGs") are categories of diagnoses used by Medicare and health plans to set reimbursement rates. 98% of Hershey's patients are in DRGs that are offered by Pinnacle. Similarly, 97% of Pinnacle's patients are in DRGs offered by Hershey.

48. According to the Defendants' documents, Pinnacle and Hershey "aggressively compete with one another in many areas" and view each other as close competitors. For example, in 2011, Hershey hired a consulting firm to conduct a detailed service line analysis, which concluded that Pinnacle was Hershey's most significant, and often the "dominant," local competitor in numerous key services lines, including neurosciences, heart and vascular,

orthopaedics, obstetrics and gynecology ("OB/GYN"), spine, and pediatrics. The analysis also states that within the local market, Hershey had increased its market share in orthopedic services by "taking away market share from Pinnacle." The same analysis also notes that Hershey is the "dominant player" in pediatrics while Pinnacle is the "second dominant player." Similarly, Pinnacle views Hershey as is its "main competitor" for OB/GYN services. A Pinnacle analysis lists the top inpatient services lines, for both Pinnacle and Hershey, as "OB/birthing services, general medicine, ortho/spine, and general surgery."

49. In addition, Pinnacle has been expanding its service offerings and is currently implementing its strategic Vision 2017 Plan, which includes renovating Pinnacle's Harrisburg Hospital to establish it as a "tertiary referral center" that would further enhance its competition with Hershey.

50. Pinnacle's ordinary course documents and business plans identify Hershey and Holy Spirit Hospital as its two principal competitors and frequently focus on Hershey as its main competitor. Pinnacle routinely generates reports tracking "leakage" of referrals from primary care physicians to Hershey, and it routinely tracks Hershey's market shares by service line. While Holy Spirit competes in the Harrisburg Area, Pinnacle's documents reveal that "[d]espite its efforts to become indispensable to the entire Harrisburg market, Holy Spirit

remains a medium-sized community hospital with a limited (West Shore) service area and few distinctions." Its service lines are "modest when compared to Pinnacle's."

51. Similarly, Hershey's internal documents reveal that Hershey identifies Pinnacle as being one of its principal competitors. Hershey focuses significant attention on Pinnacle's strategy, while focusing its own competitive strategies on capturing market share from Pinnacle.

52. The Defendants are also close competitors because of their geographic proximity. Competition between Hershey and Pinnacle is particularly intense in Dauphin County, where Hershey and Pinnacle operate the only GAC hospitals and the only emergency departments (where the Defendants draw approximately half of their inpatient admissions), and both draw more patients from Dauphin County than any other county. Post-Merger, the Defendants will operate the only two emergency rooms in Dauphin County and two of only three emergency rooms within 25 miles of downtown Harrisburg.

53. Competition between Hershey and Pinnacle also extends into Cumberland and Lebanon Counties. Hershey has expanded its primary care services in Cumberland County to drive referrals to Hershey Medical Center following Pinnacle's opening of West Shore Hospital in Cumberland County in

2014. Pinnacle has expanded its primary care services in Lebanon County, near Hershey Medical Center, in order to compete with Hershey and drive referrals to Pinnacle hospitals. Both Pinnacle and Hershey have both expanded their oncology services in Cumberland County.

54. Health plans that serve the Harrisburg Area confirm that Hershey and Pinnacle are large health systems that compete closely against one another by offering very similar services and high levels of quality. Because Holy Spirit's services are more limited, health plans consider it to be in a lower tier than Hershey and Pinnacle. Health plans do not view other hospitals in the Harrisburg Area—Carlisle Regional Medical Center or Good Samaritan Hospitals—as viable substitutes for the Defendants for Harrisburg Area residents due to their more limited service offerings and distance.

C.

The Merger Would Eliminate Price Competition and Increase the Merged Entity's Bargaining Leverage

55. Because the Merger would eliminate direct competition between Pinnacle and Hershey, a combined Hershey/Pinnacle would have increased bargaining leverage, allowing it to raise rates for GAC inpatient services in the Harrisburg Area. This increased leverage could manifest itself in multiple ways

including through an increase in rates across the entire combined hospital system or by raising Pinnacle's rates to Hershey's rate levels, which are higher. Such leverage could negatively affect agreements with traditional fee-for-service arrangements and/or new reimbursement models such as risk sharing, by, for example, allocating more risk to the health plan and less risk to a combined Hershey/Pinnacle.

56. Currently, health plans in the Harrisburg Area can negotiate lower rates by threatening to exclude Hershey or Pinnacle from their networks because the other hospital serves as a close alternative for patients living in the Harrisburg Area. For example, a large health plan that serves the Harrisburg Area recently resisted rate increases proposed by Pinnacle by threatening to exclude Pinnacle from its network and create a hospital network limited to Hershey and Holy Spirit. This threat resulted in Pinnacle accepting a more modest rate increase than it had demanded.

57. If Hershey and Pinnacle were to merge, health plans could no longer threaten to exclude the combined Hershey/Pinnacle from their networks or otherwise use competition between Hershey and Pinnacle to negotiate better reimbursement rates. In fact, one of Pinnacle's stated "transaction objectives" was to "establish a health care provider that is a 'must have' for payers."

58. Moreover, health plans have confirmed that a provider network that lacked the combined Hershey/Pinnacle would be very difficult, if not impossible, to market to Harrisburg Area residents. This is evidenced by the recent experience of one area health plan. For over a decade, this health plan was able to market a viable network in the Harrisburg Area that included Pinnacle and Holy Spirit, but did not include Hershey. However, in 2015, after Pinnacle terminated its provider agreement with the health plan, the health plan rapidly lost almost half of its members in the Harrisburg Area and is now unable to market a viable network in the area.

59. Numerous health plans have expressed concern that the proposed Merger will eliminate competition and result in price increases. For example, a representative of Capital BlueCross, the second large health plan in the Harrisburg Area, sent an email to the Defendants which stated that "[w]ith the proposed merger, the new entity would control greater than 50% of the market and without a strategic long-term partnership defined for Capital, we would have concerns that the new entity would ultimately have too much leverage and Capital would not be able to negotiate market appropriate pricing and terms." Indeed, the CEO of Hershey acknowledged that health plans had "a lot of anxiety" that the Defendants would use the Merger as a means to raise prices.

60. As confirmed by numerous area health plans, the Harrisburg Area currently benefits from competition between Hershey and Pinnacle and has lower reimbursement rates than those that prevail in more concentrated markets in Pennsylvania, most notably York and Lancaster Counties, where a single health system dominates each market.

61. Post-Merger, the transaction would eliminate this beneficial competition and create a dominant health system in the Harrisburg Area. Accordingly, if allowed to proceed, the Merger would substantially increase the combined entity's bargaining leverage in negotiations and result in higher rates.

D.

The Merger Eliminates Vital Quality Competition

62. In addition to price competition, Hershey and Pinnacle compete extensively on non-price dimensions, including expansion of services, quality of care, and the use of state-of-the-art facilities and technology. Patients in the Harrisburg Area have benefitted from this competition.

63. In order to further compete with Hershey, Pinnacle has expanded its tertiary services in recent years. For example, Pinnacle has expanded and modernized its facilities, and introduced new advanced service lines pursuant to its Vision 2017 Plan, all to the benefit of Harrisburg Area residents. Pinnacle recently

renovated Harrisburg Hospital and its other hospitals to modernize, increase the number of private rooms, and add clinical space. Pinnacle has also expanded its service line offerings and implemented numerous operational improvements and best practices to improve its quality metrics and patient satisfaction. These improvements were driven by Pinnacle's desire to improve the patient experience and attract additional patients to Pinnacle and away from Hershey.

64. Competition between Pinnacle and Hershey is particularly evident in their efforts to improve and expand their respective oncology services. Pinnacle's strategic plan for its new state-of-the-art Ortenzio Cancer Center in Cumberland County states that "[t]he one competitor that brings the biggest challenge to us is the University Hospital for the medical school at Penn State Milton S. Hershey Medical Center ... In order for Pinnacle to be competitive we will have to assure that the patient experience is superior." An internal Hershey document about Pinnacle's Cancer Center notes "the future of the West Shore cancer market is at risk" and that Pinnacle is "making aggressive moves to grow its market share."

65. Pinnacle also has improved the quality of care at its hospitals to attract more patients from the Harrisburg Area. Pinnacle's internal documents show that it implemented operational improvements and best practices in order to improve its quality metrics and patient satisfaction.

66. Hershey has begun to implement strategic plans to expand its network of primary care practices and to construct a new outpatient ambulatory facility to increase access for patients in the Harrisburg Area and to compete with Pinnacle. It expanded outpatient services in Cumberland County to drive referrals to Hershey Medical Center and "steal market share from Pinnacle."

67. Hershey's documents also show its recognition that it needs to reduce costs and improve its quality and efficiency to remain competitive with Pinnacle and other competitors. It is "working to improve operational and cost performance" with specific initiatives on "quality & safety" and "cost efficiency."

68. The Merger would eliminate this beneficial competition between Hershey and Pinnacle on these vital non-price factors, thereby reducing incentives to improve quality, implement new medical technologies, and expand services in the Harrisburg Area. In addition, the Defendants intend, post-Merger, to move low acuity cases from Hershey to Pinnacle and high acuity cases from Pinnacle to Hershey. Such plans will further reduce the combined Hershey/Pinnacle's incentive to continue to invest in tertiary services at Pinnacle, and reduce costs and improve efficiency at Hershey. Losing these important benefits would affect all patients in the Harrisburg Area.

E.

Defendants' Recent Rate Agreements With Two Health Plans Would Not Prevent Competitive Harm

69. The Defendants have recently entered into multi-year agreements with the two largest health plans in the Harrisburg Area. These rate agreements – one is a term sheet, the other is letter agreement – purport to extend the Defendants' existing rate agreements with the health plans and commit to maintain the rate differential between Pinnacle and Hershey. The rate agreements were designed to forestall opposition to the Merger. One of these health plans requested the agreement "to ensure that [its] members are protected for a significantly long period of time from any adverse economic impact of the Pinnacle-Hershey merger." Accordingly, these rate agreements are strong evidence that the payors believe that the Merger would result in anticompetitive increases in reimbursement rates to health plans imposed by the combined Hershey/Pinnacle. However, these rate agreements do not alleviate the anticompetitive effects of the Merger.

70. First, the rate agreements are limited to only two health plans. The Defendants have not entered into similar agreements with other health plans in the Harrisburg Area. Accordingly, the combined Hershey/Pinnacle would be able to use its enhanced bargaining leverage to demand higher prices or better terms,

without any constraints, when negotiating with these other health plans.

71. Second, the rate agreements foreclose the possibility that, absent the Merger, competition could lead to rates that increase less quickly or even decrease. Similarly, they do not address that the change in bargaining dynamics due to the merged entity's increased leverage would also apply to different types of agreements, such as risk-sharing arrangements, which are purportedly contemplated by the letter agreements in the future. Under such newer reimbursement arrangements, the health plan and the provider must negotiate over the level of risk that each party bears. Here, the combined entity could use its increased bargaining leverage post-Merger to the detriment of health plans (and ultimately their members) when negotiating risk-sharing or value-based agreements.

72. Third, the rate agreements do nothing to preserve the service and quality competition between Pinnacle and Hershey that has benefitted Harrisburg Area residents and patients and that the Merger would eliminate.

73. Finally, the rate agreements are of limited duration. When they terminate, the Defendants will no longer be subject to any purported commitment to maintain the rate differential. Accordingly, the combined Hershey/Pinnacle would be able to use its enhanced bargaining leverage to demand higher prices or

better terms from the two health plans, without any constraints, when negotiating both traditional fee-for-service contracts as well as contracts with newer reimbursement models.

ENTRY BARRIERS

74. Neither entry by new healthcare providers into the relevant service market nor expansion by existing market participants will deter or counteract the Merger's likely serious competitive harm in the relevant service market.

75. New hospital entry in the Harrisburg Area would not be likely, timely, or sufficient to offset the Merger's harmful effects. Construction and operation of a new GAC inpatient hospital involves high costs and serious financial risk. The construction of a new hospital also would take much more than two years from the initial planning stage to opening, as evidenced by the significant time and expense involved in the building of Pinnacle's West Shore Hospital and Hershey's Children's Hospital.

76. Even if new hospital entry did occur, it likely would not be sufficient to offset the Merger's harm because a new hospital could not achieve the scale required to offer the broad cluster of GAC services comparable to those offered by the Defendants. Hershey and Pinnacle are both large, high-quality health systems, which offer a full range of GAC services and employ a significant number of

physicians. Their service capabilities, strong reputations, and significant share of the relevant market present significant barriers to entry and would be extremely challenging for a new entrant to replicate in a manner sufficient to counteract the likely anticompetitive effects of the Merger.

77. Moreover, hospitals both outside and within the Harrisburg Area have affirmed that they have no plans to enter or build new hospitals in the Harrisburg Area. In fact, the Defendants are the only healthcare providers that have constructed new hospitals in the relevant area (one each) in over a decade.

EFFICIENCIES

78. No court ever has found, without being reversed, that efficiencies rescue an otherwise illegal transaction. Here, in order to rebut the presumption that the Merger is unlawful, Defendants would need to present evidence that extraordinary merger-specific efficiencies, which will be passed on to consumers, outweigh the Merger's likely significant harm to competition in the Harrisburg Area. However, Defendants' efficiency claims are overstated, speculative, unverifiable, not merger-specific, or result from an anticompetitive reduction in output, quality, or services, and are largely non-cognizable. Overall, Defendants' efficiency claims, to the extent they are cognizable, are insufficient to offset the substantial competitive harm the Merger is likely to cause.

79. Defendants have claimed that Hershey is at capacity and the Merger will allow the Defendants to transfer patients suffering from less severe illnesses from Hershey to Pinnacle, which has the capacity to treat them. Defendants further claim that this will allow Hershey to avoid constructing a new inpatient bed tower to alleviate its capacity issues.

80. However, Hershey could alleviate its capacity constraints in a timely manner without the Merger. Moreover, the Defendants' alleged efficiency plans would result in competitive harm. Defendants' plans would force patients to go to a different hospital than the one they originally chose. Defendants' plans would also reduce output, capacity, and service compared to the but-for world without the Merger, thereby denying patients the benefits of new inpatient rooms at Hershey. Accordingly, these claims are not cognizable under the law.

81. The Defendants have also claimed that the Merger may achieve other operational efficiencies. However, these efficiency claims are speculative, overstated, and have not been substantiated by the Defendants.

LIKELIHOOD OF SUCCESS ON THE MERITS, BALANCE OF EQUITIES, AND NEED FOR RELIEF

82. Section 13(b) of the FTC Act, 15 U.S.C. § 53(b), authorizes the Commission, whenever it has reason to believe that a proposed merger is unlawful, to seek preliminary injunctive relief to prevent consummation of a merger until the

Commission has had an opportunity to adjudicate the merger's legality in an administrative proceeding. The Court may grant preliminary injunctive relief upon a proper showing that weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest. The principal public equity weighing in favor of issuance of preliminary injunctive relief is the public interest in effective enforcement of the antitrust laws. Private equities affecting only Defendants' interest cannot defeat a preliminary injunction.

83. The Commission is likely to succeed in proving that the effect of the Merger may be substantially to lessen competition or tend to create a monopoly in violation of Section 7 of the Clayton Act, 15 U.S.C. § 18, or Section 5 of the FTC Act, 15 U.S.C § 45.

84. Preliminary relief is warranted and necessary. Should the Commission rule, after the full administrative trial, that the Merger is unlawful, reestablishing the *status quo ante* of vigorous competition between Hershey and Pinnacle would be difficult, if not impossible, if the Merger has already occurred in the absence of preliminary relief. Moreover, in the absence of relief from this Court, substantial harm to competition would likely occur in the interim, even if suitable remedies were obtained later.

85. Accordingly, the equitable relief requested here is in the public

interest. WHEREFORE, the Commission and the Commonwealth of Pennsylvania respectfully request that the Court:

1. Temporarily restrain and preliminarily enjoin Defendants from taking any further steps to consummate the Merger, or any other acquisition of stock, assets, or other interests of one another, either directly or indirectly;

2. Retain jurisdiction and maintain the *status quo* until the administrative proceeding that the Commission has initiated is concluded;

3. That Plaintiffs be awarded their costs of this action, including attorneys' fees to the Commonwealth of Pennsylvania; and

4. Award such other and further relief as the Court may determine is appropriate, just, and proper.

Dated: December 9, 2015

Respectfully submitted,

WILLIAM H. EFRON
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EXHIBIT N

No. 16-2365

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

FEDERAL TRADE COMMISSION *et al.*,
Appellants,

v.

PENN STATE HERSHEY MEDICAL CENTER *et al.*,
Appellees.

On Appeal from the United States District Court
for the Middle District of Pennsylvania
No. 1:15-cv-2362 Hon. John E. Jones III

BRIEF OF THE FEDERAL TRADE COMMISSION AND THE COMMONWEALTH OF PENNSYLVANIA

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GLOSSARY

For ease of reference, the following abbreviations and citation forms are used in this brief:

App.	Appellants' appendix
PX	Plaintiffs' exhibit
Hrg.	Transcript of testimony from preliminary injunction hearing

JURISDICTION

The district court had jurisdiction over the FTC's request for a preliminary injunction to preserve the status quo under 15 U.S.C. § 53(b), and over Pennsylvania's request for a preliminary injunction under 15 U.S.C. § 26. The district court entered the order under review on May 9, 2016 (App. 4), and the Government plaintiffs filed a notice of appeal the following day (App. 1). This Court has jurisdiction because the order under review is final and disposed of all issues presented, 28 U.S.C. § 1291, and because the lower court denied an injunction, 28 U.S.C. § 1292(a)(1).

QUESTION PRESENTED

The Government plaintiffs sought a preliminary injunction blocking the merger of the two largest health systems in the Harrisburg, Pennsylvania area while the FTC conducts an administrative adjudication to determine whether the merger violates the antitrust laws. The hospitals are close rivals for inclusion in insurance company healthcare networks, and together they would control nearly 80 percent of the market for general acute care inpatient services sold to commercial health insurers in the Harrisburg area. The questions presented are:

1. Whether the district court improperly determined that the Government did not show that the four-county area around Harrisburg is a proper antitrust geographic market; and

2. Whether the district court improperly assessed the "equities" of the merger in declining to preliminarily enjoin it.

STATEMENT OF RELATED CASES AND PROCEEDINGS

This case has not been before the Court previously. An administrative proceeding challenging the merger and related directly to this case is pending before the Federal Trade Commission in FTC Docket No. 9368.

STATUTES AND REGULATIONS

Pertinent materials are attached.

STATEMENT OF THE CASE

This is an antitrust case under Section 7 of the Clayton Act, 15 U.S.C. § 18, involving the merger of the two largest hospital systems in the area around Harrisburg, Pennsylvania. The hospitals have long been close competitors, but in 2015 they decided to stop competing and agreed to combine into a single economic entity. The Federal Trade Commission found reason to believe that the merger would significantly reduce competition in the Harrisburg-area hospital market, and its Commissioners voted unanimously to issue an administrative complaint to block the merger. That matter will be tried before an agency administrative law judge later this year.

In the meantime, the FTC and the Commonwealth of Pennsylvania asked the district court below to issue a preliminary injunction preventing the merger from closing before the administrative adjudication is complete. Recognizing the need

to protect consumers from competitive harm until the adjudication is finished and to preserve the FTC's ability to secure effective relief if the merger is held unlawful, Congress authorized district courts to grant preliminary injunctions temporarily barring mergers in this type of case. 15 U.S.C. § 53(b).

The Government alleged that the merger will substantially lessen competition in the market for general acute care inpatient hospital services sold to commercial insurers in the Harrisburg, Pennsylvania area. The combined hospital systems would control 76% of the market, dramatically increasing their bargaining power over health insurers and enabling them to raise prices and reduce output, while reducing their incentives to improve patient care and service.

After a five-day hearing, at which 15 witnesses testified and numerous exhibits were introduced, the district court denied the Government's request for a preliminary injunction. The FTC and Pennsylvania appeal from that order. On May 24, 2016, this Court granted the Government's motion for an injunction pending appeal.

A. The Proposed Merger

Hershey and Pinnacle operate the two largest hospital systems in the four county area surrounding Harrisburg, which includes Dauphin, Cumberland, Perry, and Lebanon counties. Those counties have a combined population of almost

700,000. PX01062-37-38.[1] Hershey, which commands a 36 percent share of inpatient hospital services in the four-county area, owns the Penn State Milton S. Hershey Medical Center in Dauphin County, a 551-bed facility. Pinnacle, with a 40 percent share, operates three hospitals in the Harrisburg area, including two in Dauphin County, with a combined 646 beds. Defendants operate the only hospitals in Dauphin County, where the city of Harrisburg is located. The next largest hospital, Holy Spirit, located in Cumberland County, has a 15 percent market share. Each of the two remaining hospitals in the four-county area has a share of 5 percent or less. PX01062-21, 28, 116.

Pinnacle and Hershey offer an extensive range of inpatient hospital treatment and provide almost entirely overlapping services. PX01062-127-131. Approximately 98% of Hershey's patients could be treated at Pinnacle, and nearly all of Pinnacle's patients could be treated at Hershey. PX01062-131; Hrg. 334:17-21 (App. 81). Both hospitals are sophisticated health systems with teaching hospitals that offer highly complex treatments and innovative medical technology. Hrg. 523:15-530:12; PX00280-002; PX00027-081; PX00030-128; PX00253-009; PX00379-002-06.

[1] PX01062 is the report of the Government's expert economist, Dr. Nathan Wilson. PX01424 is his Rebuttal Report.

B. Economics Of Insurer/Hospital Price Negotiations

1. Understanding the competitive dynamics of hospital markets is essential for assessing the competitive effects of a hospital merger. Unlike the typical two-party market, the market for hospital services has four participants: *hospitals*, which provide healthcare services; *health insurance companies*, which negotiate the prices of hospital services and market health plans to employers and their employees; *employers*, who select among the competing health plans offered by insurance companies; and *employees*, who are the ultimate consumers of service and decide which hospital to use.[2]

Those four participants engage in a complex relationship. Because insurers compete with one another to sell policies, they must offer attractive health plans. Whether a policy is attractive depends not only on its price, but also on the desirability of the service providers, including hospitals, in the insurance "network." The network is the group of healthcare providers that have agreed to treat the insurer's policyholders at negotiated prices. Those prices are usually significantly lower than the prices charged by providers outside of the insurer's network. Insurers thus strive to assemble a desirable network at the lowest cost.

[2] We refer to employees as "policyholders," "consumers," and "patients" interchangeably. Insurance companies were referred to below as "payors."

Hrg. 305:12-22, 306:14-20 (App. 65-66); PX01062-55, 58-60, 65, 75; PX01424-061.

Because insurers rather than policyholders negotiate prices, they are the hospitals' direct customers. PX01062-59-60; Hrg. 306:10-13 (App. 66). Once the price that an insurer will pay a hospital for service has been established, policyholders who need hospital care typically face no significant price difference between in-network hospitals. PX01062-59-60. Instead, hospitals compete for their business on the basis of quality and convenience. In particular, patients typically demand access to local care. A hospital's proximity to policyholders therefore is a core consideration for insurers when assembling their provider network. PX01062-64-65, 93; PX01424-61; Hrg. 315:13-20, 320:11-22 (App. 72, 76). The Supreme Court has recognized that "in most service industries, convenience of location is essential to effective competition." *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 358 (1963).

At the same time, hospitals compete to be included in insurance company networks. Insured patients rarely choose providers outside their health plan's network. Health plans typically either do not cover the cost of out-of-network care at all or require patients to bear a significantly larger share of it. Thus, a hospital that is not included in an insurance company's network is likely to lose access to virtually all of that insurer's policyholders. Competition between hospitals leads to

both lower prices (as described immediately below) and to improvements in quality of care and service to patients. PX01062-55,68-69; Hrg. 305:23-306:09, 309:03-06 (App. 65-67).

2. Prices are negotiated between each hospital and health insurance company. Like any business deal, both sides have some amount of bargaining power, or "leverage," and the agreement reached depends on the relative strengths of that leverage. Leverage ultimately is a function of a party's ability to walk away from the negotiation and refuse to do business with its negotiating partner. Thus, in bargaining over hospital prices, if the hospital demands too high a price and the insurer abandons the negotiation, the hospital will lose access to most of that insurer's members. Hrg. 309:12-25 (App. 67). Conversely, if the insurer insists on an unacceptably low price and the hospital walks away, the insurer will be unable to include the hospital in its network and must offer a policy that does not cover the hospital. A hospital's leverage thus depends on how important it is to the insurer's network, which reflects both patient preferences for the hospital and the availability of desirable alternative substitute hospitals. PX01062-65-67; Hrg. 309:12-311:20 (App. 67-69). *See ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 562 (6th Cir. 2014); *St. Alphonsus Medical Center v. St. Luke's Health System*, 778 F.3d 775, 784-785 (9th Cir. 2015).

Greater hospital competition leads to lower hospital prices. The more hospitals that compete for inclusion in insurance networks, the more an insurer can plausibly substitute one hospital for the other when forming its network and the stronger its ability to resist price increases. PX01062-067-71; Hrg. 309:22-310:11 (App. 67-68); *see ProMedica*, 749 F.3d at 562. Competition between hospitals thus constrains their prices, which allows insurers to charge lower premiums, co-payments, and deductibles to employers and their employees. PX01062-55. And, as mentioned, competition between hospitals also spurs them to improve quality of care.

But less competition among hospitals for inclusion in insurance networks increases the hospital's leverage, leading to higher prices, higher policy costs, and lower quality of care. Hrg. 339:19-341:6 (App. 82-84); PX01062-73-76. An insurer facing a hospital with superior bargaining leverage will agree to pay higher prices because doing so is preferable to marketing a network that lacks the hospital. When hospitals that formerly competed for inclusion in the network merge, it diminishes the insurer's bargaining position. PX01062-65-67.

3. The record showed that the bargaining model described above accurately depicts the commercial reality of the Harrisburg market. Through sworn declarations and deposition testimony, area insurers repeatedly confirmed that the outcome of price negotiations turns on their relative bargaining leverage with

hospitals. The declaration of one area insurer, for example, stated that a hospital's leverage "is largely determined by the extent to which [policyholders] demand to receive care at that hospital." PX00701 ¶¶15-17 (App. 268-269). The insurer's leverage in turn depends on "how many competing providers are located in a particular area." *Id.* ¶15. Where alternatives are limited, "a [hospital] is generally able to negotiate higher reimbursement rates … because [it] could credibly threaten to terminate its contract with [insurer], which would result in [insurer] having a significantly less attractive network to offer to members." *Id.* ¶17. Other insurance company executives testified to the same effect. PX00700 ¶5; PX00704 ¶¶4-5; PX01062-076-78; PX01236, 38:10-40:15 (App. 490). One testified that the availability of competing hospitals affects a hospital's leverage because it determines the credibility of an insurer's threat "to walk away from a negotiation and yet still market an attractive network at competitive rates." PX00707 ¶16. Defendants do not disagree. *See* PX01382-004 (App. 515) (discussed in greater detail at page 15 below).

C. The Harrisburg Market

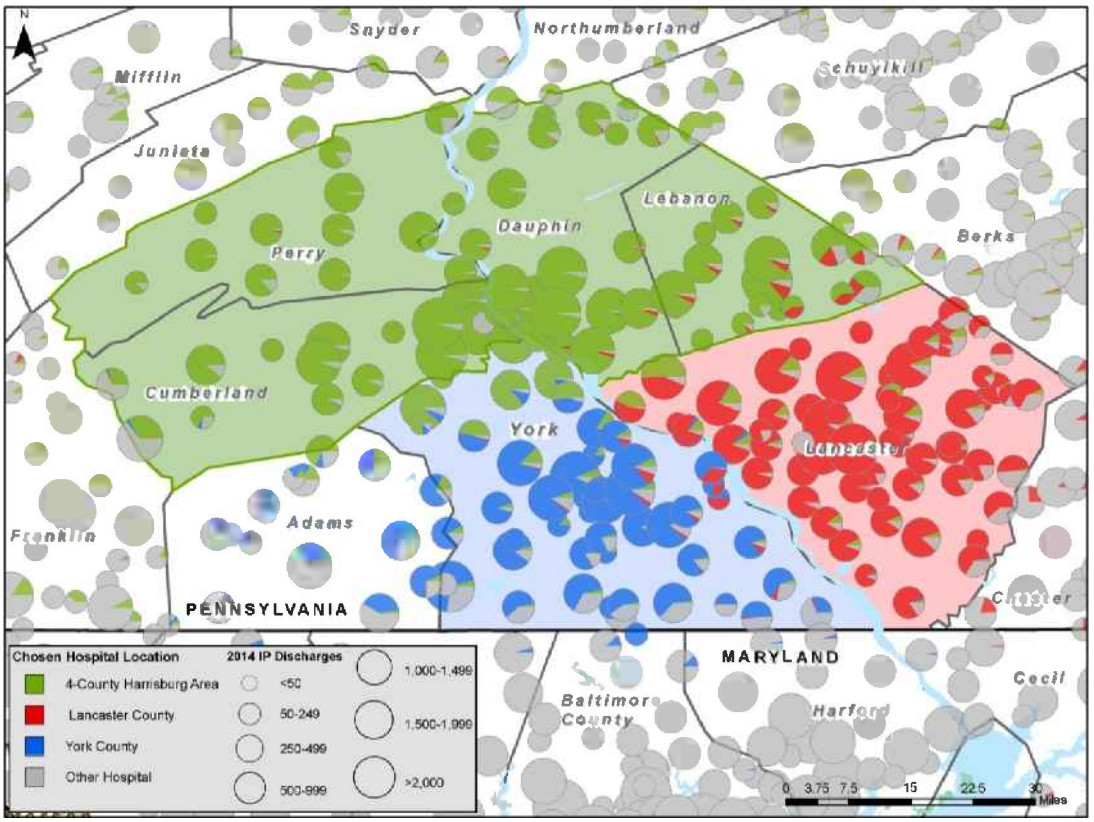
Hershey and Pinnacle compete against each other both for patients and for inclusion in insurers' hospital networks. Pinnacle's CFO testified that they compete closely on quality, price, and range of services offered. Hrg. 537:7-10, 540:17-541:8, 541:20-542:4 (App. 116-119). Indeed, Pinnacle identified Hershey

as "our main competitor," PX00527-001, and Hershey described Pinnacle as a "primary competitor," PX00140-008. Pinnacle indicated that the two systems "aggressively compete." PX00037-008. Other of defendants' documents and testimony show aggressive competition across a wide range of services including cancer treatment, PX00039-006; heart surgery, PX00940-001; breast surgery, PX00327-001-2; PX01473-001; and kidney transplants, PX01202, 74:5-13. As the hospitals' own expert testified, the evidence showed a "local rivalry" for cancer treatment and kidney transplants that is "particularly hot." PX01232, 252:25-255:18.

1. The two hospitals are especially close rivals in the Harrisburg area because consumers in the Harrisburg area overwhelmingly demand hospital care close to their homes. The evidence showed that 91% of Harrisburg area patients sought care at hospitals located in the four-county area, with a median travel time of 15 minutes. Hrg. 315:12-20, 319:22-320:22 (App. 72, 75-76); PX01062-97-102, 120. By contrast, the largest hospitals in York and Lancaster counties, which are each 30 to 45 minutes away, collectively provide care to fewer than 2 percent of Harrisburg area patients. PX01062-043, 122.

An economic analysis performed by the Government's expert graphically shows the strong preference of Harrisburg area patients for local hospitals. The chart below shows by color where patients who live within a given zip code go for

hospital care (each circle represents one zip code, and its size indicates the insured population). It indicates clearly that patients living in the Harrisburg area (shown in green) overwhelmingly prefer to receive care in hospitals inside the area. Similarly, residents of York (shown in blue) and Lancaster (shown in red) counties overwhelmingly receive care at hospitals in their own home counties.



Source: 2014 commerical discharges from the Pennsylvania Health Care Cost Containment Council (PHC4) and the Maryland Health Services Cost Review Commission (MD HSCRC).

PX01062-99-101. Put simply, patients use hospitals close to home.

Defendants' own analyses reached the same conclusion. A survey they conducted showed that 92% of Central Pennsylvania residents would go either to the closest or to a very convenient hospital to receive non-life threatening care, and

that convenient location was consumers' most important factor in selecting a hospital. Hrg. 320:16-321:16 (App. 76-77); PX01360-024 (App. 511).

Similarly, Hershey's CEO testified that the desire for local care is a "big determinant in people's choice of health care." Hrg. 474:7-10 (App. 100). Pinnacle's CFO testified likewise. Hrg. 521:17-522:6 (App. 106-107). Indeed, the President of PinnacleHealth's Medical Group said in an email that most Central Pennsylvania patients would not travel more than 10 miles or 20 minutes from home to receive hospital care. PX01277-001.

Area insurers also consistently affirmed that residents in the Harrisburg area strongly prefer to go to local hospitals. The director of provider contracting for one insurer stated that most of its Dauphin County policyholders used either Pinnacle or Hershey "[b]ecause of the proximity of these two quality health systems," and that "very few members who live in Dauphin County travel outside the county for general acute services." More broadly, "the vast majority of [insurer's] members in the four-county Harrisburg area utilize health systems locat[ed] within this area, with few members leaving for general acute care." PX00701 ¶¶7-8 (App. 266); *see also* PX00707 ¶9; PX00700 ¶¶12-13. The demand for local hospital care was further confirmed by the testimony of a former Harrisburg area hospital CEO explaining that most patients in Dauphin County receive care at either Pinnacle or Hershey. Hrg. 90:11-16 (App. 36).

The strong preference among Harrisburg-area residents for Hershey and Pinnacle specifically was confirmed by defendants' own brand study, which concluded that Pinnacle's Harrisburg Hospital "leads or is second to Penn State Hershey in the Primary market," which the study defined as the Harrisburg area. PX01360-11 (App. 510).

2. Because Harrisburg residents demand local hospital service, insurance company networks are marketable to them only if the network provides access to Harrisburg-area hospitals. Employers in the Harrisburg area provided sworn declarations that both they and their employees will consider using a health plan only if its provider network includes local hospitals.[3] Insurance company representatives recognize this strong preference and consistently affirmed the need to include local hospitals in their networks. PX00704 ¶¶6-8, 11; PX00707 ¶4; PX00701 ¶¶7-8 (App. 266-267).

A natural experiment described at the hearing vividly illustrates the need for either Hershey or Pinnacle in an insurance network marketed to Harrisburg-area employers. For more than a decade, one small insurer successfully marketed policies to those employers that included Pinnacle and Holy Spirit, but not Hershey, in the network. PX00704 ¶10; Hrg. 208:25-209:11 (App. 51-52). In

[3] PX00708 ¶¶5, 9; PX00717 ¶¶8, 13; PX00718 ¶¶5, 7, 10; PX00719 ¶¶5, 11; PX00720 ¶4.

2014, Pinnacle terminated its participation in the insurer's network. PX01533-001; Hrg. 209:18-210:13 (App. 52-53). Once Pinnacle withdrew, half of its commercial policyholders switched to other insurers even though its network included Holy Spirit and large hospitals in York and Lancaster counties and the insurer offered a substantial discount. PX01542; PX01608; Hrg. 223:20-226:19 (App. 54-57); PX01610; PX00704 ¶10. Brokers opined that the network without Hershey and Pinnacle was unmarketable at any price point. PX00704 ¶10; PX00708 ¶¶ 7-13; Hrg. 225:15-226:19 (App. 56-57).

The experience of that small insurer was confirmed by the two largest ones in the Harrisburg area. Their representatives testified at depositions that they too could not successfully market a network without either Hershey or Pinnacle. One stated that without the two hospitals, "[f]or all intents and purposes there would be no network." PX01236, 48:17-22 (App. 491). He predicted that a network without defendants' hospitals would lose half its membership in Dauphin County. PX01236, 144:6-16 (App. 494).

His counterpart at the other large insurer testified similarly. Asked, "When you market a plan in the Harrisburg area, would you need to include a combined Hershey and Pinnacle in your network to successfully market it?" he answered simply, "Yes." PX00804, 64:13-20 (App. 317). That testimony establishes that

even the largest insurers in the Harrisburg area would not try to sell a network that includes neither Hershey nor Pinnacle.

3. The evidence showed that competition between Hershey and Pinnacle for inclusion in insurers' networks has constrained their prices and that eliminating the competition would lead to increased prices. A real-world example demonstrates the constraint. In 2014, Pinnacle demanded a substantial price increase from one of the area's largest insurance companies. When the insurer responded by threatening to exclude Pinnacle from its network and instead rely on a network that included only Hershey and Holy Spirit, Pinnacle relented. PX00701 ¶18 (App. 269).

Defendants have explicitly acknowledged in this litigation how the separate existence of Hershey and Pinnacle has benefitted insurers in contract negotiations. Indeed, they sought (unsuccessfully) to keep Pinnacle's price capitulation, which was described in the Government's complaint, under seal. They argued that

> If this information is made public, health plans will learn that a competitor was able to resist Pinnacle's request for a rate increase by threatening to exclude Pinnacle from its network. As a result, health plans will have increased leverage in resisting future requests by Pinnacle for reasonable rate increases. Similarly, if other hospitals learn about this, they will know that health plans may be able to exclude Pinnacle from their networks, and those hospitals could thus seek to negotiate better deals for themselves by proposing plans that exclude Pinnacle.

PX01382-004 (App. 515).

Evidence from insurers likewise showed that the merger would eliminate this favorable bargaining dynamic and allow the combined entity to demand a price increase. An executive of one of the two largest area insurers emailed that the Harrisburg market "has been a very fortunate market" that has benefitted from competition among health systems, but he was concerned that a combined Hershey/Pinnacle "would ultimately have too much leverage and [the insurer] would not be able to negotiate market appropriate pricing and terms." PX00378-002 (App. 221); *accord* PX01200, 34:8-20 (App. 458). The executive responsible for hospital contracting at the other large area insurer testified at his deposition that if the merged hospitals demanded a price increase, his company "wouldn't have a whole lot of choice," but to pay it. PX01236, 49:3-19 (App. 492). He estimated that the company would have no realistic alternative but to pay prices 25 percent higher to keep them in the network. PX01236, 91:16-25,144:6-16, 48:23-49:19 (App. 491-494); *see also* PX01201, 70:21-71:18. Finally, in sworn declarations, other area insurers explained their concerns that the merger would increase defendants' bargaining leverage, resulting in higher prices for these insurers and their policy holders. PX00700 ¶19; PX00704 ¶14.

Hershey's own CEO acknowledged at his deposition that insurers had "a lot of anxiety" that defendants would increase prices post-merger and were particularly concerned that the merger would allow defendants to raise prices at

Pinnacle, whose prices are lower than Hershey's. PX00801, 103:24-105:9. A representative from one of the two largest area insurers, who analyzed the potential financial impact of the merger, estimated substantial price increases if defendants increased Pinnacle's prices. PX00612-003.

Pinnacle too recognized the potential for post-merger price increases. One of its stated "objectives" for the merger was to "establish a health care provider that is a 'must have' for [insurers]." PX00463-010. A Pinnacle executive even queried whether it would "make sense to put a charge increase in now while we can without it looking like we completed the merger, then raised charges?" PX00301-001.

4. The Government's expert testified that for antitrust purposes the four-county Harrisburg area is a relevant geographic market. Principally, the expert applied the "hypothetical monopolist" test, a standard tool of market definition used by economists, antitrust agencies, and courts. *See* U.S. Dep't of Justice & Federal Trade Commission, *Horizontal Merger Guidelines*, §§ 4.1.2, 4.2; *see Atlantic Exposition Servs. Inc. v. SMG*, 262 F. App'x 449, 452 (3d Cir. 2008); *see also St. Luke's Health Sys.*, 778 F.3d at 784-785. The test asks whether a hypothetical monopolist in a proposed geographic market—*i.e.*, a single owner of every hospital in that area—could profitably impose a small but significant (about 5 percent) non-transitory price increase (called a "SSNIP"). If the hypothetical

monopolist could profitably impose a SSNIP from at least one location of the merging firms, then the market is properly defined for antitrust purposes. The analysis showed that a monopolist in the four-county Harrisburg area could impose a SSNIP, which means that the Harrisburg area is a proper antitrust geographic market. PX01062-84-86, 91-92; Hrg. 313:17-314:21 (App. 70-71).

As shown above, insurers testified that, post-merger, they would pay a combined Hershey/Pinnacle in excess of a SSNIP in order to keep those hospitals in their network. Thus, as the Government's expert explained, a hypothetical monopolist of just these two Harrisburg area hospital systems could demand a SSNIP. PX01264-64-65; Hrg. 386:19-24 (App. 91). By necessary implication, a hypothetical monopolist of all Harrisburg-area hospitals would therefore also be able to demand a SSNIP. PX01062-092.

Additional fact witness testimony confirmed as much. Insurers uniformly view the Harrisburg area as a distinct market.[4] Indeed, when one large insurer calculated the financial impact of the merger, it measured defendants' post-merger market shares only in the four-county Harrisburg area and a narrower two-county Dauphin/Cumberland area. PX00613-002.

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[4] PX00700 ¶¶2, 8; PX00704 ¶¶6-8, 11; PX00707 ¶4; PX00701 ¶¶3, 8; PX00804, 16:21-17:2 (App. 314-315); PX01201, 6:22-17:8; PX00784-004; PX01027-006; PX01062-101-06 (quoting the consistent views of market participants that the Harrisburg area is a distinct market).

The hospitals' own contemporaneous business documents show that they too see the Harrisburg area as a distinct market. Hershey's Chief Marketing Officer and Pinnacle's Director of Marketing agreed that the "[p]rimary" market for defendants' brand survey should be limited to the four counties in the Harrisburg area. PX00373-002. Hershey's COO testified that defendants' agreement with one large insurer defined their "Core Service Area" as the Harrisburg area and granted exclusive rights and competitive restrictions solely within this area. Hrg. 591:24-595:20; PX00029-008. Hershey identified the Harrisburg area as a distinct region reflecting "natural referral patterns" and requiring its own strategic plan. PX01198-001; PX00881-004; Hrg. 599:2-600:24. Pinnacle's CFO stated that Pinnacle's primary service area fell within the Harrisburg area and identified its closest competitors to be Hershey and Holy Spirit. Hrg. 537:4-10 (App. 116); PX00802, 63:9-13; PX00380-037; PX00006-001; PX00251-009.

D. Presumption That The Merger Is Anticompetitive

A merger that substantially increases market concentration in an already concentrated market is presumptively anticompetitive and unlawful. *See Philadelphia Nat'l Bank*, 374 U.S at 363. The *Merger Guidelines* measure market concentration using the "Herfindahl-Hirschman" Index ("HHI"), which is calculated by summing the squares of market share percentages. A transaction that increases the HHI by more than 200 points in a market that is already highly

concentrated (over 2,500) is presumed likely to enhance market power. *Merger Guidelines* § 5.3. Currently, the HHI of the Harrisburg market is 3,132—highly concentrated. The post-merger HHI would be 5,984, an increase of 2,852 points, which is *nearly fifteen times* greater than the *Merger Guidelines*' threshold for a presumptively anticompetitive merger. PX01062-115-16; Hrg. 323:22-324:10 (App. 79-80). That increase reflects the enormous 76 percent market share of the combined hospitals. *See Philadelphia Nat'l Bank*, 374 U.S. at 364 (30 percent market share unlawfully concentrated).

Consistent with the increase in market concentration, the Government's economic expert showed that the merger would likely allow the combined hospitals to raise their prices. Using common econometric techniques, the Government's expert concluded that the merger was likely to result in substantial price increases up to $178 million per year and insurance premium increases of as much as 33 percent. Hrg. 339:19-23 (App. 82); PX01062-148; PX01424-36. These estimates of harm were consistent with those provided by a large insurer. PX00612-003.

The Government's expert also testified that competition would be harmed by Hershey's cancellation of its plan to expand its facility by building a new "bed tower" should the merger take place. The bed tower would increase Hershey's ability to serve patients, and the increased capacity would lower prices. Hrg.

341:16-342:7 (App. 84-85), 988:16-990:1. Canceling the project would amount to a reduction in output, which would constrain supply and increase prices. Hrg. 341:5-15 (App. 84); PX01062-154-157. Defendants' own economic expert largely agreed that capacity expansion by Hershey would likely lower prices at both Hershey and Pinnacle. PX01232, 112:15-116:18.

Finally, the Government presented evidence that the merger would eliminate substantial competition between Hershey and Pinnacle on non-price dimensions such as quality of care and expanding access to services. For example, a Pinnacle document stated with respect to oncology services that "[i]n order for Pinnacle to be competitive we will have to assure that the patient experience is superior" to Hershey's. PX00039-006.

E. The District Court's Order

The district court denied the Government's request for an injunction. The parties had agreed that the relevant *product* market is general acute care services sold to commercial payors. App. 9. The court found that the Government had not shown the four-county Harrisburg area to be a properly defined antitrust *geographic* market, which was "dispositive to the outcome" of the proceeding. App. 11. The court believed the Government's proposed market to be a "starkly narrow view of the amount of hospitals patients could turn to if the combined Hospitals raised prices or let quality suffer." *Id.* at 13. It concluded that "19 other

hospitals within a 65 minute drive of Harrisburg provide a realistic alternative that patients would utilize." *Id.* at 12. The court based that conclusion on the fact that 43.5% of Hershey's patients travel to Hershey from outside the Harrisburg area. Because those patients travel to the Harrisburg area to receive care, the court held, the Government had failed to proffer a geographic market in which "'few' patients leave…and 'few' patients enter." *Id.* at 10 (quoting *Little Rock Cardiology Clinic PA v. Baptist Health*, 591 F.3d 591, 598 (8th Cir. 2009)).

The court also found it "extremely compelling" for purposes of geographic market definition that the hospitals have entered into long-term contracts with two large insurers that "maintain existing rate structures." App. 13-14. The court elaborated that, in applying the hypothetical monopolist test, it "simply cannot be blind to [the] reality" that defendants cannot increase prices to these two insurers for at least five years. *Id.* at 14. The court declined to make a "prediction" of what might happen to prices in 5 years, stating that doing so would be "imprudent." *Id.*

At no point in its analysis did the court discuss how hospital prices are established or describe the bargaining dynamic between hospitals and insurance companies. Nor did the court mention how insurers create their provider networks or what consumers require when they chose insurance networks and use hospital care. Instead, the court rested its consideration of the geographic market entirely on Hershey's out-of-area patients and the two temporary price agreements.

Because the court determined that the Government had not established a likelihood of success on the merits of its case, it did not engage in the ordinary antitrust burden-shifting regime. *See FTC v. H.J. Heinz Co.*, 246 F.3d 708, 715 (D.C. Cir. 2001). It therefore did not require the defendants to prove that the proposed transaction would not cause anticompetitive effects. The court nevertheless went on to address the "equities," stating that the hospitals "presented ample evidence demonstrating that anticompetitive effects would not arise" from their merger. App. 15. Although the court recognized that defendants' claimed efficiencies are not a "defense to illegality," it nevertheless found the merger "would provide beneficial effects to the public, such that equitable considerations weigh in favor of denying the injunction." App. 17-18.

That "weighing of the equities" considered several factors. First, the court found that the merger would alleviate capacity constraints at Hershey because patients could be shifted from Hershey to Pinnacle. That, in turn, would allow Hershey to avoid construction of the bed tower. Second, the court found that "repositioning" by other nearby hospitals—*i.e.*, their association with large hospital systems in an attempt to attract patients—"has already occurred" and will result in a meaningful constraint on prices. Third, the district court found that the merger would beneficially affect the defendants' ability to engage in "risk-based contracting," a method of payment in which the hospital accepts some of the risk

ordinarily borne by the insurer. The court reached that determination even though it also found that "Hershey and Pinnacle independently are capable of continuing to operate under the risk-based model." App. 26.

The FTC and the Commonwealth of Pennsylvania appeal from that decision. On May 24, 2016, a panel of this Court enjoined the merger pending appeal.

SUMMARY OF ARGUMENT

Hershey and Pinnacle are by far the two largest hospital systems in the Harrisburg area. Their merger will eliminate competition between them and result in a single dominant hospital system with a 76 percent market share. Insurers will be unable to successfully market a network without the merged hospitals, which will therefore enjoy greatly enhanced bargaining power. The upshot will be substantial price increases and lower incentives to improve quality of care.

The Clayton Act prohibits mergers that "*may* ... substantially lessen competition." 15 U.S.C. § 18 (emphasis added). Section 13(b) of the FTC Act authorizes a court to enjoin a merger pending an administrative adjudication where the Government is "likely" to prove a merger unlawful. The Government satisfied both statutes here, and the district court therefore committed error when it declined to enjoin the merger.

1. The Government showed that the four-county Harrisburg area is a proper antitrust geographic market. The district court committed errors of both law and fact when it rejected that proposed market.

A geographic market is the area where buyers may "rationally look" to purchase services. Determining the relevant geographic market in an antitrust case must be grounded in the commercial realities faced by the relevant customers—here, insurers. Insurers bargain with hospitals over prices and they pay the bills directly. Defendants do not dispute this. The evidence clearly showed that insurers that wish to sell policies in the four-county Harrisburg area must purchase hospital services in that area because area residents overwhelmingly use Harrisburg-area hospitals and require policies that include local hospitals. As a result, insurers cannot rationally look to hospitals outside of the area if they wish to have a marketable product.

As the parties and the district court acknowledge, geographic markets are properly assessed using the "hypothetical monopolist test" set forth in the *Horizontal Merger Guidelines*. As that test applies here, the relevant question is whether a hypothetical owner of all Harrisburg area hospitals (*i.e.*, the monopolist) could successfully demand a price increase from insurers. If so, then the Harrisburg area is a properly defined antitrust market.

The Government submitted overwhelming evidence, including testimony from Central Pennsylvania's two largest insurers, that insurers would pay a demanded price increase rather than market a network without Harrisburg area hospitals. Nevertheless, the district court rejected the Harrisburg area as an antitrust market. In doing so, the district court committed three independent legal errors, all stemming from its failure to consider the commercial realities of the hospital marketplace and to properly formulate and apply the hypothetical monopolist test. Any one of those errors would justify reversal.

First, the court completely ignored both the role of insurers in negotiating hospital prices and the bargaining process through which hospital prices are set. Erasing the role of insurers in turn led the court to disregard the critical and conclusive evidence that an insurance network that does not include Harrisburg-area hospitals is not marketable to Harrisburg-area employers, and that an insurer would rather pay more than create a network without them. Instead, the district court based it analysis of the geographic market on the fact that a subset of Hershey's patients travel to Hershey from outside the area. The preferences of those patients have no bearing on the central question whether insurers can market a network to Harrisburg area employers without area hospitals. The district court's focus on out-of-area patients, rather than on the relevant insurance company

buyers, was unmoored from the "commercial reality" of the hospital marketplace, a basic error of law.

Second, the court misapplied the hypothetical monopolist test. The *Merger Guidelines* require analysis of whether the hypothetical monopolist could raise prices at *any* of the merging firms' hospitals. The court therefore should have asked whether a hypothetical monopolist of Harrisburg area hospitals could raise prices at either Hershey or Pinnacle. But the court completely failed to examine whether prices could be raised at Pinnacle. That too was legal error.

Third, the district court committed yet another fundamental error of law when it based its application of the hypothetical monopolist test on private price agreements between the hospitals and two large insurance companies. Such agreements have no proper place in the inquiry, as established by legal precedent. The insurers sought these agreements as protection from what they perceived as the likely price increases from the merger. Thus, if anything, the agreements prove that the Harrisburg area is a proper geographic market. Insurers would not need price protection if hospitals outside the Harrisburg area could constrain prices inside the area. Reliance on the agreements is also fundamentally inconsistent with the hypothetical monopolist test, which assumes that buyers actually face a price increase and asks how they would react. Insurers testified as to what they would

do if faced with a price increase demand from a combined Hershey and Pinnacle: they would accept it.

Reliance on such private agreements in defining a geographic market has troubling implications that go beyond this case. Under the district court's approach, merging parties with presumptively unlawful market shares would be able to stymie a proposed geographic market merely by privately agreeing not to raise prices

2. In light of the court's errors in assessing the geographic market, its consideration of the "equities" provides no independent basis to affirm its denial of the injunction. Had the court not erred about the market, it necessarily would have found the merger presumptively unlawful, and defendants would then have faced the heavy burden of proving either that the merger clearly was not anticompetitive or that it was nevertheless justified by extraordinary efficiencies. The court's cursory review of defendants' claimed benefits of the merger under the guise of equities in no way justifies the merger.

The principal efficiency defense examined by the court was defendants' claim that the merger would relieve overcrowding at Hershey by allowing it to shift patients to Pinnacle. The hospitals claimed that doing so would enable Hershey to avoid building a new 100-bed facility costing $277 million. But under the law, canceling the construction of a new facility is not an efficiency at all; it is

a reduction in output and therefore an anticompetitive harm. Moreover, the court did not undertake the rigorous analysis needed to evaluate and verify an efficiency claim. Instead, the court uncritically relied on the testimony of two of defendants' own executives that they would build the bed tower absent the merger. Such "speculation and promises about post-merger behavior" are badly insufficient under a proper antitrust analysis.

The court also wrongly analyzed defendants' "repositioning" defense. Defendants claim that affiliations between other hospitals in Central Pennsylvania and larger health care systems from out of the area will negate the anticompetitive effects of this merger. Much of the repositioning on which the district court relied has already occurred, however, yet the evidence showed that insurers *still* could not defeat a price increase demanded by a combined Hershey/Pinnacle. Repositioning therefore cannot possibly alleviate the price consequences of this merger. This merger is substantially likely to lessen competition in violation of the Clayton Act, and it should have been enjoined until the adjudicative process has run its course.

STANDARD OF REVIEW

This Court reviews a district court's denial of a preliminary injunction under three standards: findings of fact for clear error; conclusions of law de novo; and the ultimate decision to grant or deny the preliminary injunction for abuse of

discretion. *Miller v. Mitchell*, 598 F.3d 139, 145 (3d Cir. 2010) (*citing McTernan v. City of York*, 577 F.3d 521, 526 (3d Cir. 2009)). "Factual findings are clearly erroneous if the findings are unsupported by substantial evidence, lack adequate evidentiary support in the record, are against the clear weight of the evidence or where the district court has misapprehended the weight of the evidence." *United States v. 6.45 Acres of Land*, 409 F.3d 139, 145 n.10 (3d Cir. 2005) (quoting *United States v. Roman*, 121 F.3d 136, 140 (3d Cir. 1997)); *see also Lame v. U.S. Department of Justice*, 767 F.2d 66, 70-71 (3d Cir. 1981). A district court also commits clear error when its finding of fact is "completely devoid of a credible evidentiary basis or bears no rational relationship to the supporting data." *Shire U.S., Inc. v. Barr Labs., Inc.*, 329 F.3d 348, 352 (3d Cir. 2003) (quoting *American Home Prods. Corp. v. Barr Labs., Inc.*, 834 F.2d 368, 370-71 (3d Cir. 1987)).

A district court's definition of an antitrust geographic market is typically regarded as a question of fact reviewed for clear error. *E.g.*, *Borough of Lansdale v. Phila. Elec. Co.*, 692 F.2d 307 (3d Cir. 1982). But review is de novo where the lower court is alleged to have erred "in formulating or applying legal principles," including analytical flaws. *Allen-Myland, Inc. v. International Business Machines Corp.*, 33 F.3d 194, 201-204 (3d Cir. 1994). *See* L.A.R. 28.1(b) (Court engages in "plenary review" where the district court "erred in formulating or applying a legal precept"). Thus, the Court will review de novo when a district court does not

"apply the correct legal standard" to analyze a case. *A.J. Canfield Co. v. Honickman*, 808 F.2d 291, 307 (3d Cir. 1986); *accord Sabinsa Corp. v. Creative Compounds, LLC*, 609 F.3d 175, 182 (3d Cir. 2010); *see also White & White, Inc. v. American Hospital Supply Corp.*, 723 F.2d 495, 499-500 (6th Cir. 1983) (in antitrust cases, court will "freely review[] … as a matter of law" district court's "formulation of the market tests").

As set forth below, the district court failed to properly formulate and apply the test used to define a relevant geographic market, and that determination should be reviewed de novo. But even if the Court determines to review under a more lenient standard, the district court clearly erred in its assessment of the market and the equities.

ARGUMENT

Section 7 of the Clayton Act prohibits mergers that "may" substantially lessen competition or tend to create a monopoly. 15 U.S.C. § 18. Congress used the word "may" deliberately, for its "concern was with probabilities, not certainties." *United States v. El Paso Natural Gas Co.*, 376 U.S. 651, 658 (1964); *accord Brown Shoe Co., Inc. v. United States*, 370 U.S. 294, 323 (1962). The Clayton Act thus creates an "expansive definition of antitrust liability." *California v. American Stores Co.*, 495 U.S. 271, 284 (1990).

Congress vested principal responsibility for enforcement of Section 7 with the FTC through an administrative adjudication. *See Heinz*, 246 F.3d at 714. But it recognized that agency proceedings take time and thus provided a mechanism to maintain the status quo pending the administrative process, thereby preventing interim harm to competition and preserving the Commission's ability to fashion effective relief. Specifically, Section 13(b) of the FTC Act authorizes a federal district court to grant a preliminary injunction "[u]pon a proper showing that, weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest." 15 U.S.C. § 53(b)(2); *Heinz*, 246 F.3d at 714 n.5.[5]

The Government met both prongs of that test, and this Court should either enjoin the merger itself or direct the district court to do so. In seeking a preliminary injunction, the Government is "not required to *establish* that the proposed merger would in fact violate Section 7." *Heinz*, 246 F.3d at 714 (emphasis in original). Rather, Section 13(b) requires only that the Government show a *likelihood* that the merger ultimately will be found unlawful. "[D]oubts are to be resolved against the transaction." *FTC v. Elders Grain, Inc.*, 868 F.2d 901, 906 (7th Cir. 1989).

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[5] Section 16 of the Clayton Act also permits a State to seek injunctive relief against a threatened antitrust violation. 15 U.S.C. § 26.

I. THE GOVERNMENT IS LIKELY TO SUCCEED ON THE MERITS

The Government demonstrated that the merger will likely be found unlawful in the administrative adjudication. Setting aside for the moment the validity of the Government's proposed geographic market, the evidence shows that the combined hospital system would have a 76 percent market share and extraordinarily high HHI figures. Such concentration is "so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects." *Philadelphia Nat'l Bank*, 374 U.S at 363.

Had the district court properly found the Harrisburg area to be a relevant geographic market, it necessarily would have found the merger to be presumptively illegal. At that point, defendants would have borne the burden to "clearly show that their combination would not cause anticompetitive effects," App. 15, or to show "extraordinary efficiencies," *Heinz*, 246 F.3d at 720-21. The district court did not seriously assess these issues, but the record is clear that defendants would not have met their heavy burden. In the administrative adjudication, they are unlikely to overcome the presumption that the merger is unlawful.

The district court reached none of these issues because it found that the Government had not shown the four-county Harrisburg area to be a proper antitrust

geographic market. We show below that the court committed multiple fundamental errors in reaching that determination. In particular, it ignored entirely the commercial reality of the hospital market and the bargaining process by which prices are set.

The Government presented overwhelming evidence that the relevant geographic market is the Harrisburg area. As the Government's expert explained at the hearing, the relevant question to ask in determining the relevant geographic market is whether the direct purchasers—insurers—would pay a higher price to one of defendants' hospitals rather than attempt to market a network to Harrisburg-area consumers that includes no Harrisburg-area hospitals. Hrg. 306:11-13, 313:23-314:04 (App. 66, 70-71). The evidence conclusively established that because patients demand access to Harrisburg area hospitals, insurers could not offer a viable network without them. Insurers thus would pay at least a SSNIP to a Harrisburg area hypothetical monopolist rather than attempt to market a network with no Harrisburg area hospitals. In fact, the Government presented clear evidence that a hypothetical monopolist of defendants' hospitals alone would be able to impose a SSNIP on insurers, indicating that the Government's alleged geographic market is conservative.

A. The District Court Failed to Properly Formulate and Apply The Test For Defining A Geographic Market.

An antitrust geographic market is "the area in which a potential buyer may rationally look for the goods or services he or she seeks." *Pennsylvania Dental Ass'n v. Medical Service Ass'n of Pa.*, 745 F.2d 248, 260 (3d Cir. 1984). As this Court has recognized, "economic realities rather than a formalistic approach must govern." *United States v. Dentsply Int'l, Inc.*, 399 F.3d 181, 189 (3d Cir. 2005); *see Brown Shoe*, 370 U.S. at 336 (market definition must reflect "commercial reality"); *see also Philadelphia Nat'l Bank*, 374 U.S. at 357 (geographic market is "the area of competitive overlap" where "the effect of the merger on competition will be direct and immediate").

The district court committed three independent errors when it rejected the Government's proposed geographic market. Any of them would be sufficient in itself to overturn the ruling on review. First, and most basic, it utterly ignored the commercial reality of the hospital marketplace and how prices are set. Instead, by focusing on patients who live outside the Harrisburg area, it relied on an analysis untethered from market reality. Second, the court failed to assess whether, post-merger, the combined hospital system could raise prices at Pinnacle's hospitals. The unrebutted evidence showed that they could. Third, the court improperly rested its geographic market analysis on defendants' temporary price protection

agreements with two insurers. Such agreements play no proper role in a market determination.

1. The District Court Ignored the Commercial Reality of the Hospital Market.

The district court fundamentally erred by turning a blind eye to the role of the buyer when it rejected the Government's geographic market. There is no genuine dispute that the direct buyer in the market for hospital services is the insurance company. The parties agreed (and the district court found) that the product market was defined as general acute care services "*sold to commercial payors*." App. 9 (emphasis added). Defendants admitted in their opposition to the Government's motion for a preliminary injunction that insurers are the "relevant customers" in analyzing the markets for general acute care services. Dkt. No. 96 at 8.[6]

Yet in defining the area where buyers turn for services, the district court wholly ignored the role of the relevant buyers—insurers. Analyzing the geographic market without considering the relevant buyers was a basic error of

[6] Recent judicial and administrative decisions similarly recognize that health care mergers must be analyzed through the lens of contract negotiations between health care providers and health insurers. *See St. Luke's Health Sys.*, 778 F.3d at 784-85; *ProMedica*, 749 F.3d at 562-63; *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1083-84 (N.D. Ill. 2012); *In re Evanston*, 2007 WL 2286195, at *51-53. Even though insurers are the direct purchasers, individual consumers also suffer the adverse consequences of anticompetitive healthcare mergers.

law. In the face of considerable uncontested evidence about how insurers and hospitals negotiate prices, the role of provider networks, and the economic necessity of accommodating consumer demand for local care, the court said exactly nothing. The court thus wholly overlooked the "particular structure and circumstances" of the hospital market, *Verizon Comms. v. Law Offices of Curtis V. Trinko*, 540 U.S. 398, 411 (2004), and utterly ignored "commercial reality," *Brown Shoe*, 370 U.S. at 336.

Nor can the district court's ruling withstand factual scrutiny, because it "bears no rational relationship" to the evidence. *Shire*, 329 F.3d at 352. Both sides agreed that the market should be defined using the hypothetical monopolist test, which asks whether a buyer would pay a SSNIP to a monopoly provider in the proposed geographic area. *See Merger Guidelines* § 4.2.1; *St. Luke's Health Sys.*, 778 F.3d at 784-85. The district court seemingly agreed. App. 10. The Government presented considerable expert and fact evidence that any rational insurer would agree to pay 5 percent (or more) to keep a hypothetical Harrisburg-area monopolist in its network. Yet the court's geographic market determination is totally unmoored from both the proper analytical framework and any of that evidence.

In particular, the district court ignored the uncontested deposition testimony of Central Pennsylvania's two largest insurers that, without defendants' hospitals,

they could not successfully market a network to employers. PX01236, 48:17-22 (App. 491); PX00804, 64:13-20 (App. 317). The court ignored unrebutted testimony of one of these insurers that it would have no realistic alternative but to pay well in excess of a 5 percent increase to retain the defendants' hospitals (much less to retain a monopolist of all Harrisburg area hospitals). PX01236, 144:6-16 (App. 494); *see also* PX01201, 70:21-71:18. The court ignored unrebutted testimony of the other large insurer that it was concerned about post-merger price increases due to the defendants' increased bargaining leverage. PX00378-002 (App. 221). It also ignored deposition testimony from one of those large insurers that without either Hershey or Pinnacle in its network, it would lose half its membership in Dauphin County—and a natural experiment proving that would in fact happen. PX01236 (App. 494), 144:6-16; PX00704 ¶10. Indeed, the insurer that attempted to market a network without either Hershey or Pinnacle lost half of its customers even though its network contained many of the very hospitals outside the Harrisburg area that the district court deemed to be within a proper market. PX00704 ¶10; PX01542-002. The undisputed testimony that insurers, even the largest ones, were concerned that the merger would force them to pay increased prices, *e.g.*, PX01200, 34:8-20 (App. 458), cannot be reconciled with the court's view of the geographic market. Defendants' merger would have caused no consternation if hospitals outside the Harrisburg area could readily substitute in

insurer networks for Hershey and Pinnacle and thereby constrain their prices. All of these failures to address unrebutted evidence from the relevant customers affected by the merger render the court's decision "completely devoid of a credible evidentiary basis." *Shire*, 329 F.3d at 352.

Those basic analytical errors are not salvaged by the court's reliance on the statistic that 43.5 percent of Hershey patients reside outside of the Harrisburg area and travel up to an hour to get there. App. 13. In the court's view, those patients would go elsewhere if Hershey and Pinnacle raised prices post-merger, and the merged firm therefore would be constrained. But the court cited no record evidence that these patients would use other hospitals if Hershey and Pinnacle raised their prices, and there is none. The court's central conclusion is no more than sheer speculation.

To the contrary, the court's conclusion cannot be squared with the economic functioning of the insurance market. First, although Hershey attracts patients from Lancaster, Pittsburgh, and other distant places, its doing so does not alter the "commercial reality" that insurers wishing to sell policies to the substantial population of the four-county Harrisburg area must have Harrisburg-area hospitals in their networks—and would pay significantly increased prices in order to keep them. Harrisburg-area consumers demand local care and would not purchase an insurance policy that required them to drive 65 minutes away for hospital

treatment. Hrg. 314:12-316:4 (App. 71-73); 415:7-416:15; 474:7-10; 521:17-522:6 (App. 106-107); PX01277-001. Far beyond a mere SSNIP, one of the largest insurers in Central Pennsylvania testified that it would have no realistic alternative but to pay prices up to 25 percent higher rather than attempting to sell a policy without Hershey or Pinnacle in the network. PX01236, 91:16-25, 144:6-16 (App. 493-494).[7]

Furthermore, the district court was wrong that price increases at "a hypothetical monopolist such as the combined Hospitals" would cause consumers to seek care at other hospitals within the court's broader geographic market. App. 13. In fact, price plays little role when patients choose between in-network hospitals. Rather, insured patients pay roughly the same amount to go to any in-network hospital. PX01062-55; PX01424-061. As the Ninth Circuit thus recognized in directly analogous circumstances, the marketplace reality is that patients "would not change their behavior in the event of a SSNIP" because "the

[7] By defining the geographic market based on patient in-flow, the district court essentially applied the discredited "Elzinga-Hogarty" test, which has been rejected for use in analyzing hospital mergers by the FTC and by its own creator. The test was created for markets with posted prices like coal and accounts for neither the role of the insurer in setting prices nor the price-insensitivity of patients. *See In re Evanston*, 2007 WL 2286195 at **64-66; PX01062-110-115. No recent court has used the analysis; to the contrary recent judicial decisions recognize that health care mergers are properly analyzed by scrutinizing the relative bargaining power of healthcare providers and insurers. *See St. Luke's Health Sys.*, 778 F.3d at 784-85; *ProMedica*, 749 F.3d at 562-63; *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1083-84.

impact of a SSNIP likely would not register." *St. Luke's Health Sys.*, 778 F.3d at 785.

Even though consumers demand local care and insurers thus require local hospitals in their networks, the court's geographic market analysis leads inevitably to an absurdly large geographic market encompassing Harrisburg, Lancaster, York, and even more distant places. But unrebutted evidence (including the chart reproduced at page 11 above) showed that 91 percent of Harrisburg area residents seek care in the four-county area and that fewer than 2 percent of them go to the largest hospitals in Lancaster and York counties. PX01062-120-122. Similarly, residents of Lancaster and York overwhelmingly use hospitals in their own home counties. PX01062-100. Indeed, insurers testified that hospitals in York and Lancaster are able to demand higher prices because they face limited local competition. PX00704 ¶13; PX00701 ¶17 (App. 268); PX00700 ¶17; PX00804, 34-35, 102-103 (App. 316, 319); PX01201, 142:19-144:25. This commercial reality is undisturbed by the fact that some subset of patients have travelled beyond their local area for hospital care. *See Houser v. Fox Theatres Mgmt. Corp.*, 845 F.2d 1225, 1229-1230 n.10 (3d Cir. 1988) ("evidence that a minority of customers might travel to Harrisburg, Lancaster or even Philadelphia to attend a picture unavailable in Lebanon" does not show that "the relevant geographic market should be expanded to include those cities as a matter of law").

2. The District Court Failed To Assess Whether Pinnacle Could Impose A SSNIP

The court committed a second, and independent, error of law when it failed to apply the hypothetical monopolist test to Pinnacle's hospitals. The test requires an inquiry into whether the monopolist could impose a SSNIP "from at least one location" of the merging firms. *Merger Guidelines* § 4.2.1. As applied here, the geographic market is properly defined as the four-county Harrisburg area if a hypothetical monopolist of Harrisburg-area hospitals could profitably impose a post-merger SSNIP at *any* of Pinnacle's hospitals *or* at Hershey. The district court plainly did not engage in this analysis with respect to Pinnacle, which is barely mentioned in the opinion.

The failure to consider price increases at Pinnacle is especially striking in light of unrebutted evidence that: (a) insurers were specifically concerned that the merger would allow defendants to substantially raise prices at Pinnacle, PX00612-003; (b) one insurer successfully defeated Pinnacle's demand for a large price by threatening to construct a network that included Hershey but not Pinnacle; and (c) Pinnacle overwhelmingly draws its patients from within the Harrisburg area. PX01062-26-27. The linchpin of the district court's reasoning—that patients who currently travel long distances to Hershey will choose not to do so if it raises prices—therefore does not apply to Pinnacle. Even if the district court were right about Hershey (which it was not), the court's theory would not support a finding

that Pinnacle's prices will be constrained by hospitals closer to patients outside the Harrisburg area.

3. The District Court Improperly Based Its Geographic Market Analysis On Defendants' Temporary Price Protection Agreements with Two Insurers.

The court committed yet a third independent error of law when it based its analysis of the geographic market on private price agreements between defendants and two large insurers.

As described above, the proposed merger raised alarm among area insurers that the merged hospitals could successfully demand a price increase. In exchange for the promise of the two largest insurers not to complain to the FTC about the merger, defendants entered into contracts with those insurers promising limited price increases for several years. PX00029-001-02; PX00503-004; PX01000-001; PX01011-002; PX00664-001; PX00804, 77:23-78:8 (App. 318). Specifically, the agreements maintain the price differential between Hershey and the lower-cost Pinnacle and limit price increases to stated amounts for at least 5 years.

The court relied on the price agreements in its geographic market analysis. After reciting that it "heard hours of economic expert testimony regarding the hypothetical monopolist's ability to impose a SSNIP," the court stated it found the protection agreements to be "extremely compelling" evidence to the contrary. App. 13. The court reasoned that because the agreements restrict defendants from

raising prices for at least 5 years, it "simply cannot be blind to this reality when considering the import of the hypothetical monopolist test." *Id.* 14. The court then concluded that in light of the agreements, the relevant time period for performing the hypothetical monopolist test would be five years from now. *Id.* Yet the court refused to examine that time period, finding it speculative to do so. It then added that it did "not find that the outcome of the hypothetical monopolist test aids the FTC in this matter." *Id.*

That reasoning suffers from multiple serious flaws. To begin with, the court failed to acknowledge that the very existence of the price protection agreements reveals that insurers do not view hospitals outside the Harrisburg area as "realistic alternatives" to the defendants that would allow them to defeat a SSNIP. If they did, they would have had no need to enter into such agreements, but would have been able to constrain Hershey and Pinnacle's prices by threatening to use non-Harrisburg area hospitals in their networks. The insurers' need to enter into post-merger price protections is an admission of anticompetitive concern that "strongly supports the fears of impermissible monopolization." *FTC v. Cardinal Health*, 12 F. Supp. 2d 34, 67 (D.D.C. 1998).

More fundamentally, the price protection agreements have no proper place in a geographic market analysis. The hypothetical monopolist test is just that—hypothetical—and it asks how customers would react to a SSNIP. The court,

however, assumed that the agreements prevented the monopolist from imposing a SSNIP, App. 14, thus defeating the whole purpose of the inquiry, which *necessarily* assumes that customers face the SSNIP, unprotected by a contract. This assumption is explicit in the *Merger Guidelines*, which hinge market definition "solely on demand substitution factors, *i.e.*, on customers' ability and willingness to substitute away from one product to another in response to a price increase." *Merger Guidelines* § 4. The record is clear about how the two largest insurers would react to a SSNIP: one testified it would have no realistic alternative but to pay well in excess of a SSNIP (PX01236, 91:16-25,144:6-16 (App. 493-494)); and the other testified it could not successfully market a network without the merged firm and estimated substantial potential price increases as a result of the merger. PX00612-003; PX00613-001.

This Court has recognized the irrelevance of private contracts to antitrust market determination. In *Queen City Pizza v. Domino's Pizza*, 124 F.3d 430, 438-439 (3d Cir. 1997), the Court held that a plaintiff's particular contractual restraints did not alter the determination of a product market, which turns on whether the products are interchangeable. It explained that in making a market determination the Court does not "look[] … to the contractual restraints assumed by a particular plaintiff." The Court recognized that "no court has defined a relevant product

market with reference to the particular contractual restraints of the plaintiff." *Id.* at 438-439.

The court's refusal to assess a hypothetical monopolist's ability to impose price increases after the price agreements expire because doing so would be "imprudent" was also error. App. 14. The record was again clear about what would happen on expiration. One of the two insurers testified that at that point it would have no realistic choice but to give in to price increase demands. Indeed, the witness suggested that to keep the merged hospitals in its network, the company would be willing to pay as much as 25 percent more—five times higher than a SSNIP. PX01236, 91:16-25, 144:6-16 (App. 493-494). The future may be unpredictable, but the risk of anticompetitive price increases is not. The court's ruling thus cannot be squared with the underlying thrust of the Clayton Act that courts should protect against the *likelihood* of anticompetitive effects and that "doubts are to be resolved against the transaction." *Elders Grain*, 868 F.2d at 906.

The court's reliance on the price agreements is erroneous in several additional ways. It fails to consider the effect of the merger on insurers in the Harrisburg area that are *not* covered by the price agreements. Those companies would be immediately subject to price increases as a result of defendants' enhanced bargaining power. It fails to consider the limited scope of the agreements, which cover fee-for-service prices but do not apply to other types of

payment contracts, which the court viewed as becoming increasingly important in the modern era. App. 26. With respect to those prices, the hospitals are free to demand any increase they wish. And it fails to consider the harm to patients when hospitals no longer compete over quality of care.

Beyond mere error, the court's reliance on private price agreements to define a geographic market marks an unprecedented departure from legal precedent and from the standard framework of antitrust analysis employed by the nation's antitrust enforcers. The district court's ruling has troubling implications beyond this case, for it would empower merging parties with presumptively unlawful market shares to stymie a proposed geographic market by privately agreeing not to raise prices.

B. The District Court's Assessment Of The "Equities" Cannot Justify The Merger.

Defendants argued in response to the Government's motion for injunction pending appeal that the district court's determination of the "equities" supports its decision. Not so. Nothing about the court's discussion of the equities offers an independent basis to affirm its denial of the preliminary injunction. In fact, the court's erroneous assessment of the geographic market fatally infected its subsequent analysis. Had the court properly found the Harrisburg area to be a relevant geographic market, it necessarily would have found the merger to be presumptively illegal. The burden then would have shifted to defendants either to

"'clearly' show that their combination would not cause anticompetitive effects," App. 15, or to show "extraordinary efficiencies." *Heinz*, 246 F.3d at 720-21. The court never put defendants to the burden of crossing that hurdle. On the record before the district court, they could not have met that burden. Indeed, no court has ever found a presumptively unlawful merger to be saved by efficiencies.

An efficiency defense requires antitrust defendants to prove four elements. First, they must prove "extraordinary efficiencies" that offset the anticompetitive concerns in highly concentrated markets. *St. Luke's Health Sys.*, 778 F.3d 790 (citing *Heinz*, 246 F.3d at 720-22). Second, they must demonstrate that the claimed efficiencies are "merger-specific," *i.e.*, they can be achieved only via the merger. *St. Luke's Health Sys.*, 778 F.3d at 790 (citing *United States v. H & R Block, Inc.*, 833 F. Supp.2d 36, 89–90 (D.D.C. 2011)). Third, they must show that the efficiencies are "verifiable" and not "speculative." *St. Luke's Health Sys.*, 778 F.3d at 791. The analysis of those factors must be "rigorous" to ensure that alleged efficiencies "represent more than mere speculation and promises about post-merger behavior." *Heinz*, 246 F.3d at 721. Fourth, claimed efficiencies must "'not arise from anticompetitive reductions in output or service'." *H&R Block, Inc.*, 833 F. Supp. 2d at 89 (quoting *Merger Guidelines* § 10).

Because the district court found the geographic market issue dispositive of the Government's case, it did not engage in an efficiencies analysis, under which

defendants would have borne the substantial burden of proving each element of the defense. Instead of performing the rigorous inquiry required for an efficiencies defense, the court transformed it into a gratuitous discussion of the "equities" that lacked any analytical rigor.

Similarly, the district court failed to properly assess defendants' argument that repositioning by hospitals outside the Harrisburg area would fill the "competitive void" created by the merger and "clearly" prevent the likely anticompetitive harm.

1. Defendants' Plan to Reduce Capacity By Foregoing Construction Of Additional Facilities Is Neither An Efficiency Nor An "Equity."

Defendants claimed below that patient demand for service at Hershey exceeds the number of beds available, and that the merger increase its capacity, allowing Hershey to avoid construction of an expensive bed tower. The district court accepted those claims and determined that "the Hospitals have presented a compelling efficiencies argument … in that the merger would alleviate some of Hershey's capacity constraints." App. 17. The court also found that Hershey's avoidance of a large capital outlay to construct the new facility would also benefit consumers. App. 21-22.

As an initial matter, the court's analysis turns antitrust law on its head by converting a reduction in output—an anticompetitive *harm*—into a *benefit* of the

merger. A merging entity's pledge to cancel a planned capacity expansion as the result of the merger is not an "efficiency" that can somehow justify the deal. It is a classic reduction in output that will lead to higher prices. For that reason, a nearly identical claim was specifically rejected as non-cognizable by a federal district court enjoining a hospital merger. *FTC v. ProMedica Health Sys., Inc.*, WL 1219281 at *36 (N.D. Ohio Mar. 29, 2011); *see Merger Guidelines* § 10. Investment in businesses serve to "enhance consumer welfare" and when "competition-driven investments are 'avoided,' consumers are generally left worse off." *ProMedica*, *supra*. Yet the district court did not even consider that dimension of the issue, although the Government squarely raised it.

If Hershey and Pinnacle do not merge and Hershey constructs the bed tower, it will have both the additional ability to serve the public and the incentive to fill the new beds, in part by competing with Pinnacle on price and quality of care. Both outcomes would result in substantial consumer benefits. By contrast, if the hospitals merge and the tower project is canceled, there will be fewer beds to serve the public and a reduced incentive to lower prices and compete on quality. Consumers will be worse off. Hrg. 341:5-342:7 (App. 84-85).

Moreover, the district court's conclusion that the merger will add bed capacity is plainly wrong. The merger merely combines two existing facilities; it cannot add a single bed to the supply now available in the Harrisburg area. If

Hershey is currently full, it can refer patients to Pinnacle, where the vast majority of them can receive the very same high-quality treatments they seek at Hershey. Hrg. 716:7-15, 717:1-718:9.

In any event, the district court could not properly have found the bed tower claim to be a "compelling efficiencies argument" because the court failed to engage in the rigorous efficiencies analysis. The Government presented overwhelming evidence that defendants' capital avoidance claim failed because there is no relationship between Hershey's actual bed need and defendants' claim that Hershey could solve any capacity issues only by building a $277 million, 100-bed tower.[8]

Yet the court relied on the very sort of "speculation and promises about post-merger behavior" that *Heinz* rejected. It uncritically accepted the self-serving statements of defendants' executives that they would build the bed tower absent the merger. The court even chastised the Government for "impermissibly" asking it to "second guess Hershey's business decision in building the tower." App. 21. And although the court admitted that Hershey may have "partially overstated" the

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[8] Defendants' efficiencies expert admitted that Hershey needs only 13 beds to alleviate its capacity constraints today, and only 36 beds in five years. PX01343-069; Hrg. 767:15-21. Defendants' contention that this modest need can be remedied only through the construction of a 100-bed tower or merger with Pinnacle cannot withstand scrutiny. *See, e.g.*, PX00258; PX00754-059; PX01238, 279:18-22.

cost of alleviating its capacity issues, it failed to make any attempt to determine the magnitude of that overstatement. App. 20. Indeed, the court wrongly stated that it was not within its "purview to question" these statements and concluded that defendants' testimony on this issue "is sufficiently reliable." *Id.* That is not the way a proper antitrust efficiency analysis is conducted.

The court's insistence that it must accept defendants' business decision to build a bed tower has troubling implications similar to its reliance on temporary rate agreements to find against the Government on geographic market. If the court's deference were proper, then any defendant could proffer any efficiency justification for a merger without having to show that it meets the strict requirements of an efficiency defense. That approach would upend decades of merger law.

2. The District Court Improperly Analyzed Defendants' Risk-Based Contracting Claim.

Risk-based contracting is a developing payment model in which healthcare providers bear some financial risk and share in financial upside based on the quality and value of the services they provide. Hrg. 128:13-20. It is an alternative to the traditional fee-for-service model in which the hospital receives a payment for every service performed and the insurer bears the risk. The district court found that the merger enhanced the hospitals' efforts to engage in risk-based contracting to the benefit of the public.

The district court found "persuasive" the testimony of Hershey's CEO that "there will be some advantages in terms of size of scale, in terms of being able to spread of costs [sic] of the infrastructure of population health over a larger health care system." App. 26. But the court did not analyze whether such a claim was verifiable—and it could not have done so since it relied not on extrinsic evidence but only on the self-interested testimony of Hershey's own chief executive.

Nor does the evidence support the claim that risk-based contracting is an "equity" that weighed against an injunction. The evidence showed that hospitals and insurers engage in the same bargaining process for risk-based contracts that they do for traditional ones. PX01422-016-017 (McWilliams Rebuttal Report); PX01062-065. The merger will enable the combined hospital system to use its market power to obtain higher reimbursement from insurers under a risk-based approach for the very same reasons it can obtain higher fee-for-service prices. Hrg. 348:21-349:6 (App. 86-87); PX01236, 165:21-166:2 (App. 495). Thus, allowing the creation of a near-monopoly hospital system no more serves "equity" with respect to risk-based contracting than it does with any other form of business dealing.

The court speculated that changing from fee-for-service to risk-based contracting would have a "beneficial impact" because it would allow Hershey to "continue to use its revenue to operate its College of Medicine and draw high-

quality medical students and professors into the region." App. 26. It then assumed, without any analysis, that additional post-merger revenue to Hershey from risk-based contracting would inure to the benefit of consumers. But for the reasons explained above, the combined hospitals will be able to obtain higher prices—and consumers will ultimately bear the increase. Hrg. 348:21-349:6 (App. 86-87); PX01236, 165:21-166:2 (App. 495). That is not an "equity."

3. "Repositioning" By Other Hospitals Will Not Negate The Anticompetitive Effects Of The Merger.

The district court stated in passing that "the Hospitals presented ample evidence demonstrating that anticompetitive effects would not arise through the merger of Hershey and Pinnacle." App. 15-16. But the only evidence it cited for this conclusion had to do with the affiliation of hospitals in and around the Harrisburg area with large outside health systems and a trauma center being developed at one hospital. App. 26-28. That evidence does not support the court's conclusion.

In antitrust law, "repositioning" refers to a response by competitors that is sufficient to deter or counteract the anticompetitive effects of a merger. *Merger Guidelines* § 6.1. *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 148-150 (D.D.C. 2004). To be credited as "repositioning," the expansion or development should be "equivalent to new entry" and "greatly reduce[] the anticompetitive effects of a merger." *FTC v. CCC Holdings, Inc.*, 605 F. Supp. 2d 26, 57 (D.D.C. 2009)

(citing *Arch Coal*, 329 F. Supp. 2d at 148). Antitrust defendants therefore must show that repositioning will be timely, likely, and sufficient to constrain market power. *Merger Guidelines* § 6.1; *see also FTC v. Sysco*, 113 F. Supp. 3d 1, 80 (D.D.C. 2015) (defendants bear the burden of demonstrating the ability of other competitors to "fill the competitive void" that will result from the proposed merger) (citing *FTC v. Swedish Match*, 131 F. Supp. 2d 151, 169 (D.D.C. 2000)).

First, the court credited as "repositioning" developments that had *already* occurred. But overwhelming evidence from insurers showed that, even considering all of the recent developments, they could not defeat a price increase if Hershey and Pinnacle merge. The district court ignored that evidence, which defeats any possible claim that past repositioning will constrain hospital prices in the Harrisburg area.

Indeed, although the court pointed to a number of affiliations, such as Geisinger's purchase of Holy Spirit Hospital, it failed to ask the critical question whether such "repositioned" hospitals could replace Pinnacle or Hershey *in an insurer's network* for Harrisburg area residents. For all the reasons discussed above, they plainly cannot. *See also* PX1201, 255:7-18 (deposition testimony of a large insurer explaining "we don't believe that we could create a Holy Spirit-centric product, we don't believe their scope of services is broad enough"). The court's analysis was also infected by its error in defining the geographic market.

Believing that the market included places outside the Harrisburg area, the court considered the repositioning of hospitals in places like Lancaster. Such hospitals could not replace Hershey or Pinnacle in an insurance network marketed to Harrisburg-area residents.

Second, the district court did not seriously consider whether future repositioning by hospital systems inside the Harrisburg area would be sufficient to counteract anticompetitive effects from the merger. For example, the court noted Holy Spirit's plans to develop a Level II trauma center, but it did not assess whether the trauma center would make Holy Spirit a suitable post-merger replacement for a combined Hershey/Pinnacle in an insurer network. It also ignored unrebutted evidence that the trauma center would have a negligible impact on competition with the merged parties (*see*, *e.g.*, PX01221, 56:25-59:3, 96:16-98:1). Repositioning by Holy Spirit would not have the constraining power of "new entry." *CCC Holdings*, 605 F. Supp. 2d at 57. The court also again ignored evidence from a large area insurer that it did not believe it would be able to defeat a substantial price increase five years from now if the combined entity raised rates –indicating future repositioning will not be sufficient to constrain defendants.

4. The Affordable Care Act Does Not Justify Anticompetitive Mergers.

The district court stated that its decision was informed by "a growing need" for hospitals "to adapt to an evolving landscape of health care that includes … the

institution of the Affordable Care Act." App. 28. The court found that the ACA "has created a climate that virtually compels institutions to seek alliances such as the Hospitals intend here." *Id.* In other words, the court determined that the perceived needs of the healthcare system must take precedence over the antitrust laws. That conclusion was legal error.

The Clayton Act contains no healthcare exception. To the contrary, the Supreme Court determined long ago that Congress declined to provide antitrust exceptions "for specific industries" and rejected the notion that "monopolistic arrangements will better promote trade and commerce than competition." *National Society of Professional Engineers v. United States*, 435 U.S. 679, 689-90 (1978). The antitrust laws thus "apply to hospitals in the same manner that they apply to all other sectors of the economy." *Boulware v. Nevada*, 960 F.2d 793, 797 (9th Cir. 1992). Indeed, Congress recognized as much in the Affordable Care Act itself, which provides that it "shall not be construed to modify, impair, or supersede the operation of any of the antitrust laws." 42 U.S.C. § 18118(a) (2010).

5. The District Court Regarded Healthy Hospitals As If They Were Failing Firms.

In passing, at the very end of its opinion, the district court surmised that "it is better for the people they treat that such hospitals unite and survive rather than remain divided and wither." App. 28. Instead of properly viewing the combination as a near-monopoly of the two close rivals, the court appears to have

incorrectly perceived Hershey and Pinnacle as embattled survivors hanging on for life.

Antitrust law recognizes a "failing firm" defense under which parties may undertake an otherwise unlawful merger if one of them is likely to go out of business anyway. *See Merger Guidelines* § 11. But defendants never asserted that the merger was necessary for their survival or that failure of either hospital system was imminent (or even likely), as the failing firm defense requires. Nor could they have. Both Pinnacle and Hershey enjoy success and robust financial health, and both continue to expand. PX01062-27, 31. Indeed, Pinnacle recently constructed West Shore Hospital, which opened in May of 2014 and has over 100 inpatient beds. They are precisely the type of firms that should be competing to the benefit of consumers, not merging to their detriment. The district court's perception of them as enfeebled underscores its deep misunderstanding of this case.

II. THE EQUITIES FAVOR AN INJUNCTION

An FTC showing of a likelihood of success on the merits creates "a presumption in favor of preliminary injunctive relief." *Heinz*, 246 F.3d at 726. No court has ever denied an injunction under Section 13(b) where the FTC has demonstrated a likelihood of success on the merits. *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1094-95 (quoting *FTC v. ProMedica Health Sys., Inc.*, No. 3:11-CV-47, 2011 WL1219281, at *60).

For the reasons set forth above, the district court improperly found the FTC unlikely to succeed in the administrative adjudication. The court's analysis of the equities was thus fatally flawed from the outset, because the court took no account of the strong "public interest in effective enforcement of the antitrust laws." *Id.*; *see FTC v. Whole Foods Market, Inc.*, 548 F.3d 1028, 1035 (D.C. Cir. 2008); *Arch Coal*, 329 F. Supp. 2d at 116. Instead, the court examined defendants' purported efficiencies as equities (and as shown above, its analysis was faulty there too) with no counterbalance.

"Congress enacted section 13(b) to preserve [the] status quo until [the] FTC can perform its function" in the adjudicative proceeding. *Heinz*, 246 F.3d at 726 (citation omitted). Thus, where the Government shows a likelihood of success on the merits in the adjudication, parties should not merge unless they show "public equities" that would "benefit their customers" "despite the likely anticompetitive effects of their proposed merger." *CCC Holdings*, 605 F. Supp. 2d at 75-76 (emphasis added).

The equities favor enjoining this merger pending the completion of the administrative adjudication. If "the merger is ultimately found to violate section 7 of the Clayton Act, it will be too late to preserve competition if no preliminary injunction has issued." *Heinz*, 246 F.3d at 727; *FTC v. Univ. Health,* 938 F.2d 1206, 1217 n.23 (11th Cir. 1991).

Indeed, the FTC has recently had unfortunate experiences trying to unwind recent unlawful healthcare mergers. In *Phoebe Putney*, the FTC attempted to enjoin the merger, but the courts denied an injunction. Two years later, after the Supreme Court ruled that the FTC could challenge the transaction, divestiture remained too difficult to achieve, and the FTC allowed the parties to remain merged. *See* https://www.ftc. gov/system/files/documents/public_statements/634181/150331phoebeputneycommstmt.pdf. In *St. Luke's*, divestiture has not yet occurred well over a year after the court of appeals found the merger unlawful—and nearly four years after the district court denied a preliminary injunction.

Granting preliminary relief therefore will both protect Harrisburg area residents who will otherwise face immediate competitive harm and enable the FTC to fashion any suitable remedy ultimately required. By contrast, if the district court's decision stands, and the merger is allowed to close, defendants will be free to integrate operations, share competitively sensitive information, and reorganize human and physical resources. It will be difficult, if not impossible, for the FTC to "unscramble the egg" and fashion effective relief to restore competition following the merits trial.

Hershey and Pinnacle showed little on the other side of the ledger. The district court characterized the purported efficiencies of the transaction as "public equities." App. 15-28. Even apart from the district court's errors in its assessment

of the alleged efficiencies, the law is clear that efficiencies cannot be deemed public equities unless there is reason to believe that they "will not still exist when the FTC completes its work." *Heinz*, 246 F.3d at 726-27; *see OSF Healthcare Sys.*, 852 F. Supp. 2d at 1088 n.16. Here, any of the alleged benefits of this merger will be available after the trial on the merits. The purported efficiencies therefore "do not constitute public equities weighing against a preliminary injunction." *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1095 (quotation marks and citation omitted). As the D.C Circuit put it, "[i]f the merger makes economic sense now," then absent specific evidence to the contrary, there is "no reason why it would not do so later." *Heinz*, 246 F.3d at 726.

CONCLUSION

For the foregoing reasons, this Court should reverse the decision below and enjoin the proposed merger between Hershey and Pinnacle pending the outcome of the administrative adjudication.

Respectfully submitted,

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June 1, 2016

CERTIFICATE OF COMPLIANCE WITH TYPE-VOLUME LIMITATION, TYPEFACE REQUIREMENTS, AND TYPE STYLE REQUIREMENTS

I. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because the brief contains 13,495 words.

II. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2010, in 14-point Times New Roman.

/s/ Joel Marcus

June 1, 2016

CERTIFICATE OF IDENTICAL COMPLIANCE OF BRIEFS

I certify that the text of the electronically filed brief is identical to the text of the original copies that were sent on June 1, 2016, to the Clerk of the Court of the United States Court of Appeals for the Third Circuit.

/s/ Joel Marcus

June 1, 2016

CERTIFICATE OF PERFORMANCE OF VIRUS CHECK

I certify that on June 1, 2016, I performed a virus check on the electronically filed copy of this brief using Symantec Endpoint Protection Version 12.1.6867.6400 (last updated May 31, 2016). No virus was detected.

/s/ Joel Marcus

June 1, 2016

CERTIFICATE OF SERVICE

I certify that on June 1, 2016, I filed the foregoing Brief for the Federal Trade Commission and the Commonwealth of Pennsylvania via the Court's electronic filing system. All parties have consented to receive electronic service and will be served by the ECF system.

/s/ Joel Marcus

STATUTORY APPENDIX

Contents:

Clayton Act § 7, 15 U.S.C. § 18
Federal Trade Commission Act § 13(b), 15 U.S.C. § 53(b)

United States Code Annotated
Title 15. Commerce and Trade
Chapter 1. Monopolies and Combinations in Restraint of Trade (Refs & Annos)

15 U.S.C.A. § 18

§ 18. Acquisition by one corporation of stock of another

Effective: February 8, 1996
Currentness

No person engaged in commerce or in any activity affecting commerce shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another person engaged also in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.

No person shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of one or more persons engaged in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition, of such stocks or assets, or of the use of such stock by the voting or granting of proxies or otherwise, may be substantially to lessen competition, or to tend to create a monopoly.

This section shall not apply to persons purchasing such stock solely for investment and not using the same by voting or otherwise to bring about, or in attempting to bring about, the substantial lessening of competition. Nor shall anything contained in this section prevent a corporation engaged in commerce or in any activity affecting commerce from causing the formation of subsidiary corporations for the actual carrying on of their immediate lawful business, or the natural and legitimate branches or extensions thereof, or from owning and holding all or a part of the stock of such subsidiary corporations, when the effect of such formation is not to substantially lessen competition.

Nor shall anything herein contained be construed to prohibit any common carrier subject to the laws to regulate commerce from aiding in the construction of branches or short lines so located as to become feeders to the main line of the company so aiding in such construction or from acquiring or owning all or any part of the stock of such branch lines, nor to prevent any such common carrier

from acquiring and owning all or any part of the stock of a branch or short line constructed by an independent company where there is no substantial competition between the company owning the branch line so constructed and the company owning the main line acquiring the property or an interest therein, nor to prevent such common carrier from extending any of its lines through the medium of the acquisition of stock or otherwise of any other common carrier where there is no substantial competition between the company extending its lines and the company whose stock, property, or an interest therein is so acquired.

Nothing contained in this section shall be held to affect or impair any right heretofore legally acquired: *Provided*, That nothing in this section shall be held or construed to authorize or make lawful anything heretofore prohibited or made illegal by the antitrust laws, nor to exempt any person from the penal provisions thereof or the civil remedies therein provided.

Nothing contained in this section shall apply to transactions duly consummated pursuant to authority given by the Secretary of Transportation, Federal Power Commission, Surface Transportation Board, the Securities and Exchange Commission in the exercise of its jurisdiction under section 79j of this title, the United States Maritime Commission, or the Secretary of Agriculture under any statutory provision vesting such power in such Commission, Board, or Secretary.

CREDIT(S)

(Oct. 15, 1914, c. 323, § 7, 38 Stat. 731; Dec. 29, 1950, c. 1184, 64 Stat. 1125; Sept. 12, 1980, Pub.L. 96-349, § 6(a), 94 Stat. 1157; Oct. 4, 1984, Pub.L. 98-443, § 9(l), 98 Stat. 1708; Dec. 29, 1995, Pub.L. 104-88, Title III, § 318(1), 109 Stat. 949; Feb. 8, 1996, Pub.L. 104-104, Title VI, § 601(b)(3), 110 Stat. 143.)

15 U.S.C.A. § 18, 15 USCA § 18
Current through P.L. 114-143. Also includes P.L. 114-145, 114-146, 114-148, and 114-151 to 114-154.

15 U.S.C.A. § 53(b) (Section 13(b))

§ 53. False advertisements; injunctions and restraining orders

(b) Temporary restraining orders; preliminary injunctions

Whenever the Commission has reason to believe--

(1) that any person, partnership, or corporation is violating, or is about to violate, any provision of law enforced by the Federal Trade Commission, and

(2) that the enjoining thereof pending the issuance of a complaint by the Commission and until such complaint is dismissed by the Commission or set aside by the court on review, or until the order of the Commission made thereon has become final, would be in the interest of the public--

the Commission by any of its attorneys designated by it for such purpose may bring suit in a district court of the United States to enjoin any such act or practice. Upon a proper showing that, weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest, and after notice to the defendant, a temporary restraining order or a preliminary injunction may be granted without bond: *Provided, however*, That if a complaint is not filed within such period (not exceeding 20 days) as may be specified by the court after issuance of the temporary restraining order or preliminary injunction, the order or injunction shall be dissolved by the court and be of no further force and effect: *Provided further*, That in proper cases the Commission may seek, and after proper proof, the court may issue, a permanent injunction. Any suit may be brought where such person, partnership, or corporation resides or transacts business, or wherever venue is proper under section 1391 of Title 28. In addition, the court may, if the court determines that the interests of justice require that any other person, partnership, or corporation should be a party in such suit, cause such other person, partnership, or corporation to be added as a party without regard to whether venue is otherwise proper in the district in which the suit is brought. In any suit under this section, process may be served on any person, partnership, or corporation wherever it may be found.

CREDIT(S)

(Sept. 26, 1914, c. 311, § 13, as added Mar. 21, 1938, c. 49, § 4, 52 Stat. 114; amended Nov. 16, 1973, Pub.L. 93-153, Title IV, § 408(f), 87 Stat. 592; Aug. 26, 1994, Pub.L. 103-312, § 10, 108 Stat. 1695.)

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 16-2365

FEDERAL TRADE COMMISSION and
COMMONWEALTH OF PENNSYLVANIA,
Appellants,

v.

PENN STATE HERSHEY MEDICAL CENTER and
PINNACLEHEALTH SYSTEM,
Appellees.

APPENDIX VOLUME 1, Pages 1 - 29

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

FEDERAL TRADE COMMISSION and COMMONWEALTH OF PENNSYLVANIA, Plaintiffs, vs. PENN STATE HERSHEY MEDICAL CENTER and PINNACLEHEALTH SYSTEM, Defendants.	Civil Action No.: 1:15-cv-02362 Hon. John E. Jones III

NOTICE OF APPEAL

Notice is hereby given that Plaintiffs Federal Trade Commission and the Commonwealth of Pennsylvania appeal to the United States Court of Appeals for the Third Circuit from an Order of the United States District Court for the Middle District of Pennsylvania, entered on May 9, 2016 (Doc. No. 131), denying Plaintiffs' Motion For Preliminary Injunction in the above-captioned proceeding.

Dated: May 10, 2016

Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

FEDERAL TRADE COMMISSION and COMMONWEALTH OF PENNSYLVANIA, Plaintiffs, vs. PENN STATE HERSHEY MEDICAL CENTER and PINNACLEHEALTH SYSTEM, Defendants.	Civil Action No.: 1:15-cv-2362 Hon. John E. Jones III

MEMORANDUM OPINION AND ORDER

May 9, 2016

Before the Court is a motion by Plaintiffs, Federal Trade Commission ("FTC") and the Commonwealth of Pennsylvania, pursuant to Section 13(b) of the FTC Act, 15 U.S.C. § 53(b), for a preliminary injunction enjoining Defendants, Penn State Hershey Medical Center ("Hershey") and PinnacleHealth System ("Pinnacle") (collectively, "the Hospitals"), from taking any steps towards

consummating their proposed merger pending the completion of the FTC's administrative trial on the merits of the underlying antitrust claims. For the reasons that follow, the Motion for Preliminary Injunction shall be denied.

I. BACKGROUND[1]

Penn State Hershey Medical Center is a 551-bed hospital located in Hershey, Pennsylvania. It is a leading academic medical center ("AMC") and the primary teaching hospital of the Penn State College of Medicine. (DX1160-009). Hershey offers a broad array of high-acuity services, and tertiary and quaternary care, including bone-marrow transplants, neurosurgery, and specialized oncologic surgery.[2] Hershey operates central Pennsylvania's only specialty children's hospital, one of the Commonwealth's three Level I trauma centers, and the only heart-transplant center outside Philadelphia and Pittsburgh. (DX0190-005; DX0527-010; DX1160-009; DX0803-002).

PinnacleHealth System is a not-for-profit health system with 646 licensed beds across three campuses: Harrisburg Hospital and Community General Osteopathic Hospital, both in Harrisburg, and West Shore Hospital in Cumberland

[1] Citations to the record are identified in the following ways: (1) documents already on file with the Court are cited as "Doc." followed by the docket number and any further pinpoint citation; (2) references to testimony from the evidentiary hearing are cited as "Tr." followed by the specific page numbers; and (3) exhibits are cited to by reference to their marked number, and where applicable, further pinpoint citation to the specific page, paragraph, or section.

[2] Tertiary care is sophisticated, complex, or high-tech care that includes, for example, open heart surgery, oncology surgery, neurosurgery, high-risk obstetrics, neonatal intensive care and trauma services. Quaternary care is even more sophisticated and includes organ transplants.

County, Pennsylvania. (DX0196-001-002). All three of Pinnacle's hospitals are community hospitals focused on cost-effective acute care, although Pinnacle offers some higher-level services including open-heart surgery, kidney transplants, chemotherapy and radiation oncology. (Tr., pp. 523:15-525:22).

The Hospitals signed a Letter of Intent of their proposed merger in June of 2014, and received final board approval in March of 2015. (PX00643). In April of 2015, the Hospitals notified the FTC of their proposed merger and executed a "Strategic Affiliation Agreement" one month later. (PX00390-011; PX01338).

Following an investigation, on December 7, 2015, the FTC issued an administrative complaint alleging that the Hospitals' proposed merger violates Section 7 of the Clayton Act and Section 5 of the FTC Act. A merits trial in the FTC administrative proceeding is scheduled to commence on May 17, 2016. On December 9, 2015, Plaintiffs filed their Complaint in this action. (Doc. 4). The Hospitals filed their Answer on January 11, 2016. (Doc. 41). The instant Motion for Preliminary Injunction was filed on March 7, 2016 and was subsequently briefed by the parties. (Docs. 82, 96, and 102).

Following a period of expedited discovery, the Court conducted a five-day evidentiary hearing commencing on April 11, 2016. The Court heard testimony from 16 witnesses, including two economists, and admitted thousands of pages of

exhibits into evidence. Following the hearing, both sides filed post-hearing briefs. (Docs. 129 and 130). This matter is thus fully ripe for our review.

II. ANALYSIS

A. Standard of Review for Preliminary Injunctive Relief

When the FTC has reason to believe that "any person, partnership, or corporation is violating, or is about to violate, any provision of law enforced by the Federal Trade Commission," including Section 7 of the Clayton Act, it is authorized by § 13(b) of the FTC Act to "bring suit in a district court of the United States to enjoin any such act or practice." 15 U.S.C. § 53(b). The district court may grant a request for preliminary injunctive relief "[u]pon a proper showing that, weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest." *Id.* Therefore, "in determining whether to grant a preliminary injunction under section 13(b), a district court must (1) determine the likelihood that the FTC will ultimately succeed on the merits and (2) balance the equities." *FTC v. United Health, Inc.*, 938 F.2d 1206, 1217 (11th Cir. 1991); *see also FTC v. Click4Support*, 2015 U.S. Dist. LEXIS 153945, *12-13 (E.D.Pa. Nov. 10, 2015) (noting that while the Third Circuit has not expressly adopted this standard, several other circuits have done so, as well as the District of New Jersey); *FTC v. Millennium Telecard, Inc.*, 2011 U.S. Dist. LEXIS 74951, *6-7 (D.N.J. Jul. 12, 2011).

B. Section 7 of the Clayton Act

Section 7 of the Clayton Act prohibits mergers whose effect "may be substantially to lessen competition, or to tend to create a monopoly." 15 U.S.C. § 18. Section 7 is "designed to arrest in its incipiency . . . the substantial lessening of competition from the acquisition by one corporation" of the assets of a competing corporation. *United States v. E.I. du Pont de Nemours & Co.,* 353 U.S. 586, 589 (1957). To be sure, "Congress used the words 'may be substantially to lessen competition' to indicate that its concern was with probabilities, not certainties." *Brown Shoe Co. v. United States*, 370 U.S. 294, 323 (1962). "Ephemeral possibilities" of anticompetitive effects are not sufficient to establish a violation of Section 7, *United States v. Marine Bancorp., Inc.*, 418 U.S. 602, 623 (1974) (quotation marks omitted), nor will "a fair or tenable chance of success on the merits . . . suffice for injunctive relief." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045 (8th Cir. 1999) (citation omitted).

The first step in a Clayton Act analysis is "[t]he determination of the relevant market." *E.I. du Pont,* 353 U.S. at 593. "A relevant market consists of two separate components: a product market and a geographic market." *Id.* (citing *Morgenstern v. Wilson*, 29 F.3d 1291, 1296) (8th Cir. 1994). "Without a well-defined relevant market, an examination of a transaction's competitive effects is without context or meaning." *FTC v. Freeman Hosp.*, 69 F.3d 260, 268 (8th Cir.

1995). Thus, "[i]t is . . . essential that the FTC identify a credible relevant market before a preliminary injunction may properly issue," because a merger's effect cannot be properly evaluated without a well-defined relevant market. *Tenet Health*, 186 F.3d at 1051. Courts have observed that "[a] monopolization claim often succeeds or fails strictly on the definition of the product or geographic market." *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1075 (N.D. Ill. 2012) (quoting *Tenet Health*, 186 F. 3d at 1052); *see also Morgenstern,*29 F. 3d at 1296. The FTC bears the burden of defining a valid market. *See FTC v. Lundbeck, Inc.*, 650 F. 3d 1236, 1239-40 (8th Cir. 2011).

A relevant product market is a "line of commerce" affected by a proposed merger, *see Brown Shoe Co.*, 370 U.S. at 324, and is defined by determining "whether two products can be used for the same purpose, and if so, whether and to what extent purchasers are willing to substitute one for the other." *U.S. v. H&R Block,*, 883 F. Supp. 2d 36, 51 (D.D.C. 2011) (citations and quotations omitted). In the matter *sub judice,* the parties agree that the relevant product market is general acuity services ("GAC") sold to commercial payors. GAC services comprise a broad cluster of medical and surgical services that require an overnight hospital stay. (Doc. 82, pp. 7-8; Doc. 96, p. 7).

"The relevant geographic market is the area in which a potential buyer may rationally look for the goods or services he or she seeks." *Hanover 3201 Realty,*

LLC v. Vill. Supermarkets, Inc., 806 F.3d 162, 183-84 (3d Cir. 2015) (quoting *Eichorn v. AT&T Corp.*, 248 F.3d 131, 147 (3d Cir. 2001) (citing *Pa. Dental Ass'n v. Med. Serv. Ass'n of Pa.*, 745 F.2d 248, 260 (3d Cir. 1984)). Determination of the relevant geographic market is highly fact sensitive. *Tenet Health,* 186 F. 3d at 1052 (citing *Freeman Hosp.*, 69 F.3d at 271, n. 16). "This geographic market must 'conform to commercial reality,'" *Eichorn*, 248 F.3d at 147 (quoting *Acme Mkts., Inc. v. Wharton Hardware & Supply Corp.,* 890 F. Supp. 1230, 1239 (D.N.J. 1995)(citing *Brown Shoe Co.*, 370 U.S. at 336)), and can be determined "only after a factual inquiry into the commercial realities faced by consumers." *Tenet Health*, 186 F.3d at 1052 (citing *Flegel v. Christian Hosp. Northeast-Northwest*, 4 F.3d 682, 690 (8th Cir. 1993). Further, the Department of Justice and Federal Trade Commission's *Horizontal Merger Guidelines* "provides guidance" in defining a geographic market. *Atl. Exposition Servs. Inc. v. SMG,* 262 F. App'x 449, 452 (3d Cir. 2008) The most recent version of the *Merger Guidelines* defines a relevant geographic market as the smallest area in which a hypothetical monopolist could profitably raise prices by a "small but significant amount" for a meaningful period of time (referred to as a "SSNIP"). *See* U.S. Dep't of Justice and Fed. Trade Comm'n, *Horizontal Merger Guidelines*, §§ 4.1, 4.2 (2010).

C. Relevant Geographic Market

The FTC contends that the relevant geographic market for purposes of our analysis is the "Harrisburg Area," which is "roughly equivalent to the Harrisburg Metropolitan Statistical Area (Dauphin, Cumberland and Perry Counties) and Lebanon County." (Doc. 82, pp. 8-9). The FTC contends that geographic markets for GAC services are inherently local because people want to be hospitalized near their families and homes. To support this contention, the FTC posits that patients who live in the Harrisburg Area overwhelmingly utilize hospitals close to home, primarily Hershey and Pinnacle, and very few patients travel to hospitals outside of the Harrisburg Area. The FTC further contends that the two main commercial health insurance payors in the Harrisburg Area, Capital Blue Cross ("CBC") and Highmark recognize the Harrisburg Area as a distinct market and would not exclude the proposed merged entity from their networks. The Hospitals heartily disagree, arguing that the FTC's four county relevant geographic market is far too narrowly drawn and is untethered to the commercial realities facing patients and payors. It is the resolution of this threshold dispute that is dispositive to the outcome of the instant Motion.

"Properly defined, a geographic market is a geographic area 'in which the seller operates, and to which . . . purchaser[s] can practicably turn for supplies.'" *Little Rock Cardiology Clinic PA v. Baptist Health*, 591 F.3d 591 (8th Cir. 2009)

(quoting *Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320, 327 (1961)); *see also Morgenstern*, 29 F.3d at 1291. "Broken down, the test requires a court to first determine whether a plaintiff has alleged a geographic market that includes the area in which a defendant supplier draws a sufficiently large percentage of its business – 'the market area in which the seller operates,' its trade area." *Id.* (citing *Morgenstern*, 29 F.3d at 1296). "A court must then determine whether a plaintiff has alleged a geographic market in which only a small percentage of purchasers have alternative suppliers to whom they could practicably turn in the event that a defendant supplier's anticompetitive actions result in a price increase." *Id.* "The end goal in this analysis is to delineate a geographic area where, in the medical setting, "'few' patients leave. . . and 'few' patients enter." *Id.* (quoting *U.S. v. Rockford Mem'l Corp.*, 717 F. Supp. 1251, 1267 (N.D. Ill. 1989), aff'd 898 F.2d 1278 (7th Cir. 1990)).

Of particular import to our analysis is the uncontroverted fact that, in 2014, 43.5% of Hershey's patients, 11,260 people, travel to Hershey from outside of the FTC's designated Harrisburg Area, and several thousand of Pinnacle's patients reside outside of the Harrisburg Area. (DX1698-0048). Further, half of Hershey's patients travel at least thirty minutes for care, and 20% travel over an hour to reach Hershey, resulting in over half of Hershey's revenue originating outside of the Harrisburg area. (DX 1698-0034-36; DX1698-0049). These salient facts

controvert the FTC's assertion that GAC services are "inherently local," and strongly indicate that the FTC has created a geographic market that is too narrow because it does not appropriately account for where the Hospitals, particularly Hershey, draw their business.

Next, the FTC presents a starkly narrow view of the amount of hospitals patients could turn to if the combined Hospitals raised prices or let quality suffer. There are 19 hospitals within a 65 minute drive of Harrisburg, and many of these hospitals are closer to patients who now come to Hershey. Thus, if a hypothetical monopolist such as the combined Hospitals imposed a SSNIP, these other hospitals would readily offer consumers an alternative. Further, given the realities of living in Central Pennsylvania, which is largely rural and requires driving distances for specific goods or services, it is our view that these 19 other hospitals within a 65 minute drive of Harrisburg provide a realistic alternative that patients would utilize. Thus, the relevant geographic market proffered by the FTC is not one in which "'few' patients leave. . . and 'few' patients enter." *Little Rock Cardiology*, 591 F. 3d at 591.

Finally, during the evidentiary hearing, the Court heard hours of economic expert testimony regarding the hypothetical monopolist's ability to impose a SSNIP in the context of this proposed merger. The Court finds it extremely compelling that the Hospitals have already taken steps to ensure that post-merger

rates do not increase with CBC and Highmark, central Pennsylvania's two largest payors, representing 75-80% of the Hospitals' commercial patients. (DX 1166-01; DX 1167-003; DX 1698-0120-0124). To wit, the Hospitals have executed a 5-year contract with Highmark and a 10-year contract with CBC that not only require the Hospitals to contract with these payors for those periods, but to maintain existing rate structures for fee-for-service contracts and preserve the existing rate-differential between the Hospitals. The result of these agreements is that the Hospitals cannot walk away from these payors and that rates cannot increase for at least 5 years. (DX 0095 ¶ 14). The Court simply cannot be blind to this reality when considering the import of the hypothetical monopolist test advanced by the *Merger Guidelines*. Thus, the FTC is essentially asking the Court prevent this merger based on a prediction of what might happen to negotiating position and rates in 5 years. In the rapidly-changing arena of healthcare and health insurance, to make such a prediction would be imprudent, and as such, we do not find that the outcome of the hypothetical monopolist test aids the FTC in this matter.

In sum, we find based on the hours of testimony and thousands of pages of exhibits presented by the parties and considered by this Court, that the FTC's four county "Harrisburg Area" relevant geographic market is unrealistically narrow and does not assume the commercial realities faced by consumers in the region. Because the Government has failed to set forth a relevant geographic market, it

cannot establish a *prima facie* case under the Clayton Act. Therefore, the FTC's request for injunctive relief must be denied because it has not demonstrated a likelihood of ultimate success on the merits. *See Tenet Health*, 186 F.3d at 1053-55 (denying a preliminary injunction on the grounds of failure to provide sufficient evidence of a relevant geographic market); *Freeman Hosp.*, 69 F.3d at 268-72 (same); *California v. Sutter Health Sys.*, 130 F. Supp.2d 1109, 1132 (N.D. Cal. 2001) (same).

D. Equities

The FTC's impermissibly narrow interpretation of the relevant geographic market has caused this Court to determine that the FTC has not established a likelihood of success on the merits. Had the FTC demonstrated a likelihood of ultimate success, however, the burden of proof would have shifted to the Hospitals to "clearly" show that their combination would not cause anticompetitive effects. *U.S. v. Citizens & S. Nat. Bank*, 422 U.S. 86, 120 (1975) (explaining that once the Government plainly made out a *prima facie* case establishing a violation of Section 7, it "was incumbent upon [the defendants] to show that the market-share statistics gave an inaccurate account of the acquisitions' probable effects on competition."). As a precaution, then, the Hospitals presented ample evidence demonstrating that anticompetitive effects would not arise through the merger of Hershey and

Pinnacle. This evidence warrants consideration in our weighing of the equities here.

As noted in the Standard of Review, *see* Section II.A, along with consideration of the FTC's likelihood of success, a weighing of the equities present in this case is required to determine whether enjoining the merger would be in the best interests of the public. *F.T.C. v. H.J. Heinz Co.*, 246 F.3d 708, 714 (D.C. Cir. 2001) ("Section 13(b) provides for the grant of a preliminary injunction where such action would be in the public interest—as determined by a weighing of the equities and a consideration of the Commission's likelihood of success on the merits."). "Absent a likelihood of success on the merits, however, equities alone will not justify an injunction." *F.T.C. v. Arch Coal, Inc.*, 329 F.Supp.2d 109, 159 (D.D.C. 2004) (citing *F.T.C. v. PPG Indus., Inc.*, 798 F.2d 1500, 1508 (D.C. Cir. 1986)). The Seventh Circuit has adopted a "sliding scale" approach to a consideration of the equities: "[t]he greater the plaintiff's likelihood of success on the merits . . . the less harm from denial of the preliminary injunction the plaintiff need show in relation to the harm that the defendant will suffer if the preliminary injunction is granted." *F.T.C. v. Elders Grain, Inc.*, 868 F.2d 901, 903 (7th Cir. 1989); *OSF Healthcare Sys.,* 852 F.Supp.2d at 1094-95 (also utilizing the sliding-scale standard). The inverse has also been adopted; where a defendant can demonstrate that a preliminary injunction would inflict "irreparable harm," a ruling

that a plaintiff would likely succeed on the merits is less probable. *Elders Grain*, 868 F.2d at 903 ("[T]he sliding scale approach just sketched is appropriate . . . in cases where defendants are able to show that a preliminary injunction would do them irreparable harm."). Because of this relationship, once a court has made a determination of the likelihood of success, discussions on equitable considerations are often scant. *See OSF*, 852 F.Supp.2d at 1094-95; *Arch Coal*, 329 F.Supp.2d at 159-60. However, as alluded to in the rationale above, there are several important equitable considerations that merit further elucidation here.

1. Hershey's Capacity Constraints

"The Supreme Court has not sanctioned the use of an efficiencies defense in a case brought under Section 7 of the Clayton Act. However, 'the trend among lower courts is to recognize the defense.'" *Arch Coal*, 329 F.Supp.2d at 150 (internal citations omitted) (quoting *Heinz*, 246 F.3d at 720); *see FTC v. Procter & Gamble Co.*, 386 U.S. 568, 580 (1967) ("Possible economies cannot be used as a defense to illegality."). Here, the Hospitals have presented a compelling efficiencies argument in support of the merger, in that the merger would alleviate some of Hershey's capacity constraints. As we have already found the merger to be legal, this argument is not relevant as a defense to illegality. However, the efficiencies wrought by the merger would nonetheless provide beneficial effects to

the public, such that equitable considerations weigh in favor of denying the injunction.

Though the exact range is contested, both parties concur that a hospital's optimal occupancy rate is approximately 85%.[3] During the evidentiary hearing on this matter, Ms. Sherry Kwater, former Chief Nursing Officer at Hershey Medical Center, testified extensively to her experience with the overcrowding and capacity problems rampant at Hershey. (Tr., pp. 688-89). Specifically, Ms. Kwater testified that the average capacity percentage at Hershey in the last several years had hovered at approximately 89% during the daily midnight census,[4] and routinely climbed to as high as 112-115% occupancy during midday.[5] (Tr., p. 688). Ms. Kwater also testified to a variety of ongoing renovation projects at Hershey designed to procure more beds, including those in the maternity ward and in the emergency room, as well as a project to convert a large storage room into space for observation beds. (Tr., pp. 671-72, 675-76, 679, 685). Ultimately, however, Hershey's Chief Executive Officer Craig Hillemeier and Chief Operating

[3] (Doc. 96, p. 18 ("The consensus in medical literature is that a hospital's optimal occupancy rate is 80-85%.")); (Doc. 129, pp. 24-25).

[4] Efficiencies expert Brandon Klar later testified that an occupancy review excluding the pediatric beds and focusing only on the remaining adult beds yielded a midnight occupancy rate averaging 90.5%. (Tr., p. 737:25-738:1-7).

[5] Ms. Kwater's testimony indicates that a hospital may be at over 100% capacity by placing patients in beds that were not designed for inpatient care. (Tr., p. 689:3-6). Obviously, this overcrowding results in negative consequences for patients at Hershey, who may not be comfortable placed in the hallway beds described, or 4- and 6- bedded rooms. (Tr., p. 684:17-23).

Officer Robin Wittenstein both testified that the renovation projects have not been sufficient to keep pace with the demand for care. (Tr., pp. 443:15-20; 579:12-19). Thus, without the merger, Hershey intends to build a new bed tower, costing approximately $277 million and generating 100 inpatient beds (yielding a total net gain of 70-80 new beds after renovations are complete). (Doc. 130, p. 21); (Tr., p. 579:12-19 ("[W]e will immediately begin moving forward on the construction of a new bed tower.")).

In response, the FTC assembled a series of arguments designed to rebut Hershey's stated need to build the bed tower. Evidence was introduced indicating that as few as two and as many as thirteen beds could alleviate Hershey's capacity constraints, and that Hershey would need a total of just thirty-six (36) beds in five years to relieve its capacity issues. (Doc. 129, p. 26). Under this reasoning, Plaintiffs suggest that Hershey would not need to build a bed tower at all. (*Id.*). Furthermore, Plaintiffs argue that even if it were built, Hershey has artificially inflated the cost of constructing the bed tower, and the cost would not ultimately be passed on to patients as the tower would be funded by grants or by existing funds in Hershey's fixed cost budget. (Tr., pp. 779-82, 989:4-8 ("Such a capital expense [as the building of a bed tower] . . . is properly understood as a fixed cost. As such, economic theory would not predict that it would be passed on in the form of higher prices.")).

This line of reasoning defies logic. Even if the cost of the bed tower has been partially overstated, its construction would undoubtedly strain Hershey's financial resources, resulting in either increased charges for services or less investment in quality improvements. (Doc. 130, p. 23 (citing to testimony by Defendants' expert economic witness, Dr. Willig)). Both outcomes would negatively impact patients at least until the bed tower could be completed, fully paid for, and operational. By contrast, the merger would immediately make additional capacity available to Hershey, causing near instantaneous benefits to Hershey's patients. (*See* Tr., pp. 819:25-820:4 ("[T]he merger will immediately make more effective capacity available to alleviate Hershey's capacity problem. That's a relatively immediate, maybe instantly, but certainly within a few months, impact of the merger.")).

Further, for the Court to expect Hershey to rely on assumptions of grants for the construction would be to expect a reliance on unsound business practice, as the FTC has presented no evidence that such grants would definitively be forthcoming. (Tr., pp. 779:24-781:10 (cross examination of Brandon Klar, noting that the FTC's prediction of philanthropic donations is only assumed, and not guaranteed, and that donations for a bed-tower with no designated specialty like a children's ward or cancer facility are unlikely to accumulate in any great frequency)).

Finally, Plaintiffs impermissibly ask the Court to second guess Hershey's business decision in building the tower. It is not within our purview to question the CEO and COO's determination of this need, and their sworn testimony that they will embark upon this project absent the merger is sufficiently reliable. Further, as our nation's population continues to age and increasingly demand more complex and numerous medical treatments, it is entirely reasonable that Hershey would decide that, absent a merger, construction of a large bed tower is in its best interest.

Hershey has also presented testimony of the capital avoidance that will occur if the combination with Pinnacle is allowed to go forward and the bed tower is not built. Pinnacle has sufficient capacity available such that Hershey may transfer its lower-acuity patients to Pinnacle, simultaneously allowing both hospitals' physicians to treat more people while Hershey's capacity constraints are alleviated. (Tr., pp. 732-33, 748:13-18). Further, Hershey's facilities will be able to admit more high-acuity patients who will benefit from Hershey's greater offering of complex treatments and procedures. (*Id.* p. 737)[6]; (Doc. 96, p. 29). Of course, the ability of both hospitals to treat more patients at the locations best suited to their

[6] Here, Mr. Klar explained that "[site-of-service adjustments] will allow [Hershey] to reduce their occupancy rate . . . to 80 percent, which will allow space for patients that are currently being denied access within Central Pennsylvania to get the available access that they need locally and close to home." (Tr., p. 737:1-13).

healthcare needs will also generate more revenue.[7] Finally, the merger will prevent the outpouring of capital for the construction of the tower, allowing Hershey to forego this expenditure, serve more patients, and generate downward pricing pressure that greater efficiencies and a larger supply of services typically facilitates.[8]

Where, as here, "an injunction would deny consumers the procompetitive advantages of the merger," courts have found that the equities may weigh in favor of allowing the combination to go forward. *See Heinz*, 246 F.3d at 726-27 (citing *FTC v. Pharmtech Research, Inc.*, 576 F.Supp. 294, 299 (D.D.C. 1983)). We find

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[7] This increase in revenue was discussed in detail during the Hospitals' testimony, and relates primarily to a two-step savings process. First, because Pinnacle handles on average, lower-acuity care patients, there is an average price differential of $3,400 per case at Pinnacle as compared to Hershey. (Tr., p. 749:12-24). This, multiplied by the expected 2,000-3,000 cases that will be transferred over the next five years, yields a great deal of the expected savings, between approximately $31.3 and $46.2 million. (*Id.*). Second, because the patients transferred from Hershey to Pinnacle will be replaced by primarily higher-acuity care patients, the income that Hershey will generate from providing their treatment will drastically increase, by as much as $17,000 per case (Hershey stresses that other AMCs are routinely reimbursed at even higher commercial rates for high-acuity care procedures—approximately 15 percent higher). (*Id.*, pp. 750:18-751:5). This two-step increase in revenue was presented as one of the main reasons for the Hospitals' desire to pursue the merger. It was also cited as a reason for why the Hospitals would have no need to impose a SSNIP on Harrisburg area payors, even if they could do so. While we certainly acknowledge the merit of the efficiencies argument, we find this secondary rationale regarding the SSNIP unpersuasive, as in the Court's experience it is rare that a company decides it has made enough money already, such that it does not need more. *See In the Matter of ProMedica Health Sys., Inc.*, Docket No. 9346, 2012 WL 2450574, at *21 (F.T.C., June 25, 2012) (describing the lower court's holding that the evidence did not support that "excess hospital bed capacity in Toledo, repositioning by competitors, and steering patients away from high-priced hospitals . . . would constrain post-Joinder price increases."). Rather, it is for the reasons discussed *supra* that we feel the Hospitals are unlikely to be able to unreasonably raise costs for payors.

[8] (Doc. 96, p. 29 (noting that the adjustments will save patients and payors $49.5-82.7 million over five years); (Tr., pp.732-34 (same)).

that the efficiencies evidence overwhelmingly indicates that procompetitive advantages would be generated for the Hospitals' consumers such that the equities favor the denial of injunctive relief.

2. Repositioning by Competitors Will Constrain Hershey and Pinnacle

The 2010 *Horizontal Merger Guidelines* advise that "[i]n some cases, non-merging firms may be able to reposition . . . to offer close substitutes for the products offered by the merging firms." 2010 *Horizontal Merger Guidelines*, §6.1. "A merger is unlikely to generate substantial unilateral price increases if non-merging parties offer very close substitutes." *Id.* Where, as here, firms are already present in the market but are repositioning, that "[r]epositioning . . . is evaluated much like entry, with consideration given to timeliness, likelihood, and sufficiency." *Id.* Courts weighing the anticompetitive effects of a merge have considered such repositioning as a factor in whether to give great weight to predictions of a combined entity's ability to control the marketplace. *See ProMedica Health*, 2012 WL 2450574, *64-65 (discussing hospitals' competitors and concluding that they did not possess the significant competitive ability necessary to constrain the merged entity).

In the case *sub judice*, the market that Hershey and Pinnacle exist within has already been subject to extensive repositioning. Competition, in the form of

nearby hospitals' growing ability to offer close substitutes for Hershey and Pinnacles' advanced care, is escalating. Specifically, Geisinger Health System recently acquired Holy Spirit Hospital, with the intent to create a "regional referral center and tertiary care hospital" (DX0090-002); WellSpan Health has acquired Good Samaritan Hospital—with the specific goal of taking patients from Hershey (DX 0095 ¶ 6; DX0851); the University of Pennsylvania partnered with Lancaster General Hospital to "take more volume away from Hopkins, Hershey, and Philadelphia competitors" (DX0136-232; *see also* DX0095 ¶ 7); and Community Health Systems acquired Carlisle Regional Hospital. (Tr., p. 80:23-25). Notably, this repositioning would not happen in response to the combination of Hershey and Pinnacle—it has already occurred. Thus, in terms of a timeliness and likelihood analysis, there is no delay here that other courts have found to be a significant concern in a competitor's ability to constrain a merged entity. *ProMedica Health*, 2012 WL 2450574, *64-65 (expressing concern that a rival hospital, Mercy, had no location chosen or deadline implemented for the construction of its outpatient facility, which "casts doubt on whether Mercy is likely to accomplish such repositioning and suggests that its . . . strategy will not provide a timely constraint.").

Furthermore, this repositioning represents a direct and concerted effort to erode both hospitals', but mainly Hershey's, patient base. Far from being isolated

from service, other hospitals have realized and begun to capitalize on the large market of patients in the Harrisburg area.[9] The Office of the Attorney General cites to these hospitals, not as small community hospitals, but as "dominant providers" that demand high prices for their services. (Tr., p. 42:15-19). It neglects, however, to emphasize that these providers are located in York, Lancaster, Reading and Danville[10]—well within driving distance from the "Harrisburg Area." (Tr., p. 487:4-15). Rather than monopolizing a geographic space, merging allows Hershey and Pinnacle to remain competitive in a climate where nearby hospitals are routinely partnering to assist each other in achieving growth and dominance. The rival hospitals'' competitive strength will result in a meaningful constraint on competition, benefitting Harrisburg area residents in a manner consistent with the analysis set forth in the Guidelines.

3. Risk-Based Contracting

Over the course of the five-day hearing, a substantial amount of testimony on the increase in risk-based contracting was presented. Risk based contracting

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[9] For example, Geisinger has already committed to invest $100 million in Holy Spirit to open a children's hospital and a Level II trauma center that Charles Chiampi, director of contracting for Highmark, submits shall directly compete with Hershey for complex emergency trauma care. DX0095-0001, ¶ 5. Further, the partnership between Geisinger and Holy Spirit allows for Geisinger to more easily refer higher-acuity patients from its Harrisburg location out to its larger facility in Danville. (Tr. 938:16-939:7).

[10] (Tr., p. 42:15-19). The Attorney General's Office simply cannot have its cake and eat it too. These hospitals cannot both be examples of behemoth institutions that have negatively impacted the Central Pennsylvania patient base but also be too small to meaningfully compete with a combined Hershey and Pinnacle entity.

"begins to introduce new concepts and terms that begin to transfer the risk for the cost of care for the individual to the provider." (Tr., 493:18-25). Over the ensuing three years, the government and various private payors intend to evoke a shift towards risk-based forms of contracting, and the payors with which Hershey and Pinnacle contract are no exception. (Tr. 254:17-255:3; Tr., p. 939:19-21 ("these agreements . . . between the payers and the hospitals . . . include a strong mutual assurance of movement toward . . . risk-based forms of contracting, and framework for doing that cooperatively.")). In fact, the government intends to shift 50-80% of payments into risk based contracts by 2018. (Tr., p. 498: 6-14). In order to perform best under risk-based contracting, hospitals must offer a "total continuum of care." (Doc. 130, p. 30). Though we agree with the FTC that Hershey and Pinnacle independently are capable of continuing to operate under the risk-based model, we find the testimony of Hershey CEO Craig Hillemeier to be persuasive in that "there will be some advantages in terms of size of scale, in terms of being able to spread of costs [sic] of the infrastructure of population health over a larger health care system." (Tr. 445:21-446:4). This adaptation to risk-based contracting will have a beneficial impact. One persuasive benefit involves Hershey's ability to continue to use its revenue to operate its College of Medicine and draw high-quality medical students and professors into the region. (*Id.*, 448:13-15 ("[P]art of the purpose of the Medical Center is, indeed, to support the College of Medicine . .

. . If patients don't fill the beds, then we can't do it.")). Particularly as the payment models continue to shift, the local populace has a continued interest in seeing its most closely situated medical center remain competitive.

4. Public Interest in Effective Enforcement of Antitrust Laws

"The principal public equity weighing in favor of issuance of preliminary injunctive relief is the public interest in effective enforcement of the antitrust laws. The Congress specifically had this public equity consideration in mind when it enacted Section 13(b)." *Heinz*, 246 F.3d at 726 (internal citations omitted). However, where an injunction would deny consumers the procompetitive advantages of the merger, this equity is no longer as compelling. These advantages have now been discussed at length, above. Further, though the FTC is correct to caution that "unscrambling" the assets of two merged entities is made more difficult after the combination has been completed, *see F.T.C. v. Univ. Health, Inc.*, 938 F.2d 1206, 1216 n. 23 ("once an anticompetitive acquisition is consummated, it is difficult to "unscramble the egg"), it is by no means unheard of that a merged entity would be asked to divest the assets of the previously separate institution. *See ProMedica Health*, 2012 WL 2450574, *66 ("Divestiture is the most appropriate remedy to restore the competition eliminated by the Joinder.").

Further we note that the parties have not emphasized, and we do not credit, any argument that "an injunction would 'kill this merger,'" as courts in the past

have found this line of reasoning to be unpersuasive and "at best a 'private' equity which does not affect [an] analysis of the impact on the market." *Heinz*, 246 F.3d at 726-27; *but see Freeman Hosp.*, 69 F.3d at 272 ("[A] district court may consider both public and private equities.").

After a thorough consideration of the equities in play, we find that the majority of these factors weigh in the public interest. The patients of Hershey and Pinnacle stand to gain much from a combined entity that is capable of competing with a variety of other merged and already growing hospital systems in the region. This decision further recognizes a growing need for all those involved to adapt to an evolving landscape of healthcare that includes, among other changes, the institution of the Affordable Care Act, fluctuations in Medicare and Medicaid reimbursement, and the adoption of risk-based contracting. Our determination reflects the healthcare world as it is, and not as the FTC wishes it to be. We find it no small irony that the same federal government under which the FTC operates has created a climate that virtually compels institutions to seek alliances such as the Hospitals intend here. Like the corner store, the community medical center is a charming but increasingly antiquated concept. It is better for the people they treat that such hospitals unite and survive rather than remain divided and wither.

III. CONCLUSION

Based on the foregoing analysis, the Court finds that the FTC failed to meet its burden to show a likelihood of ultimate success on the merits of their antitrust claim against the Hospitals. Accordingly, the Plaintiffs' Motion for a Preliminary Injunction shall be denied.

NOW, THEREFORE, IT IS HEREBY ORDERED THAT:

1. The Plaintiffs' Motion for Preliminary Injunction (Doc. 82) is **DENIED**.

s/ John E. Jones III
John E. Jones III
United States District Judge

EXHIBIT O

UPMC LIFE CHANGING MEDICINE

January 16, 2019

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Re: *Commonwealth v. UPMC, et al., No. 334 M.D. 2014; Commonwealth Court; Modification of Consent Decrees*

Dear Jim:

I write to provide our response to your office's request that we join Highmark in agreeing to the revised draft Modified Consent Decree you sent to us on January 8. As I believe you anticipated, we cannot consent to it.

First, like your prior draft, this proposal would not be a "modification" of the existing Consent Decrees at all, but rather a complete abrogation of them and the initiation of radical new arrangements for the delivery of all healthcare in Pennsylvania. Note that each of the existing Consent Decrees specifies that it "is not a contract extension and shall not be characterized as such." Yet your proposed Modified Consent Decree tries to do exactly that by mandating a contract between Highmark and UPMC to be effective when the existing Decrees expire and extending that relationship into perpetuity. We believe that if your office wants to impose the "principles" embodied in the "modification" on UPMC or any other nonprofit healthcare provider it should do so without trying to shoehorn those principles into the existing, expiring Decrees.

In addition, we want to point out again that the five-year transition envisioned by the original Consent Decrees has been a resounding success. The cost of employer-sponsored plans and individual health insurance in Western Pennsylvania is now lower than anywhere else in the Commonwealth and among the very lowest in the United States. Notably, in their recent proposal to Amazon for its new headquarters, Pittsburgh Mayor Bill Peduto, Allegheny County Executive Rich Fitzgerald, and Allegheny Conference CEO Stefani Pashman boasted about Pittsburgh's excellent, affordable healthcare and credited UPMC and Highmark as two integrated health systems that were "managing patients'

insurance and medical care" in a way that "many experts believe provides better treatment at lower costs."

We do believe, of course, that the delivery of healthcare in Pennsylvania could be improved. Numerous governors and legislatures around the country are considering or actively experimenting with various reforms, including multi-state single payer systems, Medicaid-buy-in proposals, and individual mandates. None, to our knowledge, has ever adopted—or even proposed—the any-willing-payer-any-willing-provider-private-rate-arbitration regime described in your proposal, let alone proposed to impose it by executive fiat without any public hearing rather than through the legislative process. In fact, far less radical any-willing-payer legislation was promoted by Highmark in both 2011 and 2013 but failed after a public hearing in December 2013 to gain the approval of Pennsylvania's General Assembly. As we testified at that public hearing, we believe that insurer-centric proposals like yours are the wrong medicine for whatever might ail healthcare in the Commonwealth and if enacted would take us back to the pre-Consent-Decree era when Highmark and other large insurers dominated healthcare and routinely inflicted annual, double-digit premium increases on employers and consumers.

Finally, we want to point out that Highmark would appear to be precluded from entering into the proposed modified consent decree unless it has first provided the Insurance 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 [West Penn Allegheny Health System, the predecessor to Allegheny Health Network] as well as an independent analysis of an expert on the impact of the New Contract on both the insurance and provider markets in the region including but not limited to any effects on competition." *Approving Determination and Order of the Highmark/West Penn Allegheny Health System Affiliation*, Pennsylvania Insurance Department, April 29, 2013, ¶ 22(A). Note that this Approving Order is expressly incorporated into the existing Consent Decrees at paragraph I.A. To our knowledge, no such analysis has been submitted to the Insurance Department—or even performed. Please correct us if we are mistaken in that regard.

In short, we decline to join Highmark in agreeing to the revised draft Modified Consent Decree.

Please let me know if you have any questions.

Very truly yours,

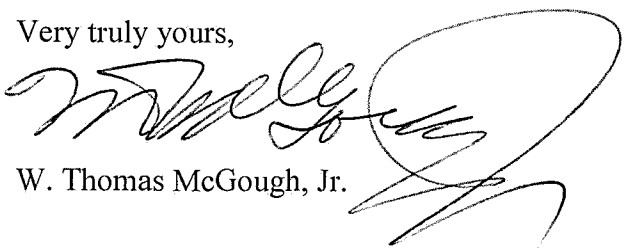

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EXHIBIT P

IN THE COURT OF COMMON PLEAS OF ALLEGHENY COUNTY, PENNSYLVANIA

CITY OF PITTSBURGH, a Pennsylvania Second Class City and Home Rule Municipality, by its Treasurer,

Plaintiff

vs.

UPMC, a Pennsylvania Nonprofit, Non-Stock Corporation,

Defendant

CIVIL DIVISION

NO. GD-13-005115

OPINION AND ORDER OF COURT

HONORABLE R. STANTON WETTICK, JR.

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OPINION AND ORDER OF COURT

WETTICK, J.

UPMC's preliminary objections requesting dismissal of plaintiff's Second Amended Complaint seeking declaratory relief pursuant to the Declaratory Judgments Act, 42 Pa.C.S. § 7531, *et seq.*, is the subject of this Opinion and Order of Court. UPMC's grounds for dismissal include the failure to state a cause of action and the failure to exhaust administrative remedies.

This case arises because neither UPMC nor its wholly-owned subsidiaries pay the Pittsburgh Payroll Tax. The subsidiaries rely on the provisions in the Payroll Tax exempting charitable organizations. UPMC contends that it does not have any employees. It also contends that it is a charitable organization.

Section 53 P.S. 6924.303(a) of an Enabling Act (53 P.S. § 6924.303) allows the City of Pittsburgh to assess a payroll tax on employers conducting business activity within the City:

> (a) A city of the second class may levy, assess or collect a tax that does not exceed fifty-five hundredths percent on payroll amounts generated as a result of an employer conducting business activity within a city of the second class. For purposes of a payroll tax levied, assessed or collected by a city of the second class, the business activity shall be directly attributable to activity within a city of the second class. For purposes of computation of the payroll tax imposed pursuant to this section, the payroll amount attributable to the city shall be determined by applying an apportionment factor to total payroll expense based on that portion of payroll expense which the total number of days an employe, partner, member, shareholder or other individual works within

> the city bears to the total number of days such employe or person works within and outside of the city.

Section 6924.303(a.1) governs charitable organizations:

> (a.1) A charitable organization that qualifies for tax exemption pursuant to the act of November 26, 1997 (P.L. 508, No. 55), known as the "Institutions of Purely Public Charity Act," shall calculate the tax that would otherwise be attributable to the city, but shall only pay the tax on that portion of its payroll expense attributable to business activity for which a tax may be imposed pursuant to section 511 of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 1 et seq.). If the charity has purchased or is operating branches, affiliates, subsidiaries or other business entities that do not independently meet the standards of the "Institutions of Purely Public Charity Act," the tax shall be paid on the payroll attributable to such for-profit branches, affiliates or subsidiaries, whether or not the employes are leased or placed under the auspices of the charity's umbrella or parent organization. Nothing in this subsection shall restrict the ability of a charitable organization to contract with the city to provide services to the city in lieu of some or all taxes due under this section.

(Footnote omitted.)

Section 6924.303(j) of the Enabling Act defines *employer* as all persons conducting business activity within a city of the second class, and defines *payroll amounts* as all amounts paid by an employer as salaries. It allows a city of the second class to "levy, assess or collect a tax that does not exceed fifty-five hundredths percent on payroll amounts generated as a result of an employer conducting business activity within a city of the second class." 53 P.S. § 6924.303(a).

Pittsburgh's ordinance imposing the Payroll Tax permitted by the enabling legislation is codified in Chapter 258 of the Pittsburgh Code (see Attachment 1).

The provisions of this ordinance, referred to in this Opinion as the Payroll Tax, mirror the terms of the Enabling Act. An *employer* means "any person conducting

business activity within the City, except for a governmental entity." § 258.01(e). An *employee* includes "any individual in the service of an employer . . . ." § 258.01(d). A *payroll expense* means "all compensation earned by an employee or by a self-employed individual." § 258.01(g). A tax is levied at the rate of fifty-five hundredths (.55) of one percent on the amount of payroll expense generated as a result of an employer conducting business activity within the City. § 258.02.

Thousands of persons are employees of UPMC wholly-owned subsidiaries. Plaintiff contends that for purposes of the Payroll Tax, UPMC is the employer of the persons employed by UMPC's wholly-owned subsidiaries or, in other words, that the term *employer* as used in the Payroll Tax means the parent of a wholly-owned subsidiary, at least where the parent exercises control over the subsidiary.

Thus, in its Second Amended Complaint, Pittsburgh seeks the following declaratory relief:[1]

> (1) A declaratory judgment that UPMC is an "employer" of all employees of all the subsidiaries, affiliates and other entities which it controls;
>
> (2) A declaratory judgment that UPMC is not an Institution of Purely Public Charity ("IPPC") exempt from the payment of The City's Payroll Tax.
>
> (3) An order requiring UPMC to file quarterly Payroll Tax returns covering all of its operations beginning from March 31, 2007 to the present.

[1]In this litigation, plaintiff seeks an interpretation of the Payroll Tax. Plaintiff cites case law indicating that a declaratory judgment action is appropriate when the plaintiff seeks an interpretation of the language in an ordinance or statute.

I initially consider Pittsburgh's request that I declare that any employee of a wholly-owned subsidiary shall be treated as an employee of UPMC for purposes of Pittsburgh's Payroll Tax.[2]

If this relief is granted, UPMC and its wholly-owned subsidiaries would be compressed into a single employer (UPMC), and UPMC would now be responsible for the reporting requirements for each of its subsidiaries and would be responsible for payment of any payroll taxes based on a subsidiary's payments to its employees. UPMC seeks dismissal based on the language of the Payroll Tax which, according to UPMC, taxes the entity conducting the business activity in Pittsburgh based on the amount of compensation the entity pays its employees.

I begin with a hypothetical that has nothing to do with charitable exemptions.

Miller, Inc. has ten employees on its payroll. These employees oversee and provide administrative services to Miller, Inc.'s holdings, including the following wholly-owned subsidiaries: Miller Builders, Inc. (31 employees on its payroll); Miller Transportation, Inc. (53 employees on its payroll); and Miller Paving, Inc. (16 employees). Each of the four corporations has its office in the City of Pittsburgh. Each is a for-profit corporation.

For this hypothetical, under the language of the Enabling Act and City ordinance, each corporation is an employer (defined as a person conducting business activity within Pittsburgh). Each corporation compensates individuals in its service. Thus, each corporation is responsible for payment of the Payroll Tax based on that corporation's payroll.

[2]If UPMC prevails as to the relief sought in Pittsburgh's first prayer for relief, Pittsburgh cannot prevail in its remaining requests for relief.

There is nothing in the Enabling Act or the Payroll Tax which suggests that subsidiaries will be treated in a different fashion from other corporate entities. The tax is levied on the corporate entity which conducts "business activity within the City" at a rate of .55 of 1% of its payroll.

If a subsidiary fails to make a payment, under well-recognized legal principles, the City may look to the parent for payment upon a showing that the corporate structures are a sham. However, as long as the payrolls include all 110 employees described in the hypothetical, the Payroll Tax looks to each employer to pay the wage tax for wages paid to its employees.

In summary, the Payroll Tax is a tax that can be easily administered. The employer's payroll triggers the duty to pay this tax and the amount of the tax. There is nothing in the Enabling Act or the Payroll Tax that compresses several taxpayers into a single taxpayer. There is nothing in the Enabling Act or Payroll Tax that excuses a corporation from paying the Payroll Tax on the ground that it is a wholly-owned subsidiary. Under the clear language of the Enabling Act and the Payroll Tax, the payroll tax is levied upon the entity that conducts the business and pays the salary.

Pittsburgh contends that the provisions of the Enabling Act governing charitable organizations (53 P.S. § 6924.303(a.1)) support its contention that the parent is deemed to be the employer of employees of wholly-owned subsidiaries claiming to be charitable organizations qualifying for tax exemption. Plaintiff relies on the following provision within the Enabling Act:

> If the charity has purchased or is operating branches, affiliates, subsidiaries or other business entities that do not independently meet the standards of the "Institutions of Purely Public Charity Act," the tax shall be paid on the payroll attributable to such for-profit branches,

> affiliates or subsidiaries, whether or not the employes are leased or placed under the auspices of the charity's umbrella or parent organization.[3]

Plaintiff has not offered a satisfactory explanation as to how this provision supports plaintiff's contention that the Enabling Act and the Payroll Tax provide that the parent is the employer of employees of wholly-owned subsidiaries claiming to be charitable organizations.

Also, since it is plaintiff's position that UPMC is not a charitable organization, it would seem that the legislation applicable to a "charity" which has purchased or is operating branches, affiliates, subsidiaries, or other entities does not apply.

Furthermore, this legislation (53 P.S. § 6924.303(a.1)) addresses the obvious—a charitable organization and a for-profit subsidiary cannot avoid the Payroll Tax by placing employees of a for-profit enterprise on the payroll of a charity.

Finally, the above provision of the Enabling Act never addresses whether the tax shall be paid by the for-profit subsidiary or the charity.

My ruling is a narrow ruling that does not consider whether UPMC or any of its subsidiaries are charitable organizations. I am dismissing plaintiff's Second Amended Complaint because there is no basis in the law for this court to disregard corporate form and the existence of UPMC's subsidiaries. Employees of a subsidiary, such as Mercy Hospital, are not employees of UPMC. Thus, Pittsburgh cannot look to UPMC to pay a payroll tax based on payments Mercy Hospital made to its employees.

This lawsuit is brought on behalf of the City of Pittsburgh by its Treasurer. I agree with UPMC that if the Treasurer believes that a subsidiary, such as Mercy

[3]Similar language is set forth in § 258.03(d) governing computation of the Payroll Tax.

Hospital, is not a charitable organization that qualifies for tax exemption, laws permit the Treasurer to calculate the tax that the subsidiary should have paid and to institute proceedings against the subsidiary to recover the unpaid tax based on the subsidiary's payroll. Nothing in this Opinion suggests that the Treasurer may not proceed in this fashion.

For these reasons, I enter the following Order of Court:

IN THE COURT OF COMMON PLEAS OF ALLEGHENY COUNTY, PENNSYLVANIA
CIVIL DIVISION

CITY OF PITTSBURGH, a Pennsylvania Second Class City and Home Rule Municipality, by its Treasurer, Plaintiff vs. UPMC, a Pennsylvania Nonprofit, Non-Stock Corporation, Defendant	NO. GD-13-005115

ORDER OF COURT

On this 25 day of June, 2014, upon consideration of the preliminary objections of UPMC, it is ORDERED, ADJUDGED, AND DECREED that plaintiff's Second Amended Complaint is dismissed for failure to state a cause of action.

BY THE COURT:

WETTICK, J.

Pittsburgh, Pennsylvania, Code of Ordinances >> - HOME RULE CHARTER of the CITY OF PITTSBURGH, PENNSYLVANIA >> TITLE TWO: - FISCAL >> ARTICLE VII: - BUSINESS RELATED TAXES >> CHAPTER 258: PAYROLL TAX >>

CHAPTER 258: PAYROLL TAX

§ 258.01 DEFINITIONS.
§ 258.02 LEVY AND RATE.
§ 258.03 COMPUTATION OF TAX.
§ 258.04 PAYMENTS.
§ 258.0 REGISTRATION.
§ 258.06 RETURNS.
§ 258.07 PENALTIES AND INTEREST.
§ 258.08 REPEALS.

§ 258.01 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:

(a) ***BUSINESS*** means any activity, enterprise, profession, trade or undertaking of any nature conducted or engaged in, or ordinarily conducted or engaged in, with the object of gain, benefit or advantages, whether direct or indirect, to the taxpayer or to another or others. The term shall include subsidiary or independent entities which conduct operations for the benefit of others and at no profit to themselves, nonprofit businesses, and trade associations. A person shall be deemed to be conducting business within the City who engages, hires, employs or contracts with one (1) or more individuals as employees or is self-employed and, in addition, does at least one (1) of the following: (1) maintains a fixed place of business within the City; (2) owns or leases real property within the City for purposes of such business; (3) maintains a stock of tangible, personal property in the City for sale in the ordinary course of business; (4) conducts continuous solicitation within the City related to such business; or (5) utilizes the streets of the City in connection with the operation of such business, other than for the mere transportation from a site outside the City, through the City, to a destination outside of the City. A person shall be deemed to be engaged in business who, in return for rental income, rents, leases or hires real or personal property to others. A person shall not be deemed to be engaged in business solely by reason of the receipt of income from passive investments for which no services were rendered.

(b) ***CHARITY*** means a charitable organization that qualifies for tax exemption pursuant to the act of November 26, 1997 (P.L. 508, No 55), known as the "Institutions of Purely Public Charity Act."

(c) ***COMPENSATION*** means salaries, wages, commissions, bonuses, net earnings and incentive payments, whether based on profit or otherwise, fees, tips and any other form of remuneration earned for services rendered, whether paid directly or through an agent, and whether in cash or in property or the right to receive property.

(d)

EMPLOYEE means any individual in the service of an employer, under an appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed. In addition, for purposes of this tax, and irrespective of the common law tests for determining the existence of an independent contractor relationship, an individual performing work or service for compensation shall be deemed to be an employee of the person for whom the work or service is performed unless: (1) such individual has been and will continue to be free from control or direction over the performance of such work or service, both under his/her appointment of contract of hire or apprenticeship; (2) such work or service is either outside the usual course of the business of the person for which such service is performed; or, (3) such individual is customarily engaged in an independently established trade, occupation, business or profession.

(e) ***EMPLOYER*** means any person conducting business activity within the City, except for a governmental entity.

(f) ***INTERNAL REVENUE CODE*** means the Internal Revenue Code of 1986 (Public Law 99-514), as amended.

(g) ***PAYROLL EXPENSE OR AMOUNTS*** means all compensation earned by an employee or by a self-employed individual.

(h) ***PERSON*** means a corporation, partnership, business trust, other association, estate, trust, foundation or natural person.

(i) **PROFITS** means a share of net income earned for services rendered from a partnership, a limited liability company, a business trust or S corporation, after provision for all costs and expenses incurred in the conduct thereof, determined either on a cash or accrual basis in accordance with accepted accounting principles and practices, and including, but not limited to, any amount treated as net earnings from self-employment for services rendered.

(j) ***TAX YEAR*** means a twelve-month period from January 1 to December 31.

(k) ***TEMPORARY SEASONAL OR ITINERANT BUSINESS*** shall mean an employer whose presence in the City is of a duration of one hundred twenty (120) days or less.

(Ord. 26-2004, eff. 12-20-04; Ord. No. 3-2005, § 1, eff. 1-1-05)

§ 258.02 LEVY AND RATE.

For general revenue purposes a tax is hereby levied at the rate of fifty-five hundredths (.55) of a percent on the amount of payroll expense generated as a result of an employer conducting business activity within the City.

(Ord. 26-2004, eff. 12-20-04; Ord. No. 3-2005, § 1, eff. 1-1-05)

§ 258.03 COMPUTATION OF TAX.

(a) For purposes of computation of the tax imposed in Section 258.02, the payroll amount attributable to the City shall be determined by applying an apportionment factor to total payroll expense based on that portion of payroll which the total number of days an employee, partner, member, shareholder or other individual works within the City bears to the total number of days such employee or person works both within and outside the City.

(b) Tax base. The tax shall be computed on the payroll expense of the previous quarter attributable to the City.

(c)

An employer, which conducts business in the City on a temporary, seasonal or itinerant basis, shall calculate the tax on the total compensation earned while in the City.

(d) A charitable organization, as defined above, shall calculate the tax that would otherwise be attributable to the City, but shall only pay the tax on that portion of its payroll expense attributable to business activity for which a tax may be imposed pursuant to Section 511 of the Internal Revenue Code. If the charity has purchased or is operating branches, affiliates, subsidiaries or other business entities that do not independently meet the standards of the "Institutions of Purely Public Charity Act", the tax shall be paid on the payroll attributable to such for-profit branches, affiliates or subsidiaries, whether or not the employees are leased or placed under the auspices of the charity's umbrella or parent organization.

(Ord. 26-2004, eff. 12-20-04; Ord. No. 3-2005, § 1, eff. 1-1-05)

§ 258.04 PAYMENTS.

An employer subject to the tax shall make a return and shall pay the tax quarterly at such time or times and in such manner as provided in Section 258.06.

(Ord. 26-2004, eff. 12-20-04; Ord. No. 3-2005, § 1, eff. 1-1-05)

§ 258.0 REGISTRATION.

Registration. Every person having an office, factory, workshop, branch, warehouse, or other place of business, including banks, schools, hospitals, non-profit, and trade associations, located in the City or outside the City, who, during any tax year, performs work or renders services in whole or in part in the City, who has not previously registered, shall within fifteen (15) days, register with the Treasurer its name and address and shall provide such other information as the Treasurer may require.

(Ord. 26-2004, eff. 12-20-04; Ord. No. 3-2005, § 1, eff. 1-1-05)

§ 258.06 RETURNS.

The first quarterly return, which is due February 28 of the current year, shall be filed and the tax shall be paid based on the amount of payroll expense during the months of October, November, and December of the preceding year; the second quarterly return, which is due May 31 of the current year, shall be filed and the tax shall be paid based on the amount of payroll expense during the months of January, February, and March of the current year; the third quarterly return, which is due August 31, shall be filed and the tax shall be paid based on the amount of payroll expense during the months of April, May, and June of the current year; the fourth quarterly return, which is due November 30 of the current year, shall be filed and the tax shall be paid based on the amount of payroll during the months of July, August, and September of the current year.

An employer which conducts business in the City on a temporary, seasonal or itinerant basis shall file a return and pay the tax within ten (10) days of the completion of the temporary, seasonal, or itinerant business.

(Ord. 26-2004, eff. 12-20-04; Ord. No. 3-2005, § 1, eff. 1-1-05)

§ 258.07 PENALTIES AND INTEREST.

If for any reason the tax is not paid when due, interest at the rate of six (6) percent per annum on the amount of said tax and an additional penalty of one (1) percent of the amount of the unpaid tax for each month or fraction thereof during which the tax remains unpaid shall be added and collected.

In addition to any other penalties or enforcement proceedings provided for by ordinance for the collection and enforcement of taxes:

(1) Any employer who willfully makes any false or untrue statement on the employer's return shall be guilty of a misdemeanor of the second degree and shall, upon conviction, be sentenced to pay a fine of not more than two thousand dollars ($2,000.00) or to a term of imprisonment of not more than two years, or both;

(2) Any employer who willfully fails or refuses to file a return required by this chapter shall be guilty of a misdemeanor of the third degree and shall, upon conviction, be sentenced to pay a fine of not more than one thousand dollars ($1,000.00) or to a term of imprisonment of not more than one (1) year, or both; and

(3) Any person who willfully fails or refuses to appear before the Treasurer or his agent in person with the employer's books, records or accounts for examination when required under the provisions of this Title to do so, or who willfully refuses to permit inspection of the books, records or accounts of any employer in the person's custody or control when the right to make such inspection by the Treasurer or his agent is requested, shall be guilty of a misdemeanor and shall, upon conviction, be sentenced to pay a fine of not more than five hundred dollars ($500.00) or to a term of imprisonment of not more than six (6) months, or both.

(Ord. 26-2004, eff. 12-20-04; Ord. No. 3-2005, § 1, eff. 1-1-05)

§ 258.08 REPEALS.

All ordinances and parts of ordinances are repealed to the extent they are inconsistent with this ordinance.

(Ord. 26-2004, eff. 12-20-04; Ord. No. 3-2005, § 1, eff. 1-1-05)

EXHIBIT Q

Charities and the Orphans' Court

Marc S. Cornblatt & Bruce P. Merenstein[*]

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I. INTRODUCTION — THE BEST LAID PLANS

In 1909, Milton Hershey created a charitable trust to build and operate a school for orphans. To the trust, he gave the stock and, therefore, the ownership of his candy company. By the late 20th century, the Milton Hershey School was one of the richest educational institutions in the world, surpassed in endowment in the United States by only a handful of major universities. In 2002, the trustees of the trust concluded that good business practice might call for a more diversified asset base than the stock of a single corporation and prepared to solicit offers for the purchase of a substantial portion, or possibly all, of such stock.

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In 1922, Dr. Albert Barnes established a charitable trust to maintain a school and gallery in Merion, Pennsylvania to teach his views about art and art appreciation and to exhibit the collection of paintings that he had acquired and had donated, and would continue to donate, to the trust. By the time of Dr. Barnes's death in 1951, the Barnes Foundation owned and displayed one of the world's finest collections of impressionist and post-impressionist paintings and other art. By the beginning of the 21st century, the trustees of the foundation determined that the finances of the Foundation and the vitality of its continuing operations called for an expansion of its Board and the move of its gallery to a new, larger, and more accessible facility in Philadelphia.

In 1975, a number of individuals in the Philadelphia health care community started a corporation that eventually became Philadelphia Health Care Trust to preserve a hospital facility scheduled to be separated from the University of Pennsylvania and shut down. By 1995, that organization operated a health care system that included seven hospitals and a health maintenance organization. By 1999, it had transferred the hospitals and the HMO and continued as one of the largest health care foundations in the area. Two years later, it reached an understanding for a process to conclude its business as a foundation and to transfer its assets to the health care system of the University of Pennsylvania.

Were these organizations business corporations or entities, their boards of directors or trustees would have reviewed and decided on the proposals for changes, sales, or transfers and implemented their decisions. Assuming that the decisions involved no self-dealing, bad faith, or similar breach of fiduciary duty, no further approval would have been required for that exercise of business judgment. The Hershey School, the Barnes Foundation, and Philadelphia Health Care Trust, however, are not business corporations, and their boards do not have that level of discretion. Instead, they are nonprofit charities and must function in the very different and very special world of controlling trusts, settlor's intent, charitable purposes, *parens patriae*, the Attorney General, and the Orphans' Court.

II. THE PLAYERS

A. Charities

In Pennsylvania, anyone can form a nonprofit corporation by filing Articles of Incorporation listing any variation of the purposes

authorized by section 5301 of the Pennsylvania Nonprofit Corporation law,[1] and asserting that the corporation "is one which does not contemplate pecuniary gain or profit, incidental or otherwise."[2] Almost everyone who does form a nonprofit corporation or trust or other organization wants the entity to qualify as a charity because in most cases only charities can claim exemption from federal income tax and state real estate and sales taxes. Unlike a nonprofit corporation, creating a charity exempt from taxes requires a good deal more than a simple declaration of purpose and intent.

Pennsylvania grants a tax exemption to nonprofit organizations only if they qualify as "purely public charities." The authority to exempt such entities first appeared in section 1 of article 9 of the Pennsylvania Constitution of 1873. The constitution authorized the General Assembly to "exempt from taxation public property used for public purposes, actual places of religious worship, places of burial not used or held for private or corporate profit, and institutions of purely public charity."[3] The current state constitution contains a similar provision in article VIII, section 2(a)(v), which provides that the "General Assembly may by law exempt from taxation: . . . Institutions of purely public charity, but in the case of any real property tax exemptions only that portion of real property of such institution which is actually and regularly used for the purposes of the institution."[4]

In its first decision applying a "purely public charity" tax exemption, the Pennsylvania Supreme Court held that the Library Company of Philadelphia (founded by Benjamin Franklin and others in 1731) constituted a purely public charity.[5] The court established the modern definition of a "purely public charity" in *Hospital Utilization Project v. Commonwealth.*[6] A little more than a decade after the decision in *Hospital Utilization Project*, the state legislature codified this definition in the Institutions of Purely Public Charity Act.[7] To qualify as tax exempt in Pennsylvania, a nonprofit charity must advance a charitable purpose such as relief of poverty, advancement of education or religion, treatment of disease or the like; operate entirely free from private profit motive;

1. 15 PA. CONS. STAT. ANN. § 5301 (West 1995).
2. *Id.* § 5306(4).
3. PA. CONST. of 1873, art. 9, § 1.
4. PA. CONST. art. VIII, § 2(a)(v).
5. *In re* Donohugh's Appeal, 86 Pa. 306, 317-18 (1878).
6. 487 A.2d 1306, 1317 (Pa. 1985).
7. 10 PA. CONS. STAT. ANN. § 375 (West 1997).

donate or provide without charge a substantial portion of its services; benefit a substantial and indefinite class of people who are legitimate subjects for charity; and relieve the government of its burden by providing services that the government would be required to provide or that are generally the responsibility of government.[8]

For most nonprofit charities, exemption from federal income tax derives from § 501(c)(3) of the Internal Revenue Code and requires that the organization be established and operated for, and fulfill, an exempt purpose, such as charitable, educational, or religious functions; assure that none of its income inures to any individual; not engage in political activity; and not violate public policy.[9] A federal tax exemption also involves distinguishing between public charities and private foundations, a significant body of statutory, regulatory, and case law, and Internal Revenue Service rulings and interpretations as to what the organizations can and cannot do under numerous variations of facts and circumstances.

At both the state and federal levels, the recognition of tax exempt status necessary for the right not to pay taxes and the deductibility of contributions involves a reasonably complex application process that must satisfy the Pennsylvania Department of Revenue or the Internal Revenue Service. While there are exceptions, establishing the recognition of a state or federal tax exemption is not often routine and can be difficult, expensive, and time consuming.

Although Pennsylvania statutes, rules, and court decisions refer to charities and charitable status for a number of purposes, such as jurisdiction, use of assets, diversion of resources, and solicitation of donations, none of these authorities define what makes a corporation, trust, or other organization a "charity" for any purpose other than exemption from taxes. As a result, organizations that seek qualification as a charity define their structure, purposes, and operations to meet the requirements of federal and state tax exemption and recognition standards.

Even when recognized as a charity by the taxing authorities, however, an organization must deal with a good deal more than tax rules. It must, among other things, fulfill its charitable mission, devote its assets only to its charitable purposes, and operate

8. *See* Menno Haven, Inc. v. Franklin County Bd. of Assessment & Revision of Taxes, 919 A.2d 333 (Pa. Commw. Ct. 2007).

9. I.R.C. § 501(c)(3) (2000).

under the continuing scrutiny of the Office of the Attorney General and the jurisdiction and control of the Orphans' Court.

B. Attorney General

As in most states, the Attorney General of Pennsylvania serves as *parens patriae* and has the authority and responsibility to protect, monitor, and enforce obligations to the state and its citizens.[10] In that capacity, the Attorney General looks over the shoulder of all charities who serve the people of the Commonwealth and can question substantially anything that a charity does, particularly if it involves a transfer of assets, a change of purposes, or another fundamental transaction.[11]

Pennsylvania law grants to the Attorney General standing to intervene and participate in all matters involving charities, charitable bequests and trusts, and *cy pres* actions.[12] The Supreme Court Orphans' Court Rules require fifteen days advance notice to the Attorney General of "every proceeding in the Orphans' Court involving or affecting a charitable interest."[13] As a result, if it chooses to do so, the Office of the Attorney General may participate as an observer or active party in any matter involving a charity that comes before the Orphans' Court.

In 1997, to try to support and possibly enhance its role in reviewing and participating in matters before the Orphans' Court involving charities engaged in health care, the Office of the Attorney General issued a publication entitled *General Review Protocol for Fundamental Change Transactions Affecting Health Care Nonprofits*. The protocol provides for ninety days advance notice to the Attorney General for information about proposed substantial transactions such as sales, mergers, or joint ventures. It also sets forth a process for review of the proposal, possible notice to the public, and response by the Attorney General to the notice. As the protocol itself provides, however, it is "to be used as a guide by attorneys and reviewers in the charitable trust & organization section, and its outside experts." It is not law or a regulation with the force of law. While the Attorney General can draw conclusions

10. *See, e.g.*, Buck Mt. Coal Co. v. Lehigh Coal & Navigation Co., 50 Pa. 91, 99-100 (1865). *See also* Commwealth Attorneys Act, 71 PA. CONS. STAT. § 732-204 (1980).

11. *See, e.g., In re* Estate of Coleman, 456 Pa. 163, 168-69 (1974).

12. 71 PA. CONS. STAT. ANN. § 732-204(c) (West 2006) (stating that the Attorney General may intervene in actions involving charitable bequests and trusts); *cf.* 20 PA. CONS. STAT. ANN. § 7735(c) (West 2006).

13. PA. ORPHANS' CT. R. 5.5·

and act on the basis of the failure of a health care charity to comply with the protocol, it cannot compel compliance.

Contrary to some popular understanding, as well as the occasional implied position of the Office of the Attorney General, mergers, sales, transfers, and other fundamental transactions by charities do not require the advance approval of the Attorney General, and the Attorney General cannot stop such transactions without recourse to a court. The Attorney General's real authority and power in matters relating to charities derives from its standing to participate as a party in interest in all proceedings involving charities.

Any charity that ignores the Office of the Attorney General may find itself compelled to respond to and deal with the Attorney General's views or objections in any matter presented to the Orphans' Court. Not surprisingly, courts tend to take very seriously the position advanced by the Attorney General as the designated advocate for the state and its citizens.

C. The Orphans' Court

In Pennsylvania, the court having jurisdiction over substantially anything involving a charity is a division of the Court of Common Pleas, the state's primary trial level court, known as the "Orphans' Court." The court began during Pennsylvania's colonial era as an institution to protect orphaned children and their right to their deceased family's estate against claims and abuses by step-parents and others.[14] As the modern court system developed, the court became a type of probate division of the state trial court, dealing with decedents' estates, trusts, and charities.[15] Despite the changes, the colonial name stuck, and the division remains the "Orphans' Court."

All issues involving the business, affairs, and activities of charities that call for court review or approval and all challenges to the way charities conduct their business and spend money require proceedings before the Orphans' Court.[16] The jurisdiction of the court covers everything from diversion of assets to deviation of purposes to *cy pres*. Because of the specialized nature of the

14. An Act for Establishing Orphans' Courts, ch. 197, 1803 Pa. Laws 92 (1713); ROSCOE POUND, ORGANIZATION OF COURTS 79 (1940).

15. *See* Orphans' Court Act of 1951, 1951 Pa. Laws 1163; Orphans' Court Act of 1917, 1917 Pa. Laws 363; Cunnius v. Reading Sch. Dist., 56 A. 16, 19 (1903); Yohe v. Barnet, 1 Binn. 358, 364 (Pa. 1808).

16. *See* PA. R. JUD. ADMIN. 2156; 20 PA. CONS. STAT. ANN. § 711(21) (West 2005).

court's jurisdiction and the matters that it considers, proceedings before the Orphans' Court often tend to be less formal and more equitable than other actions and proceedings in civil courts. Even at its most informal and accommodating, however, the Orphans' Court remains a division of the Court of Common Pleas, and any charity that requires relief from the court must prove its case to the court under the scrutiny of the Attorney General.

The special nature of the standards governing charities and the practice before the Orphans' Court does, however, present at least one opportunity not usually available in other trial level courts. As discussed below, the standards governing the requirement for court approval for certain types of transactions, including particularly matters relating to diversion of assets, can be sufficiently vague in practical operation as to be difficult to apply to specific significant transactions. The generally equitable and relatively permissive nature of proceedings before the Orphans' Court has led to an increasingly common type of action in which a charity that does not consider itself bound to obtain court approval for a proposed undertaking, nonetheless, requests a decree in the nature of a declaratory judgment. The approval is unnecessary, but puts the Orphans' Court's "seal of approval" on the proposed transaction or action and protects it from subsequent challenge.

III. ORPHANS' COURT ISSUES FOR CHARITIES

A. Testators, Settlors, and Intent

A charitable trust derives from a trust instrument established by a settlor in his or her lifetime or by a will. Settlors describe what the trust will do and how it will do it in as much or as little detail as the settlor considers appropriate. The management and operation of the trust rests with one or more trustees, or a board or other group of trustees, as the settlor determines, with as much or as little discretion as the settlor desires to give. Trustees and boards of trustees are expected to follow the settlor's direction and intent, and the Orphans' Court is expected to make sure that they do so.

Strict adherence to a settlor's intent leads to difficulty for one principal reason—the world changes over time, both in general and specifically with respect to the issues and activities that concern the trust and the law that governs those issues and activities. When the world or circumstances change so much that implementing the settlor's directions and intent become impossible, illegal,

obviously unreasonable, or even extremely unwise, someone must do something. Since trustees and other private parties cannot change a trust or a settlor's directives on their own, whoever chooses to do something to respond must use the courts to implement change.

In some instances, such as older trusts that mandate unlawful segregation or discrimination, the issues seem obvious even if the solutions are less simple. In the *Girard* will cases, for example, 19th century Philadelphia merchant Stephen Girard directed by his will that his estate be used to establish a school for "poor male white orphan children."[17] It took nearly fifteen years of litigation for the courts finally to establish that the racial restrictions under the will were unconstitutional and, therefore, unenforceable.[18]

Most cases concerning a change from a settlor's plain or implied directives or intent present much more complex and difficult issues. For example, does "impossible" really mean physically impossible or is impracticable or even impractical enough? When does excessive cost rise to impossibility? Is it when there is no money to make a required payment or when the costs deplete resources beyond reasonable levels? What about directives that make no sense in the modern world, such as travel instructions given before the era of automobiles or air travel or directives on information transfer given before the world of e-mail? What happens when the settlor's apparent general intent for the operation of a trust conflicts with specific directives because of cost, changes in technology or law, or other factors?

In some instances, changing circumstances and the passage of time place the administrative requirements of a trust instrument or other governing document at odds with the document's basic purposes and the settlor's intent. For example, if a trust instrument provided that the principal executive or operating officer of the trust was to be a recognized expert in the appropriate field but limited the officer's compensation on the basis of standards in effect many decades earlier, it is necessary to have recourse through the courts to the "deviation doctrine" to vary from the compensation requirements in order to fulfill the basic intent of highly qualified principal officers.[19] In the *Barnes* matter, discussed be-

17. *In re* Estate of Girard, 386 Pa. 548, 551 (1956), *rev'd*, 353 U.S. 230 (1957).

18. *See* Pennsylvania v. Bd. of Dirs. of City Trusts of Phila., 353 U.S. 230 (1957); Pennsylvania v. Brown, 392 F.2d 120 (3d Cir. 1968).

19. *See* RESTATEMENT (THIRD) OF TRUSTS § 66(1) (2003); 20 PA. CONS. STAT. § 7740.3(c) (2006).

low, the court applied the deviation doctrine to permit a change in the administrative requirements of the composition of the Foundation's Board of Trustees and the location of its art gallery in order to prevent financial collapse and to fulfill Dr. Barnes's intent and the Foundation's principal purpose with respect to the display and use of the art collection.

On occasion, deviation is not enough and changing the administrative terms or requirements of a trust document will not make the impossible possible or permit the fulfillment of the settlor's intent. For example, when the settler creates a charitable trust to support a nonprofit institution, such as a hospital, the trust purposes become truly impossible if the hospital changes its ownership or operations and converts to a for-profit business. The same result obtains when a trust was created to fund an institutional program that no longer exists or to fight a disease that has been cured. In such circumstances, the law provides for relief by recourse to the Orphans' Court for the implementation of the doctrine known as "cy pres," a term derived from an old French phrase meaning "as close as possible."

The *cy pres* doctrine, now codified in Pennsylvania law,[20] permits the court to approve a change in the terms of a trust to direct it to purposes that are as close as reasonably possible to the settlor's original intent and that are possible to fulfill.[21] In the above example of the hospital, the court could permit the trust to direct its funds and support to another nonprofit hospital in or around the same area or to a charitable foundation committed to helping the community served by the hospital.[22]

B. Nonprofit Corporations — Diversion of Property

Unlike charitable trusts, nonprofit corporations generally are not governed by a detailed fundamental instrument describing the specifics of the organization's business and operations. In most cases, a charitable nonprofit corporation will include in its Articles of Incorporation a very brief summary of its purposes, which usually is as simple as a one or two sentence recitation of a purpose authorized by section 5301 of the Pennsylvania Nonprofit Corpo-

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20. 20 PA. CONS. STAT. § 7740.3(a) (2006).

21. *See also* 20 PA. CONS. STAT. § 6110 (repealed by Act of July 7, 2006, 2006 Pa. Laws 98, § 3.2).

22. *See In re* Estate of Elkins, 888 A.2d 815 (Pa. Super. Ct. 2005), *appeal denied*, 916 A.2d 1103 (Pa. 2007); *In re* Trust of Farrow, 602 A.2d 1346, 1347-48 (1992).

ration Law.[23] While there may be somewhat more detailed statements of the purpose in other documents, such as the Form 1023 application for recognition of a federal tax exemption, the governing statement of purpose for the corporation will remain the summary in its Articles of Incorporation. A nonprofit corporation must, of course, operate in accordance with its stated purpose, but the statement is usually so broad and general that conformance to it rarely presents significant problems. In most cases, the issue of a charitable nonprofit corporation changing direction or purposes falls under the simple directive of section 5547(b) of the Nonprofit Corporation law, which provides:

> Property committed to charitable purposes shall not, by any proceeding under Chapter 59 (relating to fundamental changes) or otherwise, be diverted from the objects to which it was donated, granted or devised, unless and until the board of directors or other body obtains from the court an order under 20 Pa. C.S. Ch. 61 (relating to estates) specifying the disposition of the property.[24]

In some cases, the diversion of property covered by the law is evident and the mandate of section 5547(b) very clear, so that recourse to the courts is obviously necessary. For example, when a nonprofit community hospital sells its assets to a for-profit hospital system, the sale plainly diverts the assets sold from charitable purposes. In such a situation, the parties commonly try to deal with the issue of diversion by transferring assets or funds of a total value equal to those diverted to a charitable foundation established to serve the health care interests of the affected community. While there are alternatives, no one seriously doubts the requirement of Orphans' Court approval of the arrangement.

Other situations can be considerably more difficult. Except for sales to for-profit businesses, nonprofit corporations rarely transfer assets under circumstances that plainly constitute diversion from charitable purposes. Hospitals do not usually sell significant assets to environmental groups and health planning organizations do not sell their businesses to churches. In most significant mergers or transfers between two nonprofit corporations, strict compliance with the precise language of section 5547(b) will not require recourse to the Orphans' Court.

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23. 15 PA. CONS. STAT. ANN. § 5301 (West 1995).
24. *Id.* § 5547(b).

In 1996, the nonprofit Graduate Health System, Inc. transferred by merger its hospitals to a nonprofit affiliate of the nonprofit and charitable Allegheny hospital system. Although a very substantial and fundamental transaction, the transfer by merger of hospitals from one nonprofit health care system to another, in the same community without any changes in operation or endowment or restricted funds, did not constitute a diversion of property from its charitable purposes and did not, under the specific language of section 5547(b), require approval of the Orphans' Court.

As noted above, the Office of the Attorney General has issued its Review Protocol at least in part to provide for scrutiny of major transactions in the nonprofit health care sector that might escape court review because of the limited practical application of section 5547(b). Notice under the Protocol, if given, will provide the Attorney General with sufficient information to consider challenging a transaction that might not otherwise come before the court. As also noted, however, the Protocol is not law or regulation.

No matter how the Office of the Attorney General views its Protocols and procedures in matters of possible diversion, neither the Attorney General nor the court can change the law. If a transaction of any type does not divert the assets of a nonprofit corporation from the charitable purposes for which the assets were given, nothing authorizes the Attorney General or the court to prevent or change the transaction because the Attorney General does not think it appropriate or believes that another use of the assets might be preferable. Nothing in the Attorney General's *parens patriae* status or powers gives the Attorney General the authority to substitute his judgment for that of the board or trustees of a nonprofit corporation acting in good faith. While common sense usually calls for openness and cooperation with the Attorney General in matters involving fundamental transactions by nonprofit corporations, nothing in the law requires common sense.

An increasingly common mechanism for nonprofit corporations to deal with very substantial or fundamental transactions that do not fall within the precise terms of section 5547(b) involves the "seal of approval" proceeding. If a nonprofit corporation proposes a significant arrangement that is not a true diversion of property, it can satisfy the Attorney General and protect against subsequent challenges by a petition to the Orphans' Court for a declaratory judgment determining that the proposal, in fact, does not improperly divert property. The Attorney General and the courts have not challenged the propriety of this type of action and generally welcome the opportunity for advance scrutiny and evaluation. In

1999, for example, Philadelphia Health Care Trust (PHCT) changed its Articles of Incorporation in order to convert to a private foundation for purposes of federal taxes. Although the change probably did not involve a diversion of assets covered by section 5547(b), the issues and controversy surrounding the Allegheny bankruptcy and PHCT's former subsidiary hospitals of the Graduate Hospital group made a cautious approach appropriate. Thus, PHCT requested, and obtained after a hearing, a decree confirming the propriety of its action and, as a practical matter, insulating the action from further challenge or dispute, including challenges by the Attorney General.

C. Standing — Who Asked You?

No issue relating to charities has attracted the attention of the courts as much as the question of who has standing to challenge before a court the operations, management, and other activities of a charity. Charities control and give out a great deal of money. Not surprisingly, many individuals, groups, and organizations want some of that money and even consider themselves entitled to it. When they do not receive it, they sometimes try to use the Orphans' Court to claim a right to it.

Charities do not owe a duty to individual members of the general public or to other groups or organizations as to how the charities use their assets and spend their money, and well- established standing rules significantly limit who can participate as parties in cases involving charities. In general, standing to challenge a charity before the Orphans' Court resides only with stated beneficiaries of the charity, members of the charity's duly constituted board of directors or trustees or other governing body, the Attorney General, and parties with a genuine "special interest" that materially exceeds the interest of the public.[25]

Because only a very small group qualifies as direct beneficiaries or trustees of a charity and there is only one Attorney General, almost all standing disputes that reach the courts involve claims of a special interest. The courts' definitions of a special interest for standing tended to the conceptual and, in 1994, the Pennsylvania Supreme Court declared the following:

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25. *See In re* Milton Hershey Sch., 911 A.2d 1258, 1262-63 (Pa. 2006); Valley Forge Historical Soc'y v. Washington Mem'l Chapel, 426 A.2d 1123, 1127 (Pa. 1981); *In re* Phila. Health Care Trust, 872 A.2d 258, 261 (Pa. Commw. Ct. 2005).

> [T]he interest must have substance — there must be some discernible adverse effect to some interest other than the abstract interest of all citizens in having others comply with the law. That an interest be direct requires than an aggrieved party must show causation of the harm to his interest by the matter of which he complains. To find an immediate interest, we examine the nature of the causal connection between the action complained of and the injury to the person challenging it.[26]

The most instructive cases on the meaning of the concept may be those in which the courts denied standing, usually on the basis that an interest shared with a portion of the public does not qualify as "special." On those grounds, the courts have found that parties with an interest in a charity that may appear substantial do not have enough of a special interest for standing, so that the Society for the Advancement of the Deaf had no special interest in a charitable trust established to benefit organizations that aid the blind and deaf,[27] and the Milton Hershey School Alumni Association did not have a special interest in the Milton Hershey School.[28]

The *Valley Forge Historical Society* case probably provides the best example of a special interest sufficient to confer standing. In *Valley Forge*, a single settlor created both the Washington Memorial Chapel and the Valley Forge Historical Society for substantially the same purpose. The two organizations occupied the same building for sixty years, and the Society made significant contributions to the Chapel.[29] In the litigation that lead to the supreme court decision, the trustees of the Chapel decided to evict the Society from the Chapel building that both occupied.[30] The Society sued to prevent the eviction, and the Chapel asserted that the Society lacked standing to challenge the action. The court, noting the history and relationship of the organizations, found that the Society had a special and immediate interest that would be directly affected by the proposed action of the Chapel that was materially different from the interests of any segment of the general

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26. *In re* Francis Edward McGillick Found., 642 A.2d 467, 469 (Pa. 1994) (internal quotation omitted).
27. *In re* Estate of Nevil, 199 A.2d 419, 423 (Pa. 1964).
28. *Milton Hershey Sch.*, 911 A.2d at 1263.
29. *Valley Forge*, 426 A.2d at 1125.
30. *Id.*

public, and it concluded that the interest was sufficient to confer standing.[31]

When an attempt to intervene as a party on the basis of a special interest fails, as it usually does, the next and most likely final resort involves a request to proceed in a case as *amicus curiae*. In Pennsylvania, as in many states, *amicus curiae* is a difficult and not easily-definable status. In the appellate courts of Pennsylvania, anyone can file a brief *amicus curiae* without leave of court, although court approval is necessary to participate in oral argument.[32] Before the Court of Common Pleas and the Orphans' Court division, the grant of *amicus* status rests entirely within the discretion of the court, as does the role of *amicus* when the status is approved.[33] For example, in the *Barnes* and in one of the *Hershey* cases,[34] Barnes students and Hershey alumni were given *amicus* status after the denial of intervention as a party, while in the PHCT proceedings, community groups denied intervention were also denied *amicus* status.[35]

An *amicus curiae* is not a party and, therefore, is not entitled to assert claims, request relief, or raise new issues.[36] Once in a case, however, the role of *amicus* can easily expand, so that the grant of *amicus* status can involve a good deal more than the right to file a brief. In the *Barnes* case, the three individuals granted *amicus* status were ultimately given the authority to participate substantially as parties, with the right to review discovery, call witnesses and produce testimony, cross examine witnesses, and object to the introduction of evidence.

IV. THE DEVELOPING LAW

A. *The* Barnes *Decision*

When Dr. Barnes established his art collection at his property in Merion, Pennsylvania, he also set out detailed instructions for operation of the Foundation, its gallery, and its educational pro-

31. *Id.* at 1127-28.

32. PA. R. APP. P. 531.

33. *Accord* Wortham v. KarstadtQuelle AG (*In re* Nazi Era Cases Against German Defendants Litig.), 153 F. App'x 819, 827 (3d Cir. 2005) (stating that a trial court's decision to accept or reject an amicus filing is entirely within the court's discretion); Waste Mgmt., Inc. v. City of York, 162 F.R.D. 34, 36 (M.D. Pa. 1995).

34. *See In re* Milton Hershey Sch., 867 A.2d 674, 679 (Pa. Commw. Ct. 2005).

35. *See In re* Phila. Health Care Trust, 872 A.2d 258, 259 (Pa. Commw. Ct. 2005).

36. *See, e.g.*, Stilp v. Commonwealth, 588 Pa. 539, 556 n.14 (2006); Commonwealth v. Tharp, 562 Pa. 231, 236 n.5 (2000).

grams, down to a listing of job positions and salaries. He provided for a five member board of trustees to govern the Foundation after his and his wife's deaths, with one board member being nominated by a bank and four by an educational institution. Shortly before his death, Dr. Barnes designated Lincoln University, a historically black institution located in a rural community outside of Philadelphia, as the nominating body for the four non-bank trustees.

By the late 1990's, a succession of lawsuits in state and federal court over disputes with the Foundation's Merion neighbors and zoning disputes involving visitation levels, traffic congestion, and parking at the Foundation's gallery had depleted the Foundation's small endowment (worth about $10 million at Dr. Barnes's death in 1951). The restrictions on visitation placed on the Foundation by local authorities also limited the Foundation's ability to raise funds for its endowment and to expand its educational or art appreciation offerings.

In 2002, facing imminent financial collapse, the Foundation determined that the best possible means for reversing decline and ensuring long term success in fulfilling Dr. Barnes's mission was to deviate from some of the terms of the Foundation's governing documents. In addition to modernizing many outdated provisions in its bylaws, it looked to three major changes to its trust documents: (1) relocating its gallery from Merion to center city Philadelphia; (2) expanding its Board from five to fifteen members, with the new members being nominated by the Board itself and not an outside institution; and (3) enhancing public access to the Foundation's gallery. The Foundation filed a petition in the Orphans' Court to invoke the "deviation doctrine," to authorize the changes.

The Petition generated considerable publicity and interest and, not surprisingly, a number of individuals and groups claiming an interest sought to intervene in the proceedings. Three Barnes Foundation students claimed that the changes would damage Dr. Barnes's educational vision; a separate charitable institution, the de Mazia Trust, which had been formed following the death of Dr. Barnes's protégé Violette de Mazia, sought to join; and Lincoln University, which believed itself entitled to nominate eighty percent of the trustees to the Foundation's Board, also asked to participate.

A few months after the petitions to intervene were filed, the Orphans' Court issued an opinion and decree denying all of the requests to intervene except for Lincoln's (which the Foundation had

not opposed).[37] Shortly before the first hearing on the Foundation's petition in late 2003, the Foundation and Lincoln resolved their disagreements, and Lincoln withdrew from the case. At that point, another group of three students (which included one of the students originally denied intervention) again asked to intervene, as did the de Mazia Trust. The court again denied the requests to intervene, reiterating that neither party had standing. The court did, however, permit the three students to participate in the matter as *amicus curiae*. As discussed, the *amici*'s role expanded dramatically throughout the case, to the point where they effectively became a party and actively participated in the two hearings on the Foundation's petition. In December 2004, following the second hearing, the Orphans' Court issued a decree and extensive opinion, granting the Foundation all of the relief it sought.[38]

In January 2005, one of the three students originally denied intervention (but not one of the *amici*) sought to appeal from the court's final judgment. The Foundation, concerned that a delay in obtaining final resolution of its requested changes would seriously impact its ability to begin its financial turnaround, filed an extraordinary King's Bench Petition with the Supreme Court of Pennsylvania. The Foundation asked the court to take jurisdiction over the appeal (which was then pending in the Superior Court) and summarily affirm the Orphans' Court's decree or dismiss the appeal as untimely. In April 2005, the Supreme Court granted the Foundation's petition and, in a unanimous opinion, held that the appeal was untimely, as the student had waited almost two years after his petition for intervention had been denied before seeking to appeal that ruling.[39]

B. The Hershey *Cases*

Soon after he founded the Milton Hershey School, Milton Hershey directed the formation of a school alumni organization, known as "the Milton Hershey School Alumni Association" for the purpose of promoting the interests of the School. Since its incep-

37. *See In re* Barnes Found., 23 Fid. Rep. 2d 127 (Orphans' Ct. Montg. 2003).

38. *See In re* Barnes Found., 69 Pa. D. & C.4th 129 (Orphans' Ct. Montg. 2004).

39. *In re* Barnes Found., 871 A.2d 792, 795 (Pa. 2005). More than two years after the supreme court's opinion, two new petitions were filed by parties, including Montgomery County, seeking to reopen the prior proceedings and intervene. On May 15, 2008, the Orphans' Court dismissed these petitions for lack of standing. *See In re* Barnes Found., 28 Fid. Rep. 2d 258 (Orphans' Ct. Montg. 2008) (citing *In re* Milton Hershey Sch., 911 A.2d 1258 (Pa. 2006), and *In re* Phila. Health Care Trust, 872 A.2d 258 (Pa. Commw. Ct. 2005)).

tion, the Association's membership has consisted only of former students of the School, and it has operated from offices on School property owned by the Trust. The Association is not, however, formally affiliated with either the Hershey School or Hershey Trust and it is not mentioned in any governing trust documents.

Although the Alumni Association enjoyed a good relationship with the School over the years, the Association, at times, believed that the trust was not managing its assets in the best interests of the School. For example, in the 1990s, the Association, participating in court proceedings as an *amicus curiae*, successfully opposed the Trust's plans to create the Catherine Hershey Institute of Learning and Development.[40] Around the same time, the Association prodded the Attorney General to investigate allegations that the Trust was diverting its assets from its primary purpose of funding and operating the School. After a lengthy investigation, the Attorney General concluded that the allegations were well-founded and, following negotiations, the Attorney General, the Trust, and the School entered into a consent decree governing the Trust's activities going forward. The Association did not have a formal role in the negotiations and was not a party to the eventual agreement.

In 2002, the Trustees caused considerable controversy with a proposal to sell the Trust's controlling interest in Hershey Foods Corporation (successor to Hershey Chocolate Company). Finding that the sale would likely not be in the best interests of the Trust or the School, the Orphans' Court issued and the Commonwealth Court affirmed a preliminary injunction against proceeding toward a sale, and the trustees did not pursue the matter further. The sale proposal and court decisions led to changes in the governing boards of the trust and the School and to an agreement with the Attorney General to modify the consent decree.[41] The Association, believing that the modified decree failed to provide the necessary protections guaranteeing fulfillment of the trust's central purpose, filed a petition in the Orphans' Court for Dauphin County seeking rescission of the new agreement, reinstatement of the prior agreement, and appointment of a guardian *ad litem* and a trustee *ad litem*.[42] The trial court granted the trust's and School's preliminary objections contending that the Association

40. *See Hershey Sch.*, 867 A.2d at 679.

41. *See generally In re* Milton Hershey Sch. Trust, 807 A.2d 324 (Pa. Commw. Ct. 2002).

42. *See In re* Milton Hershey Sch., 911 A.2d 1258, 1260 (Pa. 2006).

did not have standing to bring the action, but, in a 4-3 decision, the Commonwealth Court sitting en banc reversed, holding that the Association had the necessary "special interest" to bring its action.[43]

In a unanimous decision (with two justices not participating), the Pennsylvania Supreme Court reversed. The court began its analysis with the principle that "[p]rivate parties generally lack standing to enforce charitable trusts."[44] Citing, among other things, the *Valley Forge* case and a 1953 decision involving the Barnes Foundation,[45] the court noted that only the Attorney General, "a member of the charitable organization, or someone having a special interest in the trust" could bring an action to enforce a charitable trust.[46] The court then analyzed the question whether the Association had the requisite "special interest" to confer standing on it.

The court compared the facts in the *Hershey* case unfavorably to those in the *Francis Edward McGillick Foundation* and *Valley Forge* cases. Distinguishing *McGillick*, in which the court had held that the Catholic Diocese of Pittsburgh had standing to sue a Foundation with which the diocese had "integral involvement," the court noted that the Association in *Hershey* did not have "any decision-making power or administration over" the trust.[47] The court also rejected the Association's attempt to compare itself to the Society in *Valley Forge*, which had standing because of its enduring and close relationship to the charitable institution at issue there. According to the supreme court, the Association's relationship to the trust was distinguishable from the Society's relationship to the Chapel in *Valley Forge* because the Association was created twenty years after the trust, and the trust's governing documents were not amended to create a close relationship such as existed in *Valley Forge* between the two institutions or to make the Association an express beneficiary of the trust.[48]

The court concluded with a sweeping rejection of the Association's purported basis for standing, which applies with equal force to students and alumni seeking to intervene in the Barnes Foun-

43. *Hershey*, 911 A.2d at 1260.
44. *Id.* at 1262.
45. Wiegand v. Barnes Found., 97 A.2d 81 (Pa. 1953).
46. *Hershey*, 911 A.2d at 1262.
47. *Id.*
48. *Id.* at 1262-63.

dation cases, or community groups clamoring to participate in proceedings involving the Philadelphia Health Care Trust:

> The Association's intensity of concern is real and commendable, but it is not a substitute for an actual interest. Standing is not created through the Association's advocacy or its members' past close relationship with the School as former individual recipients of the Trust's benefits. The Trust did not contemplate the Association, or anyone else, to be a "shadow board" of graduates with standing to challenge actions the Board takes.[49]

C. The PHCT Saga

In 1996, Graduate Health System, Inc., parent of the "Graduate" group of nonprofit hospitals mainly in the greater Philadelphia area, transferred the hospitals to components of the nonprofit Allegheny Health System. Two years later, the Allegheny System collapsed and filed Chapter 11 bankruptcy proceedings. Shortly thereafter, Graduate Health System, having no further relationship with any Graduate institution and no operations, changed its name to "Philadelphia Health Care Trust" and determined to change the purposes in its Articles of Incorporation to function as a private foundation. It concluded that the controversy surrounding the Allegheny System called for the presentation of the change to the Orphans' Court for a full and open discussion and a "seal of approval" determination that the change did not constitute a diversion of property under section 5547(b) of the Nonprofit Corporation law. After a contentious hearing and the objection of most of the principal parties involved in the Allegheny case, the court approved the change of purposes and issued the requested decree, subject to a number of conditions including a requirement that PHCT file accounts for five years. Although the court's decree served the intended seal of approval purpose and foreclosed any future objections to PHCT's conversion to a private foundation, there followed seven years of efforts by an exceptionally diverse collection of individuals and organizations to use the Orphans' Court to obtain PHCT's money for themselves or to obtain the right to direct how the money would be used.

A little more than a year after the conversion, PHCT reached a tentative agreement for the phased transfer of its assets to the

49. *Id.* at 1263.

health care components of the University of Pennsylvania. It filed a petition with the Orphans' Court for the approval of the proposal, although the parties subsequently terminated their intended agreement and the petition was withdrawn. The petition for approval of the arrangement with the University and the accounts filed by PHCT in accordance with the directive of the Decree of the Court approving private foundation status led to a barrage of petitions to intervene or participate in the Orphans' Court proceedings. The putative intervenors sought to challenge PHCT's proposed arrangements with the University of Pennsylvania and, particularly, its use of its money.

The claimants attempting to join the PHCT proceedings in the Orphans' Court included an unemployment program project, a senior citizens alliance, a mental health/mental retardation center, a hospital system, a Pennsylvania state senator, a Philadelphia city councilman, the director of a Philadelphia city consumer agency, and a local university. While the petitioners and claimants stated their positions in different words and with different factual and legal justifications, they all asserted basically the same claim—each did not like how PHCT used its assets and each wanted to take the assets for itself or to control how the assets were used.

In trying to find a way into the Orphans' Court proceedings, each of the petitioners asserted some variation of a claim to standing on the basis of a special interest. The community groups claimed a special relationship to the community served by PHCT's purposes; the health institutions asserted that they served the communities intended to be beneficiaries of PHCT's purposes; the political figures raised their roles as elected representatives of the community; and one petitioner even argued that it was the true successor of the rightful charitable owner of PHCT's funds. All of the petitioners requested intervention as parties and three also asked for *amicus curiae* status.

In proceedings over the course of several years, the Orphans' Court dismissed all of the petitions, denying all requests for intervention or appointment as *amicus curiae*. Some of the petitioners appealed the final group of dismissals, and the Pennsylvania Commonwealth Court affirmed the ruling of the Orphans' Court and the dismissal of the petitions. In its opinion, the Commonwealth Court stated:

> In Pennsylvania, standing requires that "an aggrieved party have an interest which is *substantial, direct, and immediate.*

> That is, the interest must have substance — there must be some discernible adverse effect to some interest other than the abstract interest of all citizens in having others comply with the law." Although appellants attempt to establish that waste and diversion of assets constitute issues of social concern, such by itself is insufficient for purposes of demonstrating standing under [*In re Francis Edward McGillick Found.*, 537 Pa. 194, 642 A.2d 467 (1994)]. Furthermore, Appellants fail to specifically articulate how their interests are mutually exclusive or distinct from the public interest already being represented by the Attorney General.[50]

As to the requests to become *amicus curiae*, the Orphans' Court stated:

> The proceedings now before this Court do not raise issues of broad social concern . . . . Accounts have been filed. The Attorney General has filed Objections to said Accounts. Said Objections include many of the complaints of the Petitioners. Prosecution of said Objections may result in the surcharge or removal of members of the Board of Directors of PHCT. The Petitioners are free to raise their concerns to the Attorney General. They are free to offer their resources, and the fruits of their investigations, to the Attorney General. They are free to consult and work with the Attorney General. Under all of the foregoing circumstances, this Court sees no need to appoint the Petitioners, or any of them, to serve as *Amicus Curiae*.[51]

The PHCT decisions confirm both the rules and concepts of standing before the Orphans' Court in matters involving a charity. The court rejected every claim, category, and variation of the concept of special interest that each of the petitioners could conjure up, and it denied all of the efforts to circumvent the standing rules by *amicus curiae* status. While imaginative future petitioners will undoubtedly find some basis to claim a special interest in a charity that the petitioners did not utilize in the PHCT cases, they will not find many, and few petitioners who do not have a true close

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50. *Phila. Health Care Trust*, 872 A.2d at 262-63 (citations omitted).

51. *In re* Phila. Health Care Trust, 2004 Phila. Ct. Com. Pl. LEXIS 113, at *15-*16 (Orphans' Ct. July 19, 2004), *aff'd*, 872 A.2d 258 (Pa. Commw. Ct. 2005).

connection to a charity will find a basis to claim a special interest that the Orphans' Court in *PHCT* has not rejected.

The PHCT cases send a clear message solidly confirmed by the supreme court in *Hershey*. Despite the unique circumstances of the *amici curiae* in the *Barnes* proceedings, the standing rules remain firmly in place. Community groups, related charitable institutions, elected officials, government agencies, and members of the population served by charities may have a good faith interest in how a charity operates and spends its money, but that interest involves some variation of the interest of the community or the citizenry in general. Only the Attorney General serves as *parens patriae*, and only the Attorney General may represent the community and the citizenry before the Orphans' Court. Others who consider themselves interested, affected, or even aggrieved, may present their positions to the Attorney General. They do not have standing before the Orphans' Court.

V. CONCLUSION

Charities live and operate in a different world than businesses conducted for profit for the benefit of shareholders, members, or other equity holders. Most charities, and particularly large charities, do conduct a species of business and must make business decisions about operations, finance, risks, and rewards and most of the other things that concern every business. In making those decisions, however, charities act for, and are responsible to, a very different constituency and are governed by very different standards than for-profit businesses, and that makes a very big difference.

As the designation makes clear, for-profit businesses operate to make a profit for their shareholders. Charities operate to pursue their charitable purposes for the benefit of the public or the community. Shareholders protect themselves individually or as a group and have recourse to the state or federal court systems when wronged. The Attorney General protects the public and the citizens of the state and has recourse on behalf of the public to the Orphans' Court when he considers the public wronged.

The Attorney General naturally plays a very important part in any proceeding or action relating to a major transaction by a charity. He has the right and standing to participate as a party in all aspects of any proceeding before a court and the right to object to or challenge any proposed action or transaction. The Orphans' Court also protects the interests of the public and naturally takes

the positions of the Attorney General very seriously. Any charity contemplating a major transaction or other significant activity would do well to disclose everything of significance to the Office of the Attorney General and to keep it up to date.

Decisions by charities as to whether and how to proceed before the Orphans' Court depend on the nature of the proposal under consideration. Some matters, like deviation and *cy pres*, dissolution, and material change of purpose, require approval by the court and leave no room for discretion. Others, such as nondiversion of property by nonprofit corporations, usually are not as clear and often involve some discretion and may depend on factors such as the visibility of the case, the likely size and intensity of possible opposition to the proposal, and the position of the Attorney General.

In deciding whether to present a matter to the court, charities should consider that the Orphans' Court differs in a number of potentially important respects from the civil division of the Court of Common Pleas and other trial level courts. Petitions before the Orphans' Court may not need to follow the traditional forms of adversary pleading, and petitioners have reasonable latitude in framing the issues presented. The standing rules often keep out of proceedings the most virulent opponents, and the Attorney General, most often the only opposing party, has no personal stake in the matter and can thus often be more reasonable than a true adversarial litigant. The moderately permissive procedures of the court in proceedings involving only the court and the Attorney General can allow for a more reasoned consideration of the issue and evaluation of reasonable alternatives. Finally, a decree of the Orphans' Court, subject of course to any appeals, settles a matter and ends all meaningful opposition. It allows a transaction or activity to proceed with the usually unbreakable seal of approval.

EXHIBIT R

COMMONWEALTH OF PENNSYLVANIA
OFFICE OF ATTORNEY GENERAL

REVIEW PROTOCOL FOR FUNDAMENTAL CHANGE TRANSACTIONS AFFECTING HEALTH CARE NONPROFITS

Underlying Principle

Whenever a nonprofit, charitable health care entity enters into a transaction effecting a fundamental corporate change which involves a transfer of ownership or control of charitable assets, regardless of the form of the transaction contemplated (i.e., sale, merger, consolidation, lease, option, conveyance, exchange, transfer, joint venture, affiliation, management agreement or collaboration arrangement, or other method of disposition); unless the transaction is in the usual and regular course of the nonprofit's activities; and regardless of whether the other party or parties to the transaction are a nonprofit, mutual benefit or for-profit organization; the Office of Attorney General, as parens patriae, must review each transaction to ensure that the public interest in the charitable assets of the nonprofit organization is fully protected. Consequently, to review each transaction, the OAG must be provided relevant financial, corporate, and transactional information, in order to reach a decision on whether or not to object to or withhold objection to the proposed transaction. This decision will determine the Attorney General's position relative to Orphans' Court proceedings required in fundamental change transactions under the Nonprofit Corporations Law.

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Review Protocol

This Protocol was developed to be used as a guide by attorneys and reviewers in the Charitable Trusts & Organizations Section, and its outside experts, in reviewing fundamental transactions affecting nonprofit, charitable health care entities. It provides broad, general guidelines with respect to issues that routinely appear in such transactions and is not intended to be an exhaustive or exclusive list of items to be reviewed and investigated, as these will vary on a case-to-case basis.

1. Notice to the Attorney General

The parties to the transaction shall provide written notice of same to the Attorney General at least 90 days prior to the contemplated date of its consummation. The Attorney General shall be given sufficient time from the receipt of the written notice within which to review and evaluate adequately and fully the proposed transaction. This notice shall include any and/or all of the following documents as the Attorney General may determine to be necessary:

a) all information, including organic documents such as Articles of Incorporation, bylaws, endowment fund documentation, trust restrictions, expenditure history, and other information necessary to define the trust upon which the charitable assets are held;

b) all complete transaction documents with attachments, including collateral or ancillary agreements involving officers, directors or employees (i.e., employment contracts, stock option agreements in the acquiring entity, etc.);

c) all documents signed by the principals or their agents which are necessary to determine the proposed transaction's effect, if any, on related or subsidiary business entities, whether nonprofit or for-profit;

d) all asset contribution agreements, operating agreements, and management contracts, if any, which comprise part or all of the transaction;

e) all financial information and organic documents regarding the post-transaction successor or resulting charitable entity (foundation), including the information detailed in Item (a), supra; and including relevant information with respect to officers, directors, and employees (current and post-transaction), in order to determine independence, board composition, charitable purpose, and to review any financial arrangements with officers, directors, or employees which may be affected by the transaction, particularly those which have the potential of affecting an individual's objectivity in supporting or approving the transaction;

f) all information necessary to evaluate the effects of the transaction on each component of an integrated delivery system, where transactions involve hospitals, including any changes in contracts between the integrated delivery system entities and related physician groups;

g) all financial documents of the transaction parties and related entities, where applicable, including audited financial statements, any fiduciary accounts whether or not filed with the various Orphans' Courts of the Commonwealth, ownership records, business projection data, current capital asset valuation data (assessed at market value), and any records upon which future earnings, existing asset values and fair market value analysis can be

based;

h) all fairness opinions and independent valuation reports of the assets and liabilities of the parties, prepared on their behalf;

i) all relevant contracts (assets and liabilities) which may affect value, including, but not limited to, business contracts, employee contracts such as buy-out provisions, profit-sharing agreements, severance packages, etc.;

j) all information and/or representations disclosing related party transactions, which are necessary to assess whether or not the transaction is at arms length or involves self-dealing;

k) all documents relating to non-cash elements of the transaction, including pertinent valuations of security for loans, stock restrictions, etc.;

l) all tax-related information, including the existence of tax-free debt subject to redemption, disqualified person transactions yielding tax liability, etc.;

m) a listing of ongoing litigation, including full court captions, involving the transaction parties or their related entities, which may affect the interests of the parties and the valuation of charitable assets;

n) all information in the possession of the transaction parties relative to the perspective of the nonprofit's beneficiary class or representatives thereof (e.g., the community);

o) all information, including internal and external reports and studies, bearing on the effect of the proposed transaction on the availability or accessibility of health care in the affected community;

p) organizational charts of the parties to the transaction, as they exist both pre- and post- consummation of the transaction involved, detailing the relationship between the principal parties and any and all subsidiaries thereof; and

q) any and all additional documents that the Office of Attorney General deems necessary for its review purposes.

Any and all confidential information provided in the course of the review will be held in confidence by the Office of Attorney General as a part of its investigative files and, as such, will not be returned to the transaction parties. Only information that is a public record will be privately or publicly disseminated concerning any transaction that is not objected to by the Attorney General, unless such a dissemination is ordered by a court of competent jurisdiction. The Attorney General will notify all transaction parties of any formal or informal request seeking access to the information provided.

2. The Review Process

The Attorney General is entitled to retain outside experts and consultants for the purpose of evaluating information detailed in Item 1, supra. This is more likely to occur in a nonprofit to for-profit transaction. These consultants may be either from state agencies, the private sector, or both. They shall be retained pursuant to written contracts, and the costs for retaining such consultants shall be paid by the parties requesting transaction approval.

The review of the transaction shall include, among other components:

a) information gathering;

b) review of fiduciary responsibilities of directors, particularly relative to the exercise of due diligence, the assessment of self-dealing and whether or not the transaction is at arms length;

c) fair market valuation analysis;

d) inurement inquiry, including stock options, pension plans and perquisites, performance bonuses, consulting contracts or other post-transaction employment agreements, corporate loans, golden parachute provisions and severance packages, salaries, and related party transactions;

e) public interest review to evaluate the transaction's effect upon the availability and accessibility of health care in the affected community, to include community involvement and antitrust review; and

f) appropriate cy pres determination, to ensure that all restricted funds remain segregated and used for their restricted purposes; and that the remaining or successor charitable organization competently and efficiently utilizes the assets for a like charitable purpose benefitting the same class of beneficiaries. The analysis is particularly important when the transaction results in the reallocation of charitable funds from operational use to grant-making use, to ensure that a constancy of charitable purpose is maintained. It is critical to evaluate whether the acquiring entity will maintain control of the charitable assets, post-transaction, through the creation of a newly controlled foundation or through appointments to the existing charity's board.

3. Notice to the Public

The role of the Office of Attorney General in its review of the proposed transaction is to ensure that the actions of nonprofit directors satisfied their fiduciary duties to the public beneficiaries of the health care entity, and to ensure that the charitable assets thereof are

preserved and used for their proper charitable purpose. Further, the Attorney General will consider the broad public policy issue of whether the transaction is in the public interest, specifically whether the proposed transaction will adversely affect the availability or accessibility of health care in the affected community or region.

Implicit in this review is that reasonable public notice of a proposed transaction shall be provided by the parties to the affected community or region, along with reasonable and timely opportunity for such community to contribute to the deliberations of the parties and the Attorney General relative to the health care and charitable trust issues.

In this way, a thorough and complete review of the transaction can be accomplished in a manner that is open to public scrutiny, and the interest of public beneficiaries of nonprofit health care entities may best be protected.

4. Response of Attorney General

Upon completion of its review of the transaction, the Office of Attorney General may: issue a letter indicating that it has no objection to the transaction; bring judicial proceedings to enjoin consummation of any disputed transaction; seek to void any transaction consummated as being in derogation of the law or contrary to public policy; or take any other action it deems appropriate. If, in the opinion of the Office of Attorney General the public interest will be best served thereby, the Office of Attorney General may request that the parties to the transaction seek approval of the Orphans' Court in the county of the nonprofit charitable corporation's registered office. This is more likely to occur in a nonprofit to for-profit transaction.

The procedures set forth in this protocol are in addition to all other powers conferred on the Office of Attorney General by statute or common law.

5. Post-transaction Oversight

The Office of Attorney General will maintain oversight of the transaction after its consummation to ensure that no subsequently executed contracts or arrangements between the parties or their agents effect a denigration of its terms. This oversight may mandate that the resulting entity or surviving charity report on some basis to the OAG to ensure that the terms of the transaction are fulfilled.