Received 3/11/2019 7:10:54 PM Commonwealth Court of Pennsylvania

Filed 3/11/2019 7:10:00 PM Commonwealth Court of Pennsylvania
334 MD 2014

EXHIBIT 1

June 25, 2014 Preservation of Highmark Community Blue Claims

COMMONWEALTH OF PENNSYLVANIA
OFFICE OF ATTORNEY GENERAL
HARRISBURG, PA 17120

KATHLEEN G. KANE
ATTORNEY GENERAL

16TH FLOOR
STRAWBERRY SQUARE
HARRISBURG, PA 17120
(717) 787-3391

June 25, 2014

Gerald J. Pappert, Esquire
Cozen O'Connor
1900 Market Street
Philadelphia, PA 19103

Re: UPMC/Highmark

Dear Jerry:

As you know, this Office and your client, UPMC, have been discussing whether UPMC's conduct and communications with regard to Highmark Community Blue members during the period January 1, 2013 to the present has been lawful. As part of the process that lead to the agreement on a consent decree that will be signed by this Office and UPMC, UPMC asked us to put aside our concerns about UPMC and Community Blue to a later time. We have agreed to do that with the understanding that any release contained in the Consent Decree does not release any claims this office may have against UPMC for its conduct and communications regarding Community Blue members during the period January 1, 2013 to the present.

Please acknowledge your agreement below.

Sincerely,

James A. Donahue, III
Executive Deputy Attorney General

Acknowledged and Accepted:

By: Gerald Pappert 6/30/2014
Gerald J. Pappert, Esquire

EXHIBIT 2

Commonwealth's Petition to Modify Consent Decrees w/Attachments A – G

Received 2/7/2019 2:33:43 PM Commonwealth Court of Pennsylvania

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

COMMONWEALTH'S PETITION TO MODIFY CONSENT DECREES

A. INTRODUCTION

Pennsylvania's nonprofit charitable healthcare systems are obliged to benefit the public by following their stated charitable purposes. According to its mission statement, the University of Pittsburgh Medical Center's (hereinafter UPMC) charitable purposes are to develop a high quality, cost effective and accessible health care system advancing medical education and research while providing governance and supervision to its subsidiary tertiary and community hospitals related to those purposes. Based on these charitable purposes, the Commonwealth granted UPMC its status as a charitable nonprofit health care institution and the public benefits that

status affords. Consequently, UPMC may not pursue financial gain, commercial success, or market expansion to the exclusion of its charitable purposes.

It is the Commonwealth's responsibility to ensure that UPMC fully and faithfully meets its mission and fulfills its charitable responsibilities. This petition alleges UPMC's conduct in a number of areas violates its stated mission making it non-compliant with Pennsylvania's charities laws.

The modification being sought in this petition is in the public interest as UPMC's actions, backed by its Board of Directors, are causing widespread confusion among the public and personal hardships for many individual UPMC patients. UPMC's exorbitant executive salaries and perquisites in the form of corporate jets and prestigious office space waste and divert charitable assets. Moreover, UPMC's misleading promotional campaigns and unnecessary litigation damage UPMC's goodwill and reputation, which were earned through public tax exemptions, charitable donations and public financing.

Accordingly, Petitioner, the Commonwealth of Pennsylvania acting as *parens patriae* through its Attorney General, Josh Shapiro (Commonwealth), respectfully seeks modification of the Consent Decrees of record pursuant to paragraph IV.C.10. This modification is necessary to maintain the Consent Decrees' principles to protect and promote the public interest through enforcing the respondents' charitable missions by: enabling open and affordable access to the respondents' health care

services and products through negotiated contracts; requiring last best offer arbitration when contract negotiations fail; and ensuring against the respondents' unjust enrichment by prohibiting excessive and unreasonable charges and billing practices inconsistent with the respondents' status as public charities providing medically necessary health care services to the public.

All parties (Office of Attorney General, Pennsylvania Insurance Department, Pennsylvania Department of Health, Highmark and UPMC) agreed under paragraph IV.C.10 of the Consent Decrees that if modification of the decrees would be in the public interest, the party seeking modification should give notice to the other parties and attempt to agree on the modification. If an agreement cannot be reached, the party seeking modification may petition this Court for modification and shall bear the burden of persuasion that the requested modification is in the public interest.

The Commonwealth has duly attempted to secure the respondents' agreement to modify their respective decrees for the past two years. Those attempts have involved numerous meetings with both organizations involving the exchange of concerns and justifications for the respondents' conduct. The Attorney General gave both Highmark and UPMC a formal proposal to modify the existing Consent Decrees. Significantly, Highmark did agree to the terms, provided UPMC would be subject to those same terms. However, UPMC was unwilling to agree to these same modifications. Consequently, court intervention is now required.

As such, through the actions alleged more fully within, UPMC is operating in violation of its stated charitable purposes as well as the Solicitation of Funds for Charitable Purposes Act, 10 P.S. §§ 162.1 *et seq.*, the Nonprofit Corporation Law of 1988, 15 Pa.C.S. §§ 5101 *et seq.*, and the Unfair Trade Practices and Consumer Protection Law, 73 P.S. §§ 201-1 *et seq.*

UPMC's failure to fulfill all of its charitable obligations in their entirety, and comply with other applicable law compels the requested relief to protect the health and welfare of the people of Pennsylvania.

In summary, this petition will address: UPMC's stated charitable purposes; public financial support for UPMC; history of the case; UPMC's departure from its charitable purposes; UPMC's expansion; and legal causes of action.

The Commonwealth offers the following in support.

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

The foundation for seeking this modification is primarily based on UPMC's status as a charitable nonprofit health care institution governed by Pennsylvania's charitable laws. UPMC's status requires that it operate consistent with its purpose.

1. UPMC's Amended and Restated Articles of Incorporation set forth UPMC's stated charitable purposes as follows:

[T]o engage in the development of human and physical resources and organizations appropriate to support the advancement of programs in health care, the training of professions in the health care fields, and medical research, such activities occurring in the regional, national and international 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, 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 **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 to the construction, purchase, ownership, maintenance, operation and leasing of one or more hospitals and related 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** *(emphasis added)*. See Exhibit A attached.

2. At all times relevant and material hereto, UPMC has operated as the parent 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.

3. UPMC and all of its constituent nonprofit charitable hospitals have been recognized as tax-exempt entities under Section 501(c)(3) of the Internal Revenue Code (IRC) and are all classified as public charities under Section 509(a)(3) of the IRC.

4. UPMC and all of its constituent nonprofit, charitable hospitals have registered as institutions of purely public charity under the Institutions of Purely Public Charity Act, 10 P.S. §§ 371 et seq., and are exempt from Pennsylvania income, sales, use and local property taxes.

5. In addition to their stated charitable purposes, UPMC also has a Patient's Bill of Rights required by the DOH at 28 Pa.Code § 103.22, published in various handbooks of its subsidiaries, posted in their offices, and published on the UPMC website as its "Patient Rights & Responsibilities at UPMC Hospitals" which provides in pertinent part:

> At UPMC, service to our patients is our top priority. We are committed to making your stay as pleasant as possible. We have adopted the following Patient Bill of Rights to protect the interests and promote the well-being of our patients.
>
> . . .
>
> **A patient has the right to medical and nursing services without discrimination** based upon race, color, religion, ancestry, national origin, age, sex, genetics, sexual orientation,

> gender identity, marital status, familial status, disability, veteran status, or any other legally protected group status.[1]
>
> . . .
>
> Make Payment for Services: You are responsible for all services provided to you by UPMC. **Payment may be made through third-party payers (such as your insurance company), by self-payment, or by making other payment arrangements for services not covered by insurance** (emphasis added).

6. An additional representation made by UPMC can be found at its web site at www.upmc.com through which it solicits the public for donations of financial support and volunteers, answering the question "Why Support UPMC?" as follows:

> Life Changing Medicine. Every day at UPMC lives are saved and quality of life is restored. **We provide hope during difficult illnesses and compassion for every patient.**
>
> **We are deeply committed to the people who make up our communities and to making sure that everyone who comes through our doors has access to the very best, most advanced health care available.**
>
> . . .

[1] https://www.upmc.com/patients-visitors/patient-info/Pages/rights-and-responsibilities.aspx.
Since the entry of its Consent Decree in 2014 UPMC deleted "**source of payment**" from the non-discrimination clause within the above-cited paragraph 5 of "Patient Rights." The non-discrimination provision based upon a patient's source of payment under the "Patient Bill of Rights" is provided for under 28 Pa. Code § 103.22(b)(13) and UPMC's deletion thereof is subject to disciplinary actions pursuant to 28 Pa. Code § 103.24.

It is our mission to provide outstanding patient care and to shape tomorrow's health care through clinical innovation, biomedical and health services research, and education.

No matter the size or type, all gifts are meaningful and provide important support for all of the programs at UPMC. Please consider giving today (emphasis added).[2]

C. PUBLIC FINANCIAL SUPPORT FOR UPMC

As a charitable organization committed to public benefit, UPMC has enjoyed and benefitted from strong public financial support throughout its existence.

7. Some examples of the public's financial support for UPMC include:

   a. Since at least 1952, the Hillman Company and the Hillman Family Foundations have donated a total of $77,098,497 to benefit the public-at-large through what are today various UPMC entities and health care initiatives, including the UPMC Hillman Cancer Center. The Hillman's never intended that their donations would be used to only treat patients with certain types of insurance.

   b. In 2002, Highmark, whose funds come from its premium paying individual and employer customers, donated $250,000,000 as part of a joint initiative with UPMC, the

[2] https://www.upmc.com/about/support/why/Pages/default.aspx

Children's Hospital of Pittsburgh (now the Children's Hospital of Pittsburgh of UPMC), the St. Francis Health System, and the Jameson Health System (now UPMC Jameson), as follows:

i. $233,000,000 to the Children's Hospital of Pittsburgh for the purchase of its Lawrenceville site and construction of a new hospital and pediatric research facility; and

ii. $17,000,000 to the Jameson Health System (now UPMC Jameson) for the acquisition of the St. Francis Hospital of New Castle; and

c. Since 2001 Highmark has donated another $4,161,600 to the Children's Hospital or its foundation to benefit the public-at-large.

8. From July 1, 2005 through June 30, 2017, UPMC reported in its IRS Form 990 UPMC Group returns that it has received **$1,272,514,014** in public and private contributions and grants to support its charitable health care, education and research missions.

9. From its inception UPMC has additionally benefitted from hundreds of millions of dollars in accumulated state and federal income tax exemptions; city and

county property tax exemptions; and low-interest, tax-exempt government bonds and debt financing. UPMC receives approximately $40 million in annual real estate tax exemptions in Allegheny County alone from Allegheny County, the City of Pittsburgh, the Pittsburgh School District and the Carnegie Library.

10. The public's support has not gone unrewarded in that UPMC has grown into one of Pennsylvania's largest health care providers and health care insurers.

11. The public has paid for UPMC's dramatic expansion, yet thousands of those taxpayers who built UPMC are now being shut out of the very care they helped pay for.

D. HISTORY

In addressing the current matter, it is important to discuss the conduct that led to the current Consent Decrees and efforts that resulted in the second mediated agreement.

Conduct Leading Up to Consent Decrees

12. This case arose out of a dispute between UPMC and Highmark, two of Pennsylvania's largest ***charitable*** institutions, and has spread to impact healthcare consumers across the Commonwealth. It began in the spring of 2011 after Highmark and UPMC were unable to agree on new health care provider contracts

and Highmark announced its intention to acquire control of the West Penn Allegheny Health System ("West Penn Allegheny").

13. West Penn Allegheny was UPMC's main health care provider competitor in southwestern Pennsylvania and the Highmark/West Penn Allegheny affiliation resulted in the region's second Integrated Delivery and Finance System (IDFS)[3] – UPMC was the region's first.

14. UPMC reacted to the Highmark/West Penn Allegheny affiliation by refusing to renew its health insurance provider contracts due to expire after December 31, 2012[4] on the basis that Highmark had become UPMC's competitor as a provider. UPMC took this position despite the fact that UPMC had been competing against Highmark as a health care insurer for more than a decade without similar objection from Highmark, and both UPMC and Highmark are charitable institutions committed to providing the public with access to high-quality, cost effective health care.

15. In order to protect the interests of the general public caught in the middle of the respondents' contractual dispute, an agreement was negotiated between UPMC and Highmark through the auspices of then Governor Tom Corbett

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[3] An "Integrated Delivery and Finance System" is comprised of health care providers and health care insurers under common control.

[4] The subject contracts had been in effect since 2002.

on May 1, 2012 (Mediated Agreement). The Mediated Agreement was intended to provide members of the public with additional time, *i.e.*, until December 31, 2014, to transition insurance coverages to include the medical providers of their choice. Otherwise, thousands of patients risked disruptions in the course of their medical care and/or exposure to UPMC's substantially higher "Out-of-Network" charges.

16. On January 1, 2013, Highmark re-launched its Community Blue Health Plan which was exempt from the anti-tiering and anti-steering[5] provisions under the respondents' existing 2002 contract as well as the Mediated Agreement. UPMC reacted by refusing treatment to Highmark Community Blue subscribers under any circumstance – even when those subscribers attempted to forego their Highmark insurance coverage and pay UPMC's charges directly out-of-pocket. UPMC's refusal to treat Highmark Community Blue subscribers occasioned considerable

[5] An anti-tiering/anti-steering provision is a contract provision between a health plan, like Highmark, and a health provider, like UPMC, which prohibits the health plan from providing customers with the option of using less costly health care providers while "steering" them away from more costly providers. Plans with these types of provisions are usually sold at a discount to plans that offer unfettered access to any provider. Anti-tiering and anti-steering provisions have recently been successfully challenged by the United States Department of Justice and the North Carolina Attorney General as anticompetitive. As part of a Joint Stipulation and Order Regarding a Proposed Final Judgment, the provisions were rendered void in existing health care provider contracts with health plans and their use was prohibited in future health care provider contracts with health plans. *United States v. Charlotte-Mecklenburg Hospital Authority d/b/a/ Carolinas Healthcare System*, 3:16-cv-00311 (W.D. NC Nov. 5, 2018)

hardship on Community Blue patients, many of whom were forced to find other providers.[6]

17. UPMC and Highmark then engaged in aggressive and often misleading marketing campaigns which caused widespread public confusion and uncertainty as to the cost and access of Highmark subscribers to their UPMC physicians.

18. In response, the "Patients First Initiative" was formed pulling together the Office of Attorney General (OAG), the Pennsylvania Insurance Department (PID) and the Pennsylvania Department of Health (DOH) to resolve the disrupted health care and In-Network access issues presented. After lengthy negotiations UPMC and Highmark agreed upon the terms reflected in the reciprocal Consent

[6] By way of example, UPMC: a) Refused to write and/or refill prescriptions for medications; b) Refused to schedule medical appointments and/or procedures, including pre and post-operative procedures and examinations; c) Refused obstetrics and gynecological services to long-term patients; d) Refused non-emergency based follow-up treatment to a patient admitted through the emergency room after learning that the patient subscribed to Highmark Community Blue; e) Advised a transplant patient who had been on the waiting list for four (4) years that he would have to find another provider f) Refused treatment to a patient with multiple health insurance policies because Highmark Community Blue was among the multiple policies held; and g) Refused to treat Highmark Community Blue patients, on a non-emergency basis, even though they offered to pay UPMC's charges out-of-pocket with cash.

Decrees approved by this Honorable Court on July 1, 2014, including for future modification of the Consent Decrees to promote the public's interest.[7]

19. In spite of the Consent Decrees, however, UPMC and Highmark have continuously engaged in recurrent disputes that required informal mediations by the Office of Attorney General and other state agencies and foretell the negative consequences that will be suffered upon the public after the expiration of the existing Consent Decrees.[8]

The Second Mediated Agreement

20. On or about December 20, 2017, a Second Mediated Agreement was negotiated between UPMC and Highmark through the auspices of Governor Tom Wolf. Despite the administration's best efforts, the agreement will only apply to Highmark's commercial insurance products – it does not include Highmark's Medicare Advantage products important to seniors or any other health plan UPMC decides it disfavors. .

21. Moreover, this latest agreement will only extend In-Network access to certain UPMC specialty and sole provider community hospitals for a period of two

[7] Copies of each of the respective Consent Decrees are attached as Exhibits B and C.

[8] In addition to the recurrent disputes recounted here, the record reflects the Commonwealth's three past formal enforcement actions before this Court – none of those enforcement actions involved the modification relief requested here.

to five years after June 30, 2019 and retreats from broader protections afforded under the Consent Decrees concerning emergency room and Out-of-Network rates as well as balance billing practices.

22. As a result, despite the past assurances from UPMC that seniors would never be impacted by their contractual disputes, UPMC has failed to ensure that senior citizens and other vulnerable members of the public will continue to have affordable access to their health care providers.

23. In light of the above circumstances and public statements by UPMC, the expiration of the Consent Decrees can only be expected to result in UPMC's eventual refusal to contract with other health insurers. Such refusal will result in more patients seeking access patients seeking access to UPMC on a cost-prohibitive Out-of-Network basis. These circumstances are in direct conflict with UPMC's status as a charitable institution developed through decades of public donations, tax-exemptions, and debt financing.

E. UPMC'S DEPARTURE FROM ITS CHARITABLE PURPOSES

As a charitable nonprofit health care institution, UPMC must continuously satisfy *all* of its obligations to the public, not only those that further its commercial goals. It is not a balancing test, UPMC's obligations to the public under state charities laws are not abated when a consumer has a health plan UPMC disfavors.

Although UPMC may receive reasonable compensation for the value of its services, it may not profit and is prohibited from private, pecuniary gain – the financial success of its health care operations must inure to the benefit of the public-at-large.

Disputed Payments Concerning Highmark's Out of Network Riders

24. Under the Consent Decrees, UPMC agreed that Highmark subscribers would pay no more than 60% of charges when Highmark subscribers sought care from UPMC on an Out-of-Network basis. Highmark created Out-of-Network policy riders offered to some of its self-insured employers under which Highmark would pay the 60% of Out-of-Network charges, less the usual co-payments and co-insurance. UPMC has thwarted the efforts of patients to use this rider which caused confusion as to:

a. How much insurance coverage was actually provided by Highmark's Out-of-Network Riders in addition to a patient's applicable deductible, co-payment and/or co-insurance;

b. Whether patients must pay all 60% of UPMC's Out-of-Network charges "up front" pursuant to paragraph IV(A)(6) of the decrees before receiving any treatment and before being reimbursed by Highmark;

c. Whether Highmark is obliged to pay UPMC directly under the prompt payment provision of paragraph IV(A)(6) of the Consent Decrees; and/or

d. Whether UPMC must accept Highmark's pledge of prompt payment in lieu of demanding "up front" payments from patients for the entire 60% of UPMC's Out-of-Network charges or only the patients' applicable deductibles, co-payments and/or co-insurance.

25. The above issues imposed both financial hardships, treatment denials and/or treatment delays upon Out-of-Network patients, for example:

a. A patient had to change hospitals to have required surgery performed in February 2017 on an In-Network basis by her physician in order to avoid paying UPMC $11,816.67 in up-front charges; this was only possible because her physician was an independent provider with privileges at both UPMC and West Penn Hospital.

b. Another patient was required to pay UPMC $65,181.70 in "up front" charges before UPMC would perform time sensitive brain surgery in November 2015 to remove a cyst that could lead to the patient's coma and sudden death.

The patient paid this amount to avoid treatment delay despite the fact that UPMC completed a "UPMC Patient In-Network Attestation" form for In-Network coverage under the cancer/oncology provision of the Consent Decree. UPMC ultimately reimbursed the patient months after the surgery and the unnecessary and exorbitant fees.

26. The foregoing circumstances evidence the Consent Decrees' material shortcomings in securing the respondents compliance with their stated charitable purposes and support the merits of the Commonwealth's requested modifications.

Refusal to Contract and Practices to Increase Revenue

27. UPMC has made clear that it has no intention of contracting with Highmark concerning any of Highmark's Medicare Advantage plans, after June 30, 2019.

28. UPMC's latest refusal to contract with Highmark's Medicare Advantage plans after June 30, 2019 constitutes a reversal of prior representations to the public and the Commonwealth that seniors would never be affected by its contractual disputes with Highmark – that seniors would always have In-Network access to their UPMC physicians. See Exhibit D attached.

29. UPMC's refusal to contract with Highmark has the practical effect of denying cost-effective In-Network access to a substantial segment of the very public

that is subsidizing and helping to sustain UPMC's charitable mission. Highmark has more than 100,000 Medicare Advantage participants in Pennsylvania.

30. Additionally, UPMC has largely refused to commit its newly acquired health care systems to contracting with all health insurers going forward, saying only that it will agree to contract if health plans are willing to pay UPMC's self-defined, often higher, market rates.

31. UPMC also employs practices that increase its revenue without apparent regard for the increase on the costs of the region's health care, including, but not limited to:

a. Transferring medical procedures to its higher cost specialty providers;

b. Utilizing "provider based," "facilities based" and/or "hospital based" billing practices that permit increased service charges in facilities where they had not been before;

c. Balance billing Out-of-Network patients even when the insurance payments UPMC receives generally exceed the actual costs of UPMC's care; and

d. Insisting upon full "up front" payments from Out-of-Network insureds before rendering any medical services.

Unfair and Misleading Marketing

32. With large numbers of Pennsylvanians in health plans disfavored by UPMC, UPMC had an incentive to convince people to abandon those disfavored plans.

33. On or about July 17, 2017, the UPMC Health Plan circulated a promotional flyer that offered employers within the service area of UPMC Susquehanna the opportunity to "[p]ut a lock on health care costs."

34. The promotional flyer represented that:

> [w]ith this special, limited-time offer from UPMC Health Plan, you can lock in to single-digit premium increases through 2020. Given the double-digit increases during the last decade, this offer could translate to massive savings for your organization. Meanwhile, with UPMC Health Plan, your employees will be getting extensive in-network access to hospitals and providers, affordable plan options, and world-class local customer service they can count on.

See Exhibit E attached.

35. However, in the far lower-right hand corner of the flyer under "Terms and conditions" the flyer noted that, "UPMC Health Plan may, at its sole discretion, cancel, amend, modify, revoke, terminate or suspend this program at any time. Participation in this program and/or election of the offer is not a guarantee of continued plan availability or renewal."

36. UPMC also markets a limited UPMC Health Plan such that subscribers have unwittingly purchased coverage for UPMC's community hospitals that does not include In-Network access to UPMC's premier and/or exception[9] hospitals, resulting in unexpected and much more costly Out-of-Network charges should subscribers need heightened levels of care from UPMC's premier or exception hospital providers.

Access and Treatment Denials

37. Despite UPMC's representation that it is "deeply committed to the people who make up our communities," UPMC **does not** ensure "that everyone who comes through [its] doors has access to the very best, most advanced health care available." Rather, only certain people who carry the right In-Network insurance card or are able to pay up front and in full for non-emergency medical services get access to UPMC's health care.

[9] Exception Hospitals are identified in Para. 5 of the Consent Decrees as "...Western Psychiatric Institute and Clinic, UPMC Bedford, UPMC Venango (Northwest),UPMC/Hamot and UPMC/Altoona, UPMC Horizon and any facility, any physician, facility or other provider services located outside the Greater Pittsburgh Area currently owned or acquired in the future by UPMC, or with whom UPMC has an agreement to handle provider contracting such as, but not limited to Kane Hospital, or any other physician or facility outside the Greater Pittsburgh Area determined by DOH to be essential to meet local community needs, by July 15, 2014..."

Individuals:

a. An established UPMC cancer patient with a rare and aggressive form of Uterine Carcinosarcoma has been advised that there is an 85% chance of her disease recurring within two years of her recently completed initial treatments, but nevertheless, was advised in July 2018 that she will no longer be able to see her UPMC oncologists In-Network after June 30, 2019 unless she switches from her husband's employer provided Highmark health insurance to a non-Highmark In-Network insurance plan or prepays for the services she needs.

b. An established UPMC kidney transplant patient with a history of complications from the removal of her ovaries and fallopian tubes is under the care of three UPMC specialists, but will no longer be able to see her UPMC transplant, gynecological and pain specialists after June 30, 2019 unless she changes to a non-Highmark In-Network insurance plan with UPMC or prepays for the medical services she needs.

c. An established UPMC patient with five types of cancer from her experience as a World Trade Center first responder will not be able to continue to access UPMC facilities for treatments and procedures despite having three layers of available insurance, which included Highmark, and will be forced to travel more than 90 miles to receive specialized care or prepays for the services she needs.

d. An established UPMC patient with Parkinson's disease, who has an Allegheny Health Network primary care physician and who treats with a UPMC Movement Disorder Specialist, which is critical to her treatment, will lose access to her UPMC Movement Disorder Specialist and be forced to travel over 90 miles to receive this specialized care or prepay for the medical services she needs.

Employers:

38. On or about August 14, 2017, UPMC Susquehanna notified patients of its Susquehanna Medical Group physician practice, who were employees of a Williamsport area manufacturing business, PMF Industries, that it was discontinuing

its access to the physician practice despite PMF's insurer having a contract with the physician practice.[10] PMF's insurer calculated hospital reimbursements using reference-based pricing and did not have a separate hospital contract. UPMC contended that:

a. Although PMF employees' physicians visits would be covered under the physician practice contract, any hospital care the employees could need would not be covered as PMF Industries did not have a provider contract with UPMC Susquehanna for hospital services;

b. Although PMF employees' physician visits would be covered under the physician practice contract, any tests or other services including, but not limited to, outpatient and hospital-based services, such as labs, imaging and cancer care, would not be covered as PMF did not have a provider contract with UPMC Susquehanna for these hospital-based services and PMF employees would be billed at full charges for these services;

[10] These actions are reminiscent of UPMC's complete refusal to treat any of Highmark's Community Blue subscribers during 2013 and 2014 and predict UPMC's future conduct.

c. The standard approach within the entire healthcare industry was to negotiate mutually agreed upon contracts for both physician and hospital services;

d. In order to eliminate confusion about which services were covered and which were not, UPMC Susquehanna decided to discontinue access to the physician group to PMF employees until the matter was resolved to protect the employees against the risk of large out-of-pocket expenses;

e. After 30 days Susquehanna Health Medical Group physicians would stop caring for their medical needs until further notice;

f. If the employee felt he or she still required ongoing medical care they should seek an alternative physician provider immediately and that UPMC Susquehanna would assist in transferring their medical records to another provider if requested; and

g. That UPMC Susquehanna remained hopeful that PMF Industries would reconsider its position so that they could

work together again to help meet the needs of the employee and his or her loved ones.[11]

See Exhibit F attached.

39. Like PMF, many employers purchase health insurance for their employees. Also like PMF, many other employers look at innovative health plan products, like Reference Based Pricing to lower their health care costs.

40. Reference Based Pricing means using prices hospitals actually receive, i.e., the market based prices UPMC says it desires, as opposed to the "chargemaster prices" hospitals often open with in contract negotiations.

41. UPMC rejects efforts by employers to use reference based prices or other cost comparison tools, like tiering and steering mentioned above, as a means to deny access to patients with certain disfavored health plans.

42. In addition to the denial of access to Highmark patients, in cases where an employer determines that another member of the Blue Cross and Blue Shield Association, such as Capital Blue Cross or Anthem or other health plan provides the best, most cost-effective health insurance for its employees, those employers and their employees will be forced to pay up front and in full UPMC's estimated charges for non-emergency health care services, even when the estimated charges may be in

[11] PMF Industries subsequently secured access to both the physician group and hospital through another insurer, but at a higher cost.

the tens of thousands of dollars and in excess of UPMC's costs and reasonable value of services provided.

Medicare and Older Pennsylvanians:

43. UPMC's decision to not participate in certain Highmark or other Blue Cross Blue Shield Medicare Advantage plans imposes special costs and hardships on seniors.

44. If a Medicare participating patient should desire to switch to a new health care insurer to retain In-Network access to their UPMC physician, they risk being medically underwritten and the possibility of higher insurance premiums should they have a pre-existing medical condition, a circumstance that many senior citizens on fixed incomes can ill-afford. For example:

a. After 12 months in a Medicare Advantage plan, seniors cannot switch to a Medicare Supplement plan (Medigap) without the possibility of being medically underwritten for pre-existing conditions, be subjected to a six-month "look back period" before coverage begins, and be required to pay higher premiums and other costs as a result of those conditions. [12]

[12] Original Medicare is not a part of the Affordable Care Act (ACA) and is not subject to the ACA's prohibition against medical underwriting for pre-existing conditions.

b. Seniors with pending surgeries, costly diagnostic tests, chronic illnesses, and those living in nursing homes or assisted living facilities, who desire to change to a Medigap insurer, may simply have their applications denied outright.

c. Seniors with employer or union coverage may not be able to switch back from a Medicare Advantage plan after changing insurers and could also lose coverage for their spouse and dependents.

d. Although Medicare Advantage plans are required to cover pre-existing conditions, they often entail restrictive provider networks and coverage differences that can also result in higher deductibles, co-pays and/or premiums.

e. For example, an established UPMC Medicare patient diagnosed with Lymphocytic Leukemia who receives blood transfusions every two weeks at the Hillman Cancer Center, and could suffer a fatal "brain bleed" should she stop treatment, who has a Highmark Freedom Blue PPO Medicare Advantage Plan, has been told she will no longer be able to see her oncologist after June 30, 2019 unless she

pays for UPMC's services up-front, which can cost upwards of $100,000; financial constraints prevent this patient from using other insurers due to higher co-pays for specialist visits and routine scans as well as more restrictive Out-of-Network coverage.

Emergency:

45. Further, under Section 1395dd of the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd, hospitals are required to treat all persons who come to an emergency room when in an emergency medical condition or in labor.

46. UPMC acquires more than 60% of its patient admissions through its emergency rooms and 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.

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

48. In those situations, the health plan pays the bill of the hospital at rates negotiated on an ad hoc basis.

49. In such circumstances for commercial patients[13], UPMC tenders bills to the health plans at its full charges, representing UPMC's highest prices, and each bill is individually negotiated. If the price negotiated is below UPMC's posted chargemaster price, the patient may be billed for this difference or balance.

50. If UPMC can deny contracting with Highmark (or any other health insurer for that matter), those insurer's members will nonetheless still arrive at UPMC's emergency rooms through no choice of their own; those insurers and UPMC will negotiate each bill; and those insurers, employers in the case of self-insured employers, and their members will pay significantly higher prices for UPMC's emergency care.

51. These higher costs will be borne immediately by all employers who are self-insured under an Administrative Services Only (ASO) contract with Highmark or another disfavored health plan, while employers who are fully insured with Highmark will pay higher insurance rates in the future as the higher costs are incorporated into their future rates. Imposing these higher costs conflicts with UMC's stated charitable mission.

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

[13] Medicare patients are reimbursed according to the Medicare Fee Schedule and Medicare patients cannot be balanced bill for the difference between the Medicare Fee Schedule and UPMC's Chargemaster prices. 35 P.S. § 449.34.

52. UPMC has made clear that after the expiration of its Consent Decree on June 30, 2019, ***all*** Out-of-Network patients regardless of their insurer will be required to pay all of UPMC's expected ***charges*** for their non-emergency health care services up-front and in-full before receiving any services from UPMC providers.[14]

53. Although UPMC's Out-of-Network charges for Medicare patients will be limited to the applicable rates established by the Centers for Medicare and Medicaid (CMS), UPMC's up-front and in-full payment demand will effectively deny access to all those who lack the financial wherewithal and ability to pay the Medicare rates up-front or in-full.

54. All non-Medicare patients will be in an even more difficult position as they will be required to pay UPMC's charges in-advance and in-full ***without*** the limitation of CMS's applicable rates or the existing 60% limitation under paragraph IV.A.6. of UPMC's Consent Decree.

55. UPMC's refusal to entertain any non-contract "referenced based pricing" coupled with its intended up-front and in-full billing practice post-June 30, 2019 will result in both UPMC's unjust enrichment as patients will be forced to pay amounts in excess of the reasonable value of UPMC's services and denial of care to

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14 https://www.upmc.com/-/media/upmc/patients-families/choice-is-vital/medicareadvancepay.pdf

patients in contradiction to UPMC's stated charitable mission and representations to the public.[15]

Assets, Spending and Compensation Practices

UPMC's Current Financial Success Belies Its Need to Deny Care to Anyone

56. At its fiscal year ended December 31, 2017, UPMC's consolidated financial statements reported:

a. $5,601,837,000 in net assets which included $529,631,000 in cash and cash equivalents consisting of savings and temporary cash investments, as well as $5,072,206,000 in publicly traded securities and other investments, all with maturities of three days or less that are unrestricted as to their expenditure.

b. Further analysis of UPMC's consolidated financial statements reveals that after satisfying all of its current liabilities, *i.e.,* liabilities payable within one year, UPMC reports that it will still have $1,462,477,000 in cash and cash equivalents as well as publicly traded securities and other investments with maturities of three days or less that are unrestricted as to their expenditure.

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[15] *Temple University Hospital, Inc., v. Healthcare Management Alternatives, Inc.*, 832 A.2d 501 (Pa. Super. Ct., 2003)(Absent express agreement to pay, the law implies a promise to pay a reasonable fee for a health provider's services based upon what the services are ordinarily worth).

57. As such, UPMC's financial position and large share of the provider and insurance markets belie any contention that contracting with Highmark, or any other competing health provider or insurer, will place its charitable assets and mission at any unreasonable risk.

58. In fact, UPMC was able to obtain its financial position and large share of the provider and insurance markets while subject to its Consent Decree and while providing access to seniors with Highmark Medicare Advantage plans.

59. UPMC's executives and governing board appear to simply prefer the status and perquisites associated with purely commercial pursuits rather than furthering the public's interests in high quality, cost-effective and accessible health care.

60. UPMC's spending and compensation practices mimic material aspects of a purely commercial enterprise in that:

a. UPMC's CEO receives in excess of $6 million in annual compensation and UPMC has 31 executives who receive in excess of $1 million in compensation. A comparison of UPMC's IRS Forms 990 with other nonprofit charitable health care systems reveals that UPMC pays executive compensation well-above that of its nonprofit competitors,

calling into question whether the compensation is unreasonably excessive;

b. UPMC's corporate offices occupy the top floors of the U.S. Steel Building in Pittsburgh, one of the city's most prestigious and costly locations.

Wasteful Expenditures of Charitable Resources

61. In recent years, UPMC has made a series of decisions about how to use its significant charitable resources. Many of those decisions are clearly motivated by commercial gain without regard to UPMC's charitable purposes, as evidenced by the duplicative services it is creating. For example:

a. UPMC's $250M construction of its UPMC East hospital within 1.2 miles of Highmark's Forbes Regional Hospital;

b. UPMC's proposed construction of its UPMC South hospital in close proximity to Highmark's Jefferson Regional Medical Center;

c. UPMC's recently announced $2 billion expansion plan to construct three specialty-care hospitals in areas already concentrated with existing health care providers within Pittsburgh's city limits.

62. In addition to the wasteful duplications alleged, the above-circumstances risk reducing the quality of the respondents' services through the sub-optimization that occurs when the limited number of medical procedures required to develop expertise is divided among two or more providers.

63. These additional wasteful expenditures will be paid for by taxpayers, employers and those who purchase health insurance and health care services individually. They pay once through the tax benefits and charitable donations they provide to UPMC and they pay a second time through higher prices for inefficiently used, duplicative facilities owned by UPMC and other providers. Some who pay twice are then denied care at the very UPMC facilities they helped build.

F. UPMC'S EXPANSION

The effects on the public of UPMC's conduct were previously limited to the greater Pittsburgh area. However, with its expansion across the Commonwealth, even more patients and payers will experience these negative impacts.

64. Since the implementation of the Consent Decrees, UPMC has acquired control of the following health care providers and grown well beyond its initial southwestern Pennsylvania footprint:

a. Susquehanna Health System, in Williamsport, PA, now operating as UPMC Susquehanna;

b. Jameson Health System, in New Castle, PA, now operating as UPMC Jameson;

c. Pinnacle Health System, in Harrisburg, PA, now operating as UPMC Pinnacle;

d. A joint venture with the Reading Health System, in Reading, PA, now known as Tower Health that commits the system to the UPMC Health Plan;

e. Charles Cole Memorial Hospital in Coudersport, PA; and

f. Somerset Hospital in Somerset, PA.

65. Three of the above transactions involve significant additional acquisitions:

a. UPMC Pinnacle has acquired control of five additional hospitals in Cumberland, York and Lancaster Counties; [16]

b. Reading Health System/Tower Health has acquired control of five additional hospitals in Chester, Montgomery and Philadelphia Counties; [17] and

[16] Carlisle Hospital, York Memorial Hospital, Heart of Lancaster Hospital, Lancaster Regional Hospital and Hanover Hospital.

[17] Brandywine Hospital, Phoenixville Hospital, Pottstown Memorial Medical Center, Jennersville Regional Hospital, and Chestnut Hill Hospital.

c. UPMC Susquehanna has acquired two hospitals in Clinton and Northumberland Counties.[18]

66. These additional acquisitions have significantly expanded UPMC's footprint throughout most of Pennsylvania as both a health care provider and insurer.

67. UPMC now controls more than 30 academic, community and specialty hospitals, more than 600 doctors' offices and outpatient sites, and employs more than 4,000 physicians.[19]

68. UPMC describes its Insurance Services Division, which includes the UPMC Health Plan, as being the largest medical insurer in western Pennsylvania, covering approximately 3.2 million members.[20]

69. UPMC purports to be the largest non-governmental employer in Pennsylvania with 80,000 employees.[21]

70. As UPMC grows in both clinical and geographic scope, its potential to deny care or increase costs will impact thousands more Pennsylvanians.

G. COUNTS

COUNT I

[18] Sunbury Hospital and Lock Haven Hospital.

[19] ***https://www.upmc.com/about/facts/pages/default.aspx***

[20] ***https://www.upmc.com/about/facts/pages/default.aspx***

[21] ***https://www.upmc.com/about/facts/pages/default.aspx***

Modification of the Consent Decrees is Necessary to Ensure Compliance with Charities Laws

71. Paragraphs 1 through 70 are incorporated as if fully set forth.

72. The Consent Decrees provide, in part, that they are to be interpreted consistent with protecting the public and the respondents' charitable missions. Paragraph IV(C)(10) of the Consent Decrees further provides that, "if the OAG . . . believes modification of [the Consent Decrees] would be in the public interest, [the OAG] shall give notice to the other [sic] and the parties shall attempt to agree on a modification. . . . If the parties cannot agree on a modification, the party seeking modification may petition the Court for modification and shall bear the burden of persuasion that the requested modification is in the public interest."

73. As required by paragraph IV(C)(10) of the decrees, the Commonwealth has notified all other parties of its belief that modification of the Consent Decrees is needed to protect the public's interests in order to:

a. Enable patients' continued and affordable access to their preferred health care providers and facilities;

b. Protect against the respondents' unjust enrichment;

c. Promote the efficient use of the respondents' charitable assets; and

d. Restore the respondents to their stated charitable missions beyond June 30, 2019.

74. UPMC's conduct including, but not limited to the following, will result in it not operating free from a private profit motive:

a. Demanding up-front payments in-full from all Out-of-Network patients based upon UPMC's estimated charges and resulting in payments in excess of the value of the services rendered by UPMC;

b. Utilizing facilities based billing for services where they had not been before; and

c. Transferring medical procedures to its higher cost specialty providers.

75. Consequently, the Commonwealth sought the following modifications to the Consent Decrees. Highmark agreed to these modifications, UPMC did not. Those terms included:

a. Imposing internal firewalls on the respondents that prohibit the sharing of competitively sensitive information between the respondents' insurance and provider subsidiaries;

b. Imposing upon the respondents' health care ***provider*** subsidiaries a "Duty to Negotiate" with any health care insurer seeking a services contract and submit to single, last best offer arbitration after 90 days to determine all unresolved contract issues;

c. Imposing upon the respondents' health care ***insurance*** subsidiaries a "Duty to Negotiate" with any credentialed health care provider seeking a services contract and submit to single, last best offer arbitration after 90 days to determine all unresolved contract issues;

d. Prohibiting the respondents from utilizing in any of their provider or insurance contracts any practice, term or condition that limits patient choice, such as anti-tiering or anti-steering;

e. Prohibiting the respondents from utilizing in any of their provider or insurance contracts any "gag" clause, practice, term or condition that restricts the ability of a health plan to furnish cost and quality information to its enrollees or insureds

f. Prohibiting the respondents from utilizing in any of their provider or insurance contracts any "most favored nation" practice, term or condition;

g. Prohibiting the respondents from utilizing in any of their provider or insurance contracts any "must have" practice, term or condition;

h. Prohibiting the respondents from utilizing any "provider-based" billing practice, otherwise known as "facility-based" or "hospital-based" billing;

i. Prohibiting the respondents from utilizing in any of their provider or insurance contracts any "all-or-nothing" practice, term or condition;

j. Prohibiting the respondents from utilizing in any of their provider or insurance contracts any exclusive contracts or agreements;

k. Requiring the respondents' health care provider subsidiaries to limit charges for all emergency services to Out-of-Network patients to their average In-Network rates;

l. Prohibiting the respondents from terminating any existing payer contracts prior to their termination dates for anything other than cause;

m. Requiring the respondents' health care insurance subsidiaries to pay all health care providers directly for emergency services at the providers' In-Network rates;

n. Prohibit the respondents from discriminating against patients based upon the identity or affiliation of the patients' primary care or specialty physicians, the patients' health plan or utilization of unrelated third-party health care providers;

o. Requiring the respondents to maintain direct communications concerning any members of their respective health plans being treated by the other's providers;

p. Prohibiting the respondents from engaging in any public advertising that is unclear or misleading;

q. Requiring the respondents to replace a majority of their respective board members who were on their respective boards as of April 1, 2013 by January 1, 2020, with

individuals lacking any prior relationship to either respondent for the preceding five (5) years; and

r. Extending the duration of the modified Consent Decrees indefinitely.

76. Nothing in the requested relief will prohibit the respondents from continuing to develop both broad and narrow health care provider and/or health care insurance networks.

77. Nothing in the requested relief will limit or suppress competition among health care providers or insurers – it will create a level playing field and promote competition on the basis of provider-versus-provider and insurer-versus-insurer.

78. As public charities, the respondents will only be precluded from refusing to contract with any insurer or provider who desires a contractual relationship through the usual course of negotiations with last best offer arbitration compulsory after 90 days of failed negotiations.

79. The above terms were discussed with Highmark on November 14, 2018 and with UPMC on November 26, 2018. After receiving and responding to the respondents' feedback the terms were formally presented to them contemporaneously on December 14, 2018.

80. Highmark has agreed to the Commonwealth's requested modifications set forth in the proposed modified decree attached as Exhibit G as long as they also apply to UPMC.

81. UPMC has rejected the Commonwealth's requested modifications of its Consent Decree thus requiring that the Commonwealth petition this Court for the desired relief pursuant to paragraph IV(C)(10) of UPMC's Consent Decree.

82. Paragraph IV(C)(11) of UPMC's Consent Decree provides that, "[u]nless this Consent Decree is terminated, jurisdiction is retained by this Court to enable any party to apply to this Court for such further orders and directions as may be necessary and appropriate for the interpretation, ***modification*** and enforcement of this Consent Decree " (emphasis added).

83. There are no limitations or parameters imposed on the scope of permissible modifications, only that they must be shown to promote the public interest.

84. Modification as requested herein has never been considered by this Court nor by our Supreme Court.

WHEREFORE, the Commonwealth respectfully requests that this Honorable Court modify the Consent Decrees of both UPMC and Highmark through the single combined decree attached hereto as Exhibit G to ensure that the benefits of In-Network access to their health care programs and services are available to the public-

at large and not just to those patients acceptable to them based upon their competitive strategic and financial considerations.

IN THE ALTERNATIVE, the Commonwealth respectfully requests that reimbursements to both UPMC's and Highmark's provider subsidiaries and physicians for all Out-of-Network services be limited to the reasonable value of their services which is no more than the average of their In-Network rates; In-Network rates for this purpose meaning the average of all the respondents' In-Network reimbursement rates for each of its specific health care services, including, but not limited to, reimbursement rates for government, commercial and their integrated health plans.

COUNT II

UPMC's Violation of the Solicitation of Funds for Charitable Purposes Act (Charities Act)

85. Paragraphs 1 through 84 are incorporated as if fully set forth.

86. Section 3 of the Charities Act, 10 P.S. § 162.3, defines "Charitable purposes" in pertinent part as follows:

> Any benevolent, educational, philanthropic, humane, scientific, patriotic, social welfare or advocacy, public health, environmental conservation, civic or other eleemosynary objective, ...

87. Section 3 of the Charities Act, 10 P.S. § 162.3, defines "Charitable organization," in pertinent part, as follows:

> Any person granted tax exempt status under section 501(c)(3) of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 501(c)(3)) . . . .

88. Section 3 of the Charities Act, 10 P.S. § 162.3, defines "Solicitation" in pertinent part as follows:

> Any direct or indirect request for a contribution on the representation that such contribution will be used in whole or in part for a charitable purposes, including, but not limited to, any of the following:
>
> . . .
>
> (2) Any written or otherwise recorded or published request that is mailed, sent, delivered, circulated, distributed, posted in a public place or advertisement or communicated by press, telegraph, television or any other media.

89. Section 3 of the Charities Act, 10 P.S. § 162.3, defines a "Contribution" in pertinent part as follows:

> The promise, grant or pledge of money . . . or other thing of any kind or value . . . in response to a solicitation, including the payment or promise to pay in consideration of a performance, event or sale of a good or service . . . .

90. Section 6(a)(2) of the Charities Act, 10 P.S. § 162.6(a)(2), exempts from the registration requirements of the Charities Act, "[h]ospitals which are subject to regulation by the Department of Health or the Department of Public Welfare and the hospital foundation, if any, ..."

91. Section 6(b) of the Charities Act, 10 P.S. § 162.6(b), provides however that, "[e]xemption from the registration requirements of this act shall in no way limit the applicability of other provisions of the act to a charitable organization . . . except that written notice under section 9(k) and 13(c) shall not apply."

92. Section 13(d) of the Charities Act, 10 P.S. §162.13(d), provides that, "[a] charitable organization may not misrepresent its purpose or nature or the purpose or beneficiary of a solicitation. A misrepresentation may be accomplished by words or conduct or failure to disclose a material fact."

93. In pertinent part, Section 15 of the Charities Act, 10 P.S. § 162.15, prohibits the following acts in the planning, conduct or execution of any solicitation or charitable sales promotion:

> (a) General rule. — Regardless of a person's intent or the lack of injury, the following acts and practices are prohibited in the planning, conduct or execution of any solicitation or charitable sales promotion:
>
> (1) Operating in violation of, or failing to comply with, ***any*** of the requirements of this act (emphasis added). . . .
>
> (2) Utilizing any unfair or deceptive acts or practices or engaging in any fraudulent conduct which creates a likelihood of confusion or of misunderstanding.
>
> . . .
>
> (5) Misrepresenting or misleading anyone in any manner to believe that . . . the proceeds of such solicitation or charitable sales promotion will be

used for charitable purposes when such is not the fact.

94. At all times relevant and material hereto, UPMC has represented to its contributors:

a. that UPMC provides hope during difficult illnesses and compassion for every patient;

b. that UPMC is deeply committed to the people who make up their communities and to making sure that ***everyone who comes through their doors has access to the very best, most advanced health care available;*** and

c. that UPMC makes sure that their patients benefit from every available medical innovation.

95. As evidenced by UPMC's IRS Form 990 filings covering its fiscal years ended June 30, 2006 through June 30, 2017, UPMC reported receiving public contributions and grants totaling $1,272,514,014.

96. UPMC's decisions to deny access to the public, including PMF, self-insured employers, others and Highmark's Community Blue members and forego future contracts with Highmark after June 30, 2019 contradict UPMC's prior representations to donors in violation of Sections 13 and 15 of the Charities Act, 10 P.S. §§ 162.13 and 162.15.

97. Section 19 of the Charities Act, 10 P.S. § 162.19(a) provides:

(a) General rule.—Whenever the Attorney General or any district attorney shall have reason to believe, or shall be advised by the secretary, that the person is operating in violation of the provisions of this act, the Attorney General or district attorney may bring an action in the name of the Commonwealth against such person who has violated this act, to enjoin such person from continuing such violation and for such other relief as the court deems appropriate. In any proceeding under this subsection, the court may make appropriate orders, including:

(1) the appointment of a master or receiver;

(2) the sequestration of assets;

(3) the reimbursement of persons from whom contributions have been unlawfully solicited;

(4) the distribution of contributions in accordance with the charitable purposes expressed in the registration statement or in accordance with the representations made to the person solicited;

(5) the reimbursement of the Commonwealth for attorneys' fees and the costs of investigation, including audit costs;

(6) the assessment of a civil penalty not exceeding $1,000 per violation of the act, which penalty shall be in addition to any other relief which may be granted; and

(7) the granting of other appropriate relief.

WHEREFORE, the Commonwealth respectfully requests that this Honorable Court:

a. Find UPMC to be in violation of the Charities Act, for engaging in acts prohibited by Section 15(a)(1), (2) and (5) of the Charities Act, 10 P.S. § 162.15(a)(1), (2), and (5);

b. Enjoin UPMC from conducting any further charitable solicitations in violation of the Charities Act;

c. Order UPMC to provide a full accounting of the contributions received since July 1, 2006;

d. Impose a civil penalty upon UPMC of One Thousand Dollars ($1,000) for each violation of the Charities Act;

e. Award the Commonwealth its costs of investigation, attorneys' fees, filing fees and costs of this action;

f. Limit UPMC's reimbursements for all Out-of-Network services to the reasonable value of its services which are no more than the UPMC's average In-Network rates; In-Network rates for this purpose meaning the average of all UPMC's In-Network reimbursements for each of its specific health care services, including but not limited to, reimbursement rates for government, commercial and its integrated health plan; and

g. Order any other relief the Court deems appropriate.

COUNT III

UPMC's Breach of its Fiduciary Duties of Loyalty and Care Owed to its Constituent Health Care Providers and Public-at-Large

98. Paragraphs 1 through 97 are incorporated as if fully set forth.

99. Section 5712 of the Nonprofit Corporation Law provides:

> Standard of care and justifiable reliance
>
> (a) Directors.--A director of a nonprofit corporation shall stand in a fiduciary relation to the corporation and shall perform his duties as a director, including his duties as a member of any committee of the board upon which he may serve, in good faith, in a manner he reasonably believes to be in the best interests of the corporation and with such care, including reasonable inquiry, skill and diligence, as a person of ordinary prudence would use under similar circumstances. In performing his duties, a director shall be entitled to rely in good faith on information, opinions, reports or statements, including financial statements and other financial data, in each case prepared or presented by any of the following:
>
> > (1) One or more officers or employees of the corporation whom the director reasonably believes to be reliable and competent in the matters presented.
> >
> > (2) Counsel, public accountants or other persons as to matters which the director reasonably believes to be within the professional or expert competence of such person.
> >
> > (3) A committee of the board upon which he does not serve, duly designated in accordance with law, as to matters within its designated

> authority, which committee the director reasonably believes to merit confidence.
>
> (b) Effect of actual knowledge.--A director shall not be considered to be acting in good faith if he has knowledge concerning the matter in question that would cause his reliance to be unwarranted.
>
> (c) Officers.--Except as otherwise provided in the bylaws, an officer shall perform his duties as an officer in good faith, in a manner he reasonably believes to be in the best interests of the corporation and with such care, including reasonable inquiry, skill and diligence, as a person of ordinary prudence would use under similar circumstances. A person who so performs his duties shall not be liable by reason of having been an officer of the corporation.

15 Pa.C.S. § 5712.

100. Section 5547(a) of the Nonprofit Corporation Law provides in pertinent part:

> (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. The board of directors or other body of the corporation shall, as trustees of such property, be held to the same degree of responsibility and accountability as if not incorporated, . .

15 Pa.C.S. § 5547(a).

101. Section 5547(b) of the Nonprofit Corporation Law provides that:

> (b) Nondiversion of certain property. -- Property committed to charitable purposes shall not . . . 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. 77 Subch. D (relating to creation, validity, modification and termination of trust) specifying the disposition of the property (footnote omitted).

15 Pa.C.S. § 5547(b).

102. Section 7781 of the Uniform Trust Act, provides in pertinent part:

(a) What constitutes breach of trust.--A violation by a trustee of a duty the trustee owes to a beneficiary is a breach of trust.

b) Remedies.--To remedy a breach of trust that has occurred or may occur, the court may order any appropriate relief, including the following:

(1) Compelling the trustee to perform the trustee's duties.

(2) Enjoining the trustee from committing a breach of trust.

(3) Compelling the trustee to redress a breach of trust by paying money, restoring property or other means.

(4) Ordering a trustee to file an account.

(5) Taking any action authorized by Chapter 43 (relating to temporary fiduciaries).

. . .

(7) Removing the trustee as provided in section 7766 (relating to removal of trustee - UTC 706).

(8) Reducing or denying compensation to the trustee.

> (9) Subject to section 7790.2 (relating to protection of person dealing with trustee - UTC 1012):
>
> (i) voiding an act of the trustee;
>
> (ii) imposing a lien or a constructive trust on trust property; or
>
> (iii) tracing trust property wrongfully disposed of and recovering the property or its proceeds. . . .

20 Pa.C.S. § 7781.

103. UPMC instituted a policy of not treating Highmark Community Blue members, even when those members were UPMC patients, Highmark had committed to paying UPMC, and UPMC had contractually committed to treating such patients.

104. UPMC Susquehanna closed one of its physician practices, the Susquehanna Health Medical Group, to the employees of PMF Industries because PMF lacked a hospital provider contract with UPMC Susquehanna for hospital-based services – UPMC Susquehanna took this action despite PMF Industries having contracted with the physician practice through another insurer and leaving PMF's employees with 30 days to find alternative physicians.

105. UPMC has further decided against extending or entering into any new contracts that would provide Highmark members with In-Network access to many

of UPMC's hospitals or physicians beyond June 30, 2019, even though such a decision will increase health care costs to consumers and employers throughout western Pennsylvania, especially when consumers require emergency care.

106. UPMC is also refusing to contract with Highmark for any of its non-commercial Medicare Advantage plans which will deny In-Network access to seniors who cannot change their insurance plan and may result in higher premium costs for seniors with a pre-existing medical condition.

107. The actions of UPMC are defeating the very purposes of the corporate charter under which UPMC was created, in that:

a. it denied medical care to Highmark's more than 30,000 Community Blue members as well as the employees of PMF Industries in spite of UPMC's stated purpose of providing an accessible health care system and its contractual commitments to serve those customers; and

b. its decision to forego future commercial contracts with Highmark after June 30, 2019 as well as Highmark's non-commercial Medicare Advantage plans will subject hundreds of thousands of Highmark insurance members to UPMC's higher Out-of-Network charges for emergency care and further operate to reduce UPMC's accessibility

by discriminating against patients based upon their source of payment and making UPMC's health care services cost-prohibitive.

108. The discriminatory policies pursued by UPMC are:

a. in breach of its stated charitable purposes and inherent contractual obligations owed to the Commonwealth under UPMC's corporate charter;

b. in breach of its fiduciary duties and stated charitable purposes to further the charitable missions of its constituent subsidiary hospitals as their sole controlling member;

c. inapposite to the public's interest in having access to high quality, affordable health care;

d. in callous disregard of the treatment disruptions and increased costs suffered by its patients;

e. in disregard of the substantial public subsidies and donations UPMC has enjoyed throughout its existence from the general public; and

f. a clear and misguided effort to pursue commercial policies and objectives designed to increase UPMC's revenue and

market shares at the public's expense and its stated charitable purposes.

109. The actions complained of are causing widespread confusion among the public and personal hardships for many individual UPMC patients. UPMC's exorbitant executive salaries and perquisites in the form of corporate jets and prestigious office space waste and divert charitable assets. Moreover, UPMC's misleading promotional campaigns and unnecessary litigation damage UPMC's goodwill and reputation which were earned through public tax and charitable donation support.

110. Absent the intervention of this Court, nothing will prevent UPMC from refusing to contract with any other health care insurer in the future such that only subscribers to the UPMC Health Plan will have In-Network access to UPMC's providers, further limiting In-Network access to UPMC's providers and increasing the public's overall costs of health care.

WHEREFORE, the Commonwealth respectfully requests that this Honorable Court:

a. Find that UPMC is failing to operate in compliance with its stated charitable purposes of providing the public with high quality, cost-effective and accessible health care;

b. Find that UPMC is in breach of its fiduciary duties and stated charitable purpose of furthering the charitable missions of its constituent subsidiary hospitals as their sole controlling member;

c. Find that UPMC is failing to ensure that its advertising and promotional materials are truthful and not misleading;

d. Find that UPMC is failing to comply with the representations made to donors in its solicitations for donations;

e. Enjoin UPMC from denying access or treatment to any patient based upon the source of the patient's payment or the identity of their health care insurer;

f. Modify the terms of UPMC's Consent Decree as proposed in Count I or, alternatively, limit UPMC's reimbursements for all Out-of-Network services to the reasonable value of its services which are no more than the average of UPMC's In-Network rates; In-Network rates for this purpose meaning the average of all of UPMC's In-Network reimbursement rates for each of its specific health care services provided, including, but not limited to, reimbursement rates for government, commercial and their integrated health plan;

g. Order UPMC to reimburse Highmark members for any Out-of-Network costs and expenses suffered as a result of the actions complained of;

h. Order UPMC to substantiate the reasonableness of:

A) UPMC's executive staff compensation;

B) the expenditures on its chartered and/or corporate jets;

C) the costs of UPMC's expansive building and expansions plans; and

D) the costs of its public advertising, promotions, advocacy campaigns and litigation fees to support its unlawful activities;

i. Make structural changes to the Board of Directors and Executive Management of UPMC; and

j. Order any other relief this Court deems appropriate.

COUNT IV

UPMC'S Violations of the Unfair Trade Practices and Consumer Protection Law (Consumer Protection Law)

111. Paragraphs 1 through 110 are incorporated as fully set forth.

112. 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 73 P.S. §§ 201-1, *et seq.*

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

114. 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 unlawful by Section 3 of the Consumer Protection Law, 73 P.S. §201-3.

115. 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 . . . ."

116. 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).

117. UPMC has presented conflicting messages to the public generally, and to its patients in particular, that it will treat all patients regardless of their source of payment, but it has refused treatment to its patients with Highmark insurance and will no longer contract with Highmark for any of its commercial or Medicare Advantage insurance products after June 30, 2019 which will significantly increase the costs of care for all of Highmark's subscribers. For example:

a. University of Pittsburgh and Penn State retirees received letters in late summer 2018 that as of January 1, 2019 UPMC would no longer accept Highmark plans – Security Blue, Freedom Blue, Signature 65 (supplemental), despite the fact that retirees will have access through June 30, 2019 under the Consent Decrees.

b. UPMC also sent mailers that omitted Gateway as having In-Network access to UPMC. This created confusion for Gateway members and Gateway received several calls from members

during open enrollment. Gateway serves a very vulnerable population of Medicare and Medicaid dual eligible beneficiaries.

118. UPMC previously created confusion and misunderstanding as to its affiliation, connection, or association with Highmark and its Community Blue insurance plan by representing that it would treat Community Blue members pursuant to the Mediated Agreement and 2012 Agreement, only to repudiate those agreements months later:

a. The Mediated Agreement and 2012 Agreement required UPMC to provide in-network access to all UPMC hospitals and physicians for Highmark Commercial and Medicare Advantage members through December 31, 2014.

b. Furthermore, the 2012 Agreement which was to be read together and harmonized with the Mediated Agreement, provided a mechanism by which Community Blue members could receive care at all UPMC hospitals and that care would be paid for by Highmark at rates UPMC agreed to accept.

c. In spite of its contractual agreements, UPMC denied Highmark Community Blue subscribers access to its

facilities and providers even when patients offered to self-pay without accessing their health insurance.

119. More recently as alleged:

a. UPMC Susquehanna unilaterally closed its physician practice, the Susquehanna Health Medical Group, to a local employer due to the local employer's lack of a hospital provider contract with UPMC Susquehanna, even though the employer had a contract with the Susquehanna Medical Group and even though most visits to a doctor do not result in a hospital stay.

b. The UPMC Health Plan distributed a promotional flyer to local employers within UPMC Susquehanna's service area that offered the opportunity to lock-in single digit premium increases through 2020, while, at the very same time, reserving UPMC's right to unilaterally terminate the program at any time.

c. UPMC is refusing to contract with Highmark regarding its Medicare Advantage products despite its prior representations to the Commonwealth and the public that

seniors would never be affected by its commercial contractual disputes with Highmark.

120. UPMC created public confusion regarding the loss of In-Network access for seniors prior to the expiration of UPMC's Consent Decree when it publicly announced its termination of its Highmark Medicare Advantage contracts on September 26, 2017 effective December 31, 2018, when UPMC knew or should have known its actions:

a. violated this Court's May 29, 2015 Order requiring the Court's pre-approval of such termination,

b. was merely speculating as to the consequences for seniors who remained subscribers to Highmark's Medicare Advantage plans when this Court had yet to approve UPMC's contract terminations, and

c. disparaged Highmark's Medicare Advantage plans as lacking In-Network access to UPMC's health care providers when UPMC knew its Consent Decree requires that it remain in contract with Highmark through

June 30, 2019 and its premature termination

lacked this Court's pre-approval.[22]

121. Most recently, UPMC's refusal to contract with Highmark's Medicare Advantage products at the expiration of its Consent Decree resulted in 15,000 more seniors than usual contacting the Apprise program in Allegheny County expressing confusion and seeking guidance on the best options available to them during the last Medicare enrollment period that ran from October 15, 2018, to December 7, 2018. Despite UPMC's participation in the Apprise program conducted on October 11, 2018, even UPMC was unable to offer clear guidance in responding to the many questions it received from the audience comprised of insurance brokers, advocates, trainees and seniors.

122. UPMC's conduct more fully described herein is, accordingly, proscribed and unlawful pursuant to Section 3 of the Consumer Protection Law.

123. The aforesaid methods, acts or practices constitute unfair or deceptive acts or practices within the meaning of Section 2(4) of the Consumer Protection Law, including, but not limited to:

---

[22] UPMC's subsequent terminations of those same Highmark Medicare Advantage contracts in January of 2018 to be effective December 31, 2018 were determined by the Supreme Court to comply with the terms of the Consent Decrees in light of the six-month run out period within those contracts which continued In-Network access through June 30, 2019. See the Supreme Court's July 18, 2018 Opinion. The issue of the modifications requested herein, however, has never been presented to nor addressed by either this or the Supreme Court.

(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).

124. The above described conduct has been willful within the meaning of Section 8(b) of the Consumer Protection Law.

125. The Commonwealth believes that the public interest is served by seeking a permanent injunction from this Honorable Court to restrain methods, acts and practices described herein, as well as provide restitution for Pennsylvania

consumers and civil penalties for violations of the law. The Commonwealth believes that citizens of the Commonwealth are suffering and will continue to suffer harm unless the methods, acts or practices complained of herein are permanently enjoined.

WHEREFORE, the Commonwealth respectfully requests that as an additional alternative to the relief requested under Count I, 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 willfully engaged in unfair, fraudulent, or deceptive acts or practices in violation of Section 201-3 of the Consumer Protection Law by creating the likelihood of consumer confusion or misunderstanding as to its affiliation, connection, or association with Highmark and Highmark's Community Blue health insurance product, as alleged;

c. Find that UPMC willfully engaged in unfair, fraudulent, or deceptive acts or practices in violation of Section 201-3 of the Consumer Protection Law by unilaterally closing

its Susquehanna Health Medical Group to a local employer because the employer lacked a provider contract with UPMC Susquehanna, as alleged;

d. Find that UPMC willfully engaged in unfair, fraudulent, or deceptive acts or practices in violation of Section 201-3 of the Consumer Protection Law by creating the likelihood of consumer confusion or misunderstanding as to its affiliation, connection, or association with Highmark and Highmark's non-commercial Medicare Advantage health insurance products, as alleged;

e. Enjoin UPMC, its agents, representatives, servants, employees, successors, and assigns pursuant to Section 201-4 of the Consumer Protection Law, from directly or indirectly engaging in the aforementioned acts, practices, methods of competition, or any other practice that violates the Consumer Protection Law;

f. Enjoin UPMC from denying access and treatment to Highmark subscribers generally and Community Blue and Medicare Advantage members specifically;

g. Determine pursuant to Section 201-4.1 the amount of restitution due to consumers who suffered losses as a result of UPMC's unlawful acts and practices as alleged and any other acts or practices which violate the Consumer Protection Law and order UPMC to pay restitution to the affected consumers;

h. Determine the amount of civil penalties, pursuant to Section 201-8(b) of the Consumer Protection Law, which are assessable up to $1,000.00 for each and every violation of the Consumer Protection Law and up to $3,000.00 for each violation involving a victim aged sixty (60) or older and order UPMC to pay those civil penalties to the Commonwealth;

i. Award the Commonwealth its costs of investigation and attorneys' fees pursuant to Section 201-4.1, for this action; and

j. Order any other relief the Court deems appropriate.

Respectfully submitted,
COMONWEALTH OF PENNSYLVANIA,
JOSH SHAPIRO,
Attorney General,

By: /s/ James A. Donahue, III
James A. Donahue, III
Executive Deputy Attorney General
Public Protection Division
PA. ID. 42624

Mark A. Pacella
Chief Deputy Attorney General
Charitable Trusts and Organizations Section
PA. ID. 42214

Tracy W. Wertz
Chief Deputy Attorney General
Antitrust Section
PA. ID. 69164

14th Fl., Strawberry Square
Harrisburg, PA 17120
717.787.4530

Date: February 7, 2019

CERTIFICATE OF COMPLIANCE

I certify that this filing complies with the provision of the *Public Access Policy of the Unified Judicial System of Pennsylvania Case Records of the Appellate and Trial Courts* that require filing confidential information and documents differently from non-confidential information.

/s/ James A. Donahue, III
James A. Donahue, III
Executive Deputy Attorney General
Public Protection Division

February 7, 2019

CERTIFICATE OF SERVICE

I hereby certify that I am this 7th day of February, 2019, serving a true and correct copy of the foregoing ***Commonwealth's Petition to Modify Consent Decrees with exhibits*** on all parties via electronic mail as indicated below:

Stephen A. Cozen, Esquire
COZEN O"CONNOR
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(Counsel for UPMC)

Leon F. DeJulius, Jr., Esquire
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/s/ James A. Donahue, III
James A. Donahue, III
Executive Deputy Attorney General
Public Protection Division

EXHIBIT

A

UPMC's AMENDED AND RESTATED ARTICLES OF INCORPORATION

4126477852 10:37:36 a Date Filed: 07/27/2011
Carol Aichele
Secretary of the Commonwealth

PENNSYLVANIA DEPARTMENT OF STATE
CORPORATION BUREAU

Articles of Amendment-Domestic Corporation
(15 Pa.C.S.)

☐ Business Corporation (§ 1915)
☑ Nonprofit Corporation (§ 5915)

Name
Scott Kundrick, Paralegal, UPMC Corporate Legal Department

Address
600 Grant Street, U.S. Steel Tower, 57th Floor

City | State | Zip Code
Pittsburgh | Pennsylvania | 15219

Document will be returned to the name and address you enter to the left.

Fee: $70

In compliance with the requirements of the applicable provisions (relating to articles of amendment), the undersigned, desiring to amend its articles, hereby states that:

1. The name of the corporation is:
UPMC

2. The (a) address of this corporation's current registered office in this Commonwealth or (b) name of its commercial registered office provider and the county of venue is (the Department is hereby authorized to correct the following information to conform to the records of the Department):

(a) Number and Street | City | State | Zip | County
200 Lothrop Street | Pittsburgh | Pennsylvania | 15213 | Allegheny

(b) Name of Commercial Registered Office Provider | County
c/o

3. The statute by or under which it was incorporated: Non-Profit Law of 1972

4. The date of its incorporation: June 10, 1982

5. *Check, and if appropriate complete, one of the following:*

☑ The amendment shall be effective upon filing these Articles of Amendment in the Department of State.

☐ The amendment shall be effective on: _____ (Date) at _____ (Hour)

Commonwealth of Pennsylvania
ARTICLES OF AMENDMENT-NONPROFIT 9 Page(s)

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DEPT. OF STATE

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DSCB:15-1915/5915-2

6. *Check one of the following:*

☐ The amendment was adopted by the shareholders or members pursuant to 15 Pa.C.S. § 1914(a) and (b) or § 5914(a).

☑ The amendment was adopted by the board of directors pursuant to 15 Pa. C.S. § 1914(c) or § 5914(b).

7. *Check, and if appropriate, complete one of the following:*

☐ The amendment adopted by the corporation, set forth in full, is as follows

☑ The amendment adopted by the corporation is set forth in full in Exhibit A attached hereto and made a part hereof.

8. *Check if the amendment restates the Articles:*

☑ The restated Articles of Incorporation supersede the original articles and all amendments thereto.

IN TESTIMONY WHEREOF, the undersigned corporation has caused these Articles of Amendment to be signed by a duly authorized officer thereof this

27th day of July

2011

UPMC

Name of Corporation

Signature

Secretary

Title

EXHIBIT A

AMENDED AND RESTATED ARTICLES OF INCORPORATION UPMC

In compliance with the requirements of the Pennsylvania Nonprofit Corporation Law of 1988, UPMC, a Pennsylvania nonprofit corporation, hereby amends and restates its Articles of Incorporation as follows, which restated articles supersede the original articles and all amendments thereto:

1. The name of the Corporation is UPMC.

2. The location and post office address of the registered office of the Corporation in this Commonwealth is 200 Lothrop Street, Pittsburgh, Pennsylvania 15213.

3. The Corporation is incorporated under the Nonprofit Corporation Law of the Commonwealth of Pennsylvania for the following purpose or purposes: to engage in the development of human and physical resources and organizations appropriate to support the advancement of patient care through clinical and technological innovation, research and education, such activities occurring in the regional, national and international medical communities. The Corporation is organized and will be operated exclusively for charitable, educational and scientific purposes within the meaning of Section 501(c) (3) of the Internal Revenue Code of 1986, as amended (the "Code") by operating for the benefit of, to perform the functions of and to carry out the purposes of the University of Pittsburgh of the Commonwealth System of Higher Education ("University of Pittsburgh"), UPMC Presbyterian Shadyside, and other hospitals, health care organizations and health care systems which are 1) described in Sections 501(c) (3) and 509(a)(1), (2) or (3), 2) are affiliated with the Corporation, University of Pittsburgh and UPMC Presbyterian Shadyside in developing a high quality, cost effective and accessible health care system in advancing medical education and research, and 3) which will have the Corporation serving as their sole member or shareholder. Further, the Corporation provides governance and supervision to a system which consists of a number of subsidiary corporations, including, among others, both tertiary and community hospitals. The Corporation shall guide, direct, develop and support such activities as may be related to the aforedescribed purposes, as well as to the construction, purchase, ownership, maintenance, operation and leasing of one or more hospitals and related service facilities. Solely for the above purposes, and without otherwise limiting its power, the Corporation is empowered to exercise all rights and powers conferred by the laws of the Commonwealth of Pennsylvania upon not-for-profit corporations. The Corporation does not contemplate pecuniary gain for profit, incidental or otherwise.

4. The term for which the Corporation is to exist is perpetual.

5. The Corporation is organized upon a nonstock basis and shall have no members.

6. The business, property and affairs of the Corporation shall be managed and controlled by its Board of Directors, which shall have the authority to make the bylaws of the Corporation which shall prescribe the authorized number and qualifications of its directors, the names and time of election of directors and the term of office thereof, and the power to amend all or any part of the bylaws or the articles of incorporation.

7. The Corporation shall not conduct or carry on any activities not permitted to be conducted or carried on by an organization exempt under Section 501(c)(3) of the Code, or by an organization contributions to which are deductible under Section 170(c)(2) of the Code. No substantial part of the activities of the Corporation shall be devoted to attempting to influence legislation, by propaganda or otherwise, nor shall the Corporation participate in or intervene in (including the publication or distribution of statements) any political campaign on behalf of any candidate for public office.

8. No part of the net earnings of the Corporation shall inure to the benefit of any private person; provided, however, the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make such lawful payments and distributions in furtherance of the purposes set forth in Article 3 hereof, as may from time to time be either required or permitted by Section 501(c)(3) of the Code.

9. The Corporation shall not merge or consolidate with any corporation which is not exempt from federal income taxation under Section 501(a) of the Code, as an organization described in Section 501(c)(3) of the Code (an "exempt organization").

10. In the event the Corporation is dissolved and liquidated, the Board of Directors, after paying or making provisions of all of the liabilities of the Corporation, shall distribute the corporate property and assets to one or more organizations which further charitable purposes within the meaning of Section 501(c)(3) of the Code as, in the judgment of this Corporation's Board of Directors, have purposes most closely allied to those of this Corporation.

11. References in these Articles to a section of the Internal Revenue Code of 1986 shall be construed to refer both to such section and to the regulations promulgated thereunder, as they now exist or may hereafter be adopted or amended in this or in subsequent internal revenue laws.

12. No Director or Officer of the Corporation will be personally liable for monetary damages as such for any action taken or any failure to take action, unless:

a. the Director or Officer has breached or failed to perform the duties of his office in good faith, in a manner he reasonably believes to be in the best interest of Corporation, and with such care, including reasonable inquiry, skill and diligence, as a person of ordinary prudence would use under similar circumstances; and

b. the breach or failure to perform constitutes self-dealing, willful misconduct or recklessness.

The provision of this Article 12 shall not apply to:

a. the responsibility or liability of a Director or Officer pursuance to any criminal statute; or

b. the liability of a Director Officer for the payment of taxes pursuant to local, state or federal law.

RECEIVED TIME JUL. 27. 10:41AM

EXHIBIT

B

UPMC's CONSENT DECREE

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

2014 JUN 27 A 10:18

MOTION TO APPROVE CONSENT DECREE WITH RESPONDENT UPMC

1. The Commonwealth of Pennsylvania acting through its Attorney General, Kathleen G. Kane, its Insurance Commissioner, Michael F. Consedine, and its Secretary of Health, Michael Wolf (Petitioners), initiated an action by filing a Petition for Review on June 27, 2014, against the Respondent UPMC, the allegations of which are incorporated herein by reference.

2. The Petitioners and Respondent, UPMC, have resolved the allegations in the Petition for Review subject to this Court's approval of the terms and conditions contained in the proposed Consent Decree attached.

WHEREFORE, Petitioners respectfully request that this Honorable Court approve the proposed Consent Decree.

Respectfully submitted

COMMONWEALTH OF PENNSYLVANIA

KATHLEEN G. KANE
Attorney General

Date: 6/27/2014 By: _____

James A. Donahue, III
Executive Deputy Attorney General
Public Protection Division
Attorney I.D. No.: 42624
14th Floor Strawberry Square,
Harrisburg, PA 17120
(717) 787-4530

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. _____ M.D. 2014

CONSENT DECREE

AND NOW, this _____ day of _____, 2014, upon the Motion to Approve Consent Decree with Respondent UPMC filed by the Commonwealth of Pennsylvania, acting through its Attorney General, Kathleen G. Kane, its Insurance Commissioner, Michael F. Consedine, and its Secretary of Health, Michael Wolf (Commonwealth or Petitioner), which initiated an action by filing a Petition for Review (Petition) on June 26, 2014, the allegations of which are incorporated herein by reference.

SETTLEMENT TERMS

NOW THEREFORE, for good and valuable consideration, Respondent, UPMC agrees for itself, its successors, assigns, agents, employees, representatives, executors, administrators, personal representatives, heirs and all other persons acting on their behalf, directly or through any corporate or other device, as follows:

I. INTERPRETATIVE PRINCIPLES

A. The Court's 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), and the 2012 Mediated Agreement and to protect consumers and UPMC'S charitable mission. The outcome of the actions embodied in the Consent Decree shall be incorporated in the Transition Plan to be filed by Highmark by July 31, 2014, as provided under Condition 22 of the UPE order. The Consent Decree is not a contract extension and shall not be characterized as such.

II. DEFINITIONS

A. "Balance Billing" means when a Health Care Provider bills or otherwise attempts to recover the difference between the provider's charge and the amount paid by a patient's insurer and through member cost-shares.

B. "Children's Final Order" means the Final Order in the matter of *In Re: Children's Hospital of Pittsburgh and Children's Hospital of Pittsburgh Foundation*, No. 6425 of 2001 (All. Co. 2001).

C. "Emergency Services/ER Services" means medical services provided in a hospital emergency department in response to the sudden onset of a medical condition requiring intervention to sustain the life of a person or to prevent damage to a person's health and which the recipient secures immediately after the onset or as soon thereafter as the care can be made available, but in no case later than 72 hours after the onset.

D. "Greater Pittsburgh Area" means the counties of Allegheny, Beaver, Butler, Washington and Westmoreland.

E. "Health Plan" means all types of organized health-service purchasing programs, including, but not limited to, health insurance or managed-care plans, offered by government, for-profit or non-profit third-party payors, health care providers or any other entity.

F. "Health Care Provider" means hospitals, skilled nursing facilities, ambulatory surgery centers, laboratories, physicians, physician networks and other health care professionals and health care facilities.

G. "Highmark" means Highmark, Inc., the domestic nonprofit corporation incorporated on December 6, 1996, with a registered office at Fifth Avenue Place, 120 Fifth Avenue, 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.

H. "Hospital" means a health care facility, licensed as a hospital, having a duly organized governing body with overall administrative and professional responsibility and an organized professional staff that provides 24-hour inpatient care, that may also provide outpatient services, and that has, as a primary function, the provision of inpatient services for medical diagnosis, treatment and care of physically injured or sick persons with short-term or episodic health problems or infirmities.

I. "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.

J. "Mediated Agreement" means the Mediated Agreement entered into by UPMC and Highmark on May 1, 2012, with assistance of a mediator appointed by the Governor and all agreements implementing the Mediated Agreement.

K. "Out-of-Network" means where a Health Care Provider has not contracted with a Health Plan for reimbursement for treatment of the Health Plan's members.

L. "Payor Contract" means a contract between a Health Care Provider and a Health Plan for reimbursement for the Health Care Provider's treatment of the Health Plan's members.

M. "Trauma" means medical services that are provided to an individual with a severe, life threatening injury which is likely to produce mortality or permanent disability and which are provided at the designated Trauma Center in a facility that provides specialized medical services and resources to patients suffering from traumatic, serious or critical bodily injuries and which is accredited by the Pennsylvania Trauma Systems Foundation and services needed for appropriate continuity of care.

N. "UPE", also known as Highmark Health, means the entity incorporated on October 20, 2011, on a non-stook, non-membership basis, with its registered office located at Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, Pennsylvania 15222. UPE serves as the controlling member of Highmark.

O. "UPE Order" means the Pennsylvania Insurance Department's April 29, 2013 Approving Determination and Order of the Highmark/West Penn Allegheny Health System Affiliation, *In Re Application of UPE*, No. ID-RC-13-06 (Pa. Insur. Dept. 2013).

P. "UPMC" means the non-profit, tax-exempt corporation organized under the laws of the Commonwealth of Pennsylvania having its principal address at: 200 Lothrop Street, Pittsburgh, PA 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.

Q. "UPMC Health Plan" means the Health Plan owned by UPMC which is licensed by the Pennsylvania Department of Insurance.

R. "UPMC Hospitals" means the Hospitals operated by the following UPMC subsidiaries: UPMC Presbyterian-Shadyside, Children's Hospital of Pittsburgh of UPMC, Magee Women's Hospital of UPMC, UPMC McKeesport, UPMC Passavant, UPMC St. Margaret, UPMC Bedford Memorial, UPMC Horizon, UPMC Northwest, UPMC Mercy, UPMC East, UPMC Hamot, UPMC Hamot, affiliate - Kane Community Hospital, UPMC Altoona, Western Psychiatric Institute and Clinic of UPMC and any other Hospital acquired by UPMC following the entry of the Court's Consent Decree.

S. "Western Pennsylvania" means the 29-county area designated by the Blue Cross Blue Shield Association in which Highmark does business as Highmark Blue Cross Blue Shield.

IV. TERMS

UPMC shall comply with the following terms:

A. **Access**

1. **ER/Trauma Services** - UPMC shall negotiate in good faith to reach an agreement with Highmark on In-Network rates and patient transfer protocols for emergency and trauma services for hospital, physician and appropriate continuity of care services at all UPMC and Allegheny Health Network hospitals by July 15, 2014 or be subject to the Dispute Resolution Process set forth in paragraph C (1) below. This does not mean that Hospitals or physicians rendering emergency or trauma services to a patient are In-Network for purposes or services other than treating the emergency condition for which a patient is admitted or the treating physicians are otherwise In-Network under other terms of this Consent Decree including, but not limited to, the Continuity of Care, Unique/Exception Hospitals or Oncology. The agreement shall be for a commercially reasonable period of time as provided in Condition 3 of the UPE Order. UPMC shall not Balance Bill consumers until the ER services agreement is resolved.

2. **Vulnerable Populations** – UPMC and Highmark mutually agree that vulnerable populations include: (i) consumers age 65 or older who are eligible or covered by Medicare, Medicare Advantage, (ii) Medigap health plans, (iii) Medicaid and/or (iv) CHIP. With respect to Highmark's covered vulnerable populations, UPMC shall continue to contract with Highmark at in-network rates for all of its hospital, physician and appropriate continuity of care services for CHIP, Highmark Signature 65, Medigap and commercial retiree carve out as long as Highmark

does not make unilateral material changes to these programs. UPMC shall treat all Medicare participating consumers as In- Network regardless of whether they have Medicare as their primary or secondary insurance. UPMC reserves the right to withdraw from these arrangements if Highmark should take the position that it has the authority to revise the rates and fees payable under those arrangements unilaterally and materially.

3. **Local Community Needs** – Where UPMC is the provider of services provided locally that the patient's treating physician believes the patient needs and DOH has determined such services are not available from another source, and member is Out-of-Network, UPMC will not Balance Bill the member, and UPMC and Highmark shall negotiate a payment that shall not be greater than the Out-of-Network rates established by this Consent Decree.

4. **Oncology/Cancer Services**– Highmark subscribers may access, as if In-Network, UPMC services, providers, facilities, and physicians involved in the treatment of cancer, if a patient's treating physician determines that a patient who is diagnosed with cancer should be treated by a UPMC oncologist and the patient agrees to be so treated. In addition, UPMC and Highmark shall negotiate an agreement for treatment of illnesses which result from cancer treatment. These resulting illnesses may include, but not be limited to, mental health, endocrinology, orthopedics and cardiology. The need for a treatment of a resulting illness shall be determined, in the first instance, by the patient's treating physician acting in consultation with and in accordance with the wishes of the patient or the patient's representative. Moreover, all UPMC joint ventures and physician services

provided at or on behalf of independent hospitals, whether related to oncology or not, shall be In-Network. If UPMC and Highmark do not reach an agreement on rates for cancer treatment and resulting illnesses by July 15, 2014, the parties will be subject to the Dispute Resolution Process set forth in paragraph C(1) below. UPMC shall not Balance Bill consumers until this agreement is resolved. The agreement shall be for a commercially reasonable period of time as provided in Condition 3 of the UPE Order.

5. **Unique/Exception Hospitals and Physicians** – UPMC shall negotiate in good faith to reach an agreement with Highmark for hospital, physician services and follow-up care services at Western Psychiatric Institute and Clinic, UPMC Bedford Memorial, UPMC Venango (Northwest), UPMC/Hamot, UPMC/Altoona, UPMC Horizon and any facility, any physician services, or any other provider services located or delivered outside the Greater Pittsburgh Area currently owned or acquired in the future by UPMC, or with whom UPMC has an agreement to handle provider contracting, such as, but not limited to, the Kane Community Hospital, or any other physician services or facility outside the Greater Pittsburgh Area determined by DOH to be essential to meet local community needs, by July 15, 2014 or be subject to the Dispute Resolution Process set forth in paragraph C (1) below. The agreement shall be for a commercially reasonable period of time as provided in Condition 3 of the UPE order. The Children's Final Order will continue in effect.

6. **Out-of-Network Services** – For all other Highmark subscribers whose care is not otherwise governed by other provisions in this Consent Decree, beginning

January 1, 2015, UPMC will provide services to all such subscribers on an Out-of-Network basis. UPMC's reimbursement rates for Out-of-Network services for Highmark subscribers shall be no more than 60% of charges if paid promptly and provided that UPMC informs consumers of such charges before rendering services.

7. **Continuity of Care** – UPMC and Highmark mutually agree that the continuation of care of a Highmark member in the midst of a course of treatment at UPMC shall be on an In-Network basis at In-Network rates. The need for a continuing course of treatment shall be determined, in the first instance, by the patient's treating physician acting in consultation with and in accordance with the wishes of the patient or the patient's representative. While undergoing a continuing course of treatment with UPMC, the services covered In-Network will include all services reasonably related to that treatment, including, but not limited to, testing and follow-up care. In the event that Highmark disputes the opinion of the treating physician that a continuation of care is medically appropriate, or disputes the scope of that care, the DOH or its designated representative will review the matter and make a final, non-appealable determination.

8. **Transfer of Services** – If any services covered by this Consent Decree are transferred or consolidated at one or more UPMC Hospitals, the terms of this Consent Decree shall apply to those transferred services where such services are transferred or consolidated.

9. **Referrals and UPMC Transfer of Patients** - (a) UPMC shall not require its physicians to refer patients to a UPMC Hospital in situations where the patient is

covered by a Health Plan that does not participate with such UPMC Hospital or otherwise expresses a preference to be referred to a non-UPMC Hospital; (b) UPMC shall not refuse to transfer a patient, whether for diagnosis or treatment, to a non-UPMC Hospital or health care provider if such transfer is requested by the patient, the patient's representative when such representative is authorized to make care decisions for the patient, or the patient's physician; provided the patient is stable and that the transfer is medically appropriate and legally permissible; (c) When a patient is in need of transfer and is covered by a Health Plan with which the UPMC Hospital does not contract, UPMC shall transfer the patient to the Health Plan's participating non-UPMC facility (provided the patient is stable and that the transfer is medically appropriate and legally permissible) unless, (i) the patient or the patient's representative expresses a contrary preference after having been informed of the financial consequences of such a decision, or (ii) is otherwise approved by the patient's Health Plan.

10. **Safety Net** – UPMC and Highmark mutually agree to establish a one-year safety net beginning January 1, 2015, for any existing UPMC patient and Highmark subscriber (i) who used UPMC physicians and services In-Network during the 2014 calendar year, (ii) who is not in a continuing course of treatment, and (iii) who is unable to find alternative physicians and services in their locality during the one year period. UPMC and Highmark shall hold such consumers harmless if they continue to use such physicians and services prior to January 1, 2016. Rates for the safety net period shall be as set forth under the Dispute Resolution Process

set forth in paragraph C(1) below. The safety net is not a contract extension, and neither Highmark nor UPMC nor their agents shall characterize it as such.

11. **Advertising** – UPMC shall not engage in any public advertising that is unclear or misleading in fact or by implication.

B. **Monetary Terms**

Consumer Education Fund and Costs – UPMC shall contribute $2 million dollars to the Consumer Education Fund to be used by the OAG, PID or DOH for education and outreach purposes during the transition; and to cover costs, including attorneys' or consultant fees of the OAG, PID and DOH within 60 days of the entry of this Consent Decree.

C. **Miscellaneous Terms**

1. **Dispute Resolution Process -** Where required in this Consent Decree, UPMC and Highmark shall negotiate in good faith. If the parties are unable to reach agreement on any of the issues raised in this Consent Decree by July 15, 2014, or such other date as may be set by OAG, PID and DOH, then the terms or rates shall be subject to the following:

   a. Rates

      i. For the period, January 1, 2015 to December 31, 2015, rates for all In-Network services covered in this Consent Decree, except for those rates currently being arbitrated by UPMC and Highmark, shall revert to the last mutually agreed upon rates or fees by UPMC and Highmark with the applicable medical market basket index (MBI) increase applied January 1, 2015.

ii. For rates currently being arbitrated, in the event that the current arbitration between UPMC and Highmark finds in favor of UPMC, then the rates and fees under the Consent Decree will revert to the rates in effect before April 1, 2014 as of the date of the arbitral award and shall remain in place through December 31, 2015. If as a consequence of the arbitral award, Highmark owes UPMC for underpayments, Highmark shall pay UPMC appropriate interest. If as a consequence of the arbitral award, UPMC owes Highmark for overpayments, UPMC shall pay Highmark appropriate interest. If an arbitral award is not decided before January 1, 2015, Highmark shall increase its payments by one-half the difference between Highmark's April 1, 2014schedule and its rate schedule in effect before April 1, 2014 for the period January 1, 2015 to December 31, 2015.

iii. For the period beginning January 1, 2016 to the expiration of the Consent Decree or the expiration of any agreements between UPMC and Highmark for all In-Network services, whichever is later, the rates shall be the rates mutually agreed to by Highmark and UPMC, or UPMC and Highmark shall engage in a single last best offer binding arbitration to resolve any dispute as to rates after December 31, 2015 as set forth in paragraph C (2) below.

iv. Any agreement or award as to rates and fees will be binding on both UPMC and Highmark, meaning that each will bill and make payments consistent with the agreement or award.

b. Non-Rate Term – Disputed terms set forth in this Consent Decree and unrelated to rate and reimbursement shall be subject to mediation before the OAG, PID and DOH. If mediation does not result in resolution within 30 days or such other time set by the OAG, PID and DOH, UPMC and Highmark shall engage in binding arbitration to resolve the dispute as to terms as set forth in Paragraph C (2) below.

2. **Binding Arbitration**

a. The Parties will file a joint plan with this court for a single last best offer binding arbitration before independent and neutral parties by August 14, 2014 or seek court intervention to resolve any disputes over such process.

3. **Binding on Successors and Assigns** – The terms of this Consent Decree are binding on UPMC, its directors, officers, managers, employees (in their respective capacities as such) and to its successors and assigns, including, but not limited to, any person or entity to whom UPMC may be sold, leased or otherwise transferred, during the term of the Consent Decree. UPMC shall not permit any substantial part of UPMC to be acquired by any other entity unless that entity agrees in writing to be bound by the provisions of this Consent Decree.

4. **Enforcement** - The OAG, PID and DOH shall have exclusive jurisdiction to enforce the Consent Decree. If the OAG, PID or DOH believe that a violation of the Final Decree has taken place, they shall so advise UPMC and give UPMC 20 days to cure the violation. If after that time the violation is not cured, the OAG, PID or DOH may seek enforcement of the Consent Decree in the Commonwealth Court. Any person who believes they have been aggrieved by a violation of this

Consent Decree may file a complaint with the OAG, PID or DOH for review. If after that review, the OAG, PID or DOH believes either a violation of the Final Decree has occurred or they need additional information to evaluate the complaint, the complaint shall be forwarded to UPMC for a response within 30 days. If after receiving the response, the OAG, PID or DOH, believe a violation of the Consent Decree has occurred, they shall so advise UPMC and give UPMC twenty (20) days to cure the violation. If after that time the violation is not cured, the OAG, PID or DOH may seek enforcement of the Final Decree in this Court. If the complaint involves a patient in an ongoing course of treatment who must have the complaint resolved in a shorter period, the OAG, PID or DOH may require responses within periods consistent with appropriate patient care.

5. **Release** –This Consent Decree will release any and all claims the OAG, 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. Any other claims, including but not limited violations of the crimes code, Medicaid fraud laws or tax laws are not released.

6. **Compliance with Other Laws** - The Parties agree that the terms and agreements encompassed within this 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.

7. **Notices** – All notices required by this Consent Decree shall be sent by certified or registered mail, return receipt requested, postage prepaid or by hand deliver to:

If to the Attorney General:

Executive Deputy Attorney General
Public Protection Division
Office of Attorney General
14th Floor, Strawberry Square
Harrisburg, PA 17120

If to UPMC:

Chief Executive Officer
University of Pittsburgh Medical Center
U.S. Steel Tower
62nd Floor
600 Grant Street
Pittsburgh, PA 15219

Copies to:

General Counsel
University of Pittsburgh Medical Center
U.S. Steel Tower
62nd Floor
600 Grant Street
Pittsburgh, PA 15219

8. **Averment of Truth** – UPMC avers that, to the best of its knowledge, the information it has provided to the OAG, PID and DOH in connection with this Consent Decree is true.

9. **Termination** – This Consent Decree shall expire five (5) years from the date of entry.

10. **Modification** – If the OAG, PID, DOH or UPMC believes that modification of this Consent Decree would be in the public interest, that party shall give notice to the other and the parties shall attempt to agree on a modification. If the parties

agree on a modification, they shall jointly petition the Court to modify the Consent Decree. If the parties cannot agree on a modification, the party seeking modification may petition the Court for modification and shall bear the burden of persuasion that the requested modification is in the public interest.

11. **Retention of Jurisdiction** – Unless this Consent Decree is terminated, jurisdiction is retained by this Court to enable any party to apply to this Court for such further orders and directions as may be necessary and appropriate for the interpretation, modification and enforcement of this Consent Decree.

12. **No Admission of Liability** – UPMC, desiring to resolve the OAG's, PID's and DOH's concerns without trial or adjudication of any issue of fact or law, has consented to entry of this Consent Decree, which is not an admission of liability by UPMC as to any issue of fact or law and may not be offered or received into evidence in any action as an admission of liability, whether arising before or after the matter referenced herein.

13. **Counterparts** – This Consent Decree may be executed in counterparts.

NOW THEREFORE, without trial or adjudication of the facts or law herein between the parties to this Consent Decree, Respondent agrees to the signing of this Consent Decree and this Court hereby orders that Respondent shall be enjoined from breaching any and all of the aforementioned provisions.

WE HEREBY consent to this Consent Decree and submit the same to this Honorable Court for the making and entry of a Consent Decree, Order or Judgment of the Court on the dates indicated below.

WHEREFORE, and intending to be legally bound, the parties have hereto set their hands and seals.

BY THE PETITIONERS

COMMONWEALTH OF PENNSYLVANIA
KATHLEEN G. KANE
Attorney General

Date: June 27, 2014 By: Kathleen G. Kane

Date: 6/27/2014 By: James A. Donahue, III
James A. Donahue, III
Executive Deputy Attorney General
Public Protection Division
Attorney I.D. No.: 82620
14th Floor Strawberry Square,
Harrisburg, PA 17120
(717) 787-4530

Date: _____ By: _____
MICHAEL F. CONSEDINE, COMMISSIONER
PENNSYLVANIA INSURANCE DEPARTMENT

Date: _____ By: _____
MICHAEL WOLF, SECRETARY
PENNSYLVANIA DEPARTMENT OF HEALTH

Date: _____ By: _____
JAMES D. SCHULTZ, GENERAL COUNSEL

Date: 6/27/14 By: _____
Yen Lucas
Chief Counsel
Insurance Department
13th Floor, Strawberry Square
Harrisburg, PA 17120

WHEREFORE, and intending to be legally bound, the parties have hereto set their hands and seals.

BY THE PETITIONERS

COMMONWEALTH OF PENNSYLVANIA
KATHLEEN G. KANE
Attorney General

Date: _____ By: _____

James A. Donahue, III
Executive Deputy Attorney General
Public Protection Division
Attorney I.D. No.: 82620
14th Floor Strawberry Square,
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Date: 6/27/14 By: _____

MICHAEL F. CONSEDINE,
COMMISSIONER
PENNSYLVANIA INSURANCE DEPARTMENT

Date: 6/27/14 By: _____

MICHAEL WOLF
SECRETARY
PENNSYLVANIA DEPARTMENT OF HEALTH

Date: 6/27/14 By: _____

JAMES D. SCHULTZ, GENERAL COUNSEL

Date: _____ By: _____

Yen Lucas
Chief Counsel
Insurance Department
13th Floor, Strawberry Square
Harrisburg, PA 17120

Counsel for the Commonwealth of Pennsylvania

BY THE RESPONDENT
UPMC

Date: June 27, 2014

By: _____

W. Thomas McGough, Jr.
Executive Vice President & Chief Legal Officer
UPMC
U.S. Steel Tower, Suite 6241
600 Grant Street
Pittsburgh, PA 15219

EXHIBIT

C

HIGHMARK's CONSENT DECREE

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

MOTION TO APPROVE CONSENT DECREE WITH RESPONDENT HIGHMARK

1. The Commonwealth of Pennsylvania acting through its Attorney General, Kathleen G. Kane, its Insurance Commissioner, Michael F. Consedine, and its Secretary of Health, Michael Wolf (Petitioners), initiated an action by filing a Petition for Review on June 27, 2014, against the Respondent Highmark, the allegations of which are incorporated herein by reference.

2. The Petitioners and Respondent, Highmark, have resolved the allegations in the Petition for Review subject to this Court's approval of the terms and conditions contained in the proposed Consent Decree attached.

WHEREFORE, Petitioners respectfully request that this Honorable Court approve the proposed Consent Decree.

Respectfully submitted

COMMONWEALTH OF PENNSYLVANIA

KATHLEEN G. KANE
Attorney General

Date: 6/27/2014 By: _____

James A. Donahue, III
Executive Deputy Attorney General
Public Protection Division
Attorney I.D. No.: 42624
14th Floor Strawberry Square,
Harrisburg, PA 17120
(717) 787-4530

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. _____M.D. 2014

CONSENT DECREE

AND NOW, this _____ day of _____, 2014, upon the Motion to Approve Consent Decree with Respondent Highmark filed by the Commonwealth of Pennsylvania, acting through its Attorney General, Kathleen G. Kane, its Insurance Commissioner, Michael F. Consedine, and its Secretary of Health, Michael Wolf (Commonwealth or Petitioner), which initiated an action by filing a Petition for Review (Petition) on June 26, 2014, the allegations of which are incorporated herein by reference.

SETTLEMENT TERMS

NOW THEREFORE, for good and valuable consideration, Respondents agree for themselves, their successors, assigns, agents, employees, representatives, executors, administrators, personal representatives, heirs and all other persons acting on their behalf, directly or through any corporate or other device, as follows:

I. INTERPRETATIVE PRINCIPLES

A. The Consent Decree shall be construed in a manner that is consistent with the Insurance Department's April 29, 2013 Approving Determination and Order of the Highmark/West Penn Allegheny Health System Affiliation ("UPE Order") and the 2012 Mediated Agreement entered into by the UPMC and Highmark and to protect consumers and the charitable mission of the Parties. The outcome of the actions embodied in the Consent Decree shall be incorporated in the Transition Plan to be filed by Highmark by July 31, 2014 as provided under Condition 22 of the UPE Order. The Consent Decree is not a contract extension and shall not be characterized as such.

II. DEFINITIONS

A. "Allegheny Health Network" ("AHN") means the domestic, nonprofit corporation, incorporated on October 20, 2011 with its registered office located at Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, PA 15222. Allegheny Health Network is a health care system with seven hospitals serving Western Pennsylvania. Allegheny Health Network's sole controlling member is Highmark Health

B. "Balance Billing" means when a Health Care Provider bills or otherwise attempts to recover the difference between the provider's charge and the amount paid by a patient's insurer and through member cost-shares.

C. "Children's Final Order" means the Final Order in the matter of *In Re: Children's Hospital of Pittsburgh and Children's Hospital of Pittsburgh Foundation*, No. 6425 of 2001 (All. Co. 2001).

D. "Emergency Services/ER Services" means medical services provided in a hospital emergency department in response to the sudden onset of a medical condition requiring intervention to sustain the life of a person or to prevent damage to a person's health and which the recipient secures immediately after the onset or as soon thereafter as the care can be made available, but in no case later than 72 hours after the onset.

E. "Greater Pittsburgh Area" means the counties of Allegheny, Beaver, Butler, Washington and Westmoreland.

F. "Health Plan" means all types of organized health-service purchasing programs, including, but not limited to, health insurance or managed-care plans, offered by government, for-profit or non-profit third-party payors, health care providers or any other entity.

G. "Health Care Provider" means hospitals, skilled nursing facilities, ambulatory surgery centers, laboratories, physicians, physician networks and other health care professionals and health care facilities.

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

I. "Hospital" means a health care facility, licensed as a hospital, having a duly organized governing body with overall administrative and professional responsibility

and an organized professional staff that provides 24-hour inpatient care, that may also provide outpatient services, and that has, as a primary function, the provision of inpatient services for medical diagnosis, treatment and care of physically injured or sick persons with short-term or episodic health problems or infirmities.

J. "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.

K. "Mediated Agreement" means the Mediated Agreement entered into by Highmark and UPMC on May 1, 2012 with assistance of a mediator appointed by the Governor and all agreements implementing the Mediated Agreement.

L. "Out-of-Network" means where a Health Care Provider has not contracted with a Health Plan for reimbursement for treatment of the Health Plan's members.

M. "Payor Contract" means a contract between a Health Care Provider and a Health Plan for reimbursement for the Health Care Provider's treatment of the Health Plan's members.

N. "Trauma" means medical services that are provided to an individual with a severe, life threatening injury which is likely to produce mortality or permanent disability and which are provided at the designated Trauma Center in a facility that provides specialized medical services and resources to patients suffering from traumatic,

serious or critical bodily injuries and which is accredited by the Pennsylvania Trauma Systems Foundation and services needed for appropriate continuity of care.

O. "UPE", also known as Highmark Health, means the entity incorporated on October 20, 2011, on a non-stock, non-membership basis, with its registered office located at Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, Pennsylvania 15222. UPE serves as the controlling member of Highmark.

P. "UPE Order" means the Pennsylvania Insurance Department's April 29, 2013 Approving Determination and Order of the Highmark/West Penn Allegheny Health System Affiliation, *In Re Application of UPE*, No. ID-RC-13-06 (Pa. Insur. Dept. 2013).

Q. "UPMC" means the non-profit, tax-exempt corporation organized under the laws of the Commonwealth of Pennsylvania having its principal address at: 200 Lothrop Street, Pittsburgh, PA 15213. Unless otherwise specified, all references to UPMC include all of its controlled non-profit and for-profit subsidiaries, partnerships, trusts, foundations, associations or other entities however styled.

R. "UPMC Health Plan" means the Health Plan owned by UPMC which is licensed by the Pennsylvania Department of Insurance.

S. "UPMC Hospitals" means the Hospitals operated by the following UPMC subsidiaries: UPMC Presbyterian-Shadyside, Children's Hospital of Pittsburgh of UPMC, Magee Women's Hospital of UPMC, UPMC McKeesport, UPMC Passavant, UPMC St. Margaret, UPMC Bedford Memorial, UPMC Horizon, UPMC Northwest, UPMC Mercy, UPMC East, UPMC Hamot, UPMC Hamot affiliate – Kane Community Hospital, UPMC Altoona, Western Psychiatric Institute and Clinic of

UPMC and any other Hospital acquired by UPMC following the entry of the Court's Consent Decree.

T. "Western Pennsylvania" means the 29-county area designated by the Blue Cross Blue Shield Association in which Highmark does business as Highmark Blue Cross Blue Shield.

IV. TERMS

Highmark, Inc. and UPE (collectively Highmark) shall comply with the following terms:

A. Access

1. **ER Services** – Highmark shall negotiate in good faith to reach an In-Network agreement with UPMC on rates and patient transfer protocols for Emergency and Trauma Services for Hospital, physician and appropriate continuity of care services at all UPMC and Allegheny Health Network hospitals by July 15, 2014 or be subject to the Dispute Resolution Process set forth in paragraph C (1) below. This does not mean that Hospitals or physicians rendering emergency or trauma services to a patient are In-Network for purposes or services other than treating the emergency condition for which a patient is admitted or the treating physicians are otherwise In-Network under other terms of this Consent Decree including, but not limited to, the Continuity of Care, Unique/Exception Hospitals or Oncology. The agreement shall be for a commercially reasonable period of time as provided in Condition 3 of the UPE Order. Highmark shall not Balance Bill consumers until the ER Services agreement is resolved.

2. **Vulnerable Populations** – Highmark and UPMC mutually agree that vulnerable populations include: (i) consumers age 65 or older who are eligible or covered by

Medicare, Medicare Advantage, (ii) Medigap health plans, (iii) Medicaid and (iv) CHIP. With respect to Highmark covered vulnerable populations, UPMC shall continue to contract with Highmark at In-Network rates for all of its Hospital, physician and appropriate continuity of care services for CHIP, Highmark Signature 65, Medigap and commercial retiree carve out as long as Highmark does not make unilateral material changes to these programs. UPMC shall treat all Medicare participating consumers as In-Network regardless of whether they have Medicare as their primary or secondary insurance. Highmark acknowledges that UPMC reserves the right to withdraw from these arrangements if Highmark should take the position that it has the authority to revise the rates and fees payable under those arrangements unilaterally and materially.

3. **Local Community Needs** – Where UPMC is the provider of services provided locally that the patient's treating physician believes the patient needs and DOH has determined such services are not available from another source, and member is Out-of-Network, UPMC will not Balance Bill the member, and Highmark and UPMC shall negotiate a payment that shall not be greater than the Out-of-Network rates established by this Consent Decree.

4. **Oncology** – Highmark subscribers may access, as if In-Network, UPMC services, providers facilities and physicians involved in the treatment of cancer, if a patient's treating physician determines that a patient who is diagnosed with cancer should be treated by a UPMC oncologist and the patient agrees to be so treated. In addition, UPMC and Highmark shall negotiate an agreement for treatment of illnesses which result from cancer treatment. These resulting illnesses may

include, but not be limited to, mental health, endocrinology, orthopedics and cardiology. The need for a treatment of a resulting illness shall be determined, in the first instance, by the patient's treating physician acting in consultation with and in accordance with the wishes of the patient or the patient's representative. Moreover, all UPMC joint ventures, physician services provided at or on behalf of independent hospitals whether related to oncology or not shall be In-Network. If UPMC and Highmark do not reach an agreement on rates for cancer treatment and resulting illnesses by July 15, 2014, the parties will be subject to the Dispute Resolution Process set forth in paragraph C (1) below. UPMC shall not Balance Bill consumers until this agreement is resolved. The agreement shall be for a commercially reasonable period of time as provided in Condition 3 of the UPE Order.

5. **Unique/Exception Hospitals/Physicians** – Highmark shall negotiate in good faith to reach an agreement with UPMC for Hospital, physician and follow-up care services at Western Psychiatric Institute and Clinic, UPMC Bedford, UPMC Venango (Northwest), UPMC/Hamot and UPMC/Altoona, UPMC Horizon and any facility, any physician, facility or other provider services located outside the Greater Pittsburgh Area currently owned or acquired in the future by UPMC, or with whom UPMC has an agreement to handle provider contracting such as, but not limited to, the Kane Hospital, or any other physician or facility outside the Greater Pittsburgh Area determined by DOH to be essential to meet local community needs, by July 15, 2014 or be subject to the Dispute Resolution Process set forth in paragraph C (1) below. The agreement shall be for a

commercially reasonable period of time as provided in Condition 3 of the UPE Order. The Greater Pittsburgh Area shall mean the Counties of Allegheny, Beaver, Butler, Washington and Westmoreland. The Children's Final Order will continue in effect.

6. **Out-of-Network Services** – For all other Highmark subscribers whose care is not otherwise governed by other provisions in this Consent Decree, beginning January 1, 2015, UPMC will provide services to all such subscribers on an Out-of-Network basis. UPMC's reimbursement rates for Out-of-Network services for Highmark subscribers shall be no more than 60% of charges if paid promptly and provided that UPMC informs consumers of such charge before rendering services.

7. **Continuity of Care** – Highmark and UPMC mutually agree that the continuation of care of a Highmark member in the midst of a course of treatment at UPMC shall be on an In-Network basis at In-Network rates. The need for a continuing course of treatment shall be determined, in the first instance, by the patient's treating physician acting in consultation with and in accordance with the wishes of the patient or the patient's representative. While undergoing a continuing course of treatment with UPMC the services covered In-Network will include all services reasonably related to that treatment, including but not limited to testing and follow-up care. In the event that Highmark disputes the opinion of the treating physician that a continuation of care is medically appropriate, or disputes the scope of that care, the DOH or its designated representative will review the matter and make a final, non-appealable determination.

8. **Transfer of Services** - If any services covered by this Consent Decree are transferred or consolidated at one or more AHN Hospitals, the terms of this Consent Decree shall apply to those transferred services where such services are transferred or consolidated.

9. **Referrals and Highmark Transfer of Patients** – (a) Highmark shall not require its physicians to refer patients to an AHN Hospital in situations where the patient is covered by a Health Plan that does not participate with such AHN Hospital or otherwise expresses a preference to be referred to a non-AHN Hospital; (b) AHN shall not refuse to transfer a patient, whether for diagnosis or treatment, to a non-AHN Hospital or Health-Care Provider if such transfer is requested by the patient, the patient's representative when such representative is authorized to make care decisions for the patient, or the patient's physician; provided the patient is stable and that the transfer is medically appropriate and legally permissible. (c) When a patient in need of transfer is covered by a Health Plan with which the AHN Hospital does not contract, AHN shall transfer the patient to the Health Plan's participating non-AHN facility (provided the patient is stable and that the transfer is medically appropriate and legally permissible) unless, (i) the patient or the patient's representative expresses a contrary preference after having been informed of the financial consequences of such a decision, or (ii) is otherwise approved by the patient's Health Plan.

10. **Safety Net** – Highmark and UPMC mutually agree to establish a one year safety net beginning January 1, 2015, for any existing UPMC patient who is, a Highmark subscriber (i) who used UPMC physicians and services In-Network during the

2014 calendar year, (ii) who is not in continuing course of treatment, and (iii) who is unable to find alternative physicians and services in their locality during the one year period. Highmark and UPMC shall hold such consumers harmless if they continue to use such physicians and services prior to January 1, 2016. Rates for the safety net period shall be as set forth under the Dispute Resolution Process set forth in paragraph C (1) below. The safety net is not a contract extension and neither Highmark nor UPMC nor their agents shall characterize it as such.

11. **Advertising** – Highmark shall not engage in any public advertising that is unclear or misleading in fact or by implication to consumers.

B. **Monetary Terms**

Consumer Education Fund and Costs – Highmark shall contribute $2 million for use by the OAG, PID or DOH for outreach and education purposes during the transition; and to cover Costs, including Attorney's or consultant fees of the OAG, PID and DOH within sixty (60) days of entry of this Consent Decree

C. **Miscellaneous Terms**

1. **Dispute Resolution Process** – Where required in this Consent Decree, Highmark and UPMC shall negotiate in good faith. If the parties are unable to reach agreement as to any of the issues raised in this Consent Decree by July 15, 2014 or such other date as may be set by the OAG, PID and DOH, then the terms or rates shall be subject to the following:

    a. Rates –

        i. For the period, January 1, 2015 to December 31, 2015, rates for all In-Network services covered in this Consent Decree, except for

those rates currently being arbitrated by UPMC and Highmark, shall revert to the last mutually agreed upon rates or fees by UPMC and Highmark with the applicable Medical Market Basket index (MBI) increase applied January 1, 2015.

ii. For rates currently being arbitrated, in the event that the current arbitration between UPMC and Highmark and finds in favor of UPMC, then the rates and fees under the Consent Decree will revert to the rates in effect before April 1, 2014 as of the date of the arbitral award and shall remain in place through December 31, 2015. If as a consequence of the arbitral award, Highmark owes UPMC for underpayments, Highmark shall pay UPMC appropriate interest. UPMC and Highmark will use their best efforts to conclude their current arbitration before the end of December 31, 2014. If as a consequence of the arbitral award, UPMC owes Highmark for overpayments, UPMC shall pay Highmark appropriate interest. If an arbitral award is not decided before January 1, 2015, Highmark shall increase its payments by one-half the difference between Highmark's April 1, 2014 schedule and its rate schedule in effect before April 1, 2014 for the period January 1, 2015 to December 31, 2015.

iii. For the period beginning January 1, 2016 to the expiration of the Consent Decree or the expiration of any agreements between UPMC and Highmark for all In-Network services, whichever is

later, the rates shall be the rates agreed to by Highmark and UPMC, or UPMC and Highmark shall engage in a single last best offer binding arbitration to resolve any dispute as to rates after December 31, 2015 as set forth in paragraph C (2) below.

iv. Any agreement or award as to rates and fees will be binding on both UPMC and Highmark, meaning that each will bill and make payments consistent with the agreement or award.

v. For rates for UPMC Health Plan patients at Allegheny Health Network hospitals, if those rates are not resolved by current litigation between the Allegheny Health Network and the UPMC Health Plan in the Allegheny Court of Common Pleas, or by agreement between Highmark and UPMC, Allegheny Health Network and the UPMC Health Plan shall engage in last best offer arbitration to determine those rates for the period not covered by the current litigation to the termination of the Consent Decree.

b. Non-Rate Term – Disputed terms set forth in this Consent Decree and related to the Consent Decree and unrelated to rate and reimbursement shall be subject to mediation before the OAG, PID and DOH. If mediation does not result in resolution within thirty (30) days, Highmark and UPMC shall engage in binding arbitration to resolve the dispute as to terms.

2. **Binding Arbitration**

a. The Parties will file a joint plan with this court for a single last best offer binding arbitration before independent and neutral parties by August 14, 2014 or seek court intervention to resolve any disputes over such process.

3. **Binding on Successors and Assigns** – The terms of this Consent Decree are binding on Highmark, its directors, officers, managers, employees (in their respective capacities as such) and to its successors and assigns, including, but not limited to, any person or entity to whom Highmark may be sold, leased or otherwise transferred, during the term of this Consent Decree. Highmark shall not permit any substantial part of Highmark to be acquired by any other entity unless that entity agrees in writing to be bound by the provisions of this Consent Decree.

4. **Enforcement of the Consent Decree** - The OAG, PID and DOH shall have exclusive jurisdiction to enforce the Consent Decree.

(a) If the OAG, PID or DOH believe that a violation of the Consent Decree has taken place, they shall so advise Highmark and give Highmark twenty (20) days to cure the violation. If after that time the violation is not cured, the OAG, PID and DOH may seek enforcement of the Consent Decree in the Commonwealth Court; (b) Any person who believes they have been aggrieved by a violation of this Consent Decree may file a complaint with the OAG, PID or DOH for review. If after that review, the OAG, PID or DOH believes either a violation of the Consent Decree has occurred or they need additional information to evaluate the complaint, the complaint shall be forwarded to Highmark for a response within thirty (30) days. If after receiving the

response, the OAG, PID or DOH, believe a violation of the Consent Decree has occurred, they shall so advise Highmark and give Highmark twenty (20) days to cure the violation. If after that time the violation is not cured, the OAG, PID or DOH may seek enforcement of the Consent Decree in the Commonwealth Court. If the complaint involves a patient in an ongoing course of treatment who must have the complaint resolved in a shorter period, the OAG, PID or DOH may require responses within periods consistent with appropriate patient care.

5. **Release** – This Consent Decree will release any and all claims the OAG, PID or DOH brought or could have brought against Highmark 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. Any other claims, including but not limited violations of the crimes code, Medicaid fraud laws or tax laws are not released.

6. **Compliance with Other Laws** - The Parties agree that the terms and agreements encompassed within this Consent Decree do not conflict with Highmark's obligations under the laws governing non-profit corporations and charitable trusts, consumer protection laws, antitrust laws, insurance laws and health laws.

7. **Notices** – All notices required by this Consent Decree shall be sent by certified or registered mail, return receipt requested, postage prepaid or by hand delivery to:

If to the Attorney General:

Executive Deputy Attorney General
Public Protection Division
Office of Attorney General
14th Floor, Strawberry Square
Harrisburg, PA 17120

If to Highmark:

Chief Executive Officer
120 Fifth Avenue, Suite 3112
Pittsburgh, PA 15222

Copies to:

Executive Vice President and Chief Legal Officer
120 Fifth Avenue, Suite 3112
Pittsburgh, PA 15222

8. **Averment of Truth** – Highmark avers that, to the best of its knowledge, the information it has provided to the OAG, PID and DOH in connection with this Consent Decree is true.

9. **Termination** – This Consent Decree shall expire five (5) years from the date of entry.

10. **Modification** – If the OAG, PID, DOH or Highmark believes that modification of this Consent Decree would be in the public interest, that party shall give notice to the other and the parties shall attempt to agree on a modification. If the parties agree on a modification, they shall jointly petition the Court to modify the Consent Decree. If the parties cannot agree on a modification, the party seeking modification may petition the Court for modification and shall bear the burden of persuasion that the requested modification is in the public interest.

11. **Retention of Jurisdiction** – Unless this Consent Decree is terminated, jurisdiction is retained by the Commonwealth Court of Pennsylvania to enable any party to apply to this Court for such further orders and directions as may be necessary and appropriate for the interpretation, modification and enforcement of this Consent Decree.

12. **No Admission of Liability** – Highmark, desiring to resolve the OAG's, PID's, DOH's concerns without trial or adjudication of any issue of fact or law, has consented to entry of this Consent Decree, which is not an admission of liability by Highmark as to any issue of fact or law and may not be offered or received into evidence in any action as an admission of liability, whether arising before or after the matter referenced herein.

13. **Counterparts** – This Consent Decree may be executed in counterparts.

NOW THEREFORE, without trial or adjudication of the facts or law herein between the parties to this Consent Decree, Respondents agree to the signing of this Consent Decree and this Court hereby orders that Respondents shall be enjoined from breaching any and all of the aforementioned provisions.

WE HEREBY consent to this Consent Decree and submit the same to this Honorable Court for the making and entry of a Consent Decree, Order or Judgment of the Court on the dates indicated below.

WHEREFORE, and intending to be legally bound, the parties have hereto set their hands and seals.

BY THE PETITIONERS

COMMONWEALTH OF PENNSYLVANIA
KATHLEEN G. KANE
Attorney General

Date: June 27, 2014 By: _____

Date: 6/27/2014 By: _____
James A. Donahue, III
Executive Deputy Attorney General
Public Protection Division
Attorney I.D. No.: 42624
14th Floor Strawberry Square,
Harrisburg, PA 17120
(717) 787-4530

Date: _____ By: _____
MICHAEL F. CONSEDINE, COMMISSIONER
PENNSYLVANIA INSURANCE DEPARTMENT

Date: _____ By: _____
MICHAEL WOLF, SECRETARY
PENNSYLVANIA DEPARTMENT OF HEALTH

Date: _____ By: _____
JAMES D. SCHULTZ, GENERAL COUNSEL

Date: 6/27/14 By: _____
Yen Lucas
Chief Counsel
Insurance Department
13th Floor, Strawberry Square
Harrisburg, PA 17120
Counsel for the Commonwealth of Pennsylvania

WHEREFORE, and intending to be legally bound, the parties have hereto set their hands and seals.

BY THE PETITIONERS

COMMONWEALTH OF PENNSYLVANIA
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MICHAEL WOLF, SECRETARY
PENNSYLVANIA DEPARTMENT OF HEALTH

Date: 6/27/14 By: _____
JAMES D. SCHULTZ, GENERAL COUNSEL

Date: _____ By: _____
Yen Lucas
Chief Counsel
Insurance Department
13th Floor, Strawberry Square
Harrisburg, PA 17120
Counsel for the Commonwealth of Pennsylvania

Counsel for the Commonwealth of Pennsylvania

BY THE RESPONDENTS

UPE, a/k/a, HIGHMARK HEALTH

Date: 6/27/2014 By: Thomas L VanKirk

HIGHMARK, INC.

Date: 6/27/2014 By: Thomas L VanKirk, Sec.

Thomas L. VanKirk
Executive Vice President & CLO
Highmark
Fifth Avenue Place
120 Fifth Avenue, Suite 3112
Pittsburgh, PA 15222-3099

EXHIBIT

D

UPMC's PRIOR REPRESENTATIONS SENIORS WOULD NEVER BE AFFECTED

UPMC LIFE CHANGING MEDICINE

October 27, 2014

Dear,

We are writing you today with important information about this year's Medicare Advantage open enrollment.

Highmark has introduced a new Medicare Advantage product called "Community Blue Medicare HMO" that **excludes all of UPMC's doctors and hospitals.** Choosing this product will prevent you from affordably accessing UPMC's services, ranging from the Hillman Cancer Center, to UPMC's designated National Center of Excellence in Geriatric Medicine, because **all** of UPMC is out-of-network for Highmark's Community Blue Medicare HMO product. Out-of-network means you could be forced to pay large medical bills to receive care from UPMC doctors and hospitals.

The Commonwealth of Pennsylvania, led by the Attorney General and the Insurance Commissioner, determined that Highmark's Community Blue HMO is a "clear violation" of the Consent Decree that Highmark signed just this past summer and are suing Highmark to stop it. The Consent Decree was created to protect seniors and other patient groups and their access to UPMC.

In addition, according to the Commonwealth, Highmark is promoting Community Blue Medicare HMO with "misleading" advertisements that will cause "misunderstanding and confusion" for seniors. Insurance brokers have also been told by the Commonwealth that selling Highmark's Community Blue HMO may violate Pennsylvania's Unfair Insurance Practice Act. These concerns are also echoed in a *Pittsburgh Post-Gazette* editorial attached to this letter.

As a UPMC doctor, I appreciate the trust that patients place in us for care. We believe there is a special bond between our older patients and our entire medical staff. That's why UPMC pledged more than three years ago that the changing relationship between Highmark and UPMC would not affect seniors. We thought that Highmark shared that commitment, but see now that it does not.

During this year's Medicare open enrollment period for Medicare Advantage, you will have many options to choose from, including UPMC *for Life* and Advantra from Health America. These products will provide in-network access to all UPMC doctors and hospitals. Highmark's Community Blue Medicare HMO will not.

We hope that this information is helpful and allows you to make an informed decision during open enrollment.

If you would like more information, including whether a specific UPMC doctor or hospitals is in the network of a plan you are considering, we are here to help. Please contact our toll-free Senior Info Line at 1-855-946-8762.

Sincerely,

Steven D. Shapiro, MD
Chief Medical and Scientific Officer, UPMC

Forum

COMMENTARY, EDITORIALS, LETTERS, BOOKS, PUZZLES • Pittsburgh Post-Gazette • SUNDAY, JUNE 26, 2011

Section F

Imagine a better health care system in Pittsburgh

Dropping Highmark will allow UPMC to introduce more choices, argues UPMC's **TOM McGOUGH**

A lifetime spent in Pittsburgh has armed me with three topics guaranteed to get a conversation started: change, health care and large nonprofits acting like businesses.

Change? We're against it. Unless, of course, someone goes way out on a limb and proves that it's a good thing. Then we really like it.

Health care? We're for it, particularly where it's world class, readily accessible and creates tens of thousands of jobs in the region. But it's too expensive.

Nonprofits acting like businesses? We're highly suspicious, to say the least. After all, they're exempt from some taxes and are supposed to put the public interest ahead of pursuing profits. As Sally Kalson expressed it in her Post-Gazette column last Sunday, "[T]he Pittsburgh Symphony doesn't try to take down the opera."

When all three of those topics get mashed together, as they have in the face-off between Highmark and University of Pittsburgh Medical Center, we can expect a torrent of opinionating. So, as chief legal officer of UPMC, I haven't been surprised by either the amount or the passion of the public debate that has occurred. What has surprised me, however, is how shortsighted some of the commentary has been, particularly from quarters where more imagination usually resides.

I was stunned, for example, by a recent Post-Gazette editorial that posed two supposedly unthinkable propositions: "Imagine Highmark insurance policies that don't cover care by UPMC doctors. Imagine UPMC hospitals where Highmark insurance is no good." You would have thought they were asking us to imagine a world where the Pirates were above .500 in mid-June.

Wait. That last one really happened. And so could a world where Highmark isn't the region's dominant health insurer, the gatekeeper for more than 65 percent of the care delivered in Western Pennsylvania.

I realize that concept will take a while to settle in, even though the last decade hasn't exactly been a picnic for health insurance subscribers. Unfettered by national competition, Highmark has imposed double-digit premium increases, while the rates it paid to UPMC increased only at the rate of inflation. Ms. Kalson accurately, if unintentionally, captured our collective ambivalence about Highmark's performance as gatekeeper when she demanded, "I want to pick my doctors of my own free will and have their services covered by the insurance that's already costing a king's ransom."

How did we get to this strange place?

The 10-year contracts that keep UPMC hospitals and doctors in Highmark's service network expire in mid-2012, so the companies began discussing renewal more than a year ago. Recently, Highmark has been saying that UPMC demanded a 20 percent increase in rates. Or was it 40 percent? Highmark can't seem to remember, probably because it was neither.

In fact, after months of halting discussions, UPMC and Highmark reached an understanding that an independent third party would advise both companies on the market rates in comparable cities for similar services. That understanding became completely irrelevant, however, when the press revealed in April that Highmark was buying West Penn Allegheny Health System to compete directly with UPMC and all the other hospitals in this region.

Why was that a showstopper? Remember Highmark's historical role as everyone's gatekeeper. If Highmark spends, say, $2 billion of its hard-earned subscriber premiums to acquire and rebuild a twice-failed hospital system, it's going to make darned sure those hospital beds are filled. Every other hospital for which it had been gatekeeping would lose patients accordingly.

In addition, premiums Highmark earned on any UPMC contract would wind up funding Highmark's own hospital system, making such a deal illogical, unrealistic and ultimately anticompetitive. So UPMC will not reappoint Highmark as gatekeeper and instead will compete head-on, hospital system to hospital system.

As disconcerting as competition among nonprofits may seem, nothing about nonprofit status exempts a company from market forces or antitrust regulation – any more than it exempts it from the law of gravity. If the Pittsburgh Symphony announced that it was going to produce and market its own opera series – in the name of operatic choice, of course – few would criticize the Pittsburgh Opera if it let any contracts with the symphony expire and looked about for new musical partners.

As Highmark transforms itself into a hospital system, let's at least give it credit for competitive imagination. Consider what the market might look like a few years from now.

Four large national insurers (Aetna, CIGNA, HealthAmerica and United Healthcare) have contracted with UPMC to include its doctors and hospitals in their existing networks. UPMC's own health plan offers a network featuring UPMC hospitals and doctors as well as many community hospitals. Highmark offers a network featuring WPAHS and other community hospitals. So if you want WPAHS, choose Highmark insurance. If you want UPMC, choose the UPMC Health Plan or any of the national insurers. And if you want both, choose any of the national insurers, which will offer those options and more.

The transition will, of course, involve some disruption. But the really disruptive event is Highmark's impending self-transformation into a hospital system; the other disruptions are just the inevitable aftershocks, and mild ones at that.

Employers will have to make sure they offer their employees the insurance options they need. Individuals will have to choose their plans based in part upon where they want to get their health care. If people change doctors rather than changing insurance plans, electronic records will have to be carefully transferred. But we have months to accomplish all those things and six different insurers to get the messages out. They will, after all, be competing for your business on price, quality and access.

Any disruption will also be confined to the "commercial" market; Medicare and Medicaid plans will not be affected. In that commercial market, individual issues will undoubtedly arise relating to continuity of care, ongoing courses of treatment and longer-term commitments extending beyond the expiration date. But the contracts between UPMC and Highmark are designed to expire someday and therefore address many of these complexities. Others can be managed cooperatively, in the best interests of the patients and the community, as they arise.

Our health care system, both locally and nationally, is changing rapidly. Closing our eyes and digging in our heels is not an option. The current rift between Highmark and UPMC actually provides us with an opportunity to change things for the better.

Imagine that.

Tom McGough is senior vice president and chief legal officer of UPMC.

EXHIBIT

E

UPMC's MISLEADING AND DECEPTIVE PROMOTIONAL FLYER

Put a lock on health care costs.

With this special, limited-time offer from UPMC Health Plan, you can lock in to single-digit premium increases through 2020.

Given the double-digit increases during the last decade, this offer could translate to massive savings for your organization.

Meanwhile, with UPMC Health Plan, your employees will be getting extensive in-network access to hospitals and providers, affordable plan options, and world-class local customer service they can count on.

Benefits for your organization:

- Healthier, more productive, more engaged employees
- An improved benefits package to help you attract and retain top talent
- Greater employee loyalty
- An improved bottom line

IMPORTANT NOTE

This limited-time offer is available to new and renewing employers.

Call 1-888-383-UPMC (8762) today to hear more.

UPMC HEALTH PLAN

Terms and conditions:

- This rate cap and premium credit program (the "program") applies to new and renewing business. For new business the qualifying period is July 2017 through January 1, 2018, effective dates. For renewing business the qualifying period is August 2017 through January 1, 2018, renewing dates. Each "Renewal Year" refers to a subsequent, contiguous 12-month contract period following initial purchase or renewal under this offer.
- Premium credit is available only to groups who effectuate a third Renewal Year contract with UPMC Health Plan and select and maintain an available UPMC *HealthyU* or MyCare *Advantage* plan design for such third Renewal Year.
- Group's medical and prescription drug coverage must be purchased exclusively through UPMC Health Plan (full replacement) throughout the initial year and each Renewal Year to qualify for this offer.
- This program applies to Pennsylvania-issued, fully insured group business with 51 or more employees only.
- Rate caps are exclusive of PPACA taxes (Insurer Fee and PCORI) and any new taxes or assessments that may be imposed by an applicable regulatory or taxing authority in the future.
- Enrolled employee count is based on number of employees enrolled in employer's qualifying UPMC Health Plan group product in the first month of initial year and each Renewal Year.
- This offer and the premium quoted pursuant hereto is contingent upon group maintaining a qualifying plan design, maintaining current plan year/renewal date, and meeting UPMC Health Plan's otherwise applicable 51+ underwriting guidelines throughout the term of the program, including, but not limited to, minimum participation rules. UPMC Health Plan reserves the right to modify premiums under the terms of our applicable 51+ underwriting guidelines.
- Terms and conditions are subject to change without prior notice as may be necessary to comply with applicable law, regulation, or other governmental authority. This program may be subject to the approval of Pennsylvania Insurance Department or other governmental authority.
- UPMC Health Plan may, at its sole discretion, cancel, amend, modify, revoke, terminate, or suspend this program at any time. Participation in this program and/or election of this offer is not a guarantee of continued plan availability or renewal.

EXHIBIT

F

UPMC SUSQUEHANNA's
30 DAY NOTICE TO PATIENTS
EMPLOYED BY PMF INDUSTRIES

UPMC Susquehanna

August 14, 2017

[redacted]

Dear [redacted]

We would like to inform you that your employer, PMF Industries and its claims service, INDECS, do not have a contract with UPMC Susquehanna for hospital-based services. This means you are covered for your visit with your physician, however, if your physician determines you need tests or services including but not limited to routine outpatient/inpatient hospital care, laboratory services, x-rays, CAT scans, MRI's or cancer care, heart or lung care or bone and joint care you will receive a bill for full charges at your personal expense.

This is an unconventional approach to providing health insurance. With other health plans we have negotiated mutually agreed upon contracts for services. This is the standard practice for most business arrangements and for the entire healthcare industry.

To help eliminate confusion about what services are covered and which are not, we are discontinuing Susquehanna Health Medical Group physician office services until this matter is resolved; this protects you from the risk of large out of pocket expenses. This letter provides you with 30 days of notice that Susquehanna Health Medical Group (SHMG) will stop caring for your medical needs until further notice. Please note that during these next 30 days, your SHMG physician will continue to address and care for any emergent medical conditions that arise.

However, if you feel you still require ongoing medical care, we encourage you to seek an alternative physician provider immediately. Also please be assured, we will assist you in transferring your medical records to another provider if requested.

In the meantime, we remain hopeful that PMF Industries will reconsider its position so we will be able to work together again and help meet you and your loved ones' healthcare needs. If you have any questions please talk with your local Human Resources department or call UPMC Susquehanna's customer service department at 570-326-8196 or 1-800-433-0816 to discuss any billing issues or concerns.

Sincerely,
UPMC Susquehanna

was given to [redacted] on 7-19-17 @ [redacted] physician's ofc. [redacted]

*You have INDECS Insurance with PMF. For services received by physician (SHMG) you have coverage through PHCS network which Susquehanna Health Medical Group has a contract with; **however** for your hospital/ambulatory (x-ray/lab/etc.) coverage, services are considered out of network.*

*We need to let you know that **your** company has selected a claims service which UPMC Susquehanna (hospital/ambulatory service) **does** not have a contract. You are still able to come to UPMC Susquehanna for your care, but we would like to make you aware **you will be responsible for all costs that are incurred based on the total charges for the procedure/testing.***

You will be required to pay for hospital services prior to receiving care.

This new health plan represents a big change for employees. We regret any inconvenience it causes and will be happy to work with you to meet your financial obligations. We accept credit cards and can set up an extended payment plan for you if needed. Our Customer Service phone number is 570-326-8196 or 1-800-433-0816.

Thank you for choosing Susquehanna Medical Group!

EXHIBIT

G

PROPOSED
MODIFIED CONSENT DECREE

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA, By JOSH SHAPIRO, Attorney General; PENNSYLVANIA DEPARTMENT OF INSURANCE, By JESSICA ALTMAN, Insurance Commissioner; And PENNSYLVANIA DEPARTMENT OF HEALTH, By DR. RACHEL LEVINE, 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

MODIFIED CONSENT DECREE

AND NOW, this _____ day of _____, 20___, upon the ***Petition for Supplemental Relief to Modify Consent Decrees*** filed by the Commonwealth of Pennsylvania through its Attorney General, Josh Shapiro, and the record in this case, the Consent Decrees approved by this Court on July 1, 2014 are hereby combined into this single decree and modified as follows:

INTERPRETIVE PRINCIPLES

1. The terms of this Modified Consent Decree are based upon the status of the respondents as charitable institutions committed to public benefit and are intended to promote the public's interest by: enabling open and affordable access to the respondents' health care services and products through negotiated contracts; requiring last best offer arbitration when contract negotiations fail; and, ensuring against the respondents' unjust enrichment by prohibiting excessive and unreasonable charges and billing practices in the rendering of medically necessary health care services.

DEFINITIONS

2.1 "Acquire" means to purchase the whole or the majority of the assets, stock, equity, capital or other interest of a corporation or other business entity or to receive the right or ability to designate or otherwise control the corporation or other business entity.

2.2 "All-or-Nothing" means any written or unwritten practice or agreement between a Health Care Provider and a Health Plan that requires either party to contract for all of the other party's providers, services or products in order to contract with any of the other party's providers, services or products.

2.3 "Anti-Tiering or Anti-Steering" means any written or unwritten agreement between a Health Care Provider and a Health Plan that prohibits the Health Plan from placing the Health Care Provider in a tiered Health Plan product for the purpose of steering members to Health Care Providers based on objective price, access, and/or quality criteria determined by the Health Plan, or which requires that the Health Plan place the Health Care Provider in a particular tier in a tiered Health Plan product.

2.4 "Average In-Network Rate" means the average of all of a Health Care Provider's In-Network reimbursement rates for each of its specific health care services provided, including, but not limited to, reimbursement rates for government, commercial and integrated Health Plans.

2.5 "Balance Billing" means when a Health Care Provider bills or otherwise attempts to recover the difference between the provider's charge and the amount paid by a patient's insurer and through member Cost-Shares.

2.6 "Cost-Share" or "Cost-Sharing" means any amounts that an individual member of a Health Plan is responsible to pay under the terms of the Health Plan.

2.7 "Credential" or "Credentialing" means the detailed process that reviews physician qualifications and career history, including, but not limited to, their education, training, residency, licenses and any specialty certificates. Credentialing is commonly used in the health care industry to evaluate physicians for privileges and health plan enrollment.

2.8 "Emergency Services/ER Services" means medical services provided in a hospital emergency or trauma department in response to the sudden onset of a medical condition requiring intervention to sustain the life of a person or to prevent damage to a person's health and which the recipient secures immediately after the onset or as soon thereafter as the care can be made available, but in no case later than 72 hours after the onset.

2.9 "Exclusive Contract" means any written or unwritten agreement between a Health Care Provider and a Health Plan that prohibits either party from contracting with any other Health Care Provider or Health Plan.

2.10 "Gag Clause" means any written or unwritten agreement between a Health Care Provider and a Health Plan that restricts the ability of a Health Plan to furnish cost and quality information to its enrollees or insureds.

2.11 "Health Care Provider" means hospitals, skilled nursing facilities, ambulatory surgery centers, laboratories, physicians, physician networks and other health care professionals and health care facilities but excludes services from for-profit ambulance and air transport providers.

2.12 "Health Care Provider Subsidiary" means a Health Care Provider that is owned or controlled by either of the respondents, and also includes any joint ventures with community hospitals for the provision of cancer care that are controlled by either of the respondents.

2.13 "Health Plan" means all types of organized health-service purchasing programs, including, but not limited to, health insurance, self-insured, third party administrator or managed-care plans, whether offered by government, for-profit or non-profit third-party payors, Health Care Providers or any other entity.

2.14 "Health Plan Subsidiary" means a Health Plan that is owned or controlled by either of the respondents.

2.15 "Highmark" means Highmark Inc., the domestic nonprofit corporation incorporated on December 6, 1996, with a registered office at Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, Pennsylvania 15222. Unless otherwise specified, all references to Highmark include Highmark Health and all of its controlled nonprofit and for-profit subsidiaries, partnerships, trusts, foundations, associations or other entities, including entities for which it manages provider contracting, however styled.

2.16 "Hospital" means a health care facility, licensed as a hospital, having a duly organized governing body with overall administrative and professional responsibility and an organized professional staff that provides 24-hour inpatient care, that may also provide outpatient services, and that has, as a primary function, the provision of inpatient services for medical diagnosis, treatment and care of physically injured or sick persons with short-term or episodic health problems or infirmities.

2.17 "Inflation Index" means the Medicare Hospital Inpatient PPS market basket index published annually by the Centers for Medicaid and Medicare Services.

2.18 "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 Cost-Share required

pursuant to 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.

2.19 "Material Contract Terms" means rates, term, termination provisions, the included providers, assignment, claims processes, addition or deletion of services, outlier terms, dispute resolution, auditing rights, and retrospective review.

2.20 "Most Favored Nations Clause" means any written or unwritten agreement between a Health Care Provider and a Health Plan that allows the Health Plan to receive the benefit of a better payment rate, term or condition that the provider gives to another Health Plan.

2.21 "Must Have" means any written or unwritten practice or agreement between a Health Care Provider and a Health Plan that requires either party to contract for one or more of the other party's providers, services or products in order to contract with any of the other party's providers, services or products.

2.22 "Narrow Network Health Plan" means where a Health Plan provides access to a limited and specifically identified set of Health Care Providers who have been selected based upon criteria determined by the Health Plan which shall include cost and quality considerations.

2.23 "Out-of-Network" means where a Health Care Provider has not contracted with a Health Plan for reimbursement for treatment of the Health Plan's members.

2.24 "Payor Contract" means a contract between a Health Care Provider and a Health Plan for reimbursement for the Health Care Provider's treatment of the Health Plan's members.

2.25 "Provider Based Billing," also known as "Facility Based Billing" and "Hospital Based Billing," means charging a fee for the use of the Health Care Provider's building or facility at which a patient is seen in addition to the fee for physician or professional services.

2.26 "Tiered Insurance Plan" or "Tiered Network" means where a Health Plan provides a network of Health Care Providers in tiers ranked on criteria determined by the Health Plan which shall include cost and quality considerations, and provides members with differing Cost-Share amounts based on the Health Care Provider's tier.

2.27 "Top Tier" or "Preferred Tier" means the lowest Cost-Share Healthcare Providers within a Tiered Insurance Plan or Tiered Network.

2.28 "Unreasonably Terminate" means to terminate an existing contract prior to its expiration date for any reason other than cause.

2.29 "Highmark Health," means the entity incorporated on October 20, 2011, on a non-stock, non-membership basis, with its registered office located at Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, Pennsylvania 15222. Highmark Health serves as the controlling member of Highmark.

2.30 "UPMC" and the "UPMC Health System," also known as the "University of Pittsburgh Medical Center," means the non-profit, tax-exempt corporation organized under the laws of the Commonwealth of Pennsylvania having its principal address at 600 Grant Street, Pittsburgh, Pennsylvania 15219. Unless otherwise specified, all references to UPMC include all of its controlled nonprofit and for-profit subsidiaries, partnerships, trusts, foundations, associations or other entities, including entities for which it manages provider contracting, however styled.

2.31 "UPMC Health Plan" means the Health Plans owned by UPMC which are licensed by the Pennsylvania Department of Insurance or otherwise operating in Pennsylvania.

2.32 "UPMC Hospitals" means the Hospitals operated by the following UPMC subsidiaries: UPMC Presbyterian-Shadyside, Children's Hospital of Pittsburgh of UPMC, Magee Women's Hospital of UPMC, UPMC McKeesport, UPMC Passavant, UPMC St. Margaret, UPMC Bedford Memorial, UPMC Horizon, UPMC Northwest, UPMC Mercy, UPMC East, UPMC Hamot, UPMC Hamot, affiliate - Kane Community Hospital, UPMC Altoona, UPMC Jameson, UPMC Susquehanna, UPMC Pinnacle, UPMC Cole, Western Psychiatric Institute and Clinic of UPMC and any other Hospital Acquired by UPMC following the entry of the Court's July 1, 2014 Consent Decree or this Modified Consent Decree.

TERMS

3.1 Internal Firewalls – Highmark and UPMC shall implement internal firewalls as described in Appendix 2 by the Pennsylvania Insurance Department in its April 29, 2013 Order as part of Highmark's acquisition of West Penn Allegheny Health System.

3.2 Health Care Provider Subsidiaries' Duty to Negotiate – Highmark's and UPMC's respective Health Care Provider Subsidiaries shall negotiate with any Health Plan seeking a services contract and submit to single, last best offer arbitration after 90 days to determine all unresolved Material Contract Terms, as provided in Section 4 below.

3.3 Health Plan Subsidiaries' Duty to Negotiate – Highmark's and UPMC's respective Health Plan Subsidiaries shall negotiate with any credentialed Health Care Provider seeking a services contract and submit to single, last best offer arbitration after 90 days to determine all unresolved Material Contract Terms, as provided in Section 4 below. Nothing herein shall be construed to require a Health Plan Subsidiary to include a Health

Care Provider in a particular Narrow Network Health Plan, including in any particular tier in a Tiered Insurance Plan or Tiered Network.

3.4 Prohibited Contract Terms – Highmark and UPMC are prohibited from utilizing in any of their Health Care Provider or Health Plan contracts:

3.4.1 Any Anti-Tiering or Anti-Steering practice, term or condition;

3.4.2 Any Gag Clause, practice, term or condition;

3.4.3 Any Most Favored Nation practice, term or condition;

3.4.4 Any Must Have practice, term or condition;

3.4.5 Any Provider-Based Billing practice, term or condition;

3.4.6 Any All-or-Nothing practice, term or condition;

3.4.7 Any Exclusive Contracts practice, term or condition;

3.5 Limitations on Charges for Emergency Services – Highmark's and UPMC 's Health Care Provider Subsidiaries shall limit their charges for all emergency services to their Average In-Network Rates for any patient receiving emergency services on an Out-of-Network basis.

3.6 Limitations on Terminations – Highmark and UPMC shall not Unreasonably Terminate any existing Payor Contract.

3.7 Direct Payments Required – Highmark's and UPMC's Health Plan Subsidiaries shall pay all Health Care Providers directly in lieu of paying through their subscribers for services.

3.8 Non-Discrimination – Highmark and UPMC shall not discriminate in the provision of health care services, the release of medical records, or information about patients based upon the identity or affiliation of a patient's primary care or specialty physician, the patient's Health Plan or the patient's utilization of unrelated third-party Health Care

Providers – provided, however, that this provision shall not be understood to require Highmark and UPMC to provide privileges or credentials to any Health Care Provider who otherwise does not qualify for privileges and credentials.

3.9 Duty to Communicate – Highmark and UPMC shall maintain direct communications concerning any members of their respective health plans that are being treated by the other's provider to ensure that their respective agents, representatives, servants and employees provide consistently accurate information regarding the extent of their participation in a patient's Health Plan, including, but not limited to, the payment terms of the patient's expected out-of-pocket costs.

3.10 Advertising – Highmark and UPMC shall not engage in any public advertising that is unclear or misleading in fact or by implication.

3.11 Changes to Corporate Governance – Highmark Health and UPMC Health System shall replace a majority of their respective board members who were on their respective boards as of April 1, 2013 by January 1, 2020, with individuals lacking any prior relationship to Highmark Inc. or UPMC, respectively, for the preceding five (5) years.

CONTRACT RESOLUTION (LAST BEST OFFER ARBITRATION)

4.1 Highmark and UPMC shall provide a copy of this Modified Consent Decree to any Health Plan licensed by the Pennsylvania Department of Insurance seeking a services contract or, to any Health Care Provider licensed by the Pennsylvania Department of Health seeking a services contract. Any such Health Plan or Health Care Provider may, at its option, require Highmark or UPMC to participate in the two-step contract resolution provisions of this Modified Consent Decree contained in paragraphs 4.2 through 4.8 by opting in, as set forth in paragraph 4.2, provided that: in the case of Health Care

Providers, the Health Care Provider has identified the specific Health Plan product of either Highmark or UPMC with which the Health Care Provider desires to contract.

4.1.1 First Step - period of good faith negotiations. If no contract is reached during the period;

4.1.2 Second Step - the Health Plan or Health Care Provider may request binding arbitration as outlined in paragraphs 4.3 through 4.8.

4.2 A Health Plan or Health Care Provider must give written notice to Highmark or UPMC of its desire to opt in and utilize the contract resolution provisions of this Modified Consent Decree at least ninety (90) days prior to the expiration of its existing contract with Highmark or UPMC. If a Health Plan or Health Care Provider does not have an existing contract with Highmark or UPMC, the Health Plan or Health Care Provider must give such notice within thirty (30) days after it has notified Highmark or UPMC, in writing, of its interest in a contract. A failure to opt-in to this contract resolution provision is deemed an opt- out for a period of one year.

4.3 As the First Step, a Health Plan or Health Care Provider shall negotiate in good faith toward a contract for Highmark's or UPMC's health care services and/or health plan for at least ninety (90) days. At the conclusion of the ninety (90) day negotiation period, if the negotiations have been unsuccessful, the Health Plan or Health Care Provider may trigger binding arbitration with Highmark or UPMC (hereinafter collectively referred to as the "Arbitration Parties") before an independent body, but must do so, in writing, within thirty (30) days after the conclusion of good faith negotiations:

4.3.1 The arbitration panel will be an independent body made up of five representatives. A representative or his or her employer shall not have been an

officer, director, employee, medical staff member, consultant or advisor, currently or within the past five (5) years with either of the Arbitration Parties:

4.3.1.1 The local or regional Chamber of Commerce shall appoint one (1) member from an employer with less than 100 employees;

4.3.1.2 The local or regional Chamber of Commerce shall appoint one (1) member from an employer with more than 100 employees;

4.3.1.3 The Pennsylvania Health Access Network shall appoint one (1) member;

4.3.1.4 The Health Plan or Health Care Provider shall appoint one (1) member; and

4.3.1.5 Highmark or UPMC, where they are an Arbitration Party, shall appoint one (1) member.

4.3.2 The Arbitration Parties shall each submit to the independent body its last contract offer and a statement of agreed upon contract terms and those Material Contract Terms which remain unresolved. The independent body may reject a request for arbitration if the number of unresolved Material Contract Terms exceeds the number of agreed upon Material Contract Terms and order the Arbitration Parties to engage in another sixty (60) days of negotiation.

4.3.3 The independent body may retain such experts or consultants with expertise in health plan and health care provider contracting issues to aid it in its deliberations, provided that any such experts or consultants shall not have been an officer,

director, employee, medical staff member, consultant or advisor, currently or within the past five (5) years with either of the Arbitration Parties. The cost of such experts or consultants shall be divided equally between the Arbitration Parties.

4.3.4 If, during the course of the negotiation process outlined above, either of the Arbitration Parties fails to propose Material Contract Terms prior to arbitration, the arbitration panel shall impose the proposed terms of the party which did make a proposal with respect to such Material Contract Terms. If both Arbitration Parties submit proposed contracts, the independent body shall inform the Arbitration Parties of any information the independent body believes would be helpful in making a decision. The independent body shall not prohibit the presentation of information by either of the Arbitration Parties for consideration, but must consider the following:

4.3.4.1 The existing contract or contracts, if any, between the Arbitration Parties.

4.3.4.2 The prices paid for comparable services by other Health Plans and/or accepted by other Health Care Providers of similar size and clinical complexity within the community.

4.3.4.3 The criteria required by either Highmark or UPMC concerning the credentialing of Health Care Providers seeking an agreement with either Highmark or UPMC.

4.3.4.4 Whether the Health Care Provider is seeking an agreement in a tiered Health Plan of either Highmark or UPMC; in no event shall either respondent be required to permit a Health Care Provider to participate in a Narrow Network Health Plan, including in a particular tier in either of the respondents' Tiered Insurance Plans or Tiered Networks.

4.3.4.5 Whether a contract between the Arbitration Parties would prevent other Health Care Providers in such Health Plan from meeting quality standards or receiving contracted for compensation.

4.3.4.6 The weighted average rates of other area hospitals of similar size and clinical complexity for all payors, separately for each product line (commercial, Medicare managed care and/or Medicaid managed care) for which the Health Plan or Health Care Provider is seeking an agreement with either Highmark or UPMC.

4.3.4.7 The costs incurred in providing the subject services within the community and the rate of increase or decrease in the median family income for the relevant county(ies) as measured by the United States Department of Labor, Bureau of Labor Statistics.

4.3.4.8 The rate of inflation as measured by the Inflation Index, and (i) the extent to which any price increases under the existing contract between the Health Plan or Health Care Provider and Highmark or UPMC (as applicable) were commensurate with the rate of inflation and (ii) the extent to which the Health Plan's premium increases, if any, were commensurate with the rate of inflation.

4.3.4.9 The rate of increase, if any, in appropriations for Managed Care Organizations participating in Pennsylvania's Medical Assistance program for the Department of Public Welfare, in the case of a Medicaid Managed Care Organization participant in this arbitration process.

4.3.4.10 The actuarial impact of a proposed contract or rates paid by the Health Plan and a comparison of these rates in Pennsylvania with Health Plan or Health Care Provider rates in other parts of the country.

4.3.4.11 The expected patient volume which likely will result from the contract.

4.3.4.12 The independent body shall not consider the extent to which a party is or is not purchasing health plan or health care services from the other party.

4.4 Once the arbitration process has been invoked, the independent body shall set rules for confidentiality, exchange and verification of information and procedures to ensure the fairness for all involved and the confidentiality of the process and outcome. In general, the Arbitration Parties may submit confidential, competitively-sensitive information. Therefore, the independent body should ensure that it and any consultants it retains do not disclose this information to anyone outside the arbitration process.

4.5 The independent body must select the Material Contract Terms proposed by one of the Arbitration Parties. The parties are bound by the decision of the independent body. Any disputed non-Material Contract Terms shall be resolved in favor of the Respondents to this Modified Consent Decree unless the arbitration is between the Respondents in which case the non-Material Contract Terms of the Respondent whose Material Contract Terms are selected shall apply.

4.6 Because of the important interests affected, the independent body shall commence the arbitration process within twenty (20) days after it is triggered by a written request from a Health Plan or Health Care Provider. It shall hold an arbitration hearing, not to exceed three (3) days, within sixty (60) days of the commencement of the arbitration process. The independent body shall render its determination within seven (7) days after the conclusion of the hearing. The Arbitration Parties, by agreement, or the independent body, because of the complexity of the issues involved, may extend any of the time periods in this section, but the arbitration process shall take no more than ninety (90) days from its commencement.

4.7 The Arbitration Parties shall each bear the cost of their respective presentations to the independent body and shall each bear one-half of any other costs associated with the independent review.

4.8 During the above arbitration process:

4.8.1 If the Arbitration Parties have an existing contract, the reimbursement rates set forth in that contract will remain in effect and the reimbursement rates will be adjusted retroactively to reflect the actual pricing determined by the independent body.

4.8.2 If the Arbitration Parties have no contract, the Health Plan shall pay for all services by Highmark or UPMC (as applicable) for which payment has not been made, in an amount equal to the rates in its proposed contract. This amount will be adjusted retroactively to reflect the actual pricing determined by the independent body.

4.8.3 If the amounts paid pursuant to paragraphs 4.8.1 and 4.8.2 are less than the amounts owed under the contract awarded as the result of arbitration, the Health Plan shall pay interest on the difference. If the amounts paid pursuant to paragraphs 4.8.1 and 4.8.2 are greater than the amounts owed under the contract awarded as the result of arbitration, the Health Care Provider shall reimburse the excess and pay interest on the difference. For purposes of calculating interest due under this paragraph, the interest rate shall be the U.S. prime lending rate offered by PNC Bank or its successor as of the date of the independent body's decision on arbitration.

MISCELLANEOUS TERMS

5. Binding on Successors and Assigns – The terms of this Consent Decree are binding on Highmark and UPMC, their directors, officers, managers, employees (in their respective capacities as such) and to their successors and assigns, including, but not limited to, any person or entity to whom Highmark or UPMC may be sold, leased or otherwise transferred, during the term of this Modified Consent Decree. Highmark and UPMC shall not permit any of their substantial parts to be acquired by any other entity unless that entity agrees in writing to be bound by the provisions of this Modified Consent Decree.

6. Enforcement – The OAG, PID and DOH shall have exclusive jurisdiction to enforce this Modified Consent Decree. If the OAG, PID or DOH believe that a violation of this Modified Consent Decree has taken place, they shall so advise Highmark and UPMC and give the offending respondent twenty (20) days to cure the violation. If after that time the violation has not been cured, the OAG, PID or DOH may seek enforcement of the Modified Consent Decree in the Commonwealth Court. Any person who believes they have been aggrieved by a violation of this Modified Consent Decree may file a complaint with the OAG, PID or DOH for review. If after that review, the OAG, PID or DOH believes either a violation of the Modified Consent Decree has occurred or they need additional information to evaluate the complaint, the complaint shall be forwarded to Highmark or UPMC for a response within thirty (30) days. If after receiving the response, the OAG, PID or DOH, believe a violation of the Consent Decree has occurred, they shall so advise Highmark or UPMC and give the offending party twenty (20) days to cure the violation. If after that time the violation is not cured, the OAG, PID or DOH may seek enforcement of the Modified Consent Decree in this Court. If the complaint

involves a patient in an ongoing course of treatment who must have the complaint resolved in a shorter period, the OAG, PID or DOH may require responses within periods consistent with appropriate patient care.

7. Release – This Modified Consent Decree releases any and all claims the OAG, PID or DOH brought or could have brought against Highmark or UPMC for violations of any laws or regulations within their respective jurisdictions, including claims under laws governing nonprofit 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 Modified Consent Decree for the period of July 1, 2012 to the date of filing. Any other claims, including but not limited to violations of the crimes code, Medicaid fraud laws or tax laws are not released.

8. Compliance with Other Laws – The parties agree that the terms and agreements encompassed within this Consent Decree do not conflict with the obligations of Highmark and UPMC under the laws governing nonprofit corporations and charitable trusts, consumer protection laws, antitrust laws, insurance laws and health laws.

9. Notices – All notices required by this Modified Consent Decree shall be sent by certified or registered mail, return receipt requested, postage prepaid or by hand deliver to:

If to the Attorney General:

Executive Deputy Attorney General
Public Protection Division
Office of Attorney General
14th Floor, Strawberry Square
Harrisburg, PA 17120

Chief Deputy Attorney General
Charitable Trusts and Organizations Section
Office of Attorney General
14th Floor, Strawberry Square
Harrisburg, PA 17120

Chief Deputy Attorney General
Health Care Section
Office of Attorney General
14th Floor, Strawberry Square
Harrisburg, PA 17120

Chief Deputy Attorney General
Antitrust Section
Office of Attorney General
14th Floor, Strawberry Square
Harrisburg, PA 17120

If to Highmark

Chief Executive Officer
120 Fifth Avenue, Suite 3112
Pittsburgh, PA 15222

Copies to:

Executive Vice President and Chief Legal Officer
120 Fifth Avenue, Suite 3112
Pittsburgh, PA 15222

If to UPMC:

Chief Executive Officer
University of Pittsburgh Medical Center
U.S. Steel Tower 62nd Floor
600 Grant Street
Pittsburgh, PA 15219

Copies to:

General Counsel
University of Pittsburgh Medical Center
U.S. Steel Tower 62nd Floor
600 Grant Street
Pittsburgh, PA 15219

10. Averment of Truth – Highmark and UPMC aver that, to the best of their knowledge, the information they have provided to the OAG, PID and DOH in connection with this Modified Consent Decree is true.

11. Termination – This Consent Decree shall remain in full force and effect until further order of the Court.

12. Modification – If either the OAG, PID, DOH, Highmark or UPMC believes that further modification of this Modified Consent Decree would be in the public interest, that party shall give notice to the other parties and the parties shall attempt to agree on a modification. If the parties agree on a modification, they shall jointly petition the Court to modify the Consent Decree. If the parties cannot agree on a modification, the party seeking modification may petition the Court for further modification and shall bear the burden of persuasion that the requested modification is in the public interest.

13. Retention of Jurisdiction – Unless this Modified Consent Decree is terminated, jurisdiction is retained by this Court to enable any party to apply to this Court for such further orders and directions as may be necessary and appropriate for the interpretation, modification and enforcement of this Modified Consent Decree.

BY THE COURT:

_____

, J.

EXHIBIT 3

In the Matter of Evanston Northwestern Healthcare Corp., Dkt. No. 9315 Final Order (FTC April 29, 2008)

UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION

COMMISSIONERS: William E. Kovacic, Chairman
Pamela Jones Harbour
Jon Leibowitz
J. Thomas Rosch

In the Matter of	)	
EVANSTON NORTHWESTERN HEALTHCARE CORPORATION, a corporation, and	)	Docket No. 9315
ENH MEDICAL GROUP, INC., a corporation.	)	

FINAL ORDER

This matter having been heard by the Commission upon the appeal of Respondent and the cross-appeal of complaint counsel; and the Commission having determined that the acquisition by Evanston Northwestern Healthcare Corporation ("ENH") of Highland Park Hospital ("Highland Park") in 2000 violated Section 7 of the Clayton Act, for the reasons stated in the Opinion of the Commission issued on August 6, 2007 ("Opinion"); and the Commission having affirmed the Initial Decision as to liability, but having vacated the proposed order issued as part of the Initial Decision, for the reasons stated in the Opinion; and the Commission having considered the submissions of Respondent and complaint counsel regarding a proposed final order; the Commission has now determined to issue a Final Order to remedy Respondent's violation of Section 7 of the Clayton Act. Accordingly,

It is ordered that the following order to cease and desist be, and hereby is, entered:

I.

IT IS ORDERED that, as used in this Order, the following definitions apply:

A. "Commission" means Federal Trade Commission.

B. "Contract Administration" means the act or acts associated with compliance with and implementation of final contract terms, such as payment monitoring, communication of Payor medical and administrative policies, utilization management, liaison to the business office, annual updates, and organizing

managed care-related budget information.

C. "Contract Management System" means a software application or other system that houses contract rates and is utilized for patient billing and modeling Pre-existing Contract rates and/or proposed rates.

D. "Corporate Managed Care Department" means the department that will be responsible for Contract Administration for both Evanston and Highland Park.

E. "ENH" or "Respondent" means Evanston Northwestern Hospital Corporation, its directors, officers, employees, agents, representatives, successors, and assigns; its joint ventures, subsidiaries, divisions, groups and affiliates controlled by Evanston Northwestern Hospital Corporation, and the respective directors, officers, employees, agents, representatives, successors, and assigns of each.

F. "Evanston," means Evanston Hospital and Glenbrook Hospital, the hospitals owned by ENH and located at 2650 Ridge Avenue, Evanston, Illinois, and 2100 Pfingston Road, Glenview, Illinois, respectively.

G. "Evanston Negotiating Team" means the team responsible for negotiating a Managed Care Contract for Hospital Services for Evanston when a Payor negotiates Managed Care Contracts for Hospital Services for Evanston separate from Hospital Services for Highland Park.

H. "Final Offer Arbitration" means a manner of arbitration whereby each party in a disputed matter submits its best and final offer to an arbitrator who is then required to choose what he or she believes is the best offer (sometimes referred to as "baseball style arbitration").

I. "Highland Park," means Highland Park Hospital, the hospital owned by ENH and located at 777 Park Avenue West, Highland Park, Illinois.

J. "Highland Park Negotiating Team" means the team responsible for negotiating a Managed Care Contract for Hospital Services for Highland Park when a Payor negotiates Managed Care Contracts for Hospital Services for Highland Park separate from Hospital Services for Evanston.

K. "Hospital" means any human medical care facility licensed as a hospital in the state in which the facility is located.

L. "Hospital Services" means all inpatient hospital services, which include a broad cluster of medical, surgical, diagnostic, treatment, and all other services that are included as part of an admission of a patient to an inpatient bed within Evanston

or Highland Park, and all outpatient services that are related to the use of that Hospital.

M. "Managed Care Contract" means a contract or agreement for Hospital Services between ENH and a Payor, including but not limited to rates, definitions, terms, conditions, policies, and pricing methodology (*e.g.*, per diem, discount rate, and case rate).

N. "Managed Care Contracting Information" means information concerning Managed Care Contracts and negotiations with a specific Payor for Hospital Services; provided, however, that "Managed Care Contracting Information" shall not include: (i) information that is in the public domain or that falls in the public domain through no violation of this Order or breach of any confidentiality or non-disclosure agreement with respect to such information by Respondent; (ii) information that becomes known to ENH from a third party that has disclosed that information legitimately; (iii) information that is required by law to be publicly disclosed; or (iv) aggregate information concerning the financial condition of ENH.

O. "Merger" means the 2000 merger of Evanston Northwestern Healthcare Corporation with Highland Park Hospital.

P. "Operate" means to own, lease, manage or otherwise control or direct the operations of a Hospital, directly or indirectly.

Q. "Ownership Interest" means any and all rights, present or contingent, of Respondent to hold any voting or nonvoting stock, share capital, equity or other interests or beneficial ownership in an entity.

R. "Payor" means any Person that pays, or arranges for payment, for all or any part of any Hospital Services for itself or for any other Person. Payor includes any Person that develops, leases, or sells access to networks of Hospitals. The term does not include government payors for public health insurance programs, such as Medicare and Medicaid.

S. "Person" means any individual, partnership, joint venture, firm, corporation, association, trust, unincorporated organization, joint venture, or other business or government entity, and any subsidiaries, divisions, groups or affiliates thereof.

T. "Pre-existing Contract" means a Managed Care Contract between a Payor and ENH that is in effect on the date this Order becomes final.

II.

IT IS FURTHER ORDERED that Respondent shall

A. Negotiate Managed Care Contracts for Hospital Services for Highland Park separately and independently from Managed Care Contracts for Hospital Services for Evanston, and vice versa;

B. Not make any Managed Care Contract for Hospital Services for Evanston contingent on entering into a Managed Care Contract for Hospital Services for Highland Park, or vice versa;

C. Not make the availability of any price or term included in a Managed Care Contract for Hospital Services for Evanston contingent on entering into or agreeing to any particular price or term included in a Managed Care Contract for Hospital Services at Highland Park, or vice-versa; and

D. At the request of the Payor, submit any disputes as to prices and/or terms arising out of the separate and independent negotiations required by Paragraphs II.A.- C. of this Order:

1. first to mediation under the Commercial Mediation Rules of the American Arbitration Association ("AAA"), and, if the dispute cannot be settled by mediation, at the request of the Payor to a single arbitrator, mutually agreed upon by ENH and the Payor, who shall conduct binding arbitration in accordance with the Commercial Arbitration Rules of the AAA at a location mutually agreed upon by ENH and the Payor, in order to determine fair and reasonable prices and/or terms assuming competition between the hospitals as would exist but for the Merger;

2. the arbitration shall be conducted as Final Offer Arbitration, unless ENH and the Payor agree to an alternative manner of arbitration;

3. costs of the arbitration (other than attorneys fees, which shall be borne by the party that incurs them) shall be borne by the loser if Final Offer Arbitration; if a manner other than Final Offer Arbitration or if the parties settle the matter prior to issuance of the final decision by the arbitrator, the arbitrator shall assess costs, unless the parties agree as to the allocation of costs;

4. *provided, however,* that neither the mediator nor the arbitrator shall have any responsibility or authority to resolve issues concerning any violation or possible violation of this Order; the Commission retains jurisdiction over these issues.

Provided further, however, that nothing in this Paragraph shall prohibit Respondent from negotiating a Managed Care Contract with a particular Payor for Hospital Services for both Highland Park and Evanston jointly, if that Payor elects to negotiate jointly for all Hospitals rather than to negotiate separate Managed Care Contracts.

III.

IT IS FURTHER ORDERED that

A. No later than thirty (30) days after this Order becomes final, Respondent shall establish and thereafter maintain the Evanston Negotiating Team and the Highland Park Negotiating Team, which teams shall operate independent of each other and negotiate Managed Care Contracts separately and in competition with each other and other Hospitals.

B. The Highland Park Negotiating Team shall be exclusively responsible for negotiating Managed Care Contracts for Hospital Services for Highland Park when separate contracts are negotiated pursuant to Paragraph II. of this Order.

C. The Evanston Negotiating Team shall be exclusively responsible for negotiating Managed Care Contracts for Hospital Services for Evanston when separate contracts are negotiated pursuant to Paragraph II. of this Order.

D. At the request of a specific Payor, ENH shall be permitted to negotiate a Managed Care Contract for Hospital Services jointly for both Evanston and Highland Park for that specific Payor for that specific Managed Care Contract; *provided, however*, that neither the Highland Park Negotiating Team nor the Evanston Negotiating Team shall be involved in the joint negotiations.

IV.

IT IS FURTHER ORDERED that

A. Respondent shall maintain Managed Care Contracting Information with respect to Evanston separate and confidential from Managed Care Contracting Information with respect to Highland Park.

B. Managed Care Contracting Information with respect to Evanston shall not, directly or indirectly, be transmitted to or received by the Highland Park Negotiating Team, and Managed Care Contracting Information with respect to Highland Park shall not, directly or indirectly, be transmitted to or received by the Evanston Negotiating Team, except as otherwise provided in this Order.

C. No later than thirty (30) days after this Order becomes final, Respondent shall implement procedures and protections to ensure that Managed Care Contracting Information for Evanston, on the one hand, and Highland Park, on the other, is maintained separate and confidential, including but not limited to:

1. establishing a firewall-type mechanism that prevents the Evanston Negotiating Team from requesting, receiving, sharing, or otherwise obtaining any Managed Care Contracting Information with respect to Highland Park, and prevents the Highland Park Negotiating Team from requesting, receiving, sharing, or otherwise obtaining any Managed Care Contracting Information with respect to Evanston;

2. establishing a Contract Management System for the Highland Park Negotiating Team that is separate or clearly-partitioned from the Contract Management System for the Evanston Negotiating Team to ensure the confidentiality of Managed Care Contracting Information; and

3. causing each of Respondent's employees with access to Managed Care Contracting Information to maintain the confidentiality required by the terms and conditions of this Order, including but not limited to:

   a. requiring each employee to sign a statement that the individual will comply with these terms;

   b. maintaining complete records of all such statements at Respondent's headquarters; and

   c. providing an officer's certification to the Commission stating that such statements have been signed and are being complied with by all relevant employees.

D. Nothing in this Order shall prevent the Highland Park Negotiating Team from requesting, receiving, sharing, using or otherwise obtaining Managed Care Contracting Information with respect to Hospital Services for Highland Park.

E. Nothing in this Order shall prevent the Highland Park Negotiating Team from requesting, receiving, sharing, using or otherwise obtaining non-Managed Care

Contracting Information relating to any ENH Hospital or the entire ENH system, including, but not limited to, information related to costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses, and overhead.

F. Nothing in this Order shall prevent the Evanston Negotiating Team from requesting, receiving, sharing, using, or otherwise obtaining Managed Care Contracting Information with respect to Hospital Services for Evanston.

G. Nothing in this Order shall prevent the Evanston Negotiating Team from requesting, receiving, sharing or otherwise obtaining non-Managed Care Contracting Information relating to any ENH Hospital or the entire ENH system, including, but not limited to, information related to costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses, and overhead.

H. If a Payor elects to negotiate and contract jointly for Hospital Services for both Highland Park and Evanston, nothing in this Order shall prohibit ENH from requesting or obtaining Managed Care Contracting Information with respect to Hospital Services for both Evanston and Highland Park for that particular Payor or from using that Managed Care Contracting Information for that particular Payor with respect to the joint negotiations and contracting for that particular Managed Care Contract.

I. Nothing in this Order shall prevent the Corporate Managed Care Department from requesting Managed Care Contracting Information from the Evanston Negotiating Team or the Highland Park Negotiating Team, *provided, however*, that

1. the Managed Care Contracting Information that is requested and obtained is used solely for the purpose of Contract Administration, and

2. the Corporate Managed Care Department is prohibited from providing, sharing, or otherwise making available Managed Care Contracting Information:

    a. from the Highland Park Negotiating Team to or with the Evanston Negotiating Team; or

    b. from the Evanston Negotiating Team to or with the Highland Park Negotiating Team.

V.

IT IS FURTHER ORDERED that Respondent shall, solely at the option of the Payor and with no penalty to the Payor, allow Payors with Pre-existing Contracts the option to re-open and renegotiate their contracts under the terms of this Order:

A. No later than thirty (30) days after this Order becomes final, Respondent shall notify all Payors with a Pre-existing Contract of their rights under this Order, and, for each such Pre-existing Contract, offer the opportunity to negotiate a separate Managed Care Contract for Hospital Services for Highland Park on the one hand and Evanston on the other hand.

B. Respondent shall send notification of the above requirement and a copy of this Order to the Chief Executive Officer, the General Counsel, and the network manager of each such Payor by first class mail or e-mail, with return receipt requested, and keep a file of such receipts for three (3) years after the date on which this Order becomes final.

1. Respondent shall maintain complete records of all such notifications at Respondent's headquarters, and

2. Respondent shall provide an officer's certification to the Commission stating that such notification program has been implemented and that Respondent has complied with its provisions.

VI.

IT IS FURTHER ORDERED that, no later than ten (10) days after being contacted by a Payor to negotiate a Managed Care Contract, Respondent shall notify said Payor of its rights under this Order by sending a copy of this Order to the Chief Executive Officer, the General Counsel, and the network manager of the Payor by first class mail or e-mail, with return receipt requested. Respondent shall maintain complete records of all such notifications and return receipts at Respondent's headquarters and shall include in reports filed to the Commission an officer's certification to the Commission stating that such notification requirement has been implemented and is being complied with.

VII.

IT IS FURTHER ORDERED that Respondent shall,

A. Within ten (10) days after this Order becomes final, and every sixty (60) days thereafter until submission of the first annual report required by Paragraph VII.B. of this Order, submit a verified written report to the Commission setting forth in detail

1. the manner and form in which it will comply with Paragraphs II. and III. of this Order, including but not limited to the composition, structure, and intended operation of the Evanston Negotiating Team and the Highland Park Negotiating Team, including but not limited to who will comprise the teams, where they will be located, who will supervise the teams, who will approve the Managed Care Contracts, what instructions the team members will receive, how the team members will be compensated, what other responsibilities the team members will have, and other details necessary for the Commission to evaluate Respondent's compliance with this Order; and

2. the manner and form in which Respondent will comply with Paragraph IV. of this Order.

B. One (1) year from the date this Order becomes final, annually for the next nineteen (19) years on the anniversary date this Order becomes final, and at such other times as the Commission may require, submit a verified written report to the Commission setting forth in detail the manner and form in which it has complied and is complying with the Order. In each such verified written report, include, among other things that are required from time to time, the following:

1. a full description of the efforts being made to comply with each Paragraph of the Order, including all internal memoranda and all reports and recommendations concerning compliance with the requirements of this Order;

2. notification of all requests for mediation and/or arbitration and a full description of the mediation and/or arbitration, including but not limited to identification of the arbitrator and the location of the arbitration, a full description of the status and results of mediation, a full description of the status of the arbitration and, if resolved, of the resolution of each arbitration; and

3. the identity of each member of the Evanston Negotiating Team, the Highland Park Negotiating Team, and the Corporate Managed Care Department.

C. Within sixty (60) days after the date this Order becomes final, and every sixty (60) days thereafter until Respondent has fully complied with paragraphs V and IX.A., and has obtained the signed statements of all of Respondent's employees described in Paragraph IV.C.3. and who are employed by the Respondent as of the date this Order becomes final, submit a verified written report to the Commission setting forth in detail the manner and form in which it has complied and is complying with the Order.

VIII.

IT IS FURTHER ORDERED that, for the purpose of determining or securing compliance with this Order, and subject to any legally recognized privilege, and upon written request and five (5) days notice to the Respondent made to its headquarters address, Respondent shall, without restraint or interference, permit any duly authorized representative of the Commission:

A. Access, during business office hours of the Respondent and in the presence of counsel, to all facilities and access to inspect and copy all books, ledgers, accounts, correspondence, memoranda, calendars, and all other records and documents in its possession, or under its control, relating to any matter contained in this Order, which copying services shall be provided by Respondent at the request of the authorized representative(s) of the Commission and at the expense of the Respondent; and

B. To interview officers, directors, or employees of the Respondent, who may have counsel present, regarding such matters.

IX.

IT IS FURTHER ORDERED that Respondent shall

A. Within thirty (30) days after the date this Order becomes final, send by first class mail, return receipt requested, a copy of this Order to each officer and director of ENH; and

B. Within ten (10) days of appointment of any new officer or director of ENH, send by first class mail, return receipt requested, a copy of this Order to such officer or director.

X.

IT IS FURTHER ORDERED that, for a period commencing on the date this Order becomes final and continuing for ten (10) years, Respondent shall not, directly or indirectly, through subsidiaries or otherwise, without providing advance written notice to the Commission:

A. Acquire any Ownership Interest in:

1. a Hospital that is located within the Chicago Metropolitan Statistical Area; or

2. any Person that Operates a Hospital that is located within the Chicago Metropolitan Statistical Area; or

B. Enter into any agreement or other arrangement to Operate or otherwise obtain direct or indirect ownership, management, or control of a Hospital that is located within the Chicago Metropolitan Statistical Area, or any part thereof, including but not limited to a lease of or management contract for any such Hospital.

Said notification shall be given on the Notification and Report Form set forth in the Appendix to Part 803 of Title 16 of the code of Federal Regulations as amended (hereinafter referred to as the "Notification"), and shall be prepared and transmitted in accordance with the requirements of that part, except that no filing fee will be required for any such Notification; Notification shall be filed with the Secretary of the Commission; Notification need not be made to the Department of Justice; and Notification is required only of the Respondent and not of any other party to the transaction. Respondent shall provide two (2) complete copies (with all attachments and exhibits) of the Notification to the Commission at least thirty (30) days prior to consummating any such transaction (hereafter referred to as the "first waiting period"). If, within the first waiting period, representatives of the Commission make a written request for additional information or documentary material (within the meaning of 16 C.F.R. § 802.20), Respondent shall not consummate the transaction until thirty (30) days after substantially complying with such request. Early termination of the waiting periods in this Paragraph may be requested by Respondent and, where appropriate, granted by a letter from the Commission's Bureau of Competition, *provided however*, that prior notification shall not be required by this Paragraph for a transaction for which notification is required to be made, and has been made, pursuant to Section 7A of the Clayton Act, 15 U.S.C. § 18a.

XI.

IT IS FURTHER ORDERED that, Respondent shall notify the Commission at least thirty (30) days prior to (1) any proposed dissolution of Respondent; (2) any proposed acquisition, merger, or consolidation of Respondent; or (3) any other change in Respondent including, but not limited to, assignment or creation or dissolution of subsidiaries, if such change might affect compliance obligations arising out of this Order.

XII.

IT IS FURTHER ORDERED that this Order shall terminate twenty (20) years from the date on which this Order becomes final.

By the Commission.

Donald S. Clark
Secretary

SEAL
ISSUED: April 24, 2008

EXHIBIT 4

July 8, 1968 Statement of
Representative Daniel E. Beren

On the question,
Shall the bill pass finally?

The SPEAKER. The Chair recognizes the gentleman from Montgomery, Mr. Beren.

Mr. BEREN. Thank you, Mr. Speaker.

As we are now considering House bill No. 2431 and on the assumption that this bill will pass and that we will have completed our consumer package of House bills Nos. 2429, 2430 and 2431, I state, in my opinion, this bill, House bill No. 2431, is the most meaningful bill in this package because it defines unfair methods of competition and deceptive trade practices. It gives the Attorney General the right to enforce this act. It, therefore, makes the Bureau of Consumer Protection a meaningful adjunct of state government. As a result, it protects both the unsuspecting and innocent consumer and the legitimate businessman, both of whom are subject to fraudulent schemes by the unscrupulous profiteer.

Finally, Mr. Speaker, it is the hope of all of us that section 7 of this act, which calls for a 48-hour cooling-off period for door-to-door sales, will provide the consumer in our urban areas a fair chance when dealing with those members of the door-to-door trade who have taken advantage of them.

As I said before, this package gives Pennsylvania the strongest consumer-protection laws in the States.

On the question recurring,
Shall the bill pass finally?

Agreeable to the provisions of the constitution, the yeas and nays were taken and were as follows:

YEAS—185

Alexander, G. W.	Frank	Luger	Ryan
Alexander, J. M.	Fryer	Lutty	Rybak
Allen, F. M.	Fulmer	Lynch, Francis	Saloom
Allen, W. W.	Galley	Lynch, Frank	Scanlon
Anderson, J. H.	Gallagher	Maack	Schmitt
Anderson, S. A.	Gallen	Manbeck	Seltzer
Bellomini	Geisler	Manderino	Semanoff
Beloff	Gekas	Markley	Shelhamer
Bennett	Gelfand	McAneny	Shelton
Beren	George	McCurdy	Sherman
Berkes	Gerhart	McMonagle	Shuman
Berson	Gillette	McNally	Shupnik
Bittle	Gola	Mebus	Slack
Bixler	Good	Meholchick	Smith
Blair, J. E.	Greenfield	Mifflin	Snare
Blair, R. J.	Gring	Miller, M. E.	Spencer
Bonetto	Gross	Miller, P. W.	Stauffer
Bossert	Halverson	Moscrip	Steele
Brunner	Hamilton, J. H.	Mullen	Stemmler
Buchanan	Hamilton, R. K.	Murray, H. P., Jr.	Sullivan
Bush	Harner	Musto	Taylor
Butera	Haudenshield	Needham	Tighman
Caputo	Headlee	Nicholson	Torak
Cioffi	Hetrick	Nitrauer	Tuscano
Clay	Hill	O'Brien, B.	Uritis
Claypoole	Hippel	O'Brien, F.	Vann
Comer	Holman	O'Connell	Walker
Coppolino	Homer	Odorisio	Walsh
Dager	Hopkins	Pancoast	Wansacz
Dardanell	Horner	Parker	Wargo
Davis	Irvis	Perry	Weidner
DeMedio	Johnson, R. A.	Pezak	Westerberg
De Meo	Johnson, T.	Pievsky	Wilson
Donaldson	Kahle	Piper	Wilt, R. E
Dorsey	Kaufman	Polaski	Wilt, W. W.
Dumas	Kelly	Prendergast	Wise
Dwyer	Kennedy	Renninger	Worley
Eckensberger	Kester	Renwick	Worrilow
Emerson	Kistler	Reynolds	Wright
Englehart	Klingensmith	Rigby	Yahner
Eshback	Kowalyshyn	Ritter	Zemprelli
Fenrich	Kury	Ruane	Zimmerman
Filo	Lain	Rubin	Zord
Fineman	LaMarca	Rudisill	
Fischer	Laudadio	Ruggiero	Lee, K. B.,
Foor	Lawson	Rush	Speaker
Fox	Lench	Rutherford	

NAYS—6

Appleton	Hepford	Kernaghan	King
Bair	Johnson, G. R.		

NOT VOTING—12

Ashton	Dininni	Monroe	Rieger
Bachman	Lederer	Murphy	Stone
Blair, S. L.	McGraw	O'Donnell	Welsh

The majority required by the constitution having voted in the affirmative, the question was determined in the affirmative.

Ordered, That the clerk present the same to the Senate for concurrence.

QUESTION OF PERSONAL PRIVILEGE

The SPEAKER. The Chair recognizes the gentleman from Columbia, Mr. Shelhamer.

Mr. SHELHAMER. Mr. Speaker, our machines are locked out.

The SPEAKER. Will the gentleman try to vote again? How does the gentleman desire to be recorded?

Mr. SHELHAMER. In the affirmative, Mr. Speaker.

Mr. SPEAKER. The gentleman will be so recorded, and the gentleman from Lackawanna also, Mr. Needham.

Agreeable to order,

The House proceeded to the consideration on final passage of **Senate bill No. 479, printer's No. 2207**, entitled:

An Act creating a regional intergovernmental compact agency for the planning, conservation, utilization, development, management and control of water and related natural resources of the Susquehanna river basin, for the improvement of navigation, preservation of amenities, reduction of flood damage, regulation of water quality, control of pollution, development of water supply, hydroelectric energy, fish and wildlife habitat and public recreational facilities, and other purposes, and defining the functions, powers and duties of such agency; providing for the relation of such regional agency to other agencies of and in the state government; and for related purposes.

On the question,
Shall the bill pass finally?

The SPEAKER. The Chair recognizes the gentleman from Chester, Mr. Reynolds.

Mr. REYNOLDS. Mr. Speaker, I would like permission to make a few remarks on Senate bill No. 479.

The SPEAKER. The gentleman is in order and may proceed.

Mr. REYNOLDS. Thank you, Mr. Speaker.

I rise to discuss briefly my reasons for voting as I will on this piece of legislation. I shall vote "no" not because I am against the tri-state agreement to cooperatively protect and develop the resources of the Susquehanna River Basin, but because I am against this legislation as it is written. The amendments to the compact as proposed by the House Appropriations Committee are now placed in the enabling legislation. It would appear then that both sides of the aisle are in full accord that the compact should be amended. They just do not agree on the method to be used.

I cannot accept the version now before us. I must oppose any measure that will give away the sovereign rights of the people of Pennsylvania and, in my opinion, that is just what this compact will do to us.

I have had more than one attorney review this legislation for me in order to gain an insight into the impact of this measure and I can sum up their various re-

EXHIBIT 5

Com. v. Koscot Interplanetary, Inc., 54 Erie 79, 99 (Erie Co.C.P.1971)

COMMONWEALTH OF PENNSYLVANIA acting by ATTORNEY GENERAL FRED SPEAKER vs. KOSCOT INTERPLANETARY, INC. A FOREIGN CORPORATION 4805 SAND LAKE ROAD ORLANDO, FLORIDA 32809

Unfair Trade Practice and Consumer Protection Law — 73 P.S. 201 — Injunction — Constitutionality of Consumer Protection Law — Legality of Promise to Pay Buyer Compensation for Procurement of Other Contracts — Legality of Making Statements Which Would Create Likelihood of Confusion or Misunderstanding — Fraud — Article 1, Section 1 of the Pennsylvania Constitution — Section i, Fourteenth Amendment of the Constitution of the United States of America

The purchasers of franchises, whether they are distributors or sub-distributors are buyers under the Unfair Trade Practice and Consumer Protection Law.

The payment of substantial and disproportionate sums for bringing other distributors or sub-distributors into a franchise system of promise of said payment violates the Unfair Trade Practice and Consumer Protection Law.

The purchase of a distributorship or subdistributorship is covered by the Unfair Trade Practice and Consumer Protection Law, and if actions by a defendant are declared fraudulent, such unfair trade practices are dealt with by said law since the said law since the said law is not directed only at the ultimate consumer, but at other parties in the chain of said business, such as, wholesalers, distributors and sub-distributors.

Representations relative to articles made by a franchise or its representatives, servants or employees in its manuals at its meetings or elsewhere are in violation of the Unfair Trade Practice and Consumer Protection Law if they are not based upon the experience of a substantial of the members of the system.

A franchise system which pays or promises to pay a fee, reward or compensation to a distributor, sub-distributor or any other person in the chain who shall purchase a position in the chain or system of the franchise by bringing said other person into said chain creates a likelihood of confusion or misunder-

standing, which constitutes fraudulent conduct under the Unfair Trade Practice and Consumer Protection Law, and is illegal.

The Unfair Trade Practice and Consumer Protection Law does not violate the Constitution of the Commonwealth of Pennsylvania, nor the Constitution of the United States of America.

In the Court of Common Pleas of Erie County, Pa.

Civil Action - In Equity

No. 57 Equity Docket 1970

William J. Kelly, Esq., Assistant Attorney General, for the Commonwealth

F. Lee Bailey, Esq., Attorney for the Defendant

OPINION

CARNEY, P. J., March 25, 1971 —

The Commonwealth of Pennsylvania instituted this Action in Equity in the Court of Common Pleas of Erie County, requesting this court to restrain by either temporary or permanent injunction, conduct of the defendant, Koscot Interplanetary, Inc., allegedly in violation of the Unfair Trade Practice and Consumer Protection Law, 1968 December 17, P. L. ____ No. 387, Sec. 1, 73 P. S. 201. There is of record another proceedings brought under the authority of this Act, termed "An Assurance of Voluntary Compliance" at 1941 A of 1969.

The Commonwealth now alleges that Koscot has not abided by its assurances and, in addition, contends that the respondent is and has been using procedures illegal under the Pennsylvania Unfair Trade Practice and Consumer Protection Law.

With regard first to the Assurance of Voluntary Com-

pliance, Section 5 of the Act states that *"Such assurance of voluntary compliance shall not be considered an admission of violation for any purpose."* In addition, the Act does not provide any sanctions for violation of the assurance. Therefore, while the prior proceedings may serve as a background for the equity action, it shall not here have any bearing on the Commonwealth's burden of proof in the matter now before the Court.

While the Commonwealth has alleged numerous violations of the Act, for our purposes they will be grouped in two general classifications.

First, that the respondent has violated Section 2 (4) xii of the Act, in that it pays a fee or consideration to a person who has a position in the distribution system of Koscot for the "procurement of a contract of purchase of a distributorship, sub-distributorship, or other similar position by another person, or for bringing said person into the Koscot distribution system,". and

Secondly, in making representations through its agents, servants, or employees, in its manuals, at Golden Opportunity meetings, and at other times and places, in violation of Section 2 (4) xiii of the Act, in that said representations are not based upon the actual experience of the corporation.

In addition, the Commonwealth alleged that Koscot was in violation of both the Pennsylvania Business Corporation Law, 15 P. S. 2004 et seq., and the Fictitious Corporate Name Act. However, both of these matters have been resolved to the satisfaction of the Commonwealth, and warrant no further discussion.

The Commonwealth originally requested a temporary injunction, the same to become permanent after the testimony was completed. It was later agreed between the parties that no responsive pleading need be filed by Koscot; that action on the request for a temporary injunction be deferred, and that the testimony, briefs, and argument be

considered the judicial proceedings on the Commonwealth's request for a permanent injunction.

Hearings were held on December 30, 1970 and January 5th and 6th, 1971. Briefs have been filed, oral arguments have been held, and the matter is now ripe for decision.

In summary, the facts are as follows. Koscot Interplanetary, Inc. was conceived by Glenn W. Turner, a native of South Carolina, and was incorporated in the State of Florida in 1967. It is engaged in the production and sale of cosmetics, hair fashions, and clothing for both men and women. It was testified that Koscot dispenses 141 separate items in the cosmetic field. Thirty to forty percent are manufactured by Koscot, the remaining products come from other manufacturers and are packaged and marketed by the respondent.

Koscot began doing business in Pennsylvania during the early part of 1968. Its method of operation in Pennsylvania has varied in its three years of operation, as indicated by the content of the manuals introduced by the Commonwealth. Exhibits A and B, labeled "Director's Training Manual" and "The Distributor's Training Manual," outline the methods used until the latter part of 1970. The respondent was, at the time of the Complaint in Equity, using Exhibit C., labeled "Distributor's Training Manual." Therefore, we will restrict our consideration for the purposes of this suit to the latter. That Exhibit C was so used was confirmed by the Testimony of Malcolm Julian, International Vice President of special products for Koscot.

The current manual contains a forward by Mr. Turner, a preface by a Terrell Jones, International Assistant to the Chairman of the Board, a brief biography of Mr. Turner and Mr. Jones, suggestions for Golden Opportunity meetings, and a suggested format for said meetings. The latter is actually a script setting forth in detail how the meeting is to be conducted, what is to be said, the figures,

diagrams and statistics to be used, and the enthusiastic manner in which all of these directives are to be carried out.

The testimony of both the Commonwealth's witnesses who have attended Golden Opportunity meetings, as well as that of Mr. Julian, indicate that the format of the meetings closely follows the script suggested in the manual.

The respondent's method of distributing its product, rather than through established retail channels, is to set up an independent chain of distributors, with the "distributor" at the top level, a "sub-distributor," and at the bottom, a "beauty advisor," who sells directly to the public, usually door-to-door, or at parties arranged for that purpose.

It is also set forth in the manual, and corroborated by the testimony, that a distributor is qualified to solicit offers for a distributorship, and if successful, the soliciting distributor receives a sum of money. (The manual states $3,000.00, the testimony indicates $2,600.00).

The respondent has set a quota of 1,500 distributorships for Pennsylvania, or one for every 7,000 of the population. At the time of the hearings there were in excess of 800 distributorships in Pennsylvania.

FINDINGS OF FACT

(1) Koscot was incorporated in the State of Florida in the year 1967, and is presently registered to do business in the Commonwealth of Pennsylvania. R - 2 - 40, R - 3 - 283.

(2) Koscot began doing business in Pennsylvania during either the latter part of 1967 or early 1968. R - 3 - 270.

(3) In order to market the cosmetics and other products which it sells, Koscot has created a network of dis-

tributors and sub-distributors throughout Pennsylvania, and a number of other states. R - 3 - 249.

(4) In addition to the network of distributors and sub-distributors there are retail sales personnel, i. e. beauty advisors, who contract with the distributors and sub-distributors to sell cosmetics on a commission. R - 3 - 249 - 250.

(5) The products sold and distributed by Koscot are of good quality equal to competitively priced products.

(6) Koscot has engaged an advertising agency on a national level and is at present doing substantial advertising in both the broadcast and magazine media.

(7) Koscot has sold in Pennsylvania as of January 1, 1971, 503 distributorships and 343 sub-distributorships, a total of 846. Com. Ex. L. R, R - 2 - 43.

(8) The franchise cost for a distributor is $4,500, and for a sub-distributor $1,000.00. Com. Ex. C and R - 1 - 291 - 292.

(9) Koscot has a self-imposed quota in Pennsylvania of 1,500 distributorships, or one for each seven thousand of the population. Koscot Ex. IX.

(10) Koscot pays distributors and sub-distributors substantial sums for bringing other distributors and sub-distributors into the system. R - 3-291-292-295.

(11) In Pennsylvania a distributor who brings another distributor into the Koscot organization receives $2,650.00 from Koscot from the fee of $4,500.00 paid by the new distributor. R - 3-291-292-295.

(12) A distributor in Pennsylvania who brings in a sub-distributor at a fee of $1,000.00 receives $650.00. R - 3-295.

(13) The distributors and sub-distributors initially sign an application in which it is stated "*I hereby offer to*

purchase a distributorship from Koscot Interplanetary Incorporated." Comm. Ex. D and Defendant's Ex. 14.

(14) As part of its program to build a network of distributors and sub-distributors in the Commonwealth of Pennsylvania, Koscot has conducted organizational meetings which are called "Golden Opportunity Meetings" and are so referred to in the manuals. Ex. A, B and C.

(15) Koscot has issued a policy statement dated November 1969 stated to be a report to Attorneys General of the several states to Koscot attorneys, and to all distributors, and is used in conjunction with the current manual.

(16) Koscot instructs distributors and sub-distributors as to the conduct of the Golden Opportunity meetings and gives them detailed instructions as to the method of bringing other distributors into the system. Ex. A, B and C, R. -8-286.

(17) Distributors and sub-distributors already in the system conduct these meetings according to the manuals with the help of Koscot officers, agents, and employees, and also assist in the "Go-Go Tours" to the home of the corporation in Orlando, Florida. R -8-287.

(18) Said meetings are conducted in an atmosphere of enthusiasm and high pressure salesmanship.

(19) At said meetings it is indicated to prospective distributors and sub-distributors that "Alice," the hypothetical beauty advisor will earn $8,000.00 or more per year.

> *"This is over $8,000.00 per year (5)! Alice is working less hours than the average woman and earning far more.*
>
> *(5) $8,000.00*
>
> *We know that every woman won't earn this much money. Some will only be part-time sales ladies. But others will work full time and earn*

this much and more." Ex. C. Figure 5.

(20) There is no evidence before the court that any beauty advisor so employed in the Commonwealth of Pennsylvania ever earned $8,000.00 per year.

(21) With regard to distributors and sub-distributors, the potential applicants, after the discussion concerning the beauty advisors and their activities, are told that their sales activities can yield $50,000.00 per year.

> *"Ladies and gentlemen, this is over $50,000.00 (30) a year and now we are talking about a great deal of money, aren't we? Do you know what excites me about this figure? THESE ARE KOSCOT DISTRIBUTORS WHO ARE PRESENTLY EARNING THIS KIND OF MONEY AND MORE!"* (Emphasis added). Ex. C, Figures 26 and 30.

(22) The potential distributors and sub-distributors are also told that they can make an additional $36,000.00 per year bringing new distributors into the organization, or a total of $86,000.00 per year.

> *"Koscot solicits offers to buy distributorships through salesmen. As a Koscot distributor, you are qualified to solicit such offers. Each time a person you solicit purchases a distributorship you receive $3,000.00."*[1]
>
> *Do this once a month and you will earn $36,000 a year! As a distributor with 24 well trained beauty advisors you can be earning over $50,000.00 (41) a year on their sales volume! This is $86,000.00 a year you can earn!"* Ex. C, Figures 40-41-42.

(23) There is no evidence in this case that any dis-

[1]Malcolm Julian testified the fee referred to was $2,650.00. R. 3-292.

tributor or sub-distributor in the Commonwealth of Pennsylvania has even made the retail profit suggested in the manuals and at the Golden Opportunity meetings, as set forth in Findings 21 and 22.

(24) The profits expected from the "sale of distributorships" is a prime inducement to persons buying into the organization.

(25) The said system of attracting distributors tends to create distributorships in areas where recruiting distributors are active, thus over-saturating some areas and undersaturating others. R-2-44.

(26) The Koscot system of recruiting distributors in Pennsylvania has created a distribution network characterized by:

(a) A tendency for distributors and sub-distributors to bring in family members, relatives, friends and neighbors.

(b) A system which tends to attract persons with little business experience.

(c) A system which tends to emphasize recruitment of distributors and sub-distributors over retail sales.

(d) A system which attracts the super-salesman whose interest in the large recruitment fee.

(27) The Koscot system tends to bring into the organization large numbers of distributors and sub-distributors who are destined to failure and economic loss.

DISCUSSION

The Commonwealth of Pennsylvania, acting through the Attorney General, has asked that the respondent be restrained from certain practices which it contends is in

direct violation to the Act of 1968, Dec. 17, P. L. ____ No. 387, 73 P. S. 201-1 et seq. entitled the "Unfair Trade Practices and Consumer Act."

The pertinent portions of Sec. 201-2 reads as follows:

"(4) 'Unfair methods of competition' and 'unfair or deceptive acts or practices' mean any one or more of the following:

(Xii) Promising or offering to pay, credit or allow to any buyer, any compensation or reward for the procurement of a contract of purchase with others;

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

The Commonwealth alleges that sub-section Xii is being violated in that the plan under which Koscot is operating in Pennsylvania at the present time pays a distributor a fee of $2,650.00 for each new distributorship he brings into the organization. In addition, the distributor obtains a commission, in reality a fee of $650.00 on merchandise purchased at retail by a sub-distributor for $1,000.00. It is further alleged that statements found in the manuals and made at the Golden Opportunity meetings relative to the earnings of distributors, sub-distributors and beauty advisors, as indicated in Findings of Fact 19, 21 and 22, supra, are in violation of sub-section Xiii in that they are not based on fact and are knowingly fraudulent.

On the basis of these allegations the court is now requested to enjoin Koscot from paying the fee complained of, and further, from making any representation not based on the experience of a substantial number of people engaged in the program.

In reply, the respondent asserts

(1) That the purchasers of distributorships are not "buyers" as that term is used in the Act.

(2) That the transaction does not constitute a contract of purchase because of the supervisory service required of the distributor or sub-distributor.

(3) That the fraudulent conduct referred to in subsection Xiii refers to consumer fraud.

(4) That the representations were not fraudulent, but merely hypothetical illustrations and were not made to consumers as intended by the Act.

(5) That the Act is unconstitutional as not being a proper exercise of the police power, and further, that the sections in question are vague and indefinite.

(6) That factually, the system used is in no way comparable to the fraudulent "referral" scheme.

Let us first consider the alleged violation of subsection Xii, the sale of positions in the Koscot system. The respondent argues with considerable logic that this is not the ordinary referral scheme condemned by many courts, but a multi-million dollar corporation with quality products that has, for the benefit of the members of its system, devised a rotating cash plan which allows those with little capital to participate and prosper. Not an endless "chain letter" type of operation, but one that operates on a quota system devised for the corporation by a reputable firm.

While we are in agreement that the facts before us do not depict a situation as blattently fraudulent as many of the schemes referred to, we do feel that the Koscot system, as conducted in Pennsylvania, does violate this particular sub-section of the Act.

That to limit the Act's application as suggested would be to restrict and narrow the original intention of the legislature.

Section 201-3 of the Act states in part *"Unfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce are hereby declared unlawful."* This is almost identical with Sec. 45(a) of the Federal Trade Commission Act. 18 U. S. C. A. 41 et seq. The Act in question, and sub-section Xii in particular, was passed by our legislature in 1968 after the inherent dangers and the dire consequences of referral selling had become apparent.

In *Norman v. World Wide Distributors, Inc. 202 Pa. Superior 53, 56 (1963)* the court said:

> *"The referral plan was a fraudulent scheme based on an operation similar to the recurrent chain letter racket. It is one of the many sales rackets being carried on throughout the nation which are giving public officials serious concern."*

Almost the identical situation existed in *United Consumer Discount Company of Ligionier vs. Paulovich, 38 D & C 2d, 718* and *Transcontinental Consumer Discount Co. of Erie vs. Weaver, 52 Erie 4,* where purchasers of rugs and central vacuum cleaning systems were promised credits and/or payments for subsequent purchasers solicited by them.

The same situation was recognized by the court in *Com. Ex Rel. Pa. Sec. Com. v. Consumer's Research and Consultants, Inc. 414 Pa. 253, 254 (1964). "Appellee's activities clearly border on the fraudulent and are a studied attempt to fleece purchasers of a 'built-in-vacuum' by securing an unconscionable overcharge, which overcharge the purchaser is prevailed upon to believe can be recouped by returns he would receive from an advertising commission agreement."*

A similar operation was condemned in *State of N. Y.* by *Lefkowicz V. I. & M. Inc., 275 U. S. S. 2d 303.*

It was the recognition of these and similar situations

that undoubtedly prompted the enactment of sub-section Xii. Furthermore, we do not believe that the application of this sub-section is limited to the obvious fraudulent schemes described in these citations, but that it applied with equal force to the more sophisticated method of operation here used by Koscot.

The manual now in use (Ex. C) states:

> *"Kosoot solicits offers to buy distributorships through salesmen. As a Koskot distributor you are qualified to solicit such offers. Each time a person you solicit purchases a distributorship you receive $3,000.00."*

The testimony of not only the Commonwealth's witnesses, but also that of Mr. Julian, leaves no doubt that Koscot's operation now being carried out in Pennsylvania is in violation of sub-section Xii. That Koscot produces and markets a quality product, that each distributor or sub-distributor coming into the organization is supplied an inventory of products, makes this no less a violation.

In discussing an Iowa Statute prohibiting referral sales, the court in *State of Iowa, Ex Rel. Richard C. Turner vs. Koscot Interplanetary, Inc. In Equity, 74441* in the District Court of Polk County, Iowa, in a case almost identical with that before the court, and with the identical defendant, the court rationalized its statute as follows:

> *"And like it is not to say that all situations or persons coming within the statute are fraudulent, it is simply to say that the situation is an apt vehicle for fraud, and experience shows, unhappily, that it has been used often for fraud and that the general good will be better advanced by banning the fraud prone situation altogether, although some legitimate dealings or situations are banned with it.*

The argument that the transaction does not constitute

a contract of purchase, that the purchaser of a distributorship is not a buyer, is not impressive.

We need only to look to the Distributor's Training Manual (Ex. C) previously quoted, to learn that Koscot itself looked upon these transactions as contracts of purchase and the new distributor a buyer.

> *"Koscot solicits offers to BUY distributorships through salesmen. As a Koscot distributor you are qualified to solicit such offers. Each time a person you solicit PURCHASES a distributorship you receive $3,000."* (Emphasis ours).

The usage of the term buy and purchase, patently indicates a sales transaction, and that it was considered as such by the respondent.

This is further borne out by Exhibits D and 14, the sub-distributors. They contain the following printed statement.

> *"I hereby offer TO PURCHASE a distributorship from Koscot Interplanetary, Incorporated."*
>
> (Emphasis supplied).

In any event, as in *Iowa vs. Koscot*, supra, the sale of such position is so intertwined with the sale of the cosmetics which goes to the purchaser, as to be a part of the sale of that product.

The argument that the transaction does not constitute a contract of purchase because of the supervisory service required of the distributor is also not pursuasive. According to evidence before us the fee paid is disproportionate to the service rendered, which from all indications, is minimal.

With regard to the alleged violation of sub-section XIII we have already found as a fact that certain statements set forth in the manuals, and enunciated at the Golden

Opportunity meetings as to the earnings of distributors, sub-distributors, and beauty advisors, were not substantiated by the facts. (Findings of Fact 19, 21, 22 and 23). In this respect the respondent contends that the "fraudulent conduct" used in the Act refers to consumer fraud, and that the representations made by Koscot were not only not fraudulent but were not made to "consumers" as intended by the Act.

First, to limit the application of the Act solely to a consumer, the one who ultimately uses the product, would be to say that this is the only party you cannot defraud. Do what you will to the wholesaler, the middleman, but don't defraud the consumer. This cannot be so. The Act, by its very title, signifies that it is not solely a Consumer Law. Sec. 201-1 states *"This act shall be known and may be cited as the 'Unfair Trade PRACTICES and Consumer Protection Law."* (Emphasis ours).

That the Act is not limited solely to the protection of the consumer is inherent in Section 201-3. *"Unfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce are hereby declared unlawful."*

In its brief the respondent agrees that it would have no objection to limiting the statements made at the meetings and in its manuals regarding earnings to representations based on the experience of a substantial number of people engaged in the program, provided that the potential income possible to a Koscot distributor or sub-distributor was also included.

We would agree with the erespondent provided that the potential earnings so represented had some basis in fact. To represent that a beauty advisor will earn $8,000.00 or more per year without any known factual basis, with knowledge that either the statement is false, or made recklessly without any concern for its truth or falsity is, in

our opinion, a fraudulent representation.

The same situation exists with regard to statements that distributors can earn $50,000. a year retail, when according to the evidence, no one in Pennsylvania has ever done so, or that by bringing one new distributor into the organization a month, the distributor can earn an additional $80,000. a year.

While we certainly approve of the patriotic atmosphere of the meetings, and have no objection to the enthusiasm displayed, this type of representation, in our opinion, is calculated to deceive, mislead and confuse.

At the time of the hearings there were over 800 distributors in Pennsylvania. According to Koscot they have a self-imposed quota of 1,500 in Pennsylvania. Suppose all 800 were successful in soliciting one, not twelve, additional distributors in the coming year. This would amount to over 800 additional distributors and exceed the quota. Or, suppose that 60 out of the 800 plus distributors were successful in soliciting one additional distributor each month for the next year. This would result in an additional 720 distributorships, once again exceeding the quota, while the remaining 740 plus distributors had not brought in a single new distributor nor earned a single dollar from this source. Thus, the representation is without a logical basis.

In *Goodman v. F. T. C. 244 F. 2d, 584,* involving an appeal from a Federal Trade Commission order directing the petitioner to cease and desist from representing directly or by implication that the typical earnings of persons selling petitioner's course of instruction, are greater than they actually were, the court said:

> *"It should be added that we are not in the realm of civil torts. Even in that realm the old rule of CAVEAT EMPTOR has been abandoned, in favor of the more ethical attitude that one dealing with another in business had the right to*

rely upon representations of fact as the truth. And the Supreme Court has applied with great consistency this approach in dealing with the Federal Trade Commission by stating in a leading case:

'The fact that a false statement may be obviously false to those who are trained and experienced does not change its character, nor take away its power to deceive others less experienced. There is no duty resting upon a citizen to suspect the honesty of those with whom he transacts business. LAWS ARE MADE TO PROTECT THE TRUSTING AS WELL AS THE SUSPICIOUS. The best element of business has long since decided that honesty should govern competitive enterprises, and that rule of CAVEAT EMPTOR should not be relied upon to reward fraud and deception.' (Emphasis added)."

There is no question that the representations complained of, and which were not based upon factual experience, were calculated to deceive the prospective customers into believing that this was the experience of many distributors, and sub-distributors who had preceeded them, calculated to impress them on this basis and to secure their purchase of a distributorship. The unconcern over the accuracy of the representations or their truthfulness is, in our opinion, the type of deceptive practice prohibited by the sub-section in question.

The remaining contention of the respondent is that the Unfair Trade Practices and Consumer Protection Act is inoperative, void and unconstitutional in that it is an improper exercise of the police power and that the specific sections sought to be applied here are vague and indefinite. It is submitted that the pertinent constitutional provisions involved are Article 1, Section 1 of the Pennsylvania Constitution and Section 1 of the Fourteenth Amendment to the Constitution of the United States,

(1) Article 1, Section 1 of the Pennsylvania Constitution:

> *"All men are born equally free and independent and have certain inherent and indefeasible rights, among which are those of enjoying and defending life and liberty, of acquiring, possessing and protecting property and reputation, and the pursuing of happiness."*

(2) Section i, Fourteenth Amendment of the Constitution of the United States of America:

> *"All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and the state wherein they reside. No state shall abridge the privileges of immunities of citizens of the United States: nor shall any state deprive any person of life, liberty, or property, without due process or law: nor deny to any person within its jurisdiction the equal protection of the law."*

The respondent having here alleged the Act in question to be unconstitutional, has the burden of overcoming the presumption of constitutionality.

The court in *Searfoss v. School Dist. of Borough of White Haven, 397 Pa. 604,* said that *". . . to construe a statute, if at all possible, so as not to render it unconstitutional, is our bounden duty . . . a statute should not be declared unconstitutional unless it violates the constitution clearly, palpably, plainly and in such a manner as to leave no doubt or hesitation in the mind of the court."*

Applying these standards we must reject and dismiss the contention of unsonstitutionality. We find no merit in the allegation relative to police power. An Act that has as its main purpose the prohibition of unfair methods of competition and unfair or deceptive acts or practices, is

clearly not restricted by the state or federal constitutional provisions cited.

The court in *Lefkowicz vs. I. & M. Inc.*, supra said:

> *"Legislation designed to protect the consuming public against persistent fraud and illegality is certainly considered the rightful domain of the state, and the wrongdoer will not be held to shield himself behind the cloak of the alleged unconstitutionality of a meritless statute."*

The same defense was raised in *State of Iowa v. Koscot*, supra, and rejected with this explanation:

> *"As to the total ban after July 1, 1970: the legitimacy of the application of the state's police power in such a statute, is that referral sales have been a fertile field for fraud. Such has been the experience with such sales methods throughout the nation including Iowa. To say that such a statute is constitutional is not to say that referral sales intrinsically cannot be legitimate and honest —doubtless many or some have been or are—it is simply to say that common experience indicates many are not and it is difficult to distinguish until after the fact. The same reasoning applies to many statutes—to sustain a dead man's statute, a statute of frauds, a statute of limitations and the like is not to say that all situations or persons coming within the statute are fraudulent. It is simply to say that the situation is an apt vehicle for fraud and experience shows, unhappily, that it has been used often for fraud and that the general good will be better advanced by banning the fraud prone situation altogether although some legitimate dealings or situations are banned with it. Such is the situation with this statute which restricts, and after July 1, 1970, bans, referral type*

sales. Accordingly the constitutional attack on the statute is rejected."

Furthermore, sub-section Xii is not, in our opinion, either vague, indefinite or ambiguous. It plainly and clearly prohibits the practice carried on by the respondent, the payment of or the promise to pay, a fee or commission to a purchaser not as specific does convey its precise meaning when read against the background of the enactment of the Act and its purpose, as exemplified by Section 201-8.

The court in *Pa. Human Relations Comm. v. Chester Sch. D. 427 Pa. 157* stated: *"The Canons of statutory construction require that a statute be read in a manner which will effectuate its purpose, a task which compels consideration of more than a statute's literal words."* The court then went on to say that the court may consider the historical setting which gave impetus to the law and the circumstances of its passage.

Nor does the fact that this sub-section is couched in general terminology render it unconstitutional. That reasonable certainty was sufficient was set forth in *Charles Dunn v. Mayor and Council of the City of Wilmington, 212 Atl. 2d. 602.*

> *"A statute is not unconstitutional as indefinite because it employs general terms, when such terms convey to a person of ordinary understanding and intelligence an adequate description of the prohibited act, for impossible standards of certainty are not required. Reasonable certainty is sufficient."* See also *Henke v. Fisher, 314 Fed. Suppl 107.*

For these reasons the allegation of unconstitutionality is rejected.

The Commonwealth has also contended that the conduct of the respondent constituted a violation of the lottery statute. We find little merit in this argument, and in view

of our findings we need not further discuss this contention. Nor do we feel that we can accede to the request of the Commonwealth that Koscot be restrained from conducting business in the Commonwealth until settlement of all claims made by its distributors and other members of the system. It is our opinion that the merit of each dispute rests entirely on the facts presented in the specific claim. Therefore, to issue a blanket directive compelling settlement of all claims, regardless of the circumstances, would be not only unwise and improper, but contrary to good legal principles.

CONCLUSIONS OF LAW

(1) The purchasers of franchises of Koscot, whether they be distributors or sub-distributors, are "buyers" as the term is used in the Unfair Trade Practices and Consumer Protection Law.

(2) Koscot violates the Unfair Trade Practices and Consumer Protection Law by paying distributors substantial sums for bringing other distributors into the Koscot system.

(3) Koscot violates the Unfair Trade Practices and Consumer Protection Law by paying distributors and sub-distributors substantial sums for bringing sub-distributors into the Koscot distributor system.

(4) The Unfair Trade Practices and Consumer Protection Law covers not only frauds directed at the ultimate consumer, but also any other unfair trade practices.

(5) The Unfair Trade Practices and Consumer Protection Law prohibits unfair methods of competition and unfair or deceptive acts or practices and is not limited to the protection of the ultimate consumer only.

(6) Representations relative to earnings made by Koscot, its representatives, servants or employees, in its manuals, at its meetings or elsewhere, where they are not

based upon the experience of a substantial number of the members of the system, are in violation of the Unfair Trade Practices and Consumer Protection Law.

(7) The Unfair Trade Practices and Consumer Protection Law is constitutional.

ORDER OF COURT

AND NOW, to-wit, this 25th day of March, 1971, it is hereby ordered, directed and decreed, that the respondent, Koscot Interplanetary, Inc., a Florida Corporation, or under any other name or designation, and respondent's representatives, agents and employees, directly or through any corporate or other device, do forthwith within the Commonwealth of Pennsylvania, cease and desist from:

(1) Paying, or promising to pay, any fee, compensation, reward or other consideration, either directly or indirectly, to a distributor, sub-distributor, supervisor, director, or beauty advisor, or to any other person who shall purchase a position in the distribution system of Koscot Interplanetary, Inc. for the procurement of a contract of purchase of a distributorship, sub-distributorship, or other similar position by another person or for bringing said other person into the Koscot distribution system.

(2) Making representations through its representatives, officers, agents, servants, employees, distributors, sub-distributors, directors, supervisors, or beauty advisors, in its manuals, at Golden Opportunity meetings, or elsewhere relating to earnings which are not based upon the experience of a substantial number of persons engaged in the Koscot program.

(3) Utilization of any advertisement or promotional device which would in any way be a misrepresentation or cause a likelihood of confusion.

(4) Conducting business in the Commonwealth of Pennsylvania through any deceptive act or practices, or

through any and all acts in aid or furtherance of said deceptive acts or practices.

(5) Violating the provisions of the Pennsylvania Unfair Trade Practices and Consumer Protection Law by any direct or indirect means.

(6) Enaging in any activity which would violate the other provisions of the injunction, either directly or indirectly.

Nothing herein contained shall affect the obligation of the respondent as set forth in the Assurance of Voluntary Compliance, effective July 1, 1969 and recorded at 1941 A 1969 in the Court of Common Pleas of this county. Furthermore, this court shall retain jurisdiction over the respondent for the purpose of enforcing this injunction, including the assessment of Civil Penalties, as provided for in Section 8 of the Unfair Trade Practices and Consumer Protection Law.