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39 MAP 2019

IN THE SUPREME COURT OF PENNSYLVANIA

No. 39 MAP 2019

COMMONWEALTH OF PENNSYLVANIA, by Josh Shapiro, Attorney General; PENNSYLVANIA DEPARTMENT OF INSURANCE, by Jessica K. Altman, Insurance Commissioner and PENNSYLVANIA DEPARTMENT OF HEALTH, by Rachel Levine, Secretary of Health,

v.

UPMC, a nonprofit corp.; UPE, a/k/a HIGHMARK HEALTH, a nonprofit corp.; and HIGHMARK, INC., a nonprofit corp.,

Appeal of: Commonwealth by Josh Shapiro, Attorney General

REPRODUCED RECORD
VOLUME II

APPEAL FROM THE ORDER OF THE COMMONWEALTH COURT ENTERED ON APRIL 3, 2019 AT NO. 334 MD 2014

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DATE: April 24, 2019

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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. 394 M.D. 2014

NOTICE

YOU HAVE BEEN SUED IN COURT. If you wish to defend against the claims set forth in the following pages, you must take action within twenty (20) days after this Complaint and Notice are served, by entering a written appearance personally or by attorney and filing in writing with the Court your defenses or objections to the claims set forth against you. You are warned that if you fail to do so the case may proceed without you and a judgment may be entered against you by the Court without further notice for any money claimed in the Complaint or for any other claim or relief requested by the Plaintiff. You may lose money or property or other rights important to you.

YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE. IF YOU DO NOT HAVE A LAWYER, GO TO OR TELEPHONE THE OFFICE SET FORTH BELOW. THIS OFFICE CAN PROVIDE YOU WITH INFORMATION ABOUT HIRING A LAWYER.

IF YOU CANNOT AFFORD TO HIRE A LAWYER, THIS OFFICE MAY BE ABLE TO PROVIDE YOU WITH INFORMATION ABOUT AGENCIES THAT MAY OFFER LEGAL SERVICES TO ELIGIBLE PERSONS AT A REDUCED FEE OR NO FEE.

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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

AVISO

USTED HA SIDO DEMANDADO/A EN CORTE. Si usted desea defenderse de las demandas que se presentan más adelante en las siguientes páginas, debe tomar acción dentro de los próximos veinte (20) días después de la notificación de esta Demanda y Aviso radicando personalmente o por medio de un abogado una comparecencia escrita y radicando en la Corte por escrito sus defensas de, y objecciones a, las demandas presentadas aquí en contra suya. Se le advierte de que si usted falla de tomar acción como se describe anteriormente, el caso puede proceder sin usted y un fallo por cualquier suma de dinero reclamada en la demanda o cualquier otra reclamación o remedio solicitado por el demandante puede ser dictado en contra suya por la Corte sin más aviso adicional. Usted puede perder dinero o propiedad u otros derechos importantes para usted.

USTED DEBE LLEVAR ESTE DOCUMENTO A SU ABOGADO INMEDIATAMENTE. SI USTED NO TIENE UN ABOGADO, LLAME O VAYA A LA SIGUIENTE OFICINA. ESTA OFICINA PUEDE PROVEERLE INFORMACION A CERCA DE COMO CONSEGUIR UN ABOGADO.

SI USTED NO PUEDE PAGAR POR LOS SERVICIOS DE UN ABOGADO, ES POSIBLE QUE ESTA OFICINA LE PUEDA PROVEER INFORMACION SOBRE AGENCIAS QUE OFREZCAN SERVICIOS LEGALES SIN CARGO O BAJO COSTO A PERSONAS QUE CUALIFICAN.

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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

PETITION FOR REVIEW

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

JURISDICTION

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

PARTIES

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

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

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

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

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

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

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

FACTS

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

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

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

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

Our Mission:

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

Our Vision:

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

Our Values:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COUNT I

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COUNT II

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

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

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

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

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

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

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

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

> . . .
>
> (iii) Causing likelihood of confusion or of misunderstanding as to affiliation, connection or association with, or certification by, another;
>
> . . .
>
> (v) Representing that goods or services have sponsorship, approval, characteristics, ingredients, uses, benefits or quantities that they do not have or that a person has a sponsorship, approval, status, affiliation or connection that he does not have;
>
> . . .

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

. . .

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

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

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

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

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

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

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

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

73 P.S. §201-8(b).

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

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

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

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

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

WHEREFORE, the Commonwealth respectfully requests that this Honorable Court:

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

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

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

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

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

COUNT III

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WHEREFORE, the Commonwealth respectfully requests that this Honorable Court:

a. Find that UPMC's and Highmark's ongoing contractual dispute has threatened and continues to threaten the adequacy of Highmark's network in violation of Act 68, 40 P.S.§ §991.2111(1) and 21ll(4);

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

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

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

physician and follow-up care services at all UPMC hospitals within 30 days of this Court's order and, failing such an agreement, impose last best offer arbitration ;

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

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

Respectfully submitted,

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UPMC LIFE CHANGING MEDICINE

NEWS RELEASE SEARCH

GO

UPMC/University of Pittsburgh Schools of the Health Sciences

UPMC LIFE CHANGING MEDICINE

Joint Statement by Highmark and UPMC

For Journalists

Paul Wood
Vice President & Chief Communications Officer, Public Relations
Telephone: 412-647-6647

Other Inquiries
Contact Us

PITTSBURGH, May 2 – Highmark and UPMC are pleased to announce that they have reached an agreement in principle to provide for in-network access to all UPMC hospitals and physicians for Highmark Commercial and Medicare Advantage members until December 31, 2014.

In addition, in recognition of special local community needs and certain unique services offered by UPMC, and to minimize access to care and rate disputes, Highmark and UPMC have agreed to negotiate rates and terms for continued Highmark member access to certain UPMC services on an in-network basis starting in 2015, including Western Psychiatric Institute and Clinic, certain oncological services, UPMC Bedford, and UPMC Northwest. Highmark members in a continuing course of treatment at UPMC will also continue to have in-network access to UPMC hospital and physician services.

Current Highmark-UPMC arrangements regarding UPMC Mercy and Children's Hospital are unaffected by this agreement and will remain in effect. The current Highmark-UPMC arrangements regarding UPMC Hamot, which expire on June 30, 2013 with an additional one-year run-out period, will be extended by six months to December 31, 2014.

As part of its community benefit mission, UPMC will also continue to provide in-network hospital and physician services at preferred rates for certain Highmark plans which serve vulnerable populations, specifically Special Care, pa fair care, CHIP and Guaranteed Issue plans, for such time as these plans continue to be offered by Highmark.

The contractual extension until the end of 2014 will provide for sufficient and definite time for patients to make appropriate arrangements for their care and eliminate the need for any possible governmental intervention under Act 94. Highmark has agreed not to seek or support such intervention in return for UPMC's agreement to the extension.

This agreement was reached with the assistance of a mediator designated by Governor Corbett and the support of interested legislators. The agreement in principle is binding and will be implemented through formal agreements to be completed by June 30, 2012.

Exhibit "A"

RR 465a

medical questions that you have. Further, UPMC.com is not a tool to be used in the case of an emergency. If an emergency arises, you should seek appropriate emergency medical services.

For UPMC Mercy Patients: As a Catholic hospital, UPMC Mercy abides by the Ethical and Religious Directives for Catholic Health Care Services, as determined by the United States Conference of Catholic Bishops. As such, UPMC Mercy neither endorses nor provides medical practices and/or procedures that contradict the moral teachings of the Roman Catholic Church.

Pittsburgh, PA, USA UPMC.com

VERIFICATION

I, GARY A. SHADE, being duly sworn according to law, hereby state that I am authorized to make this verification on behalf of the plaintiff, and that the allegations in the foregoing Petition for Review are true and correct to the best of my knowledge, information and belief.

Gary A Shade

SWORN AND SUBSCRIBED TO

before me this 27th day of June 2014

Melissa M Ritzman

Notary Public

My commission expires 4/29/2016

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
MELISSA M RITZMAN, Notary Public
Dauphin County, City of Harrisburg
My Commission Expires April 29, 2016

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

HIGHMARK'S BRIEF IN OPPOSITION TO PETITIONERS' APPLICATION TO HOLD HIGHMARK IN CONTEMPT, ENFORCE CONSENT DECREE AND ISSUE A PRELIMINARY INJUNCTION

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Respondents UPE a/k/a Highmark Health and Highmark Inc. (collectively "Highmark"), through their undersigned counsel, file this Brief in response to Petitioners' Brief supporting their Application to Hold Highmark in Contempt, Enforce Consent Decree and Issue a Preliminary Injunction (the "Application").[1] Highmark states as follows:

I. INTRODUCTION

On October 10, 2014, Petitioners filed their Application asking this Court to impose on Highmark obligations to which it did not contractually agree, and to take away from Western Pennsylvania seniors a critically important Medicare Advantage alternative that has been approved by the federal government – a low cost, limited network product offering access to high quality health care called Community Blue Medicare HMO ("Community Blue "MA").

Petitioners' revisionist interpretation of the Consent Decree entered by this Court on or about July 1, 2014 (the "Consent Decree"), Ex. 1 hereto, ignores the

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[1] Highmark Health serves as the sole controlling member and parent of Highmark Inc. Highmark Health is a party to the Consent Decree. However, Petitioners' collective reference to Highmark and Highmark Health as "Highmark" in their Application is overly broad. The product design, sale and marketing of the Community Blue MA product at issue in Petitioners' Application are performed by Highmark Inc and Keystone Health Plan West, Inc. ("KHPW"). Highmark Health reserves the right to object to any reference to "Highmark" in Petitioners' Application as implying action or conduct by Highmark Health but for purposes of this Opposition Brief will use the same terminology as Petitioners. KHPW is an affiliate of Highmark Inc. and shall also be included in the reference to "Highmark."

plain language of the Decree itself as well as numerous surrounding facts, all of which demonstrate that Highmark did not agree to the anti-competitive result Petitioners now seek. Highmark's rollout of its Community Blue MA product, as one of several Medicare Advantage options available to Western Pennsylvania seniors, is fully consistent with Highmark's obligations under the Consent Decree.

The federal government comprehensively regulates what products may be offered under the Medicare Advantage program. Community Blue MA and its marketing materials have been vetted by, and fully comply with, the federal statute and regulations enacted by Congress and the Department of Health and Human Services's Center for Medicare & Medicaid Services ("CMS"), the exclusive government authority charged with oversight and regulation of Medicare Advantage products like Community Blue MA. Petitioners improperly ask this Court to exceed the bounds of state law by ordering that a federally approved Medicare Advantage product be drastically altered or withheld entirely from sale to the public.

Petitioners' requested relief also is harmful to competition and restricts the type of consumer choice the Pennsylvania Insurance Department ("PID") and Attorney General purportedly aim to protect. Highmark's Community Blue MA product adds to the choices available to Western Pennsylvania seniors. If Petitioners' Application is granted, it will amount to a decision by the

Commonwealth that all Highmark subscribers, including Medicare Advantage subscribers, must pay more for their health insurance in order to have access to the UPMC system, whether they want that access or not. If Petitioners succeed, the only beneficiary will be UPMC.

Despite the fact that Petitioners were informed by Highmark about the limited network available under Community Blue MA months ago, and did not then object, Petitioners now request drastic relief that would disrupt the status quo and cause mass confusion mere hours before more than hundreds of thousands of Western Pennsylvania seniors will begin enrolling in federally approved Medicare Advantage products, including those offered by Highmark. This Court should therefore act quickly in denying Petitioners' Application in full.

II. FACTS

A. Highmark's Medicare Advantage Products

This dispute centers around a new Highmark Medicare Advantage ("MA")[2] product for the 2015 enrollment year called Community Blue MA. Declaration of Timothy Lightner ("Lightner Decl."), Ex. 2 hereto, at ¶ 12. Community Blue MA

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[2] The Medicare Act, enacted as Title XVIII of the Social Security Act and codified at 42 U.S.C. §§ 1395–1395kkk (2012), creates a federally subsidized nationwide health insurance program for elderly and disabled individuals. Pursuant to Part C of the Act, beneficiaries may receive Medicare benefits through MA plans provided by private entities called MA organizations. 42 C.F.R. § 422.2 (2010). KHPW, a Highmark subsidiary, is a contracted MA organization.

is a product that Highmark has developed to provide Western Pennsylvania seniors with an additional Medicare Advantage alternative that offers a limited network of high quality health care providers at a lower cost than Highmark's broad network products. *Id.* at ¶ 14. Open enrollment for Community Blue MA begins on October 15, 2014 and Highmark's marketing of the product has already begun. *Id.* at ¶ 16.

Highmark is offering Community Blue MA in addition to two other types of MA products – Security Blue and Freedom Blue – which provide broader networks that include UPMC services, but at higher monthly premiums. *Id.* at ¶ 15. UPMC hospitals and doctors are "in-network" to Medicare Advantage subscribers who purchase the Security Blue or Freedom Blue MA products. *Id.* at ¶ 23. UPMC hospitals and doctors are "out-of-network" to Medicare Advantage subscribers who purchase Community Blue MA. *Id.*

B. Highmark and Petitioners Discussed Community Blue MA Repeatedly, and Petitioners Never Expressed the Position that the Consent Decree Prohibited It.

Months ago, Petitioners knew about, and did not object to, the aspects of Community Blue MA they now claim justify twelfth-hour injunctive relief. Highmark executives were involved in discussions with Petitioners throughout 2014 leading up to the entry by this Court of the Consent Decree on July 1, 2014. Declaration of Deborah Rice-Johnson ("Rice Decl."), Ex. 3 hereto, at ¶ 2. During

those discussions, Petitioners were advised well prior to the entry of the Consent Decree of Highmark's intention to launch a new limited network MA product to be offered in Western Pennsylvania. *Id.* at ¶ 4.

Highmark expressly advised Petitioners that Community Blue MA would be a limited network, lower cost alternative to Highmark's other broad network Medicare Advantage products and that Community Blue MA would not include access to UPMC hospitals and physicians or certain other hospitals. *Id.* at ¶ 5. Highmark also advised Petitioners that Highmark, no later than February 18, 2014, had invited all Western Pennsylvania hospitals, including UPMC, to participate in Community Blue MA as in-network providers and that UPMC and certain other hospitals had declined participation in the product. *Id.* at ¶¶ 6-8.

During negotiation of the Consent Decree, the notion that Highmark would be required to include UPMC in new Medicare Advantage products, including Community Blue MA, was never raised by the state regulators nor discussed with Highmark. *Id.* at ¶ 9. Had this subject been raised, Highmark would have expressly rejected such a requirement to include UPMC in its new MA products for 2015. *Id.* at ¶ 10. In executing the Consent Decree, Highmark had no intention, and did not agree, to accept a provision requiring Highmark to include UPMC oncology services and Exception Hospitals in new products. *Id.* at ¶ 16.

In short, throughout the numerous discussions and emails leading up to the Consent Decree, no one from the Attorney General's Office, PID or Department of Health ever expressed the view that they now advocate before this Court – that the Consent Decree was intended to prevent the introduction of Community Blue MA. *Id.* at ¶ 13.

C. The Parties Reach Agreement on the Terms of the Consent Decree

Following the Spring 2014 negotiations detailed above, Highmark and Petitioners reached agreement on the language of the Consent Decree and this Court approved and entered the Decree on July 1, 2014. The "Vulnerable Populations" provision, section IV(A)(2) of the Consent Decree, is noticeable for its absence of any requirement that Highmark include UPMC in all its Medicare Advantage products. The express language of that section provides:

> 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 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 customers as In-Network regardless of whether they have Medicare as their primary or secondary insurance.

Consent Decree § IV(A)(2) (emphasis added). Nowhere in this section of the Consent Decree, or elsewhere, is Highmark required to include UPMC in all MA products.

Notably, in a prior agreement mediated by Governor Corbett, which expires at the end of 2014, [redacted] *See* Ex. 4 hereto. And, prior commercial contracts between Highmark and UPMC, but not the contracts governing Medicare Advantage services, contain language expressly requiring that UPMC be included in all products. In contrast, the Medicare Advantage contracts between Highmark and UPMC contemplate that a network offered by Highmark would contain "some or all" participating providers. *See* Ex. C to Petitioners' Application at § 2.14.

D. Highmark Obtains Federal CMS Approval for Community Blue MA

Medicare Advantage products, including Highmark's Community Blue MA, are subject to extensive and exclusive regulation by the federal government, specifically CMS. Lightner Decl. at ¶ 2; *see also* 42 C.F.R. § 422 *et seq.* Indeed, the Medicare Part C statute governing MA plans contains an express preemption clause which provides:

> The standards established under this part **shall supersede any State law or regulation** (other than State licensing laws or State laws

> relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part.

42 U.S.C. § 1395w-26(b)(3) (2006) (emphasis added).

CMS has explained and regulations confirm "[t]he scope of Federal preemption [under 1395w–26(b)(3)] is broad [....] All State standards, **including those established through case law**, are preempted to the extent that they would specifically regulate health plans (including MA plans), with the exceptions of State licensing and solvency laws." *Medicare Managed Care Manual*, Chapter 10, § 30.1-30.2 (Rev. 103, Nov. 4, 2011) (emphasis added), attached as Ex. 5 hereto. CMS has further stated that "States may not review or impose State standards for network or organizational capacity." *Id.* § 60.

The regulations contained in 42 C.F.R. § 422 *et seq.* govern numerous aspects of MA products, including issues of provider selection, network adequacy, and quality assurance, as well as review and approval of marketing materials.

In accordance with the applicable regulatory requirements, in early June 2014, Highmark submitted to CMS its proposed plan designs for each of its MA products, including Community Blue MA, which included the benefit package and rate filing for Community Blue MA. Lightner Decl. at ¶ 17. Highmark also provided CMS in early June 2014 detailed information about the providers that would be included in the network for Community Blue MA. *Id.* at ¶ 18. Specifically, Highmark provided to CMS "HSD

tables," which contain detail about the number, mix and distribution (addresses) of providers to be included in a plan network. *Id.*

In addition to providing data, Highmark representatives had multiple communications with CMS regulators before and throughout the CMS review process, explaining the Community Blue MA product and detailing the fact that Community Blue MA has a limited network. *Id.* at ¶ 20. Highmark representatives specifically discussed with CMS regulators that, although UPMC had been offered participation in the Community Blue MA network, UPMC declined and UPMC doctors and hospitals, as well as certain other area providers, would not be included in Community Blue MA network. *Id.* at ¶ 21. With full knowledge of these facts, CMS approved Community Blue MA on August 18, 2014. *Id.* at ¶ 22.

Highmark also developed and submitted to CMS for review and approval the materials that would be used to market Community Blue MA. *Id.* at ¶ 26. During its review, and recognizing that Community Blue MA was a limited network product, CMS regulators reached out to Highmark to require that Highmark include a disclaimer on its Community Blue MA marketing materials clearly indicating to subscribers that the product was a limited network product. *Id.* at ¶ 28. Highmark complied by including the following language in the Community Blue MA marketing materials, which was specifically approved by CMS:

> **Not all providers will accept Community Blue Medicare HMO. Please verify that your providers are participating before enrolling. If a provider does not participate, neither Medicare nor Community Blue Medicare HMO will be responsible for the costs.**

Id. at ¶ 29.

CMS approved the Community Blue MA marketing materials on a rolling basis on July 24, August 5, August 15, August 18, August 26, August 28, August 29, September 3, September 4, September 5, September 11 and September 22. *Id.* at ¶ 30. In addition, CMS recently approved language for Highmark's website and marketing materials that states: "Limited network plan" and "**Community Blue Medicare HMO is a limited network plan. If you want access to Highmark's full provider network, including UPMC hospitals and physicians, you may wish to consider our Security Blue HMO and Freedom Blue PPO Medicare Advantage products.**" *Id.* at ¶ 33.

E. <u>After Entry of the Consent Decree, Petitioners Construed the Consent Decree to Permit Community Blue MA.</u>

Highmark was required by Condition 22 of the Insurance Department's April 29, 2013 Approving Determination and Order of the Highmark/West Penn Allegheny Health System Affiliation ("UPE Order") to submit to Petitioners a "UPMC Contract Transition Plan" (the "Transition Plan"), the final verison of which is attached as Ex. 6 hereto. By its terms, the provisions of the Consent

Decree "are incorporated into this Transition Plan" and the Consent Decree was attached as exhibit thereto.

In August 2014, Highmark submitted a draft of the Transition Plan to Petitioners specifically discussing Community Blue MA:

> **New Medicare Advantage Products**. In order to provide additional consumer choice and a less costly option for area seniors, Highmark has applied and received approval from the Centers for Medicare and Medicaid ("CMS") to introduce a new narrow network Medicare Advantage product (Community Blue Medicare Advantage), **that generally does not include UPMC providers**. The network for this product will include most of the Community Blue providers, AHN and the community hospitals that have chosen to participate. **UPMC has chosen not to participate in this product. However, members enrolled in this product will have in-network access to UPMC emergency and trauma services, consistent with CMS guidelines.**

Declaration of Steven C. Nelson ("Nelson Decl."), Ex. 7 hereto at ¶ 5 and Ex. 2 thereto (emphasis added).

In follow-up discussions with the PID in August 2014, Highmark stated its understanding that Community Blue MA was not part of the Consent Decree's protections. *Id.* at ¶ 6 and Ex. 3 thereto. The PID did not contradict Highmark's statement that "Community Blue Medicare Advantage is not part of the Consent Decree protections." *Id.* at ¶ 8 and Ex. 4 thereto. In fact, the PID instead suggested that Highmark remove the "New Medicare Advantage Products" section (quoted above), which addressed Community Blue MA from the Transition Plan, stating "[B]ecause the Transition Plan deals with those Highmark members

affected by this transition, we don't believe that it's appropriate to include new products in the Transition Plan." *Id.* at ¶ 9 and Ex. 5 thereto.

In other words, the PID instructed Highmark **not** to include information about Community Blue MA in the Transition Plan, which incorporated the terms of the Consent Decree, because by the PID's own interpretation, "new products" were **not covered**.

F. The Present Dispute

The instigator of this dispute is UPMC. On September 26, 2014, UPMC sent a letter to Highmark expressing "alarm" that Highmark was about to begin marketing Community Blue MA, which has no UPMC doctors or providers in its network (except for emergency care). *See* Ex. A to Petitioners' Application. Also copied on the letter were various state officials representing Petitioners and a regional CMS representative. *Id.* In the September 26th letter, UPMC claimed that Community Blue MA – the product that UPMC declined to join six months earlier – violates the Consent Decree because it does not include UPMC hospitals and doctors in the provider network. *Id.* Highmark responded on September 29, 2014, reaffirming Highmark's position that Community Blue MA does not violate the Consent Decree for the reasons set forth herein. *See* Ex. 8 hereto.

Highmark subsequently received a letter from Petitioners dated October 1, 2014, requesting "an explanation as to why Highmark believes a Medicare

Advantage product that does not include all the protections of the consent decree is consistent with the consent decree." *See* Ex. B to Petitioners' Application.

Highmark responded on October 2, 2014, reiterating its positions as set forth herein. *See* Ex. C to Petitioners' Application. On October 3, 2014, Petitioners rejected Highmark's positions and stated Petitioners' intention to seek enforcement of the Consent Decree in this Court. *See* Ex. 9 hereto.

On October 10, 2014, Petitioners filed the Application claiming that Highmark's rollout of Community Blue MA violates the Consent Decree. Specifically, Petitioners allege that Highmark has violated sections IV(A)(2) (vulnerable populations), IV(A)(11) (advertising) and IV(A)(1) (ER services), (4) (oncology) and (5) (exception hospitals). As a result of these alleged violations, Petitioners seek to require Highmark or KHPW to, *inter alia*:

> "expand its provider network for any Medicare Advantage Plan it offers in Western Pennsylvania to include UPMC physicians, facilities and services, for the duration of the Consent Decree";
>
> "refrain from restricting its Community Blue [MA] members from using UPMC";
>
> "reimburse any member of its Medicare Advantage plans who is charged by UPMC on an out-of-network basis after January 1, 2015 for the duration of the Consent Decree"; and
>
> be enjoined "from the promotion, marketing or sale of any Limited Network Medicare Advantage Product that excludes

> UPMC physicians, facilities and services" (collectively referred to herein as "Defendants' Requested Enforcement Relief").

Application at 14-15.

Also on October 10, 2014, the Pennsylvania Insurance Department Executive Offices issued a Notice to Western Pennsylvania insurance brokers (the "Notice"), stating that:

> [A]t this point, Community Blue Medicare Advantage – the Medicare Advantage product recently announced by Highmark, which denies its subscribers In-Network access to UPMC facilities and providers – may not be compliant with the Consent Decree and is currently the subject of legal review in Commonwealth Court. Therefore producers offering this product, which may be inconsistent with the Consent Decree, may run the risk of violating Pennsylvania's Unfair Insurance Practices Act (40 P.S. §§ 1171.1) et seq., and its prohibition of making false or fraudulent statements, or misrepresentations in the context of the sale of an insurance product.

Exhibit 10 hereto.

III. ARGUMENT

A. The Consent Decree's "Vulnerable Populations" Provision Does Not Require Highmark to Include UPMC in All MA Products as Petitioners Suggest.

Petitioners contend that the "Vulnerable Populations" section of the Consent Decree requires that Highmark include UPMC doctors and hospitals in all MA products, including Community Blue MA. Petitioners argue for what they, and

UPMC, now apparently would like the Consent Decree to say, ignoring the terms to which Highmark actually agreed.

1. Contract Principles Require This Court to Look First to the Plain Language of the Consent Decree.

Petitioners argue in the Commonwealth's Brief in Support of Its Application ("Petitioners' Brief") that a "consent decree is not a legal determination by the court, but instead is … an agreement between the parties, functioning as a contract binding the parties thereto to the terms of the agreement." Petitioners' Brief at 4-5 (citations omitted). Petitioners further suggest that "[a]s a contract, the court, in the absence of fraud, accident or mistake does not have the authority to modify or vary the terms set forth." *Id.* at 5. With these basic principles, Highmark agrees.

Petitioners then, however, entirely ignore the bedrock first tenet of contract interpretation – that the court look to the language contained in the four corners of the agreement to ascertain the parties' intent. *Steuart v. McChesney*, 444 A.2d 659, 661 (Pa. 1982) ("It is well established that the intent of the parties to a written contract is to be regarded as being embodied in the writing itself, and when the words are clear and unambiguous the intent is to be discovered only from the express language of the agreement."); *Banks Eng'g Co. v. Polons*, 697 A.2d 1020, 1023 (Pa. Super. Ct. 1997) ("[W]hen the language of a contract is clear and unequivocal, courts interpret its meaning by its content alone, within the four corners of the document.").

The plain language of the "Vulnerable Populations" provision upon which Petitioners rely, *see supra* at 6, is clear that Highmark and UPMC **mutually agreed** only that "vulnerable populations" included "(i) consumers age 65 or older who are eligible or covered by Medicare, Medicare Advantage, (ii) Medigap health plans, (iii) Medicaid and (iv) CHIP." Outside the confines of the Consent Decree, as Petitioners' papers demonstrate at Ex. C to their Application, Highmark and UPMC have a contract for the provision by UPMC of services as a "participating provider" under Highmark Medicare Advantage plans. That contract specifically states that a Highmark Network Access Arrangement may include "some or all" participating providers. Ex. C to Petitioners' Application at § 2.14.

With respect to the "Access" commitments in this section, they are specifically written with a requirement that "**UPMC shall**" and there is no corresponding requirement that "Highmark shall" include UPMC in all Medicare Advantage products. Despite being fully aware of Highmark's intention to introduce a Community Blue MA product with a limited network, and Highmark's other Community Blue products which also have a limited network, Petitioners did not include, and Highmark did not commit to, a requirement that "Highmark shall" do anything related to including UPMC in all product networks.[3]

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[3] The Consent Decree did require Highmark, *inter alia*, to accept a framework for determining the prices that would be paid to UPMC for services provided to Highmark subscribers.

Moreover, the "Vulnerable Populations" provisions require UPMC to "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." These are specific products identified by name and this requirement does not include Medicare Advantage or new products generally.

There is simply no requirement in the plain language of the Consent Decree that Highmark include UPMC in all Medicare Advantage products. Absent a finding that the Consent Decree is ambiguous, this should be the end of the Court's analysis, and Petitioners' Application should be denied. *See Stuart, Banks supra.*

2. This Court Should Avoid a Contract Interpretation that Would Conflict with Controlling Federal Law.

Petitioners urge this Court to go beyond the four corners of the Consent Decree and interpret the "surrounding circumstances," Petitioners' Brief at 5, in a manner that would exceed the permissible bounds of state law and constitute impermissible state action that interferes with, burdens and frustrates the federal Medicare Advantage programs and the purpose of the federal regulatory scheme that Congress and CMS established to regulate Medicare Advantage products like Community Blue MA.

On the eve of the federally-mandated open enrollment period for this product, Petitioners ask this Court to issue an order that would require Highmark to drastically alter the federally-approved provider network and benefit design for Community Blue MA or enjoin Highmark from marketing or selling altogether a product the federal government has determined may properly be taken to market.

Petitioners cite no authority to support such a result. To the contrary, courts routinely avoid interpreting contracts in a manner that frustrates controlling federal law. *See Armstrong v. Standard Ice Co.*, 195 A. 171, 173 (Pa. Super. Ct. 1937) (quoting Restatement of Contracts § 236(a)) ("An interpretation which gives a reasonable, lawful and effective meaning to all manifestations of intention is preferred to an interpretation which leaves part of such manifestations … unlawful[.]"); *Rothstein v. Jefferson Ice Mfg. Co.*, 9 A.2d 149, 153 (Pa. Super. Ct. 1939) (same); *see also* Restatement (Second) of Contracts § 203; *Gustine Uniontown Associates, Ltd. ex rel. Gustine Uniontown, Inc. v. Anthony Crane Rental, Inc.*, 832 A.2d 830, 837 (Pa. Super. Ct. 2006) (same); 17A Am. Jur. 2d Contracts § 340 ("Generally, where a contract is fairly open to two constructions, by one of which it would be lawful and the other unlawful, the former will be adopted.").

The scope of federal preemption with respect to Medicare Advantage is broad. Congress has clearly expressed its intent that federal statutes and

regulations regarding Medicare Advantage, including those related to provider networks and marketing materials, shall preempt state law. The Medicare Part C statute governing MA plans contains an express preemption clause which provides:

> The standards established under this part **shall supersede any State law or regulation** (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part.

42 U.S.C. § 1395w-26(b)(3) (2006) (emphasis added).

CMS has explained and regulations confirm "[t]he scope of Federal preemption [under 1395w–26(b)(3)] is broad [...] All State standards, **including those established through case law**, are preempted to the extent that they would specifically regulate health plans (including MA plans), with the exceptions of State licensing and solvency laws." *Medicare Managed Care Manual*, Chapter 10, § 30.1-30.2 (Rev. 103, Nov. 4, 2011) (emphasis added). CMS has further stated that "States **may not review or impose** State standards for network or organizational capacity." *Id.* § 60 (emphasis added).

The breadth of section 1395-w26(b)(3) is deliberate and reflects Congress's judgment that state actors may not, directly or indirectly, add to, burden, or control the federal MA program regulated by CMS, except with respect to licensing of MA organizations and as to solvency. Prior to the 2003 amendments, the preemption clause provided that federal standards would supersede state law and regulations

only "to the extent such law or regulation is inconsistent with [federal Medicare] standards" and specified several "[s]tandards specifically superseded." 42 U.S.C. § 1395w–26(b)(3)(A) (2000).[4] In 2003, Congress struck both that qualifying clause and the enumerated standards, resulting in statutory text that is even broader than it was previously. *See* 42 U.S.C. § 1395w–26(b)(3)(A) (2003). The Conference Report accompanying the 2003 amendments explains that, through the amendments, Congress intended to broaden the preemptive effects of the Medicare Advantage statutory regime:

> The conference agreement clarifies that the MA program is a federal program operated under Federal rules. **State laws, do not, and should not apply, with the exception of state licensing laws or state laws related to plan solvency.**

H.R. Rep. No. 108–391, at 557 (2003) (Conf. Rep.).

Courts have found that the MA statute and CMS regulations preempt various types of state action, including statutory and common law claims. *See Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134, 1152, 1157 (9th Cir. 2010) (consumer protection law and common law fraud claims preempted by federal regulations governing marketing of Medicare products); *Massachusetts Ass'n of HMOs v. Ruthardt*, 194 F.3d 176, 185 (1st Cir. 1999) (Massachusetts Insurance

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[4] Even under the prior version of the MA preemption statute, state law requirements "relating to inclusion or treatment of providers" were expressly preempted. 42 U.S.C. § 1395w–26(b)(3) (2000).

Commissioner's actions to continue requiring supplemental providers to offer full prescription drug coverage were preempted by federal Medicare statute); *Clay v. Permanente Med. Grp., Inc.*, 540 F. Supp. 2d 1101, 1108-09 (N.D. Cal. 2007) (federal regulations governing marketing materials, including enrollment forms, preempted the California Health & Safety Code arbitration notice and disclosure requirements); *Morrison v. Health Plan of Nev.*, 328 P.3d 1165, 1170 (Nev. 2014) (common law negligence claims preempted).

In *Morrison*, for example, an insured brought common law negligence claims against an insurer operating an MA plan, alleging that the insurer failed to properly investigate a contracted medical provider and should have known the provider engaged in unsafe practices that resulted in the insured contracting hepatitis C. 328 P.3d at 1166-67. In holding the insured's claims to be preempted by the Medicare Act, the court explained that CMS has promulgated regulations regarding the selection of providers. *Id.* at 1169. The court ultimately concluded that "federal law provides standards that MA organizations must adhere to in conducting the relationship with their contracted providers. A state law action asserting that [insurer] was negligent in directing its insureds to the Clinic could result in the imposition of additional state law requirements on the quality assurance regime regulated by CMS." *Id.* at 1169-70.

Similarly, in *Uhm*, Medicare beneficiaries brought a putative class action against insurer, alleging failure to receive promised coverage for prescription drugs. 620 F.3d at 1138. The court found that plaintiffs' claims for violation of state consumer protection laws, and common law fraud claims, were expressly preempted by the Medicare statute. *Id.* at 1153, 1157. The court's reasoning regarding the state consumer protection law claim is instructive here. The *Uhm* court found that the enrollment forms on which the plaintiffs based their claims were marketing materials, and as a result, the state law consumer protection claims were preempted, stating:

> **allowing a suit to proceed based on a state … consumer protection law risks the possibility that materials CMS has deemed not misleading—and therefore allowed to be distributed—will later be determined "likely to mislead" by a state court.** In other words, application of these state laws could potentially undermine the Act's standards as to what constitutes non-misleading marketing.

Id. at 1152.

The *Uhm* court applied the same reasoning in finding that the insured's common law fraud claim was preempted, recognizing that a state court's determination would also undermine CMS's standards:

> **Were a state court to determine** that Humana's marketing materials constituted misrepresentations resulting in fraud or fraud in the inducement, **it would directly undermine CMS's prior determination** that those materials were not misleading and in turn undermine CMS's ability to create its own standards…

Id. at 1157 (emphasis added).

Petitioners' Application, and the Requested Enforcement Relief they seek, likewise are based on state statutory and common law. *See* Petitioners' Brief at 6 (setting forth Pennsylvania common law breach of contract requirements) and 8-10 (invoking the Pennsylvania Unfair Insurance Practices Act and Unfair Trade Practices and Consumer Protection Law, 40 P.S. § 1171.5; 31 Pa. Code § 51.21; 73 P.S. § 101-2). In addition, the notice sent by the PID to Western Pennsylvania insurance brokers on October 10, 2014 also invokes state law. The PID warns brokers that, in the PID's view, by selling Community Blue MA, brokers "may run the risk of violating Pennsylvania's Unfair Insurance Practices Act (40 P.S. §§ 1171.1) et seq., and its prohibition of making false or fraudulent statements, or misrepresentations in the context of the sale of an insurance product." Ex. 10 hereto.

As in *Morrison* and *Uhm*, Petitioners' state law claims are preempted by federal statute and regulations. CMS has reviewed and approved the Community Blue MA network and marketing materials. Permitting Petitioners to take enforcement action second-guessing CMS's determinations regarding the adequacy of Community Blue MA's provider network and marketing materials would undermine the federal standards and CMS's authority, and ultimately undermine

the clearly-expressed intent of Congress that federal law control this type of product. This Court should reject Petitioners' invitation to do so.

3. Facts and Circumstances Surrounding the Consent Decree Also Undercut Petitioners' Interpretation of the Parties' Intent.

Finding no support for its position in the plain text of the "Vulnerable Populations" provision, Petitioners argue more generally that the circumstances surrounding the Consent Decree demonstrate that Highmark is required to protect vulnerable populations by including UPMC in all Medicare Advantage products. *See, e.g.* Petitioners' Brief at 11-12. If this Court finds the "Vulnerable Populations" provision to be ambiguous and looks to surrounding circumstances to understand the parties' intent, the following circumstances, all of which Petitioners omit from their Application, undercut Petitioners' interpretation of the Consent Decree:

First, Petitioners drafted the Consent Decree. Pennsylvania law is clear that contractual ambiguities should be construed against the party that drafted the agreement. *Rusiski v. Pribonic*, 515 A.2d 507, 510 (Pa. 1986) ("[D]oubtful language is construed most strongly against the drafter thereof"); *Com., State Pub. Sch. Bldg. Auth. v. Noble C. Quandel Co.,* 585 A.2d 1136, 1144 (Pa. Commw. 1991) ("When a contract is ambiguous, it is undisputed that the rule of *contra proferentem* requires the language to be construed against the drafter and in favor

of the other party if the latter's interpretation is reasonable.") (citing *Com., Dep't of Transp. v. Semanderes*, 531 A.2d 815, 818 (Pa. Commw. 1989). The same rule should apply here.

Second, Petitioners' Application and requested relief violates the provision in the Consent Decree that it be interpreted consistent with the UPE Order. Consent Decree § 1(A). The UPE Order states: "After the issuance of this Approving Determination and Order, no Domestic Insurer shall enter into a contract or arrangement with a Health Care Provider that prohibits and/or limits the ability of any Domestic Insurer to implement Consumer Choice Initiatives, without the prior Approval of the Department." UPE Order at ¶ 20.

"Consumer Choice Initiatives" are defined in the UPE Order as:

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

UPE Order, Ex. 6 hereto, at ¶ 22. Community Blue MA is a limited network, low cost alternative offered by Highmark to consumers. Rice Decl. at ¶ 33. Community Blue MA provides consumers with a choice to select this product

and use a more limited network of hospitals and providers at lower cost. *Id.* Consumers also have the choice of selecting Highmark's Security Blue or Freedom Blue products for a broader network of hospitals, which includes UPMC hospitals and providers, but at a higher cost. *Id.* The relief Petitioners now seek through their interpretation of the Consent Decree – a requirement that UPMC be in Highmark's Community Blue MA product – is in direct conflict with the prior UPE Order because it limits Highmark's ability to offer Consumer Choice Initiatives.

Third, Petitioners' Application and requested relief violates the provision in the Consent Decree that it be interpreted consistent with the terms of the 2012 Mediated Agreement between UPMC and Highmark. Consent Decree § 1(A). The public portion of the 2012 Mediated Agreement states that "Highmark and UPMC are pleased to announce that they have reached an agreement in principle to provide for in-network access to all UPMC hospitals and physicians for Highmark Commercial **and Medicare Advantage members <u>until December 31, 2014</u>**." But, it also goes on to say, in the non-public portion of the agreement: [redacted] The Community Blue MA product is not in effect in 2014 and, in any event, is within the specific

exception for products marketed as Community Blue, as to which UPMC is not entitled to participate.

Fourth, Petitioners' Application and requested relief conflicts with Highmark's current Medicare Advantage agreements with UPMC, which, as UPMC admits, were not terminated by either party and remain in effect for 2015. Rice Decl. at ¶ 23; Ex. C to Petitioners Application. Pursuant to the terms of its current Medicare Advantage agreements with UPMC, Highmark need not include UPMC in the new Community Blue MA product. Rice Decl. at ¶ 25.

By contrast, Highmark's commercial product hospital agreements, which in any event have been terminated by UPMC as of December 31, 2014, contain a requirement that Highmark "agree to offer participation in and the Hospital agrees to accept participation in all current and future [Highmark] products, exclusive of any and all current and future [Highmark] products marketed under the name Community Blue (collectively hereinafter "Community Blue Products")." *Id.* at ¶ 26. Petitioners essentially ask this Court to read into Highmark's Medicare Advantage contracts with UPMC a provision that both parties knew how to include if they intended to, but did not.

In the face of these numerous binding contracts and the UPE Order, all of which conflict with Petitioners' requested relief, Petitioners point only to general and unsubstantiated notions of unintended "imbalance," Application at ¶ 20 and

Highmark's alleged "frustrat[ion of] the intent of this portion of the agreement, which was to ensure access to services for seniors." Petitioners' Brief at 13. Both the plain language of the Consent Decree and surrounding circumstances prove that Highmark is not required to include UPMC in all Medicare Advantage products.

B. Highmark's Medicare Advantage Products, Including Community Blue MA, Benefit Seniors and Offer Valuable Healthcare Options.

Petitioners suggest that Highmark is jeopardizing seniors with the rollout of Community Blue MA. Nothing could be further from the truth. Community Blue MA is one of three families of Highmark MA products, all of which will be available to seniors for the 2015 enrollment year. Lightner Decl. at ¶ 15. The Freedom Blue and Security Blue MA products will continue to provide subscribers with In-Network access to UPMC doctors and hospitals as those products always have. *Id.* at ¶ 23. Although the Consent Decree contains no obligation for Highmark to provide "Vulnerable Populations" access to UPMC in all products, by continuing to offer Freedom Blue and Security Blue, Highmark has fully satisfied any alleged obligation in the Consent Decree to continue to provide Medicare Advantage customers in-network access to UPMC. If Highmark subscribers want In-Network access to UPMC, they can enroll in either Freedom Blue or Security Blue. If they do not, they may enroll in Community Blue MA at lower cost.

Petitioners entirely fail to demonstrate how offering consumers an additional choice – a lower cost MA product with a limited network of high quality health care providers that does not include UPMC and certain other facilities – is bad for seniors, many of whom may welcome a distinctive product that includes a lower out-of-pocket monthly premium. Petitioners' Application wrongly seeks to protect UPMC, by seeking to require all seniors buying Highmark MA products to pay more for access to UPMC, whether they want it or not. The requested relief is anti-competitive and anti-consumer.

C. Highmark Has Not Violated the Advertising Provision of the Consent Decree.

Petitioners also allege that Highmark has violated section IV(A)(11) of the Consent Decree, which provides that Highmark "shall not engage in any public advertising that is unclear or misleading in fact or by implication to consumers." Petitioners' advertising claim is fatally-flawed for three separate reasons:

First, Highmark's marketing materials are not misleading, as the federal government has already determined. CMS is the exclusive government authority charged with oversight and regulation, including the marketing, of Medicare Advantage products. The Community Blue MA marketing materials that have been reviewed and approved by CMS clearly state: "Not all providers will accept Community Blue [MA]. Please verify that your providers are participating before

enrolling." Lightner Decl. at ¶ 29. Highmark included this disclaimer at the express request of CMS given the limited network nature of Community Blue MA. *Id.* at ¶ 28. The marketing materials approved by CMS clearly identify that UPMC hospitals and providers are not in the network. *Id.* at ¶ 33.

Highmark's website and CMS-approved marketing materials also state: "Limited network plan" and "Community Blue [MA] is a limited network plan. If you want access to Highmark's full provider network, including UPMC hospitals and physicians, you may wish to consider our Security Blue HMO and Freedom Blue PPO Medicare Advantage products." *Id.* Highmark's marketing materials are true and are not misleading. Highmark has fully disclosed on its website and in its written materials the fact that Community Blue MA product is a limited network product.[5]

Second, Petitioners offer absolutely no evidence of any **actual** subscriber confusion as a result of the Community Blue MA marketing materials. Instead, Petitioners offer a misleading and inaccurate account from their own investigator, which references certain products that are not even Medicare Part C products, like Community Blue MA, Freedom Blue and Security Blue, and attempts to blame

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[5] The version of Highmark's Personal Plan Overview, a core Community Blue MA document, attached to Petitioners' Application as Exhibit G in the version filed with the Court online is incomplete. Missing from Petitioners' version of the document is, among others, page 4, which is the page that contains the express limited network disclaimer CMS required Highmark to include.

Highmark for the content of the federal Medicare website, which it does not control, in an effort to create confusion where none exists. Application at ¶¶ 30-41. Suggesting, without any actual evidence, that a "consumer **can** easily be confused" falls far short of Petitioners' burden to prove a violation of the Consent Decree by Highmark.

Third, the specific advertisement on which Petitioners focus their claim ran in June 2014. Application at ¶ 25. The Community Blue MA product was not yet approved by CMS, nor had it been marketed, at the time of this advertisement. Lightner Decl. at ¶ 22. Indeed, Highmark was prohibited from marketing Community Blue MA, or providing details publicly prior to obtaining CMS approval. *Id.* at ¶ 25. However, the advertisement was true at the time and it continues to be true, even after the introduction of Community Blue MA. All seniors will have access to "UPMC facilities and providers on an In-Network basis" in Highmark's Freedom Blue or Highmark's Security Blue products. Lightner Decl. at ¶ 23. No senior is required to enroll in the Community Blue MA product. These consumers should have a choice, and Highmark is providing an additional lower cost alternative for consumers, which is pro-consumer and pro-competitive. Rice Decl. at ¶ 34.

D. Highmark Has Not Violated Any Other Consent Decree Provisions by Selling and Marketing Community Blue MA

Petitioners also allege that Highmark has violated sections IV(A)(1) (ER services), (4) (oncology) and (5) (exception hospitals) of the Consent Decree. Petitioners again are incorrect. With respect to "ER services," by operation of law, UPMC as a healthcare provider must treat all persons appearing at an emergency room regardless of their health insurance. Petitioners' Brief at 14 (citing applicable federal statute). Further, the Community Blue MA plan specifically includes coverage for ER services and the CMS-approved marketing materials clearly state that such services are covered. Lightner Decl. at ¶ 38. As such, there is no violation of the Consent Decree with respect to its provisions addressing ER services.

As to oncology services, there is no requirement in the Consent Decree that Highmark include in every product that it offers in Western Pennsylvania, whether Medicare Advantage or otherwise, oncology services at UPMC. During the negotiation of the Consent Decree, the state regulators never raised, nor did they discuss with Highmark, a requirement that, for new products, Highmark must include UPMC oncology and the Exception Hospitals in the network. Rice Decl. at ¶ 14. This is despite the fact that the state regulators were apprised of Highmark's intent to offer a new lower cost, limited network product. *Id.* at ¶ 4.

The absence of any such requirement in the Consent Decree shows that Highmark is permitted to introduce new products without UPMC oncology and Exception Hospitals in scope. Had the regulators wanted such a requirement, it should have been discussed first, then incorporated in the Consent Decree. It was not discussed, and Highmark had no intention of agreeing a requirement that UPMC be included in all new products. *Id.* at ¶ 11.

Further, Highmark invited UPMC to become a participating provider in the Community Blue MA product as early as February 18, 2014. *See* Ex. 8 hereto. On March 26, 2014, UPMC declined Highmark's offer to become a participating provider in the new Community Blue MA product, stating: "UPMC specifically rejects Highmark's offer." Ex. 8 hereto. UPMC's oncology services nevertheless are available to Highmark subscribers who enroll in the Freedom Blue or Security Blue plans.

As to the Exception Hospitals, all of the foregoing arguments apply equally here. Indeed, Highmark subscribers have in-network access to all Exception Hospitals through Freedom Blue and Security Blue. Lightner Decl. at ¶ 37.

E. Petitioners Cannot Meet Their Burden to Prove Civil Contempt by Highmark.

Petitioners have asked that this Court hold Highmark in contempt for failure to comply with the provisions of the Consent Decree. Petitioners bear the burden

of proving noncompliance by Highmark by a preponderance of the evidence. *Barrett v. Barrett,* 368 A.2d 616, 621 (Pa. 1977). Petitioners fall woefully short of that burden here. As stated above, Highmark has not violated the Consent Decree and therefore a finding of contempt would be inappropriate. "Where … the specific terms of the order have not been violated, there can be no contempt." *C.R. by Dunn v. Travelers*, 626 A.2d 588, 592 (Pa. Super. 1993) ("The order that forms the basis for the contempt process in civil proceedings must be definitely and strictly construed.").

At most, Petitioners may demonstrate that the Consent Decree – which they drafted – is ambiguous. Highmark should not be held in contempt for failing to comply with the provisions of an ambiguous order. Pennsylvania law is clear that any ambiguity or omission in the order forming the basis for a civil contempt proceeding must be construed in favor of the defendant. *Wetzel v. Suchanek,* 541 A.2d 761 (Pa. Super. 1988); *Grubb v. Grubb,* 473 A.2d 1060 (Pa. Super. 1984). *See also C.R. by Dunn*, 626 A.2d at 594 (citing *Carborundum Co. v. Combustion Eng'g Inc.*, 396 A.2d 1346 (Pa. Super. 1979)). The *Dunn* court noted further that "Where the order is contradictory or the specific terms of the order have not been violated, there is no contempt." *Id.* (citing *Carborundum* and *In re Capuzzi's Estate*, 148 A. 48 (Pa. 1929); *Janet D. v. Carros*, 362 A.2d 1060 (Pa. Super. 1976)).

Petitioners' request for a finding of contempt should be denied.

F. Petitioners Fail to Satisfy Any of the Requirements For Injunctive Relief.

While Petitioners recite the correct standards under Pennsylvania law for issuance of a preliminary injunction, Brief at 16, they fail to satisfy any of them in this case. Petitioners' request for preliminary injunction should be denied.

1. Petitioners Are Unlikely to Succeed on the Merits of Any of Their Claims

First, for the reasons stated above, Petitioners are not likely to succeed on the merits of any of their claims for breach of the Consent Decree. In addition to the numerous other fatal flaws with Petitioners' claims summarized herein, Petitioners also are unlikely to succeed on the merits because they come to this Court seeking equitable relief with unclean hands and should be estopped.

Petitioners themselves were aware of the limited network nature of Community Blue MA and of Highmark's intention to sell it in 2015 at least four months ago. Moreover, Petitioners essentially stand in UPMC's shoes making the argument that UPMC must now be included in the Community Blue MA product. They should be estopped from such an argument in view of their full knowledge that UPMC previously refused participation in the product prior to Highmark seeking CMS approval.

"Equitable estoppel applies to prevent a party from assuming a position or asserting a right to another's disadvantage inconsistent with a position previously taken.... [T]he person inducing the belief in the existence of a certain state of facts is estopped to deny that the state of facts does in truth exist, over a different or contrary state of facts as existing at the same time, or deny or repudiate his acts, conduct or statements." *Young v. Cerone*, 487 A.2d 965, 968 (Pa. Super. 1985) (quoting *Blofsen v. Cutaiar*, 333 A.2d 841, 844 (Pa. 1975)); *see also Barcia v. Fenlon*, 37 A.3d 1, 6 (Pa. Commw. 2012) (plaintiff who did not lodge a timely objection to a proxy vote in a board dispute, and instead continued attempts at gamesmanship, corporate and legal maneuvering, and manipulation was estopped from seeking equitable relief).

2. Greater Injury than Public Benefit Would Result from Issuance of the Injunction.

If Petitioners' injunctive relief is granted, at least three types of injury would result, each of which would be greater than the harm that would result if Petitioners' request is denied.[6] First, Petitioners' requested relief would result in massive public confusion. Petitioners have already generated significant confusion among seniors and the public generally as a result of their public statements, their

[6] Highmark also does not concede that Petitioners have demonstrated, or will be able to demonstrate, sufficient irreparable harm to justify issuance of an injunction. For example, with respect to Petitioners' marketing claim, Petitioners entirely fail to show any alleged harm from purportedly misleading marketing materials that could not be remedied simply by issuing revised marketing material.

statements to brokers, and the filing of this Application. If Petitioners' request for injunctive relief is granted and Highmark is required to halt a federally-approved marketing campaign, the planning for which has been underway for months, and cancel or postpone open enrollment of a federally-approved program at the twelfth hour, or is required to attempt to modify the provider network for the product, even further, likely incurable consumer confusion will result. Rice Decl. at ¶ 34.

Second, Petitioners' requested injunctive relief also would harm consumer choice and competition, with potential long-term consequences flowing from the immediate competitive advantage that would inure to other limited network MA products in the market, including the MA product currently being marketed by UPMC. Rice Decl. at ¶ 36. Highmark will not be able to compete against other limited network MA products in the market without Community Blue MA. *Id.* In addition, Petitioners' requested relief will amount to a mandate by state regulators that consumers must spend more money out of pocket for access to UPMC, whether they want such access or not. *See* Rice Decl. at ¶ 38.

Third, Highmark itself will suffer significant harm, including the waste of resources spent having obtained approval from CMS of Community Blue MA, and disclosing the details of the product to Petitioners. Rice Decl. at ¶ 36. In addition, Highmark will have to expend significant additional resources going back to CMS to attempt to comply with this Court's orders. *Id.* Moreover, Petitioners'

requested relief would result in immediate and potentially pervasive harm to Highmark's reputation and credibility, as well as incalculable damage to the Community Blue brand. *Id.* Finally, if Highmark is required to include UPMC in the Community Blue MA network, and is not permitted, either by this Court, Petitioners or CMS, to adjust reimbursement rates or premiums, Highmark will suffer economic losses, from having to underwrite the significantly higher provider rates charged by UPMC. *Id.* at ¶ 37.

By contrast, if Petitioners' request for injunctive relief is denied, open enrollment in a product already approved by CMS, based on marketing materials also approved by CMS, will proceed as scheduled. The likelihood of consumers inadvertently enrolling in Community Blue MA without knowing the plan does not include UPMC is minimal, particularly given that each Community Blue MA applicants will receive a telephone call from Highmark to confirm the details of the plan prior to acceptance by CMS of that person's application. When speaking with applicants, Highmark will reiterate the limited network nature of Community Blue MA. Lightner Decl. at ¶ 35.

3. Issuance of Petitioners' Requested Injunction Would Disrupt, Not Preserve, the Status Quo.

Community Blue MA marketing and open enrollment, as approved by the federal government, are proceeding as scheduled. That is the status quo. Petitioners' requested injunction would halt open enrollment, and significantly

alter the details of the Community Blue MA product that have already been approved by CMS as described to consumers. Such disruption of the status quo militates against issuance of the injunction.

III. CONCLUSION

For the reasons stated herein, Highmark respectfully requests that this Court deny Petitioners' Application in its entirety.

Respectfully submitted,

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VIA E-MAIL

W. Thomas McGough, Jr.
Senior Vice President & Chief Legal Officer
UPMC
6241 US Steel Tower
600 Grant Street
Pittsburgh, PA 15219

Dear Tom:

Enclosed, on behalf of Insurance Commissioner Michael Consedine, Secretary of Health Michael Wolf and Attorney General Kathleen Kane, is a Term Sheet that reflects the conditions which must be imposed on Highmark and UPMC as part of a resolution of the contract dispute. We believe that these terms would be incorporated into a consent decree that would be filed with the Commonwealth Court of Pennsylvania.

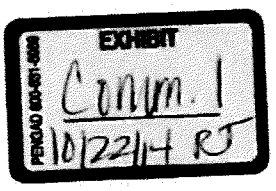
We look forward to discussing this with you. I will be traveling tomorrow, Thursday, June 12, but you can reach me on my cell at (717) 439-0073. You can also reach Yen Lucas, the Chief Counsel of the Insurance Department, at (717) 783-1975.

Very truly yours,

James A. Donahue, III
Executive Deputy Attorney General

JAD/lkl/mcgough1162
Enclosure

cc: Yen Lucas



Confidential Settlement Proposal--Not For Public Dissemination.

UPMC Term Sheet for Consent Petition for Final Decree

*Denotes identical or mirrored term in both Highmark and UPMC Term Sheets. Identical or mirrored terms require same action by both parties.

1. *Form of document – final decree filed in Commonwealth Court by the Office of Attorney General ("OAG"), Pennsylvania Insurance Department ("PID") and Pennsylvania Department of Health ("DOH").

2. *This term sheet shall be construed in a manner that is consistent with the PID's April 29, 2013 Approving Determination and Order of the UPMC/West Penn Allegheny Health System Affiliation ("UPE Order") and to protect consumers and the charitable mission of the parties. The Term Sheets shall be binding on Highmark and UPMC. The outcome of the actions contemplated in the Term Sheets 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.

3. *ER Services –UPMC shall negotiate in good faith to reach an agreement with Highmark 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 31, 2014 or be subject to the binding arbitration similar to the provisions contained in Mercy and Children's Final Orders. The agreement will be binding on both parties meaning that the parties will bill each other and make payments consistent with the agreement. The agreement shall be for a commercially reasonable period of time as provided in Condition 3 of the UPE Order. UPMC shall not balance bills to consumers until the ER services agreement is resolved.

4. *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 "vulnerable populations" including, but not limited to consumers age 65 and older who are eligible or covered by Medicare, Medicare Advantage, MediGap health plans; and consumers who are eligible or covered by CHIP, Medicaid and Medicaid Managed Care health plans or such other health care options as may be approved by the Commonwealth. UPMC shall treat all Medicare participating consumers as in network regardless of whether they have Medicare as their primary or secondary insurance.

5. *Local Community Needs – Where UPMC is a provider of a service that the DOH determines must be provided locally, such as but not limited to, HIV, transplant, serious mental health disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM), neo-natal intensive care unit services, neurology, endocrinology

dialysis, primary care physician services, imaging and any other service as determined by DOH, and UPMC is the only provider of that service in a local area the Department of Health determines is appropriate for that service, UPMC shall agree to accept provide patients pay UPMC for those services to its members on an in network basis. Highmark shall negotiate in good faith to reach an agreement with UPMC on in-network rates for such services.

6. *Oncology – The Hillman Cancer Center and its physicians shall be in-network for all health plans serving Western Pennsylvania. UPMC shall negotiate in good faith on an agreement with Highmark for rates for treatment of cancer patients. 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. To determine the appropriate scope of the resulting illnesses, UPMC and Highmark shall appoint oncologists from their respective hospital systems to design treatment protocols. Such resulting treatments in the treatment protocol shall be in network at UPMC if the patient chooses to use UPMC. Moreover, all UPMC cancer centers and physicians based at independent hospitals shall be in-network. If UPMC and Highmark do not reach an agreement on rates for cancer treatment and resulting illnesses by July 31, 2014, the parties will be subject to the binding arbitration provisions similar to those contained in Mercy and Children's Final Orders. The agreement will be binding on both parties meaning that the parties will bill each other and make payments consistent with the agreement. 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. Nothing in the treatment protocol shall interfere with a plan design dealing with co-pays and co-insurance for using different providers.

7. *Unique/Exception Hospitals/Physicians - UPMC 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, Magee Womens Hospital of UPMC (for all obstetric and gynecological services), UPMC Bedford Memorial, UPMC Venango (Northwest), UPMC/Hamot and UPMC/Altoona and any physician, facility or other provider 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 determined by DOH to be essential to meet local community needs, by July 31, 2014 or, be subject to the binding arbitration provisions similar to those contained in the Children's and Mercy Final Orders. The agreement will be binding on both parties meaning that the parties will bill each other and make payments consistent with the agreement. 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 beyond its term so long as Children's Hospital is determined by the DOH to be essential to meet local community needs.

8. *Out-of-Network Services – UPMC's reimbursement rates for "out-of-network" services for all payors at its hospitals must be reasonable and consistent with its charitable mission.

9. *Safety Net – UPMC and Highmark shall negotiate in good faith to establish a one year safety net beginning January 1, 2015, for any consumers who use UPMC physicians and services and who are unable to find alternative physicians and services in their locality. UPMC and Highmark shall hold such consumers harmless if they continue to use such physicians and services. The safety net is not a contract extension. Rather, it is a back-office mechanism whereby Highmark and UPMC shall hold consumers harmless under these circumstances.

10. *Continuity of care - The continuation of care of any patient in the midst of a course of treatment at UPMC shall be on an in-network basis at in-network rates. UPMC and Highmark shall appoint a committee of doctors from their respective hospitals to prepare protocols for determining what a course of treatment is and when a course of treatment is completed. If a consumer believes, his or her care should continue, the consumer may appeal to a court appointed Special Master. UPMC and Highmark shall jointly pay for the selection of a Special Master who will make recommendations to the court in the event a consumer appeals a decision on continuity of care. The OAG, Insurance PID and DOH shall nominate one or more candidates for a Special Master and Highmark and UPMC shall have the opportunity to comment on such nominees. The Court shall have final say on the selection of a Special Master.

11. *UPMC shall comply with the terms of the Mediated Agreement and 2012 Agreement as they relate to its Community Blue product.

12. *Consumer Restitution Fund[1] - UPMC shall reimburse any consumer who incurred extra or duplicative medical costs because of UPMC's refusal to treat certain Community Blue patients included on an in-network basis during the period of January 1, 2013 to present. The amount of the fund shall be $2 million but UPMC shall pay additional amounts to make consumers whole if necessary. The cost of a claims administrator and notice to potentially affected consumers will be paid by UPMC separately.

[1] The reasons for the consumer restitution are different for Highmark and UPMC.

13. *Consumer Education Fund – Highmark and UPMC shall each contribute $2 million to the Consumer Education Fund to be used by the OAG, PID or DOH for education and outreach purposes during the transition. Unused funds shall be deposited into the Consumer Restitution Fund.

14. Transfer of Services – If any Services covered by this term sheet 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.

15. 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 in need of transfer is covered by a Health Plan with which the UPMC Hospital does not contract, UPMC shall transfer the patient to a 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) otherwise approved by the patient's Health Plan.

16. *The Payment of Attorneys' Fees and Costs

17. *The Payment of Civil Penalties

18. * Special Master – If the court determines that it will require technical medical expertise to deal with the issues raised by this consent decree, UPMC and Highmark shall jointly pay for such special master. The OAG, Insurance and Health shall nominate one or more candidates for a Special Master and UPMC and Highmark shall have the opportunity to comment on such nominees. The Court shall have final say on the selection of a Special Master.

19. *Extension – Any party to the Final Decree can ask that binding arbitration provisions of the Final Decree be extended before initial agreements contemplated by this term sheet expire.

COMMONWEALTH OF PENNSYLVANIA
OFFICE OF ATTORNEY GENERAL

June 11, 2014

ANTITRUST SECTION
14th Floor, Strawberry Square
Harrisburg, PA 17120
Tel: (717) 705-2523
Fax: (717) 787-1190

VIA E-MAIL

W. Thomas McGough, Jr.
Senior Vice President & Chief Legal Officer
UPMC
6241 US Steel Tower
600 Grant Street
Pittsburgh, PA 15219

Dear Tom:

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We look forward to discussing this with you. I will be traveling tomorrow, Thursday, June 12, but you can reach me on my cell at (717) 439-0073. You can also reach Yen Lucas, the Chief Counsel of the Insurance Department, at (717) 783-1975.

Very truly yours,

James A. Donahue, III
Executive Deputy Attorney General

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Enclosure

cc: Yen Lucas

COMMONWEALTH **EXHIBIT 8**

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Highmark Term Sheet for Consent Petition for Final Decree

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1. *Form of document – final decree filed in Commonwealth Court by the Office of Attorney General ("OAG"), Pennsylvania Insurance Department ("PID") and Pennsylvania Department of Health ("DOH").

2. *This term sheet shall be construed in a manner that is consistent with the PID's April 29, 2013 Approving Determination and Order of the Highmark/West Penn Allegheny Health System Affiliation ("UPE Order") and to protect consumers and the charitable mission of the parties. The Term Sheets shall be binding on Highmark and UPMC. The outcome of the actions contemplated in the Term Sheets 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.

3. *ER Services –Highmark shall negotiate in good faith to reach an 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 31, 2014, or be subject to the binding arbitration similar to the provisions contained in Mercy and Children's Final Orders. The agreement will be binding on both parties meaning that the parties will bill each other and make payments consistent with the agreement. The agreement shall be for a commercially reasonable period of time as provided in Condition 3 of the UPE Order. Highmark shall cover any balance billings to consumers by UPMC until the ER services agreement is resolved.

4. *Vulnerable Populations – Highmark shall continue to contract with UPMC at in-network rates for all of its hospital, physician and appropriate continuity of care services for "vulnerable populations" including, but not limited to consumers age 65 and older who are eligible or covered by Medicare, Medicare Advantage, MediGap health plans; and consumers who are eligible or covered by CHIP, Medicaid and Medicaid Managed Care health plans, or such other health care options as may be approved by the Commonwealth. Highmark shall treat all Medicare participating consumers as in network regardless of whether they have Medicare as their primary or secondary insurance.

5. *Local Community Needs – Where UPMC is a provider of a service that the DOH determines must be provided locally, such as but not limited to, dialysis, HIV, transplant,

serious mental health disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM), neo-natal intensive care unit services, neurology, endocrinology, primary care physician services, imaging and any other service as determined by DOH, and UPMC is the only provider of that service in a local area the DOH determines is appropriate for that service, UPMC shall agree to accept payment from Highmark for those services to Highmark's members on an in-network basis at in-network rates.

6. *Oncology – The Hillman Cancer Center and its physicians shall be in-network for all health plans serving Western Pennsylvania. Highmark shall negotiate in good faith on an agreement with UPMC for rates for treatment of cancer patients. 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. To determine the appropriate scope of the resulting illnesses, UPMC and Highmark shall appoint oncologists from their respective hospital systems to design treatment protocols. Such resulting treatments in the treatment protocol shall be in network at UPMC if the patient chooses to use UPMC. Moreover, all UPMC cancer centers and physicians based at independent hospitals shall be in-network. If Highmark and UPMC do not reach an agreement on rates for cancer treatment and resulting illnesses by July 31, 2014, the parties will be subject to the binding arbitration provisions similar to those contained in Mercy and Children's Final Orders. The agreement will be binding on both parties meaning that the parties will bill each other and make payments consistent with the agreement. Highmark shall cover any balance billings to consumers by UPMC 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. Nothing in the treatment protocol shall interfere with a plan design dealing with co-pays and co-insurance for using different providers.

7. *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, Magee Womens Hospital of UPMC (for all obstetric and gynecological services), UPMC Bedford, UPMC Venango (Northwest), UPMC/Hamot and UPMC/Altoona and any physician, facility or other provider 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 determined by DOH to be essential to meet local community needs, by July 31, 2014, or be subject to the binding arbitration provisions similar to those contained in the Children's and Mercy Final Orders. The agreement will be binding on both parties meaning that the parties will bill

each other and make payments consistent with the agreement. The agreement shall be for a commercially reasonable period of time. The Greater Pittsburgh area shall mean the Counties of Allegheny, Beaver, Butler, Washington and Westmoreland. The Children's Final Order will continue in effect beyond its term so long as Children's Hospital is determined by the DOH to be essential to meet local community needs.

8. *Out-of-Network Services – Highmark's reimbursement rates for "out-of-network" services for all payors at its Allegheny Health Network hospitals must be reasonable and consistent with its charitable mission. Consistent with its charitable mission, Highmark shall not use an amount greater than the amount UPMC charges for "out-of-network" services to its customers when calculating deductibles, co-pays and coinsurance payments for such members.

9. *Safety Net – Highmark and UPMC shall negotiate in good faith to establish a one year safety net for any consumers who use UPMC physicians and services and who are unable to find alternative physicians and services in their locality. Highmark and UPMC shall hold such consumers harmless if they continue to use such physicians and services. The safety net is not a contract extension. Rather, it is a back-office mechanism whereby Highmark and UPMC shall hold consumers harmless under these circumstances. Highmark shall not characterize or market the safety net to consumers, brokers or employers as a contract extension with UPMC.

10. *Continuity of care - Highmark shall pay for the continuation of care of any patient in the midst of a course of treatment at UPMC on an in-network basis at in-network rates. UPMC and Highmark shall appoint a committee of doctors from their respective hospitals to prepare protocols for determining what a course of treatment is and when a course of treatment is completed. If a consumer believes, his or her care should continue, the consumer may appeal to a court appointed Special Master. UPMC and Highmark shall jointly pay for the selection of a Special Master that will make recommendations to the court in the event a consumer appeals a decision on continuity of care. The OAG, PID and DOH shall nominate one or more candidates for a Special Master and Highmark and UPMC shall have the opportunity to comment on such nominees. The Court shall have final say on the selection of a Special Master.

11. *Highmark shall comply with the terms of the Mediated Agreement and 2012 Agreement as they relate to its Community Blue product.

12. *Consumer Restitution Fund[1] - Highmark shall reimburse any consumer who was confused by Highmark's advertising into believing that Community Blue included all

[1] The reasons for the consumer restitution are different for Highmark and UPMC

UPMC hospitals and doctors on an in-network basis during the period of January 1, 2013 to present. In-network for purposes of this paragraph means that the consumer can visit any UPMC hospital, physician or other provider without pre-approval from Highmark and will pay no more in co-pays than for any other in-network provider. The amount of the fund shall be $2 million but Highmark shall pay additional amounts to make consumers whole if necessary. The cost of a claims administrator and notice to potentially affected consumers will be paid by Highmark separately.

13. *Consumer Education Fund – Highmark and UPMC shall each contribute $2 million to the Consumer Education Fund to be used by the OAG, PID or DOH for education and outreach purposes during the transition. Unused funds shall be deposited into the Consumer Restitution Fund.

14. Transfer of Services – If any Services covered by this term sheet 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.

15. Referrals and AHN Transfer of Patients–(a) AHN shall not require its physicians to refer patients to a 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) otherwise approved by the patient's Health Plan.

16. *Advertising – Highmark shall not engage in any public advertising that has the tendency to confuse or mislead consumers.

17. *The Payment of Attorneys' Fees and Costs

18. *The Payment of Civil Penalties

19. Extension – Any party to the Consent Decree can ask that binding arbitration provisions of the Final Decree be extended before initial agreements contemplated by this term sheet expire.

COMMONWEALTH OF PENNSYLVANIA
OFFICE OF ATTORNEY GENERAL
HARRISBURG, PA 17120

KATHLEEN G. KANE
ATTORNEY GENERAL

15TH FLOOR
STRAWBERRY SQUARE
HARRISBURG, PA 17120
(717) 787-3391

June 24, 2014

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

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

Dear Tom & Tom:

Yen Lucas and I have worked to try to achieve an agreement satisfactory to us and to each of your respective organizations. We believe the enclosed achieves that goal on behalf of western Pennsylvania consumers that our respective agencies have represented during these negotiations. In addition, in the interests of fairness, we have been preparing two separate documents on parallel tracks and trying to the best of our ability to mirror the documents so that each company is essentially under the same obligation. Attached are copies of each of your respective Term Sheets with the language about releases and compliance of law still being drafted.

The Term Sheets reflects some of the changes that each of you have requested over the past 24-hours. We have made a number of accommodating changes to better reflect the thus far collaborative process to try to resolve outstanding issues and to formulate a pro-consumer transition plan. The OAG, however, reserves the right to pursue still outstanding issues related to the charitable/nonprofit status of your respective institutions as well as consumer protection measures that are not addressed in these documents. While there will be ongoing opportunities and negotiations between the parties to resolve some of the open items as part of Highmark's Transition Plan, high level agreement around core principles must be resolved now. With regard to the attached, however, we would emphasize that this represents the Commonwealth's last, best and **final** terms around these core principles.

COMMONWEALTH

EXHIBIT 9

Our respective principals have set today as the date by which the parties must reach agreement on the Term Sheets. If we do not have agreement by today, we will commence joint litigation against both parties. Our strong desire, however, is to bring this matter to an amicable resolution and so we encourage you to work with your senior management and boards to gain approval to move forward with the attached.

Thank you for your cooperation.

Sincerely,

James A. Donahue, III
Executive Deputy Attorney General

Enclosures

cc: Attorney General Kane
Michael F. Consedine, Commissioner of Insurance
Michael Wolf, Secretary of Health
Jim Schultz
Yen Lucas

Confidential Settlement Proposal--Not For Public Dissemination.

UPMC Term Sheet for Consent Petition for Final Decree

*Denotes identical or mirrored term in both Highmark and UPMC term sheets. Identical or mirrored terms require same action by both parties.

1. *Form of document – final consent decree filed in Commonwealth Court by the Office of Attorney General ("OAG"), Pennsylvania Insurance Department ("PID") and Pennsylvania Department of Health ("DOH") in response to a Petition for Review.

2. *The Consent Decree shall be construed in a manner that is consistent with the PID'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 be characterized as such.

3. *Dispute Resolution Process – Where required in this term sheet, UPMC and Highmark shall negotiate in good faith. If parties are unable to reach agreement to any of the issues raised in this term sheet 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 term sheet, 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 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 the Highmark's April 1, 2015 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 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.

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 term sheet and related to 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.

4. Key Transition Issue Agreements

a. *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.

b. *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 covered vulnerable population, UPMC shall continue to contract with Highmark at in-network rates for all of its hospital,

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

FIRST SET OF STIPULATIONS BETWEEN THE COMMONWEALTH OF PENNSYLVANIA AND UPMC

A. Medicare and Medicare Advantage

1. UPMC is a participating provider under Medicare.

2. Federal law requires Medicare Advantage insurers to "[m]aintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served." 42 C.F.R. § 422.112.

3. A provider who has "written agreements" with the insurer to provide services to Medicare Advantage subscribers is in-network. *See id.*

4. In Medicare Advantage plans, a provider without a contract establishing payment amounts is out-of-network. *See id.*

B. The UPMC-Highmark Medicare Advantage Agreements

5. For years, UPMC and Highmark contracted to include UPMC as in-network for Highmark's Medicare Advantage products (the "Medicare Advantage Agreements").

C. The 2012 Mediated Agreement

6. In addition to the Medicare Advantage Agreements, UPMC and Highmark also were parties to a series of commercial contracts governing UPMC's provision of services to Highmark commercial-plan subscribers.

7. Exhibit 18 to the UPMC Brief is an example of a commercial contract between UPMC and Highmark.

8. Most of UPMC's and Highmark's commercial hospital contracts were set to expire on June 30, 2012.

9. In May 2012, then-Governor Tom Corbett, appointed a mediator who brokered a Mediated Agreement between UPMC and Highmark.

10. The Mediated Agreement extended the commercial contracts between UPMC and Highmark through 2014. Mediated Agreement (Ex. 6 to UPMC Br.) § 1.

11. The Mediated Agreement also provided that "[t]he current Medicare Advantage agreement (including rates) will remain in place, but cannot be terminated by either party prior to December 31, 2014." *Id.* § 2.A.

12. UPMC and Highmark thereafter executed an amendment to their Medicare Advantage Agreements. *See* 2012 MA Amendment (Ex. 7 to UPMC Br.).

13. The 2012 Amendment to the Medicare Advantage Agreements memorialized UPMC's and Highmark's agreement not to terminate the Medicare Advantage Agreements before December 31, 2014. *Id.* § 5.

14. The 2012 MA Amendment set April 1 as the deadline for Highmark or UPMC to provide "written notice of termination" of the Medicare Advantage Agreements without cause effective at the end of any year thereafter. *Id.* § 5.

15. UPMC sent notice to Highmark on March 20, 2015, that it would not renew the Medicare Advantage Agreements for 2016. 3/20/15 McGough Ltr. (Ex. 34 to UPMC Br.).

D. Negotiation of The Consent Decrees

16. In order to develop a transition plan for the expiration of the UPMC-Highmark contracts at the end of 2014, Governor Corbett assembled a team of state officials, including the Attorney General, Insurance Commissioner, and Secretary of Health (collectively, the "Patients First Leadership Team").

17. The discussions convened by the Patients First Leadership Team culminated in UPMC and Highmark each executing a Consent Decree with The Commonwealth.

18. The Consent Decrees resolved a number of issues stemming from the wind-down of the UPMC-Highmark contracts.

E. Key Terms of the Consent Decrees

19. The Consent Decrees contain a provision regarding "Vulnerable Populations." *See* Consent Decrees § IV.A.2.

20. The vulnerable-populations provision provides in its entirety:

> **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 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 rates and fees payable under those arrangements unilaterally and materially.

See Consent Decrees § IV.A.2.

F. Medicare As "Primary and Secondary" Insurance

21. Many Medicare beneficiaries also have commercial insurance plans because they remain covered by an employer-provided or spouse's plan.

22. The Patients First Leadership Team met with UPMC on June 5, 2014.

G. Highmark's August 29, 2014 Transition Plan and Lawsuit

23. Highmark issued its final "UPMC Contract Transition Plan" on August 29, 2014 ("Transition Plan") (Ex. 47 to UPMC Br.).

24. On September 3, 2014, Highmark filed a complaint, verified by Highmark's Vice President Thomas Fitzpatrick, in the Court of Common Pleas of Allegheny County against UPMC, certain UPMC hospitals, and certain UPMC subsidiary organizations.

25. UPMC advised the Patients First Leadership Team via letter dated September 10, 2014 that, in UPMC's opinion, by filing its lawsuit and making those assertions, Highmark had violated its obligation to use best efforts to resolve

the arbitration by December 31, 2014. 9/10/14 McGough Ltr. (Ex. 23 to UPMC Br.).

H. Highmark's Out-Of-Network Community Blue MA Product And Contempt Proceeding

26. In the fall of 2014, Highmark unveiled to the public a new Medicare Advantage product, Community Blue ("Community Blue MA"). *See* Contempt Op. ("Op.") at 7–9.

27. Community Blue MA does not include any UPMC hospitals or physicians in-network except in emergencies. *See id.*

28. Community Blue MA subscribers are out-of-network for UPMC providers except in emergencies.

29. On October 10, 2014, The Commonwealth filed in this Court an Application to Hold Highmark in Contempt and Enforce Consent Decree and Issue a Preliminary Injunction.

30. The Commonwealth argued in its application that Highmark's offering of Community Blue MA violated the vulnerable-populations provision.

I. Effects Of UPMC's Nonrenewal Of Medicare Advantage Agreements

31. The Medicare Advantage Agreements will remain in effect until the end of 2015.

32. UPMC's termination of the Medicare Advantage Agreements will not become effective until January 1, 2016.

33. The Medicare Advantage Agreements have a six-month run-out period that runs from the effective date of termination (through June 30, 2016).

34. Pursuant to the run-out provision, UPMC is "to provide services to [Highmark] Members for six (6) months after the date on which the termination becomes effective." 2002 Amendment to Medicare Acute Care Provider Agreement, effective Jan. 1, 2002 (attached hereto as Ex. A) § 16.3.

35. On October 15, 2015, eligible persons will enter open enrollment for Medicare and Medicare Advantage for 2016.

36. For purposes of the hearing on May 27, 2015, the parties agree to the following regarding authenticity: Documents that parties produced that appear on other parties' exhibit lists will be deemed authentic. The only exception is where a third party document is attached to a party's produced email. By way of example, if Party A produced an email containing an attachment from a non-party, this authenticity agreement does not relieve the requirement to separately address the attachment (although the parties do agree that the attachment was, in fact, attached

to the email). If, however, a document drafted and produced by Party A is attached to an email produced by Party B, that email and the attachment are deemed authentic.

37. For purposes of the hearing on May 27, 2015, the parties agree that (a) exhibits to the parties' briefs/pleadings, (b) the pleadings in this litigation, and (c) the pleadings from the arbitrations before the AAA and AHLA are deemed admissible, subject to each party reserving the right to object to these documents on the grounds of relevance at the May 27th hearing.

Dated: May 27, 2015

Respectfully submitted,

By: */s/ Rebekah B. Kcehowski*

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Leon F. DeJulius, Jr. (Pa. 90383)
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EXHIBIT A

AMENDMENT TO THE MEDICARE ACUTE CARE PROVIDER AGREEMENT

This Amendment to the Medicare Acute Care Provider Agreement (this "Amendment") is made and entered into as of the 1st day of January, 2002 (the "Effective Date") by and between Keystone Health Plan West, Inc. (hereinafter "Health Plan") and **UPMC PASSAVANT** (hereinafter the "Provider").

WHEREAS, Highmark Inc., d/b/a Highmark Blue Cross Blue Shield owns 100% of the voting stock of Health Plan (hereinafter "Highmark"); and

WHEREAS, Health Plan and the Provider are parties to an agreement to establish terms and conditions for the provision and payment of hospital services to eligible members of Health Plan, in accordance with individual or group benefit agreements for the provision of hospital services (hereinafter "Agreement"); and

WHEREAS, Health Plan and the Provider wish to modify certain provisions of the Agreement as provided below.

NOW, THEREFORE, in consideration of the mutual covenants stated herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto, intending to be legally bound hereby, agree as follows:

I. Part 2. DEFINITIONS

Part 2. of the Agreement, definition 2.2. is hereby modified as follows *(changes in italics):*

2.2. "Contract Year" shall mean each twelve (12) month *period occurring during the term of this Agreement.*

Part 2. of the Agreement is hereby modified by adding a new definition 2.19. as follows (current definitions 2.19. through 2.22. are renumbered 2.20. through 2.23):

2.19. "Per Case" shall mean payment for an authorized admission based on an entire length of stay in an acute care bed at a Provider participating in Health Plan's Medicare Program.

II. Part 3. PROVIDER OBLIGATIONS

Section 3.1.18. of the Agreement is hereby modified as follows *(changes in italics):*

3.1.18. Agree that the U.S. Department of Health and Human Services, the Comptroller General, *the Pennsylvania Department of Health (DOH) and all other applicable regulatory agencies* or their designees have the right to inspect,

evaluate and audit any pertinent contracts, books, documents, papers and records of the Provider involving transactions related to Health Plan's Medicare Program and to inspect, evaluate and audit any pertinent information for any particular Contract Year for a period of six (6) years from the final date of the Contract Year or from the date of completion of any audit, whichever is later.

III. Part 7. PAYMENT AND BILLING

Section 7.1. of the Agreement is hereby modified as follows *(changes in italics):*

7.1. Payment. Health Plan agrees that Provider's payment for Covered Services shall be at rates set forth in the Provider payment rates attached hereto as Exhibit I and made a part hereof. *The parties agree that Exhibit I may define a "Rate Period," which may coincide with or be independent of the term and Contract Years of this Agreement. Health Plan agrees that, no later than February 1 of the Contract Year in which the payment rates on Exhibit I expire, it will provide to the Provider notification of rates to take effect in the following Rate Period or Contract Year(s), as applicable. No later than sixty (60) days after the rate notification date, Provider must notify Health Plan, in writing, of its intent to renew the Agreement for the following Rate Period or Contract Year(s), as applicable, or terminate the Agreement according to Sections 16.2. and 16.3.*

IV. Part 12. MEDICAL RECORDS AND CONFIDENTIALITY

Section 12.1. of the Agreement is hereby modified as follows *(changes in italics):*

12.1. Provider shall maintain, with respect to each Member receiving Provider Services, a single standard Provider medical record in such form, containing such information and preserved for such time periods as are required by all applicable Laws which govern its operations, including, but not limited to, the state regulatory authority, the federal Medicare program or the Joint Commission on Accreditation of Health Care Organizations (JCAHO). Upon prior written notice from Health Plan, Provider also agrees to maintain such further records and provide such further information to Health Plan as may be required for compliance by Health Plan with applicable Laws and the federal Medicare program as currently provided or hereafter amended. Obligations under this subsection shall survive the expiration or termination of this Agreement. Health Plan shall have access at reasonable times, upon reasonable demand, to the books, medical records, other records and papers of Provider relating to the health care services provided to Members, to the charges therefore and to payments received by Provider from Members or other third-party payers for the Health Plan's Members. Access to medical records shall be extended to the U.S. Department of Health and Human Services, the Comptroller General, the DOH, any approved DOH external quality review

organization *and to all applicable regulatory agencies and their agents or designees.*

V. Part 16. TERM AND TERMINATION

Section 16.2. of the Agreement is hereby modified as follows *(changes in italics):*

16.2. Notwithstanding any other provision of this Agreement to the contrary, this Agreement may be terminated by *Health Plan* without cause as of the end of *the* Contract Year *that expires on December 31, 2002* upon *at least* one hundred and fifty (150) days written notice prior to the expiration of such Contract Year.

Beginning with the Contract Year effective January 1, 2002 this Agreement may be terminated without cause by: (i) Health Plan as of the end of any Contract Year upon at least one hundred and fifty (150) days written notice prior to the expiration of such Contract Year to Provider; (ii) Provider as of the end of any Contract Year with written notice to Health Plan no later than April 1 of such Contract Year.

Provisions 16.2.1 through 16.2.10. remain unchanged.

Section 16.3. of the Agreement is hereby modified as follows *(changes in italics):*

16.3. In the event of termination of this Agreement for any reason *other than default by Provider*, the Provider shall *be obligated to continue to comply with the terms and conditions of this Agreement and continue to provide services to Health Plan's Members for six (6) months after the date on which the termination becomes effective. For services rendered during this six (6) month period, Provider shall accept Health Plan's payment rates in effect on the termination date.*

In addition to the rights stated herein, the non-defaulting party shall have any and all remedies otherwise available at law or in equity, including, without limitation, specific performance.

VI. Part 17. GENERAL PROVISIONS

Section 17. of the Agreement is hereby modified by adding the following provision:

17.10. Interpretation. Interpretation of provisions of this Agreement shall be in accordance with all applicable state and federal Laws and regulations including, but not limited to, the Laws of Pennsylvania governing the operations of health maintenance organizations.

VII. No Offer

This Amendment shall not be binding until executed and delivered by all of the parties hereto.

VIII. Authority

Each party represents to the other that it has full power and authority to execute this Amendment.

IX. Whole Agreement

No representation, promises or inducements have been made by the parties other than as appear in this Amendment. The Agreement remains in full force and effect, except as amended herein. This Amendment, upon execution by the parties, becomes part of the Agreement. This Amendment constitutes the entire understanding of the parties hereto and supercedes any prior oral or written communications, representations or agreements pertaining to the subject matter hereof.

(Signatures on next page)

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date first above written.

UPMC PASSAVANT

By: _____

John W. Paul

(Please print or type name.)

Title: Executive Vice President

Date: August 3, 2001

Provider Address

9100 Babcock Boulevard
Pittsburgh, PA 15237-5842

(412) 367 - 6700
(Telephone number)

KEYSTONE HEALTH PLAN WEST, INC.

By: Sandra R. Tomlinson

Title: Senior Vice President

Date: 8/24/01

120 Fifth Avenue
Suite 871
Pittsburgh, PA 15222-3099

MEDICARE ACUTE CARE PROVIDER AGREEMENT

EXHIBIT I

PAYMENT RATES

RATE PERIOD I

Inpatient Payment Rates

For Discharges during the Rate Period January 1, 2002 through December 31, 2002.

Payment Category	Payment Rate
PER DIEM PAYMENT(S)	**Per Diem**
Acute care services - Tier A - Tier B	[redacted]
"Stepdown" services	

cait 8/24/01 alk 8/24/01

~~Determinations of admission to Stepdown level are subject to mutual agreement between Health Plan and Provider~~. Determinations of admission to Stepdown level are subject to mutual agreement, by Health Plan's Medical Director and Provider's Medical Director for Denial Management, whereupon the within rates shall apply.

PER CASE PAYMENT(S)	**Per Case Price**
	[redacted]

MEDICARE ACUTE CARE PROVIDER AGREEMENT

EXHIBIT I

PAYMENT RATES

RATE PERIOD I

Outpatient Payment Rates

Fee Schedule Payment Rates

For Covered Services provided during the Rate Period January 1, 2002 through December 31, 2002.

Payment will be at [redacted]

Percentage of Charge Payment Rate

Payment Rate in effect for the Rate Period January 1, 2002 through December 31, 2002.

Those covered outpatient services denoted by a valid HCPCS procedure code but with no fee included on the Health Plan Institutional Outpatient Fee Schedule [redacted]

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	: : :	334 MD 2014

PROOF OF SERVICE

I hereby certify that this 27th day of May, 2015, I have served the attached document(s) to the persons on the date(s) and in the manner(s) stated below, which service satisfies the requirements of Pa.R.A.P. 121:

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

PROOF OF SERVICE

(Continued)

Service

Served:	Amy Griffith Daubert
Service Method:	eService
Email:	adaubert@pa.gov
Service Date:	5/27/2015
Address:	Pennsylvania Insurance Department 1341 Strawberry Square Harrisburg, PA 17120
Phone:	717--78-7-2567
Representing:	Petitioner Department of Insurance

Served:	Amy Griffith Daubert
Service Method:	First Class Mail
Service Date:	5/28/2015
Address:	PA Dept of Insurance 1341 Strawberry Sq Harrisburg, PA 171200046
Phone:	717-787-2567
Representing:	Petitioner Department of Insurance

Served:	Daniel I. Booker
Service Method:	First Class Mail
Service Date:	5/28/2015
Address:	Reed Smith Llp 225 5TH Ave Ste 1200 Pittsburgh, PA 152222716
Phone:	412-288-3132
Representing:	Respondent Highmark Health Respondent Highmark, Inc. Respondent UPE

Served:	James A. Donahue III
Service Method:	eService
Email:	jdonahue@attorneygeneral.gov
Service Date:	5/27/2015
Address:	Office of Attorney General Public Protection Division 14th FL. Strawberry Square Harrisburg, PA 17120
Phone:	717--70-5-2523
Representing:	Petitioner Commonwealth of Pennsylvania Petitioner Kathleen G. Kane

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

PROOF OF SERVICE

(Continued)

Served:	James A. Donahue III
Service Method:	First Class Mail
Service Date:	5/28/2015
Address:	Public Protection Division 14th Fl Strawberry Square Harrisburg, PA 17120
Phone:	717-787-9716
Representing:	Petitioner Commonwealth of Pennsylvania Petitioner Kathleen G. Kane

Served:	Jeffrey Michael Weimer
Service Method:	eService
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Service Date:	5/27/2015
Address:	Reed Smith LLp 225 Fifth Avenue, Suite 1200 Pittsburgh, PA 15222
Phone:	412–28-8-7982
Representing:	Respondent Highmark Health Respondent Highmark, Inc. Respondent UPE

Served:	Jeffrey Michael Weimer
Service Method:	First Class Mail
Service Date:	5/28/2015
Address:	Reed Smith Llp 225 5TH Ave Ste 1200 Pittsburgh, PA 152222716
Phone:	412-288-7982
Representing:	Respondent Highmark Health Respondent Highmark, Inc. Respondent UPE

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

PROOF OF SERVICE

(Continued)

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Served:	Joseph Daniel Filloy
Service Method:	First Class Mail
Service Date:	5/28/2015
Address:	Reed Smith Llp 225 Fifth Ave Pittsburgh, PA 15222
Phone:	412-288-3842
Representing:	Respondent Highmark Health Respondent Highmark, Inc. Respondent UPE

Served:	Mark A. Pacella
Service Method:	First Class Mail
Service Date:	5/28/2015
Address:	PA Ofc Attorney General 14TH Fl Strawberry Sq Harrisburg, PA 171200001
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Served:	Michael F. Consedine
Service Method:	First Class Mail
Service Date:	5/28/2015
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IN THE COMMONWEALTH COURT OF PENNSYLVANIA

PROOF OF SERVICE

(Continued)

Served:	Michael Wolf
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Service Date:	5/28/2015
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Representing:	Petitioner Michael Wolf

Served:	Neil Mara
Service Method:	First Class Mail
Service Date:	5/28/2015
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Phone:	717-787-4951
Representing:	Petitioner Kathleen G. Kane

Served:	Paul Gavin Eastgate
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Representing:	Respondent Highmark Health Respondent Highmark, Inc. Respondent UPE

Served:	Paul Gavin Eastgate
Service Method:	First Class Mail
Service Date:	5/28/2015
Address:	Reed Smith Llp 225 5TH Ave Ste 1200 Pittsburgh, PA 152222716
Phone:	412-288-5710
Representing:	Respondent Highmark Health Respondent Highmark, Inc. Respondent UPE

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

PROOF OF SERVICE

(Continued)

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Representing:	Petitioner Department of Health Petitioner Department of Insurance

Served:	Sean Martin Concannon
Service Method:	First Class Mail
Service Date:	5/28/2015
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Phone:	717-783-6563
Representing:	Petitioner Department of Health Petitioner Department of Insurance

Served:	Thomas L. Van Kirk
Service Method:	First Class Mail
Service Date:	5/28/2015
Address:	Highmark Health 120 Fifth Ave Ste 3112 Pittsburgh, PA 152223099
Phone:	412-544-8190
Representing:	Respondent Highmark Health Respondent Highmark, Inc. Respondent UPE

Served:	Tracy Wright Wertz
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Service Date:	5/28/2015
Address:	PA Attorney Gen Anti Trust Strawberry Sq 14th Fl Harrisburg, PA 17120
Phone:	717-787-4530
Representing:	Petitioner Commonwealth of Pennsylvania Petitioner Kathleen G. Kane

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

PROOF OF SERVICE

(Continued)

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IN THE COMMONWEALTH COURT OF PENNSYLVANIA

PROOF OF SERVICE

(Continued)

Courtesy Copy

Served:	Claude Joseph Hafner II
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Served:	Jason Michael Staloski
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Service Date:	5/28/2015
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Phone:	570-704-9388
Representing:	Amicus Curiae House Democratic Leaders

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IN THE COMMONWEALTH COURT OF PENNSYLVANIA

PROOF OF SERVICE

(Continued)

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Phone:	717--78-7-3002
Representing:	Amicus Curiae House Democratic Leaders

Served:	Tara Lynn Smith
Service Method:	First Class Mail
Service Date:	5/28/2015
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Representing:	Amicus Curiae House Democratic Leaders

Served:	Thomas F. Lebo
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Address:	Senate of Pennsylvania 535 Main Capitol Building Harrisburg, PA 171200022
Phone:	717-787-1331
Representing:	Amicus Curiae Senate Democratic Leaders

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

/s/ S. Rebekah Byers Kcehowski

(Signature of Person Serving)

Person Serving:	Kcehowski, S. Rebekah Byers
Attorney Registration No:	090219
Law Firm:	Jones Day
Address:	Jones Day 500 Grant St Ste 4500 Pittsburgh, PA 152192500
Representing:	Respondent UPMC

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.	:	No. 334 MD 2014
UPMC, A Nonprofit Corp.; UPE, a/k/a Highmark Health, A Nonprofit Corp., and Highmark, Inc., A Nonprofit Corp., Respondents	:	

TRANSCRIPT OF PROCEEDINGS

Before: THE HONORABLE DAN PELLEGRINI, Senior Judge

Date: January 17, 2018, 2:20 p.m.

Place: Commonwealth Court of Pennsylvania
Pennsylvania Judicial Center
601 Commonwealth Avenue, Courtroom No. 3001
Harrisburg, Pennsylvania

APPEARANCES:

James A. Donahue, III, Esquire
Mark A. Pacella, Esquire
For - Commonwealth of Pennsylvania, by Kathleen G. Kane, Attorney General, Petitioner

Mary Abbegael Giunta, Esquire
For - Pennsylvania Department of Insurance and Pennsylvania Department of Health, Petitioners

Leon F. DeJulius, Jr., Esquire
S. Rebekah Byers Kcehowski, Esquire
Thomas A. Panighetti, Esquire
For - UPMC, Respondent

APPEARANCES (cont'd):

Daniel I. Booker, Esquire
Douglas E. Cameron, Esquire
Conor M. Shaffer, Esquire
Jeffrey M. Weimer, Esquire
For - UPE, a/k/a Highmark Health, and Highmark, Inc., Respondents

THE COURT CRIER: All rise. Commonwealth Court is now in session. The Honorable Dan Pellegrini presiding.

THE COURT: Good afternoon. Please be seated.

We had a conference before. I will not characterize the conference.

Commonwealth, it's your motion.

MR. PACELLA: Yes, Your Honor. Mark Pacella on behalf of the Commonwealth, also Attorney General, Your Honor.

We are here today on the Commonwealth's motion to -- petition to enforce the consent decree with respect to UPMC. As Your Honor is aware, in our papers, we maintain that UPMC is in violation of its consent decree in two respects.

The first respect is in its early termination of its Medicare Advantage contracts. Under the consent decree, UPMC is required to remain in contract with Highmark through June 30th of 2019. UPMC issued termination notices of its Medicare Advantage contracts now twice with regard to those contractual relationships. The first was in the fall, in September of last year. That termination provision -- that termination notice triggered Highmark's filing an action to hold or find UPMC in contempt of Your Honor's May 29th --

THE COURT: If you want to bring that up, I -- I think that the podium also moves up. There's a button, isn't

there? No, not on that one. I'm sorry. That one doesn't have --

MR. PACELLA: Oh, you mean -- you're talking about --

THE COURT: It moves the -- it moves the podium --

MR. PACELLA: How's that?

THE COURT: It goes up and down.

Does that one go up and down?

MR. PACELLA: There is a button. You just want the volume up?

THE COURT: Yeah. There's -- is there a button on that?

MR. PACELLA: There is a little button over here, but I don't --

THE COURT: Push it. It will go up. It will make it easier for you.

MR. PACELLA: Oh, oh, it was all the way up.

THE COURT: Okay.

MR. PACELLA: That's as good as we're going to get.

THE COURT: Okay.

MR. PACELLA: Okay. As I was saying, these termination issues first presented to the Court back in the fall of last year. Highmark responded with an action for determination to hold UPMC in contempt of this Court's May 29th, 2015 order. Pleadings were filed, and UPMC

withdrew its terminations. It's cured the violation in that respect. But no decision from the Court has ever been entered with regard to Highmark's outstanding request for injunctive relief and a ruling as to whether or not UPMC violated back in last fall, in September.

In January of this year, UPMC renewed its terminations on January the 2nd with regard to nine hospitals again without seeking the Court's prior approval as required under the May 29th, 2015 order. Consequently, the Commonwealth, having been directed by the Court to file a petition to enforce alleging whatever circumstances are that UPMC -- we contend UPMC violated its consent decree is based on those two actions.

UPMC has again issued termination notices without first coming to Your Honor to get approval. And secondly, its terminations to be effective December 31st of this year, 2018, we believe clearly violates the terms of the consent decree which requires them to remain in contract through twenty -- June 30th, 2019.

UPMC's position as is reflected in its papers and its filing contend that it is in fact in compliance because its contract that it's terminating effective December of 2018 provides for a six-month runout period.

The Commonwealth believes that this is a contract interpretation matter; that in fact under the specific terms

of the contract that had been negotiated between UPMC and Highmark, the only way that six-month runout period is in fact triggered requires one of the parties to terminate the contract.

And so as we've said in our -- in our filings, UPMC's termination is premature; it occurs prior to the expiration of the consent decrees and has been effected, if you will, or taken action without Your Honor's approval.

We think that there are really no facts -- material facts at issue with regard to those two issues. You have in the record the -- and it's been attached in everybody's pleadings -- the actual contract, the Medicare Advantage contract, which is some hundred and thirty-four pages long.

The operative provision in there is paragraph 5 under a 2012 amendment that provides for the termination to occur between January the 1st and April 30th of the contract year. Those contracts have for over a decade run on a calendar year basis, and they automatically renew unless terminated by either party. It's that termination that's required to trigger the six-month runout and, again, under the specific terms of the contracts between the parties really can't be effected without violating the consent decree.

We're asking the Court to recognize that those two documents, the consent decrees and the existing underlying

Medicare Advantage contracts, need to be interpreted in unison and compliance with those terms requires that UPMC -- a finding that UPMC's terminations were premature and constitute a violation.

The consent decrees themselves are intended to protect the interests of the general public, the people who are caught up in these contract disputes between these two -- these two respondents. It's not really about who gets the better of whatever commercial interests are implicated here.

Regardless of how the Judge -- let me strike that.

Should the Judge agree with the Commonwealth's position, this is not a case in which UPMC will have to continue to treat patients for free or without remuneration. They'll continue to get paid at the existing rates that they're getting under the contract now. This is not a circumstance where it will impose any severe prejudice on -- on UPMC to continue to treat these folks as in-network which, again, is consistent with what they had agreed to do when the consent decrees were entered.

Because we don't think that there are any material facts at issue that are necessary for Your Honor to decide this, we don't feel it necessary to call any witnesses but would reserve the right to offer any rebuttal should the other parties do so.

THE COURT: Well, let me make sure I understand the

Commonwealth's position. The Commonwealth is saying under paragraph Roman numeral IV 2 that with -- with respect to Highmark's covered vulnerable populations, UPMC shall continue to contract with Highmark at all in-network rates for all hospital, physician, dot, dot, dot. And you're saying by the term contract -- are you saying that UPMC -- when can UPMC terminate the contract? What is your position on that?

MR. PACELLA: Under the terms of the consent decree and their existing Medicare Advantage contracts, they can petition this Court to terminate that contract anytime between January the 1st of 2019 and April 30th of 2019, next year at this -- within the same window.

THE COURT: So let's say they can petition the Court. Or let's say they just -- we'll just -- for the sake, we'll say petition the Court. When is the contract termination effective?

MR. PACELLA: Under the terms of the contract, when they trigger that termination provision, it's effective at the end of that calendar year. So it would be December the 31st of whatever calendar year the termination would have been triggered.

THE COURT: Does the runout apply?

MR. PACELLA: Yes. There's a six-month runout that applies under their contract.

THE COURT: So here's -- so under your interpretation, you -- this contract ends June 30th, 2019 -- this agreement, the consent decree, ends June 30th, 2019. And there's these overlaps that no one took into consideration here. But under your interpretation, Highmark -- or UPMC would be required to take Highmark Advantage patients until June 30th, 2020.

MR. PACELLA: Yes. If they -- if they terminate their contract in 2019, that would be in conformity with the terms of their contract, which is very clear. There -- there are no ambiguities in the -- in the contract. The provisions are very clear.

They -- they can under the terms of their contract and without violating the terms of the consent decree issue their termination notices next year between January the 1st and April 30th.

If they do that, Your Honor, that contract's termination would be effective December 31st of 2019; and that contract by its additional terms has a six-month runout period in it so that under those circumstances, UPMC would be required under its contract to continue to accept Highmark Medicare Advantage subscribers as in-network through the rest of that six-month runout period which would carry that through June 30th of 2020.

THE COURT: But you're essentially getting at least

six more months than the consent decree under the contract.

MR. PACELLA: Your Honor, the consent decrees, as Your Honor is aware, were negotiated by the respondents. The contract was not something --

THE COURT: Well, they were negotiated by you and the respondents.

MR. PACELLA: Well, actually the consent decrees were mediated; the negotiations were mediated by us. But the provisions --

THE COURT: No, I --

MR. PACELLA: -- in those consent decrees were --

THE COURT: But you're one of the parties. You were the moving party to the agreements. Don't --

MR. PACELLA: Yes.

THE COURT: Don't parse that.

MR. PACELLA: That's true. That's true.

The -- we were never a party to the underlying Medicare Advantage contracts, however.

THE COURT: Well, that -- that I understand, but what -- the problem I'm having with all of this is that people negotiated these agreements and they have this June 30th end date to them. And, you know, while it's embodied in a consent decree, I have to interpret these agreements. And we're bringing in these third-party agreements to essentially extend the term for a year.

MR. PACELLA: Well --

THE COURT: I guess what I'm asking is, what does June 30th mean?

MR. PACELLA: June 30th, Your Honor, means they need to be in contract through June 30th of 2019. I would ask the Court to appreciate that there is nothing in the consent decrees that prohibit the respondents from being in contract status beyond December -- beyond June 30th of 2019. And --

THE COURT: UPMC argues that if the contract -- they terminate the contract on January 1st, 2019, that the runout provisions of the contract -- the runout provisions contained in the agreement still mean they're under contract and therefore they're complying with the terms that you negotiated under the consent decree.

MR. PACELLA: I think --

THE COURT: How do you respond to that?

MR. PACELLA: Yeah. I -- I think their position is they can terminate now in 2018 and the six-month runout period carries them through and they're in the compliance.

THE COURT: Yeah --

MR. PACELLA: Our provision is if -- our position on that is if you just look at the plain meaning in the terms of their contract which is not in any way ambiguous, that can't happen unless they terminate. We're -- our argument is

that they cannot terminate under the terms of the consent decree prior to June 30th, 2019. And --

THE COURT: Well, if they terminate the -- theoretically under the -- under the agreement between Highmark and UPMC, there is nothing in that agreement that they can't terminate that except between April 1st and April 4th.

MR. PACELLA: That -- that's correct, Your Honor. And that's why we -- we think that they --

THE COURT: January 1st and April 4th.

MR. PACELLA: Right.

THE COURT: If under that agreement -- so what you're saying is under the agreement, the termination only takes place January 1st, 2020.

MR. PACELLA: Right. We -- our position is that UPMC cannot comply with the terms of the consent decree and terminate those Medicare Advantage contracts prior to January, February, or March of 2019.

THE COURT: So the June 30th date in the consent decree is kind of meaningless.

MR. PACELLA: It -- no, we don't think it's meaningless because it -- that is the operative date that guides us in terms of when can UPMC terminate these contracts. If the -- if -- for example, if the consent decrees expired on December 31st of 2018, UPMC's -- the

termination notices that bring us to court today would not constitute a violation of the consent decrees. That June 30th, 2019 date had -- has been agreed to by all the parties. And we intend to have UPMC honor its commitments.

Both of those parties knew the terms of their Medicare Advantage contracts when they entered the consent decrees, and they certainly knew the terms of the consent decrees when they signed off on these things. We're --

THE COURT: So what you're in effect saying is that the provider agreements are incorporated into the consent decrees.

MR. PACELLA: I think -- I think that's right. I don't think that -- that you can look at just the contracts themselves to answer the question. You have to look at that in the context along with the terms of the consent decree to determine whether or not they're in violation.

This is why we believe that the CMS regulations, whatever they are, whatever they may say, are not determinative of this issue because it is not simply compliance with those regs that control. The CMS has no knowledge of or interest in the consent decrees. That's for Your Honor to decide.

THE COURT: Well -- well, you know, overlapping all -- underlying all of this is the CMS.

MR. PACELLA: Well, it -- it certainly underlies

this. But, again, CMS doesn't determine whether there's a violation of the consent decrees. And in that context, while we certainly aren't suggesting that any of the relief that we're demanding, for instance, that UPMC be -- that their termination notices be voided, that doesn't violate any aspect of any of the CMS regulations.

THE COURT: How much of the provider agreements are dictated by CMS?

MR. PACELLA: I honestly don't know the answer to that question, Your Honor.

THE COURT: Because we learned today that continuity of care is required by CMS and the -- I was just wondering if anything else was --

MR. PACELLA: I don't know the answer to that. I -- it's my understanding that the continuity of care provisions in the consent decree are somewhat broader than what's required under CMS regulations. But I --

THE COURT: So you don't intend to offer any witnesses.

MR. PACELLA: We would want to reserve the right to present rebuttal evidence if -- if the Court hears any.

THE COURT: Thank you.

MR. PACELLA: Thank you.

THE COURT: UPMC.

MR. DeJULIUS: Good afternoon, Your Honor.

At the end of the last hearing, the Court instructed the Commonwealth to file a petition to enforce so that all the parties would have notice as to what the issues --

THE COURT: I said if they wanted to file, they could file.

MR. DeJULIUS: That's right.

THE COURT: But they -- they said they wanted to file one, so --

MR. DeJULIUS: Right. But the -- the key was -- was that the Court --

THE COURT: I just want to say I didn't instigate it.

MR. DeJULIUS: Fair enough. Fair enough, Your Honor. You didn't instigate it, but the Commonwealth did file that petition to enforce. And that's what's before the Court today, and it's the only pleading that's before the Court. And the Commonwealth has filed that petition to enforce against UPMC, alleging that UPMC has violated the consent decree. That's the sole claim that's raised in the petition.

The Commonwealth argued the May 29th order this afternoon. The May 29th order was not in the petition to enforce. The petition to enforce was whether or not UPMC can terminate effective January -- I'm sorry, effective

January 1st, 2019, with the six-month runout, whether that's compliant with the consent decree. And that's the only issue that's before the Court.

And in its petition and again today, the Court -- the Attorney General has never explained why that six-month runout is not a contract or how UPMC fails to comply. It doesn't cite any precedent. It doesn't make an argument that 16.3, the runout period, is not a contract between UPMC and Highmark. And it's -- it's -- frankly it's hard to see what the Court's -- or what the Attorney General's argument is.

In 2002, the parties specifically amended the Medicare Advantage contracts. They used to run calendar year to calendar year. And they amended those contracts to provide a six-month runout period. And it was clear that the same terms and conditions would continue to apply for those six months; Highmark would pay rates. And it actually has a provision in there that says either party can enforce remedies, including specific performance. Specific performance is only available if there's a contractual breach. And there's no -- no question; no one has raised that that was somehow an invalid contractual amendment. It was -- senior executives by both parties signed. There was mutual consideration. It was in writing.

And under the plain terms of the agreement -- this is one area where we do agree with the Commonwealth, that the

agreements are plain and that this is a pure issue of law. Under the plain terms of the agreement, UPMC will continue to provide services on the same terms and conditions through June 30th, 2019, following the termination. And I heard -- under Pennsylvania law, that's a contract, and that's all that's required.

And I heard -- I heard the Attorney General say, But you can't terminate until effectively December or next year, some other time period in which this will extend out to June of 2020. I mean, what I heard the Commonwealth say is we're still going to be dealing with the June date. I haven't figured out why we're dealing with that June date. And to be honest, the Supreme Court has already addressed and answered this question.

On page 48 of its opinion in the twenty-five -- the 2015 proceeding, the -- the Supreme Court said -- because we had -- UPMC had terminated the agreements at that time. The Supreme Court said UPMC can terminate the underlying contracts; they can do whatever they want with those terms; they just have to be in a contract through June 30th, 2019; it doesn't matter if it's this one, another one, any one that they choose.

And our position is that we are in the contract; we are in a contract through June 30th, 2019. And in fact what I heard the Attorney General say is that UPMC will be

obligated under its definition to continue to treat as in-network, continue to treat patients, Highmark subscribers, for six months during the runout period. And that's exactly what we're saying, is that you will have to treat throughout that runout period. And we will do that through June 30th, 2019. How that is not compliance with the consent decrees is absolutely bewildering. We have a contractual agreement that takes us to the end.

And the fact that Highmark has now stepped in and said that they may not comply and that they -- they've argued that somehow there's not a sufficient contract. And, again, I don't understand what that is. Even if Highmark doesn't comply, that doesn't mean that we're in violation. We comply with the consent decree if we provide in-network access through that time period.

The second part of the petition to enforce that is under the consent decrees is an opportunity to cure. And in this instance, the Attorney General has indicated that it wants a different contract perhaps for those six months, and it has acknowledged that if we had a different contract, that it would be okay.

And UPMC has both said that it will continue to contract, provided a draft contractual amendment which it signed. And it also has said that despite what anybody else does, it will continue to treat patients as in-network. UPMC

is fully onboard and compliant with the consent decrees, and how that's not a cure is unexplained. The Attorney General has never told us why that's not a cure of our violation of the consent decree.

And -- and at the end of the day, I think it's very clear that this is not about a violation of the consent decrees but about an extension of those consent decrees for -- for six months. As the Attorney General said, everybody agreed this ends on June 30th, 2019. And as this Court recognized in its 2014 opinion on Community Blue, the Court can't read in extra requirements to the consent decrees. It's a contractual interpretation: what do the underlying agreements mean; what do the consent decrees mean?

These consent decrees were sent through mutual agreement. The parties have talked about the June 30th, 2019 date for years. It's three and a half years in. We've got 18 more months. You'll surely hear that date a few more times between now and then.

Highmark has told people it was the June 30th date. They've told seniors it's June 30th, 2019. UPMC with CMS approval has told people it's June 30th, 2019. There's been little anxiety or concern addressed about any of these issues.

THE COURT: Well, you know, underlying all of this is, you know, these agreements don't in some ways correspond

to the real world because subscriber agreements run on a calendar year basis, and so essentially in the middle of the year, if we adopt your interpretation, that subscribers will not have access to UPMC hospitals -- Medicare Advantage subscribers, not Medigap subscribers, won't -- won't have access to UPMC hospitals after June 30th.

MR. DeJULIUS: That was the agreement that the parties agreed to --

THE COURT: No, I understand --

MR. DeJULIUS: -- including the Commonwealth, Your Honor.

THE COURT: I understand that argument, but you have this overlay -- everybody talks about CMS -- is the subscriber agreements run for a calendar year. And so as I indicated in chambers before in much more colorful language, this agreement doesn't seem to take that into consideration. It seems to have been wrapping up because the agreement was ended -- the agreement was entered on June 30th, June 27th just to go for five years, and five years happened to end in the middle of a calendar year.

But in the real world, all of these plans are calendar years. And if I'm a subscriber in the middle of the year, if I purchased your plan, a Highmark plan that allows access to all hospitals, that in the middle of the year, that changes. And that seems to -- that's the real world that's

underlying, and none of the parties seem to have taken that into consideration.

MR. DeJULIUS: Well, I would -- I would answer that a couple ways, Your Honor. I mean, first, the runout agreement was entered into in 2002. The parties specifically added six months to go from a calendar year termination to a June 30th termination. So that was very, very intentional that the parties did that.

I would say the commercial agreements also have all run June 30th --

THE COURT: 2002 is before the hospital wars.

MR. DeJULIUS: Well, that's correct, Your Honor. But the -- the commercial agreements also end in -- June 30th, 2019. The consent decree was made to sync up with the parties' existing agreements to provide five years for seniors to transition to different plans. They could enroll in different plans every year. And there's no confusion about this. As this Court recognized in the 2014 Community Blue decision, that there is consumer protection, that -- that the CMS runs consumer protection and they will make sure that people aren't confused and they have tools to work with in the event that they -- that they are confused.

None of that is before the Court. The Court's only view is, what do the agreements require? And for better or worse, for better or worse, health care in Pennsylvania is

run by private party contracts. If the Attorney General wants to change a law and they want to change the way that health care is done in the Commonwealth, they can do so. But it's unfair to require a different standard here. The parties have agreed to the terms of the agreement. They agreed to the consent decree, and those should be enforced.

THE COURT: Well, let's get back to the consent decree. Paragraph 2, the vulnerable populations; it says, UPMC shall continue the contract with Highmark.

It's your position that 16.3 of the agreement is -- which is the runout, constitutes the agreement.

MR. DeJULIUS: Let me make sure. It's paragraph 2. Which subsection?

THE COURT: Paragraph 2 -- IV 2, vulnerable populations.

MR. DeJULIUS: Yes.

THE COURT: It says with respect to Highmark's covered vulnerable populations, UPMC shall continue to contract with Highmark.

MR. DeJULIUS: Yes.

THE COURT: And so the issue is really what contract means. I -- the -- the Commonwealth is saying it's a full-blown contract and all the terms of the provisions of the contract apply. You're saying the runout is under the contract already, so it's part of the contract.

MR. DeJULIUS: It is --

THE COURT: That's your position, right?

MR. DeJULIUS: Well, it's -- yes. But it is part of the contract, and it specifically incorporates all of the terms and the conditions of the contract. So it doesn't change --

THE COURT: Right.

MR. DeJULIUS: -- the relationship between the parties. We are in a contract through June 30th, 2019.

THE COURT: The -- the first sentence of 16.3, in the event of termination of the agreement for any reason, why isn't terminate -- the contract is terminated for that provision to come into play.

MR. DeJULIUS: Yes.

THE COURT: So why -- if -- if you interpret contract to mean this contract has to be in place, 16.3 says the contract is terminated.

MR. DeJULIUS: Yes. 16.3 says there's contractual --

THE COURT: So -- so the -- I'm sorry. Finish.

MR. DeJULIUS: 16.3 says the contractual obligations, the terms and the conditions will continue for six months. That is a binding, enforceable contract.

THE COURT: Okay.

MR. DeJULIUS: That incorporates everything.

THE COURT: So it really comes down to -- because I'm bound by the terms of the -- this agreement. Everybody -- that's the general law. Unless they file something to modify or something, I can't change it. I'm bound by the language. So I've got to interpret what under contract means.

If I -- if I interpret under contract means to be this whole contract, 16.3 doesn't apply. If I interpret it to mean that if you're in a runout and I ignore -- ignore the first in the event of termination, then I -- then you win. So it really comes down to that distinction as to who wins in this case.

MR. DeJULIUS: Well, the Supreme Court has already answered this question, Your Honor, because they said you can terminate and it can be a contract. It didn't say the contract. It said specifically with respect with this language in subsection IV; it doesn't refer to a contract. It doesn't refer to the parties' existing contract.

So the way I would modify what the Court has just said is the only way it could determine and rule against UPMC is if it determines that 16.3 does not provide a contractual relationship between the two parties.

THE COURT: And let's say --

MR. DeJULIUS: And that's the way it --

THE COURT: That's essentially the issue in the

case.

MR. DeJULIUS: Correct, Your Honor.

THE COURT: The issue is if this whole thing has to be in place. If I interpret that, this whole thing has to be in place, the whole -- the whole agreement, then you lose. If I interpret 16.3 to be and -- that the event of termination language doesn't terminate the agreement, then you win. Is it as simple as that?

MR. DeJULIUS: No, it's not, Your Honor, because the Supreme Court has already rejected the first part of your argument. And with all due respect, it has said there is no -- it does not require any existing contract; it just requires a contract. So in order to rule in favor of the Commonwealth, the Court must determine that we --

THE COURT: Well, what does shall continue to contract mean?

MR. DeJULIUS: The Supreme Court said you shall have a contract. And it specifically said you don't have to have this one; you can terminate; you just have to have a contract. So the question is, do we have a contract? And 16.3 is binding on the parties. It's in writing. There's mutual consideration.

As the Attorney General said, UPMC would have to continue to provide coverage under that agreement for six months under its theory.

THE COURT: No --

MR. DeJULIUS: That is a contract. And that -- under the Supreme Court opinion, that's --

THE COURT: Maybe shall --

MR. DeJULIUS: -- that's all we have to have. We don't have to have this.

THE COURT: So in other words what you're telling me -- and I -- and I don't remember this -- it says shall continue to contract with Highmark. That doesn't refer to this agreement.

MR. DeJULIUS: That's correct, Your Honor. The Supreme Court specifically said on page 48 of its decision, UPMC can terminate the agreement -- and we cited in our papers -- they can terminate the agreement, but they have to have a contract. It doesn't require this one. There are independent obligations under the consent decree that they must satisfy. So this contract can go away.

THE COURT: Well --

MR. DeJULIUS: And we have a contract.

THE COURT: Well, let's say, you know -- essentially what you're saying is that if there is a provision in the contract, the 16.3 is the contract for next year.

MR. DeJULIUS: 16.3 which incorporates all terms and conditions of the parties' existing contracts; yes.

THE COURT: Sixteen -- because -- in the event of termination because the rest of the agreement is the contract.

MR. DeJULIUS: Right.

THE COURT: What you're saying, for next year, 16.3 is the entire contract.

MR. DeJULIUS: You would -- you would seal under 16.3. And the terms of 16.3 make that very clear, that it provides an ongoing contractual relationship for six months.

THE COURT: That's what I -- but that's the decision.

MR. DeJULIUS: Correct, Your Honor. That's the decision.

THE COURT: If I decide that the whole contract has to be in place, then you lose. If the entire contract is 16.3, you win. Simple as that?

MR. DeJULIUS: You have to find that we are in a contract --

THE COURT: Pardon me?

MR. DeJULIUS: -- in order -- we -- you have to determine whether or not we are in a contract. And if we are --

THE COURT: Well, we'll have to say with respect -- shall continue to contract, and the question is, what does that mean?

MR. DeJULIUS: And the Supreme Court has answered that question.

THE COURT: Let me go to this issue. We have a consent decree, and the consent decree ends on -- on June 30th. And June 30th, Mr. Pacella is arguing that under another agreement -- I don't think it's in this one -- it's -- that you can only terminate it between January 1st and August 30th and then it runs out.

MR. DeJULIUS: That's not this agreement, Your Honor. This agreement requires termination between January 1st --

THE COURT: No. No. I'm -- there -- he -- but I'm just -- what he referred to, that you can only -- there was another agreement. Do you know what he's talking about?

MR. DeJULIUS: I don't, Your Honor.

THE COURT: Okay. That makes it even more difficult.

What if -- let's assume whatever that agreement is, it doesn't exist when you can terminate. If the agreement says -- if I interpret the agreement to say that you can terminate the entire agreement by June 30th and then the runout applies, what happens?

MR. DeJULIUS: Well, Your Honor, I don't -- that's not what the contracts provide.

THE COURT: I --

MR. DeJULIUS: And if --

THE COURT: I'm just trying to get the consequences. I'm not trying to get your agreement.

MR. DeJULIUS: If there were a runout that started on June 30th, it would provide a contract -- that's the same as 16.3, would provide a contractual relationship to go for another six months. That's what -- that's what 16.3 does. And it's what the Attorney General effectively says when he says you'll have to stay in contract through June 30th, 2020, or whatever other date he has when you apply that six-month contract. That six-month runout is a contract, and it would apply. But that's not these agreements.

This runout starts at the beginning of the year, and it runs for six months which is June 30th. And it is in compliance with the consent decree.

THE COURT: Well, that essentially gets back to the original argument: what's the agreement, what's the contract? And you're saying it's this paragraph. They're -- they're essentially saying it's the entire agreement, and then they're saying you have this -- and it's not in this agreement. It's in this other thing that they refer to which is, I guess, a CMS reg which you can only terminate an agreement between January 1st and April 30th.

MR. DeJULIUS: No, that's not correct, Your Honor.

THE COURT: Where is -- no, but where is --

MR. DeJULIUS: There is no -- CMS -- you can terminate at any time.

THE COURT: I probably should ask him where he came up with those dates.

MR. DeJULIUS: I mean, these contracts, Your Honor, require termination between -- notice of nonrenewal, termination between January 1st and April 1st that will be effective on December 31st.

THE COURT: Okay. That's -- where is --

MR. DeJULIUS: And the six-month --

THE COURT: That's not in this agreement.

MR. DeJULIUS: It is in this agreement, Your Honor.

THE COURT: Where is it in this agreement? What paragraph?

(Counsel conferring.)

MR. DeJULIUS: The agreement -- we'll find it for you, Your Honor.

THE COURT: I have -- well, there's a bunch. The one I'm reading from is the acute -- amendment to the Medicare Acute Provider Agreement.

And as of today, what is the entire agreement? Is the entire agreement what -- that's in effect the exhibit -- Exhibit 1? If I were going to enforce an agreement today, would it be Exhibit 1?

MR. DeJULIUS: Of the petition to enforce?

THE COURT: Yeah.

MR. DeJULIUS: Petition 1 of the exhibit to enforce is the entire agreement, correct?

THE COURT: They have -- is that the entire agreement?

MS. KCEHOWSKI: I have to take a look at it.

THE COURT: It's the Commonwealth's exhibit.

MR. DeJULIUS: I believe -- I believe it is, Your Honor.

Let me make sure it includes 16.3.

We can -- we can confirm that, Your Honor.

THE COURT: And where is the -- and I'd like to know the paragraph of when they can terminate. What's the paragraph in this?

MR. PACELLA: Your Honor, in --

VOICE: Exhibit 1 is just the '99. Exhibit 1 is just the 1999 --

MR. DeJULIUS: Okay.

MR. PACELLA: Your Honor --

MR. DeJULIUS: So Exhibit 1 is not the entire that the Commonwealth -- it's just the 1999 agreement. It has subsequently been amended and then added to --

THE COURT: Well, there's three. There's three. There's more?

MR. BOOKER: May I help the Court on this issue?

THE COURT: Yes, you may.

MR. BOOKER: I have with me our exhibit book, and it has the agreement that has the --

THE COURT: Have you shown the other parties the exhibit book?

MR. BOOKER: We've given --

THE COURT CRIER: Hand it to me please.

THE COURT: Is that the entire -- I just want to get -- is that the entire agreement between the parties?

(Counsel conferring.)

MR. DeJULIUS: Which exhibit?

MR. BOOKER: This Exhibit 1 a, b, and c are the relevant -- the original contract and the relevant amendments. And 1 c, paragraph 5 I believe is the termination provision that Mr. Pacella referenced.

THE COURT: 1 c.

MR. BOOKER: Paragraph 5.

THE COURT: 1 c, paragraph 5.

MR. BOOKER: Entitled No Termination Prior to December 31.

THE COURT: It says the agreement will renew from year to year thereafter unless either party provides written notice of termination no later than April 1st.

Is that the one you're talking about --

MR. BOOKER: No later than April 1st of the

contract year.

MR. DeJULIUS: Correct, Your Honor. And that's why the parties -- UPMC will terminate between January and April.

It has subsequently been amended through the -- an amendment on January 1st, 2002, which provided for 16.3 which is what we've been referring to as the runout agreement and specifically inserted into that agreement that it would continue -- all terms and conditions would continue in effect for six months thereafter.

THE COURT: As -- as -- just as a housekeeping, the provisions that I should look at, at issue in this textual analysis is 2, IV 2 of the agreement; is there anything -- in the consent decree. Is there anything else in the consent decree that you think I should look at?

MR. DeJULIUS: No, Your Honor.

THE COURT: On the -- and this is everybody, that I should look at 16.3 and -- and obviously the entire agreement and that paragraph, the one that was just handed to me, paragraph 5 of the amendment to the Medicare Advantage plan dated July 1, 2012. Those are the only three paragraphs in these agreements that have been mentioned to me. Is there anything else that I should look at?

MR. DeJULIUS: I don't believe so, Your Honor.

THE COURT: Okay. So textually that's it.

MR. DeJULIUS: UPMC's position is that 16.3

provides a contract through June 30th, 2019, and that's all we're required to do under the consent decrees.

We agree with the Attorney General that there is no need for witnesses. This is a contractual interpretation matter on the petition to enforce. We think that -- that they have to prove the Philip Morris standard as to us in light of the contractual interpretation but that we don't believe there's any issues of fact that have to be determined. The Court has the case before them.

THE COURT: As I mentioned, this agreement is not the model of clarity. And there is no parol evidence that there was a mutual mistake of fact or aide me in interpreting -- interpreting any of these provisions.

MR. DeJULIUS: To the contrary, Your Honor, in 2002, the parties specifically amended the contract to insert 16.3 and that six-month runout. There wasn't a mutual mistake of fact that was --

THE COURT: I was thinking about the consent decree.

MR. DeJULIUS: No, Your Honor. That argument has not been raised.

THE COURT: I think the -- yeah. Okay. Thank you.

MR. DeJULIUS: Thank you.

MR. BOOKER: Well, I raised the argument that there is evidence that helps -- would help the Court, clarify for

the Court what the intention of the parties and understanding of the parties was. And we're prepared to offer that evidence.

And it -- the evidence we're prepared to offer in the exhibit book that I just handed to you is the collective Exhibit 9 where we attach as B -- as 9 a through g the original source documents, but we summarize them on the first page of -- on Exhibit 9 where three separate times in advance of the consent decree, including just a month or two before the consent decree was being negotiated, UPMC repeatedly said that the consent decree -- that the dispute about the commercial contracts that the parties had --

MR. DeJULIUS: Objection.

THE COURT: Excuse me one --

MR. DeJULIUS: Just one moment. We haven't seen the binder, and I --

MR. BOOKER: I'm --

MR. DeJULIUS: -- maybe misheard. I thought you said there's a summary document in it that we didn't know about, that this is --

MR. BOOKER: I'm sorry. I'm sorry.

MR. DeJULIUS: Your Honor, we would -- is this on the exhibit list?

This is the first we're seeing of this summary document. We would -- we would object --

THE COURT: I understand.

MR. BOOKER: We had offered to exchange exhibits five days before the hearing, and we never heard from UPMC. So we just on our own gave them the -- identified the exhibits on Monday. We did not give them a copy of this -- Mr. DeJulius is right about that -- because we didn't have it done.

But in any event, and in addition to saying that these disputes would not affect, adversely affect seniors, they specifically said that they were going to honor the commitments to seniors by rolling forward unchanged the current noncommercial contracts -- that's the Medicare providers' contracts -- unless they are terminated by Highmark.

Then the consent decree was entered. And three times after that, after the consent decree was entered, they repeated the same statements. Their chief medical officer in a letter to all of their -- to all of Highmark's enrollees said that there is a special bond between our older patients and our entire medical staff; that's why we pledged more than three years ago that the changing relationship between Highmark and UPMC would not affect seniors; that seniors would be insulated from involvement in the dispute over our expiring commercial contracts; and that the MA agreements will, therefore, continue under the terms -- under their

terms after December 31, 2015. So --

THE COURT: But wouldn't that mean that these contracts would go on forever? We would never have any expiration.

MR. BOOKER: No, they can -- they can change their mind. What our position is, is they can't change it during the term of a consent decree that was entered into on the understanding that this was the position -- the position of UPMC and the meaning of the consent decree.

So we're not saying that they aren't allowed under the terms of the consent decree to terminate it after the consent decree ends. We're talking about what they can do during the consent decree that has an effect on the vulnerable populations.

THE COURT: But what we're really after here is when -- what is involved in the consent decree; what -- what does the consent decree mean?

MR. BOOKER: Yes.

THE COURT: And so --

MR. BOOKER: And as Your Honor said --

THE COURT: -- obviously it's going to impact vulnerable populations and all patients when the consent decrees end. So --

MR. BOOKER: Unfortunately that appears to be the case.

THE COURT: But that's -- that's the necessary implication of a five-year deal. That's what the Commonwealth negotiated with UPMC and what they negotiated with you because -- I don't want to get into that anymore. You couldn't be in a room together. But that's -- that was the deal that everybody entered into.

MR. BOOKER: The -- the deal was -- the consent decree deal -- because there are really two deals here. There's a consent decree deal, and there's a private contract deal. But the consent decree deal that the parties entered into was that they would remain in contract. As Your Honor has said, it's not the model of clarity. What is the contract that that means? And this evidence is relevant to our position that what that shall be in a contract meant was the continuation of the calendar year contracts that would be coincident with the calendar year terms of Medicare Advantage plans.

So there -- by the way, Your Honor, there is a scenario in which Highmark agrees the Court need not hear witnesses, but let me be precisely clear about that, what that circumstance is.

The -- the undoubted core focus for today's proceeding is the consent decrees' terms and its requirements and the consequences of that, those requirements, and of this Court's May 29th, 2015 order that was upheld by the Supreme

Court.

And disputes over these contracts, including these Medicare service contracts through 2019, were to have been presented to the Court. Under your May 29th order, they were to have been presented in June 2015. Now, my understanding at the time of that order was that the purpose of that was so that the disputes between the parties would be vetted and brought forward then so we wouldn't have to be dealing with them sometime later. This was your order, and you know what it meant. But this is what it communicated to us as a party.

And UPMC committed to the Court at that time that if there were any disputes related to Medicare Advantage contracts, that they would bring them to you in 2016. They didn't do that. They did not come to you or to us, never until September of 2017, long after they said, If we have a problem with rolling over these contracts, we'll come back to you in 2016. That never happened.

If Your Honor -- if I've understood the May 26 -- May 29th, 2015 order correctly, in that circumstance, they've waived this issue and they are compelled until the consent decree is over to proceed with the contracts that have been in place. So in that circumstance --

THE COURT: I don't follow that, to be honest, with all due -- I don't follow that logic.

MR. BOOKER: I --

THE COURT: I mean, I'm sorry. In other words, if they didn't come to me beforehand, what you're saying is, I guess, the sanction is they can't do it, they --

MR. BOOKER: No --

THE COURT: -- they can't terminate --

MR. BOOKER: No --

THE COURT: Here's what you're saying: if you -- they can't terminate in accordance with what they believe is the way they can terminate the contract.

MR. BOOKER: No. There were -- there was a provision of your order that required that they come to you first before making any change. There's a separate provision of your order --

THE COURT: No; I understand all of that. But we're here today to find out what the contract means -- the consent decree means.

MR. BOOKER: What the consent decree means. That's right. And I -- Your Honor --

THE COURT: I mean, essentially what you said is this is -- they didn't come to me to ask to terminate the agreement and that was a change and because they made that change, that I should issue a sanction that they can't make the change unless they comply with the way you think it -- and make them -- interpret the agreement the way you think it should be interpreted.

MR. BOOKER: No.

THE COURT: Okay.

MR. BOOKER: No. No. What I'm saying is that Your Honor had the authority to and did issue an order to the parties that had to do with the administration of the consent decree in a fashion that would avoid disruption, undue disruption to seniors.

That order required both parties that if we have a dispute over the terms of our contracts that is going to come up and it's going to affect seniors under the consent decree, tell me about that so that we can get it resolved. And that didn't happen. Instead -- and so there was ample opportunity for each party to advise Your Honor of, Judge, this 2019 deadline is coming and we have an annual contract --

THE COURT: When do you market your 2019 contracts? When do you market your 2019 contracts?

MR. BOOKER: In the fall of 2018.

THE COURT: I guarantee you'll get a decision well in advance of the fall.

MR. BOOKER: We actually need a decision -- and I have evidence on this that I'd like to offer to Your Honor -- in time --

THE COURT: When do you need a -- when do you need a decision by? Two weeks? Two days ago, right?

MR. BOOKER: If I look back at my client, Deborah

Smith, she would tell me, Tomorrow if we could. But here -- here's the timetable that she would testify to. The final bid needs to be submitted on June 1, so working back from that. By May 1, in the normal process in order to be able to file -- realize they're filing for eight different plans that would include UPMC in-network. So they have to file bids for each one of those eight plans, and they need a month. They -- they sign off; senior management signs off on here's the plan, the pricing, the coverage, the -- the plan design. That's done by May 1.

The actuarial, financial, and product design work that's done to put them in the position to do that needs to be completed in final draft somewhere around the middle of April. The work that it takes to get to a final draft requires that they have the April 1 final rates that CMS tells them will be governing in the following year so they know how much they're going to be paid and they can do the financial analysis. They get a preliminary idea of those rates on February 1. And they are already working today to be ready --

THE COURT: How --

MR. BOOKER: -- to get those plans ready.

THE COURT: The decision is going to come -- be late no matter what I do.

MR. BOOKER: There are a hundred -- there are --

Ms. Smith has a hundred and sixty people who work in her unit. This is what they work on. She has -- they have actuarial and financial -- so --

THE COURT: This is too much into the weeds. I am willing -- I will get this out as fast as I can.

MR. BOOKER: Can't ask for any more than that, Your Honor.

THE COURT: And -- but I can't get it out yesterday.

MR. BOOKER: I can't -- I can't ask for anything more than as soon as you responsibly can.

THE COURT: And I generally get them out pretty fast.

MR. BOOKER: Yes. You have been prompt about that.

Your Honor, we're prepared to offer testimony, in addition, as to, and -- and in more detail, what the particular kinds of adverse consequences there will be for seniors if there is a six-month contract or a runout compared to a one-year contract.

With respect to the runout, I do want to make one or two points. In some ways, the runout is a red herring. I mean, UPMC has said, We'll give you a six-month contract. Highmark's problem is it is required to certify to CMS that there is a contract. You have to have a contract in order to say somebody is in-network. That's a rule I think everybody

could agree exists. You have to have a contract to say that they're in-network.

So they've offered a six-month contract. That six-month contract is not acceptable to Highmark because it does not protect -- it does not provide to enrollees the same benefit; it doesn't put them in the same position that the enrollees in the first four and a half years have been in.

THE COURT: This all comes back to that this agreement ends in the middle of the year and everything else --

MR. BOOKER: Right.

THE COURT: -- is on a calendar year.

MR. BOOKER: That's right.

THE COURT: And --

MR. BOOKER: That's right.

THE COURT: -- that's what puts everybody, including me, in a very difficult position because the contract -- the consent decree doesn't reflect how the real world buys Medicare Advantage plans.

MR. BOOKER: That's right.

THE COURT: And --

MR. BOOKER: I -- I should --

THE COURT: I have to say, I had no part in drafting, negotiating, mediating anything with these consent decrees. They were presented to me as signed. Like you

said, I wasn't the lawyer. I said, I wasn't the Judge.

MR. BOOKER: I was going to say, Your Honor, you're channeling my words.

But the consent decree deals with a lot of things in addition to vulnerable populations. It deals with continuity of care. It deals with oncology services. It deals with exception hospitals. It deals with lots of things where this -- and for commercial contracts, our evidence would be that commercial -- about -- you know, it's about 60, 40. Forty percent of them expire in the middle of the year. Sixty percent expire at the end of the year. For commercial contracts, this is -- it doesn't make a difference when the expiration is in any material way.

It does have uniquely an impact in the Medicare Advantage world where that world is governed by one-year plan periods, calendar years dictated by CMS. So the Medicare issue is unique.

The principal focus -- many -- there were many focuses of the consent decree separate from vulnerable populations that -- that -- where this six-month issue really isn't a problem. But it is a problem for Medicare. And so this question of what the parties had in mind and what they understood would happen and that the calendar year contracts would roll forward, that's why that evidence is important as to what the intention and meaning of the consent decree was.

There is one very important term of the contracts that is not continued by that 13.7 or 12 -- and that is --

THE COURT: 16.3.

MR. BOOKER: Excuse me. Let me be -- it's 16.3. It's Exhibit 1 b of our book.

And that is -- there are -- first of all, I'd point out that this provision 16.3 does -- does not include a one-year term. As Your Honor was saying, there's an issue whether the entire contract continues. If it does, that's a one-year term. The runout has as much to do with assuring that -- that enrollees have a form of continuity of care; it has to do with -- it does not have to do with marketing.

I mean, Highmark's position is this is not a contract. If there is a runout in twenty -- for six months in 2020, if there is, Highmark's view is it cannot advertise that UPMC is in-network because it doesn't have a -- its view is this is not a contract; it doesn't have the same control over the parties --

THE COURT: But the -- see, that goes back to the original problem. Everybody negotiated the June 30th date.

MR. BOOKER: Yep.

THE COURT: And as you admitted, if this was commercial insurance, it was -- it's a -- it's a date that -- whether you can advertise it or not. I -- you know, what am I going to do with the June 30th date?

MR. BOOKER: Right. Well, the point is, Your Honor, the whole consent decree was precipitated by UPMC's decision that it wanted to terminate the commercial contracts. And the parties had an understand- -- they said, Okay, well, we need a consent decree. And the -- you know, the Commonwealth parties were pressing for a result. They weren't -- and -- and they were concerned, and we were all -- the parties, my clients were concerned about seniors.

But the dominating impetus for these consent decrees was the UPMC decision to terminate the commercial contracts. And those contracts -- on those contracts, the 30-day -- the June 30 was simply not an issue. Is it --

THE COURT: No, it -- you know, they wanted -- they didn't want Medicare Advantage to be included in this at all. They just said it really covered Medicare and --

MR. BOOKER: That's true.

THE COURT: -- not Medicare Advantage.

MR. BOOKER: That's true. That's true.

THE COURT: So they --

MR. BOOKER: UPMC you're saying?

THE COURT: Yeah. They -- UPMC said, We don't -- we'll take Medicare or Medigap, essentially, coverage, but we don't want Medicare Advantage. That was the last case.

MR. BOOKER: That's right, Your Honor.

THE COURT: And so they weren't -- you know, this

idea that consistently they were -- first of all, the agreement has this agreement on vulnerable populations. And they have consistently said that they do not want your Medicare Advantage patients. Now, we said they have -- they didn't think Medicare Advantage was covered by this.

MR. BOOKER: Well, once Your Honor decided that the consent decree allowed us to sell Community Blue in a network, with a network that did not include them, they changed their mind.

THE COURT: That's -- and I'm -- and I'm dealing with this consent decree that all of you -- yours is a -- yours is not the same as UP- -- well, yours is the same --

MR. BOOKER: Pretty close.

THE COURT: -- but it's separate. And -- but that's the conundrum here. We have a -- Medicare Advantage plans run on a calendar year. This ends in the middle of the year. I don't know what people were thinking when they signed this agreement. But you're stuck with it. I'm stuck with it. And I've got to make a decision based upon the draftsmanship of the agreement. Consent decrees are contracts. And courts can't vary contracts. I -- you know, I wish I could just say, I'm going to settle this and this is -- but I can't.

MR. BOOKER: Well, Your Honor, as I started out saying when I got up here, we have taken the position that

there is parol evidence that Your Honor should hear on that issue.

THE COURT: I understand what the parol evidence is. And from the other hearings, I know this is going to seriously disadvantage people in the Medicare Advantage programs, Highmark; they're going to be seriously disadvantaged whether -- like I said before, whether it's January 1st, 2020, or January -- or June 30th, 2019. But that's the agreement that was negotiated with everybody, and that -- welcome to the world of modern health care. That's -- that's -- that's the --

MR. BOOKER: Your Honor, I -- I know that Your Honor understands the obligation to interpret the consent decree in the context of its intention both as to the evidence I've talked about and the purpose of the consent decree to protect --

THE COURT: It was -- it was to help a whole bunch of populations. But the Commonwealth said that after five years, even though there may be some impacts on those populations, that's okay. And I'm -- what I'm -- what I'm interpreting is what happens during the five years. I mean, that's -- that's -- that's -- and it comes really down to one -- one paragraph in the consent decree, one phrase in the consent decree.

MR. BOOKER: Well --

THE COURT: Okay.

MR. BOOKER: -- the requirement of a contract, and it's up to you to decide whether that requires a continuation of, under all the circumstances, the -- an annual contract or not.

THE COURT: That -- okay.

Does anybody else have anything else? Does anybody want to file anything?

MR. DeJULIUS: No, Your Honor. I think we have an agreement with the Commonwealth that the exhibits that were attached are part of the record, that were attached to the briefing.

THE COURT: Yes --

MR. DeJULIUS: I object to Highmark's submission --

THE COURT: Well, I -- all the other stuff is that I didn't have that paragraph --

MR. DeJULIUS: Which --

THE COURT: -- that Mr. Pacella referred to involving the April 1st deadline.

MR. DeJULIUS: I would suggest that the Commonwealth and UPMC submit that to the Court in the next 24 hours. We're happy to --

THE COURT: Give me the -- what the entire agreement is. But there's --

MR. DeJULIUS: We will --

THE COURT: There's only those -- like, 16.3, that -- that one, the second agreement and the consent decree, those are the -- I'm not saying all of them are relevant, but those are the only three provisions that anybody has given to me that says are -- that they say are relevant.

MR. DeJULIUS: I believe that's correct, Your Honor.

THE COURT: Okay. I just want to make that sure.

(Counsel conferring.)

MR. DeJULIUS: We'll give you the entire agreement in the next 24 hours. I just want to make sure --

MR. PACELLA: No, I understand.

MR. DeJULIUS: We'll submit it.

THE COURT: And does anybody want to submit a brief or anything else?

MR. BOOKER: Your Honor, I'd like to submit our exhibits. Most -- our exhibits are, by and large, attached to our filings. And the summary is simply that, a summary; it's just a quotation on a timeline of the -- of exhibits that we attached to our previously filed papers.

THE COURT: See, the -- well, I -- the problem with some of the statements is the ones before the consent decree would not be relevant. The ones after may be, but I don't consider them especially probative as to -- because they don't address the language.

So I'll take the book. I'll have the book here, but the rest of this stuff -- anything that went on before the agreements, that's wrapped up in the agreements. That's general contract law.

MR. BOOKER: Well, I'd submit, Your Honor, that statements of an intention of a party illuminate what the meaning of a subsequently admitted contract is. And --

THE COURT: Like I --

MR. BOOKER: -- perhaps we could brief that --

THE COURT: I always say statements that I make in court are intentions. What I put in an order is what I mean.

MR. BOOKER: Right.

THE COURT: Mr. Pohl doesn't believe that, but he keeps putting in -- my ruminations into pleadings. He thinks I'm a federal judge.

Anybody have anything else?

MR. PACELLA: Your Honor, if I may, I just want to remind the Court that the overall intention, the gravamen of these consent decrees, was to protect the public's interest in these important contractual issues.

THE COURT: I understand. And what I'm asked to interpret is how well you did it.

MR. PACELLA: Understood, Your Honor.

THE COURT: Okay.

THE COURT CRIER: Commonwealth Court is now

adjourned.

MR. DeJULIUS: Thank you, Your Honor.

MR. PACELLA: Thank you, Your Honor.

(Whereupon, the proceedings adjourned at 3:31 p.m.)

I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me on the proceedings of the above cause and that this copy is a correct transcript of the same.

DATED: February 15, 2018

Rebecca Toner, RPR

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IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

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

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Marc S. Cornblatt & Bruce P. Merenstein, *Charities & the Orphans' Court*, 46 Duq. L. Rev. 583 (2008) 32

Pennsylvania Constitution, Art. VIII, § 2(a)(v) 30

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

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

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

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

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

BACKGROUND

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

Mediated Agreement and Highmark-WPAHS Litigation

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

The parties' split grew contentious, however, attracting the involvement of Governor Tom Corbett. Concerned with the impact of an immediate termination on Pennsylvania citizens, Governor Corbett's administration negotiated a so-called "Mediated Agreement" between UPMC and Highmark in May 2012. *Id.* ¶ 24; *see also* Highmark – UPMC Agreement (the "Mediated Agreement"), attached hereto as Exhibit B. Among other things, that Mediated

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

Agreement provided that UPMC would continue to extend full in-network access to Highmark Medicare Advantage and commercial health plan subscribers through December 31, 2014. The parties acknowledged that "[t]he contractual extension until the end of 2014 will provide for sufficient and definite time for patients to make appropriate arrangements for their care and eliminate the need for any possible government intervention under Act 94." Exhibit B at 1; s*ee also* Exhibit A ¶ 25.

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

Highmark Acquisition of WPAHS

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

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

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

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

Exhibit A ¶ 30 (emphasis added).

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

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

HH_AHN%20Public%20Strategic%20and%20Financial%20Plan%202017-2020.pdf, attached hereto as Exhibit F.[3] For that reason, the PID's Approving Order required Highmark to provide the Insurance Department "updated information, based on reasonable assumptions and credible projections, on the impact of the terms of *any New UPMC Contract* on the financial performance of [WPAHS] as well as an independent analysis of an expert on the impact of the New Contract on both the insurance and provider markets in the region including but not limited to any effects on competition." Exhibit D ¶ 22A (emphasis added).

Proceedings Leading to the Consent Decree

The Consent Decrees arose roughly one year after the PID conditionally approved Highmark's acquisition of WPAHS. As a predicate for negotiating the Consent Decrees, three Commonwealth agencies — the PID, the Department of Health ("DOH"), and the Attorney General — asserted violations of the Mediated Agreement by both Highmark and UPMC in a June 2014 "Petition for Review." In its Petition for Review, the Commonwealth repeatedly acknowledged that the Mediated Agreement was intended only to be a temporary measure that expired on December 31, 2014. *See, e.g.*, Exhibit A ¶ 25; *see also, e.g.*, *id.* ¶ 47 ("Under the Mediated Agreement, Highmark's members were intended to have access to all of UPMC's providers through at least December 31, 2014 to smooth the public's transition in the changing relationship between UPMC and Highmark[.]").[4] Nonetheless, in exchange for settlement of the

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

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

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

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

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

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

- UPMC allegedly violated the Consumer Protection Law by engaging in "unfair methods of competition and unfair or deceptive acts or practices," "willfully engag[ing] in unfair and unconscionable acts or practices . . . by pursuing a strategy of subjecting consumers to unfair and substantially higher 'out-of-network' charges under circumstances beyond the consumers' control. *Id.* at 16-17.

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

The Consent Decree

On June 27, 2014, UPMC and the three Commonwealth parties (the Attorney General, the PID, and DOH) signed the Consent Decree as a settlement of the Petition for Review, "the allegations of which [were] incorporated" and released in the Consent Decree. Exhibit B to Petition, (the "Consent Decree") at 1. The parties agreed that the Consent Decree should be "interpreted consistently with" the 2013 Approving Order and the Mediated Agreement, and that

"[t]he Consent Decree is not a contract extension and shall not be characterized as such." *Id.* at 2. Indeed, under the Consent Decree, UPMC starting in 2015 largely would be out-of-network for Highmark subscribers in the Greater Pittsburgh Area. There, UPMC agreed to provide only transitional in-network services such as continuity of care, oncology, emergency services, and otherwise unique care to Highmark subscribers for another five years. *Id.* § IV.A.

In exchange for UPMC's agreement to provide these services, the three Commonwealth parties agreed to "release any and all claims [they] brought or could have brought against UPMC for violations of any laws or regulations within their respective jurisdictions including claims under laws governing non-profit corporations and charitable trusts, consumer protection laws, insurance laws and health laws relating to the facts alleged in the Petition for Review or encompassed with this Consent Decree for the period of July 1, 2012 to the date of filing." *Id.* at 14. The parties also agreed that, even though UPMC would not be providing full in-network care to all Highmark subscribers during the ensuing five years, "the terms and agreements encompassed within [the] Consent Decree do not conflict with UPMC's obligations under the laws governing non-profit corporations and charitable trusts, consumer protection laws, antitrust laws, insurance laws and health laws." *Id.*

The Attorney General's Office defended the Consent Decree in public testimony. A few months after the Consent Decree was executed, Executive Deputy Attorney General James A. Donahue, III, who negotiated and signed the Consent Decree, testified before the Democratic Policy Committee of the Pennsylvania House of Representatives. In that testimony, Mr. Donahue defended the Commonwealth's strategy in securing the Consent Decrees with UPMC and Highmark by explaining that the Commonwealth could not force UPMC to contract with Highmark or anyone else: "UPMC's announcement in 2011 that it would no longer contract with

Highmark for a full range of services raised tremendous concern in Western Pennsylvania. The simple question we faced was could we force UPMC and Highmark to contract with each other? We concluded that we could not . . . ." James A. Donahue, III, Video of Testimony before Pa. House Democratic Policy Committee, Oct. 10, 2014, available at https://wdrv.it/39aa0b6df, attached hereto as Exhibit G.

The Attorney General's Efforts to Enforce the Consent Decree

The Attorney General sued to enforce the Consent Decrees on three occasions. First, soon after the Decrees went into effect, the Attorney General sued Highmark over its refusal to include UPMC in its Community Blue Medicare Advantage program. *See Commonwealth ex rel. Kane v. UPMC*, 129 A.3d 441, 451 (Pa. 2015) ("*Kane*"). Then, in 2016, the Pennsylvania Supreme Court held that certain actions by Highmark did not trigger provisions of the Consent Decree allowing UPMC to terminate immediately its Medicare Advantage contracts with Highmark. *See Kane*, 129 A.3d at 463. Finally, on November 20, 2017, the General Shapiro filed an enforcement action against UPMC over the termination of Medicare Advantage contracts in 2019. *See Shapiro*, 188 A.3d at 1125.

In this most recent enforcement action, General Shapiro tried to force UPMC to remain in Medicare Advantage contracts with Highmark after the Consent Decree expired. General Shapiro sought to extend UPMC's obligation to remain in-network for Highmark's Medicare Advantage products for a year beyond the June 30, 2019 end date of the Consent Decree to June 30, 2020.[5]

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

The Pennsylvania Supreme Court unanimously rejected General Shapiro's attempt to extend the Consent Decree. *See Shapiro*, 188 A.3d at 1135. The Court confirmed that the Consent Decree expired on June 30, 2019, and that the Consent Decree only required UPMC to remain in its Medicare Advantage contracts with Highmark through that date. *See id.* The Court expressly rejected the Commonwealth's effort to compel UPMC's participation in the Consent Decree beyond that date. As the Court recognized, there was "no basis upon which to alter [the Expiration Date], to which the parties agreed[.]" *See id.* at 1134.

The Commonwealth Prepared For the Expiration of the Consent Decrees

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

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

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

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

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

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

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

The Petition to Modify

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

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

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

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

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

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

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

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

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

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

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

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

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

ARGUMENT

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

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

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

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

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

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

> **release[d] any and all claims** the [Attorney General's Office], PID or DOH **brought or could have brought against UPMC for violations of any laws or regulations** within their respective jurisdictions, including claims under laws governing non-profit corporations and charitable trusts, consumer protection laws, insurance laws and health laws relating to the facts alleged in the Petition for Review or encompassed within this Consent Decree for the period of July 1, 2012 to the date of filing.

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

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

- the dispute over Highmark Community Blue plan, which occurred during 2013, *see* Petition ¶¶ 16-18, 96, 103, 107, 118;
- the compensation of UPMC's executives and location of its headquarters, both of which were in place long before the Consent Decree, *id.* at ¶¶ 61–63;
- various, allegedly revenue-increasing practices — including transferring procedures to specialty providers, charging provider-based fees, and charging Out-of-Network patients for the unreimbursed balance of the services they receive

— all of which predated, and were specifically addressed by, the Consent Decree, *see id.* ¶ 31; Consent Decree §§ IV.A.8 (regulating transfer of patients), IV.A.3 & IV.A.4 (regulating balance billing), & IV.C.1 (setting a schedule of billing rates in the absence of a negotiated rate); and

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

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

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

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

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

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

General Shapiro could and should have asserted the Petition's claims in his 2017 enforcement action. All the factual allegations in the Petition allegedly took place before that enforcement action.[8] General Shapiro was aware of these various acts alleged in the Petition supposedly showing that UPMC failed to comply with its charitable mission or made misleading statements. UPMC's expansion and expenditures were also known to General Shapiro. General Shapiro could have asserted his claims based on those allegations the last time he was before the Court in this case. He chose not to do so, and the final judgment of the Pennsylvania Supreme Court precludes General Shapiro from resurrecting them now. *See Shapiro*, 188 A.3d at 1132.

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

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

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

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

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

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

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

* * *

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

II. The Petition Seeks an Invalid Modification.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Id. at 498 (emphasis added).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. The Petition Lacks Required Party-Specific Allegations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> **3. Why is the Commonwealth allowing this to happen?**
>
> The Commonwealth cannot force an insurance company and a provider to contract at in-network rates with each other.
>
> Governor Wolf has dedicated significant efforts and will continue to diligently work to protect consumers by overseeing the implementation of the Consent Decree and through the consummation of the January 2018 agreement, to ensure access for Highmark's commercial insureds who require critical, unique services.

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

Moreover, the Executive Deputy Attorney General *who signed the Consent Decree and this Petition* made exactly the same point when the Consent Decree went into effect. In testimony before the Democratic Policy Committee of the Pennsylvania House of Representatives on October 10, 2014, Executive Deputy Attorney General James A. Donahue, III defended the Commonwealth's strategy in securing the Consent Decrees with UPMC and Highmark by explaining that the Commonwealth could not force UPMC to contract with Highmark or anyone else. Specifically, Mr. Donahue testified that the Attorney General's Office evaluated whether it could "force UPMC and Highmark to contract with each other," and "concluded that we could not" because "there is no statutory basis to make UPMC and Highmark contract with each other."[17] Exhibit G.

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Counts II-IV Are Procedurally Improper.

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

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

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

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

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

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

This simplistic contention fundamentally misstates UPMC's charitable mission statement and the meaning of "access" to healthcare. Importantly, UPMC's charitable mission nowhere says that it is to provide high-quality accessible healthcare *to everyone at in-network rates*. *See* Exhibit A to Petition. That is a straw-man invented by General Shapiro.[20] Rather, the mission is, *inter alia*, to develop human and physical resources and organizations appropriate to support the advancement of patient care through clinical and technological innovation, research, and education and to develop a high-quality, cost-effective and accessible healthcare system. Specifically:

> The Corporation is incorporated under the Nonprofit Corporation Law of the Commonwealth of the Pennsylvania for the following purpose or purposes: **to engage in the development of human and physical resources and organizations appropriate to support the**

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

[20] Indeed, General Shapiro inaccurately quotes UPMC's operative articles and statement of charitable mission, which is, *inter alia*, to develop human and physical resources and organizations appropriate to support the advancement of patient care through clinical and technological innovation, research, and education, and to develop a high-quality, cost-effective and accessible healthcare system, not to provide healthcare to everyone at in-network rates. *See* Exhibit A to Petition.

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

Exhibit A to Petition (emphasis added).

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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

Dated: February 21, 2019

Respectfully submitted,

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

CERTIFICATE OF SERVICE

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

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

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Black's Law Dictionary, 6th Edition..... 36

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

COMMONWEALTH'S MEMORANDUM
IN OPPOSITION TO RESPONDENT UPMC'S
MOTION TO DISMISS PETITION TO MODIFY CONSENT DECREES

Petitioner, the Commonwealth of Pennsylvania acting in its capacity as *parens patriae* through its Attorney General, Josh Shapiro (Commonwealth), respectfully offers the following in opposition to ***UPMC's Answer in the Nature of a Motion to Dismiss or Preliminary Objections to "Commonwealth's Petition to Modify Consent Decrees":***

COUNTER-BACKGROUND
AND SUMMARY OF THE ARGUMENT

The Commonwealth entered into the Consent Decrees based upon UPMC's representations that seniors and other vulnerable populations needing specialized care would never be affected by the respondents' contractual disputes. The Commonwealth intended to provide for an orderly termination of the respondents'

commercial[1] relationships while preserving the access of vulnerable populations to UPMC's specialized care – not on the notion suggested by UPMC that the Consent Decrees were intended to authorize unbridled denials of access and care to the Citizens of the Commonwealth by UPMC after the expiration of the decrees. Due to the unique complexities of healthcare and a variety of material changes in circumstances, namely the announced impacts on out-of-network patients and the expansion of UPMC's contracting disputes both geographically and with other Health Plans, the Commonwealth now seeks to modify the decrees. This modification is sought without closing the door on future modifications should they prove necessary to promote the public interest.

Contrary to the exaggerated characterizations argued by UPMC, the ***Commonwealth's Petition to Modify Consent Decrees*** (Petition) is not an attempt to undo and reverse the Consent Decrees; it does not seek to force UPMC to return to the contractual obligations it had with Highmark before the decrees were entered; it does not require UPMC to maintain those obligations forever; and, it does not seek unprecedented and unwarranted relief.

As set forth more specifically within, the Petition seeks to ensure that, above all else, UPMC and Highmark comply with the charitable commitments they

[1] "Commercial" refers to the respondents' non-Medicare and non-Medicaid related contracts.

respectively owe to the public-at-large. In many instances, the proposed modifications involve terms and conditions that UPMC previously agreed to in this and other matters, including, but not limited to, last, best offer arbitration when good-faith contract negotiations fail.

UPMC's contention that the Commonwealth previously conceded it cannot force the respondents to contract is simply unavailing and irrelevant. The Commonwealth has never contended that it is a judicial body. Pursuant to the terms of the Consent Decrees, the parties agreed that this Court has the authority to impose the requested relief if the modification is shown to be "in the public interest." In accordance therewith, the Commonwealth has petitioned this Court which has the requisite authority. Lastly, UPMC is continuously subject to this Court's inherent equitable powers and oversight regardless of the decree's existence. Accordingly, there is nothing remarkable about imposing the requested modifications indefinitely under the continuing jurisdiction of this Court.

The Commonwealth agrees that the contractual disputes between the respondents began as a consequence of Highmark's affiliation with the West Penn Allegheny Health System, which created an integrated healthcare system in competition with UPMC. By arguing, however, that universal contracts no longer made sense for both parties, then and now, UPMC reveals its misunderstanding of the duties both respondents owe to the public. The question isn't whether preserving

the respondents' contractual relationships makes sense for the respondents – it is whether preserving the respondents' contractual relationships makes sense for the public.

UPMC's argument that the financial viability of the West Penn Allegheny Health System, now a part of the Allegheny Health Network (AHN), depended upon the termination of the contractual relationships between Highmark and UPMC is no longer relevant or persuasive. Experience since 2014 has shown that AHN has gained financial stability despite the respondents' continuing contractual relationships under the decrees. As set forth in the Commonwealth's Petition, maintaining the respondents' contractual relationships through the requested modifications to the Consent Decrees promises to preserve the public's access while promoting continued competition. Notably, Highmark has already agreed to the proposed modification provided UPMC is subject to the same terms and conditions.

Although Governor Wolf announced a Second Mediated Agreement that was reached in January of 2018 that extends In-Network commercial contracts for UPMC specialty and sole provider community hospitals for two to five years, rates for Emergency Department and Medicare Advantage contracts were not extended. Here again, despite the best efforts of Pennsylvania's Insurance Department (PID) and Department of Health (DOH), senior citizens and emergency patients will face UPMC's much higher Out-of-Network charges after the expiration of the Consent

Decrees. It is an untenable circumstance that neither agency can fully address as only the Attorney General, acting as *parens patriae,* can seek to enforce UPMC's charitable obligations of providing the public with a high quality, cost-effective and accessible health care system.

UPMC's contention that the Commonwealth is barred by *res judicata* from seeking the proposed modification in light of the Supreme Court's July 18, 2018 decision at Commonwealth, et al., v. UPMC, et al., 188 A.3d 1122 (2018), looks past the fact that the Supreme Court was not asked to construe the modification provision in paragraph IV.C.10 of UPMC's decree. That case involved a disputed interpretation of paragraph IV.A.2 concerning when and how UPMC could terminate its Medicare Advantage contract with Highmark. Under the terms of the Medicare Advantage contracts at issue, a six-month runout period followed UPMC's December 31, 2018 termination of the contracts. The Supreme Court determined that the runout period which extended through June 30, 2019 satisfied UPMC's contractual obligation under the Consent Decrees. Here, the issue of modification presents an entirely distinct legal issue that has yet to be judicially considered, thus *res judicata* is inapplicable.

ARGUMENT

I. UPMC's Motion to Dismiss and Preliminary Objections in the Nature of a Demurrer Must Admit as True all Well-Pleaded Allegations in the Commonwealth's Petition along with all Inferences Reasonably Deducible Therefrom.

It is well settled that "preliminary objections in the nature of demurrer are deemed to admit all well-pleaded facts and all inferences reasonably deduced therefrom." Commonwealth v. Events International, Inc., 137 Pa. Cmwlth. 271, 278, 585 A.2d 1146, 1149-1150 (1991) (citing Watson & Hughey Co., 128 Pa. Cmwlth. 484, 563 A.2d 1276 (1989)). "On appeal from an order sustaining preliminary objections [which would result in the dismissal of suit], we accept as true all well-pleaded material facts set forth in the appellants' complaint and all reasonable inferences which may be drawn from those facts. [citations omitted] . . . Where, as here, upholding sustained preliminary objections would result in the dismissal of an action, we may do so **only in cases that are clear and free from doubt.**" Ellenbogen v. PNC Bank, N.A., 731 A.2d 175, 177-184 (Pa. Super. 1999) (emphasis added), (citing Filipovich v. J.T. Imports, Inc., 431 Pa. Super. 552, 637 A.2d 314 (Pa. Super. 1994)); See also, Sweatt v. Dept. of Corrections, 769 A.2d 574, 576 (Pa. Cmwlth. 2001) (citing Rodgers v. Pennsylvania Dept. of Corrections, 659 A.2d 63 (Pa. Cmwlth. 1995)) (When ruling upon preliminary objections in the nature of a demurrer, the Court must accept as true all well-pleaded allegations of material fact as well as all reasonable inferences deducible therefrom).

Additionally, UPMC's speaking demurrers may not be considered in sustaining their preliminary objections. See Regal Industrial Corp. v. Crum, 890 A.2d 395 (Pa. Super. 2005) (A speaking demurrer requires the aid of facts not appearing on the face of the pleading to which objection is filed and may not be considered in sustaining a preliminary objection). Denials in the form of preliminary objections are similarly misplaced. UPMC's assertions are more properly a part of their answer and evidence that a genuine dispute exists, which supports the sufficiency of the petition. The Commonwealth has well pled its causes of action.

II. The instant petition is the proper vehicle to bring this matter before the court on the basis of Paragraph IV.C.10 of the consent decree.

The instant petition is the proper vehicle to raise modification because the parties agreed that this Court retained 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.

Consent Decree § IV.C.11 (emphasis added). The Consent decree has not terminated. It remains under the jurisdiction of this Court on this docket.

Moreover, the parties, including, UPMC agreed that:

> 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.

Consent Decree § IV.C.10 (emphasis added). As such, UPMC's contention that the requested modification "should not go forward without the unanimous consent of all concerned, including UPMC, the PID and DOH," is simply incorrect. *See*, *Resp. Brief* at 29, f.n. 11.[2]

In accordance with its obligations under the agreement, the Commonwealth reached out to UPMC but was unable to secure an agreement on modification. Following the procedure to which the parties agreed, the instant petition followed. Having signed the Consent Decree and agreed to its terms, UPMC is estopped from now claiming that the agreed-upon modification provision is inoperative. By signing the Decree, UPMC has already conceded to the Attorney General's ability to seek modification.[3]

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[2] UPMC's contention that the Attorney General has conceded that it cannot force UPMC to contract is also without merit. The Office of Attorney General has never alleged that it is a judicial body. As set forth in the plain language of the Consent Decree, the Attorney General may merely move for relief. As the Consent Decree makes clear, UPMC remains subject to the jurisdiction of this Court which may grant modification.

[3] Respondents' contention that the Attorney General lacks power because the legislature failed to pass "any willing provider" legislation is similarly without merit. It is well-settled that legislative inaction "lacks 'persuasive significance' because

Paragraph IV.C.10 places no limitations on the types of modification that may be sought so long as the party believes that seeking modification would be in the public's interest and notice is given to the other parties. Ergo, a party may seek modification of any of the provisions, including, but not limited to Paragraph 9 (Termination). *See*, Penn Tp. v. Watts, 618 A.2d 1244 (Pa. Cmwlth. 1992) (A consent decree is a contract); *See also*, Cecil Tp. v. Klements, 821 A.2d 670, 674 (Pa. Cmwlth. 2003) (A consent decree is binding until the parties choose to amend it). In this case, the parties agreed to a contractual term which permits modification by this Court and proscribed a procedure for seeking it.[4]

Modification serves the public's interest, a lack of modification results in people being denied care or being forced to pay a much higher price for it. UPMC is a public charity whose harmful actions include closing its doors to out-of-network

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'several equally tenable inferences' may be drawn from such inaction, 'including the inference that the existing legislation already incorporated the offered change." Pension Benefit Guaranty Corporation v. LTV Corp., et al, 496 U.S. 633, 650 (1990) (quoting United States v. Wise, 370 U.S. 405, 411 (1962)). In this case, the Nonprofit Corporations Law and UTPCPL are already applicable to Respondents. Further, the Commonwealth has not requested the Court impose any willing payer or provider relief. Rather, the Commonwealth has requested the Court impose a duty to negotiate in good faith on the parties with an optional last best offer arbitration back stop.

[4] UPMC mistakenly attempts to rest on the plain language of Paragraph IV.C.9 which states that the Consent Decree shall expire five (5) years from date of entry. However, this is not the end of the inquiry. The issue is the application of Paragraph IV.C.10 as it applies to all of the terms of the Consent Decree, including, the modification of Paragraph IV.C.9.

patients through prohibitive pricing and demands for upfront payment, and steering the public toward its insurance plan. UPMC has also represented that it will continue this conduct while continuing to enjoy its tax-exempt status as a nonprofit corporation subsidized by some of the very same people it chooses not to serve. In support thereof, the Commonwealth incorporates its Petition to Modify Consent Decrees and all of the averments set forth therein. *See*, Pa.R.C.P. No. 1019(g).

As such, the Commonwealth is in accord with the procedure to which the parties agreed and the petition is the proper vehicle for seeking modification.

III. UPMC's contentions that the Commonwealth's claims are barred as a matter of law are without merit given UPMC's status as a public charity subject to the continuous oversight of the court, as well as Paragraph IV.C.11 of the consent decree.

The Commonwealth is not precluded from bringing its claims on the basis of *res judicata*. By its very terms, the Consent Decree expressly permits any of the parties to petition this Court for "such further orders and directions as may be necessary and appropriate for the interpretation, **modification** and enforcement of this Consent Decree." Consent Decree § IV.C.11 (emphasis added).

As acknowledged by UPMC, the Attorney General has sued to enforce the Consent Decrees on three occasions in 2015, 2016 and 2017. *See*, UPMC' *Brief* at 8. As evidenced by the multiple actions, all parties agreed and were on notice that their agreement was ongoing and that further relief could be sought.

None of the three aforementioned actions involved a request for modification pursuant to Paragraph IV.C.10. In Commonwealth v. UPMC, 188 A.3d 1122, 1135 (Pa. 2018), the issue in the enforcement proceeding was whether a runout provision satisfied UPMC's obligations under the parties' agreement. At no point was modification pursuant to Paragraph IV.C.10 at issue. The Supreme Court clearly acknowledged however that, "[t]he Commonwealth Court, by the terms of the Consent Decree, retains jurisdiction for any necessary and appropriate interpretation, **modification**, or enforcement. *See* Consent Decree § IV(C)(11)." Id. At 1125, fn. 7 (emphasis added).

The doctrine of *res judicata* does not prevent a court from addressing multiple breaches of the same contract and claims which arise based upon different facts. See, Raab v. Domino Amjet, 530 F. Supp. 2d 1192, 1196-1197 (Dist. Ct. Kansas. 2008) (Although the claims raised in both actions arise from the same contract, the nature of those claims are fundamentally different and not precluded by *res judicata*). "The thing which the court will consider is whether the ultimate and controlling issues have been decided in a prior proceeding in which *the present parties actually had an opportunity to appear and assert their rights*." Stevenson v. Silverman, 208 A.2d 786, 788 (Pa. 1965). In certain instances, such as zoning, Pennsylvania courts have applied *res judicata* narrowly because, "the need for

flexibility outweighs the risk of repetitive litigation." Callowhill Center Associates v. Zoning Bd. of Adjustment, 2 A.3d 802, 809 (Pa. Cmwlth. 2010).

> In addition, the doctrine of *res judicata* subsumes the doctrine of collateral estoppel, which forecloses re-litigation in a later action of an issue of fact or law that was actually litigated and was necessary to the original judgment. Collateral estoppel applies if: (1) **the issue decided in the prior case is identical to one presented in the later case**; . . . .

Callowhill Center Associates v. Zoning Bd. of Adjustment, 2 A.3d 802, 809 (Pa. Cmwlth. 2010) (emphasis added) (citing City of Pittsburgh v. Zoning Board of Adjustment, 559 A.2d 896 (Pa. 1989)).

Equitable estoppel is similarly, inapplicable. Equitable estoppel may be asserted when a party's actions or representations induce another party to act in reliance upon said actions or representations. It is generally raised in instances in which one party claims that it was induced to believe that a valid contract was in place and/or that a contract was modified. The burden of proof is on the party claiming that it was misled. *See*, Novelty Knitting Mills, Inc. v. Siskind, 457 A.2d 502 (Pa. 1983). Equitable estoppel cannot be raised here because UPMC agreed to Paragraphs IV.C.10 and 11 which remain enforceable. UPMC has not been led to believe otherwise. Moreover, as set forth above, the Commonwealth has initiated multiple actions to enforce the parties' agreement which belie any contention that the Commonwealth was foreclosed from bringing the instant action for modification.

Finally, at least two events at the center of this petition occurred well after the period released in the original decrees. Last Fall, UPMC announced that all out of network patients would be required to pay for the entire expected bill before services were provided and its conduct in Lycoming County occurred in 2017. The Commonwealth is not estopped from seeking to redress UPMC's recent conduct.

UPMC's reliance upon 42 U.S.C. § 1395a (Free choice by patient guaranteed) and 42 U.S.C. § 1396a(a)(23) (deemed unconstitutional and not severable by Texas v. U.S., 340 F.Supp.3d 579 (N.D. Tex. 2018)), is also misplaced. The purpose of the cited provisions is to protect patient's rights and not to support barriers such as prohibitive pricing imposed by institutions, like UPMC.

UPMC's contention that the Commonwealth' Petition is barred as a matter of law is unfounded.

IV. The Commonwealth Has Not Released UPMC From the Claims at Issue

Contrary to UPMC's position that the Commonwealth's claims are barred under the terms of its Consent Decree, paragraph IV.C.5 of the decree releases only those claims the Commonwealth brought or could have brought relating to facts alleged or encompassed within its decree for the period July 1, 2012 to the date of filing, *i.e.,* June 27, 2014. UPMC has not been released from any claims arising prior to or after the dates specified, including UPMC's treatment denials of

Highmark Community Blue patients prior to June 27, 2014. See Commonwealth Exhibit 1.

V. As a Public Charity, UPMC Must Fulfill Its Charitable Mission For The Public As A Whole.

UPMC seeks to make its charitable mission available to some persons and not to others. As a charitable healthcare system, however, UPMC cannot discriminate against patients based upon their source of payment as UPMC contends.[5] As a public charity, UPMC owes a duty to the citizens of Pennsylvania, "[a] corporate charter is a contract with the state which may insure that corporate assets, which originate from public funds, be distributed so as to insure their continued use for charitable purposes." Tauber v. Virginia (Tauber I), 499 S.E.2d 839, 845 (Va. 1998), quoting, Hanshaw v. Day, 120 S.E.2d 460, 464 (Va. 1961). Unionville-Chadds Ford School Dist. V. Chester Cty. Bd. Assessors, 692 A.2d 1136, 1141 (Pa. Cmwlth. 1997); Donohugh's Appeal, 5 W.N.C. 196 (PA. 1878)(An essential feature of public use is that it is not confined to privileged individuals, but is open to the indefinite public).

> **A nonprofit public benefit corporation's reason for existence, however, is not to generate a profit. Thus, a director's duty of loyalty lies in pursuing or ensuring pursuit of the charitable purpose or public benefit which is the mission of the corporation.**

[5] UPMC must comply with the non-discrimination provision based upon a patient's source of payment under the "Patient Bill of Rights" provided for under 28 Pa. Code § 103.22(b)(13) or face disciplinary actions pursuant to 28 Pa. Code § 103.24.

Summers v. Cherokee Children & Family Services, Inc., 112 S.W.3d 486, 504 (Tenn. Ct. App. 2002) (emphasis added) (Attorney General of Tennessee prevailed in action to dissolve two nonprofit public benefit corporations that abandoned their charitable mission).

> Thus, **nonprofit directors and officers must be "principally concerned about the effective performance of the nonprofit's mission."** . . . **[T]hose who control a nonprofit corporation "have a special duty to advance its charitable goals** and protect its assets."

Summers v. Cherokee Children & Family Services, Inc., supra., at 504 (Citing Oberly v. Kirby, 592 A.2d 445, 472-473 (Del. 1991) (emphasis added); Harvey J. Goldschmid, *The Fiduciary Duties of Nonprofit Directors and Officers: Paradoxes, Problems, and Proposed Reforms,* 23 IOWA J. CORP. L. 631, 641 (1998); *Developments in the Law—Nonprofit Corporations,* 105 HARV. L.REV. 1578 (May 1992)).

Access is a key factor in determining whether an entity is discharging its fiduciary duty to the public and continues to qualify as a charity.

> A charity, in the legal sense, may be more fully defined as a gift, . . . for the benefit of an indefinite number of persons. . . . **An institution will be classed as charitable if the dominant purpose of its work is for the public good . . . . But if the dominant purpose of its work is to benefit its members or a limited class of persons it will not be so classed, ...**

Western Mass Lifecare Corp. v. Board of Assessors, 747 N.E.2d 97, 102-103 (Mass. 2001) (emphasis added) (relieving disease and suffering is a charitable function) (Citing Boston Chamber of Commerce v. Assessors of Boston, 54 N.E. 2d 199 (Mass. 1944); New England Legal Foundation v. Boston, 670 N.E. 2d 152 (Mass 1996)); Appeal of Dunwoody Village, 52 A.3d 408 (Pa. Cmwlth. 2012) (Facility was not providing sufficient charitable services test due, in part, to its requirement of financial security as a prerequisite for admission).

> [A] charity is a gift to the general public use which extends to the rich as well as to the poor.

Selfspot v. Butler County Family YMCA, 987 A.2d 206, 214 (Pa. Cmwlth. 2010) (Relevant factors include whether it was run free of profit motive and whether it was available to the community as opposed to dues paying members); See also, City of Pittsburgh v. Bd. of Property Assessment, Appeals and Review, 564 A.2d 1026 (Pa. Cmwlth. 1989); Appeal of Sewickly Valley YMCA, 774 A.2d 1 (Pa. Cmwlth. 2001).

VI. The Attorney General's Authority and Duty to Protect Charitable Assets and Ensure UPMC's Compliance With its Charitable Mission on Behalf of the Commonwealth are Well-Established.

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

> The beneficiary of charitable trusts is the general public to whom the social and economic advantages of the trusts

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

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

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

Attorney General, as *parens patriae*, is authorized to inquire into the status, activities and functioning of public charities reasoning that:

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

Id., at 467-68, 159 A.2d at 505.

The Court further noted: "But what more formidable cause of action could exist than the assertion that the trustees of a charitable trust are failing to carry out the mandates of the indenture under which they operate? ..." *Id.*

On remand to the Orphan's Court, the president judge granted wide latitude to the Attorney General in authorizing the Commonwealth's request that the foundation be ordered to produce, among other things, an inventory of all the art

along with appraised values, an itemized list of the foundation's total assets, the foundation's annual income since the founder's death, and an itemized account of the foundation's expenditures during the same period. Commonwealth v Barnes Foundation (No. 2), 11 Fiduc. Rep. 29 (O.C. Montg. 1961). In its analysis of the scope of inspection and discovery to be afforded the Commonwealth, the court found "[t]hat such powers, *parens patriae*, are broad and sweeping powers there can be no dispute. For it is of the essence of a public charity that it be subject to the visitorial powers of the sovereign." *Id.* At 31. It added that the "broad investigatory and visitorial powers of the Commonwealth" being asserted "should not be lightly regarded" nor restricted on technical procedural grounds. *Id.*[6] Public charities exist not for particular persons, but for the Commonwealth as a whole. In re Buhl's Estate, 300 Pa. 29, 34, 150 A. 86, 87 (1930). *See also,* Cain's Estate, 16 Pa. D. & C. 3d 50 (O.C. Del. 1980) (attorney general's interest, as *parens patriae,* is in all charitable organizations, not merely charitable trusts).

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

VII. UPMC's Failure to Honor Its Stated Charitable Purposes and Violations of the Nonprofit Corporations Law

UPMC is a nonprofit corporation whose Amended and Restated Articles of Incorporation set forth the organization's relevant 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,[7] 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

[7] UPMC contends that its corporate structure requires that the Attorney General must name and attribute to each UPMC subsidiary their respective actions that warrant being bound by a modified consent decree. UPMC's memorandum in support at 29. As UPMC's Articles of Incorporation make clear, UPMC provides governance and supervision to all its subsidiaries.

> 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).*[8]

As alleged, UPMC serves as the sole controlling member of all of its constituent domestic nonprofit, charitable hospitals. Through its "reserved powers," UPMC controls all essential aspects of its subsidiaries, including, but not limited to, their budgets, finances, contractual terms and treatment policies. As such, UPMC owes fiduciary duties to each of its subsidiaries to facilitate the public's access to their services, not deny or make them cost prohibitive.[9]

The Commonwealth's Petition alleges, however, that UPMC's Board of Directors and Executive Management are violating UPMC's stated charitable

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[8] UPMC and all of its pertinent hospitals are registered as institutions of purely public charity under the Institutions of Purely Public Charity Act, 10 P.S. §§ 371, *et seq.*

[9] Corporate articles are to be interpreted according to general rules governing contracts. In re Estate of Hall, 731 A.2d 617 (Pa. Super. 1999); Appeal of Wagner Free Institute, 25 WNC 437 (Pa. 1890); Tauber v. Commonwealth of Virginia (Tauber I), supra. at 845 ; Hanshaw v. Day, supra. at 464; 'Unigroup v. O'Rourke, 980 F.2d 1217 (8th Cir. 1992); Oberbillig v. West Grand, 807 N.W. 2d 143 (Iowa. 2011); Riccobono v. Pierce, 966 P.2d 327 (Wash. App. 1998).

purposes and the Nonprofit Corporations Law[10] in a variety of respects including, but not limited to:

a. refusing to contract with Highmark and other insurers, subjecting their subscribers to UPMC's higher Out-of-Network charges and increasing the overall costs of health care;

b. closing the Susquehanna Medical Group of physicians to patients whose employer lacked a contract with the UPMC Susquehanna hospital;

c. engaging in provider-based billing that increases reimbursements without any added value to patients while increasing the overall costs of health care;

d. prohibiting health insurers from tiering UPMC's services among the insurers' other In-Network health care providers which increases the overall costs of health care;

e. insisting upon "most favored nation" terms within provider contracts that prohibit insurers from contracting with other health care providers at rates less costly than UPMC's which increases the overall costs of health care;

f. requiring onerous lump-sum payments from Out-of-Network patients for all of their expected treatment costs before any medical services are provided, limiting access, increasing the overall costs of health care, and resulting in UPMC's unjust enrichment by receiving reimbursements in excess of the reasonable value of UPMC's services;

g. balance billing patients even after insurance payments have exceeded UPMC's actual costs and the reasonable value of the services UPMC has provided;

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[10] This memorandum focuses on UPMC's failure to comply with its stated charitable purposes, but its actions also implicate violations of the Solicitation of Funds for Charitable Purposes Act and the Unfair Trade Practices and Consumer Protection Law not discussed here.

h. expending hundreds of millions of dollars building superfluous hospitals to compete against other charitable healthcare providers without regard to the larger social costs of its projects which increases the overall costs of health care;

i. subordinating the charitable missions of the system's constituent hospitals to the expansion of the UPMC system;

j. pursuing "a new economic future for western Pennsylvania" at the expense of its primary obligation to provide a high quality, cost effective and accessible health care system;

Pennsylvania's Nonprofit Corporation Law imposes fiduciary duties on UPMC's directors, requiring that they perform their duties in good faith as they reasonably believe to be in the best interests of the corporation:

> (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. . . .

15 Pa.C.S. § 5712.

In The Health Alliance of Greater Cincinnati (Alliance) v. The Christ Hospital (Hospital), et al., 2008 WL 4394738 (Ohio App. 1 Dist. 2008), the court found that the Alliance, a multi-hospital management system, owed fiduciary duties to the Hospital under the parties' joint operating agreement (JOA). And among those duties was an obligation to keep operating The Christ Hospital ("TCH"). "The record is replete with evidence," the court said, "that the Alliance

breached its fiduciary to TCH" by constraining its access to operating capital and potentially preventing it from serving patients. Health All. of Greater Cincinnati v. Christ Hosp., Ohio-4981, ¶ 23. *See also,* Lifespan Corp. v. New England Medical Center, Inc., et al., 731 F.Supp.2d 232 (Dist. R. I. 2010) v*ac, in part, on other grounds by*, Lifespan v. New England Medical Center, 2010 WL 3718952 (Dist. R.I. 2010) (health care network owed fiduciary duties to hospital during affiliation which had reposed faith, confidence, and trust in network's judgment and advice).

Accordingly, UPMC's refusal to contract with Highmark is directly contrary to UPMC's stated charitable purposes and supports a finding that UPMC's Board of Directors and Executive Management have breached their fiduciary duties of loyalty/obedience[11] to UPMC's charitable mission and those of its subsidiary hospitals:

> It is axiomatic that the Board of Directors is charged with the duty to ensure that the mission of the charitable corporation is carried out. . . . "[U]nlike business corporations, whose ultimate objective is to make money, nonprofit corporations are defined by their specific objectives: perpetuation of particular activities are central to the raison d'etre of the organization.

In re Manhattan Eye, Ear & Throat Hosp. (MEETH), 186 Misc.2d 126, 152, 715 N.Y.S.2d 575, 593 (1999) (board could not take advantage of market

[11] The Duty of Obedience is often reasoned to be a subset of the Duty of Loyalty and used interchangeably in many case opinions.

opportunity to maximize assets at the expense of the organization's chartered purpose without breaching its fiduciary duties). *See also*, Commonwealth v. Barnes Foundation, 398 Pa. 458, 159 A.2d 500 (1960) (gallery could not be considered public as the donor's indenture provided **if** the public were admitted only upon the whim of the trustees); Unionville-Chadds Ford School Dist. v. Chester County Bd. of Assessment Appeals, 552 Pa. 212; 714 A.2d 397 (1998) ("it is fully consistent with the fundamental character of a purely public charity to benefit the general public").

> "In significant respects, the beneficiaries of the [hospital], namely its patients and community, stand in a position similar to the minority shareholders in a non-wholly owned, for-profit subsidiary," in that they are vulnerable to the power of the controlling entity." . . . "it is appropriate to apply a fiduciary standard" to a healthcare system acting as the sole member of a non-profit hospital in order "to constrain the [system's] powers and protect the interests of subsidiaries' beneficiaries," just as courts . . . have done with respect to controlling shareholders in for-profit corporations.

Lifespan Corp. v. New England Medical Center, Inc., et al., *supra.*, 731 F.Supp.2d at 240 (citations omitted). The consent decrees focus on the vulnerability of consumers when they need health care, especially the high level, lifesaving health care that UPMC and AHN provide.

Any action taken "against" the corporate purposes of UPMC may be deemed an *ultra vires* act, *i.e.,* an act taken outside the permissible scope of the board's

authority and should render that action void. Arbour v. Pittsburg Produce Trade Assoc., 44 Pa. Super. 240, 249 (Pa. Super., 1910) (Corporations cannot go beyond the powers granted to them and must exercise those powers in a reasonable manner).

Here, UPMC operates a substantial number of the region's emergency rooms which: a) serve patients in need of emergency care; and b) are a significant source of hospital admissions. UPMC can count upon a steady flow of Highmark and other out-of-network patients who will all be subject to paying UPMC's higher out-of-network rates.[12] In short, UPMC's refusal to contract with Highmark can be expected to increase UPMC's revenue stream as well as the region's overall health care costs regardless of how the market reacts to the expiration of its Highmark contract—UPMC simply cannot lose. To avoid those high costs, UPMC advises consumers to choose its health plan or another health plan that has a contract with UPMC. See ¶37, Petition to Modify. Nothing in UPMC's Articles of Incorporation authorizes UPMC's interference with a consumer's choice or a consumer's employer's choice of a health plan.

Accordingly, there is little doubt that UPMC has embarked on a business plan of pursuing profits over the faithful pursuit of its charitable mission and has clearly

[12] Health Plan's generally are obligated to pay for emergency care even if it is rendered at out-of-network hospitals. How much a consumer pays will depend on the consumer's plan design. A consumer who has a high deductible plan with a $5,000 deductible will pay all of a $4,000 bill, for example.

deviated from its charitable mission. While it dresses up this deviation with claims of having to compete, UPMC's reasons are simply a means to extract higher reimbursements from Pennsylvania consumers and employers, placing its pursuit of profits over its charitable mission.

VIII. The Commonwealth's Proposed Modified Consent Decree Serves the Public Interest by Prohibiting UPMC's Unjust Enrichment Through its Practice of Billing Out-of-Network Patients Based Upon its Published/Chargemaster[13] Rates Rather than the Reasonable Value of its Services.

UPMC is incorporated exclusively for charitable purposes without contemplation of pecuniary gain for profit, incidental or otherwise. *See* Commonwealth's Petition, Exhibit 2. As also alleged in the Commonwealth's Petition, UPMC has announced that all Out-of-Network patients must pay **all** of UPMC's estimated charges **Up-Front and In-Full** before it will provide them with any medical care. UPMC engages in this practice despite the fact that its Out-of-Network charges significantly exceed both its actual costs as well as the discounted reimbursements it willingly accepts as payment In-Full from commercial insurance companies with which it has negotiated rates.

[13] The Published/Chargemaster rate is the "list price" that a hospital unilaterally sets for the specific services it provides. For Out-of-Network Medicare Advantage patients, UPMC is limited to charging them the Medicare rate for their services, which for many medical procedures still amounts to thousands of dollars.

Under the circumstances described above, UPMC's practice results in its pecuniary gain and violates its stated charitable purposes; it violates Section 5545 of the Nonprofit Corporation Law, 15 Pa. C.S. § 5545, which limits UPMC to an "incidental profit" for its services; and it violates the governing legal principle of **unjust enrichment**. Unjust enrichment is an equitable doctrine that limits UPMC to receiving the reasonable value for its services, with reasonable value being determined by what people ordinarily pay for them. Temple Univ. Hosp., Inc., v. Healthcare Mgt. Alt., Inc., 832 A.2d 501 (Pa. Super. 2003) (where there is no express agreement to pay, the law implies a promise to pay a reasonable fee for a health provider's services, determined by what the healthcare provider actually receives for those services). *See also*, Eagle v. Snyder, 604 A.2d 253 (Pa. Super. 1992).

The modifications proposed by the Commonwealth will adequately address the above circumstances by promoting negotiated contracts with any Health Plan seeking a services contract and limiting Out-of-Network charges to UPMC's Average In-Network Rates. Moreover, far from being radical and unprecedented as UPMC suggests, the Modified Consent Decree's provisions coincide with the holding of the Temple case, *supra.* As such, the proposed modifications will further the public's interest by promoting affordable access to UPMC's healthcare services.

IX. The Commonwealth's Arguments in FTC v. Penn State Hershey Med. Ctr., 838 F.3d 327 (3d Cir. 2016)(No. 16-2365), Do Not Conflict with the Terms of the Proposed Modified Consent Decree.

UPMC's attempt to draw a conflict between the Commonwealth's opposition to the proposed merger between the Penn State Hershey Medical Center and the Pinnacle Healthcare System ignores the material distinctions between these two cases. The proposed Penn State/Pinnacle merger was challenged on antitrust grounds to prevent the reduction in competition between two health systems for hospital services and preserve a competitive marketplace where the public would continue to have access to high quality affordable health care services. FTC v. Penn State Hershey Med. Ctr., 838 F.3d 327, 334 (3d Cir. 2016). It prevented the creation of a merged entity with a 76% share of the healthcare provider market that could have used its acquired market power to refuse to contract with health plans denying the public access to its health care services or to contract only on terms advantageous to the merged entity resulting in higher prices for the public's access to its services. *Id.,* at 345-346.

This case, however, while based on charitable trust grounds, also seeks to protect the public's access to high quality affordable health care services. In this case, UPMC already possesses a dominant share of the provider market. Despite its status as a charitable institution committed to benefitting the public, UPMC is using its market power to deny the public access to the very health care services the public

funded. As a charitable institution, UPMC is required to provide public benefit, not a public detriment. The remedies the Commonwealth seeks here are behavioral remedies intended to address UPMC's misconduct as a charitable institution. They are similar to the after-the-fact behavioral remedies sought in post-merger challenges to address market power concerns. *See,* In re Evanston Northwestern Healthcare Corp., Dkt. No. 9315 Final Order (FTC April 29, 2008), attached as Exhibit 3.

Indeed, had the Penn State/Pinnacle merger been approved and the merged entity engaged in conduct similar to UPMC, the Commonwealth could have soon been forced to seek to impose substantially the same remedies pursued here.

X. UPMC's For-Profit Entities Must Be Operated to Further UPMC's Charitable Mission.

Notwithstanding its admission that UPMC is, "the nonprofit parent corporation of over a hundred entities – some for-profit, some nonprofit," UPMC asserts that "there is no conceivable basis to impose relief against for-profit companies." *See, Dfs Brief at 29-30* (emphasis added). Said argument ignores that all of the entities fall within the umbrella of the charitable mission of the nonprofit parent.

Section 5545 of the Nonprofit Corporations Law requires a nonprofit corporation apply to all of its incidental profits to its lawful mission as set forth in its Articles of Incorporation. *See,* 15 Pa.C.S. § 5545; Roxborough, *supra.*; UPMC, *supra*.

A charity can create a for-profit entity to enhance its charitable mission. "But, the diversion of surplus monies by an organization into **other entities** that are not operated free of the profit motive, **is** evidence of a profit motive." Community Gen Osteopathic Hosp v. Dauphin Cty., 706 A.2d 383, 390-391 (Cmwlth. 1998) (emphasis in original) (Investment in related for-profit family medical practices that were part of the hospital and "operated under its strict open admission policies" "which requires treatment of individuals without regard to their ability to pay" did not disqualify hospital because they furthered the charity's mission).

A charity may invest in for-profit subsidiaries but the purpose must be to further the charity's mission. See, Saint Margaret Seneca Place v. Bd. of Property Assessment, Appeals and Review, County of Allegheny, 640 A.2d 380 (Pa. 1994) (A charity may have surplus revenue so long as it is used to further the charitable mission and is not "private profit"). The determining factor is whether investment in for-profits is in furtherance of "the institution's charitable purpose." Wilson Area School Dist. v. Easton Hosp., 747 A.2d 877, 881 (Pa. 2000).

In Pinnacle Health Hosp. v. Dauphin Cty., 708 A.2d 1284, 1295 (Pa. Cmwlth. 1998), *rev'd on other grounds by* Wilson, *supra.*, the Court determined that non-compete covenants in physician contracts could have the effect of preventing otherwise qualified physicians from providing care to those in need which combined with other factors was evidence of a profit motive. See, Pinnacle, supra., at 1295-

1296; *See also*, Union-Chadds Ford School Dist. v. Chester Cty. Bd. Assessment, 692 A.2d 1136 (Pa. Cmwlth. 1997) (Competition with commercial businesses is evidence of a profit motive).

In this case, UPMC is closing its doors to certain patients through prohibitive pricing and demands for upfront payment. All in order to steer the public toward its insurance plan. All assets of UPMC's nonprofit and for-profit subsidiaries, are held in trust for the benefit of the public at large and not to be used otherwise. In Re Roxborough Memorial Hosp., 17 Fid. Rep.2d 412, 422-423 (O.C. Phila. 1997). *See also,* In re Stroudsburg Real Prop., 23 Fiduc. Rep. 2d 258, 261 (O.C. Monroe 2003) ("Because Christian Memorial Mission was charitable, the assets involved are charitable.").

Failure to apply funds to the corporation's lawful purpose constitutes "corporate action" within the meaning of the statute. *See* Ciamaichelo v. Independence Blue Cross, 928 A.2d 407, 410-411 (Pa. Cmwlth. 2007) (The court may hear and determine the validity of the corporate action.) 15 Pa. C.S. § 5508, 5793(a), *See also* 10 P.S. §162.12. In re Coleman's Estate, 317 A.2d 631, 634 (Pa. 1974) (Trustees of a charitable trust are fiduciaries and, as such, are officers of the Orphans' Court, subject to its exclusive supervision and control); 20 Pa. C.S.§ 7701, *et seq.*

By refusing to contract, closing its doors to out-of-network patients through prohibitive pricing and demanding upfront payment, UPMC has breached its fiduciary duties to the public. Even if this conduct is accomplished through UPMC's many non-profit and for-profit subsidiaries, which UPMC is unabashedly clear, it controls, the whole of UPMC's assets are within the jurisdiction of the court and subject to its orders. Respondents' reliance upon Zampogna v. Law Enf' Health Benefits, Inc., 151 A.3d 1003 (Pa. 2016), is misplaced. In that case, the Court held that a nonprofit corporation's action is authorized when:

> 1) the action is not prohibited by the NCL [Nonprofit Corporations Law] or the corporation's articles; and
>
> 2) the action is not clearly unrelated to the corporation's stated purpose.

Id., at 1013 (citing 15 Pa. C.S. 5502(a)(18)). In this case, UPMC's actions in acting contrary to its charitable purpose are prohibited by the Nonprofit Corporations Law and the corporation's articles. Moreover, its actions in trying to grow its revenue at the expense of its charitable obligations to the public are unrelated to, and in contravention of, its stated charitable purposes. The Attorney General, as *parens patriae*, is the only party with the authority and the duty to protect the public's interest in the charitable assets at stake.

XI. UPMC is Subject to the Unfair Trade Practices and Consumer Protection Law

The Attorney General has alleged that UPMC has engaged in trade and commerce in Pennsylvania and that it has done so using unfair and deceptive acts and practices within the meaning of the Unfair Trade Practice and Consumer Protection Law ("UTPCPL"), 73 P.S. § 201-1 *et seq*. The UTPCPL authorizes the Attorney General to seek temporary and permanent injunctions to block unlawful acts. The Attorney General has taken such action here.

UPMC is not exempt from the UTPCPL. UPMC contends that the law only applies to sellers and does not apply to commercial (*i.e.*, business to business) transactions, such as the contractual relationship between a hospital and health plan and, in any event, cannot be applied to conduct involving insurance. UPMC is wrong on all counts.

UPMC engages in trade and commerce as defined by the UTPCPL. "Trade" and "commerce" means "the **advertising**, … **sale** or distribution of any **services** and any **property**, … **intangible**, personal or mixed, and … or **thing of value wherever situate**, and includes **any trade or commerce directly or indirectly affecting the people of this Commonwealth**. 73 P.S. § 201-2 (3) (emphasis added). Respondent UPMC believes trade and commerce consists of just "four types of commercial activities." Respondent UPMC's Answer, p. 44. UPMC would stop the definition

of trade and commerce at "things of value wherever situate" and ignore the last independent clause of the definition.

The Pennsylvania Supreme Court has held the second part of the definition of "trade" and "commerce" is not limited by the four listed types in the first part of the definition. "Instead, it is appended to the end of the definition and prefaced by "and includes," thus indicating an inclusive and broader view of "trade" and "commerce" than expressed by the antecedent language. *See*, Danganan v. Guardian Prot. Servs., 179 A.3d 9, 16 (Pa. 2018).

The Commonwealth has sufficiently pled "trade" and "commerce" under both parts of that definition. Petition to Modify, ¶ 112. "Trade" or "commerce" "includes **any trade or commerce directly or indirectly affecting the people of this Commonwealth**." 73 P.S. § 201-2 (3) (emphasis added). Broadly, "trade" includes the business of buying and selling for money. *See*, May v. Sloan, 101 U.S. 231, 237 (1879); Pavlovich v. Nat'l City Bank, 342 F.Supp.2d 718, 725 (N.D. Ohio 2004), *aff'd,* 435 F.3d 560 (6th Cir. 2006). Broadly, "commerce" includes the business of buying and selling of commodities for money. *See*, United States v. Besser Mfg. Co., 96 F.Supp. 304, 307 (E.D. Mich. 1951), *aff'd,* 343 U.S. 444 (1952). "The words 'trade' and 'commerce,' when used in juxtaposition impart to each other enlarged signification, so as to include practically every business occupation carried

on for subsistence or profit and into which the elements of bargain and sale, barter, exchange or traffic, enter." Black's Law Dictionary, Sixth Edition.

Respondent conveniently ignores the Pennsylvania Supreme Court's statutory construction of the second independent clause. This Court should reject Respondent's interpretation.

Looking to other jurisdictions as did the Pennsylvania Supreme Court in Danganan, Washington's "Consumer Protection Act applies to 'any' trade or commerce affecting the people of the state of Washington, directly or indirectly. RCW 19.86.010(2). It shows 'a carefully drafted attempt to bring within its reaches *every* person who conducts unfair or deceptive acts or practices in *any* trade or commerce.' Short v. Demopolis, 103 Wash.2d at 61, 691 P.2d 163." Stephens v. Omni Ins. Co., 138 Wash.App. 151, 173, 159 P.3d 10, 22 (2007), *aff'd sub nom;* Panag v. Farmers Ins. Co. of Washington, 166 Wash.2d 27, 204 P.3d 885 (2009) (emphasis retained). Under the New Hampshire unfair trade practices law, "while the legislature exempted certain types of transactions from the provisions of the chapter, it did not exempt private causes of action brought by sellers against deceptive buyers. *See* RSA 358–A:3 (1995 & Supp. 2000)." Milford Lumber Co., Inc. v. RCB Realty, Inc., 780 A.2d 1259, 1262 (N.H. 2001). "Moreover, had the legislature intended to limit the protections of the CPA to the definition of

'consumer' as espoused by the defendant, it could have expressly done so as it did" in another law. George v. Al Hoyt & Sons, Inc., 27 A.3d 697, 704 (N.H. 2011).

Under Connecticut jurisprudence, "[i]f the legislature had intended to restrict private actions under CUTPA only to consumers or to those parties engaged in a consumer relationship, it could have done so by limiting the scope of CUTPA causes of action or the definition of 'person,' such as by limiting the latter term to 'any party to a consumer relationship.' 'The General Assembly has not seen fit to limit expressly the statute's coverage to instances involving consumer injury, and we decline to insert that limitation.' *See*, Larsen Chelsey Realty Co. v. Larsen, 656 A.2d 1009, 1020 (Conn. 1995) (citing McLaughlin Ford, Inc. v. Ford Motor Co., *supra.*, 473 A.2d 1185)." Likewise, under the general purpose public enforcement provisions set forth in Sections 3, 4, 4.1 and 8 of the UTPCPL, there is no express exemption for unfair or deceptive buyers in the definition of "person" or express requirement of ultimate consumer transaction nexus in the definition of "trade" and "commerce."

In this case, the Commonwealth's Petition to Modify is replete with allegations that the Respondent engaged in "trade" or "commerce" under both clauses comprising the definition of "trade" or "commerce." *See, e.g., Petition to Modify,* ¶¶ 31, 34, 37, 38, 52-55. The Commonwealth has alleged that UPMC:

> has presented conflicting messages to the public ... 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.

See, *Petition to Modify*, ¶ 117. Representations made by a health care provider, unrelated to the results of the delivery of medical services, is actionable under the UTPCPL. Com. by Shapiro v. Golden Gate Nat'l Senior Care LLC, 194 A.3d 1010, 1023-1028 (Pa. 2018)

Under the plain language of the UTPCPL, a transaction involving the sale of health care services comes within the laundry list of transactions in the first clause and no "trade" or "commerce" directly or indirectly affects the people of the Commonwealth more than the purchase of health care services. This Court should reject the Respondent's invitation to narrow the scope and protections of the UTPCPL.

UPMC argues that the UTPCPL only applies to sellers, which is an unusual argument since UPMC provides health care services in exchange for money. In short, it sells health care services. Even if UPMC is not a seller, the Pennsylvania Supreme Court directs that the UTPCPL is to be liberally construed to effectuate its purpose. *See*, Com., by Creamer v. Monumental Properties, Inc., 329 A.2d 812, 817

(Pa. 1974). The UTPCPL[14] "protects both the unsuspecting and innocent consumer and the legitimate businessman, both of whom are subject to fraudulent schemes by the unscrupulous profiteer." 40 Pa. Legis. J. – House 1231 (July 8, 1968) (statement of Rep. Beren) (prior to final vote by the House before concurrence with the Senate) (Rep. Beren was one of three members from the House on the Committee of Conference with the Senate on the UTPCPL).[15] Unlike a private plaintiff whose action is limited to violations connected to the purchase of only goods or services for limited purposes, the Office of Attorney General is empowered by statute to ensure a fair marketplace.

The UTPCPL, as enforced by the Attorney General, applies to business and commercial transactions:

> [T]o limit the application of [UDAP] solely to a consumer, the one who ultimately uses the product, would be to say that this is the only party you cannot defraud.... This cannot be so. [UDAP], 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 added).
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> That [UDAP] is not limited solely to the protection of the consumer is inherent in Section 201–3. "Unfair methods of conduct of any trade or commerce are hereby declared unlawful."

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[14] Act of December 17, 1968, P.L. 1224, *as amended,* 73 P.S. §§ 201–1 —201–9.3 ("Unfair Trade Practices and Consumer Protection Law" ("UTPCPL" or the "Law").

[15] *See* Exhibit 4.

In re Fricker, 115 B.R. 809, 818 (Bankr. E.D. Pa. 1990) (citing Com. v. Koscot Interplanetary, Inc., 54 Erie 79, 93 (Erie Co.C.P.1971)). "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." Com. v. Koscot Interplanetary, Inc., 54 Erie 79, 99 (Erie Co.C.P.1971).[16] In a related action, this Court held a pyramid scheme involving the sale of business franchises constituted a violation of the UTPCPL. See, Com. v. Tolleson, 321 A.2d 664, 692–93 (Pa. Cmwlth. 1974). The broad scope of Section 3 of the UTPCPL is "flexible and all-inclusive[.]" Com., by Creamer v. Monumental Properties, Inc., 459 Pa. 450, 466, 329 A.2d 812, 820 (1974). The Attorney General is not required to allege an offender under the UTPCPL to be a seller.

The Law permits the Attorney General to bring a public enforcement action against any "person" for violations of the statute. 73 P.S. § 201-4. "Any person" means every person as the term is defined in 73 P.S. § 201-2 (2). To accept Respondent's argument that a person must be a seller to be liable under the UTPCPL, this Court would have to engraft a restriction that the Legislature did not see fit to include, which is not permitted. *See*, Danganan v. Guardian Prot. Servs., 179 A.3d

[16] Com. v. Koscot Interplanetary, Inc., 54 Erie 79 (Erie Co.C.P.1971) is attached as Exhibit 5.

9, 17 (Pa. 2018); Com. v. Tarbert, 535 A.2d 1035, 1044 (Pa. 1987); and Com. v. Rieck Inv. Corp., 213 A.2d 277, 282 (Pa. 1965).

Moreover, UPMC is a "person" within the meaning of the UTPCPL. The Law defines "person" as "natural persons, corporations, trusts, partnerships, incorporated or unincorporated associations, and any other legal entities." 73 P.S. § 201-2 (2). UPMC in the underlying action is a corporation which unambiguously establishes UPMC as a "person" within the meaning of 73 P.S. § 201-2(2).

Actions brought by individuals under the UTPCPL are limited to a "person" who has "purchase[d] or lease[d] goods or services primarily for personal, family or household purposes." 73 P.S. § 201-9.2. UPMC mistakenly seeks to conflate the broad scope of the public enforcement sections of the UTPCPL with the limited scope of the private action. This distinction, between sections 201-4 and 201-9.2 cannot be ignored or interpreted in a way to eliminate the distinction. *See,* Golden Gate, 194 A.3d at 1028. The Commonwealth brought this underlying action under 73 P.S. § 201-4, not 73 P.S. § 201-9.2.

This Court has previously recognized the distinction between actions brought by the Attorney General under Section 4 and private persons under Section 9.2. A private person must be a buyer to have standing to bring an action. *See*, Bowers v. T-Netix, 837 A.2d 608, 613 (Pa. Cmwlth. 2003). This Court has further rejected the argument that the Attorney General must allege a buyer-seller

relationship. Instead, the Attorney General may proceed when it has reason to believe any person is violating or has violated the Law. See, Com. v. Percudani, 844 A.2d 35, 48 (Pa. Cmwlth. 2004), *as amended* (Apr. 7, 2004), *opinion amended on reconsideration,* 851 A.2d 987 (Pa. Cmwlth. 2004).

UPMC lastly argues that its conduct in engaging in health care insurance transactions as a buyer or a seller does not come within the ambit of the UTPCPL. Under the second enumerated definition of "trade" and "commerce" under the UTPCPL, the Legislature did not intend to exclude any class or classes of transactions except as otherwise provided in Section 3 of the UTPCPL. *See*, Com. by Creamer v. Monumental Properties, Inc., 329 A.2d 812, 815 n.5 (Pa. 1974). This intent was recently re-affirmed in Danganan. "Moreover, there is nothing in any of the language of the Consumer Protection Law that insurance companies are not covered by its provisions, and the General Assembly could have included such language if it desired[.]" Com. ex rel. Fisher v. Allstate Ins. Co., 729 A.2d 135, 140 (Pa. Cmwlth. 1999).

This Court has held that the Attorney General's enforcement of the UTPCPL regarding unfair and deceptive practices of insurance companies is not preempted by the powers vested in the Insurance Commissioner. Com. ex rel. Fisher v. Allstate Ins. Co., 729 A.2d 135, 139 (Pa. Cmwlth. 1999). Indeed, Anderson v. Nationwide, 187 F. Supp.2d 447, 461 (W.D. Pa. 2002), does not stand for the proposition that

insurance contracts[17] are exempt from the UTPCPL. Rather, in that case, the court determined that the conduct was a contract dispute. Here, UPMC widely advertises it services to consumers and promotes itself as a charitable institution. UPMC deals directly with consumers when it engages in its admitted practices such as demanding upfront payment from consumers in exchange for goods and services.

Finally, as the above arguments make clear, the Commonwealth's position remains that its citizens have the right to affordable health care. Its position has not changed.

CONCLUSION

For all the reasons previously set forth, ***UPMC's Motion to Dismiss the Petition to Modify Consent Decrees or Preliminarily Objections in the Nature of a Demurrer*** should be **DENIED.**

[17] A favorite misstatement of UPMC is that the Attorney General seeks to limit or regulate insurance contracts. To the contrary, insurers are free to establish any network of providers they want. The modified consent decree seeks to prevent UPMC from refusing to contract with those insurers that want to contract and pay UPMC for providing services to those insurers' patients.

Respectfully submitted,
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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.

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CERTIFICATE OF SERVICE

I hereby certify that I am this 11th day of March, 2019, serving a true and correct copy of the foregoing ***Commonwealth's Memorandum in Opposition to Respondent UPMC's Motion to Dismiss Petition to Modify Consent Decrees*** on all parties via electronic mail as indicated below:

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IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

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

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IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

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

In his response to UPMC's motion to dismiss, General Shapiro gives up the game. He reveals that the singular issue underpinning his entire Petition for Modification is UPMC's refusal to give Highmark a full, systemwide in-network contract:

> Accordingly, UPMC's refusal to contract with Highmark is directly contrary to UPMC's stated charitable purposes and supports a finding that UPMC's Board of Directors and Executive Management have breached their fiduciary duties of loyalty/obedience to UPMC's charitable mission and those of its subsidiary hospitals.

Commw.'s Mem. in Opp'n at 24 ("OAG Opp."). This acknowledgement confirms that everything that the Attorney General has done since signing the 2014 Consent Decrees—in which the Attorney General *confirmed* the legality of UPMC's refusal to give Highmark a systemwide contract, *released* UPMC from claims based on that refusal, and expressly *affirmed* that Consent Decree's purpose as preparing patients for the attendant transition—was designed to maneuver UPMC right back into a systemwide contract that both the Attorney General and the Commonwealth have acknowledged they have no power to compel.

General Shapiro's confession lays bare that Count I of the Petition to Modify Consent Decrees is unsustainable as a matter of law and should be dismissed with prejudice. Count I does not seek modification of the Consent Decree. It seeks to impose a new agreement on UPMC when the current agreement expires. And, this new agreement would vitiate the animating purpose of the parties' existing Consent Decree—providing an orderly wind-down of the UPMC-Highmark relationship—by compelling a systemwide contract *forever*. Saddled with the unambiguous text of the Consent Decree, the Supreme Court's July 2018 opinion, and admissions from his lead counsel, all of which demonstrate that his proposed modification is improper, General Shapiro contends that UPMC implicitly consented to be bound forever to a blank-check of new terms simply by agreeing to the inclusion of a modification provision in the Consent Decree. That, of course, is not credible and is contrary to Pennsylvania law.

And perhaps unsurprisingly in light of the eleventh-hour repudiation of the past five years under the Consent Decree, the Petition makes no attempt to allege how the proposed "modification" would promote the public interest. The Court should not proceed on an expedited basis to determine whether modification is in the "public interest" without General Shapiro even alleging the basis for that claim.

I. There Is No Basis For General Shapiro's Unprecedented And Extreme Interpretation Of The Consent Decree.

Count I asks this Court to install—over UPMC's objection—a radically different, permanent "modified consent decree" on the grounds that the end of in-network access to UPMC providers for Highmark subscribers is allegedly against the public interest. OAG Opp. at 24. The only legal ground for Count I is that Section IV.C.10 of the parties' existing 2014 Consent Decree permits a request for modification and, according to General Shapiro, "places no limitations on the types of modification that may be sought." OAG Opp. at 9. As such, General

Shapiro reads "modification" to include giving this Court *carte blanche* to write a new agreement that supplants the purpose and the material terms of the existing decree.

"Modification" is a misnomer, however. While Section IV.C.10 is clearly intended to permit modification during the term of the Consent Decree, General Shapiro is not seeking to modify, alter, amend, or change anything about the existing agreement. He is trying to take the Consent Decree out of existence and implement—by coercion—an entirely new agreement that would take effect when the current one expires. Section IV.C.10 therefore should not apply at all. Nevertheless, even taking Count I at face value, Pennsylvania law and the plain language of the parties' Consent Decree preclude interpreting Section IV.C.10 as permitting the Attorney General's requested modification.

A. The Modification Provision is Constrained By The Parties' Intent And Plain Language Of The 2014 Consent Decree.

General Shapiro does not dispute the key principles that must guide this Court's interpretation of the modification provision. *See* OAG Opp. at 9 (acknowledging that a consent decree is a contract). As with any contract, the fundamental rule in interpreting the 2014 Consent Decree is "to ascertain and give effect to the intention of the parties." *Lower Frederick Twp. v. Clemmer*, 543 A.2d 502, 510 (Pa. 1988). The Court must also interpret the provisions of the Consent Decree as a whole and harmonize the modification provision with the other expressions of the parties' intent. *Hazell v. Servomation Corp.*, 440 A.2d 559, 560 (Pa. 1982) ("In construing the parties' agreement, we are required to read the contract as a whole and interpret each part with reference to the whole, so as to give effect to its true purpose.").

Nor does General Shapiro dispute that courts apply these same principles when addressing whether to *modify* a consent decree. The Attorney General does not even acknowledge—much less try to rebut—the decision in *Salazar v. District of Columbia*, which

held that modifications to a consent decree must "give effect to and enforce the operative terms of the original consent decree," and that courts "*may not, under the guise of modification, impose entirely new injunctive relief.*" 896 F.3d 489, 498 (D.C. Cir. 2018) (emphasis added); Mem. in Support of UPMC's Mot. to Dismiss at 21 ("UPMC Br.").[1]

General Shapiro cites no authority holding otherwise. And, *Salazar* is hardly unique. Black-letter law from both Pennsylvania state and federal courts holds that the power to modify a consent decree does *not* include the power to "impose a duty on the defendant that was not contained in" the original agreement. *Fox v. U.S. Dep't Housing & Urban Dev.*, 680 F.2d 315, 322-23 (3d Cir. 1982); *see also Universal Builders Supply, Inc. v. Shaler Highlands Corp.*, 175 A.2d 58, 61-62 (Pa. 1961) (holding that the court lacked authority to modify "clear and unequivocal" provisions of the consent decree); *Watson v. City of Sharon*, 406 A.2d 824, 826-27 (Pa. Commw. Ct. 1979) (holding that a trial court did not have authority to add terms to consent decree where one party never agreed to the terms, did not request them, and objected, and the additional terms went to the heart of the underlying dispute); *Holland v. N.J. Dep't of Corrections*, 246 F.3d 267, 281, 283-84 (3d Cir. 2001) (holding that courts must guard against a modification provision overtaking the original purpose or material terms of the original consent

[1] While General Shapiro ignores *Salazar* altogether, Highmark—which tries to muddy the waters with its own brief on behalf of the Attorney General's claims—attempts to distinguish that case on the grounds that the decree at issue supposedly did not contain a modification provision. Highmark Opp. at 36. That is not true; the decree in *Salazar* did provide for petitions to modify in light of changes in the law. *Salazar*, 896 F.3d at 494-95. Moreover, it is indisputable that the courts in *Salazar* and *Fox* had their own mechanisms for modification. *Id.* at 491 (noting that Fed. R. Civ. P. 60(b) allows a court to modify its orders). The point of those cases is that, while a court is empowered to modify a consent decree, there are still restrictions that prevent imposing on the parties' new duties to which they did not agree.

decree, and must "not impose terms when the parties did not agree to those terms"). "Modification" does not and cannot mean the wholesale rewriting of a consent decree.[2]

As a matter of law, General Shapiro's proposed modification therefore must be rejected. *The fundamental point of the Consent Decree was that the UPMC-Highmark contractual relationship would end.* As Judge Pellegrini already held, the parties' intent was to provide for limited access rights for certain Highmark subscribers "during a period of transition to enable them to decide whether to remain with Highmark or change insurance carriers." Jan. 29, 2018 Mem. Op. at 2, attached hereto as Exhibit S. The Consent Decree thus:

- Explicitly states in its very first provision (called "interpretive principles") that it "is not a contract extension and shall not be characterized as such," Consent Decree § I.A, and repeats later that certain access rights are not "a contract extension," *id.* § IV.A.10;
- Provides for only *limited* access to UPMC, not broad access to all UPMC services for all Highmark members, *see id.* § IV.A;
- For those obligations it does create, sets a specific termination date of June 30, 2019, *id.* § IV.C.9;
- Stipulates that this limited access and express termination date comply with the "insurance laws and health laws," as well as UPMC's obligations under the nonprofit and charitable laws, *id.* § IV.C.6; and
- Provides that this Court's jurisdiction over any request for modification ends when the Consent Decree terminates, *id.* § IV.C.11 ("*Unless this Consent Decree is terminated*, jurisdiction is retained by this Court…." (emphasis added)).

In fact, less than a year ago, the Pennsylvania Supreme Court expressly held the termination date was "an unambiguous and material term of the Consent Decree." *Commonwealth ex rel. Shapiro v. UPMC*, 188 A.3d 1122, 1132 (Pa. 2018).

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[2] In its own effort to support General Shapiro's claims, Highmark cites cases that are inapposite. The unpublished decision in *Griffith v. Griffith*, 343 WDA 2018, 2019 WL 123429 (Pa. Super. Jan. 7, 2019), was simply about whether a subsequent court order invalidated the modification provision in the parties' original consent decree. In *Melat v. Melat*, 602 A.2d 380 (Pa. Super. 1992), the court simply adjusted the due date for a payment, while emphasizing that the underlying obligations remained unaltered.

The proposed modifications repudiate the entire purpose of the existing Consent Decree and eliminate each of these terms. General Shapiro never attempts to argue that his interpretation of an unlimited modification provision and proposed modifications can be read in harmony with the existing Consent Decree. Nor could he. Basic rules of contract interpretation prohibit reading "modify" to include: (1) deleting the Consent Decree's June 30, 2019 termination date, (2) granting the Court perpetual jurisdiction over UPMC's objection well beyond what the parties agreed to; and (3) forcing the very contract extension that the current Consent Decree expressly and repeatedly disclaims.[3]

Moreover, "public interest" cannot mean the exact opposite of what it meant when the parties negotiated and agreed to the Consent Decree in 2014. The Consent Decree states that it must be interpreted "consistent" with the PID's Approving Order, in which the Insurance Department approved Highmark's acquisition of its own provider system. *See* Consent Decree § I.A; *see also* UPMC Br. at 3-4; UPMC Exhibits D-E. That Order was itself issued "to protect the public interest," and it approved the transaction on the *assumption* there would be *no* extension of the systemwide UPMC-Highmark contractual relationship that the Attorney General seeks to coerce here. UPMC Exhibit D at 3; UPMC Exhibit E at ¶ 146(e). General Shapiro cannot now re-interpret the "public interest" differently than the Approving Order in order to force a never-ending UPMC-Highmark contract.

Merely stating General Shapiro's position demonstrates its absurdity. As the Attorney General and the other Commonwealth agencies have recognized, they have no authority to

[3] This also puts the lie to General Shapiro's claim that UPMC is "estopped" from defending this action because it agreed to the modification provision. OAG Opp. at 8. The point is not whether the provision is "inoperative" but whether Count I can state a claim under that provision. Nothing about the provision allows General Shapiro to back-door a completely new consent decree, as he seeks to do in Count I.

require UPMC and Highmark to contract. UPMC Exhibits G and L at 1. But because UPMC signed a Consent Decree—one that expressly acknowledged that it was not a contract extension, provided a termination date of all existing contracts, and stated that it must be interpreted consistently with the PID's prior public-interest assumption there would be no contract—General Shapiro contends he can now require UPMC and Highmark to contract in perpetuity for the public interest. Such a reading improperly overtakes the original purpose, violates the material terms of the parties' agreement, and must be rejected. *Hazell*, 40 A.2d at 560.

Underlying General Shapiro's modification request is the suggestion that UPMC is not acting in accordance with law. But that is a different question. If the Attorney General believes that UPMC has violated the law by not extending its contracts with Highmark, he can file a complaint and the parties can litigate the claims.[4] He cannot, however, try to short circuit the process and impose such a remedy through "modification" of the Consent Decree.

B. General Shapiro's Interpretation Of The Modification Provision Violates Established Law.

General Shapiro's interpretation of Section IV.C.10 also fails for the additional reason that a contract cannot be construed in a way that is contrary to the law. As the Supreme Court made clear in interpreting this Consent Decree, "we do not countenance the interpretation of a contract which would render it illegal or incapable of performance." *Commonwealth ex rel. Kane v. UPMC*, 129 A.3d 441, 467-68 (Pa. 2015). The Attorney General's opposition concedes that the Consent Decree contemplated an end to the parties' *commercial* contracts but suggests the Court must modify the Consent Decree to impose future systemwide contracts, including

[4] For all the reasons stated in UPMC's motion to dismiss, including the fact that he released the claims, General Shapiro has no such action.

commercial contracts, because it was not known then that UPMC would not continue to contract for Highmark's *Medicare* plans.[5] *See* OAG Opp. at 2, 4. But the Attorney General has no jurisdiction over Medicare. He thus interprets the modification provision to permit this Court to overwrite federal statutes and regulations governing the Medicare Advantage program ("MA")—something that Congress has specifically directed that state officials and judges cannot do.

Medicare Advantage is a federally funded program overseen exclusively by the federal government. Under that program, "a private insurance company … contracts with the federal government ["CMS"] and … manages the administration of Medicare benefits and pays claims." *Kane*, 129 A.3d at 452 (describing evidence). Congress' underlying intent was to harness private competition in order to "create a more efficient and less expensive Medicare system." *In re Avandia Mktg., Sales Practices & Prod. Liab. Litig.*, 685 F.3d 353, 363 (3d Cir. 2012). The program is subject to extensive federal regulation regarding, for instance, the adequacy of each MA plan's provider network. *See, e.g.*, 42 U.S.C. §§ 1395w-21 – 1395w-28; *see also* 42 C.F.R. §§ 422.1 – 422.2615.

These federal laws expressly preempt *any* state regulation of the Medicare Advantage program. *See* 42 U.S.C. § 1395w-26(b)(3) ("The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA [insurers] under this part."). Thus, "all State standards, *including those established through case law*, are preempted to the extent that they specifically would regulate [Medicare Advantage] plans, with exceptions of

[5] The Consent Decree terminates in full on June 30, 2019, including as to Medicare Advantage contracts, as the Pennsylvania Supreme Court has already held. *Shapiro*, 188 A.3d at 1132. The same arguments in Part I.A, *supra*, fully apply to any request for relief related to Medicare Advantage. Medicare preemption is an additional reason why General Shapiro's "unlimited" construction of the modification provision is wrong as a matter of law.

State licensing and solvency laws." 70 Fed. Reg. 4665 (emphasis added). Judge Pellegrini previously applied this preemption statute in rejecting an earlier attempt by the Attorney General to interpret the 2014 Consent Decrees in such a way that would interfere with Medicare Advantage. *See* Oct. 30, 2014 Mem. Opinion at 18 ("Insofar as the Commonwealth claims that the written materials CMS expressly approved are 'misleading,' we find the Commonwealth's claim preempted.").[6] The Court accordingly cannot impose any new Medicare Advantage requirements on UPMC.

Even more troubling, General Shapiro's opposition expressly states an intent to *force* UPMC into a Medicare Advantage contract with Highmark. *See* Opp. at 24. Mandatory contracting, however, specifically violates both the letter and spirit of the federal law governing Medicare Advantage. In what is known as the "noninterference" statute, Congress expressly prohibited CMS from requiring that insurers contract with particular providers or include specific price structures in their provider contracts. 42 U.S.C. § 1395w-24(a)(6)(B)(iii). General Shapiro nevertheless interprets the modification provision to allow this Court—over UPMC's objection—to force Medicare Advantage contracts between UPMC and Highmark (*see* Exhibit G to Petition at ¶¶ 3.2, 3.3), force UPMC not to bill certain fees for services to Medicare enrollees (*id.* ¶ 2.26, 3.6), and force arbitrated rates for those services (*id.* ¶ 4.3.4). General Shapiro's opposition does not offer any basis for interfering with Medicare Advantage. The Court cannot override federal law, and it cannot—as both Judge Pellegrini and the Supreme Court already held

[6] *Available at Commonwealth v. UPMC*, 334 M.D. 2014, 2014 Pa. Commw. Unpub. LEXIS 652, at *22 (Pa. Commw. Ct. Oct. 30, 2014). *See also, e.g.*, *Mass. Ass'n of HMOs v. Ruthardt*, 194 F.3d 176, 177 (1st Cir. 1999) (preempting regulatory actions by state officials seeking to expand the benefits available under Medicare Advantage plans); *Pacificare of Nev., Inc. v. Rogers*, 266 P.3d 596, 600 (Nev. 2011) (preempting actions based on state contract and tort law concerning operation of an insurer's network); *Meek-Horton v. Trover Sols., Inc.*, 915 F. Supp. 2d 486, 492 (S.D.N.Y. 2013) (same).

in this case—achieve the same result through an overbroad interpretation of the modification provision. Count I fails as a result. *See, e.g.*, *Dippel v. Brunozzi*, 74 A.2d 112, 114 (Pa. 1950) (the "general rule" is that an agreement "which violates a provision of a statute" is illegal and void).[7]

C. General Shapiro's Interpretation Violates Separation Of Powers.

General Shapiro tries to defend his proposed modification as a simple exercise of his "'ancient powers of guardianship'" over nonprofits and charitable trusts. OAG Opp. at 17 (quoting *Pruner Estate*, 136 A.2d 107, 109 (Pa. 1957)). Repeatedly, General Shapiro retreats for the cover of his *parens patriae* status. That misses the point. Count I is not about nonprofit laws, charitable trusts, or standing to intervene. It is about how to interpret a provision that allows the Court to "modify" the 2014 Consent Decree in the "public interest." That provision is either (1), as UPMC maintains and caselaw indicates, a safety valve that allows the Court to clarify existing obligations where necessary to effectuate the intent of the original Consent Decree, *Fox*, 680 F.2d 315; or (2), as General Shapiro argues, an unlimited license to bring unprecedented causes of action for the sake of imposing any form of injunction on UPMC without regard for the parties' agreement, OAG Opp. at 9.

It cannot be the latter. General Shapiro's interpretation effectively transfers to the Attorney General and this Court authority to determine the public interest, a role that exclusively resides in other branches of government. *See* UPMC Br. at 37-39; *see also* Proposed Brief for *Amicus Curiae* Senate President Pro Tempore Joseph B. Scarnati, III. What General Shapiro

[7] In a separate action that certain UPMC subsidiaries filed in federal court seeking a declaration that the Medicare Act preempts General Shapiro's new requirements for nonprofit MA insurers, General Shapiro did not contest that those insurers had stated a claim, and intimated that he might just not enforce the proposed modified consent decree at issue here to the extent it purports to alter rights and obligations set forth in federal law. *See* OAG Br. at 11 n.1, Dkt. 42, *UPMC Pinnacle v. Shapiro*, No. 19-298 (M.D. Pa. 2019), attached hereto as Exhibit T.

presents as a "modification" is in fact a complete repudiation of the existing Consent Decree that replaces all of the agreement's terms with new, dramatically different, and perpetual obligations that would begin when the original Consent Decree ends. And, these new obligations would govern how healthcare is delivered for millions of Pennsylvanians and impact the economics of healthcare for third-party insurers and providers not party to this proceeding.

That is not "modifying." It is using the proxy of court proceedings and the pretense of modification to legislate General Shapiro's unilateral vision of the "public interest." The result will be an unprecedented proceeding well beyond the judiciary's purview. Deciding how healthcare should be accessed and delivered in Pennsylvania requires studied deliberation by legislators, who can convene hearings, take input from a broad array of stakeholders, and debate a multiplicity of different options before deciding how best to effectuate the public interest. It is uniquely the function of the legislature to address such matters – and notably, the legislature has repeatedly *rejected* policies like what General Shapiro proposed here. *See* UPMC Br. at 35 (detailing legislative rejections of the policy undergirding his proposed "modifications").

In contrast, General Shapiro wants this Court to set healthcare for Pennsylvania, and to do so in the context of an expedited lawsuit he filed against UPMC with limited discovery. General Shapiro has no statutory or other basis for forcing hospitals to contract because he may think it is in the "public interest"—a point that is undisputed. *See* UPMC Br. at 7-8, 10 (discussing testimony from Mr. Donahue and statements of PID).[8] Similarly, there is no legal

[8] Indeed, in separate proceedings, General Shapiro contends that the proposed modifications he wants this Court to order do not reflect the law of the land. *See* Exhibit T at 10. General Shapiro has only such powers and duties as the General Assembly has conferred by statute. *See, e.g.*, 71 P.S. § 732-101, *et seq.*; *Commonwealth v. Carsia*, 517 A.2d 956, 957-58 (Pa. 1986). Those exercises and delegations do not include re-making healthcare delivery. Highmark's own opposition brief only reinforces that limitation. Highmark relies on three cases to argue that General Shapiro's *parens patriae* authority empowers him to unilaterally impose the terms of a new decree on UPMC "into perpetuity." Highmark Br. at 39. Of those

cause of action for "public interest." This Court has no standards, precedent, claim elements or defenses to allow it to decide the nakedly public policy question: how should Pennsylvanians best access and receive their healthcare? Because that is not the function of the judiciary. The modification provision must be interpreted to respect that constitutional limitation on the court's authority. *See Kane*, 129 A.3d at 467-68 (consent decrees must be interpreted consistent with the law); *see also Cotlar v. Warminster Twp.*, 302 A.2d 859, 862 (Pa. Commw. Ct. 1973) ("[W]e are all best served by the continual awareness that we are subject to a government of laws and not of men.").

II. Count I Is Barred As A Matter Of Law.

Count I separately fails for the independent reason that General Shapiro is precluded from seeking mandatory contracts between UPMC and Highmark. With respect to commercial services, the Attorney General expressly released UPMC from any claim based on its refusal to contract with Highmark—a fact that General Shapiro does not even dispute. With respect to non-commercial Medicare Advantage services, the Attorney General fails to demonstrate that any claim can survive the parties' prior litigation and the Supreme Court's 2018 holding that the Consent Decree ends June 30, 2019.

A. Any Claim Based On UPMC's Failure To Contract With Highmark For Commercial Services Was Released.

The Attorney General's opposition all but concedes that any claim against UPMC was released insofar as it is based on the failure to contract with Highmark for commercial services to non-Medicare members. As General Shapiro acknowledges, Section IV.C.5 of the 2014 Consent

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cases, however, two did not involve a consent decree at all, while the other only ordered perpetual relief *because all of the parties expressly agreed to it*. That case only bolsters UPMC's argument. *See Commonwealth v. Philip Morris, Inc.*, 40 Pa. D. & C. 4th 225, 233 (Pa. Com. Pl. 1999) (noting the parties' agreements were "a major accomplishment because they *exceed the kind of injunctive relief that this court would have been able to extend*[.]") (emphasis added).

Decree "releases … those claims the Commonwealth brought or could have brought relating to facts alleged or encompassed within its decree for the period July 1, 2012 to the date of filing, *i.e.*, June 27, 2014." OAG Opp. at 13.

The scope of that release covers UPMC's decision not to have a commercial contract with Highmark. That decision was made in 2013—squarely within the release period—and was expressly encompassed in the original 2014 Petition for Review that initiated this case, which alleged that on "June 12, 2013, UPMC's Board of Directors allegedly resolved, *inter alia*, to forego 'any extension of the existing commercial contracts, or any new commercial contracts, providing Highmark with in-network access to any current UPMC hospitals or physicians in Southwestern Pennsylvania beyond'" certain exception services and hospitals. UPMC Exhibit A ¶ 33; *see* UPMC June 12, 2013 Board Resolution and Background Statement, attached hereto as Exhibit U.[9] Any refusal to contract with Highmark for commercial services stems from that board resolution. The Attorney General not only expressly released UPMC from any claim based on that refusal, but separately agreed that *not* extending the UPMC-Highmark commercial contracts complied with all health, insurance, nonprofit, and charitable laws. Consent Decree § IV.C.6. Count I must therefore be dismissed to the extent it seeks relief for UPMC's refusal to contract with Highmark for commercial services.

B. General Shapiro Cannot Now Seek Relief Based On The Expiration Of Medicare Advantage Contracts.

To get around the clear release of the commercial contracts, General Shapiro argues that the existing Consent Decree was never intended to help transition seniors in Highmark's *non-*

[9] With the assistance of the Governor's office and PID, UPMC has contracted with Highmark for these UPMC exception hospitals and services beyond 2019. UPMC Western Psychiatric Hospital and UPMC Children's Hospital of Pittsburgh, for instance, remain under contract with Highmark—though General Shapiro omits that point from his Petition to Modify.

commercial plans to being out-of-network for UPMC. OAG Opp. at 1-2 & n.1. But the Supreme Court has already decided two prior disputes concerning Medicare Advantage and expressly affirmed the end-date for in-network access to those services under the Consent Decree. *See, e.g.*, UPMC Br. at 8-9. None of General Shapiro's arguments save Count I from the effect of those prior rulings.

The Supreme Court held in 2015 that UPMC was free to terminate its then-existing Medicare Advantage contracts with Highmark at any time, so long as UPMC had *some* Medicare Advantage contract with Highmark through the end of the Consent Decree. *See Kane*, 129 A.3d at 469. Then, in September 2017, UPMC served notice that in-network access for Highmark's Medicare Advantage members would end June 30, 2019. General Shapiro sued to extend that date, and the Supreme Court held in no uncertain terms that the Consent Decree's termination date—including for Medicare Advantage—was "an *unambiguous* and *material term*." *Shapiro*, 188 A.3d at 1132 (emphasis added). Those rulings are binding and preclude any claim in Count I based on termination of the Medicare Advantage contracts. *See* UPMC Br. at 15-17, 19.[10]

General Shapiro unpersuasively argues that the prior Supreme Court proceeding did not entail a request for modification. OAG Opp. at 11. That is irrelevant. As General Shapiro concedes, what matters is only whether he "'had an *opportunity* to appear and assert'" his rights. *Id.* (quoting *Stevenson v. Silverman*, 208 A.2d 786, 788 (Pa. 1965) (emphasis added)). That opportunity is undisputed. General Shapiro brought the case in 2017 knowing that UPMC asserted in-network Medicare Advantage access would end in June 2019, and with every

[10] And, as noted above, federal law preempts any state law standards that purport to regulate the operation of Medicare Advantage in any event. *See* Part I.B, *supra*.

opportunity to ask the court to modify that date.[11] He chose not to, despite ample notice and opportunity to frame the issues and seek relief. That requires now dismissing any reliance on the end of Medicare Advantage contracting. *See, e.g.*, *Gesiorski v. Branch Banking & Tr. Co.*, No. 13-606, 2013 WL 1952385, at *4 (M.D. Pa. May 10, 2013) (recognizing that, under Pennsylvania law, "the proper inquiry [for claim preclusion] is whether the claims *could have been* litigated"). "A party cannot escape operation of the bar of *res judicata* by varying the form of action or adopting a different method of presenting the case. Nor can one avoid the consequences of the prior judicial adjudication merely by altering the character of the relief sought." *Swift v. Radnor Twp.*, 983 A.2d 227, 232 (Pa. Commw. Ct. 2009) (citation omitted).[12]

General Shapiro asks for lenience based on a case regarding zoning matters. *See* OAG Opp. at 11-12 (citing *Callowhill Ctr. Assocs. v. Zoning Bd. of Adjustment*, 2 A.3d 802, 809 (Pa. Commw. Ct. 2010)). But the court in *Callowhill* dismissed a claim because the petitioners "had the opportunity to appear and assert their rights" in the prior proceeding. *Callowhill*, 2 A.3d at 809. Regardless, this is a far cry from a zoning matter where General Shapiro should have leave to alter a requested variance for the size of a yard sign. His office has repeatedly and publicly misled consumers about the Consent Decree. The Attorney General negotiated and publicized an

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[11] In fact, in a conference before hearing argument on General Shapiro's request to extend the Consent Decree, on January 17, 2018, Judge Pellegrini informed the Attorney General's Office that it must proceed under all theories, including modification under Section IV.C.10, because this was their "one shot." This is one of the reasons UPMC has sought the deposition of Mr. Donahue, who has refused to stipulate to the Court's directive.

[12] This also disposes of General Shapiro's alternative argument that the issues in the 2018 Supreme Court decision were not "identical." OAG Opp. at 12. They did not need to be identical in order for Count I to be precluded. *See, e.g.*, *Balent v. City of Wilkes-Barre*, 669 A.2d 309, 313 (Pa. 1995) ("*Res judicata* applies not only to claims actually litigated, but also to claims which *could have been litigated* during the first proceeding if they were part of the same cause of action.") (emphasis added). Moreover, the Supreme Court's 2018 decision held that in-network access to UPMC under the Consent Decree would end on June 30, 2019. That General Shapiro now tries to collaterally attack that holding with a "request to modify" is exactly the kind of second bite at the apple that courts preclude. *Id.*

unambiguous five-year term for the Consent Decree. When UPMC sought to terminate its Highmark Medicare Advantage contracts coincident with that end-date, General Shapiro sued to extend the date. Now, seven months after he lost that case, General Shapiro—with another big press conference—filed this request to "modify" a deadline that the Supreme Court has already affirmed. *Res judicata* and collateral estoppel preclude his second bite at the apple.[13]

III. The Attorney General Identifies No Well-Pleaded Facts Demonstrating That The Requested Modification Is In The *Public* Interest.

Count I finally fails because it does not allege that each of the proposed modifications would serve the public interest. The deficiency in General Shapiro's pleading is captured perfectly in the heading in his opposition brief on this point: "The Commonwealth's Proposed Modified Consent Decree Serves the Public Interest by Prohibiting UPMC's Unjust Enrichment Through its Practice of Balance Billing Out-of-Network Patients Based Upon its Published/Chargemaster Rates Rather than the Reasonable Value of its Services." OAG Opp. at 27. Notwithstanding that this heading would apply to virtually every hospital in the Commonwealth, there are no allegations in the Petition that justify forced contracting as the solution to this alleged problem; indeed, there is no attempt *anywhere* to justify forced

[13] The other case on which General Shapiro principally relies is a Kansas federal decision that was not decided under Pennsylvania law and, in any event, is entirely inapposite to the instant dispute. *See Raab Sales, Inc. v. Domino Amjet, Inc.*, 530 F. Supp. 2d 1192 (D. Kan. 2008) (holding that *res judicata* did not bar a claim that could have been asserted as a counterclaim in an Illinois proceeding because, under Illinois procedure, counterclaims were not mandatory). Highmark's arguments are similarly frivolous. Highmark throws up a smokescreen about "claim splitting" (something virtually no *res judicata* cases actually discuss) and contends that Supreme Court's decision in *Shapiro* was not a "final judgment." Highmark Br. at 21, 22, n.4. But the Supreme Court's certified opinion and the docket sheet for the matter both expressly state "Judgment Entered 07/18/2018." Highmark also argues the Attorney General is not susceptible to "ordinary court rules" like preclusion. *Id.* at 15. Not even General Shapiro takes that extreme position, which is also wrong as a matter of law. *See, e.g.*, *Commonwealth v. Brown*, 260 F. Supp. 323, 343 (E.D. Pa. 1966) (applying Pennsylvania preclusion law to the Attorney General), *vacated in part on other grounds*, 373 F.2d 771 (3d Cir. 1967).

contracting. This is a clear failure to state a claim upon which relief can be granted—particularly where the PID's Approving Order (with which the Consent Decree consistently must be interpreted, *see* Consent Decree § I.A) states that a systemwide UPMC/Highmark contract would *not*, absent specified evidence, be in the public interest. UPMC Br. at 4-5; *see also Line Lexington Lumber & Millwork Co., Inc. v. Pennsylvania Publ'g Corp.*, 301 A.2d 684, 688 (Pa. 1973) ("As a minimum, a pleader must set forth concisely the facts upon which his cause of action is based.").[14]

Indeed, in a complex economic market such as healthcare, the public interest cannot be defined by anecdotal examples and without acknowledging that government interference could have significant downsides, something the Attorney General's office has done outside the courtroom. When the lead prosecutor in this case, James A. Donahue, III, testified in October 2014 before a legislative committee—to *defend* the Consent Decree as the best deal that the Commonwealth could have obtained—he noted the dangerous unpredictability of the healthcare industry as a specific reason to disfavor government interference in contracting disputes among healthcare insurers and providers: "That ability to walk away forces each side to be reasonable in most circumstances," and the Attorney General's Office concluded that "putting our finger on

[14] In a case such as this, where the Attorney General seeks to enjoin UPMC to undertake specific action, even more specificity is required. The Court cannot issue an injunction imposing each of the proposed modifications without a demonstration that the modification is carefully tailored to remedy a specific harm. *See, e.g.*, *N.A.A.C.P. v. City of Phila.*, Civil Action No. 11-6533, 2014 WL 7272410, at *1 (E.D. Pa. Dec. 19, 2014) ("'Injunctions, which carry possible contempt penalties for their violation[,] must be tailored to remedy the specific harms shown rather than to enjoin all possible breaches of the law.' Accordingly, the Court may grant injunctive relief only for harms on which Plaintiff has met its burden of proof.") (quoting *Davis v. Romney*, 490 F.2d 1360, 1370 (3d Cir. 1974)); *see also, e.g.*, *Eagleview Corp. Ctr. Ass'n. v. Citadel Fed. Credit Union*, 150 A.3d 1024, 1030 n.6 (Pa. Commw. Ct. 2016) ("[I]njunctions should be drawn narrowly."). The Court has set trial in just over two months. It is fundamentally unfair to require UPMC to go to trial on whether General Shapiro's proposed modifications are in the public interest when he has failed to even meet the most basic pleading requirements. UPMC should not have to wait until trial to hear why General Shapiro filed the Petition.

the scale in favor of one side or the other changes that dynamic in ways that are unpredictable."[15] The unpredictable response to these "modifications" is only heightened when the Commonwealth agencies best equipped to regulate healthcare—PID and DOH—continue to refuse to join in General Shapiro's aggressive demand.

On its face, General Shapiro's proposed modification is not even consistent with his conclusory interest in "public" access to UPMC. OAG Opp. at 29. The Attorney General falsely equates public access to UPMC with in-network access to UPMC *through Highmark*. *Id.* at 24, 26 (lamenting the lack of a UPMC-Highmark contract). But consumers have multiple choices for non-Highmark insurers, all of which offer plans providing in-network access to UPMC. Seniors, in particular, can chose from more than 20 plans that offer in-network access to UPMC. And where consumer choice in insurers is limited, UPMC has contracted with Highmark. *See* OAG Opp. at 4 (describing 2018 agreement mediated by the Governor's office). That people may choose to purchase a plan without UPMC in-network does not mean they lack access.

Nor does General Shapiro's proposed modification on its face actually provide in-network access to UPMC through Highmark. As General Shapiro concedes in footnote 17, *Highmark still can exclude UPMC from its plans*. Even if this Court grants his Petition, there is no indication that increased in-network access will follow. To be sure, requiring every non-profit hospital to provide its services for free sounds good, but that does not mean it would increase access to services because soon the public would have no available services; as is often

[15] *See* UPMC Exhibit G (James A. Donahue, III, Testimony before Pennsylvania House Democratic Policy Committee, October 10, 2014, video available at https://wdrv.it/39aa0b6df).

said in non-profit circles, "no margin means no mission."[16] General Shapiro's bald allegations of public interest are the equivalent of economic malpractice and should not be allowed to stand.

At bottom, this is not a proposal in the public interest but rather a proposal in Highmark's interest. The requested modification would not only permit Highmark to tier providers and steer patients away from UPMC (and into its own health system) by requiring its members to make cost-prohibitive payments in order to access UPMC, but to also exclude UPMC entirely when it suits Highmark's needs. By arming Highmark with these exclusionary tools, the Attorney General would nullify the very interest he is purportedly seeking to promote: affordable, in-network access to UPMC through compelled contracts.

Highmark's imperative to keep its subscribers from affordably accessing UPMC is not news to the Attorney General. Just months after the Consent Decrees were signed, Highmark created new Medicare Advantage plans that excluded in-network access to UPMC—a decision affirmed by this Court as authorized by the Consent Decree. *See generally* Oct. 30, 2014 Mem. Opinion, *Commonwealth v. UPMC*, 2014 Pa. Commw. Unpub. LEXIS 652. And, as the Attorney General also knows, ever since the Consent Decree was executed, non-Highmark Blue Cross/Blue Shield plans have refused to sign direct, in-network contracts with UPMC for their members, repeatedly denying their members affordable access to UPMC. Yet, the Attorney

[16] As General Shapiro is well aware, UPMC's board of directors concluded, similar to the PID, that broad access to UPMC's services would be best preserved by *not* contracting with Highmark. When Highmark acquired its own hospital system, Highmark indicated that it intended to use its share of the insurance market to move more than 41,000 in-patient admissions annually from UPMC hospitals into Highmark's own hospital system—the equivalent of closing, for example, two of UPMC's most used and highly regarded Pittsburgh-based hospitals, UPMC Shadyside and UPMC Mercy. UPMC's board determined that in such an event, UPMC would be unable to offer the services on which many communities rely. Not extending its in-network contracts was the only way to prevent that from happening. *See* Exhibit U.

General has turned a blind eye to this, doubling down on his model of exclusion and making a mockery of the very public interest he purports to support.[17]

General Shapiro seeks to impose radical, sweeping "modifications" that represent a dramatic reversal from prior practice. The Court should demand more than his "say so" before allowing a claim to proceed. The Petition needed to plead specific facts demonstrating why the modifications are necessary and how they are properly tailored to the alleged problems. It did not, and the Court should dismiss the Petition.

CONCLUSION

The Consent Decree arose from the Commonwealth's desire to promote an orderly wind-down of the UPMC-Highmark relationship. Now, on the eve of the expiration of that five-year Consent Decree, General Shapiro wants to change the rules and say that this orderly wind-down, all along, violated Pennsylvania law.

This Court should reject General Shapiro's improper attempt to "modify" the Consent Decree out of existence. If General Shapiro wants to bring a separate complaint against UPMC seeking this relief, he can bring it after the Consent Decree expires (with well-pleaded allegations that—unlike here—demonstrate how his proposed injunctive relief serves the public interest). But he cannot smuggle his proposed, wide-ranging relief through the Consent Decree's modification provision.

[17] That non-Highmark Blue Cross/Blue Shield members could have in-network "access" to UPMC if UPMC signed a system-wide contract with Highmark is of no import. The only access these members would have is through Highmark, which would be able to tier, steer and exclude them from UPMC with the Attorney General's blessing. The only way these members would secure unfettered in-network access is if their non-Highmark Blues contract with UPMC directly.

For the foregoing reasons, this Court should dismiss General Shapiro's Petition for Modification.

Dated: March 18, 2019

Respectfully submitted,

COZEN O'CONNOR

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CERTIFICATE OF SERVICE

I hereby certify that on this 18th day of March, 2019, I submitted the foregoing Reply in Support of Respondent UPMC's Motion to Dismiss the Petition to Modify Consent Decrees, or Preliminary Objections in the Nature of a Demurrer for electronic service via the Court's electronic filing system on Petitioner, The Office of Attorney General, and Respondent, Highmark, on the following:

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EXHIBIT S

LM

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 Heard: January 17, 2018

BEFORE: HONORABLE DAN PELLEGRINI, Senior Judge

OPINION NOT REPORTED

MEMORANDUM OPINION BY
SENIOR JUDGE PELLEGRINI

FILED: January 29, 2018

Before us is the motion of the Commonwealth of Pennsylvania, acting through its Attorney General, Josh Shapiro,[1] to enforce consent decrees (Petition to

[1] The Attorney General of the Commonwealth has the responsibility to supervise public charities through its *parens patriae* powers. *See In re Estate of Coleman*, 317 A.2d 631 (Pa. 1974); *In re Milton Hershey School Trust*, 807 A.2d 324 (Pa. Cmwlth. 2002). This *parens patriae* power arises when the Commonwealth asserts quasi-sovereign interests, which are interests that the Commonwealth has in the well-being of its populace. *Commonwealth ex rel.*
(Footnote continued on next page...)

Enforce) seeking to mandate UPMC to continue to contract for Medicare Advantage plans with UPE, also known as Highmark Health and Highmark, Inc. (collectively, Highmark), for all of 2019 by prohibiting UPMC from terminating its contract – that gives Highmark Medical Advantage Plan subscribers access to UPMC hospitals – prior to the expiration of the consent decree.

I.

A.

By order dated July 1, 2014, this Court approved and entered two separate but parallel consent decrees (collectively, Consent Decree) with mirror terms between the Commonwealth and Highmark and between the Commonwealth and UPMC, another nonprofit corporation. There are two consent decrees because UPMC and Highmark refused to contract directly with each other. The purpose of the Consent Decree was to ensure access for Highmark subscribers at in-network rates during a period of transition to enable them to decide whether to remain with Highmark or change insurance carriers so that they would have continued access to UPMC facilities. In negotiating the subject consent decrees, the Commonwealth attempted to lessen the anxiety of Highmark subscribers by providing certainty as to what would occur during transitional periods and providing a basis by which

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(continued...)

Pappert v. TAP Pharmaceutical Products, Inc., 885 A.2d 1127, 1143 (Pa. Cmwlth. 2005). The Nonprofit Corporation Law of 1988, 15 Pa. C.S. §§ 5101-5997, also granted the Attorney General additional powers to take certain actions regarding non-profits and charities if they veer away from their charitable missions. Highmark and UPMC are both non-profit corporations, and UPMC is also recognized as a purely public charity, thus exempt from taxation.

Highmark subscribers and others who sought to buy Highmark insurance could make informed decisions regarding their healthcare.

By the terms of the Consent Decree, this Court retained jurisdiction "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." (UPMC Consent Decree § IV(C)(11).) The Consent Decree expires on June 30, 2019.[2]

B.

On September 27, 2017, Highmark filed a Motion for Expedited Adjudication of Special Injunction Pending Hearing and for Contempt. Like the other petitions to enforce that had been previously filed in this matter, the underlying dispute involved Highmark Medicare Advantage (MA) Plans. Highmark's motion asserted that:

> (1) UPMC sent notices dated September 26, 2017 purporting to terminate 10 hospital Medicare Acute Care Provider Agreements with Highmark effective December 31, 2018;
>
> (2) UPMC intended to distribute advertising materials for the 2018 MA open enrollment period stating that UPMC

[2] A more complete recitation of the underlying facts and extensive background of this case can be found in this Court's previous decisions, *Commonwealth of Pennsylvania v. UPMC* (Pa. Cmwlth., No. 334 M.D. 2014, filed October 30, 2014 and June 29, 2015), as well as the Supreme Court of Pennsylvania's decision affirming this Court's opinion, *Commonwealth ex rel. Kane v. UPMC*, 129 A.3d 441 (Pa. 2015).

would not participate in Highmark MA networks for the full 2019 calendar year; and

(3) UPMC intended to terminate many of its physician contracts with Highmark under which those physicians provide MA services to Highmark vulnerable population subscribers.

(Highmark's "Verified Motion for Expedited Adjudication of Special Injunction Pending Hearing and For Contempt" dated September 27, 2017.) It also alleged that UPMC's intent to terminate violates the parties' obligation to continue to contract for vulnerable population services for the full period of the Consent Decree.

At the October 19, 2017 hearing on Highmark's motion, Highmark withdrew its request for an expedited hearing due to certain understandings it reached with UPMC. While it had not yet filed a petition to enforce, at the same hearing, the Commonwealth stated that it supported Highmark's position and would file a separate petition to enforce. On the same day, an order was issued directing the Commonwealth to file the petition by a certain date and scheduling a hearing.

At that scheduled hearing, no evidence was taken on the Commonwealth's Petition to Enforce because the parties agreed that the issue involved is a strictly legal determination based on a textual analysis of the Consent Decree and the Medicare Acute Care Provider Agreement (Provider Agreement).

II.

A.

The provision of the Consent Decree for which an interpretation is sought is Section IV(A)(2) of the UPMC Consent Decree, which gives Highmark MA Plan subscribers access to UPMC facilities. That section provides:

> **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.

(UPMC Consent Decree § IV(A)(2)) (emphasis added).

The dispute centers on what is meant by UPMC's obligation to "continue to contract" with Highmark until June 30, 2019, to provide in-network access to Highmark MA Plan subscribers.

The contract with which UPMC must "continue to contract" under the Consent Decree is the Provider Agreement between UPMC and Highmark that commenced on January 1, 1999. The Provider Agreement established the terms and conditions for the provision and payment of certain healthcare services for individuals enrolled in Highmark's MA Plans while being treated at a UPMC facility. The Agreement had an initial term of 4 years and would automatically renew from contract year to contract year thereafter, unless terminated by either party. The Agreement was subsequently renewed and amended several times, including on January 1, 2002 and July 1, 2012.

B.

UPMC plans to terminate the Provider Agreement on December 31, 2018, but does not dispute that under the Consent Decree it must "continue to contract" with Highmark until June 30, 2019, to provide Highmark subscribers with access to UPMC facilities.

UPMC contends that it will still remain in contract and allow access to UPMC facilities under Section 16.3 of the Provider Agreement, which provides for a 6-month "runout" period in the event of termination of the Provider Agreement, as follows:

> In the event of termination of this Agreement for any reason other than default by Provider, the Provider shall be obligated to continue to comply with the terms and conditions of this Agreement and continue to provide services to Health Plan's Members for six (6) months after the date on which the termination becomes effective. For services rendered during this six (6) month

> period, Provider shall accept Health Plan's payment rates in effect on the termination date.
>
> In addition to the rights stated herein, the non-defaulting party shall have any and all remedies otherwise available at law or in equity, including, without limitation, specific performance.

(Amendment to Provider Agreement § 16.3, effective January 1, 2002.)

UPMC argues that it will continue to contract with Highmark because the runout clause is a contract with written terms and conditions, including rates to which the parties mutually agreed to be bound. It contends that it does not matter whether UPMC provides in-network access to Highmark subscribers for the first six months of 2019 under the standard Provider Agreement or the runout provision because, in either case, it will "continue to contract" with Highmark under the Consent Decree until it expires on June 30, 2019.

The Commonwealth disagrees with UPMC's interpretation. It contends that, pursuant to the plain language of the parties' Consent Decree, UPMC must be in a contract with Highmark for the provision of MA Plans through June 30, 2019, and by "contract" that means the entire Provider Agreement must remain in effect. The Commonwealth contends that Section 16.3's 6-month runout clause expressly applies only "after the date on which the termination becomes effective," meaning that this provision does not continue the contractual relationship between the parties and is not, in and of itself, a contract.

Because the entire Provider Agreement must be in effect until June 30, 2019, the Commonwealth then contends that under Paragraph 5 of the 2012

Amendment the Provider Agreement must remain in effect for the entire calendar year. That provision provides that the Provider Agreement will "automatically renew from year to year thereafter (Contract Year) unless either party provides written notice of termination, not later than April 1 of the Contract Year." (2012 Amendment to the Provider Agreement.) The Commonwealth argues that while UPMC can give notice of termination before April 1 of any year under the Provider Agreement, under Paragraph 5 of the 2012 Amendment the Provider Agreement remains in effect for the entire contract year – *i.e.*, until December 31, 2019 – once notice of termination is given. If UPMC gives notice of termination, then Section 16.3's 6-month runout provision applies, extending Highmark MA subscribers' in-network access to UPMC hospitals until June 30, 2020. Highmark agrees with the Commonwealth's position.

III.

A.

As our Supreme Court has stated:

> [A] consent decree is a contract which has been given judicial sanction, and, as such, it must be interpreted in accordance with the general principles governing the interpretation of all contracts. *International Organization Master, Mates & Pilots of America, Local No. 2 v. International Organization Masters, Mates & Pilots of America, Inc.*, 439 A.2d 621, 624-25 ([Pa.] 1981). In interpreting the terms of a contract, the cardinal rule followed by courts is to ascertain the intent of the contracting parties. *Lesko v. Frankford Hospital-Bucks County*, 15 A.3d 337, 342 ([Pa.] 2011). If the contractual terms are clear and unambiguous on their face, then such terms are deemed to be the best reflection of the intent of the parties. *Kripp v. Kripp*, [ ] 849 A.2d

> 1159, 1162 ([Pa.] 2004). If, however, the contractual terms are ambiguous, then resort to extrinsic evidence to ascertain their meaning is proper. *Murphy v. Duquesne University Of The Holy Ghost*, [ ] 777 A.2d 418, 429 ([Pa.] 2001). A contract's terms are considered ambiguous "if they are subject to more than one reasonable interpretation when applied to a particular set of facts." *Id.* at 430.

Commonwealth ex rel. Kane v. UPMC, 129 A.3d 441, 463 (Pa. 2015).

B.

Before attempting to address the provisions of the Consent Decree and Provider Agreement at issue, some background of MA Plans is needed.

MA Plans are one of three ways Medicare-eligible consumers can receive their Medicare benefits. *See* 42 U.S.C. §§ 1395W-21-28. Those three ways are: (1) original Medicare with the beneficiary paying the resulting co-pays and deductibles; (2) original Medicare with a Medicare Supplement Plan, which will pay for some of Medicare's co-pays and deductibles; or (3) an MA Plan, which typically has lower co-pays and deductibles than original Medicare and often includes benefits that are not part of original Medicare like Vision, Dental and Hearing coverage.

MA Plans are offered by private companies that are approved by the Center for Medicaid and Medicare Services (CMS). Under an MA Plan, a person still has Medicare but the Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage is paid from the MA Plan and not regular Medicare – *i.e.*, where benefits are paid directly by the government. All MA Plan

companies must have a contract with CMS. 42 U.S.C. § 1395W-27. Under that contract, CMS agrees to pay a set sum for an eligible person's care for the entire year. Correspondingly, the MA Plan provides coverage for a full calendar year, and agreements that provide access to providers are also for the entire year. *Id.* at (c).

Medicare-eligible consumers choose an MA Plan during the period of October 15 through December 7. The plans cover the payment of medical expenses for the period of January 1 to December 31 of the following calendar year.

To fulfill its obligations under its contract with CMS, the private party offering MA Plans enters into provider agreements with hospitals for treatment of MA Plan subscribers. As previously recounted, Highmark has entered into the Provider Agreement with UPMC to provide in-network access for Highmark MA Plan subscribers on a calendar-year basis. That Provider Agreement provides that it will automatically renew for the following calendar year unless notice is given by April 1 of the current calendar year to terminate the agreement. It does not contain a provision for a six-month renewal period.

The difficulty in ascertaining the intent of the parties is that they seem not to have taken into consideration when entering into the Consent Decree that it expires mid-year while MA Plans run for a full calendar year. If UPMC's position that Section 16.3's runout provision fulfills its obligation under the Consent Decree to "continue to contract," that would mean that Highmark would only have access

at in-network rates to UPMC hospitals until June 30, 2019. The net effect is that because MA Plans must be offered on a calendar-year basis, Highmark could not offer an MA Plan for 2019 that includes access to UPMC hospitals. Even if it could, then MA Plan subscribers would no longer have access to UPMC hospitals after June 30, 2019, and whether they could obtain another MA Plan is problematic. Conversely, if the Commonwealth's and Highmark's position is adopted, that would mean that Highmark could offer MA Plans with access for all of 2019, which is beyond June 30, 2019 – the agreed-to date contained in the Consent Decree.

C.

The determinative issue is what is meant by Section IV(A)(2) of the UPMC Consent Decree when it states "UPMC shall continue to contract with Highmark at in-network rates" until June 30, 2019. UPMC contends that Section 16.3 is part of that Provider Agreement, and separately provides for Highmark MA Plan subscribers to have access to UPMC facilities until June 30, 2019; therefore, it remains in "contract" with Highmark. However, the contract referred to in "continue to contract" is the entire Provider Agreement, which has governed the relationship between UPMC and Highmark since 1999, not just a single provision of that document. As the Commonwealth points out, Section 16.3's runout provision only applies "after the date on which the termination [of the Provider Agreement] becomes effective," which evidences an intent by the parties that this provision only becomes effective when the Provider Agreement has ended. UPMC's argument is also belied by its express intention to terminate the Provider Agreement as of December 31, 2018. I find that under the terms of the Consent

Decree, the term "continue the contract" means the entire Provider Agreement and that the Provider Agreement cannot be terminated until June 30, 2019.

The question then becomes what is the effect of the June 30, 2019 termination date under the terms of the Provider Agreement. Once the termination occurs, there seems to be no dispute that Section 16.3's runout provision would apply, which means that Highmark MA Plan subscribers would have in-network access to UPMC hospitals until December 30, 2019. The Commonwealth, though, contends that under Paragraph 5 of the 2012 Amendment pertaining to how the Provider Agreement is to be terminated, the Provider Agreement remains in effect for the entire contract year – *i.e.*, until December 31, 2019. The Commonwealth contends that Section 16.3's runout period would *then* come into effect, giving Highmark MA Plan subscribers in-network rates until June 30, 2020.

However, in its brief in support of its Petition to Enforce, the Commonwealth requests that, given the contentious history between UPMC and Highmark, an order be entered fixing the rights of the party so that those Highmark MA Plan subscribers would have certainty as to what time period they will have access to UPMC facilities. To accomplish that purpose, the Commonwealth suggests that an order be entered prohibiting UPMC from terminating the Provider Agreement for the calendar year 2019, but also that Highmark be ordered not to represent that UPMC is in-network for any part of 2020 based on Section 16.3's run-out clause.

I agree with the Commonwealth's suggested resolution. It provides certainty to Highmark MA Plan subscribers as well as to UPMC and Highmark regarding their obligations for calendar year 2019 by ending all obligations under the Provider Agreement, except for continuity of care, at a date certain. This resolution is the same as fixing a June 30, 2019 date for termination of the Provider Agreement, then activating Section 16.3's runout provision with the obligations expiring December 30, 2019.

Accordingly, for the reasons set forth in this opinion, an order will be entered that the Provider Agreement must remain in effect until December 30, 2019 and that Highmark is ordered not to represent that UPMC is in-network for any part of 2020.

Dan Pellegrini

DAN PELLEGRINI, Senior Judge

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

ORDER

AND NOW, this 29th day of January, 2018, following a hearing, the Commonwealth's Petition to Enforce is granted. It is ordered that the Medicare Acute Care Provider Agreement and its amendments shall remain in effect until December 30, 2019. Highmark Health and Highmark, Inc. are ordered not to represent in any manner that UPMC is in-network for any part of 2020.

Dan Pellegrini

DAN PELLEGRINI, Senior Judge

EXHIBIT T

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

UPMC PINNACLE, *et al.*,	:	
Plaintiffs,	:	
	:	No. 1:19-CV-0298
v.	:	
	:	Hon. John E. Jones III
JOSHUA D. SHAPIRO, Attorney General of the Commonwealth of Pennsylvania,	:	
	:	Electronically Filed Document
	:	
	:	*Complaint Filed 02/21/19*
Defendant.	:	

DEFENDANT JOSHUA D. SHAPIRO'S
BRIEF IN SUPPORT OF HIS MOTION TO DISMISS THE COMPLAINT

Respectfully submitted,

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Date: March 15, 2019

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Defendant Joshua D. Shapiro, in his official capacity as Attorney General of the Commonwealth ("General Shapiro"), by and through his undersigned counsel, hereby submits this Brief in Support of his Motion to Dismiss the Complaint filed by Plaintiffs UPMC Pinnacle and other UPMC affiliates (collectively, "UPMC").

I. INTRODUCTION

This is a case of buyer's remorse. UPMC is a non-profit charitable health care institution that is obliged to benefit the public under Pennsylvania law. In order to resolve a contract dispute with Highmark Health (a fellow non-profit competitor), UPMC voluntarily entered into a contractual agreement with the Commonwealth and Highmark (the "Consent Decree"). That Consent Decree is governed by the Commonwealth Court of Pennsylvania under state law and is the subject of an overlapping matter in that court. Mot. To Approve Consent Decree, Sec. IV.C.11, *Commonwealth v. UPMC*, 334 M.D. 2014 (Cmwlth. Ct. June 27, 2014).

Pursuant to the express terms of the Consent Decree, any party – including the Pennsylvania Office of Attorney General (the "OAG") – can seek to modify the agreement by petitioning the Commonwealth Court. The standard for modification is what promotes the public interest. The OAG did precisely this when it filed a Petition to Modify the Consent Decree in the Commonwealth Court on February 7, 2019 (the "Petition to Modify"). If granted, the Petition to Modify will remedy

UPMC's non-charitable conduct through adoption of a Proposed Modified Consent Decree by the Commonwealth Court. The Petition to Modify is currently pending before the Commonwealth Court, and that Court has indicated that it expects "a portion of th[e] litigation" to be resolved before June 30, 2019. Order, *Commonwealth v. UPMC*, 334 M.D. 2014 (Cmwlth. Ct. Mar. 12, 2019).

Apparently dissatisfied with the terms of the Consent Decree that it freely entered into, and the process agreed to therein for addressing modification, UPMC has now commenced this duplicative federal action, asserting a variety of claims based on broad and fanciful notions of federal preemption and constitutional law and seeking to litigate the Commonwealth Court matter here. UPMC's Complaint is not only a transparent effort to do an end-run around the plain terms of the Consent Decree and circumvent the pending Commonwealth Court litigation, but it is separately deficient as a matter of law.

UPMC's Complaint should be dismissed for the following four reasons.

First, the dispute is not ripe for review. UPMC's claims are predicated entirely on the allegation that it will be harmed if it is subject to the "principles" or "requirements" set forth in the Proposed Modified Consent Decree. (Doc. 1, ¶¶ 27-29; 41). But it cannot and will not be subject to those terms or requirements unless and until the Commonwealth Court grants the OAG's Petition. Because the Commonwealth Court has not yet ruled on that Petition, and neither party has

exhausted its appellate remedies in state court, UPMC's claims are "not ripe for adjudication" – they "res[t] upon contingent future events that may not occur as anticipated, or indeed may not occur at all." *Texas v. United States*, 523 U.S. 296, 300 (1998) (internal quotation omitted).

Second, even if the dispute was ripe for review (it is not), this Court should abstain from hearing it under the *Younger* doctrine since (1) there is a "pending state judicial proceeding," the Commonwealth Court litigation; (2) the proceeding "implicates important state interests" in non-profit, contract, and health and welfare law; and (3) the "state proceeding affords an adequate opportunity to raise constitutional challenges." *Mir v. Behnke,* 2016 WL 3269093, at *3 (M.D. Pa. June 15, 2016) (J. Jones). UPMC can raise the exact same constitutional arguments in the Commonwealth Court proceeding that it is raising here.

Third, by voluntarily agreeing to the terms of the Consent Decree, including the ability of any party to seek a modification from the Commonwealth Court and that the terms of the Consent Decree were lawful in all respects and would be binding upon all affiliates, UPMC has waived any right of its affiliates to assert contradictory claims here.

Fourth, each of UPMC's claims fails substantively as a matter of law:

- the preemption claims (counts 1-3) fail because they are based on all-encompassing and unsupportable theories of federal preemption law;

- the Sherman Act claim (count 4) fails because it is based on the faulty allegation that the Proposed Modified Consent Decree would undermine competition when, in fact, it would promote competition through mechanisms that have been repeatedly approved by the courts; and

- the constitutional claims (counts 5-9) fail because they are based on an antiquated principle of economic constitutional rights set forth in *Lochner v. New York*, 198 U.S. 45 (1905) but expressly overruled by subsequent generations of Supreme Court precedent.

For all of these reasons, and those described further below, UPMC's Complaint should be dismissed.

II. PROCEDURAL AND FACTUAL BACKGROUND

A. The Commonwealth Court Litigation

UPMC is registered as a purely public charity under Pennsylvania's Institutions of Purely Public Charity Act, 10 P.S. §§ 371 et seq., and is obligated to benefit the public by following its stated charitable purposes. *See* Commonwealth's Pet. To Modify Consent Decree, at 1; 4-8, *Commonwealth v. UPMC*, 334 M.D. 2014 (Cmwlth. Ct. Feb. 7, 2019) (hereinafter "Cmwlth. Pet."). As a direct result of its charitable status, UPMC has received enormous financial and public support. *See id.* at 8-10. Notwithstanding that support and its corresponding legal obligation to benefit the public, UPMC has engaged in a longstanding course of conduct aimed at benefitting its bottom line to the detriment of the citizens of the Commonwealth.

In or around 2012, UPMC engaged Highmark in a contract dispute that posed extensive risks to the public. That dispute was resolved when UPMC and others voluntarily agreed to the terms of the Consent Decree, which was to be administered by the Commonwealth Court. *See id.* at 10-14. UPMC and the other parties to the Consent Decree agreed that they could modify the Consent Decree by agreement, or that the Commonwealth Court could modify the Consent Decree if any one of the parties petitioned that court and persuaded it that the party's "requested modification is in the public interest":

> **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.*

Consent Decree Sec. IV.C.10 (emphasis added).

UPMC also expressly agreed that "the terms and agreements encompassed within [the] Consent Decree do not conflict with UPMC's obligations under the laws governing non-profit corporations and charitable trusts, consumer protection laws, antitrust laws, insurance laws and health laws," *id.* Sec. IV.C.6., and that the terms of the Consent Decree would be binding upon their affiliates. *Id.* Sec. II.P ("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.").

Despite its charitable obligations under Pennsylvania law and its specific obligations under the Consent Decree, however, since 2012, UPMC has continued to engage in self-serving conduct aimed at increasing its market share and eliminating competition to the detriment of the public interest it is legally obligated to serve. *See* Cmwlth. Pet. at 15-35. For this reason, on February 7, 2019, the OAG invoked the modification provision set forth in the Consent Decree by filing its Petition to Modify in the Commonwealth Court and asking that court to require UPMC to act in accordance with its charitable obligations. The Petition to Modify is currently pending in the Commonwealth Court.

B. The Federal Litigation

Although the Complaint in this case is 50 pages in length and contains over 240 paragraphs, its factual allegations are remarkably sparse. UPMC alleges that Attorney General Josh Shapiro stated at a meeting in November 2018 "that he has 'vast authority' over all Pennsylvania nonprofit entities." (Doc. 1 ¶ 27). UPMC further alleges that General Shapiro delivered a "list of new requirements" for nonprofit entities by providing UPMC with a draft of the Proposed Modified Consent Decree (Doc 1, ¶¶ 28-29; Ex. A), and said that these "requirements" apply to all nonprofit healthcare providers and insurers in Pennsylvania, and he will

enforce them "starting with matters that the Office of the Attorney General currently has under investigation." (Doc. 1 ¶ 32). The sole basis for UPMC's allegation is its own, self-serving letter *that UPMC's counsel sent to the OAG*; not any statement or action by the OAG itself. (Doc. 1, Ex. B). Last, UPMC alleges that it is "unable to accurately project [its] costs" and that "lack of clarity will interfere with [its] operation of [its] business . . . ." (Doc. 1, at ¶ 41).

III. STATEMENT OF QUESTIONS INVOLVED

1. Is UPMC's Complaint ripe for judicial review when its claims are based entirely on specific, proposed "requirements" requested in the OAG's Proposed Modified Consent Decree which remains pending before the Commonwealth Court, even though the Commonwealth Court has not yet ruled on, much less adopted, the proposed modifications and may not do so at all?

Suggested answer: No.

2. Does the *Younger* abstention doctrine apply here, where (1) there is a pending state judicial proceeding in Commonwealth Court; (2) that proceeding implicates important state non-profit, contractual and healthcare interests; and (3) UPMC can raise its same constitutional arguments it raised here in that state proceeding before Commonwealth Court?

Suggested answer: Yes.

3. As a matter of law, did UPMC waive any right to assert its claims by agreeing to the terms of the Consent Decree which expressly (1) allow any party to seek modification before the Commonwealth Court; (2) admit that the terms of the Consent Decree are legal in all respects; and (3) acknowledge that the terms of the Consent Decree are binding on all of UPMC's affiliates?

Suggested answer: Yes.

4. Do UPMC's declaratory judgment claims (counts 1-3) fail to state a cause of action as a matter of law when they are based on all-encompassing and legally unsupportable theories of federal preemption?

Suggested answer: Yes.

5. Does UPMC's Sherman Act claim (count 4) fail to state a cause of action as a matter of law when it is based on the unsupportable allegation that the Proposed Modified Consent Decree would undermine competition when, in fact, it would promote competition through mechanisms that have been repeatedly approved by the courts?

Suggested answer: Yes.

6. Do UPMC's constitutional claims (counts 5-9) fail to state a cause of action when they are based on an antiquated theory of economic constitutional rights set forth in *Lochner v. New York*, 198 U.S. 45 (1905) but expressly overruled by subsequent generations of Supreme Court precedent?

Suggested Answer: Yes.

IV. ARGUMENT

UPMC's Complaint should be dismissed in its entirety for four independent reasons: (1) its claims are not ripe for review; (2) the *Younger* abstention doctrine applies; (3) UPMC waived any right to assert its claims; and (4) each of UPMC's claims fails to state a cause of action as a matter of law.

A. UPMC's Complaint Should Be Dismissed Because Its Claims Are Not Ripe For Judicial Review.

The Court should dismiss UPMC's Complaint because its claims are not ripe. "Ripeness reflects constitutional considerations that implicate Article III limitations on judicial power, as well as prudential reasons for refusing to exercise jurisdiction." *Stoit-Nielsen S.A. v. AnimalFeeds Int'l Corp.*, 559 U.S. 662, 670 n.2 (2010). "A claim is not ripe for adjudication if it rests upon contingent future events that may not occur as anticipated, or indeed may not occur at all." *Thomas*, 523 U.S. at 300. Here, UPMC's claims are not ripe for review and should be dismissed for the following reasons.

First, UPMC's claims are predicated entirely on the allegation that General Shapiro "announced new 'principles'" or "requirements" that purportedly "change how nonprofit health insurers and providers operate. . . ." (Doc. 1, ¶¶ 1; 27-29). This allegation is fundamentally, unquestionably false: every so-called "principle"

or "requirement" cited by UPMC is contained as a request within the four corners of the *Proposed* Modified Consent Decree that is currently being litigated before the Commonwealth Court in connection with the OAG's Petition to Modify. (*See* Doc. 1 ¶ 28; Ex. A). The Attorney General has not created new principles or requirements. He has simply asked the Commonwealth Court to grant a petition, something that the court may, or may not, do. UPMC is asserting that it will be harmed only if the Commonwealth Court grants the Petition to Modify and adopts the terms of the Proposed Modified Consent Decree. The corollary of that assertion, of course, is that UPMC will ***not*** be harmed if the Commonwealth Court *denies* the OAG's Petition to Modify and/or *refuses* to adopt the terms of the Proposed Modified Consent Decree. At this point, no one can know what that court will do. Because the Commonwealth Court has not yet ruled on the Petition to Modify and neither party has exhausted its remedies in state court, UPMC's claims simply are "not ripe for adjudication." They "res[t] upon contingent future events that may not occur as anticipated, or indeed may not occur at all." *Texas*, 523 U.S. at 300.

Second, even if the Commonwealth Court were to grant the OAG's Petition to Modify, UPMC's claims would still be premature. While UPMC contends that the mere existence of the Proposed Modified Consent Decree creates a ripe controversy, no controversy could actually exist unless and until the OAG would

seek to enforce the terms of any Modified Consent Decree against UPMC. UPMC candidly acknowledges that it is too early to know how any such hypothetical enforcement will play out, even if the Commonwealth Court modifies the Consent Decree. (*See* Doc. 1, ¶ 39) ("General Shapiro has not yet identified to Plaintiffs what specific actions he intends to take to ensure that his new rules apply to all nonprofits."); (*see* Doc. 1, ¶ 40) ("General Shapiro has not yet identified to Plaintiffs what specific actions he intends to take to force Plaintiffs to open their doors to insurers and providers who do not agree to be bound by his arbitration procedures.").

Assuming, for the sake of argument, that the Commonwealth Court modifies the Consent Decree at all, the OAG may not take any action to enforce it. One would hope that UPMC would simply abide by the order of the Commonwealth Court, should that Court see fit to issue one. And even if the OAG had to enforce an order in Commonwealth Court, it could do so in a manner that avoids UMPC's objections entirely.[1] Regardless, at this time, neither the parties nor this Court can

[1] For example, UPMC's Medicare Act preemption claim (Count 1) is based solely on the alleged effect that the Proposed Modified Consent Decree might have on the practices of specific Medicare Advantage ("MA") organizations ("MAOs"). (*See* Doc. 1, ¶¶ 49-69). But only two of the UPMC Plaintiffs are alleged to be MAOs, (*see* Doc. 1, ¶¶ 14, 16), and UPMC does not raise any preemption arguments regarding entities other than MAOs. So, if the OAG was to enforce the Proposed Consent Decree against only the vast majority of the UPMC Plaintiffs that are not MAOs (and decline to enforce it against the two UPMC Plaintiff MAOs), UPMC;s arguments would be moot.

know how the OAG might in the future seek to enforce the Proposed Modified Consent Decree – or whether it even will get the opportunity to do so.

For these reasons, UPMC fails to present a ripe controversy for adjudication and the Complaint should be dismissed.

B. UPMC's Claims Should Be Dismissed Because The *Younger* Abstention Doctrine Applies.

Even if UPMC's claims were ripe, and they are not, this Court should abstain from presiding over this matter under the *Younger* Doctrine.[2] "Abstention is appropriate when: (1) there is a pending state judicial proceeding; (2) the proceeding implicates important state interests; and (3) the state proceeding affords an adequate opportunity to raise constitutional challenges." *Mir*, 2016 WL 3269093, at *3. Here, all elements of *Younger* are satisfied. This case is more appropriately decided in the matter pending before the Commonwealth Court, which has jurisdiction to hear disputes involving the important state non-profit, contractual, and health and welfare legal issues arising under the Consent Decree and where UPMC can raise the exact arguments it raises here.

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[2] "The abstention doctrine first announced by the Supreme Court in *Younger v. Harris* . . . in the context of a pending state criminal prosecution, has since been extended to non-criminal state civil proceedings and state administrative proceedings . . . ." *O'Neill v. City of Philadelphia,* 32 F.3d 785, 789 (3d Cir. 1994) (internal citations omitted).

1. There Is A Pending State Judicial Proceeding Concerning The Same Issues As In This Case.

The first *Younger* element is satisfied because the pending Commonwealth Court litigation concerns the same issues UPMC raises in this case.

It is well-settled that, "[f]or *Younger* purposes, the State's trial-and-appeals process is treated as a unitary system, and for a federal court to disrupt its integrity by intervening in midprocess would demonstrate a lack of respect for the State as sovereign." *O'Neill v. City of Philadelphia*, 32 F.3d 785, 790 (3d Cir. 1994). Thus, "a necessary concomitant of *Younger* is that a party [wishing to contest in federal court the judgment of a state judicial tribunal first] must exhaust his state appellate remedies before seeking relief in the District Court." *Id.* (*quoting Huffman v. Pursue, Ltd.,* 420 U.S. 592, 608 (1975)) (brackets in original).

As described above, UPMC's claims are based entirely on its contingent allegation that – if the Commonwealth Court subjects it to the "principles" or "requirements" set forth in the OAG's Proposed Modified Consent Decree – it will be harmed. (Doc. 1, ¶¶ 1; 27-29).[3] This exact issue is pending before the Commonwealth Court which is considering the OAG's Petition to Modify. Therefore, the first element of *Younger* is satisfied.

[3] The Commonwealth Court will weigh UPMC's argument against the OAG's position that the Proposed Modified Consent Decree should be applied to UPMC, as a Commonwealth non-profit charity, to promote the public interest in accordance with the express standard for modification to which UPMC agreed when it entered into the Consent Decree.

2. The Commonwealth Court Litigation Implicates Important State Interests in Non-Profit, Contract, and Health and Welfare Law.

The second *Younger* element is satisfied because the pending Commonwealth Court litigation implicates important state interests in non-profit, contract, and health and welfare law. The second prong of the test is whether the proceedings at issue in the federal court "implicate an important state interest. This factor goes to the very core of the raison d'etre of *Younger* abstention inasmuch as the Supreme Court's holding in *Younger* rested primarily on considerations of 'comity,' a concept which encompasses 'a proper respect for state functions.'" *O'Neill*, 32 F.3d at 791-92. This element is interpreted broadly in favor of abstention: "When [courts] inquire into the substantiality of the State's interest in its proceedings [courts] do not look narrowly to its interest in the *outcome* of the particular case—which could arguably be offset by a substantial federal interest in the opposite outcome. Rather, what we look to is the importance of the generic proceedings to the State." *Id.*

It is beyond dispute that the Commonwealth Court litigation implicates important state interests in at least three areas. First, the state has an important interest in institutions registered as charities under state law. *See Fontain v. Ravenal,* 58 U.S. 369 (1854) (recognizing broad powers of attorney general to protect public interest and insure charitable funds are properly applied). This interest is particularly acute in Pennsylvania, where the power and duty to ensure

the proper functioning of charities in the public interest is expressly vested in the Attorney General. *Commonwealth v. Barnes Foundation,* 398 Pa. 458, 467 (Pa. 1960) ("Attorney General . . . by virtue of the powers of [the] office, is authorized to inquire into the status, activities and functioning of public charities."); *see also, Estate of Pruner*, 136 A.2d 107, 109-10 (1957) ("The beneficiary of charitable trusts is the general public to whom the social and economic advantages of the trust accrue. But because the public is the object of the settlor's benefactions, private parties have insufficient financial interest in charitable trusts to oversee their enforcement. Consequently, the Commonwealth itself must perform this function if charitable trusts are to be properly supervised.").

Second, the Commonwealth has an important interest in enforcing contracts generally, and a particular interest in enforcing and asserting its contractual rights under the Consent Decree to which it is a party. *See Travelers Health Ass'n v. Virginia,* 339 U.S. 643, 647–48 (1950) (discussing state's interest that contractual obligations be observed). Third, insofar as this matter directly affects the healthcare of millions of Pennsylvania residents, "the health and safety of [a state's] citizens" falls squarely within the "police powers [of the state] . . . as to the protection of the lives, limbs, health, comfort, and quiet of all persons." *Medtronic, Inc. v. Lohr,* 518 U.S. 470, 475 (1996) (internal quotation omitted).

In sum, because the Commonwealth Court litigation involves (1) oversight of Pennsylvania charitable institutions by the Attorney General; (2) enforcement of a contract to which the state is a party; and (3) protection of the health and safety of millions of Commonwealth citizens, UPMC's complaint implicates important state interests. The second of the *Younger* abstention doctrine elements is satisfied.

3. UPMC Can Raise Its Exact Same Arguments In The Commonwealth Court.

The third element of *Younger* is satisfied because UPMC can make its same arguments in Commonwealth Court. This "element is satisfied in the context of a state administrative proceeding when the federal claimant can assert his constitutional claims during state-court judicial review of the administrative determination." *O'Neill*, 32 F.3d at 792. Here, UPMC can raise every constitutional argument in Commonwealth Court that it seeks to raise in this case. Therefore, the third element of *Younger* is satisfied.

The Court should abstain from presiding over this case pursuant to the *Younger* abstention doctrine and dismiss UPMC's Complaint.

C. UPMC's Complaint Should Be Dismissed As A Matter of Law Because, By Entering Into The Consent Decree, UPMC Waived Any Right To Assert Its Claims.

By agreeing to the terms of the Consent Decree, UPMC and its affiliates waived any right to assert claims that conflict with the Consent Decree. Because

the causes of action in UPMC's Complaint before this Court conflict with the Consent Decree, they must fail as a matter of law and should be dismissed.

"Consent Decrees are interpreted under ordinary contract law principles." *Harris v. City of Philadelphia*, 47 F.3d 1311, 1323 (3d Cir. 1995). This makes sense because "a consent decree is a contract which has been given judicial sanction" and, as such, it must be interpreted in accordance with the general principles governing the interpretation of all contracts. *Commonwealth ex rel. Kane v. UPMC*, 129 A.3d 441, 463 (Pa. 2015). As described above, UPMC agreed expressly in the Consent Decree that any party – including the OAG – could "petition the Court for modification" and that party "shall bear the burden of persuasion that the requested modification is in the public interest." Consent Decree Sec. IV.C.10.

UPMC placed no limitation on the grounds under which the OAG could seek to modify the Consent Decree. Indeed, UPMC also agreed that the terms of the Consent Decree did "not conflict with UPMC's obligations" under relevant law, *id.* at Sec. IV.C.6., and that the Consent Decree binds its affiliates. *See id.* at Sec.II.P. UPMC cannot agree that the OAG may lawfully "petition the Court for modification" without limitation and then oppose the very modification process it agreed to by asserting its claims here.

Because UPMC waived any right to assert its claims by entering into the Consent Decree, its Complaint should be dismissed.

D. UPMC's Complaint Should Be Dismissed Because Each Claim Fails To State A Cause Of Action As A Matter Of Law.

"To survive a motion to dismiss, a complaint must contain sufficient factual allegations, taken as true, to 'state a claim to relief that is plausible on its face.'" *Fleisher v. Standard Ins.*, 679 F.3d 116, 120 (3d Cir. 2012) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). "In other words, a complaint must do more than allege the plaintiff's entitlement to relief. A complaint has to 'show' such an entitlement with its facts." *Fowler v. UPMC Shadyside*, 578 F.3d 203, 211 (3d Cir. 2009). "The District Court must accept all of the complaint's well-pleaded facts as true, but may disregard any legal conclusions." *Id.* at 210-11. Under this basic standard, each of UPMC's substantive claims must fail as a matter of law.

1. UPMC's Preemption/Declaratory Judgement Act Claims (Counts 1-3) Fail As A Matter Of Law.

UPMC asserts that the Proposed Modified Consent Decree is preempted by three federal laws: (1) the Medicare Act, 42 U.S.C. §§ 1395 – 1395lll; (2) the Affordable Care Act (the "ACA") 42 U.S.C. § 18001 et seq.; and (3) the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001–1461 (*see* Doc. 1, ¶¶ 162-166, 167-174, and 175-179, respectively). They ignore, however, "two cornerstones of [the Supreme Court's] pre-emption jurisprudence." *Wyeth v.*

Levine, 555 U.S. 555, 565 (2009). First, is "the basic assumption that Congress did not intend to displace state law." *Maryland v. Louisiana,* 451 U.S. 725, 746 (1981); *see also Medtronic, Inc. v. Lohr,* 518 U.S. 470, 485 (1996) ("because the States are independent sovereigns in our federal system, we have long presumed that Congress does not cavalierly pre-empt state-law causes of action"). Second, "[i]n all pre-emption cases, and particularly in those in which Congress has legislated . . . in a field which the States have traditionally occupied, . . . we start with the assumption that the historic police powers of the States were not to be superseded by the Federal Act *unless that was the clear and manifest purpose of Congress*.' " *Lohr,* 518 U.S. at 485 (internal quotation omitted) (emphasis added). Thus, the "presumption against preemption" (*Wyeth*, 555 U.S. at 565 n.3) applies with particular force in situations like this fall squarely within the police power of the state. *See Lohr*, 518 U.S. at 475.

a. The Medicare Act Does Not Preempt The Proposed Modified Consent Decree.

UPMC contends that four provisions of the Proposed Modified Consent Decree conflict with the Medicare Act: (1) the "Duty to Negotiate," paragraphs 3.2 and 3.3 (Doc. 1, ¶¶ 54-58); (2) the prohibition on "Provider-Based Billing practice(s)," paragraph 3.4.5 (Doc. 1, ¶¶ 59-61); (3) the "Limitations on Charges for Emergency Services," paragraph 3.5 (*see* Doc 1, ¶¶ 63-65); and (4) the "Advertising" provision, paragraph 3.10 (*see* Doc 1, ¶¶ 66-69). UPMC's

assertions are without merit in all respects and its Count 1 declaratory judgment (Count 1) claim should be dismissed as a matter of law.

(i) The Duty To Negotiate Provisions Of The Proposed Modified Consent Decree Do Not Conflict With The Medicare Act.

UPMC's assertion concerning the Duty to Negotiate Provisions in paragraphs 3.2 and 3.3 of the Proposed Modified Consent Decree can be summed up as follows: (1) two of the UPMC Plaintiffs offer MA health plans (*see* Doc 1, ¶¶ 14; 16); (2) the terms of the Proposed Modified Consent Decree "force" these two UPMC entities "to enter into involuntary MA Contracts" (Doc 1, ¶ 57); and (3) the Duty to Negotiate provisions therefore conflict with the "Noninterference" provision of the Medicare Act. (Doc 1, ¶¶ 55-58). That assertion is based on two fundamental mischaracterizations.

First, UMPC misinterprets the noninterference provision of the Medicare Act. That provision only applies to Medicare-specific benefits and services:

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

42 U.S.C. § 1395w-24(a)(6)(B)(iii) (emphasis added). By its terms, this noninterference provision applies *only* to state efforts to force an MAO to contract to provide *Medicare-specific* benefits and services. Indeed, the cases cited by UPMC support that interpretation. *See Massachusetts Ass'n of HMOs v. Ruthardt*, 194 F.3d 176, 185 (9th Cir. 1999) (Congress's intent "*to preempt all state benefit requirements* is clear and manifest") (emphasis added).[4] The noninterference provision does not apply to state efforts to regulate contracting by MAOs in areas wholly unrelated to Medicare benefits. Put otherwise, the noninterference provision of the Medicare Act does not apply to the Proposed Modified Consent Decree because the Proposed Modified Consent Decree does not impose any "state benefit" requirements on UPMC.

Second, the Duty to Negotiate Provisions of the Proposed Modify Consent Decree do not "force" UPMC to enter into involuntary contracts with anybody. Rather, those provisions require UPMC to negotiate with health plans and health care providers in good faith – nothing more. If those negotiations are unsuccessful, then Pennsylvania registered health plans and providers may invoke the binding

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[4] The other cases cited by UPMC are inapposite. *See Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134 (9th Cir. 2010) (finding only that state law claim for misleading marketing materials under consumer protection statute was preempted); *Morrison v. Health Plan of Nevada*, 328 P.3d 1165 (Nev. 2014) (finding only that state common law negligence claim was preempted); and *Meek-Horton v. Trover Sols, Inc.*, 915 F. Supp. 2d 486 (S.D.N.Y. 2013) (finding only that state law consumer protection cause of action was preempted).

arbitration procedure agreed to by UPMC and the other parties to the Consent Decree. *See* Consent Decree ¶ IV.C.2. Pursuant to the parties' agreement, that procedure is overseen by an independent body which must impose "last best offer," baseball-style arbitration. *See id.*[5] UPMC's vehement and over-the-top objections to the process it expressly agreed to are even more perplexing in that "last best offer" arbitration has been endorsed by numerous courts as an effective incentive to induce parties to negotiate in good faith and make reasonable proposals.

(ii) The Prohibition On Provider-Based Billing Practices Does Not Conflict With The Medicare Act.

UPMC asserts that the prohibition on "Provider-Based Billing practice(s)" in paragraph 3.4.5 of the Proposed Modified Consent Decree is preempted by the Medicare Act. (*See* Doc. 1, ¶¶59-62). Again, UPMC's argument is incorrect. In

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[5] The Justice Department has described the moderating benefits of these procedures as follows:

> Under baseball-style arbitration, each party submits its preferred price and other terms to the arbitrator, and the arbitrator selects the proposal that is most reasonable in light of relevant evidence. Because the arbitrator can only choose between the parties' proposals, the process creates an incentive for both parties to make reasonable proposals. The FCC has adopted this method of arbitration as a condition of approving several previous transactions involving the video programming distribution industry.

Supplemental Statement Of The United States In Support Of Entry Of The Final Judgment, at 3 n.4, *United States v. Comcast Corp.*, 11-cv-106 (D.D.C. Aug. 5, 2011); *see also United States v. AT&T*, ---F.3d----, 2019 WL 921544, at *8-9 (D.C. Cir. Feb. 26, 2019) (approving district court's findings regarding the efficacy of "baseball style arbitration" to resolve contract disputes post-merger).

support of its assertion, UPMC cites 42 C.F.R. § 413.65. But that only relates to the "requirements for a determination that a facility or an organization has provider-based status" under the Medicare Act. It does not pertain in any way, shape or form to provider-based billing practices or impose any limitation whatsoever on a state seeking to curtail or eliminate such practices. Therefore, the prohibition on provider-based billing practices set forth in the Proposed Modified Consent Decree does not conflict with the Medicare Act.

(iii) The Limitations On Charges For Emergency Services In The Proposed Modified Consent Decree Do Not Conflict With The Medicare Act.

UPMC asserts that the "Limitations on Charges for Emergency Services" provision in paragraph 3.5 of the Proposed Modified Consent Decree is preempted by the Medicare Act. Again, here, UPMC is wrong. Paragraph 3.5 states that UPMC "shall limit [its] charges for all emergency services to [its] Average In-Network Rates for any patient Receiving Emergency services on an Out-of-Network basis." In support of its preemption argument, UPMC cites to 42 U.S.C. § 1395s-22(k)(1). But that statutory provision only requires that a physician or other entity providing out-of-network services to an MA patient "accept as payment in full . . . the amounts that the . . . entity could collect if the individual" were enrolled in traditional Medicare. The statute puts a *ceiling* on the amount a provider can accept from out-of-network MA patients – i.e., the amount it could

collect from traditional Medicare – but not a *floor*. It does not preclude a state from requiring a provider to accept less than the ceiling amount.

Moreover, UPMC does not allege that its average in-network rates for MA patients are lower than rates it would receive from "traditional" Medicare patients. Thus, even if the statute were improperly interpreted to require a floor for out-of-network reimbursement rather than just a ceiling, UPMC fails to allege that the Proposed Modified Consent decree would impose a reimbursement structure that would violate such a floor.

(iv) The Advertising Provision Does Not Conflict With The Medicare Act.

UPMC also asserts that the Advertising Provision in paragraph 3.10 of the Proposed Modified Consent Decree is preempted by the Medicare Act. (*See* Doc. 1, ¶¶66-69). Again, it is wrong. Paragraph 3.10 states that UPMC "shall not engage in any public advertising that is unclear or misleading in fact or by implication." UPMC contends that the Centers for Medicare & Medicaid Services ("CMS") have "exclusive purview to regulate advertising for MA plans," and that paragraph 3.10 conflicts with CMS' authority. UPMC's newfound contention is curious because it agreed to be bound by the *exact same provision* in the Consent Decree that it now claims is unconstitutional. *See* Consent Decree Sec.IV.A.11 ("UPMC shall not engage in any public advertising that is unclear or misleading in fact or by implication.").

Moreover, assuming solely for the sake of argument that CMS is in fact the only agency that can regulate advertising *for MA plans*, UPMC says nothing about advertising for *non-MA* plans. Even if CMS has "exclusive purview" over the regulation of advertising for MA plans, the Commonwealth would not be prohibited from regulating advertising for *non-MA* plans with that same language.

The cases cited by UPMC support this interpretation. In those cases the courts struck down causes of action asserted under state laws o*nly insofar as they related to MA plans*.[6] But the courts did *not* hold that the underlying state laws/regulations upon which the causes of action were based were preempted insofar as they also related to non-MA plans. That is the argument UPMC tries to make here.

b. The Affordable Care Act Does Not Preempt The Proposed Modified Consent Decree.

UPMC asserts that the ACA preempts the Proposed Modified Consent Decree. (*See* Doc 1., ¶¶ 70-76). That assertion, however, is based on a misreading of the ACA, and it should be rejected.

UPMC contends that the Proposed Modified Consent Decree imposes "different regulatory requirements" on non-profit health insurers than for-profit

[6] *See Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134 (9th Cir. 2010) (state law claim for misleading marketing materials under consumer protection statute preempted); *Morrison v. Health Plan of Nevada*, 328 P.3d 1165 (Nev. 2014) (state common law negligence claim was preempted).

health insurers. According to UPMC, this alleged differential treatment violates Section 18012 of the ACA. 42 U.S.C. § 18012, which states:

> Any standard or requirement adopted by a State ***pursuant to this title***, or any amendment made by this title, shall be applied uniformly to all health plans in each insurance market to which the standard and requirements apply. The preceding sentence shall also apply to a State standard or requirement relating to the standard or requirement required by this title (or any such amendment) that is not the same as the standard or requirement but that is not preempted under section 18041(d) of this title.

(emphasis added).

The plain language of the statute is clear that the ACA only prohibits a state from imposing standards and requirements "pursuant to [the ACA]" to some plans but not to others. Put otherwise, the statute requires only that states impose the same *ACA requirements* for all health plans.

In the Commonwealth Court litigation, the OAG is requesting that that court adopt the Proposed Modified Consent Decree to ensure that UMPC acts consistent with its Pennsylvania state law charitable obligations to serve the public interest. This request is wholly unrelated to any requirement under the ACA. The statute cited by UPMC is, therefore, inapposite.

c. ERISA Does Not Preempt The Proposed Modified Consent Decree.

UPMC claims that the Proposed Modified Consent Decree "relates" to an employee benefit plan within the meaning of 29 U.S.C. § 1144(a) and is, therefore, preempted under ERISA.[7] This is incorrect as a matter of law. While UPMC makes a number of different arguments in support of its assertion, each fails for the same reason: UPMC does not have standing to make such an argument because none of the UPMC Plaintiffs offers an employee benefit plan covered by ERISA. Instead, a single UPMC Plaintiff allegedly acts as "a licensed third-party administrator, and that administrator then contracts with self-insured entities to provide administrative services." (Doc. 1, ¶ 18). But a third party administrator that contracts with an ERISA benefit plan does not have standing to assert such claims. Therefore, UPMC has no standing to assert any claims regarding the supposed impact the Proposed Modified Consent Decree would have on the ERISA benefit plan as opposed to the administrator itself. UPMC's ERISA arguments should be rejected, and its ERISA claim should be dismissed.

Moreover, the Modified Consent Decree gives health plans (including ERISA qualified plans) the option of availing its provisions; it does not mandate that such plans avail themselves of provisions. In short, the Modified Consent

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[7] "A rule of law relates to an ERISA plan if it is specifically designed to affect employee benefit plans, if it singles out such plans for special treatment, or if the rights or restrictions it creates are predicated on the existence of such a plan." *United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Mem'l Hosp.*, 995 F.2d 1179, 1192 (3d Cir. 1993).

Decree would enable a health plan to require UPMC to negotiate with it in good faith if it wanted UPMC's provider assets as part of its health plan design. If it did not want UPMC as part of its plan, the plan is under no obligation to add UPMC.

1. UPMC's Sherman Act (Count 4) Claim Must Fail As A Matter Of Law.

UPMC claims that the Proposed Modified Consent Decree violates the Sherman Act by "restrain[ing] competition by forcing Plaintiffs to contract with all willing insurers or providers; by enabling arbitrators to effectively level-set the prices the insurers pay; and by abdicating this unsupervised regulatory power to nonpolitical, nonresponsive private actors." (Doc. 1, ¶ 96). This claim is without merit and should be dismissed as a matter of law.

As a legal matter, UPMC's Sherman Act claim fails because the arbitration procedures that it claims are anticompetitive are the same as those repeatedly approved by numerous courts as *promoting* commercially reasonable behavior.[8] *See supra* Sec. IV.D.i.a.i. The economic and legal rationale for the arbitration

[8] As set forth above, the Proposed Modified Consent Decree does not restrain trade, because it does not "force" any UPMC entity to enter into any involuntary contract with anybody. Rather, paragraphs 3.2 and 3.3 of the Duty to Negotiate provisions require UPMC to negotiate with health plans and health care providers in good faith. If those negotiations are unsuccessful, then Pennsylvania registered health plans and providers may invoke binding arbitration procedures, overseen by an independent body, which will apply "last best offer" arbitration. These provisions facilitate access to healthcare and *promote trade and competition* by precluding UPMC from stonewalling competitors. The factual allegations in the Complaint provide no basis to infer otherwise.

procedures in those cases applies with equal weight in this case. As such, as a matter of law, "last best offer" arbitration cannot provide the basis for a viable claim under the Sherman Act.

For these reasons, UPMC's Sherman Act claim must fail and should be dismissed.

2. UPMC's Constitutional Claims (Counts 5-9) Must Fail As A Matter Of Law.

UPMC asserts five constitutional claims based on the following dubious theories: (1) regulatory taking (count 5); (2) unconstitutional condition (count 6); (3) equal protection (count 7); (4) due process (count 8); and (5) substantive due process (count 9). These claims fail for the following reasons.

As a general matter, each claim is based on an alleged "fundamental" constitutional right that the Supreme Court has explicitly held is ***not*** *fundamental.* In particular, UPMC contends that it has an "undisputed right to determine what contract [it] enter[s] and to end [its] current contracts. . . ." (Doc. 1, ¶ 43). In other words, UPMC asserts a constitutional right to "freedom of contractual relations." This is a page taken directly from the *Lochner* playbook. *See Lochner*, 198 U.S. at 53 ("The general right to make a contract in relation to his business is part of the liberty of the individual protected by the 14th Amendment of the Federal Constitution. Under that provision no state can deprive any person of life, liberty, or property without due process of law.") (internal citation omitted). Unfortunately

for UPMC, those principles originally set forth in *Lochner* have since been rebuked by generations of Supreme Court precedent. *See, e.g., West Coast Hotel Co. v. Parrish*, 300 U.S. 379, 391-92 (1937) ("Liberty under the Constitution is thus necessarily subject to the restraints of due process, and regulation which is reasonable in relation to its subject and is adopted in the interests of the community is due process. *This essential limitation of liberty in general governs freedom of contract in particular*.") (emphasis added).

There is no "undisputed [constitutional] right" to the freedom of contractual relations. (Doc. 1, ¶43). Therefore, UPMC's constitutional claims should be dismissed in their entirety.

In addition to this general ground to dismiss all of UPMC's constitutional claims as a matter of law, UPMC's specific constitutional claims fail for the following specific reasons, each of which provides a separate legal basis to dismiss the indicated constitutional claims.

a. UPMC's Regulatory Taking Claim Must Fail.

UPMC asserts that it has property rights in its alleged freedom to contract and not to contract and the "requirements" presented to the Commonwealth Court in the Proposed Modified Consent Decree "take" away those property "rights" and, therefore, "effect a taking." (Doc. 1, ¶ 198). As a matter of law, UPMC is wrong.

The takings clause of the Fifth Amendment to the Constitution provides that "private property [shall not] be taken for public use, without just compensation." Such a regulatory taking occurs when "a regulatory or administrative action places such burdens on the ownership of property that essential elements of such ownership must be viewed as having been taken." *Hendler v. United States,* 36 Fed. Cl. 574, 585 (1996). In cases like UPMC's claim, where all economically beneficial use is not taken from the property, courts conduct an "essentially ad hoc, factual inquir[y]" focused on three factors: (1) the economic impact of the regulation on the claimant; (2) the degree of interference with the reasonable, investment-backed expectations of the property owner; and (3) the character of the government action. *Penn Central Transportation Co. v. City of New York*, 438 U.S. 104, 124-128 (1978).

Even if UPMC was found to have a fundamental constitutional property right in the freedom of contractual relations in violation of Supreme Court precedent, any such right would have to be "public" and not "private" – UPMC is obligated under Pennsylvania state law to benefit *the public* and not its own bottom line. *See, e.g.*, *Pruner*, 136 A.2d at 109 ("because the public is the object of the settlor's benefactions, private parties have insufficient financial interest in charitable trusts to oversee their enforcement"). And a right that is already *public* cannot be taken in violation of the Constitution.

Because UPMC, as a Pennsylvania public charity, does not have a "private" right to freedom of contractual relations, its regulatory taking claim should be dismissed.[9]

b. UPMC's Unconstitutional Condition Claim Must Fail.

UPMC's unconstitutional condition claim is a mirror image of its regulatory taking claim, and it, too, fails as a matter of law. UPMC contends that "[b]y forcing [it] to contract with other insurers and providers, General Shapiro interferes with Plaintiff['s] reasonable expectation that [it] will enjoy the right *not* to contract." (Doc. 1, ¶ 108) (emphasis in original). This is the same regulatory taking allegation reasserted under the guise of a different theory, and it should be rejected for the same reasons.

c. UPMC's Equal Protection Claim Must Fail.

UPMC's Equal Protection claim is based on its allegation that the Proposed Modified Consent Decree "target[s] Plaintiffs (and other UPMC entities) for special regulatory burdens that have not been imposed on other similarly-situated entities." (Doc. 1, ¶ 120). In reviewing an Equal Protection claim, the first inquiry

[9] In addition, UPMC has also failed to allege any facts demonstrating that the adoption of the Proposed Modify Consent Decree would "take" its property at all. To the contrary, and as described above, the Duty to Negotiate and Arbitration provisions, if adopted by the Commonwealth Court, would merely require that UPMC negotiate in good faith and, in limited circumstances, submit to "last best offer arbitration" which would induce the parties to act in a commercially reasonable manner.

is "whether the alleged state action burdens a fundamental constitutional right or targets a suspect class." *State Troopers Non-Commissioned Officers Ass'n of New Jersey v. New Jersey*, 399 F. App'x 752, 754 (3d Cir. 2010). "If a classification neither burdens a fundamental right nor targets a suspect class, [the court] will uphold it so long as it bears a rational relation to some legitimate end." *Connelly v. Steel Valley Sch. Dist.*, 706 F.3d 209, 213 (3d Cir. 2013) (quotation omitted). This "rational basis test" is a low bar.

As set forth above, UPMC's claim to a fundamental constitutional right to the freedom of contractual relations is bogus – no such fundamental constitutional right exists. *See West Coast Hotel Co.*, 300 U.S. 379, *supra.* Nor can UPMC allege that it is a "protected class." UPMC is not a "discrete and insular" minority that has been "subjected to such a history of purposeful unequal treatment, or relegated to such a position of political powerlessness as to command extraordinary protection from the majoritarian political process." *Massachusetts Board of Ret. v. Murgia*, 427 U.S. 307, 313 (1976). Rather, UPMC is an extraordinarily powerful healthcare non-profit that owes a duty to the public under Pennsylvania state law governing charities.

As a result, UPMC's Equal Protection claim must fail as a matter of law "so long as" the Proposed Modified Consent Decree "bears a rational relation to some legitimate end.'" *Connelly*, 706 F.3d at 213. It does. Based on UPMC's long

pattern of behavior, for the reasons described above, and those further described in the Petition to Modify pending before the Commonwealth Court, the Proposed Modified Consent Decree is necessary to ensure that UMPC acts in accordance with its charitable obligations to benefit the public in the Commonwealth of Pennsylvania. It is necessary to protect the basic healthcare of millions of Pennsylvania residents. This reasoning easily satisfies a rational basis test. UPMC's Equal Protection claim should therefore be dismissed.

d. UPMC's Procedural Due Process Claim Must Fail.

UPMC's procedural due process claim is based on the notion that the OAG has deprived it of a protected property interest in contractual relations without proper procedural protections. (*See* Doc. 1, ¶¶ 225-231). To state such a claim, a plaintiff must establish that: (1) it had a protected liberty or property interest; (2) the state deprived it of that interest; and (3) the Plaintiff was deprived of basic procedural protections such as notice and an opportunity to be heard. *See Shoats v. Horn,* 213 F.3d 140, 143 (3d Cir. 2000). Again, here, UPMC's claim must fail as a matter of law.

Assuming UPMC has a protected property interest in contractual relations that is fundamental, UPMC cannot satisfy the second or third elements of a procedural due process claim. As described above, UPMC is not being "deprived" of anything – the Duty to Negotiate and Arbitration provisions in the Proposed

Modified Consent Decree do not "force" UPMC to contract with anyone and any such interest is for the benefit of the public under Pennsylvania charities law, not UPMC privately. UPMC has received ample notice and is taking complete advantage of the opportunity to be heard *in two venues* – the Commonwealth Court and duplicatively, here in the Middle District. UPMC's procedural due process claim should be dismissed.

e. UPMC's Substantive Due Process Claim Must Fail.

UPMC's substantive due process claim is based on identical allegations and it, too, must fail as a matter of law. (*See* Doc. 1, ¶¶ 232-239). To establish a substantive due process claim, a plaintiff must prove that (1) it has a constitutional interest that is protected by the substantive due process clause; and (2) that the government's deprivation of the plaintiff's interest shocks the conscience. *See United Artists Theatre Circuit, Inc. v. Township of Warrington, PA* 316 F.3d 392, 400–02 (3rd Cir. 2003). For such a constitutional deprivation to shock the conscience, "only the most egregious official conduct" qualifies. *Id.* at 400 (quoting *County of Sacramento v. Lewis*, 523 U.S. 833, 845-46 (1998).

As set forth above, the "freedom of contractual relations" claimed by UPMC is not a constitutional interest that is protected by the substantive due process clause. And, the Proposed Modified Consent Decree – which the OAG is seeking pursuant to the negotiated contractual framework expressly agreed to by UPMC –

in no way rises to "the most egregious official conduct." Indeed, the Attorney General has done nothing more than file a petition seeking relief from the Commonwealth Court, where this matter properly belongs.

For these reasons, UPMC's substantive due process claim, like the others, should be dismissed as a matter of law.

V. CONCLUSION

For the forgoing reasons, General Shapiro's Motion to Dismiss should be granted and UPMC's Complaint should be dismissed with prejudice.

Respectfully submitted,

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CERTIFICATE OF WORD COUNT

I, Jonathan Scott Goldman, Executive Deputy Attorney General, hereby certify that this brief contains 7,736 words within the meaning of Local Rule 7.8(b)(2). In making this certificate, I have relied on the word count of the word processing system used to prepare the brief.

/s/ Jonathan Scott Goldman
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CERTIFICATE OF SERVICE

I, Jonathan Scott Goldman, Executive Deputy Attorney General for the Commonwealth of Pennsylvania, Office of Attorney General, hereby certify that on March 15, 2019, I caused to be served foregoing document titled Defendant's Brief in Support of Motion to Dismiss via ECF to the following:

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EXHIBIT U

UPMC LIFE CHANGING MEDICINE

RESOLUTION

UPMC Board of Directors
June 12, 2013

It is therefore resolved as follows:

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

UPMC LIFE CHANGING MEDICINE

BACKGROUND STATEMENT

June 12, 2013

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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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.	:	

THE COMMONWEALTH OF PENNSYLVANIA'S REPLY IN SUPPORT OF ITS APPLICATION TO QUASH UPMC'S SUBPOENA TO DEPOSE ITS LEAD COUNSEL AND FOR A PROTECTIVE ORDER

The Commonwealth of Pennsylvania, acting by Attorney General Josh Shapiro and through the Office of Attorney General (the "Commonwealth"), files this short Reply in Support of its Application to Quash UPMC's Subpoena to Depose Its Lead Counsel and for a Protective Order. *See Application to Quash,* 03/06/2019. In so doing, the Commonwealth reincorporates its Application by reference and will not burden the Court by repeating it here. Rather, it files this Reply solely to address several errant claims made by Respondent UPMC, A Nonprofit Corp., et al. ("UPMC") in its Response.

First, contrary to UPMC's claim, the Commonwealth is not trying to "flip" the burden regarding Pennsylvania Rules of Civil Procedure 4007.2 and 4012. The Commonwealth properly moved under Pa. R. Civ. P. 4012, and demonstrated good

cause for a protective order. On March 7, 2019, this Court granted a temporary Protective Order pending briefing. *See* Order re Protective Order, 03/07/2019. For the reasons set forth in its Application and this Reply, the Commonwealth respectfully requests that this Court make its existing Protective Order permanent.

Second, over and over in its Response, UPMC insists that it "needs" to depose Mr. Donahue "now" solely as a witness "concerning the factual basis for the allegations in the [Commonwealth's] Petition," Response at 10, 14. It promises repeatedly that it is not seeking information that is attorney-client privileged, work product protected, or the subject of internal deliberations or investigative processes.[1] Response at 11-14. But UPMC's own arguments betray this conceit.[2]

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[1] UPMC argues, based on a D.C. Circuit case, *Black v. Sheraton Corp of America*, 564 F2.d 531, 543 (D.C. Cir. 1977), that in order to properly invoke the deliberative process or investigative privileges in the Commonwealth Court of Pennsylvania, Attorney General Josh Shapiro must – *himself* – review every such claim and submit an "affidavit … identifying the materials as to which privilege is claimed, stating that he has *personally considered them*, and that after his personal consideration, [the Attorney General, himself, believes] they are protected by the deliberative process and/or investigative privileges." Response at 13 (emphasis added). This is both absurd, and a particularly obvious example of UPMC's strategy of litigation by harassment. It is also a plain misreading of *Black*, which only suggests such consideration by the "responsible department head." *Black*, 564 F2.d at 543. Here, the Commonwealth's Application was signed and submitted to this Court by, among others, the Executive Deputy Attorneys General for the Civil Law and Public Protection Divisions, who represent the Attorney General. Importantly, under the scenario UPMC suggests to the Court, it would be literally *impossible* for the Commonwealth to ever raise any objection under the deliberative process or investigative privileges in response to questions raised at Mr. Donahue's deposition unless Attorney General Josh Shapiro – *himself* – was in

In admitting that it wishes to depose Mr. Donahue as "the lead investigator," UPMC is admitting that it wishes to depose Mr. Donahue about materials implicated by the investigative, attorney client, work product, and deliberative process privileges. The gathering of facts in a civil investigation is generally protected by these legal privileges and protections insofar as those facts were gathered by attorneys and those working for them in their course of their professional duties and those facts indicate sources and methods, legal decision-making, internal processes, negotiations and strategy. *Pennsylvania Dep't of Educ. v. Bagwell*, 131 A.3d 638, 657 (Pa. Cmwlth. Ct. 2015). In admitting that it wishes to depose Mr. Donahue as the "principal participant in the meetings, conversations and negotiations with UPMC, Highmark, and others from 2011 onward," UPMC is admitting that it wishes to depose Mr. Donahue in violation of these same

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the room, defending it. The Commonwealth invoked the deliberative process and investigative privileges properly.

[2] Demonstrating both its hyper-aggressive tactics and that it is, in fact, seeking privileged and protected information, UPMC attaches to its Response a four-page "Rule 1023 letter" that it sent to Mr. Donahue, demanding that the Commonwealth "withdraw or correct" a laundry list of allegations in its Petition. Response at 10 and Ex. 3. However, UPMC's letter, which was sent on February 21, 2019, did not require a response from the Commonwealth until March 21, 2019. *See* PA. R. CIV. P. 1023.1-1023.4. The Commonwealth responded to that letter on March 20, 2019. Thus, the Commonwealth responded to UPMC's letter after UPMC filed its response, and within the time limits contemplated by the Rules. Furthermore, the Commonwealth has support for each of the listed allegations, their inclusion in the Petition is warranted, and they are not included for an improper purpose. There is nothing for the Commonwealth to correct, and its Petition will not be withdrawn.

privileges and protections and, in addition, to elicit information relating to confidential settlement negotiations that is inadmissible pursuant to Pennsylvania Rule of Evidence 408(a).

Under Pennsylvania Law, the Consent Decree is a contract. *See Com. ex rel. Kane v. UPMC,* 129 A.3d 441, 463-64 (Pa. 2015) (citation omitted). And, more than an ordinary contract, it is a contract that has been approved by this Court as a Court Order. *Id.* In this case, all of the parties to that contract – and especially UPMC – were represented by highly sophisticated counsel. It is blackletter law that once a contract is formed, litigation over the contract is confined to the four corners of that contract. *See, e.g., Seven Springs Farm, Inc. v. Croker*, 748 A.2d 740, 744 (Pa. Super. 2000), *aff'd,* 801 A.2d 1212 (Pa. 2002). Whatever negotiations may have occurred before vanish with only the completed agreement remaining. "It is not the province of the court to alter a contract by construction or to make a new contract for the parties; its duty is confined to the interpretation of the one which they have made for themselves, without regard to its wisdom or folly." *Steuart v. McChesney*, 444 A.2d 659, 662 (Pa. 1982) (citations and quotation marks omitted).

The Pennsylvania Supreme Court recently restated these bedrock principles of law in a related matter, *Commonwealth by Shapiro v. UPMC*, 188 A.3d 1122, 1131–32 (Pa. 2018). "[I]n the absence of fraud, accident or mistake, [courts have]

neither the power nor the authority to modify or vary the terms set forth [in a contract]." *Universal Builders Supply, Inc. v. Shaler Highlands Corp.*, 405 Pa. 259, 265, 175 A.2d 58, 61 (1961) (*citing Buffington v. Buffington*, 378 Pa. 149, 106 A.2d 229 (1954)). Extrinsic evidence may be employed to ascertain the meaning of contractual terms ***only*** when they *truly are ambiguous* or *subject to more than one reasonable interpretation. Murphy v. Duquesne Univ. of the Holy Ghost*, 565 Pa. 571, 591, 777 A.2d 418, 429-30 (2001) (citation omitted) (emphasis added). Here, there is no ambiguity in the Consent Decree, and no allegation that the contract is ambiguous.[3] *See generally* UPMC's Answer to Commonwealth's Petition to Modify Consent Decrees, 02/21/2019; UPMC's Reply in Support of Motion to Dismiss the Petition to Modify Consent Decrees, 03/18/2019.

Where, as here, the terms of the contract are unambiguous, they are deemed to reflect the intent of the parties. *See Kane, supra,* at 134, 129 A.3d at 463 (*citing Kripp v. Kripp*, 578 Pa. 82, 90, 849 A.2d 1159, 1163 (2004)). And, in determining intent, courts must examine "the entire contract ..., taking into consideration the surrounding circumstances, the situation of the parties when the contract was made and the objects they apparently had in view and the nature of the subject matter."

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[3] UPMC's representation that the Commonwealth initiated a legal action against it in this Court "challenging the meaning of the Consent Decree, including particularly the modification provision" Response at 2 and 5, is false. No one is *challenging the meaning* of the Consent Decree. Rather, the Commonwealth is simply petitioning this Court to apply the modification provision of the Consent Decree to UPMC's conduct.

Lower Frederick Twp. v. Clemmer, 518 Pa. 313, 329, 543 A.2d 502, 510 (1988) (*quoting Mather's Estate*, 410 Pa. 361, 366-67, 189 A.2d 586, 589 (1963)). Therefore, even if the deposition of Mr. Donahue was not protected by the various legal privileges and protections the Commonwealth has cited – and it is – all of the information that UPMC seeks is inadmissible pursuant to Pennsylvania Rule of Evidence 408(a) and falls outside the scope of discovery.

Third, to the extent there are any legitimate, non-privileged, relevant "facts" in the soup UPMC seeks to serve, UPMC's Response shows that it already has them: They are publically available or available to UPMC without seeking to depose the Commonwealth's lead counsel. UPMC quotes liberally to Mr. Donahue's October 10, 2014 public testimony; it cites to an OAG brief in another matter; and it offers its own detailed, self-serving recollection of a January 17, 2018 off-the-record judicial conference with another then-Commonwealth Court Judge in his chambers.[4] Response at 7-9. UPMC alludes specific to "meetings, conversations, and communications back-and-forth with UPMC [*itself*], Highmark, and other Commonwealth executive departments" and alleges specific "meetings and discussions with UPMC [*itself*], Highmark, and … other third parties".

[4] It is not surprising that the Commonwealth would not stipulate to UPMC's recollection. Response at 2, Exs. 1 and 2. It is perplexing, however, why UPMC would think that any such off-the-record statements would even be relevant to the plain legal task before this Court: applying the law to the Commonwealth's Petition to modify the consent decree. *See* Commonwealth's Petition to Modify Consent Decrees.

Response at 7. How or why UPMC seems to think such statements are relevant to this Court's application of basic contract and charitable non-profit law to the Commonwealth's Petition to Modify Consent Decree is another question, entirely.[5]

Fourth, UPMC's insistence that the Commonwealth can simply assert its objections "at the time of the deposition" shows its real purpose. Response at 11. UPMC insists that the Commonwealth "will have the opportunity at the time of the deposition to object to specific questions … and those objections *can be dealt with in due course*." *Id.* But such sacred legal ground cannot be protected from planned and pervasive encroachments with piecemeal "objections as to form" that can be "dealt with" at some later time, presumably in further motion practice before this Court designed to further string out this Court's time sensitive decision on the Commonwealth's Petition.

Last, the cases UPMC cites (all trial matters, none appellate) are easily distinguishable. *See Adeniyi-Jones v. State Farm Mutual Automobile Company,* 2015 WL 6180965 (E.D. Pa. Oct. 21, 2015) (allowing deposition of car accident victims' counsel in bad faith litigation regarding existence of *oral contract* entered into between that attorney and accident victims' insurer prior to litigation where *no written settlement agreement had been entered into*); *Frazier v. Southeastern*

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[5] In applying the law to the Petition before it, extraneous statements by the Attorney General during the course of negotiation are not relevant and should have no bearing. *See* Pennsylvania Rule of Evidence 408(a).

Pennsylvania Trans. Authority, 161 F.R.D. 309 (E.D. Pa. 1995) (allowing deposition of losing personal injury plaintiff's attorney where, in later lawsuit, plaintiff alleged prior-defendant SEPTA had improperly surveilled her during initial lawsuit in violation of her constitutional rights and her attorney had specific knowledge of those facts); and *Premium Payment Plan v. Shannon Cab Co.,* 268 F.R.D. 203 (E.D. Pa. 2010) (allowing deposition of business owner's attorney *who handled day-to-day transactions of his business* where business owner testified that counsel had directly received payments and records in dispute).

In rare cases, like those above, an attorney can be deposed – but that is only where the actual actions of the attorney are at the heart of a typically separate legal dispute. The most obvious example is in a claim of malpractice. That is not what we have here. Executive Deputy Attorney General James A. Donahue, III, has no duty to UPMC. His only legal duty is to the Commonwealth, his role as lead counsel is not the basis for the matter before the Court, and the information UPMC seeks from Mr. Donahue is legally privileged and protected from disclosure. If this Court allows Mr. Donahue to be deposed, no attorney representing a client in contract or settlement negotiations can any longer be shielded from the subpoena of opposing counsel in later litigation seeking to enforce that agreement.[6]

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[6] In the private sector, such subpoenas could quickly become weaponized by aggressive opposing counsel seeking to conflict an adverse party's counsel out of litigation. For example, if a party to this litigation was to issue a similar subpoena

For all of these reasons and those set forth in its Application, this Court should grant the Commonwealth's Application to Quash UPMC's Subpoena to Depose Its Lead Counsel and for a Protective Order and make permanent its existing temporary Protective Order prohibiting UPMC from taking the deposition of the lead counsel to the Commonwealth.

Respectfully submitted,

JOSH SHAPIRO
Attorney General

By: *s/ Jonathan Scott Goldman*

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to UPMC's own lead counsel – who, based on UPMC's Response, has parallel "factual" knowledge to Mr. Donahue and was party to the same negotiations, meetings and correspondence as Mr. Donahue was – UPMC's counsel would become a fact witness to the case. UPMC, then might have to or choose to hire alternative, less "conflicted" (and less knowledgeable) counsel to represent it in the underlying litigation. Or UPMC's counsel might then conclude that it is conflicted and has to withdrawal from the representation entirely, thereby leaving its client at a strategic disadvantage.

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CERTIFICATION REGARDING PUBLIC ACCESS POLICY

I certify that this filing complies with the provisions 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 than non-confidential information and documents.

s/ Jonathan Scott Goldman
JONATHAN SCOTT GOLDMAN
Executive Deputy Attorney General
Civil Law Division

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.	:	

CERTIFICATE OF SERVICE

I hereby certify that this document was served on all counsel via PACFile.

s/ Jonathan Scott Goldman
JONATHAN SCOTT GOLDMAN
Executive Deputy Attorney General
Civil Law Division

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.	:	

ORDER

AND NOW this _____ day of _____, 2019, upon consideration of the Commonwealth of Pennsylvania's Application to Quash UPMC's Subpoena to Depose its Lead Counsel and Application for a Protective Order (the "Application"), UPMC's Response thereto and the Commonwealth's Reply, and for good cause shown, it is hereby ORDERED that the Application is GRANTED. Respondent UPMC's notice and subpoena for the deposition of Executive Deputy Attorney General James A. Donahue, III, is hereby QUASHED and a Protective Order is entered prohibiting the deposition.

BY THE COURT:

_____

, J.

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

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334 MD 2014

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

NOTICE TO PLEAD

To:

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James A. Donahue, III
Michael T. Foerster
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You are hereby notified to file a written response to the enclosed **Answer with New Matter and Counterclaims to Commonwealth's Petition to Modify Consent Decrees** within twenty (20) days from service hereof or a judgment may be entered against you.

COZEN O'CONNOR

Dated: April 15, 2019

/s/ Stephen A. Cozen
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IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

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

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

A. AS TO "INTRODUCTION"

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. AS TO "PUBLIC FINANCIAL SUPPORT FOR UPMC"

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

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

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

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

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

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

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

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

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

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

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

D. AS TO "HISTORY"

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

dismissed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

As to "Access and Treatment Denials"

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

As to "Individuals"

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

As to "Medicare and Older Pennsylvanians"

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

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

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

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

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

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

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

As to "Emergency"

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

As to "Wasteful Expenditures of Charitable Resources"

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

healthcare system.

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

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

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

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

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

F. AS TO "UPMC'S EXPANSION"

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

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

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

a) Admitted.

b) Admitted.

c) Admitted.

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

e) Admitted.

f) Admitted.

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

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

a) Admitted.

b) Admitted.

c) Admitted.

66. Admitted.

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

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

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

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

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

G. AS TO "COUNTS"

COUNT I

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

allegations of paragraph 76 hereof.

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

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

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

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

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

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

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

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

NEW MATTER AND COUNTERCLAIMS

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

INTRODUCTION

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

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

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

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

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

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

FACTUAL ALLEGATIONS

The UPMC-Highmark Relationship

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

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

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

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

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

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

The Mediated Agreement

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

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

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

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

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

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

The Highmark-WPAHS Affiliation

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

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

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

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

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

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

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

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

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

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

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

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

The Consent Decree

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Exhibit B to Petition at 14.

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

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

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

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

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

The Attorney General's Efforts to Enforce the Consent Decree

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2018 Action.

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

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

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

The Petition to Modify Consent Decrees

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

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

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

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

violate both state and federal law.

The Proposed Modifications Improperly Interfere with Medicare Advantage

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Proposed Modifications Discriminate Between Insurers Operating on ACA Exchanges

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Proposed Modifications Deny UPMC the Benefit of Its Investments

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Proposed Modifications Force UPMC to Violate Antitrust Law

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

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

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

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

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

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

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

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

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

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

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

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

Third Circuit held:

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

Id. at 103-04.

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

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

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

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

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

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

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

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

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

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

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

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

week before he filed the Petition.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

of the Sherman Act.

156. General Shapiro is aware of the Alabama litigation.

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

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

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

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

NEW MATTER AFFIRMATIVE DEFENSES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

in Count I of the Petition.

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

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

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

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

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

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

COUNTERCLAIMS

COUNTERCLAIM COUNT I – FRAUD IN THE INDUCEMENT

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

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

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

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

a) the Consent Decree would terminate;

b) the Consent Decree was not a contract extension;

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

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

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

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

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

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

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

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

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

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

COUNTERCLAIM COUNT II – DECLARATORY JUDGMENT/ UNCONSTITUTIONAL TAKING

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

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

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

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

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

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

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

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

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

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

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

Dated: April 15, 2019

Respectfully submitted,

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IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

CERTIFICATE OF SERVICE

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

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EXHIBIT A

BEFORE THE INSURANCE DEPARTMENT
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:

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

APPROVING DETERMINATION AND ORDER

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Competitive Conditions

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

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

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

Prohibition On Exclusive Contracting

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

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

Provider/Insurer Payment Contract Length Limitation

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

Termination Of Current Health Care Insurer Contracts Other Than For Cause

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

Prohibition On Most Favored Nation Contracts Or Arrangements

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

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

Firewall Policy

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

8. On or before May 1 of each year, UPE shall file with the Department a report executed by UPE's President and its Chief Privacy Officer. The report shall be a public record, shall be in a form and substance satisfactory to the Department and shall include the following certification to the best of the President's and Chief Privacy Officer's information, knowledge and belief: (i) at all times during the immediately preceding calendar year, each UPE Entity subject to Condition 7 was governed by and operated in accordance with a Department Approved Firewall Policy; (ii) at all times in the prior calendar year each Approved Firewall Policy was fully implemented, monitored and enforced in accordance with its terms, except as fully described in subsection (vi) below; (iii) mandatory training of employees with access to any Competitively Sensitive Information (including both current employees and all new hires) has occurred in accordance with the terms of the applicable Approved Firewall Policy; (iv) each UPE Entity that is subject to Condition 7 has obtained recertification biannually of each of its employees with access to any Competitively Sensitive Information stating that the employee has received a copy of the Approved Firewall Policy, understands the Approved Firewall Policy and agrees to abide by the Firewall Policy; (v) no individual with management oversight over all or part of both UPE's provider and insurer business

segments has used Competitively Sensitive Information obtained as part of his or her oversight function to competitively disadvantage a rival Health Care Provider or Health Care Insurer; (vi) each UPE Entity that is subject to Condition 7 has undertaken an annual good faith review of the UPE Entity's Approved Firewall Policy compliance for the prior calendar year and that either (a) there were no violations or other breaches of the applicable Approved Firewall Policy other than those for which the UPE Entity had previously provided notice to the Department in accordance with the Approved Firewall Policy, or (b) the Department has been provided with the non-reported breaches report and corrective action plan required in Condition 9; and (vii) such other information as the Department shall require.

9. UPE, UPE Provider Sub, and each UPE Entity that is a Health Care Provider or a Health Care Insurer shall provide the Department with such information regarding its Approved Firewall Policy and its implementation and enforcement as the Department shall from time to time request. In addition to other information to be provided to the Department, a report of non-reported breaches of the applicable Approved Firewall Policy, which shall not be a public record, shall accompany the annual certification along with a corrective action plan (which shall be satisfactory in form and substance to the Department) to assure the Department of future, timely compliance with the Approved Firewall Policy and to provide an explanation as to why prior notice of such breach had not been provided to the Department. Approved Firewall Policy implementation and enforcement shall be subject to review and/or examination by the Department, or consultants retained by the Department at the expense of the UPE Entity, to the extent that the Department believes that such review and/or examination is in the public interest.

Financial Conditions

Preamble: The following financial conditions are intended to: (i) limit the amount of policyholder funds that may be transferred to any Domestic Insurer's new parent entity or other Affiliates of the parent; (ii) establish an enhanced standard of review and assessment that is required to be undertaken prior to any Domestic Insurer entering into additional material financial commitments; (iii) implement ongoing reporting and monitoring requirements related to a Domestic Insurer's investments into the WPAHS Entities; (iv) establish criteria for a plan of corrective action to be prepared by UPE if the turnaround of WPAHS falls short of certain targets; and (v) enhance the level of transparency and accountability with respect to Highmark's stated goal of deriving tangible policyholder benefits, in the form of relative premium and cost of care savings, related to financial commitments made in connection with the Transaction.

Limitations On Donations

10. Without the Approval of the Department, no Domestic Insurer shall make, or agree to make, directly or indirectly, any Donation, which together with all other Donations made or agreed to be made by that Domestic Insurer within the twelve (12) consecutive months immediately preceding such Donation equals or exceeds the lesser of: (i) 3% of the Domestic Insurer's surplus as regards policyholders, as shown on its latest annual statement on file with the Department; or (ii) 25% of the Domestic Insurer's net income as shown on its latest annual statement; provided, however, if UPE has filed pursuant to Condition 15 a WPAHS Corrective Action Plan, any Donation made or agreed to be made by any Domestic Insurer to any UPE Entity shall be restricted solely for use in connection with implementing the Financial Commitments under and to the extent provided in the WPAHS Corrective Action Plan, until such time as all Financial Commitments related to the WPAHS Corrective Action Plan are satisfied. A Domestic Insurer may not make or agree to make a Donation which is part of a plan or series of like Donations and/or other transactions with other UPE Entities, the purpose, design or intent of which is, or could reasonably be construed to be, to evade the threshold amount set forth in this Condition and thus avoid the review that would occur otherwise. Notwithstanding the foregoing, and in addition to the requirements of (i) and (ii) of this Condition 10, in no event shall Highmark have any right, directly or indirectly, to make any Donation under this Condition if the RBC Rating of Highmark is, or as a result of the Donation is likely to be, 525% or below. This Condition 10 shall not apply to a Donation made from a Domestic Insurer that is a direct or indirect subsidiary of Highmark to Highmark or any subsidiary of Highmark. No Approval of the Department shall be required under this Condition if Department approval for the Financial Commitment has been obtained under 40 P.S. § 991.1405.

Financial Commitment Limitations

11. Any Financial Commitment made or agreed to be made to or for any Person by any of the UPE Entities designated in this Condition, directly or indirectly, shall satisfy the following requirements:

A. **Due Diligence Standard.** For all Financial Commitments: (i) the UPE Entity making or agreeing to make any Financial Commitment shall conduct a Commercially Reasonable Process to evaluate and assess the benefits and risks to policyholders, subscribers or other stakeholders, as applicable, and whether the Financial Commitment furthers and is consistent with the UPE Entity's nonprofit mission, if the UPE Entity is exempt from Federal taxation pursuant to Section 501(c)(3) of the Internal Revenue Code); and (ii) the terms of any Financial Commitment shall satisfy the provisions of 40 P.S. § 991.1405, as if the Financial Commitment transaction were made or agreed to be made between or among members of the holding company system.

B. **Transactions Requiring Only Notice.** If the amount of any Financial Commitment made or agreed to be made by one or more of the Domestic Insurers equals or exceeds $100,000,000 in the aggregate (or if such Financial

Commitment, together with all other Financial Commitments made by one or more of the Domestic Insurers, directly or indirectly, within twelve (12) consecutive months immediately preceding the making of the Financial Commitment causes the total to exceed $100,000,000), the Domestic Insurer(s) making or agreeing to make such Financial Commitment shall deliver to the Department written notice 30 days in advance of making or agreeing to make such Financial Commitment (the "Financial Commitment Notice"). The Financial Commitment Notice shall describe such Financial Commitment, and provide such information as is required by 31 Pa. Code § 27.3 relating to material transactions, together with such other information as the Department shall request. No notice is required under this Condition if notice of the Financial Commitment is provided to the Department pursuant to 40 P.S. § 991.1405.

C. **Transactions Requiring Department Approval.** Without the Approval of the Department, no Domestic Insurer shall make or agree, directly or indirectly, to make any Financial Commitment if: (i) the amount thereof, together with all other Financial Commitments made or agreed to be made directly or indirectly by all of the Domestic Insurers within the immediately preceding consecutive twelve (12) months, equals or exceeds $250,000,000; (ii) the amount thereof is made in connection with a Financial Commitment made or agreed to be made to a Person (including but not limited to any Affiliates), together with all other Financial Commitments between or among one or more of the UPE Entities, on the one hand, and such Person (including but not limited to any Affiliates), on the other hand, aggregate $250,000,000 or more; or (iii) the RBC Rating of Highmark is, or as a result of the Financial Commitment is likely to be, 525% or below.

D. **No Circumvention Mechanism.** No Domestic Insurer may undertake any action to delay any Financial Commitment or perform or agree to perform any Financial Commitment in stages or steps, or take any other action with respect to any Financial Commitment, the purpose, design or intent of which is, or could reasonably be construed to be, to evade any of the foregoing requirements.

Disclosure Of Financial Commitments And Financial And Operational Information

12. On or before May 1 of each year, UPE shall file with the Department a report setting forth: (i) all Financial Commitments made or agreed to be made by any UPE Entity within the immediately preceding calendar year; and (ii) specifying the section of this Condition pursuant to which such Financial Commitments were permitted to be made or agreed to be made. UPE shall promptly and fully respond to questions or requests of the Department for information in connection with such report.

13. Each year, no later than the date on which the financial statements are required to be filed for the holding company system under Form B or otherwise filed pursuant to 40 P.S. § 991.1404 (a), UPE shall file with the Department, as a public record, audited financial statements (including but not limited to all footnotes) of UPE prepared in accordance with GAAP, for the immediately preceding calendar year. In addition, UPE shall file with

the Department any letters from auditor(s) to management and any other information requested by the Department.

14. UPE shall file with the Department a report setting forth the below listed financial and operational information for the WPAHS Entities (the "Required WPAHS Financial and Operational Information"). The Required WPAHS Financial and Operational Information shall be filed quarterly for each quarter through the period ended June 30, 2015 (within 30 days after the end of the quarter) and thereafter annually on July 1 of each year.

A. The Required WPAHS Financial and Operational Information shall be presented on the same basis as the information was presented for the immediately preceding three (3) month period through the quarter ended June 30, 2015, or for each annual report on the same basis the information was presented for the preceding four (4) quarters of each year for which the annual report is required to be delivered. For each quarterly report, the information shall be compared to the WPAHS budget or forecast for such quarter and for each annual report, the information shall be compared to the WPAHS budget or forecast for such year and the Base Case financial projections. UPE shall make members of its management team available to the Department on a timely basis for purposes of reviewing the Required WPAHS Financial and Operational Information with the Department and any consultants retained by the Department.

B. The Required WPAHS Financial and Operational Information shall include for the WPAHS Entities:

(1) An income statement displaying a level of detail consistent with the Base Case Financial Projections for the WPAHS Entities as submitted by UPE to the Department as part of UPE's Form A filings (the "Base Case Financial Projections"). To the extent that the income statement submitted to the Department pursuant to this Condition differs from GAAP, a reconciliation shall be submitted as well.

(2) A cash flow statement displaying a level of detail consistent with the Base Case Financial Projections for the WPAHS Entities submitted by UPE to the Department as part of UPE's Form A. To the extent that the income statement and cash flow statements submitted to the Department pursuant to this Condition differ from GAAP, a reconciliation shall be submitted as well.

(3) A calculation of the WPAHS Entities' Days Cash on Hand as defined in the Master Trust Indenture (the "DCOH"), which shall present a level of detail sufficient to reconcile the components of the calculation to the income statement and balance sheets submitted as part of this Condition.

(4) A calculation of WPAHS Entities' Debt Service Coverage Ratio, as defined in the Master Trust Indenture, which shall present a level of detail

sufficient to reconcile the components of the calculation to the income statement and balance sheets submitted as part of this Condition.

(5) A schedule of capital expenditures for all WPAHS Entities, and for each WPAHS Entity for which information is requested by the Department, during the applicable calendar quarter in question and grouped by significant project categories.

(6) A schedule of inpatient and outpatient discharge volume for the WPAHS Entities in total and for each primary WPAHS Entity facility.

(7) A schedule of occupancy rates for the WPAHS Entities in total and for each primary WPAHS facility.

(8) A schedule of salaried and non-salaried employees, including but not limited to physicians, on an FTE basis for the WPAHS Entities in total and for each primary WPAHS Entity operating segment (hospitals, physician organization, etc.).

(9) A schedule of occupied beds by each primary WPAHS Entity facility.

(10) A schedule of FTEs per occupied bed by each primary WPAHS Entity facility.

(11) Audited financial statements (including but not limited to all footnotes) of WPAHS and WPAHS Affiliates specified by the Department prepared in accordance with GAAP, for the immediately preceding calendar year along with any letters from auditors to management.

(12) If WPAHS files consolidated financial statements with any UPE Entity other than WPAHS Affiliates specified by the Department, then UPE shall deliver WPAHS' consolidating financial statements showing its financial position, results of operations, changes in cash flow and related footnotes thereto of WPAHS and such specified WPAHS Affiliates on a standalone basis.

(13) Such other financial and operational information related to WPAHS and the IDN Strategy as may be requested, from time to time, by the Department.

WPAHS Corrective Action Plan

15. UPE shall prepare and produce to the Department a plan of financial and operational corrective action for WPAHS (the "WPAHS Corrective Action Plan") if either:

A. (i) From the date hereof through June 30, 2015, the aggregate amount of Financial Commitments made or agreed to be made directly or indirectly by all UPE Entities to the WPAHS Entities equals or exceeds $100,000,000 and (ii) the

WPAHS Entities have issuer ratings from two (2) of the Credit Rating Agencies of less than investment grade; or

B. As of the quarter ended June 30, 2015, either (i) the WPAHS Entities' net income, as determined in accordance with GAAP ("Net Income"), has not been greater than $0.00 after adjusting for any material non-recurring or unusual income, including but not limited to all payments received from any UPE Entity outside of the normal course of business and any Financial Commitments to the extent included in such Net Income, for two (2) out of the previous four (4) consecutive quarters; or (ii) DCOH, after adjusting for any material non-recurring or unusual cash receipts and Financial Commitments, including but not limited to all payments received from any UPE Entity outside of the normal course of business, has not been equal to or greater than a value of sixty-five (65) days for two (2) of the previous four (4) consecutive quarters.

16. If a WPAHS Corrective Action Plan is required to be prepared and produced to the Department pursuant to Condition 15A or 15B, it shall be produced promptly upon request or order of the Department to UPE and all such information when produced shall be treated as confidential pursuant to an examination process or proceeding under 40 PS § 991.1406.

17. The WPAHS Corrective Action Plan shall specify, in reasonable detail, UPE's intended actions to be taken over the subsequent twelve to twenty-four (12–24) months that are designed and anticipated to: (i) facilitate repayment or refinancing of the bond obligations of the WPAHS Entities payable to Highmark (or any UPE Entity) and on terms that would not require any Credit Enhancement Device from Highmark or other UPE Entities; (ii) generate DCOH of at least sixty-five (65) days within eighteen (18) months and for the foreseeable future thereafter; and (iii) generate net income of no less than $0 within eighteen (18) months and for the foreseeable future thereafter.

A. In addition, the WPAHS Corrective Action Plan shall specify the intended corrective actions that are proposed to be implemented, including but not limited to the following potential actions that were referenced in UPE's Form A filing: (i) efficiency improvements and revenue opportunities; (ii) changes in employment, including but not limited to in the number of employed physicians; (iii) modifications to capital expenditure plans; (iv) reductions in unfunded research; (v) non-core asset sales; (vi) restructuring of compensation and benefits; and (vii) outsourcing.

B. The WPAHS Corrective Action Plan shall include but not be limited to: (i) an estimate of total cost to adopt, implement and consummate the WPAHS Corrective Action Plan—including but not limited to write-downs, one-time or ongoing restructuring costs, anticipated litigation, consulting, legal and other advisory fees and any future capital commitments—specifying UPE's estimated value for any WPAHS Entity-related investments held by Highmark or any other UPE Entity, including but not limited to loans or bonds receivable, at the time of the WPAHS Corrective Action Plan's implementation and without consideration

of potential contingency actions; and (ii) the amount of any funding needed by the WPAHS Entities to fully pay for and carry out the WPAHS Corrective Action Plan (the "WPAHS Required Funding") and an acknowledgement that any Donations made pursuant to Condition 10 will be restricted for use in paying the WPAHS Required Funding to the extent of the amount of the WPAHS Required Funding.

C. Prior to submission, UPE shall have the WPAHS Corrective Action Plan reviewed at its sole expense by an external financial expert, who shall conclude as to the reasonableness of the plan and the sufficiency of the WPAHS Required Funding and UPE's stated actions for the purposes of limiting future WPAHS, Highmark and/or UPE losses and/or the need for additional Financial Commitments. The financial expert also shall assess the specific level of benefits and costs to be borne by Highmark's policyholders, as distinct from any franchise benefits accruing to Highmark in the form of higher enrollment, revenue and market share, and shall conclude as to the reasonableness of the value assigned by UPE to Highmark's investments in WPAHS.

Executive Compensation

18. UPE and Highmark shall ensure and maintain in effect a policy that any senior executives of any UPE Entity who have been responsible for designing, recommending and/or implementing the IDN Strategy have a meaningful portion of their long-term compensation tied to the achievement of quantifiable and tangible benefits to policyholders, if any, or to the charitable nonprofit entity, if the UPE Entity is exempt from Federal taxation pursuant to Section 501(c)(3) of the Internal Revenue Code (the "IDN Compensation Policy"). Within ninety (90) days after the date hereof, UPE shall deliver to the Department a copy of the IDN Compensation Policy which satisfies the foregoing requirements in a form and substance acceptable to the Department. Any amendments to the IDN Compensation Policy shall be submitted to the Department accompanied by a certification by the President of UPE that, to the best of his or her information, knowledge and belief, the amendment to the IDN Compensation Policy satisfies the requirements of this Condition. UPE shall report annually by May 1 of each year the amount of the compensation paid to such senior executives and describe the manner in which such compensation is consistent with the IDN Compensation Policy.

Meeting IDN Savings Benchmarks

19. On or before May 1 of each year, UPE shall file with the Department a report describing in detail whether each Benchmark contained in Appendix 3 (Benchmarks), which Appendix 3 is attached hereto and incorporated herein by reference, has been met or what progress has been made toward meeting each Benchmark. The report shall include but not be limited to a statement of savings achieved through implementation of the IDN Strategy (the "IDN Savings") during (i) the preceding calendar year; and (ii) in total since consummation of the Affiliation Agreement. Each annual report shall quantify: (i) the total savings realized by policyholders across all products and consumers compared to the estimate of the cost of care that would have been incurred by policyholders if the

Affiliation Agreement had not been consummated (the "Total IDN Savings"); (ii) the relative savings realized by consumers on a per-member-per-month claims basis (the "PMPM IDN Savings"); (iii) a comparison of the Total IDN Savings and PMPM IDN Savings to the relevant projections provided in the Form A filing and shall provide a detailed description of variances between the projections and actual savings achieved; (iv) the annual and cumulative savings actually achieved by policyholders in the eight categories for which projected savings were provided to the Department in the Form A, which categories are set forth in Attachment 4 (Total IDN Savings Categories) or such other categories as the Department may approve. UPE shall have the quantification of savings and related explanations of variances reviewed by an external actuarial consulting firm, which shall conclude as to the reasonableness of the methodologies used for quantifying the savings. Within ninety (90) days of closing of the Affiliation Agreement, UPE shall submit to the Department a detailed plan for the measurement and reporting methodologies to be followed for compliance with this Condition. If the Benchmark has not been met or if satisfactory progress has not been made toward achievement of the Benchmark, the report shall specify what corrective actions will be taken in order to assure that the Benchmark is met in a timely fashion. Specifically, if, as of December 31, 2016, either the Total IDN Savings or the PMPM IDN Savings are less than the amounts projected as part of the Form A filing, then, by April 1, 2017, UPE shall file with the Department a detailed corrective action plan to maximize IDN Savings in the future or otherwise generate tangible policyholder benefits in amounts sufficient to justify the continued investment of policyholder funds in the IDN Strategy.

Public Interest/Policyholder Protection Conditions

Consumer Choice Initiatives

Preamble: Consumer choice and other member cost-sharing initiatives, including but not limited to tiered network products based upon transparent, objective criteria that include quality and cost, are procompetitive. These initiatives are consistent with efforts to provide consumers with informed healthcare choices and to incentivize consumers to consider the costs of healthcare and quality of outcomes in choosing providers. The following consumer choice initiative Condition is designed to prohibit provider and insurer contracts that would prohibit or limit the ability of Health Care Insurers to implement such consumer choice initiatives.

20. After the issuance of this Approving Determination and Order, no Domestic Insurer shall enter into a contract or arrangement with a Health Care Provider that prohibits and/or limits the ability of any Domestic Insurer to implement Consumer Choice Initiatives, without the prior Approval of the Department. After the issuance of this Approving Determination and Order, no UPE Entity that is a Health Care Provider shall enter into a contract or arrangement with a Health Care Insurer that prohibits and/or limits the ability of the UPE Entity to implement Consumer Choice Initiatives, without the prior Approval of the Department. This Condition does not prohibit a Domestic Insurer or a UPE Entity that is a Health Care Provider from entering into a contract that provides volume

discounts, provided that such volume discounts are not conditioned upon or related to commitments not to implement Consumer Choice Initiatives.

Affiliation And IDN Impact On Community Hospitals

Preamble: UPE indicates in its filings that vibrant and financially healthy community hospitals are a key component of the IDN Strategy. Community hospitals are viewed as high quality, lower cost alternatives for healthcare delivery; and, thus, are projected to be key partners. UPE acknowledges that its efforts to reinvigorate the WPAHS Entities may result in some draw of inpatients away from community hospitals to the WPAHS Entities, but states that the IDN Strategy and UPE's "Accountable Care Alliance" strategy overall will increase inpatient admissions at community hospitals, thereby resulting in a net increase in community hospital inpatient admissions. To address concerns that the Affiliation Agreement will adversely impact inpatient admissions at community hospitals and risk the financial viability of these community assets, the Department imposes Conditions that require the monitoring and reporting of Affiliation Agreement and IDN Strategy implementation impacts on community hospital discharges, and Conditions requiring UPE to report any financial commitments and other efforts to deliver more cost-effective healthcare at community hospitals to further healthcare choices in the Western Pennsylvania area.

21. On or before May 1 of each year, UPE shall submit a document (the "IDN-Community Hospital Report"), which IDN-Community Hospital Report shall describe in detail for the immediately preceding calendar year: (a) the number of discharges for each Domestic Insurer at each hospital in the WPA service area, as such area is defined in connection with the Form A (the "WPA Service Area"); (b) the number of discharges for each Domestic Insurer at each hospital in its WPA Service Area for calendar year ended 2012 ("Base Year Discharge Data"); (c) a comparison of the discharge information in the current IDN Certification against: (i) the discharge information provided by UPE under the IDN Certification for the immediately preceding year, if any was required to be provided; and (ii) the Base Year Discharge Data; (d) an analysis of whether and to what extent Highmark's affiliation with WPAHS and the implementation of the IDN Strategy resulted in a net decrease in the Domestic Insurers' discharges at its WPA Service Area community hospitals; and (e) the amount and nature of any Financial Commitments by any and all UPE Entities in community-based facilities and service in community hospitals that any such UPE Entities have undertaken with each hospital (excluding any hospitals of WPAHS and UPMC or their respective subsidiaries), including but not limited to efforts to identify opportunities to deliver more cost-effective healthcare to ensure a robust and vibrant network with meaningful choice in key service lines.

A. Within sixty (60) days after the date of an IDN-Community Hospital Report, the Domestic Insurers shall submit to the Department a plan of operational corrective action ("IDN Corrective Action Plan") if the analysis set forth in the IDN-Community Hospital Report for the year in question reflects a net decrease of

10% or more in all of the Domestic Insurers' discharges at their WPA Service Area community hospitals with which they have a contract or arrangement. The IDN Corrective Action Plan shall specify, in reasonable detail, the Domestic Insurers' intended commercially reasonable actions to be taken over the subsequent twelve (12) months that are designed and anticipated to address the reasons for the decrease in discharges relating to the Affiliation Agreement and the IDN Strategy. The IDN Corrective Action Plan shall include but not be limited to an estimate of total cost to adopt, implement and consummate the IDN Corrective Action Plan.

B. The Domestic Insurers shall use commercially reasonable efforts to implement the IDN Strategy in a manner that utilizes and enhances the role of community hospitals in their respective WPA Service Areas to provide continued services to the communities they serve.

Transition Plan Regarding UPMC Contract

Preamble: The Department recognizes that Highmark's contract with UPMC is scheduled to terminate on December 31, 2014, and new or extended provider contracts may or may not be entered into between the parties. The Department also recognizes that the Application's Base Case is premised on a non-continuation of the UPMC Contract and that continuation of such contract may, based on the Applicant's projections, delay WPAHS' financial recovery. The potential termination of these provider contracts may be disruptive to the Domestic Insurers' enrollees and consumers of UPMC healthcare services as that termination date is reached. In the event of a contract termination and to minimize any adverse impact on healthcare consumers and protect the public interest, the Department imposes a transition plan condition on all Domestic Insurers that have contract(s) with UPMC. The Condition focuses on issues such as continuation of care and access options available to the Domestic Insurers' enrollees; adequacy of the Domestic Insurers' remaining provider networks; and appropriate communications, as necessary, to inform healthcare consumers of any issues with continued access to certain UPMC facilities and practice areas.

22. With respect to the possibility of a contract between or among one or more of the Domestic Insurers and UPMC after December 31, 2014, the following shall apply:

A. If a Domestic Insurer secures UPMC's assent to a new contract, combination, affiliation, or arrangement (or an extension of the current contract that expires on December 31, 2014) ("New UPMC Contract"), UPE shall notify the Department in advance of the execution of the New UPMC Contract and provide the Department with updated information, based on reasonable assumptions and credible projections, on the impact of the terms of any New UPMC Contract on the financial performance of WPAHS, as well as an independent analysis of an expert on the impact of the New UPMC Contract on both the insurance and

provider markets in the region including but not limited to any effects on competition.

B. If, however, one or more of the Domestic Insurers and UPMC do not enter into a New UPMC Contract by July 1, 2014, then UPE shall file with the Department and with the Pennsylvania Department of Health: (i) an update of the status of negotiations between UPMC and such Domestic Insurer(s), including but not limited to reasons that the parties have been unable to enter into a New UPMC Contract; and (ii) a formal transition plan (the "UPMC Contract Transition Plan") no later than July 31, 2014 that sets forth such information as shall be required by the Department and the Department of Health and which addresses such issues as continuation of care; options available to subscribers to access Health Care Providers; appropriate communication, as necessary, to subscribers, providers and others regarding adequacy and changes in cost or scope of coverage. The UPE Entities shall fully cooperate with the Department and the Department of Health in coordinating with UPMC for the further development and, if necessary, implementation of the UPMC Contract Transition Plan with the goal of minimizing any disruption to consumers and the marketplace and ensuring that such consumers continue to have access to quality healthcare in a competitive marketplace.

Community Health Reinvestment

Preamble: Preamble: This Condition requires Highmark to continue its commitment to non-profit activities directed to the betterment of overall community healthcare by fixing and expressly making permanent a percentage of Highmark's direct written premiums that will be dedicated to Community Health Reinvestment endeavors.

23. Commencing with calendar year 2014, Highmark shall annually dedicate to and pay for Community Health Reinvestment Activities ("CHR") an amount equal to 1.25% of all of Highmark's aggregate direct written premiums, as reported in the annual statement filed by Highmark pursuant to Condition 23B (the "Annual CHR Payment Obligation") for the immediately preceding year.

A. The Annual CHR Payment Obligation shall be calculated on a calendar year basis. Notwithstanding the foregoing, (i) Highmark's minimum Annual CHR Payment Obligation (the "Minimum Annual CHR Payment Obligation") shall be equal to 1.25% of all of Highmark's aggregate direct written premiums for the 2013 calendar year; and (ii) Highmark shall not be required to fund or commit to fund Community Health Reinvestment Activities for 2014 in an amount in excess of 105% of the Minimum Annual CHR Payment Obligation, and thereafter in an amount in excess of 105% of the actual CHR Payment made (but in no event less than the Minimum Annual CHR Payment Obligation) for the immediately preceding calendar year. Highmark shall not be required to fund or commit to fund any Community Health Reinvestment Activities to the extent that, at the time of such funding or commitment, or after giving effect thereto, its RBC

Rating level is, or is reasonably expected to be, less than 525%. If Highmark fails to meet its Annual CHR Payment Obligation in any calendar year, the deficiency in such payment obligation shall be paid by Highmark by May 1 of the following calendar year into the Insurance Restructuring Restricted Receipt Account.

B. On or before March 31 of each calendar year, Highmark shall provide to the Department a report, in form and substance acceptable to the Department, of Highmark's Community Health Reinvestment Activities for the prior calendar year.

C. The provisions of this Condition supersede and replace in their entirety any obligation by Highmark pursuant to Condition 4 of the Department's Decision and Order dated November 27, 1996 (Docket No. MS96-04-098) (the "1996 Department Order").

Miscellaneous Conditions

Modification Of Prior Orders

24. Except as expressly provided in this Approving Determination and Order, nothing in this Approving Determination and Order shall be construed to modify or repeal any term or condition of any prior order or approval of the Department, including, but not limited to, the 1996 Department Order.

25. The Department shall determine whether and to what extent any conflict or inconsistency exists between or among this Approving Determination and Order and any term or condition in any prior order(s) or approval(s) of the Department, and the Department shall have the authority to determine what term or condition controls.

Department Costs And Expenses

26. The Department may retain at the reasonable expense of the UPE Entities, as determined by the Department, any attorneys, actuaries, accountants and other experts not otherwise part of the Department's staff as, in the judgment of the Department, may be necessary to assist the Department, regardless whether retained before, on or after the date of this Approving Determination and Order, in or with respect to: (i) evaluation and assessment of any certifications, reports submissions, or notices given or required to be given in connection with this Approving Determination and Order; (ii) compliance by any of the UPE Entities with this Approving Determination and Order; (iii) the enforcement, or any challenge or contest to enforcement or validity, of the Conditions or otherwise of this Approving Determination and Order, including, but not limited to, reviewing and analyzing any certifications, reports, submissions or notices by or for any UPE Entity or auditing and reviewing any books and records of any UPE Entity to determine compliance with any of the Conditions; (iv) litigation, threatened litigation or inquiries or investigations regarding, arising from or related to the Form A filing, the process surrounding the approval of the Form A filing and/or this Approving Determination and Order; and/or (v) the defense of any request or action to require public disclosure of

information that UPE or the Department deems confidential. The obligations of the UPE Entities to the Department for all such costs and expenses shall be joint and several obligations.

Modification Of Approving Determination And Order

27. Upon written request by a UPE Entity setting forth: (a) the specific Condition(s) for which such UPE Entity seeks relief; (b) the reason for which such relief is necessary and (c) an undertaking by such UPE Entity to provide all such further information as the Department shall require to evaluate the request, the Department may evaluate and, after evaluation of the request, the Commissioner, in the Commissioner's sole discretion, may grant relief, in whole or in part, from one or more of the Conditions as the Commissioner may be deem appropriate.

28. The Commissioner reserves the right to impose additional conditions upon the approval of the Transaction or modify the Conditions in this Approving Determination and Order if, in his reasonable judgment (i) the consolidated financial position or results of operation of the WPAHS Entities suffer or incur, or are reasonably likely to suffer or incur, a material deterioration or material adverse change and the Commissioner finds that such material deterioration or material adverse change might jeopardize the financial stability of a Domestic Insurer or prejudice the interest of the policyholders of a Domestic Insurer; (ii) the Commissioner finds that actions taken or proposed to be taken by any UPE Entity might jeopardize the financial stability of a Domestic Insurer or prejudice the interest of policyholders of a Domestic Insurer; and/or (iii) the Commissioner finds that actions taken or proposed to be taken by any UPE Entity would substantially lessen competition in insurance in this Commonwealth or tend to create a monopoly therein.

Settlement Of Litigation

29. Without the prior approval of the Commissioner, UPE and each UPE Entity agrees that it will not settle, enter into a settlement agreement or otherwise consent to terminate litigation where the result of such settlement or termination of litigation will be to affect or impair in any way the objective or purpose sought by the Department in imposing or establishing any Condition in this Approving Determination and Order.

Modification Of Affiliation Agreement

30. No UPE Entity which is a party to the Affiliation Agreement may amend, waive enforcement of, modify, or enter into any other agreement or arrangement having the effect of terminating, waiving or modifying, in any material respect, the terms or conditions of the Affiliation Agreement, without the prior approval by the Commissioner.

Sunset Of Conditions

31. The Conditions contained in this Approving Determination and Order shall expire as follows:

A. The following Conditions shall not expire: Conditions 1 and 2 (Prohibition on Exclusive Contracting); 3 (Provider/Insurer Contract Length); 5 and 6 (Prohibition on Most Favored Nation Contracts or Arrangements); 7, 8, and 9 (Firewall Policy); 10 (Donations); 11 (Financial Commitment Limitations); 13 (one of the Public Disclosure of Financial Commitments and Financial and Operational Information Conditions); 20 (Consumer Choice Initiatives); 23 (Community Health Reinvestment); 26 (Department Cost and Expenses); 27 and 28 (Modification of Approving Determination and Order); 29 (Settlement of Litigation); 32 (Required Record Retention); 33, 34, and 35 (Enforcement); and 36 (Post Closing Obligations).

B. Unless a Condition is listed in Condition 31A or contains a specific expiration date, the Condition shall expire on December 31, 2018, provided that the Department may extend any of these Conditions for up to an additional five (5) years if, in the judgment of the Department, such an extension is in the public interest, and further provided that any expiration of any Condition shall not affect or limit the obligations arising under such Condition prior to its expiration.

Required Record Retention

32. The books, accounts and records of each UPE Entity shall be so maintained and be accessible to the Department as to clearly and accurately disclose the precise nature and details of the transactions between and/or among any UPE Entity and/or other Person, and to permit the Department to establish compliance with the Conditions or otherwise of this Approving Determination and Order, including, but not limited to, such accounting information as is necessary to support the reasonableness of any charges or fees to a Person.

Enforcement

33. Each of the UPE Entities shall be subject to the jurisdiction of the Department for the purpose of enforcing the terms or the Conditions or otherwise of this Approving Determination and Order. Nothing in this Approving Determination and Order is intended to create or enlarge the right of any Person to enforce, seek enforcement of, and/or seek compliance by the UPE Entities with the terms and conditions of this Approving Determination and Order.

34. To the maximum extent provided by law, a violation of any Condition shall constitute a violation of 40 Pa.C.S. § 6105 (relating to penalties), which provides that any person who violates a Department order made pursuant to 40 Pa.C.S. Chapter 61 (relating to hospital plan corporations) or hinders or prevents the Department in the discharge of its duties under that statute shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine of not more than $ 3,000 or to be imprisoned for not more than six months, or both, in the discretion of the court. This statute also provides that any act or default by any corporation, association, or common law trust who violates a Department order made pursuant to 40 Pa.C.S. Chapter 61 (relating to hospital plan corporations)

shall be deemed to be the act or default of the officers or directors who participated in authorizing or effecting such act or default or who knowingly permitted it.

35. In addition to its powers otherwise available under applicable law, the Department may apply to the Commonwealth Court for an order enjoining any UPE Entity or any director, officer, employee or agent thereof from violating or continuing to violate any term or condition of this Approving Determination and Order and for such other equitable relief as the nature of the case and the interest of any Domestic Insurer's policyholders, creditors, shareholders, members or the public may require.

Post Closing Obligations Of UPE

36. If UPE proceeds with closing the Transaction and implements the Change of Control as contemplated by Form A, UPE shall have been deemed to have agreed expressly to fully and promptly comply with each Condition set forth in this Approving Determination and Order. UPE shall have the obligation and responsibility to cause all UPE Entities to comply with their respective obligations under this Approving Determination and Order, including but not limited to the Conditions.

37. Highmark shall provide to the Department a list of closing documents for the Affiliation Agreement and the JRMC Affiliation Agreement within five (5) days after consummation of the Transaction and shall maintain the listed documents and make them available to the Department for a period of not less than five (5) years from the date of this Approval Determination and Order.

This Approving Determination and Order is effective immediately. The Department will issue further full written findings and conclusions on or before May 31, 2013 that substantially reflect the factual conclusions reached in the Blackstone Report and the Guerin-Calvert Report.

Michael F. Consedine
Insurance Commissioner
Commonwealth of Pennsylvania

Date: April 29, 2013

Appendix 1 (Definitions)

In addition to the words or terms otherwise defined in the Approving Determination and Order, as used in this Approving Determination and Order and the appendices thereto, the following terms have the following meanings:

"1996 Department Order" shall have the meaning set forth in Condition 23C.

"Addendum 1" means Addendum No. 1 to Amendment No. 1 to Form A dated August 24, 2012.

"Affiliate" means any present Person or any Future Person that, directly or indirectly through one or more intermediaries, Controls, is Controlled by, or is under Common Control with any other UPE Entity and their successors and assigns. "Affiliate" includes but is not limited to all Persons in which any UPE Entity, directly or indirectly, has a membership interest.

"Affiliation Agreement" means the contract entered into between UPE, UPE Provider Sub, Highmark, WPAHS and certain subsidiaries of WPAHS as specified therein dated October 31, 2011, as amended by that certain Amendment No. 1 to Affiliation Agreement entered into as of January 22, 2013, relating to the affiliation between or among the parties thereto.

"Annual CHR Payment Obligation" shall have the meaning set forth in Condition 23A.

"Approval of the Department" or "Approved by the Department" means, except as otherwise provided in this definition: either (1) the Department expressly grants its written approval to a written request by the applicable requesting party for Department approval; or (2) within thirty (30) days after the receipt by the Department of the written request for approval, the Department does not advise the requesting party that the Department either disapproves the request for approval or requests any further information or explanation regarding the request for approval. With respect to Condition 3 (Provider/Insurer Payment Contract Length Limitation), Condition 7 (Firewall Policy) and Condition 21 (Consumer Choice Initiatives), "Approval of the Department" means when the Department expressly grants its written approval to a written request by the applicable requesting party for Department approval.

"Approved Firewall Policy" shall have the meaning set forth in Condition 7.

"Base Case Financial Projections" means the WPAHS financial projections for fiscal years 2013–2017 as prepared by Highmark, dated January 16, 2013 and submitted by UPE to the Department as Exhibit K to Amendment No. 2 to Form A.

"Base Year Discharge Data" shall have the meaning set forth in Condition 21.

"Benchmark" shall have the meaning set forth in Appendix 3 (Benchmarks).

"Commercially Reasonable Process" means such due diligence and evaluative process that would be customarily performed by parties to an arm's length transaction in the geographic

area in which the Financial Commitment is to be made in order to assess the merits and risks of a Financial Commitment and the financial, operational and policy effects to the involved UPE Entity. This includes but is not limited to obtaining, where commercially appropriate and reasonable or to the extent required by law, of a third party fairness opinion or fair market value analysis of such Financial Commitment or other financial analysis and/or stakeholder cost-benefit assessment as may be customarily or reasonably expected to be performed in connection with such a transaction.

"Competitively Sensitive Information" means any information that is not available publicly that could potentially affect competitive innovation and/or pricing between or among one or more UPE Entities and the rivals of such UPE Entities at the provider and/or insurer levels. At a minimum, "Competitively Sensitive Information" includes but is not limited to: (i) present and future reimbursement rates by payor; (ii) payor-provider reimbursement contracts; (iii) terms and conditions included in agreements or arrangements between payors and providers, including but not limited to discounts in reimbursements in agreements; (iv) reimbursement methodologies including but not limited to provisions relating to performance, pay for performance, pay for value, tiering of providers; and (v) specific cost and member information, and revenue or discharge information specific to the payor.

"Community Health Reinvestment Activity" means community health services and projects that improve health care or make health care more accessible. The term includes funding, subsidization or provision of the following: (i) health care coverage for persons who are determined by recognized standards as determined by the Department to be unable to pay for coverage; (ii) health care services for persons who are determined by recognized standards to be uninsured and unable to pay for services; (iii) programs for the prevention and treatment of disease or injury, including but not limited to mental retardation, mental disorders, mental health counseling or the promotion of health or wellness; and (iv) such other services or programs as the Department may approve, including but not limited to health or mental health services for veterans, and the prevention of other conditions, behaviors or activities that are adverse to good health as well as donations to or for the benefit of health care providers in furtherance of any of the foregoing purposes. "Community Health Reinvestment Activity" does not include expenditures for advertising, public relations, sponsorships, bad debt, administrative costs associated with any Domestic Insurer, programs provided as an employee benefit, use of facilities for meetings held by community groups, or expenses for in-service training, continuing education, orientation or mentoring of employees.

"Consumer Choice Initiatives" mean tools and methods that assist consumers in making informed healthcare decisions that reflect differences in the price, cost and quality of care provided. These initiatives may include but are not limited to tools that enable consumers to compare quality and cost-efficiency of medical treatments, healthcare goods and services and providers, and incentives such as tiered network health plan benefit designs that reward patients who choose to use healthcare resources more efficiently. The term "Consumer Choice Initiatives" specifically includes but is not limited to products that include Tiering and Steering as part of their product design.

"Control," "Controlling," "Controlled by" or "under Common Control with" have the meaning given to those terms in 40 P.S. § 991.1401.

"Credit Enhancement Device" means any letter of credit, guaranty, line of credit, insurance or any other device, arrangement or method, financial or otherwise, given or provided as security or assurance for the payment of the principal of, premium, if any, or interest on, the applicable debt.

"Department" means the Insurance Department of the Commonwealth of Pennsylvania.

"Domestic Insurers" means the following Pennsylvania domestic insurers to which the Form A applies: Highmark Inc.; Highmark Casualty Insurance Company, a Pennsylvania stock insurance company; Highmark Senior Resources Inc., a Pennsylvania stock insurance company; HM Casualty Insurance Company, a Pennsylvania stock insurance company; HM Health Insurance Company, d/b/a Highmark Health Insurance Company, a Pennsylvania stock insurance company; HM Life Insurance Company, a Pennsylvania stock insurance company; Keystone Health Plan West, Inc., a Pennsylvania business corporation and licensed health maintenance organization; United Concordia Companies, Inc., a Pennsylvania stock insurance company; United Concordia Dental Plans of Pennsylvania, Inc., a Pennsylvania business corporation and licensed risk-assuming PPO; and United Concordia Life And Health Insurance Company, a Pennsylvania stock insurance company. "Domestic Insurers" also includes but is not limited to any Health Care Insurer hereafter formed, acquired or organized directly or indirectly by or for any of the foregoing or by any other UPE Entity. The term "Domestic Insurers" shall not include First Priority Life Insurance Company, Inc.; Gateway Health Plan, Inc.; HMO of Northeastern Pennsylvania, Inc., d/b/a First Priority Health; Inter-County Health Plan, Inc.; or Inter-County Hospitalization Plan, Inc. to the extent that those entities are not used, directly or indirectly, to circumvent, affect or impair the purpose or intent of any Condition.

"Domestic Insurer Competitively Sensitive Information" means Competitively Sensitive Information originated by, received and/or held, directly or indirectly, in any form by or for any Domestic Insurer.

"Donation" means any contribution, grant, donation, distributions under 40 P.S. § 991.1405 or other transfer or payment of funds, property or services (or a commitment to make a Donation), whether made directly or indirectly, in cash or in kind, by any UPE Entity to any other UPE Entity or to any other Person; provided, however, that "Donation" shall not include any transfer or payment made in exchange for the fair value of goods or services received by the transferring or paying Person. An expenditure made for a Community Health Reinvestment Activity is not a "Donation", so long as the expenditures are for the direct provision of community health services and direct funding of projects that improve health care or make health care more accessible. Donations that are in furtherance of the Affiliation Agreement, the JRMC Affiliation Agreement and any affiliation agreement with SVHS; and/or are capital expenditures related to the IDN or the IDN Strategy are not to be considered as Community Health Reinvestment Activity for the purposes of this definition of "Donation."

"Financial Commitment" means any direct or indirect payment or transfer of any cash or other property, any Donation, provision of services, encumbrance upon or granting of any security interest in or to any assets or properties, or the direct or indirect guaranty or incurrence of any contractual obligation or liability. The term "Financial Commitment" includes, but is not limited to, the acquisition of any assets or properties of or interests in, the merger, consolidation or affiliation with, or the entering into of any financial or contractual relationship with, any Person, except for: (i) any Financial Commitment made in the ordinary and usual course of the UPE Entity's business; or (ii) any amounts expressly required to be paid without any further consent of any Person and pursuant to the current provisions of the Affiliation Agreement, JRMC Affiliation Agreement and/or any affiliation agreement between Highmark and SVHS acceptable to the Department. Without limiting the generality of the foregoing, (i) until June 30, 2017, a Financial Commitment shall include but is not limited to (A) any advance payment by a Domestic Insurer to a WPAHS Entity pursuant to or in connection with a contract or arrangement for the payment or reimbursement for Health Care Services; or (B) an increase in contractual rates pursuant to or in connection with a contract or arrangement for the payment or reimbursement for Health Care Services between or among any Domestic Insurer and any WPAHS Entity in excess of the level of increase set forth in the Base Case Financial Projections; and (ii) in no event shall any Financial Commitment relating to the acquisition of any assets or properties of or interests in, the merger, consolidation or affiliation with, or any Donation to or investment in, any Person in connection with the IDN Strategy, as it may be renamed, modified or replaced, be considered to be in the ordinary course of business.

"Financial Commitment Notice" shall have the meaning set forth in Condition 11B.

"Firewall Policy" means a written course of action that governs the use, disclosure, release, dissemination or sharing of Competitively Sensitive Information between and/or among each UPE Entity and the employees, contractors, officers, directors, managers or other personnel of other UPE Entities. Without limiting the scope of any Firewall Policy, a Firewall Policy shall restrict each Domestic Insurer's and its directors', officers', employees' and agents' knowledge and ability to influence, directly or indirectly, the negotiations of other UPE Entities with rival insurers, and, conversely, shall restrict other UPE Entities' and their directors', officers', employees' and agents' knowledge and ability to influence, directly or indirectly, any Domestic Insurer's negotiations with rival Health Care Providers.

"Form A" means the Form A filed by UPE, as applicant, with the Department on November 7, 2011, as amended and supplemented by filings made by UPE with the Department.

"GAAP" means generally accepted accounting principles, consistently applied.

"Health Care Insurer" means the Highmark Insurance Companies or any other related or unrelated insurance company, health plan corporation, professional health services plan corporation, health maintenance organization, preferred provider organization or other Person in the business of insurance that finances or pays for health care goods and/or services.

"Health Care Provider" means a Person licensed, certified or otherwise authorized or permitted by the laws of the Commonwealth of Pennsylvania or any other state to provide or

perform a Health Care Service in the ordinary course of business or practice of a profession and any other Person who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to a physician, dentist, hospital, nursing home, assisted living provider, home health agency or any other Person that would constitute a "health care provider" pursuant to Federal HIPAA privacy laws (45 C.F.R. § 160.103).

"Health Care Service" means any medical or health care service including but not limited to the treatment or care of an individual or administration of any medical service or medical goods or supplies or dispensing of any medical goods or supplies.

"Highmark" means Highmark Inc., a Pennsylvania nonprofit corporation licensed to operate a hospital plan and a professional health services plan and its successors and assigns.

"Highmark Affiliates" means all Affiliates of Highmark. The term includes but is not limited to all of the Domestic Insurers (other than Highmark).

"Highmark Entities" or "Highmark Entity" means, individually and/or collectively, Highmark and Highmark Affiliates.

"Highmark Insurance Companies" shall have the meaning as set forth in the first paragraph of this Approving Determination and Order.

"IDN" means all aspects of and all Persons involved or to be involved with the integrated delivery network proposed by UPE referred to in Addendum 1 and which is referenced on page 1 of Addendum 1 (wherein UPE states that ". . . UPE proposed the change in control as part of a strategy to implement an integrated delivery network (IDN)"). The IDN is further described throughout the Form A and elsewhere in documents filed by UPE. The IDN includes but it's not limited to the Affiliation Agreement, the JRMC Affiliation Agreement, and proposed affiliation agreement with SVHS, the expansion of the provider network (physicians, community hospitals and medical malls), infrastructure development (including but not limited to the acquisition, expansion, development, improvement or construction of Health Care Services, Health Care Providers, facilities, physician practice management companies and group purchasing organizations), other relationships with individuals or Persons included in the Provider Group and any other activity that has been, is being or is expected to be included in the IDN when the IDN is fully implemented.

"IDN Compensation Policy" shall have the meaning set forth in Condition 18.

"IDN Savings" shall have the meaning set forth in Condition 19.

"IDN Strategy" refers to UPE's strategy to implement the IDN.

"Insurance Restructuring Restricted Receipt Account" means the restricted receipt account in the Pennsylvania State Treasury established by Section 7 of Act 62, 40 P.S. § 991.1403b.

"JRMC" means Jefferson Regional Medical Center, its successors and assigns.

"JRMC Affiliates" means all Affiliates of JRMC.

"JRMC Affiliation Agreement" means that certain affiliation agreement by, between and among UPE, UPE Provider Sub, Highmark, JRMC, the subsidiaries of JRMC and Jefferson Regional Medical Center Foundation dated as of August 13, 2012.

"Master Trust Indenture" shall have the meaning set forth in the Affiliation Agreement.

"Minimum Annual CHR Payments Obligation" shall have the meaning set forth in Condition 23A.

"Net Income" shall have the meaning set forth in Condition 15B.

"New UPMC Contract" shall have the meaning set forth in Condition 22A.

"Person" means any individual, corporation, partnership, limited liability company, trust, association, employee pension plan or stock trust or other entity or organization, including but not limited to any governmental or political subdivision or any agency or instrumentality thereof.

"PMPM IDN Savings" shall have the meaning set forth in Condition 19.

"Provider Group" refers to the Persons included or to be included in the "Provider Group" shown on the Proposed Corporate Structure after Tab N to Addendum 1.

"RBC Rating" means the risk-based capital level of a Health Care Insurer determined in accordance with the insurance laws and requirements of the Commonwealth of Pennsylvania as amended from time to time and in a manner acceptable to the Department.

"Required WPAHS Financial and Operational Information" shall have the meaning set forth in Condition 14.

"Steering" means any practice, process or arrangement the effect of which is directly or indirectly to encourage, direct or maneuver a Person into a course of action, e.g., choice of healthcare, by offering structured economic incentives that vary by their value to the consumer or other Person.

"SVHS" means Saint Vincent Health System, a Pennsylvania nonprofit corporation, its successors and assigns.

"SVHS Affiliates" means all Affiliates of SVHS.

"SVHS Entities" or "SVHS Entity" means SVHS and all SVHS Affiliates, collectively and individually.

"Tiering" means a method or design of a health care plan in which a Health Care Providers are assigned to different benefit tiers based on the Health Care Insurer's application of criteria to Health Care Providers' relative costs and/or quality, and in which enrollees pay the cost-sharing (co-payment, co-insurance or deductible) associated with a Health Care Provider's assigned benefit tier(s).

"Total IDN Savings" shall have the meaning set forth in Condition 19.

"Transaction" means the proposed Change of Control relating to the Highmark Insurance Companies as reflected in the Form A, together with all other related transactions and all aspects of the IDN Strategy, including but not limited to the Affiliation Agreement, the JRMC Affiliation Agreement, the expansion of the provider network (physicians, community hospitals and medical malls), the development of infrastructure (physician practice management companies and group purchasing organizations), formation of other relationships with individuals or entities included in the Provider Group, and any other activity that has been, is being or is expected to be included in the IDN when the IDN Strategy is fully implemented.

"UPE" means the Pennsylvania nonprofit corporation of that name formed on October 20, 2011, being the ultimate parent entity, and its successors and assigns.

"UPE Entity" or "UPE Entities" means individually and/or collectively UPE and Affiliates of UPE, including, but not limited to, UPE Provider Sub, Highmark, all Highmark Affiliates, WPAHS, and all WPAHS Affiliates, JRMC, and all of JRMC Affiliates, SVHS and all SVHS Affiliates, any entity Controlled by any of the foregoing, and their respective successors and assigns.

"UPE Health Care Provider Competitively Sensitive Information" means Competitively Sensitive Information originated by and/or held in any form by each business unit, e.g., each hospital (including, but not limited to, WPAHS and JRMC), each physician group, and other UPE Entities on the IDN side of UPE's business.

"UPE Provider Sub" means the Pennsylvania nonprofit corporation of that name formed on October 20, 2011 as referenced on page 7 of the Form A, its successors and assigns.

"UPMC" means University of Pittsburgh Medical Center and/or any and/or all of its Affiliates, its successors and assigns.

"UPMC Contract Transition Plan" shall have the meaning set forth in Condition 22B.

"WPA Service Area" shall have the meaning set forth in Condition 21.

"WPAHS" means West Penn Allegheny Health System, Inc., a Pennsylvania nonprofit corporation, its successors and assigns.

"WPAHS Affiliates" means all Affiliates of WPAHS.

"WPAHS Corrective Action Plan" shall have the meaning set forth in Condition 15.

"WPAHS Due Diligence Information" shall have the meaning set forth in the Affiliation Agreement.

"WPAHS Entities" or "WPAHS Entity" means, individually and/or collectively, WPAHS and all WPAHS Affiliates.

"WPAHS Tax-Exempt Bonds" shall have the meaning set forth in the Affiliation Agreement.

Appendix 2 (Firewall Policy)

Firewalls are a class of provisions that govern both the dissemination and/or sharing of Competitively Sensitive Information between and/or among the formerly independent operations of each UPE Entity and the personnel from each such entity that can be involved in decision-making and engaged with its rivals (who are suppliers or customers) at other UPE Entities. The purpose of developing and implementing a firewall policy is to avoid the inadvertent or intentional disclosure of Competitively Sensitive Information that could potentially reduce substantially competitive innovation or pricing between and/or among the vertically integrated entities and their rivals at the provider and insurer levels.

With respect to each UPE Entity, it is also imperative from a competitive perspective to establish firewalls that prevent persons with influence over managed care contracts and related reimbursements on the health plan side from obtaining information on rival managed contracts and related reimbursements on the provider side.

With this Condition, each UPE Entity shall develop and submit a firewall policy to the Department for approval. Different Firewall Policies may be submitted for separate UPE Entities or types of UPE Entities.

At a minimum, the Firewall Policy shall incorporate each of the following factors:

- UPE, UPE Provider Sub, Highmark, WPAHS, JRMC, and SVHS senior management involvement and support;
- Corporate firewall compliance policies and procedures;
- Mandatory training and education of current and new employees;
- Monitoring, auditing and reporting mechanisms;
- Consistent disciplinary procedures for violation of the Firewall Policy and incentives to ensure compliance; and
- A recusal policy to reduce the risk of senior management's involvement in the review and approval of contracts or arrangements containing Competitively Sensitive Information to which they should otherwise not have access.

From a competitive perspective, the following principles shall guide the development and implementation of an effective Firewall Policy among the UPE Entities' vertically integrated hospitals/providers and its insurers relating to personnel and decision-making:

- Separate managed care contracting information and activity of the hospital and of the insurer segments, including but not limited to the personnel who engage in decision-making and contracting with suppliers (customers);

- Firewall mechanisms that prevent sharing of Competitively Sensitive Information among persons at the hospital and insurer entities, with clear definition of what constitutes Competitively Sensitive Information; and

- Clear confidentiality policies, procedures and protocols that describe the specific persons and positions that can have access to Competitively Sensitive Information with clear policies and procedures for monitoring or auditing compliance with established firewalls, reporting of violations, and remedial actions taken in the event of a violation of the firewall.

Firewalls to prevent the dissemination of competitively sensitive information are common among vertically integrated firms, particularly integrated hospitals and insurance entities. At a minimum, each UPE Entity's Firewall Policy shall prohibit the exchange of Competitively Sensitive Information, including but not limited to:

- Present and future reimbursement rates by payor;

- Payor-provider reimbursement contracts;

- Terms and conditions included in agreements or contracts between payors and providers including but not limited to discounts in reimbursements in agreements;

- Reimbursement methodologies including but not limited to provisions relating to performance, pay for performance, pay for value, tiering of providers; and

- Specific cost and member information and revenue or discharge information specific to the payor.

Each UPE Entity's Firewall Policy shall incorporate monitoring, auditing and reporting mechanisms and provide consistent disciplinary procedures for violation of the Firewall Policy and incentives to ensure compliance, including but not limited to acknowledgement and certification by each employee or independent contractor with access to Competitively Sensitive Information of the employee's or independent contractor's responsibility to report actual or potential violations with the understanding that such reporting will not result in retribution. Employees also shall be required to affirmatively acknowledge that failure to report such information may subject the employee to disciplinary action and independent contractors shall be required to acknowledge that failure to report such information shall constitute cause for termination of such independent contractor's contract.

UPE's Firewall Policy shall include but not be limited to a whistleblower protection/anti-retaliation policy acceptable to the Department that specifically includes but is not limited to reports of Firewall Policy violations. The Firewall Policy may reference a whistleblower protection/anti-retaliation policy of UPE or another UPE Entity so long as that whistleblower/anti-retaliation policy is acceptable to the Department.

Appendix 3 (Benchmarks)

The following are the benchmarks (the "Benchmarks") referred to in Condition 19:

- $3,000 lower yearly premiums for a family of four by Fiscal Year 2016 relative to a "no transaction scenario" as described in the Form A.
- 10% cost savings on inpatient spend on enrollees that remain with the Domestic Insurers that are Health Care Insurers.
- 10% cost savings on outpatient spend on enrollees that remain with the Domestic Insurers that are Health Care Insurers.
- Achieve estimated IDN cost savings relative to a "no transaction scenario" as described in the Form A in the following amounts:

Period	With UPMC at Non-Par after 12/31/2014			With UPMC at Par after 12/31/2014		
	TOTAL	Utilization Shift	IDN Implementation	TOTAL	Utilization Shift	IDN Implementation
*CY14	$12M	$80M	($68M)	($91M)	$33M	($215M)
*CY15	($233M)	$4M	($238M)	($298M)	($15M)	($283M)
*CY16	($261M)	$14M	($275M)	($447M)	($15M)	($432M)

* "CY" means calendar year

Attachment 4 (Total IDN Savings Categories)

1) Oncology Shift
2) Utilization Shift
3) Reimbursement
4) Healthier Population
5) Right Setting
6) Right Treatment
7) Cost/Quality
8) Other

EXHIBIT B

UPMC LIFE CHANGING MEDICINE

BACKGROUND STATEMENT

June 12, 2013

UPMC's Mission is **to serve our communities by providing outstanding patient care and to shape tomorrow's health system through clinical and technological innovation, research, and education**. Within the comparatively short life of UPMC, this critical Mission has been advanced with levels of effectiveness and impact that probably are unsurpassed in the history of modern American medicine. Today, UPMC is widely recognized as one of the top academic medical centers in the world. The beneficiaries of UPMC's success include the patients we serve, the communities in which we work and the health of human kind. Consider the following:

- The hospitals, physicians and other health care professionals of UPMC now meet the needs of millions of patients annually. By any measure, UPMC has become the clear provider-of-choice for those living in the communities it serves. UPMC also has made Western Pennsylvania a destination-of-choice for patients from other locations around the world who seek medical care for complex conditions.
- In partnership with the University of Pittsburgh, UPMC has pioneered new approaches to transplantation, heart disease, cancer, neurological diseases and injuries, orthopedic conditions, psychiatric disorders and other life-threatening conditions. This unique and critical partnership also has provided education and training for most of the region's physicians, nurses and other healthcare professionals.
- Nearly 60,000 people earn their livelihoods at UPMC, making it Pennsylvania's largest non-governmental employer, and the spending by UPMC and its employees has been a critical factor in restoring and preserving the region's economic health. The system's total economic impact on the region is estimated to be nearly $22 billion annually, making it the principal driver of Western Pennsylvania's new "meds and eds" economy. After the decline of the smokestack industries and the more recent Great Recession, UPMC buoyed the local economy and helped the region to avoid the devastating consequences suffered by other cities.
- In the past fiscal year alone, UPMC also provided more than $622 million in community benefits, including charity care, uncompensated care from government programs for the poor, community health improvement programs and donations, funding for medical research, and education for tomorrow's health care professionals. The vast majority of the care for the region's underserved and economically disadvantaged population is provided by UPMC, while its $100 million commitment to The Pittsburgh Promise stands as an unprecedented example of philanthropic re-investment in the people of the City that has long been its principal home.

The fiduciary responsibility to pursue and protect that Mission is ultimately entrusted to UPMC's Board of Directors, twenty-four unpaid volunteers representing a broad cross-section of the communities and constituencies it serves. Its Board

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has ensured that UPMC provides innovative, high-quality, and cost-effective healthcare to the residents of Western Pennsylvania. It is a Board that also has been consistently attentive to risk – being mindful, in particular, of lessons from the recent history of healthcare in Western Pennsylvania, lessons that are telling but that, at least for some, seem to have been quickly, and perhaps conveniently, forgotten:

- As the original Allegheny General Hospital, a highly respected Pittsburgh institution with a long and proud history, became the Allegheny Health Education and Research Foundation, its operations were jeopardized by a flawed business strategy, poor management decisions, and questionable oversight. The result was the largest bankruptcy in American healthcare history, a series of criminal prosecutions, the loss of tens of millions of Western Pennsylvania dollars and thousands of Western Pennsylvania jobs, and permanent damage to what had been the Allegheny General Hospital.
- When the Board and management of the Western Pennsylvania Hospital assumed the role of "white knight" in saving what was left of the Allegheny General Hospital, their intentions almost certainly were noble. However, an objective look at the financial circumstances of these two institutions strongly suggested that West Penn lacked the strength to assume that responsibility and that the weight of Allegheny General inevitably would quickly pull West Penn, another institution with a long and proud history, into financial jeopardy, which it did.
- Meanwhile Highmark repeatedly tried to support and subsidize the new West Penn Allegheny Health System, over time infusing hundreds of millions of dollars into it. As now is absolutely clear, these subsidies did not rescue West Penn Allegheny from the financial difficulties that were the product of its own management decisions. However, by distorting the competitive environment, those subsidies caused lasting damage to other regional hospitals. St. Francis Hospital, which had been in operation since 1861 and which had particularly distinguished itself as a provider of compassionate psychiatric care and mental health services, did not survive. Mercy Hospital, the city's only remaining Catholic hospital, no longer could sustain itself and asked to become a part of UPMC under an arrangement that helped preserve its distinctive Catholic mission.

Throughout these tumultuous times, though regularly targeted by both Highmark and West Penn Allegheny, UPMC held fast to its mission, which the Board pursued with focus and foresight. A prime example of the Board's stewardship was the creation, fifteen years ago, of the UPMC Health Plan, which over the years has transformed UPMC into an integrated health system. By design, integrated health systems create provider networks that compete on quality, cost and member satisfaction when compared to traditional insurers that instead offer broad networks less attuned to clinical innovation, service, and cost. At its founding, moreover, the UPMC Health Plan emerged as the first real insurance competitor in a market historically dominated by Highmark.

When the UPMC Health Plan was formed, numerous critics, including Highmark, publicly contended that this integrated model could not and would not work—that UPMC was destined to be "another AHERF." But the Board's integrated strategy has been repeatedly confirmed as UPMC has thrived while other respected medical

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institutions in this region have struggled and sometimes failed. Indeed, nationally recognized experts today encourage providers to create financing arms, take on financial risk, and align internal incentives up and down their organizations — actions already taken by UPMC. These experts, supported by the new health reform legislation, now further promote vertical integration and vigorous competition as ways to limit the cost of healthcare and enhance value.

Given these trends, it was perhaps not surprising that two years ago Highmark reversed its longstanding condemnation of UPMC's integrated model and announced its own plan to become an integrated health system by acquiring the financially troubled West Penn Allegheny Health System. Highmark's expressed intention was, and has remained, to resurrect West Penn Allegheny as a competitor to UPMC and to put the full weight of its insurance monopoly behind this new competitor.

UPMC, consistent with its responsibilities to its patients and to the broader community, immediately advised the public of the impending expiration of the contracts allowing Highmark to include UPMC facilities and physicians in its network and specified that a renewal of those contracts would not be possible were Highmark to acquire West Penn Allegheny and reposition itself as a competing provider, both because it would put UPMC at risk and because it would undermine the very competition that should benefit the region, as a driver of even higher levels of quality and of lower cost. Then, as now, UPMC recognized the potential to move Western Pennsylvania from among the least competitive healthcare markets, with a dominant insurer and a dominant provider, to one of the most competitive, with two integrated health systems competing on the basis of quality, service, and cost, and at least three national insurers offering in-network access to both systems.

By mid-2012, with the end of the Highmark/UPMC contracts looming, Highmark and West Penn Allegheny had still not completed their proposed combination. At the Governor's behest, UPMC and Highmark therefore entered into a Mediated Agreement that extended the contracts between them until December 31, 2014, specifically to "provide for sufficient and definite time for patients to make appropriate arrangements for their care and eliminate the need for governmental intervention" when the contracts expired. As one part of that agreement and consistent with its commitments to patients and community, UPMC agreed that after 2014 Highmark subscribers would continue to have in-network access to various unique facilities and services at UPMC, including Children's Hospital, Western Psychiatric Institute and Clinic, certain oncology services not available at West Penn Allegheny, and two facilities that are essentially the sole providers of hospital services in their communities, UPMC Northwest Hospital and UPMC Bedford Memorial Hospital.

The Pennsylvania Insurance Department ultimately approved Highmark's proposal to acquire West Penn Allegheny on April 29, 2013, **an approval built on a Highmark plan that assumed no further contract extension with UPMC**. Highmark and West Penn Allegheny closed their transaction that same day.

As Highmark, UPMC, and the community in general approach this newly competitive market for what is perhaps the most personal, sensitive, and important service of all—health care—no one can afford to ignore demographic or medical reality. Southwestern Pennsylvania, where all of West Penn Allegheny's

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facilities are located, has a significant surplus of hospital beds, the product of a stable or declining population combined with advances in medical care that have reduced the need for acute admissions. As a result, any effort to increase patient admissions at one hospital will succeed only at the expense of other hospitals—a reality the consultants retained by the Pennsylvania Insurance Department described as a "zero sum game."

In the face of that reality, Highmark has put forward a business plan that requires it to increase admissions at West Penn Allegheny's hospitals by 41,000 patients per year. As the St. Francis and Mercy experiences suggest, some of those patients could come from community hospitals. In dealing with that large number, however, Highmark has made no secret of where it intends to get the vast majority of those admissions: UPMC.

As to how it would shift tens of thousands of patients per year from the UPMC doctors and hospitals that have been historically—and overwhelmingly—preferred to West Penn Allegheny's offerings, Highmark has presented two alternative plans. Highmark's "Base Case," as proposed to the Pennsylvania Insurance Department, assumes that it will have no contracts—commercial or Medicare—with UPMC after 2014 and that its subscribers will therefore not have the option of going to UPMC hospitals or physicians in network. According to Highmark, the vast majority of the "contestable volume" of patients in that Base Case will switch to West Penn Allegheny providers rather than change their insurer to keep UPMC in network. Whether or not Highmark's Base Case assumptions are sound can only be determined in the competitive marketplace. However, it is important to note that this Base Case with no UPMC contract was accepted by the Insurance Department—with extensive conditions and monitoring to assure that Highmark meets the expectations it has created. Among those conditions is one requiring Highmark to seek Insurance Department approval before signing any contract that it might offer UPMC, to ensure that, should UPMC ever agree to such a contract, it would not impair the recovery of West Penn Allegheny or otherwise lessen competition among either insurers or providers.

In fact, Highmark's alternative business plan assumes that any new contract with UPMC would, unlike the current contracts, permit Highmark to use economic incentives to "tier and steer" Highmark's subscribers away from UPMC and into the West Penn Allegheny Health System. Highmark has given these contractual provisions the appealing, but misleading, name "consumer choice initiatives," because as Highmark has already demonstrated any "choice" it might provide to its subscribers would be illusory.

In what would amount to a classic bait and switch, Highmark would lure employers and subscribers into new contracts or contract renewals with the illusion of in-network access to UPMC only to use tiers, co-pays, co-insurance, deductibles and the like to steer those subscribers over to West Penn Allegheny. While Highmark has said that it would tier and steer based on differences in "cost and quality," even those pressures would undermine patient choice. Nor could UPMC ever rely on Highmark to gauge "cost and quality" fairly and objectively, particularly where Highmark's announced intention is to drive an additional 41,000 patients every year away from UPMC and into West Penn Allegheny.

Highmark simply has no option but to force its subscribers toward West Penn Allegheny; over the

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last decade, those subscribers have overwhelmingly chosen UPMC when given an unfettered choice. That is why Highmark has outlined only two business plans supporting a rescue of West Penn Allegheny: its base plan in which its subscribers would have no in-network access to UPMC and therefore would have to use West Penn Allegheny, and its alternative plan, where its subscribers would be offered the illusion of access to UPMC only to be steered to West Penn Allegheny.

Clearly UPMC could not responsibly sign contracts giving Highmark the free use of anti-competitive weapons to harm UPMC. The diversion of 41,000 patients per year from UPMC's system would be the equivalent, for example, of closing both UPMC Mercy and UPMC Shadyside, with the attendant loss of approximately 11,000 jobs. Nor could UPMC, as a committed healthcare provider, willingly allow Highmark to discourage patients from using the hospitals and physicians they overwhelmingly prefer. Indeed, Compass-Lexecon, the consultants retained by the Insurance Department, recognized that it would be "unreasonable" to assume that UPMC would enter into the contracts proposed by Highmark.

Were Highmark to divert tens of thousands of patients away from UPMC and into West Penn Allegheny, UPMC would be greatly diminished. It could no longer invest more than $250 million in annual support of cutting edge research, education and training at the University of Pittsburgh. Nor could it make commitments to initiatives like the Pittsburgh Promise, which is investing $100 million of UPMC funds in an unprecedented opportunity for economically challenged families to send their children to college and as an incentive for families to remain in Pittsburgh. It could no longer invest more than $500 million per year in capital projects creating facilities and jobs in Pittsburgh. It could no longer provide care to the vast majority of the underprivileged and underserved. If Highmark wants to inflict that kind of damage on one of the world's best health systems and on the constituents and communities that it serves, it should have to do that by competing, integrated health system to integrated health system, without seeking to create yet another uncompetitive market by handicapping its chief competitor.

UPMC's Board owes a fiduciary obligation to preserve and protect the charitable assets that have been entrusted to it and to ensure that those charitable assets are managed and deployed in pursuit of UPMC's Mission. Highmark's announced plan to steer tens of thousands of admissions away from UPMC's hospitals in Southwestern Pennsylvania poses a direct, substantial threat to UPMC's charitable assets, to its clinical and academic mission, to its role as the economic driver of the region, and to its ability to provide future benefits to the community. Highmark's opportunity to deliver on that devastating plan would be greatly enhanced were it to secure contracts capturing UPMC's hospitals and its physicians within its network after December 31, 2014, particularly if any such contracts allowed Highmark to impede its subscriber's access to UPMC's hospitals and steer them instead into its newly formed health network.

Any concerns, moreover, about continued access to the unique community assets managed by UPMC have already been addressed in the Mediated Agreement, which provides for Highmark subscribers to have in-network access to certain UPMC specialty hospitals, certain unique oncology services, certain "sole-provider" hospitals, certain services at non-UPMC facilities under joint ventures, and certain services provided by UPMC physicians

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at non-UPMC locations or facilities, even after the existing commercial contracts expire on December 31, 2014.

Meanwhile, enhanced competition in both the insurance market and the provider market positions Western Pennsylvania to maintain high quality and affordable healthcare. There will be at least five choices of insurance sponsors available to consumers and businesses, including the UPMC Health Plan, rated as having the highest quality and consumer satisfaction of commercial plans in western Pennsylvania and having at its core UPMC's world class providers. Highmark, meanwhile, will offer plans centered on West Penn Allegheny and designed to entice patients away from UPMC. National insurers, including Aetna, Cigna, and United Healthcare, and others, already are offering and will continue to offer access to both UPMC providers and Highmark providers. Although the Pittsburgh market had long been a competitive outlier without either vibrant national carriers or consumers accustomed to shopping for less costly insurance alternatives, the region's employers and consumers have more recently been the beneficiaries of a price war that will save them tens of millions of dollars on health insurance premiums.

Finally, eighteen months is a reasonable amount of time for Highmark and UPMC to negotiate and implement a transition plan that would allow everyone affected by this development to adapt to and make informed decisions about that transition. Numerous employers are already offering their employees insurance options that will include full, in-network access to UPMC after 2014; others will follow suit once it becomes clear that the current contracts will, in fact, expire. No further time should be wasted, however, in making that expiration clear and in moving forward with the appropriate transition.

UPMC LIFE CHANGING MEDICINE

RESOLUTION

UPMC Board of Directors
June 12, 2013

It is therefore resolved as follows:

- UPMC cannot, in keeping with its central clinical and academic mission, its duty to protect and preserve its charitable assets, and its obligations to the communities it serves, enter into any extension of the existing commercial contracts, or any new commercial contracts, providing Highmark with in-network access to any current UPMC hospitals or physicians in Southwestern Pennsylvania beyond Children's Hospital of Pittsburgh of UPMC, Western Psychiatric Institute and Clinic, UPMC Northwest, UPMC Bedford Memorial and certain other services (including certain unique oncology services) as specified in the Mediated Agreement of July 1, 2012, and therefore will not do so;
- Management shall continue to enter into, or extend, commercially reasonable contracts with health insurers that do not own or control provider services that compete with UPMC's hospitals or physicians; and
- Management shall immediately attempt to engage Highmark in discussions regarding the transition that will take place between the date of this resolution and December 31, 2014, with the purposes of (1) providing all subscribers, patients, physicians, and employers with adequate, timely and accurate information on which to base the choices they will have; (2) ensure for the smooth and safe transfer of insurance coverage and patient care; and (3) provide for enhanced competition in the market for health insurance and the market for health services.

EXHIBIT C

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA, By KATHLEEN G. KANE, Attorney General; PENNSYLVANIA DEPARTMENT OF INSURANCE, By MICHAEL CONSEDINE, Insurance Commissioner and PENNSYLVANIA DEPARTMENT OF HEALTH, By MICHAEL WOLF, Secretary of Health, Petitioners, v. UPMC, A Nonprofit Corp.; UPE, a/k/a, HIGHMARK HEALTH, A Nonprofit Corp. and HIGHMARK, INC., A Nonprofit Corp.; Respondents.	:	No. 334 M.D. 2014

PETITION FOR REVIEW

The Commonwealth of Pennsylvania acting as *parens patriae* through its Attorney General, Kathleen G. Kane, its Insurance Commissioner, Michael F. Consedine, and its Secretary of Health, Michael Wolf, by and through the Office of General Counsel, bring this action to redress violations of the Unfair Trade Practices and Consumer Protection Law (Consumer Protection Law), 73 P.S. §§201-1—201-9.3, the Insurance Companies Law of 1921, 40 P.S. §§991.2101-991.2193 (Act 68), and breach of a third party beneficiary contract.

JURISDICTION

1. This Court has original jurisdiction over this action pursuant to Section 761(a)(2) of the Judicial Code, 42 Pa.C.S. § 761(a)(2), which gives this Court jurisdiction over actions initiated by the Commonwealth.

PARTIES

2. Petitioner, the Commonwealth of Pennsylvania is acting as *parens patriae* through its Attorney General, Kathleen G. Kane (Commonwealth), with her office located on the 14TH Floor of Strawberry Square, in Harrisburg, Pennsylvania 17120.

3. Petitioner, the Pennsylvania Insurance Department through its Insurance Commissioner, Michael F. Consedine, is located on the 13TH Floor of Strawberry Square, in Harrisburg, Pennsylvania 17120.

4. Petitioner, the Pennsylvania Department of Health through its Secretary of Health, Michael Wolf, is located in the 8TH Floor of the Health and Welfare Building, West 625 Forster Street, Harrisburg, PA 17120.

5. Respondent, UPMC is a domestic, nonprofit corporation incorporated on June 10, 1982, on a non-stock, non-membership basis, with its registered office located at U.S. Steel Building, 200 Lothrop Street, Pittsburgh, Pennsylvania 15213. Unless otherwise specified, all references to "UPMC" include all of its controlled nonprofit and for-profit subsidiaries, partnerships, trusts, foundations, associations or other entities however styled.

6. Respondent, UPE, also known as Highmark Health, was incorporated on October 20, 2011, on a non-stock, non-membership basis, with its registered office located at Fifth

Avenue Place, 120 Fifth Avenue, in Pittsburgh, Pennsylvania 15222. UPE serves as the sole controlling member of Highmark, Inc.

7. Respondent, Highmark, Inc., is a domestic, nonprofit corporation incorporated on December 6, 1996, with its registered office located at Fifth Avenue Place, 120 Fifth Avenue, in Pittsburgh, Pennsylvania 15222. Unless otherwise specified, all references to "Highmark" include UPE and all of its controlled nonprofit and for-profit subsidiaries, partnerships, trusts, foundations, associations or other entities however styled.

FACTS

8. Paragraphs 1 through 7 are incorporated as if fully set forth.

9. At all times relevant and material, UPMC has operated as the parent corporation and controlling member of a nonprofit academic medical center and integrated health care delivery system supporting the health care, research and educational services of its constituent hospitals and providers.

10. UPMC controls more than 20 academic, community and specialty hospitals, more than 400 clinical locations, and employs more than 3,300 physicians.

11. UPMC's website at www.upmc.com describes UPMC's mission, vision and values as follows:

Our Mission:

> **UPMC's mission is to serve our community by providing outstanding patient care** . . . .

Our Vision:

> **Putting our patients at the center of everything we do** and creating a model that assures **that every patient gets the right care, in the right way, at the right time, every time.**

Our Values:

> **Our patients and members are our first priority and we strive to be responsive to their needs as well as those of the thousands of family members, visitors and community residents who walk through our doors, email, text or call us every day.**

http://www.upmc.com/why-upmc/mission/pages/default.aspx (emphasis added).

12. UPMC's "Patients' Rights and Responsibilities," posted in various offices of its subsidiaries and published on its web site provides in pertinent part:

> At UPMC, **service to our patients is our top priority**. . . . .
>
> . . .
>
> 13. **A patient has the right to medical and nursing services without discrimination based upon** race, color, age, ethnicity, religion, sex, sexual orientation, national origin, **source of payment**, or marital, veteran, or handicapped status.
>
> . . .

See, http://www.upmc.com/patients-visitors/patient-info/pages/patient-rights-responsibilities.aspx (emphasis added).

13. UPMC is the dominant provider of health care services throughout western Pennsylvania accounting for approximately 60% of the medical-surgical market share in Allegheny County and 35.7% of the medical-surgical market share in the 29 county region of western Pennsylvania.

14. UPMC is also the ultimate controlling person of an insurance holding company system that includes, *inter alia*, three domestic stock insurance companies, two domestic risk-assuming preferred providers and three domestic health maintenance organizations (collectively UPMC Insurance Subsidiaries), including the UPMC Health Plan, covering approximately 2 million members throughout western Pennsylvania in competition with other health plans.

15. UPMC and the UPMC Insurance Subsidiaries are engaged in the business of insurance in the Commonwealth of Pennsylvania.

16. Highmark Health is the ultimate controlling person of an insurance holding company system that includes, *inter alia*, domestic hospital plan corporations and professional health services plan corporations, domestic stock insurance companies, domestic health maintenance organizations and a domestic risk-assuming preferred provider organization (collectively Highmark Health Insurance Subsidiaries).

17. Highmark Health and the Highmark Health Insurance Subsidiaries are engaged in the business of insurance in the Commonwealth of Pennsylvania.

18. Highmark's Blue Cross Blue Shield subsidiaries are independent licensees of the Blue Cross Blue Shield Association, and operate respectively as a certified hospital plan corporation (Blue Cross) and a certified professional health service corporation (Blue Shield) pursuant to Sections 6103 and 6307 of the Hospital Plan Corporations Act and the Professional Health Services Plan Corporation Act, respectively. 40 Pa.C.S. §§ 6103 and 6307.

19. Highmark is the largest health plan throughout UPMC's service area in western Pennsylvania, accounting for more than 60% of the region's health plan market.

20. Historically, UPMC has always contracted with Highmark for its commercial insurance products.

21. In the spring of 2011, UPMC announced that it would not agree to renew or renegotiate its provider agreement with Highmark, which was due to expire on December 31, 2012.

22. UPMC justified its refusal to renew its contractual relationship with Highmark in the spring of 2011 because of Highmark's proposal to affiliate with the West Penn Allegheny

Health System, another nonprofit health care provider, which would create the region's second charitable integrated health care delivery system in competition with UPMC. An integrated health care delivery system includes physicians, hospitals, ancillary care and a health insurer all under the control of one entity. UPMC was then western Pennsylvania's only integrated health care delivery system.

23. The expiration of the UPMC/Highmark provider agreement would have subjected all of Highmark's health insurance members to UPMC's significantly higher out-of-network charges for their health care needs unless they either switched their health care provider away from UPMC or their health plan away from Highmark to one of the health insurers with which UPMC had contracted, albeit at higher prices.

24. UPMC's announcement resulted in legislative hearings and an agreement with Highmark negotiated through the Governor's office, dated May 1, 2012 (Mediated Agreement).

25. Under the terms of the Mediated Agreement, UPMC and Highmark agreed to provide in-network access to all UPMC hospitals and physicians for Highmark commercial and Medicare Advantage members through December 31, 2014. Highmark and UPMC agreed to the contract extension until the end of 2014 to provide substantial and definite time for patients to make appropriate arrangements for care and eliminate the need for any possible governmental intervention under Act 94, 40 Pa.C.S. § 6124 (d), which deals with the termination of provider contracts by hospital plan corporations.

26. Under the terms of the Mediated Agreement, Highmark and UPMC also agreed to negotiate rates and terms for continued Highmark member access to certain UPMC services on an in-network basis beginning in 2015, including Western Psychiatric Institute and Clinic, certain oncological services, UPMC Bedford Memorial, and UPMC

Venango (Northwest). Highmark members in a continuing course of treatment at UPMC would also continue to have in-network access to UPMC hospital and physician services. UPMC-Highmark arrangements with UPMC Mercy and Children's Hospital of Pittsburgh of UPMC would remain in effect, with existing arrangements regarding UPMC Hamot extended until December 31, 2014.

27. The Mediated Agreement provided that, "The agreement, in principle, is binding and will be implemented through formal agreements to be completed by June 30, 2012."

28. On May 2, 2012, Highmark and UPMC issued a Joint Statement announcing the Mediated Agreement to the public as providing in-network access to all UPMC hospitals and physicians for Highmark commercial and Medicare Advantage members until December 31, 2014. A true and correct copy of the May 2, 2012 Joint Statement by Highmark and UPMC is attached as Exhibit "A".

29. On or about April 23, 2013, the Pennsylvania Insurance Department (PID) approved Highmark's affiliation with the West Penn Allegheny Health System and they now operate under a newly formed charitable, nonprofit parent, UPE, doing business as "Highmark Health."

30. Highmark's filing and supporting materials submitted to the PID contemplated a "base case" scenario where Highmark would not have a continued contractual relationship with UPMC. The PID's approval was largely premised on acceptance of Highmark's base case scenario.

31. Highmark Health serves as the sole controlling member of the system's health plan and provider subsidiaries; the health plan subsidiary continues to operate under the name, "Highmark" while another newly formed provider subsidiary operates under the name,

"Allegheny Health Network," which serves as the sole controlling member of the West Penn Allegheny Health System, the Jefferson Regional Health System, and the St. Vincent's Health System.

32. In approving the Highmark/West Penn affiliation described above, the PID prohibited Highmark from agreeing to any future provider contracts containing anti-tiering and anti-steering provisions, which are contract provisions UPMC has traditionally insisted upon.

33. On June 12, 2013, UPMC's Board of Directors allegedly resolved, *inter alia,* to forego "any extension of the existing commercial contracts, or any new commercial contracts, providing Highmark with in-network access to any current UPMC hospitals or physicians in Southwestern Pennsylvania beyond Children's Hospital of Pittsburgh of UPMC, Western Psychiatric Institute and Clinic, UPMC Northwest, UPMC Bedford Memorial and certain other services . . . as specified in the Mediated Agreement . . . ."

34. UPMC purports to have taken these actions because Highmark is now a competitor in the health care provider market and will be "tiering and steering" its health plan customers to move patients from UPMC into Highmark's new system. "Tiering" is the practice of having "tiers" of providers in a network. If members seek care from providers in preferred tiers, they typically pay lower co-pays or co-insurance (the percentage of the bill the consumer pays). If members seek care at non-preferred providers in the network, they pay higher co-pays and co-insurance. "Steering" is the practice of offering some incentive to members to use one provider over another.

35. UPMC contends that such "tiering and steering" practices by Highmark would have a deleterious financial impact on UPMC.

36. The UPMC Health Plan, however, offers tiered products providing UPMC's members lower cost-sharing amounts if they use UPMC's providers.

37. UPMC has used its UPMC Health Plan to "tier and steer" members to UPMC providers and has openly competed against Highmark in the insurance market for more than a decade without Highmark similarly refusing to contract with UPMC as one of its competitors.

38. Many people obtain their health plans through their employers and will not be able to change their insurance to avoid UPMC's higher out-of-network charges unless their employers change or add another health plan to their employee benefit plans. Moreover, UPMC's contracts with other health plans are at higher rates than Highmark's contracts and prohibit steering and tiering, thereby putting those firms at a disadvantage to Highmark and the UPMC Health Plan.

39. Pursuant to the Emergency Medical Treatment and Labor Act (EMTALA,), 42 U.S.C. § 1395dd, a hospital is required to treat all persons who come to an emergency room when in an emergency medical condition or in labor.

40. UPMC's hospitals get more than 50% of admissions from their emergency rooms. When a patient is treated for an emergency condition or admitted for an emergency, the patient's health plan is obligated to pay for the patient's care.

41. Since patients in an emergency medical condition often have no control over which emergency room they are taken to when their emergency occurs, it is common for patients to be taken to emergency rooms of hospitals which are outside the networks of their health plans.

42. In such circumstances, the health plan pays the bill of the hospital at rates negotiated on an ad hoc basis.

43. UPMC tenders bills to the health plans at full charges, their highest prices, and each bill is individually negotiated.

44. If Highmark does not have a contract with UPMC, its members will, nonetheless still arrive at UPMC emergency rooms. Highmark and UPMC will negotiate each bill and Highmark will pay significantly higher prices for the treatment of consumers in emergency medical conditions than it does currently. These high costs will be borne immediately by all area employers who are self-insured. Employers who are fully insured will pay higher insurance rates in the future as the higher costs are incorporated in their rate base.

45. The ongoing contractual disputes between UPMC and Highmark have escalated to the point that both entities have engaged in extensive and costly lobbying, advertising campaigns, and litigation which have further contributed to the public's confusion and misunderstanding.

COUNT I

UPMC'S AND HIGHMARK'S BREACH OF MEDIATED AGREEMENT, LIABILITY TO PUBLIC AS THIRD-PARTY BENEFICIARY

46. Paragraphs 1 through 45 are incorporated as if fully set forth.

47. Under the Mediated Agreement, Highmark's members were intended to have access to all of UPMC's providers through at least December 31, 2014 to smooth the public's transition in the changing relationship between UPMC and Highmark, making the public-at-large a third-party beneficiary of the Mediated Agreement.

48. In recognition of special community needs and certain unique services provided by Western Psychiatric Institute, UPMC Northwest, and UPMC Bedford Memorial, Highmark and UPMC agreed to negotiate terms and conditions for continued in-network access to those entities.

49. UPMC and Highmark agreed to negotiate terms and conditions for continued in-network access to certain UPMC oncological services.

50. Highmark and UPMC agreed that Highmark members in a continuing course of treatment would have in-network access to UPMC hospitals and providers.

51. More than two years after executing the Mediated Agreement on May 1, 2012, UPMC and Highmark have yet to reach definitive agreements for:

a. continued in-network access to Western Psychiatric Institute, UPMC Northwest, and UPMC Bedford Memorial;

b. continued in-network access to certain UPMC oncological services and are now arbitrating the appropriate rates for those services as well as their respective abilities to change the rates or fee schedules;

c. continued in-network access for Highmark members in a continuing course of treatment at UPMC hospitals and providers;

d. continued in-network access to other UPMC hospitals and providers serving special local community needs or providing unique services, including, but not limited to, UPMC Altoona, UPMC Hamot, UPMC Horizon, and Kane Community Hospital;

e. access to other UPMC providers serving non-UPMC locations or facilities under joint ventures, service agreements, or otherwise;

f. continuity of care services to be provided by UPMC to Highmark members beginning January 1, 2015 – nor have they settled upon the rates for continuity of care services; and

g. the terms and conditions under which Highmark will pay for services rendered through referrals to out-of-network UPMC facilities by in-network UPMC providers.

52. The lack of the definitive agreements complained of have caused confusion and uncertainty for patients and have denied the public the benefit of the smooth transition the Mediated Agreement intended.

WHEREFORE, the Commonwealth respectfully requests that this Honorable Court find Highmark and UPMC to be liable to the Commonwealth on behalf of the public as a third-party beneficiary to the Mediated Agreement and:

a. Require respondents to reach an agreement for hospital, physician and follow-up care services to Highmark members at Western Psychiatric Institute and Clinic, and for certain oncological, trauma and behavioral health services to Highmark members at any UPMC facility within 30 days of this Court's order and, failing such agreement, impose last best offer arbitration;

b. Require respondents to reach an agreement concerning UPMC hospitals and providers that serve special local community needs or provide unique services, including, but not limited to Western Psychiatric Institute and Clinic, UPMC Bedford Memorial, UPMC Venango (Northwest), UPMC Hamot, UPMC Altoona, UPMC Horizon, and Kane Community Hospital within 30 days of this Court's order and, failing such an agreement, impose last best offer arbitration;

c. For the emergency room services EMTALA requires UPMC to provide to Highmark members, require respondents to reach an agreement for hospital, physician and follow-up care services at all UPMC hospitals within 30 days of this Court's order and, failing such an agreement, impose last best offer arbitration;

d. Require that respondents reach an agreement for hospital, physician and follow-up services for Highmark members who are part of vulnerable populations, including, but not limited to, consumers age 65 and older who are eligible or covered by Medicare/Medicare Advantage/MediGap health plans; and consumers who are eligible or covered by CHIP, Medicaid fee-for-service and Medicaid managed care health plans within 30 days of this Court's order and, failing such an agreement, impose last best offer arbitration; and

e. Order any other relief that the Court deems appropriate.

COUNT II

UPMC'S VIOLATIONS OF THE CONSUMER PROTECTION LAW, ENGAGING IN UNFAIR CONDUCT CAUSING SUBSTANTIAL INJURY TO CONSUMERS WHO CANNOT AVOID THE RESPONDENT'S SUBSTANTIALLY HIGHER "OUT-OF-NETWORK" COSTS FOR ITS HEALTH CARE SERVICES.

53. Paragraphs 1 through 52 are incorporated as fully set forth.

54. At all times relevant and material, UPMC engaged in and continues to engage in trade or commerce within Pennsylvania by advertising, marketing, promoting, soliciting, and selling an array of medical products and services, including acute inpatient hospital care, outpatient care, physician services and the UPMC Health Plan insurance products and

services directly and indirectly to consumers, within the meaning of Section 2 of the Consumer Protection Law, 73 P.S. § 201-2.

55. UPMC's decision to forego all future contractual relationships with Highmark after December 31, 2014, violates:

a. its representations set forth in its mission statement on its web site that, "[o]ur patients and members are our first priority and we strive to be responsive to their needs . . . ."; and

b. its representations set forth in its "Patients' Rights and Responsibilities" that, "[a] patient has the right to medical and nursing services without discrimination based upon . . . [the] source of payment . . . ."

56. Sections 2(4)(iii), (v), (viii) and (xxi) of the Consumer Protection Law define "unfair or deceptive acts or practices" as follows:

. . .

(iii) Causing likelihood of confusion or of misunderstanding as to affiliation, connection or association with, or certification by, another;

. . .

(v) Representing that goods or services have sponsorship, approval, characteristics, ingredients, uses, benefits or quantities that they do not have or that a person has a sponsorship, approval, status, affiliation or connection that he does not have;

. . .

(viii) Disparaging the goods or services or business of another by false or misleading representation of fact;

. . .

(xxi) Engaging in any other fraudulent or deceptive conduct which creates a likelihood of confusion or of misunderstanding.

73 P.S. §201-2(4)(iii), (v), (viii) and(xxi).

57. Section 3 of the Consumer Protection Law, 73 P.S. §201-3, declares unfair and deceptive acts or practices to be unlawful.

58. Section 4 of the Consumer Protection Law, 73 P.S. §201-4, empowers the Attorney General to bring actions in the name of the Commonwealth to restrain persons by temporary and permanent injunction from using any act or practice declared to be unlawful by Section 3 of the Consumer Protection Law, 73 P.S. §201-3.

59. Section 4.1 of the Consumer Protection Law, 73 P.S. §201-4.1, provides that, "whenever any court issues a permanent injunction to restrain and prevent violations of this act . . . the court may in its discretion direct that the defendant or defendants restore to any person in interest any moneys or property . . . which may have been acquired by means of any violations of this act . . . ."

60. Section 8(b) of the Consumer Protection Law provides:

> In any action brought under section 4 of this act, if the court finds that a person, firm or corporation is willfully using or has willfully used a method, act or practice declared unlawful by section 3 of the act, the Attorney General . . . may recover, on behalf of the Commonwealth of Pennsylvania, a civil penalty of not exceeding one thousand dollars ($1,000) per violation, which civil penalty shall be in addition to other relief which may be granted under sections 4 and 4.1 of this act. Where the victim of the willful use of a method, act or practice declared unlawful by section 3 of this act is sixty years of age or older, the civil penalty shall not exceed three thousand dollars ($3,000) per violation, which penalty shall

be in addition to other relief which may be granted under section 2 and 4.1 of this act.

73 P.S. §201-8(b).

61. UPMC has represented to the public generally, and to its patients in particular, that UPMC's vision is "Putting our patients at the center of everything we do and creating a model that assures that every patient gets the right care, in the right way, at the right time, every time."

62. UPMC has described it values to the public generally, and to its patients in particular, that "Our patients and members are our first priority and we strive to be responsive to their needs . . . ."

63. UPMC's decision to forego all future commercial contractual relationships with Highmark after December 31, 2014, beyond those provided for in the Mediated Agreement, however, will inevitably result in thousands of unintended "out-of-network" medical procedures per year.

64. As alleged, many of those "out-of-network" procedures will be due to circumstances beyond the consumers' control.

65. As such, UPMC's discriminatory conduct subjects consumers to suffer unfair and substantially higher "out-of-network" charges for its health care services and is at odds with UPMC's representations to the public.

WHEREFORE, the Commonwealth respectfully requests that this Honorable Court:

a. Find that UPMC has engaged in unfair methods of competition and unfair or deceptive acts or practices within the meaning of Section 201-4 of the Consumer Protection Law;

b. Find that UPMC has willfully engaged in unfair and unconscionable acts or practices in violation of Section 201-3 of the Consumer Protection Law by pursuing a strategy of subjecting consumers to unfair and substantially higher "out-of-network" charges under circumstances beyond the consumers' control;

c. Pursuant to Section 201-4 of the Consumer Protection Law, enjoin UPMC its agents, representatives, servants, employees, successors, and assigns from imposing unfair and substantially higher "out-of-network" charges for its health care services by limiting UPMC's charges to no more than a reasonable price consistent with UPMC's charitable mission;

d. Award the Commonwealth its costs of investigation and attorneys' fees in this action pursuant to Section 201-4.1 of the Consumer Protection Law; and

e. Order any other relief the Court deems appropriate. .

COUNT III

UPMC AND HIGHMARK'S VIOLATIONS OF THE INSURANCE COMPANY LAW OF 1921

66. Paragraphs 1 through 63 are incorporated as if fully set forth.

67. Act 68 empowers the Pennsylvania Insurance Department and the Pennsylvania Department of Health to bring actions in the name of the Commonwealth to enjoin any action in violation of Act 68, 40 P.S. §991.2182(c).

68. In the Mediated Agreement, Highmark and UPMC agreed, in recognition of special local community needs and certain unique services provided by UPMC, to negotiate terms and

conditions for continued in-network access to Western Psychiatric Institute, UPMC Northwest, and UPMC Bedford.

69. In the Mediated Agreement, Highmark and UPMC agreed, in recognition of special local community needs and certain unique services provided by UPMC, to negotiate terms and conditions for continued in-network access to certain oncological services.

70. In the Mediated Agreement, Highmark and UPMC agreed that Highmark members in a continuing course of treatment would have in-network access to UPMC hospitals and providers.

71. UPMC and Highmark have negotiated a Term Sheet for in-network services at Western Psychiatric Institute, UPMC Northwest and UPMC Bedford Memorial. However, UPMC and Highmark have not reached a definitive agreement.

72. UPMC and Highmark have not agreed on a contract for other UPMC hospitals and providers that serve special local community needs or provide unique services, including, but not limited to, UPMC Hamot, UPMC Horizon, and Kane Community Hospital.

73. UPMC and Highmark have not agreed on a contract for other UPMC providers that service non-UPMC locations or facilities under joint ventures, services agreement, or otherwise.

74. UPMC and Highmark are currently engaged in a dispute concerning the appropriate rate of payment for oncological services and the parties' ability to change rate or fee schedules.

75. UPMC and Highmark have not agreed on the continuity of care services to be provided by UPMC to Highmark members beginning January 1, 2015 or the rates for such services.

76. UPMC and Highmark have not agreed on the terms and conditions under which Highmark will pay for services rendered upon referral to an out-of-network UPMC facility by an in-network UPMC provider.

77. The ongoing contractual dispute threatens the adequacy of Highmark's network and the access of Highmark members to emergency care at reasonable cost.

WHEREFORE, the Commonwealth respectfully requests that this Honorable Court:

a. Find that UPMC's and Highmark's ongoing contractual dispute has threatened and continues to threaten the adequacy of Highmark's network in violation of Act 68, 40 P.S.§ §991.2111(1) and 2111(4);

b. Require that respondents reach an agreement for hospital, physician and follow-up care services to Highmark members at Western Psychiatric Institute and Clinic, and for certain oncological, trauma and behavioral health services to Highmark members at any UPMC facility within 30 days of this Court's order and, failing such agreement, impose last best offer arbitration;

c. Require that respondents reach an agreement concerning UPMC hospitals and providers that serve special local community needs or provide unique services, including, but not limited to Western Psychiatric Institute and Clinic, UPMC Bedford Memorial, UPMC Altoona, UPMC Venango (Northwest), UPMC Hamot, UPMC Altoona, UPMC Horizon, and Kane Community Hospital within 30 days of this Court's order and, failing such an agreement, impose last best offer arbitration;

d. For the emergency room services EMTALA requires UPMC to provide to Highmark members, require that respondents reach an agreement for hospital,

physician and follow-up care services at all UPMC hospitals within 30 days of this Court's order and, failing such an agreement, impose last best offer arbitration ;

e. Require that respondents reach an agreement for hospital, physician and follow-up services for Highmark members who are part of vulnerable populations, including, but not limited to consumers age 65 and older who are eligible or covered by Medicare/Medicare Advantage/MediGap health plans; and consumers who are eligible or covered by CHIP, Medicaid fee-for-service and Medicaid managed care health plans within 30 days of this Court's order and, failing such an agreement, impose last best offer arbitration; and

f. Order any other relief that the Court deems appropriate.

Respectfully submitted,

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Attorney General

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Secretary of Health

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UPMC LIFE CHANGING MEDICINE

NEWS RELEASE SEARCH

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UPMC/University of Pittsburgh Schools of the Health Sciences

UPMC LIFE CHANGING MEDICINE

Joint Statement by Highmark and UPMC

For Journalists

Paul Wood
Vice President & Chief Communications Officer, Public Relations
Telephone: 412-647-6647

Other Inquiries
Contact Us

PITTSBURGH, May 2 – Highmark and UPMC are pleased to announce that they have reached an agreement in principle to provide for in-network access to all UPMC hospitals and physicians for Highmark Commercial and Medicare Advantage members until December 31, 2014.

In addition, in recognition of special local community needs and certain unique services offered by UPMC, and to minimize access to care and rate disputes, Highmark and UPMC have agreed to negotiate rates and terms for continued Highmark member access to certain UPMC services on an in-network basis starting in 2015, including Western Psychiatric Institute and Clinic, certain oncological services, UPMC Bedford, and UPMC Northwest. Highmark members in a continuing course of treatment at UPMC will also continue to have in-network access to UPMC hospital and physician services.

Current Highmark-UPMC arrangements regarding UPMC Mercy and Children's Hospital are unaffected by this agreement and will remain in effect. The current Highmark-UPMC arrangements regarding UPMC Hamot, which expire on June 30, 2013 with an additional one-year run-out period, will be extended by six months to December 31, 2014.

As part of its community benefit mission, UPMC will also continue to provide in-network hospital and physician services at preferred rates for certain Highmark plans which serve vulnerable populations, specifically Special Care, pa fair care, CHIP and Guaranteed Issue plans, for such time as these plans continue to be offered by Highmark.

The contractual extension until the end of 2014 will provide for sufficient and definite time for patients to make appropriate arrangements for their care and eliminate the need for any possible governmental intervention under Act 94. Highmark has agreed not to seek or support such intervention in return for UPMC's agreement to the extension.

This agreement was reached with the assistance of a mediator designated by Governor Corbett and the support of interested legislators. The agreement in principle is binding and will be implemented through formal agreements to be completed by June 30, 2012.

Exhibit "A"

RR 969a

medical questions that you have. Further, UPMC.com is not a tool to be used in the case of an emergency. If an emergency arises, you should seek appropriate emergency medical services.

For UPMC Mercy Patients: As a Catholic hospital, UPMC Mercy abides by the Ethical and Religious Directives for Catholic Health Care Services, as determined by the United States Conference of Catholic Bishops. As such, UPMC Mercy neither endorses nor provides medical practices and/or procedures that contradict the moral teachings of the Roman Catholic Church.

Pittsburgh, PA, USA UPMC.com

VERIFICATION

I, GARY A. SHADE, being duly sworn according to law, hereby state that I am authorized to make this verification on behalf of the plaintiff, and that the allegations in the foregoing Petition for Review are true and correct to the best of my knowledge, information and belief.

Gary A Shade

SWORN AND SUBSCRIBED TO

before me this 27th day of June 2014

Melissa M Ritzman
Notary Public

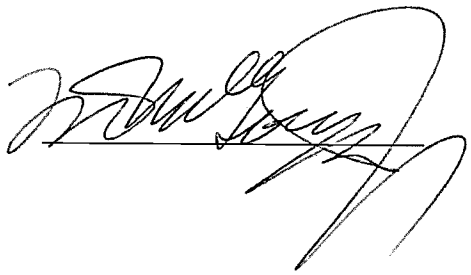
My commission expires 4/29/2016

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
MELISSA M RITZMAN, Notary Public
Dauphin County, City of Harrisburg
My Commission Expires April 29, 2016

VERIFICATION

I, W. Thomas McGough, Jr., state that I am Executive Vice President and Chief Legal Officer of UPMC, and I am authorized to verify the foregoing **Answer with New Matter and Counterclaims to Commonwealth's Petition to Modify Consent Decrees** and state that the information contained in it is true and correct to the best of my personal knowledge, information, and belief. This Verification is made subject to the penalties of 18 Pa. C.S.A. § 4904 relating to unsworn falsification to authorities.

Dated: April 15, 2019



CERTIFICATE OF SERVICE

I, J. Bart DeLone, Chief Deputy Attorney General, do hereby certify that I have this day served the foregoing Reproduced Record by electronic service via PACFile on all counsel listed on the docket.

/s/ J. Bart DeLone
J. BART DeLONE
Chief Deputy Attorney General

Date: April 24, 2019