JS 44 (Rev. 02/19)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS
UPMC Pinnacle; UPMC Pinnacle Hospitals; UPMC Pinnacle Carlisle; et al. (please see complaint for list of all remaining plaintiffs)

DEFENDANTS
Joshua D. Shapiro, in his official capacity as Attorney General of the Commonwealth of Pennsylvania

(b) County of Residence of First Listed Plaintiff Dauphin, PA
(EXCEPT IN U.S. PLAINTIFF CASES)

County of Residence of First Listed Defendant Dauphin, PA
(IN U.S. PLAINTIFF CASES ONLY)
NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

(c) Attorneys *(Firm Name, Address, and Telephone Number)*
Leon F. DeJulius Jr., Jones Day, 500 Grant St. Suite 4500, Pittsburgh PA 15219

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*
Click here for: Nature of Suit Code Descriptions.

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☒ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing *(Do not cite jurisdictional statutes unless diversity)*:
42 U.S.C. § 1983, 28 U.S.C. § 2201, and Section 1 of the Sherman Act, 15 U.S.C. § 1

Brief description of cause:
Constitutional claims pursuant to Supremacy Clause and Fourteenth Amendment

VII. REQUESTED IN COMPLAINT:

☒ CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:
JURY DEMAND: ☒ Yes ☐ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE Judge John E. Jones III DOCKET NUMBER 1:15-cv-2362

DATE 2-21-19

SIGNATURE OF ATTORNEY OF RECORD

FOR OFFICE USE ONLY

RECEIPT # AMOUNT APPLYING IFP JUDGE MAG. JUDGE

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

I.(a) **Plaintiffs-Defendants.** Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

(b) **County of Residence.** For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

(c) **Attorneys.** Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".

II. **Jurisdiction.** The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below; **NOTE: federal question actions take precedence over diversity cases.**)

III. **Residence (citizenship) of Principal Parties.** This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

IV. **Nature of Suit.** Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: Nature of Suit Code Descriptions.

V. **Origin.** Place an "X" in one of the seven boxes.
Original Proceedings. (1) Cases which originate in the United States district courts.
Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441.
Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket. **PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7.** Origin Code 7 was used for historical records and is no longer relevant due to changes in statue.

VI. **Cause of Action.** Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service

VII. **Requested in Complaint.** Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

VIII. **Related Cases.** This section of the JS 44 is used to reference related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.

Date and Attorney Signature. Date and sign the civil cover sheet.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

UPMC Pinnacle; UPMC Pinnacle Hospitals; UPMC Pinnacle Carlisle; UPMC Pinnacle Hanover; UPMC Pinnacle Lititz; UPMC Pinnacle Memorial; UPMC Somerset; UPMC Health Plan, Inc.; UPMC Health Coverage, Inc.; UPMC Health Network, Inc.; UPMC Health Options, Inc.; UPMC Benefit Management Services, Inc., Plaintiffs, on their own and on behalf of all others similarly situated, v. Joshua D. Shapiro, in his official capacity as Attorney General of the Commonwealth of Pennsylvania, Defendant.	Complaint—Class Action Civil Action No. Electronically Filed JURY TRIAL DEMANDED

COMPLAINT

NATURE OF ACTION

1. In view of unlawful and unconstitutional interference with federal programs by Attorney General Joshua D. Shapiro, Plaintiffs—both individually and on behalf of all others similarly situated—bring this class action to clarify their rights and obligations under federal law. Purporting to act in his official capacity, General Shapiro has illegally taken over nonprofit healthcare in the Commonwealth of Pennsylvania. Without rulemaking, legislation or public comment, General Shapiro has announced new "principles" that radically (and often in direct contravention of existing federal and state law) change how nonprofit health insurers and providers operate, now rendering the Attorney General the arbiter of how nonprofit health organizations should envision and achieve their mission.

2. Seizing on the unfounded idea that all nonprofits healthcare providers and all nonprofit health insurers must contract with any counterparty who asks, General Shapiro has imposed mandatory contracting requirements, has forced ratemaking arbitrations before panels that he hand-picks, and has ordered removal of corporate boards to ensure his complete control. Any entity that fails to agree to these terms faces draconian penalties, including the potential loss of nonprofit status.

3. This illegal scheme fundamentally changes the law. The healthcare industry is based on competition between closed networks of insurers and providers, and legislative efforts to change that model have failed. Just a few years ago the Attorney General's office itself conceded that "there is no statutory basis to make" payors and providers contract with each other and "no mechanism in Pennsylvania for resolving … price dispute[s]" between them. Exhibit E, at 35. But General Shapiro now asserts, pursuant to what he calls his own "vast authority," the ability to override the current federal and state system and impose his own rules.

4. General Shapiro's principles are preempted by at least four different federal laws. Medicare Advantage ("MA") statutes and regulations explicitly favor competition, preserve healthcare entities' freedom of contract, and preempt all state actions that interfere with the MA program. The Patient Protection and Affordable Care Act ("ACA") precludes states from regulating nonprofits that offer insurance plans through public exchanges differently from the for-profit insurers in that market. The Sherman Act prohibits regulatory schemes that delegate unsupervised ratemaking. The Employee Retirement Income Security Act of 1974 ("ERISA") supersedes state health care initiatives that substantially impact employer-sponsored health plans. In each of these areas Congress' policy-making power is supreme and precludes General Shapiro's conduct.

5. General Shapiro's assertion of "vast" power over nonprofits also violates the United States Constitution. Due process prohibits General Shapiro from imposing his *ultra vires* requirements on nonprofits through backroom threats with no legal process and then delegating price fixing power to self-interested private parties. This is particularly true where, as here, the Attorney General successfully argued to this Court that PinnacleHealth System (now Plaintiff UPMC Pinnacle) could not proceed with its planned merger with Hershey Medical System because it would reduce leverage and thus the ability of an insurer or provider to walk away from negotiations. *See* Exhibits C, D. General Shapiro has now arbitrarily and capriciously changed positions, seeking to eliminate *all leverage* in future contracts. The Takings Clause prohibits taking Plaintiffs' federal rights to not contract or conditioning benefits under state law, such as nonprofit status, on Plaintiffs forfeiting such rights. And General Shapiro's failure to apply the law equally among all nonprofits violates the Equal Protection Clause.

6. Accordingly, Plaintiffs, for themselves and for all Pennsylvania nonprofit healthcare entities, respectfully request declaratory and injunctive relief confirming that their rights and obligations with respect to these federal healthcare programs are set by federal law, barring General Shapiro from interfering with superior federal law and policy, and prohibiting General Shapiro from unconstitutionally depriving nonprofits of their rights and property.

PARTIES

7. Plaintiff UPMC Pinnacle is a subsidiary of UPMC and, in turn, the parent holding company for various hospitals, physician practices, and other healthcare providers. It is a nonprofit corporation organized and existing under the laws of the Commonwealth of Pennsylvania with a principal place of business at 409 South Second Street, Harrisburg, Pennsylvania 17104. UPMC Pinnacle and/or the hospitals and other providers that it owns provide health services to Medicare and Medicaid beneficiaries, to Medicare Advantage and

Medicaid managed care subscribers, and to subscribers of commercial health plans. These services are provided both on an in-network and out-of-network basis. In-network services are provided to those members covered by third-party payors, including insurers, that UPMC Pinnacle was able to negotiate and enter into participating provider agreements with upon reaching agreement on rates and terms. UPMC Pinnacle does not contract with every third party payor that requests a contract. UPMC Pinnacle also provides charity care and/or financial assistance to patients who do not have coverage and are unable to pay for services. UPMC Pinnacle merged into the UPMC system on or about September 1, 2017, three years after the execution of the Consent Decrees between and among UPMC, Highmark Inc., and the Commonwealth of Pennsylvania. Prior to that merger the Office of Attorney General of Pennsylvania reviewed the merger for compliance with the laws governing both antitrust and charitable trusts and interposed no objection.

8. UPMC Pinnacle Hospitals—doing business as Pinnacle Health Hospitals-Harrisburg, Pinnacle Health Hospitals-West Shore, and Pinnacle Health Hospitals-CGOH—is a direct subsidiary of UPMC Pinnacle, an indirect subsidiary of UPMC, and a nonprofit corporation organized and existing under the laws of the Commonwealth of Pennsylvania. UPMC Pinnacle Hospitals provides health services to Medicare and Medicaid beneficiaries, to Medicare Advantage and Medicaid managed care subscribers, and to subscribers of commercial health plans. These services are provided both on an in-network and out-of-network basis. In-network services are provided to those members covered by third-party payors, including insurers, that UPMC Pinnacle Hospitals was able to negotiate and enter into participating provider agreements with upon reaching agreement on rates and terms. UPMC Pinnacle Hospitals does not contract with every third party payor that requests a contract. UPMC

Pinnacle Hospitals also provides charity care to patients who do not have coverage and are unable to pay for services. UPMC Pinnacle Hospitals merged into the UPMC system on or about September 1, 2017, three years after the execution of the Consent Decrees between and among UPMC, Highmark Inc., and the Commonwealth of Pennsylvania. Prior to that merger the Office of Attorney General of Pennsylvania reviewed the merger for compliance with the laws governing both antitrust and charitable trusts and interposed no objection.

9. UPMC Pinnacle Carlisle is a direct subsidiary of UPMC Pinnacle, an indirect subsidiary of UPMC, and a nonprofit corporation organized and existing under the laws of the Commonwealth of Pennsylvania with a principal place of business at 361 Alexander Spring Rd., Carlisle, Pennsylvania 17015. UPMC Pinnacle Carlisle provides health services to Medicare and Medicaid beneficiaries, to Medicare Advantage and Medicaid managed care subscribers, and to subscribers of commercial health plans. These services are provided both on an in-network and out-of-network basis. In-network services are provided to those members covered by third-party payors, including insurers, that UPMC Pinnacle Carlisle was able to negotiate and enter into participating provider agreements with upon reaching agreement on rates and terms. UPMC Pinnacle Carlisle does not contract with every third party payor that requests a contract. UPMC Pinnacle Carlisle also provides charity care to patients who do not have coverage and are unable to pay for services. UPMC Pinnacle Carlisle merged into the UPMC system on or about September 1, 2017, three years after the execution of the Consent Decrees between and among UPMC, Highmark Inc., and the Commonwealth of Pennsylvania. Prior to that merger the Office of Attorney General of Pennsylvania reviewed the merger for compliance with the laws governing both antitrust and charitable trusts and interposed no objection.

10. UPMC Pinnacle Hanover is a direct subsidiary of UPMC Pinnacle, an indirect subsidiary of UPMC, and a nonprofit corporation organized and existing under the laws of the Commonwealth of Pennsylvania with a principal place of business at 300 Highland Ave., Hanover, Pennsylvania 17331. UPMC Pinnacle Hanover provides health services to Medicare and Medicaid beneficiaries, to Medicare Advantage and Medicaid managed care subscribers, and to subscribers of commercial health plans. These services are provided both on an in-network and out-of-network basis. In-network services are provided to those members covered by third-party payors, including insurers, that UPMC Pinnacle Hanover was able to negotiate and enter into participating provider agreements with upon reaching agreement on rates and terms. UPMC Pinnacle Hanover does not contract with every third party payor that requests a contract. UPMC Pinnacle Hanover also provides charity care to patients who do not have coverage and are unable to pay for services. UPMC Pinnacle Hanover merged into the UPMC system on or about September 1, 2017, three years after the execution of the Consent Decrees between and among UPMC, Highmark Inc., and the Commonwealth of Pennsylvania. Prior to that merger the Office of Attorney General of Pennsylvania reviewed the merger for compliance with the laws governing both antitrust and charitable trusts and interposed no objection.

11. UPMC Pinnacle Lititz is a direct subsidiary of UPMC Pinnacle, an indirect subsidiary of UPMC, and a nonprofit corporation organized and existing under the laws of the Commonwealth of Pennsylvania with a principal place of business at 1500 Highlands Drive, Lititz, Pennsylvania 17543. UPMC Pinnacle Lititz provides health services to Medicare and Medicaid beneficiaries, to Medicare Advantage and Medicaid managed care subscribers, and to subscribers of commercial health plans. These services are provided both on an in-network and out-of-network basis. In-network services are provided to those members covered by third-party

payors, including insurers, that UPMC Pinnacle Lititz was able to negotiate and enter into participating provider agreements with upon reaching agreement on rates and terms. UPMC Pinnacle Lititz does not contract with every third party payor that requests a contract. UPMC Pinnacle Lititz also provides charity care to patients who do not have coverage and are unable to pay for services. UPMC Pinnacle Lititz merged into the UPMC system on or about September 1, 2017, three years after the execution of the Consent Decrees between and among UPMC, Highmark Inc., and the Commonwealth of Pennsylvania. Prior to that merger the Office of Attorney General of Pennsylvania reviewed the merger for compliance with the laws governing both antitrust and charitable trusts and interposed no objection.

12. UPMC Pinnacle Memorial is a direct subsidiary of UPMC Pinnacle, an indirect subsidiary of UPMC, and a nonprofit corporation organized and existing under the laws of the Commonwealth of Pennsylvania with a principal place of business at 325 S. Belmont St., York, Pennsylvania 17403. UPMC Pinnacle Memorial provides health services to Medicare and Medicaid beneficiaries, to Medicare Advantage and Medicaid managed care subscribers, and to subscribers of commercial health plans. These services are provided both on an in-network and out-of-network basis. In-network services are provided to those members covered by third-party payors, including insurers, that UPMC Pinnacle Memorial was able to negotiate and enter into participating provider agreements with upon reaching agreement on rates and terms. UPMC Pinnacle Memorial does not contract with every third party payor that requests a contract. UPMC Pinnacle Memorial also provides charity care to patients who do not have coverage and are unable to pay for services. UPMC Pinnacle Memorial merged into the UPMC system on or about September 1, 2017, three years after the execution of the Consent Decrees between and among UPMC, Highmark Inc., and the Commonwealth of Pennsylvania. Prior to that merger the

Office of Attorney General of Pennsylvania reviewed the merger for compliance with the laws governing both antitrust and charitable trusts and interposed no objection.

13. Plaintiff UPMC Somerset is a subsidiary of UPMC and, in turn, the parent holding company for various hospitals, physician practices, and other healthcare providers. It is a nonprofit corporation organized and existing under the laws of the Commonwealth of Pennsylvania with a principal place of business at 225 South Center Avenue, Somerset, Pennsylvania 15501. UPMC Somerset and/or the hospitals and other providers that it owns provide health services to Medicare and Medicaid beneficiaries, to Medicare Advantage and Medicaid managed care subscribers, and to subscribers of commercial health plans. These services are provided both on an in-network and out-of-network basis. In-network services are provided to those members covered by third-party payors, including insurers, that UPMC Somerset was able to negotiate and enter into participating provider agreements with upon reaching agreement on rates and terms. UPMC Somerset does not contract with every third party payor that requests a contract. UPMC Somerset also provides charity care to patients who do not have coverage and are unable to pay for services. UPMC Somerset merged into the UPMC system on or about February 1, 2019, more than four-and-one half years after the execution of the Consent Decrees between and among UPMC, Highmark Inc., and the Commonwealth of Pennsylvania. Prior to that merger the Office of Attorney General of Pennsylvania reviewed the merger for compliance with the laws governing both antitrust and charitable trusts and interposed no objection.

14. Plaintiff UPMC Health Plan, Inc. is a subsidiary of UPMC and a nonprofit corporation organized and existing under the laws of the Commonwealth of Pennsylvania with its principal place of business in Allegheny County at 600 Grant Street, Pittsburgh, Pennsylvania

15219. UPMC Health Plan, Inc. offers, among other things, Medicare Advantage HMO plans pursuant to federal MA laws.

15. UPMC Health Coverage, Inc. is a subsidiary of UPMC and a nonprofit corporation organized and existing under the laws of the Commonwealth of Pennsylvania with its principal place of business in Allegheny County at 600 Grant Street, Pittsburgh, Pennsylvania 15219. UPMC Health Coverage, Inc. offers, among other things, individual and small group health insurance plans on exchanges operated pursuant to the ACA.

16. UPMC Health Network, Inc. is a subsidiary of UPMC and a nonprofit corporation organized and existing under the laws of the Commonwealth of Pennsylvania with its principal place of business in Allegheny County at 600 Grant Street, Pittsburgh, Pennsylvania 15219. UPMC Health Network, Inc. offers, among other things, Medicare Advantage PPO plans pursuant to federal MA laws.

17. UPMC Health Options, Inc. is a subsidiary of UPMC and a for-profit business corporation organized and existing under the laws of the Commonwealth of Pennsylvania with its principal place of business in Allegheny County at 600 Grant Street, Pittsburgh, Pennsylvania 15219. UPMC Health Network, Inc. offers, among other things, PPO and EPO plans on and off the exchanges operated pursuant to the ACA.

18. UPMC Benefit Management Services, Inc. is a subsidiary of UPMC and a for-profit business corporation organized and existing under the laws of the Commonwealth of Pennsylvania with its principal place of business in Allegheny County at 600 Grant Street, Pittsburgh, Pennsylvania 15219. UPMC Benefit Management Services, Inc., among other things, is a licensed third-party administrator that contracts with self-insured entities to provide administrative services.

19. Plaintiffs UPMC Health Plan, Inc.; UPMC Health Coverage, Inc.; UPMC Health Network, Inc.; UPMC Benefit Management Services, Inc. are collectively referred to herein as the "UPMC Health Plan." The UPMC Health Plan regularly negotiates reimbursement rates and other terms of payor-provider contracts, but does not have an in-network payor-provider contract with every healthcare provider in the areas where UPMC Health Plan markets insurance products.

20. Defendant Joshua D. Shapiro is the Attorney General of the Commonwealth of Pennsylvania with a principal place of business at Strawberry Square, 16th Floor, Harrisburg, Pennsylvania 17120.

JURISDICTION AND VENUE

21. Jurisdiction is premised on 28 U.S.C. § 1331, 28 U.S.C. § 1343, and § 1337(a), because the causes of action asserted herein arise under the Constitution of the United States of America, 42 U.S.C. § 1983, 28 U.S.C. § 2201, and Section 1 of the Sherman Act, 15 U.S.C. § 1.

22. This Court has jurisdiction over the claims in this action that arise under the laws of the Commonwealth of Pennsylvania pursuant to 28 U.S.C. § 1367(a), because the state law claims form part of the same case or controversy and derive from a common nucleus of operative facts.

23. Venue is proper under 28 U.S.C. § 1391 because UPMC Pinnacle maintains its headquarters in this district, the Defendant is resident here, and a substantial part of the events giving rise to Plaintiffs' claims occurred in this district.

24. A substantial, concrete controversy of sufficient immediacy and reality exists between parties having adverse legal interests, warranting the issuance of a declaratory judgment and other equitable relief. General Shapiro is forcing on nonprofit healthcare entities, including Plaintiffs, new requirements that compel them to remake their corporate governance, that

mandate compulsory contracts over their objection, dictate the terms of those contracts, and delegate unsupervised ratemaking authority to a panel of biased private arbitrators. He has indicated that his requirements immediately apply to all nonprofits in Pennsylvania.

25. The controversy between the parties substantially impacts Plaintiffs' operations and their interactions with thousands of individuals with federally-funded or federally-regulated health insurance. General Shapiro's actions are imposing on Plaintiffs conflicting requirements that make it impossible for Plaintiffs to exercise their federal rights, that are threatening Plaintiffs' financial viability, and that will lead to substantial confusion and increased healthcare costs for millions of Pennsylvanians.

26. The relief that Plaintiffs seek in this case will conclusively establish in relevant part Plaintiffs' rights under federal law, and will have the immediate practical effect of, among other things, confirming that federal law preempts alternative state-law requirements for operation of MA and ACA plans and self-insured benefit plans administered through nonprofit insurers.

BACKGROUND

I. GENERAL SHAPIRO ASSUMES CONTROL OVER NONPROFIT HEALTHCARE.

27. In November 2018, General Shapiro requested that representatives of UPMC, the parent company for Plaintiffs, attend a meeting in Harrisburg. At a November 26, 2018 meeting, General Shapiro asserted that he has "vast authority" over all Pennsylvania nonprofit entities. General Shapiro informed UPMC that, pursuant to this authority, he was preparing a formal list of terms by which all nonprofits must abide, including UPMC, each of its subsidiaries, and any hospital it later acquired. Non-compliance would constitute a violation of Pennsylvania nonprofit laws.

28. General Shapiro delivered this list of new requirements on December 14, 2018, in the form of a proposed Consent Decree, which he then slightly revised on or about January 8, 2019. A true and correct copy of General Shapiro's new requirements is attached hereto as Exhibit A.

29. General Shapiro's new requirements include the following:

(a) Nonprofit health plans must contract with any healthcare provider that seeks an MA or commercial contract;

(b) similarly, nonprofit healthcare providers must contract with any insurer that wants a commercial or MA contract;

(c) if the parties to these forced contracts cannot agree on the rates to be paid or the other terms, they must submit to arbitration before a panel empowered to set the terms of the contract for them;

(d) in the event that a nonprofit healthcare provider lacks a contract with a particular insurer, any emergency services provided to that insurer's subscribers must be reimbursed at rates established by the Office of Attorney General;

(e) nonprofits healthcare entities are barred from exercising any right to terminate a contract without cause;

(f) nonprofit healthcare providers are 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";

(g) nonprofit healthcare providers are 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;

(h) nonprofit healthcare providers are prohibited from engaging in any public advertising that the Attorney General determines is unclear or misleading in fact or by implication, even if the federal government has approved the advertising;

(i) members of the Board of Directors or similar governance body of nonprofit healthcare entities can be removed and replaced at the whim of the Attorney General.

30. These forced terms will continue in perpetuity with no end date and at the discretion of the Attorney General.

31. General Shapiro stated that these requirements were mandated by Pennsylvania nonprofit and charitable trust laws, thus imperiling the nonprofit status of UPMC and its subsidiaries under Pennsylvania law in the event of noncompliance with these requirements.

32. General Shapiro has further confirmed that his requirements apply to all nonprofit healthcare providers and insurers in Pennsylvania, and that he will enforce his new requirements against all such entities, starting with matters that the Office of the Attorney General currently has under investigation. *See* Jan. 2, 2019 Ltr. to J. Donahue, attached as Exhibit B.

33. On February 7, 2019, General Shapiro filed an application to modify a Consent Decree signed in July 2014, seeking to impose these requirements against UPMC, Plaintiffs' ultimate parent entity. None of the Plaintiffs in this action were named as parties in General Shapiro's petition. Moreover, Plaintiffs UPMC Pinnacle and UPMC Somerset were not part of the UPMC system when this Consent Decree was signed.

34. The issues raised by General Shapiro in the Consent Decree litigation are narrower than the issues raised here. In that litigation, General Shapiro seeks to force Plaintiffs to open their doors to a certain subset of insurers and providers—namely, those who are willing to agree to be bound by contract terms set by General Shapiro's panel of arbitrators. Yet General Shapiro's new requirements impose an *even broader* obligation on Plaintiffs, as he asserts that Plaintiffs are obligated to contract with *any* insurer or provider—which would necessarily include those insurers or providers who refuse to agree to arbitration.

35. The issues raised in the Consent Decree litigation are also narrower insofar as the Consent Decree would not apply if Plaintiffs were to seek to contract with other nonprofits and insurers not subject to the Decree. If Plaintiffs were to seek to contract with a nonprofit insurer or provider, that entity would be obligated to enter into a contract with Plaintiffs under the

Attorney General's new requirements, but that entity would not be subject to the Consent Decree.

36. The issues raised by General Shapiro in the Consent Decree litigation are also far broader than the issues raised here. In that litigation, General Shapiro has mounted an unfounded challenge to UPMC's nonprofit status; has wrongly accused UPMC of making misleading statements in its charitable solicitations; and has unjustly accused UPMC of departing from its stated charitable purpose.

37. Plaintiffs have filed this action to clarify their rights and obligations under federal law, as they participate in these ongoing federal regulatory schemes and seek to comply with upcoming federal deadlines. The required clarity cannot be obtained in the Consent Decree litigation, which involves only one application of the broader requirements imposed by the Attorney General.

38. Plaintiffs do not ask this Court to enjoin the Consent Decree litigation. Rather, Plaintiffs have filed this litigation so that this Court can set the terms for Plaintiffs' ongoing participation in health insurance programs that are regulated by federal law.

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.

40. General Shapiro also 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.

41. Without clarity regarding their rights and obligations under federal law, Plaintiffs will be unable to accurately project their costs. Because accurate forecasting of costs is critical

to insurers, the lack of clarity will interfere with Plaintiffs' operation of their business and with the operation of insurance markets more broadly.

42. General Shapiro's new requirements also conflict with the positions his own office has taken against Plaintiff UPMC Pinnacle in this very Court. In its Amended Complaint in *Commonwealth v. Penn State Hershey Medical Center*, No. 15-cv-2362 (M.D. Pa. Apr. 8, 2016) (Doc. 101) (attached hereto as Exhibit C), the Office of Attorney General stated that critical to payor-provider bargaining "is whether other, nearby comparable hospitals are available to the health plan and its members as alternatives in the event of a negotiating impasse," because the "presence of alternative hospitals limits a hospital's bargaining leverage and thus constrains its ability to obtain higher reimbursement rates from health plans." *Id*. at 16. The Office of Attorney General praised closed networks as key to healthcare because they foster competition between providers both in respect to rates (because hospitals are "motivate[d] … to offer lower rates to health plans to win inclusion in their networks") and with respect to non-rate terms (like quality, amenities, etc.). *Id.* at 15–16. Yet General Shapiro's new requirements would prevent nonprofit plans and providers from engaging in precisely this type of competition.

43. Had General Shapiro not taken action against Pinnacle Hospital to prevent its merger with another health system, Pinnacle would not have merged into the UPMC system.

44. Moreover, the Attorney General's office itself has conceded in testimony before Pennsylvania legislators not only that "there is no statutory basis to make" payors and providers contract with each other or to resolve their price disputes, but also that the lack of any such mechanism is good for competition: "[T]he contracting process involves two parties willingly coming to an agreement," and "one of the key things is that each party has the ability to walk

away from the negotiations." Exhibit E, at 35. This ability "forces each side to be reasonable in most circumstances," and taking away that ability would have unpredictable effects on price.

45. General Shapiro's requirements are also self-defeating, as they assure the very limitations on access that General Shapiro purports to be eliminating. By mandating compulsory contracts, General Shapiro's requirements make it impossible for insurance plans to manage their network, forecast costs, and set appropriate rates. But at the same time, General Shapiro is prohibiting "anti-tiering or anti-steering clauses." In so doing, General Shapiro is allowing insurers to impose restrictions on access by using narrow, tiered networks and benefit design to steer patients toward preferred providers. Insurers who can force a provider into a contract can market to consumers that the provider is "in-network," but then tier and steer through the benefit design in ways that are confusing and impenetrable to consumers so that there will be significant economic burdens in selecting that provider.

46. Combining mandatory contracting with tiering-and-steering gives consumers the *illusion of access*, but without removing any of the practical restrictions on access. The result will be greater confusion among members about the terms of their plan, financial barriers that prevent consumers from accessing the provider of their choice, increased administrative costs to health plans, lower overall reimbursements to providers, greater financial instability across nonprofit healthcare entities in Pennsylvania, and a corresponding competitive advantage to their for-profit counterparts.

47. In any event, General Shapiro's requirements are also, as more fully set forth below, barred under federal law.

II. GENERAL SHAPIRO'S NEW REQUIREMENTS VIOLATE FEDERAL LAW.

48. As applied to Plaintiffs and other Pennsylvania nonprofit healthcare entities, General Shapiro's new requirements constitute a radical departure from healthcare as it currently

exists and an unprecedented violation of bedrock constitutional and antitrust rights. His actions are banned under federal law in at least the following ways.

A. Federal Law Prohibits State Interference with Medicare Advantage.

49. General Shapiro's new requirements directly conflict with the federal 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.

50. 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*.

51. 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).

52. 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.

53. Federal law for the MA program preempts General Shapiro's new requirements in at least the following ways.

54. *First*, General Shapiro's new requirements wrongly impose forced contracting and rate structures on Plaintiffs. *See* Exhibit A ¶¶ 3.2–3.3.

55. 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).

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

57. General Shapiro's new requirements violate these rights. They force nonprofit providers and insurers to enter into involuntary MA contracts.

58. And, where the parties cannot agree on rates, General Shapiro's new requirements force them to adopt a specific price structure in the form of rates set according to specified arbitration procedures.

59. General Shapiro is also wrongly imposing a particular price structure on Plaintiffs by prohibiting provider-based billing. *See* Exhibit A ¶ 3.4.5.

60. Provider-based billing 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.

61. General Shapiro's new requirements bar nonprofit providers from charging this fee, regardless of whether the provider meets the federally mandated criteria. In effect, General Shapiro is preventing nonprofit healthcare providers from recovering the full cost of providing MA services, notwithstanding federal law that allows them to do so.

62. 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.

63. *Second*, General Shapiro's new rules wrongly impose specific rates on services to out-of-network MA patients. *See* Exhibit A ¶ 3.5.

64. 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.

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

66. *Third*, General Shapiro's rules interfere with CMS's exclusive purview to regulate advertising for MA plans. *See* Exhibit A ¶ 3.10.

67. 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.

68. 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).

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

B. Federal Law Prohibits Discriminating Between Insurers Operating On ACA Exchanges.

70. The ACA also preempts General Shapiro's new requirements.

71. 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)).

72. 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.

73. 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."

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

75. Specifically, nonprofit health insurers that market ACA insurance plans — including Plaintiff UPMC Health Coverage, Inc. — are subject to General Shapiro's new requirements and must 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.

76. 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 disparate treatment of nonprofit insurers offering products in the ACA marketplaces.

C. ERISA Preempts State Interference with Employer-Sponsored Health Plans.

77. 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.

78. 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).

79. "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).

80. General Shapiro's assertion of control over nonprofits extends to employee benefit plans and constitutes regulation of the benefit structure and administration of self-insured plans. Specifically, his new requirements force nonprofit health insurers to contract with all willing providers; submit to an arbitration process to establish rates in the event that rates cannot be privately determined; and forego specific contract terms.

81. General Shapiro's new rules 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 new rules 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").

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

83. General Shapiro's new rules further violate ERISA by disrupting the uniformity that Congress, through ERISA, sought to achieve across states related to employee benefit plans and employer conduct. Plaintiff UPMC Benefit Management Services, Inc. administers self-insured health plans in multiple states, including Pennsylvania. General Shapiro's Pennsylvania-

specific regulatory requirements 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.

84. 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).

D. General Shapiro is Unreasonably Restraining Trade.

85. The Sherman Antitrust Act, the relevant portion of which is codified at 15 U.S.C. § 1, prohibits "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States . . . ."

86. The purpose of the Sherman Antitrust Act is to prevent unreasonable restraints on trade.

87. A governmentally imposed trade restraint that enforces private pricing decisions is a hybrid restraint that fulfills the Sherman Act's concerted actions requirement. Members of state and local governments violate the Sherman Act when they empower private parties to set prices, and then enforce those prices by government mechanisms.

88. The Supreme Court has consistently held that when price maintenance by individual parties is facilitated or compelled by state regulation, competition is destroyed as effectively as if private parties formed an agreement not to compete.

89. Any regulation tending to stabilize prices, insulate prices from the flexibility of the free market, or impede the ability to employ market strategies through pricing is counter to the broad thrust of the Sherman Act.

90. Part of General Shapiro's express goals is to reduce competition in healthcare. General Shapiro is unreasonably restraining trade by forcing Plaintiffs to contract with any

willing third party provider or payor and delegating to interested market participants the ability to fix rates horizontally, a *per se* or rule of reason violation of the Sherman Act.

91. General Shapiro's new requirements also prohibit the use of so-called Gag Clauses, defined as any agreement that restricts an insurer's ability to furnish cost information to its enrollees. *See* Exhibit A ¶ 3.4.2. This unrestricted prohibition goes well beyond providing consumers transparency about hospital cost. It also would easily enable an insurer to obtain confidential and proprietary information about the specific reimbursement rates that other insurers have in place with each provider. This ensures that information about the reimbursement rates under any given contract cannot be kept confidentially but will be disseminated into the public sphere.

92. Insurers willing to contract with a nonprofit health provider then have a right to force a contract, including through arbitration if the parties cannot agree on reimbursement rates. And, insurers can base their proposals on information about the nonprofit healthcare provider's existing rates with other insurers.

93. Moreover, General Shapiro has delegated rate making determinations to five individuals. *See* Exhibit A ¶ 4.3.1. The Arbitrators are required to consider a series of factors, including the prices paid for comparable services by other insurers and/or accepted by other providers. *See id*. ¶ 4.3.4. Based on these factors, the Arbitrators must accept one party's proposed rates. *See id*. ¶ 4.5.

94. Of the five members of the arbitration panel, one will be appointed by the insurer making the proposal; one will be appointed by the Pennsylvania Health Access Network, an organization with the express goal of "making our health care system more affordable and accessible for all Pennsylvanians"; and two will be appointed by members of the Chamber of

Commerce, which comprises companies frequently responsible for paying the cost of healthcare. *See* Exhibit A ¶ 4.3.1.

95. Four of the five members of the arbitration panel will thus have an incentive to adopt the lowest proposal.

96. General Shapiro's new requirements for nonprofit healthcare providers restrain competition by forcing Plaintiffs to contract with all willing insurers or providers; by enabling arbitrators to effectively level-set the prices that insurers pay; and by abdicating this unsupervised regulatory power to nonpolitical, nonresponsive private actors.

97. Notably, the Office of Attorney General previously took before this Court and against Plaintiff UPMC Pinnacle the opposite of the position now behind its new requirements. Previously, the Office of Attorney General acknowledged the harms that result from reduced competition in the healthcare market, including higher prices and lower quality for consumers. *Commonwealth v. Penn State Hershey Medical Center*, No. 15-cv-2362 (M.D. Pa. Apr. 8, 2016) (Doc. 101), at 24 ¶ 59, 27 ¶ 68 (attached hereto as Exhibit C).

98. The arbitration apparatus that General Shapiro is imposing on all nonprofit healthcare entities also necessarily has an anti-competitive impact on healthcare reimbursements whether or not arbitration is actually invoked. The certainty that any dispute over reimbursement rates will be decided by a panel of unsupervised, interested market participants not only incentivizes insurers to standardize all rate offers across the industry based on publicly available pricing information, but also incentivizes providers to accept standardized rates in lieu of incurring the expense and delay of biased arbitration. By itself, an insurer's ability to force a provider into this arbitration process irrationally distorts the bargaining process in anti-competitive ways.

99. The Sherman Act prohibits General Shapiro from enabling anticompetitive conduct or encouraging interdependent prices set solely according to private marketing decisions of non-state actors.

100. The impact on Plaintiffs is an injury of the type the antitrust laws were designed to prevent.

101. Moreover, General Shapiro's new requirements interfere with free bargaining, stabilize prices, insulate prices from the flexibility of the free market, and impede the ability to employ market strategies through pricing, all of which hurt competition, disincentivize quality and innovation in healthcare, and result in higher prices for consumers.

E. Forcing Plaintiffs to Enter Contracts is an Unconstitutional Taking and Imposes an Unconstitutional Condition.

102. But for General Shapiro's actions, nonprofits healthcare entities would enjoy the right *not* to contract with any insurer or provider.

103. Plaintiffs' right not to contract arises from the United States Constitution, as a corollary of the right to contract; from federal statutes and regulations, as discussed above; and from state law. *See* 40 Pa. Stat. Ann. § 764a; *see also Torretti v. Main Line Hosps., Inc.*, 580 F.3d 168, 173 (3d Cir.), amended, 586 F.3d 1011 (3d Cir. 2009) ("There is no general common-law duty for hospitals to accept and treat all individuals.").

104. Plaintiffs' contract rights, as well as their business interests and nonprofit status under Pennsylvania law, are constitutionally protected property interests within the meaning of the Takings Clause of the Fifth Amendment and the Due Process Clause of the Fourteenth Amendment to the United States Constitution, and under the Pennsylvania Constitution.

105. General Shapiro's requirements that Plaintiffs forego their right not to contract with other insurers and providers, forego their right to terminate existing contracts with other

insurers and providers, and forego existing contractual rights to provider-based billing effect a taking under the United States Constitution and the Pennsylvania Constitution.

106. General Shapiro's decision to condition Plaintiffs' nonprofit status on their acquiescence to his new requirements also violates the unconstitutional conditions doctrine, as does his threat to enforce other (unspecified) laws against Plaintiff if they refuse his demands. Under the unconstitutional conditions doctrine, General Shapiro violates the Constitution when he conditions his regulatory forbearance on Plaintiffs' agreement to give up their protected rights, regardless of the scope of his authority under state law.

107. By way of example, Plaintiffs—and indeed all nonprofits—must now give up their federally established rights with respect to their Medicare Advantage programs, or otherwise face General Shapiro's arbitrary and unlawful enforcement actions.

108. By forcing Plaintiffs to contract with other insurers and providers, General Shapiro interferes with Plaintiffs' reasonable expectation that they will enjoy the right *not* to contract. Plaintiffs have made numerous decisions and investments in equipment, personnel, and facilities based on this reasonable expectation. And Plaintiffs have arranged their contractual relationships, business structures, and business plans based on this reasonable expectation.

109. General Shapiro's forced contracts and forced contract terms will place Plaintiffs at a disadvantage relative to for-profit competitors—who will not be subject to these same requirements—and will cause Plaintiffs to suffer long-lasting competitive harm.

110. The Office of Attorney General has previously recognized that the ability *not* to contract provides a key point of leverage in negotiations between insurers and providers. *See* Exhibit C, at 23 ¶ 56. General Shapiro would take that leverage away from nonprofit providers and insurers, but would *not* take it away from for-profit competitors in the same marketplace.

111. General Shapiro's forced contracts and forced contract terms will impose enormous costs on providers, who will have a materially reduced ability to obtain market rates for their own services in contract negotiations.

112. In addition, Plaintiffs UPMC Pinnacle and UPMC Somerset have committed resources to facilities that comply with federal requirements for provider-based billing and have contracts with private insurers that allow provider-based billing. *See, e.g.,* 42 C.F.R. § 413.65 (permitting providers who meet established criteria to bill facility fees for services to MA enrollees). These Plaintiffs made these commitments with the expectation that they would be allowed to bill insurers for services provided in a provider-based setting, consistent with federal laws and their contractual rights.

113. By prohibiting provider-based billing, General Shapiro's new rules block Plaintiffs UPMC Pinnacle and UPMC Somerset from billing in accordance with federal law and their existing contracts. This requirement also effects a taking under the United States Constitution, and General Shapiro's demand that Plaintiffs accede to this requirement or else face regulatory action violates the unconstitutional conditions doctrine and the Pennsylvania Constitution.

114. Upon information and belief, General Shapiro established his new requirements without any analysis of: the financial impact these rules will have on the nonprofit healthcare providers and insurers that will be impacted by the new requirements; the impact the new requirements will have on competition, since for-profit providers and insurers are not affected; what impact these new requirements will have on healthcare costs; or the impact that financial harm to nonprofit healthcare providers will have on communities where nonprofit healthcare is a significant contributor to local communities.

F. Targeting UPMC Affiliates While Ignoring Other Healthcare Entities in the Commonwealth Violates Equal Protection.

115. Across the Commonwealth, nonprofit healthcare entities routinely refuse to contract with particular insurers or providers, both for commercial and MA services. Similarly situated nonprofit providers also routinely practice provider-based billing and charge well beyond General Shapiro's capped rates for out-of-network emergency MA services.

116. For instance, when a UPMC Health Plan subscriber receives emergency care from an out-of-network hospital within the Allegheny Health Network (a nonprofit provider system), the reimbursement rate is typically a percentage of the hospital's actual charges, without respect to the hospital's average in-network rates for those services. General Shapiro's requirement that UPMC provider's rates be capped at an average of in-network rates imposes rates far lower than these.

117. General Shapiro's new rules foist on UPMC providers rates that fall far below industry standards and far below what insurers are, under other circumstances, willing to pay.

118. General Shapiro has indicated that he "expects" the "principles" of his new requirements to be applied to all nonprofit healthcare entities throughout the Commonwealth.

119. Upon belief, General Shapiro has not and currently is not trying to force all other healthcare nonprofits in Pennsylvania to contract with any other nonprofit insurer or provider, and General Shapiro likewise is not seeking to limit the ability of all other nonprofits to engage in provider-based billing or to charge appropriate rates for out-of-network emergency care.

120. General Shapiro has thus targeted Plaintiffs (and other UPMC entities) for special regulatory burdens that have not been imposed on other similarly-situated entities. The Attorney General has identified no reason why Plaintiffs should be subject to these special burdens, and

has, to the contrary, said that these principles *ought* to apply to all nonprofit healthcare entities in the Commonwealth.

121. Targeting Plaintiffs for retaliatory action under color of state law because they are exercising federally protected rights that most, if not all, other nonprofit healthcare entities in the Commonwealth are also exercising violates the guarantee to equal protection and disadvantages Plaintiffs.

G. General Shapiro's Rules Violate Due Process.

122. Contract rights, business interests, and nonprofit status under Pennsylvania law, are constitutionally protected property within the meaning of the Due Process Clause of the Fourteenth Amendment to the United States Constitution. In addition, Plaintiffs have a constitutionally-protected liberty interest in their right *not* to contract.

123. General Shapiro has invaded the liberty and property interests of Pennsylvania nonprofit healthcare entities without any procedure at all. Rather than proceeding through legislation, regulation, or any other form of legal process, General Shapiro simply announced his rule as binding law.

124. This lack of *pre*-deprivation process also frustrates *post*-deprivation review, as it removes the Attorney General's actions from the scope of the State's administrative review act. *See Phila. Cty. Med. Soc. v. Kaiser*, 699 A.2d 800, 806 (Pa. Commw. Ct. 1997).

125. General Shapiro's *ad hoc* rulemaking violates due process. Due process is violated when rights and liberties are determined on an *ad hoc* and subjective basis, with the attendant dangers of arbitrary and discriminatory application.

126. Moreover, the private nondelegation doctrine, an aspect of due process, forbids the government from delegating to private parties the power to determine the nature of rights to

property in which other individuals have a property interest, without supplying standards to guide the private parties' discretion.

127. Here, General Shapiro has delegated the power to set rates for medical services to private arbitrators. If nonprofits cannot voluntarily agree to the terms of the compulsory contacts the Attorney General is imposing, General Shapiro will force them into binding arbitration before private arbitrators who will set the terms and conditions of public access. But General Shapiro has set no standard to guide those arbitrators and retains no supervision over their decisions. Worse, the arbitrators are drawn from entities with a financial interest in the outcome.

128. General Shapiro has thus violated the private nondelegation doctrine by delegating the power to set rates for medical services to private arbitrators.

H. General Shapiro's New Requirements Are Arbitrary And Irrational, And Therefore Violate Substantive Due Process

129. The Third Circuit has recognized that government action violates substantive due process if it is "arbitrary, irrational, or tainted by improper motive" or is "so egregious that it 'shocks the conscience.'" *Cty. Concrete Corp. v. Town of Roxbury*, 442 F.3d 159, 169 (3d Cir. 2006).

130. Whether government action shocks the conscience is not a precise standard; rather, it "varies depending upon the factual context." *Chainey v. Street*, 523 F.3d 200, 220 (3d Cir. 2008).

131. The Office of Attorney General has previously recognized the importance of narrow networks—including the narrow networks *of these particular plaintiffs*—to the operation of the healthcare markets. Specifically, the Office of Attorney General acknowledged the importance of the narrow network operated by Plaintiff UPMC Pinnacle in prior litigation that the Attorney General filed against that entity.

132. Prior to joining the UPMC family of companies, UPMC Pinnacle (then called PinnacleHealth System, or "PinnacleHealth") sought to merge with Penn State Hershey Medical Center ("Hershey"), another hospital system operating in the same geographic area. The Attorney General opposed that merger on the ground that it would decrease competition. *See* Exhibit C.

133. In opposing the Pinnacle-Hershey merger, the Attorney General argued that the rivalry between Hershey and PinnacleHealth benefited local patients with "lower healthcare costs and increased quality of care," and that the merger would have eliminated "significant head-to-head competition between Hershey and PinnacleHealth." *See id*. at 3 ¶ 3.

134. The Attorney General argued that having competing health systems was essential to the healthcare market. According to its logic, hospitals compete to be selected as in-network providers for commercial health plans. *See id*. at 15 ¶ 37. Narrow networks, in other words, create a "dynamic" that motivate hospitals to "offer lower rates to health plans to win inclusion in their networks." *See id*. at 15–16 ¶ 39. Aside from lower rates, competition incentivizes hospital systems to "expand services, increase quality of care, and invest in state-of-the-art facilities and technologies." *See id*. at 25 ¶ 62.

135. As a corollary to narrow networks, the Attorney General emphasized the importance of the negotiation process between hospitals and insurers. Specifically, each party must have leverage, which is ultimately a function of each party's ability to walk away from the negotiation and to refuse to do business with its negotiating partner.

136. On appeal to the Third Circuit, the Attorney General argued in 2016:

> 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.

Exhibit D at 6–7 (emphasis added).

137. Further, "[a] critical determinant of the relevant bargaining positions of a hospital and a health plan during negotiations is whether other, nearby comparable hospitals are available to the health plan and its members as alternatives in the event of a negotiating impasse. The presence of alternative hospitals limits a hospital's bargaining leverage and thus constrains its ability to obtain higher reimbursement rates from health plans." Exhibit C at 16 ¶ 41.

138. And, "[i]f Hershey and Pinnacle were to merge, health plans could no longer threaten to exclude the combined Hershey/Pinnacle from their networks or otherwise use competition between Hershey and Pinnacle to negotiate better reimbursement rates." *Id*. at 23 ¶ 57.

139. Pinnacle joined the UPMC family of companies only because the OAG succeeded in blocking the Hershey/Pinnacle merger on the ground that competition between narrow networks is essential to the operation of healthcare markets.

140. Furthermore, senior representatives from the Attorney General's Office *publicly testified* before the Pennsylvania House of Representatives, on October 14, 2014, 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 E, at 35 (emphasis added).

141. Now, the Attorney General is taking the irreconcilably inconsistent position that UPMC Pinnacle *cannot* refuse to contract with any insurer, and thus it cannot walk away if the hospital system and any commercial insurer reach a negotiating impasse.

142. The Attorney General's position would have the effect of *eliminating* the very competition that it previously cited as a reason to block the Pinnacle/Hershey merger.

143. The Attorney General is taking this new position in bad faith. There has been *no change in controlling law*, nor has there been *any change* in UPMC Pinnacle's approach to its approach to contracting with insurers.

144. The Attorney General's bad faith motive for pursuing its new, inconsistent position is to achieve a short term political victory.

145. The Attorney General's decision to subject UPMC Pinnacle to fundamentally inconsistent legal positions, purely in pursuit of his own political goals, is so arbitrary and irrational that it shocks the conscience.

146. The Attorney General has violated UPMC Pinnacle's substantive due process rights by subjecting UPMC Pinnacle to contradictory, arbitrary, and fundamentally irrational arguments in pursuit of the Attorney General's own political gain.

147. The Attorney General had announced its previous position about the right *not* to contract—in no uncertain terms—before this very Court and through congressional testimony. The Attorney General is now "playing fast and loose with the courts, which has been emphasized as an evil the courts should not tolerate." *See Scarano v. Cent. R. Co. of N. J.*, 203 F.2d 510, 513 (3d Cir. 1953). The Attorney General's arbitrary and capricious actions shock the conscience.

III. CLASS ACTION ALLEGATIONS.

148. Certain issues asserted in this Complaint are properly brought as a class action. Federal Rule of Civil Procedure 23(c)(4) permits an action to be brought or maintained as a class action with respect to particular issues.

149. Count I (Declaratory Judgment / Medicare Act), Count IV (15 U.S.C. § 1 / Sherman Act Hybrid Restraint), Count V (Regulatory Taking), Count VI (Unconstitutional Condition), and Count VIII (Due Process) are brought on behalf of all nonprofit healthcare entities organized under the laws of Pennsylvania (the "Plaintiff Class"). Count II (Declaratory Judgment / ACA) is brought on behalf of a Subclass, as defined below.

150. As set forth in greater detail above, General Shapiro has asserted broad, illegitimate, and illegal authority to regulate all nonprofit entities organized under the laws of Pennsylvania.

151. Plaintiffs are members of the Plaintiff Class and are currently being targeted by General Shapiro for enforcement of his newly announced "vast authority" to control all nonprofit entities in Pennsylvania.

152. The Plaintiff Class meets the numerosity requirement of Fed. R. Civ. P. 23(a)(1). There are hundreds of nonprofit healthcare entities organized under the laws of Pennsylvania. The Plaintiff Class contains so many members that individual joinder of class members is impractical.

153. There are questions of law and fact common to all members of the Plaintiff Class pursuant to Fed. R. Civ. P. 23(a)(2), including the propriety of General Shapiro's improper assertion that he has the authority to:

(a) require compulsory contracting and rate structures for MA services where one of the parties to the forced contract is a nonprofit healthcare entity;

(b) dictate non-rate terms of these forced contracts;

(c) declare a nonprofit healthcare entity to be in violation of Pennsylvania nonprofit laws if it does not comply with the Attorney General's new requirements; and

(d) force resignations to a nonprofit healthcare entity's board of directors.

154. The claims and defenses of Plaintiffs are typical of those of the absent members of the Plaintiff Class. Fed. R. Civ. P. 23(a)(3). In particular, General Shapiro's assertion of authority applies in the same way to all class members.

155. Plaintiffs intend to fairly and adequately protect the interests of the absent members of the Plaintiff Class. Fed. R. Civ. P. 23(a)(4). In particular: (a) the undersigned

attorneys will vigorously and adequately represent the interests of the class; (b) the class representatives have no conflict of interest in maintaining a class action; and (c) the class representatives have adequate financial resources to assure that the interests of the class will not be harmed.

156. Because there are hundreds of nonprofit healthcare entities organized under the laws of Pennsylvania, prosecuting separate actions by individual class members would create a risk of inconsistent or varying adjudications with respect to individual class members that would establish incompatible standards of conduct within the Commonwealth. Fed. R. Civ. P. 23(b)(1)(A).

157. Similarly, prosecuting separate actions by individual class members would create a risk of adjudications with respect to individual class members that, as a practical matter, would be dispositive of the interests of the other members not parties to the individual adjudications or would substantially impair or impede their ability to protect their interests. Fed. R. Civ. P. 23(b)(1)(B).

158. General Shapiro has acted on grounds that apply generally to the Plaintiff Class, such that the final injunctive and declaratory relief set forth in this Complaint is appropriate to the Plaintiff Class as a whole. Fed. R. Civ. P. 23(b)(2). General Shapiro has also asserted broad authority to control all nonprofit organizations in Pennsylvania, including the authority to reconstitute nonprofit boards, to force contracts, and to dictate contractual terms—all according to his own interpretation of a particular nonprofit organization's charitable mission.

159. Federal Rule of Civil Procedure 23(c)(5) provides that a class may be divided into subclasses that are each treated as a class.

160. Accordingly, Count II (Declaratory Judgment / ACA) is brought on behalf of a subclass consisting of all Pennsylvania nonprofit health plans who offer insurance through the ACA, whether those products are offered on or off the exchange ("Nonprofit ACA Health Plan Subclass").

161. There are questions of law and fact common to all members of the Nonprofit ACA Health Plan Subclass. Fed. R. Civ. P. 23(a)(2). In particular, Counts II raises common issues related to whether the ACA preempts General Shapiro's actions, as set forth above.

COUNT I
Declaratory Judgment / Medicare Act
(by all provider Plaintiffs; UPMC Health Plan, Inc. and UPMC Health Network, Inc.; and on behalf of all Pennsylvania nonprofit healthcare entities)

162. Plaintiffs incorporate each of the foregoing paragraphs of this Complaint as if fully set forth herein.

163. General Shapiro's new requirements for nonprofit healthcare entities are in direct conflict with federal law, which, *inter alia*: exclusively governs the MA program; allows MAOs and providers to establish their own price structure; refuse to contract with one another and exercise any right to terminate contracts without cause; establishes standards for misleading advertising; permits provider-based billing, and sets rates for out-of-network emergency MA services.

164. In each respect, federal law preempts competing state law standards.

165. Pursuant to 28 U.S.C. § 2201, the Court should thus enter an order declaring that the Medicare Act allows Plaintiffs, along with the Plaintiff Class, to do the following: (1) refuse to enter MA contracts; negotiate the payment rates of their MA contracts, including for provider-based billing; enforce their MA contract rights; design and publish marketing materials related to MA products, without any state regulation or interference respecting advertising; and seek the

appropriate reimbursement rate for services to out-of-network MA enrollees, as provided according to Medicare and CMS regulations.

166. The Court should also enter an order enjoining Defendant from any actions interfering with these rights as established by the Medicare Act.

COUNT II
Declaratory Judgment / ACA

(by UPMC Health Coverage, Inc.
individually and on behalf of the Nonprofit ACA Health Plan Subclass)

167. Plaintiffs incorporate each of the foregoing paragraphs of this Complaint as if fully set forth herein.

168. General Shapiro's new requirements are in direct conflict with federal law under the ACA, which governs plans marketed and operated pursuant to the ACA, whether those products are offered on or off the exchange.

169. The ACA requires health plans to prove each year that they meet a detailed set of requirements, which ensure that the plans all meet the same standards.

170. To protect the consistency of those standards, the ACA contains an express preemption clause. Any state standards that "prevent the application of the provisions" of the ACA are preempted. 42 U.S.C. § 18041(d).

171. To further protect the consistency of those standards, the ACA prohibits states from imposing regulations on some health plans that it does not impose on others. Specifically, 42 U.S.C. § 18012 requires that any state "standard or requirement" for health plans offering insurance products on or off the exchanges "shall be applied uniformly to all health plans in each insurance market to which the standard and requirements apply."

172. General Shapiro's new requirements impose different regulatory requirements for some health plans than for others.

173. Letting Anderson as it open currently sub General Shapiro's new requirements violate 42 U.S.C.§ 18012 and are preempted pursuant to 42 U.S.C. § 18041(d).

174. The Court should enter a declaratory judgment and an appropriate order enjoining Defendant from regulating nonprofit and for-profit insurers differently with respect to plans that meet the federal requirements of the ACA.

COUNT III
Declaratory Judgment / ERISA
(by UPMC Benefit Management Services, Inc. individually)

175. Plaintiffs incorporate each of the foregoing paragraphs of this Complaint as if fully set forth herein.

176. General Shapiro's new requirements are in direct conflict with federal law under ERISA, which, *inter alia*, exclusively governs the administration and benefit structure of self-insured health plans.

177. ERISA preempts competing state law requirements for how third-party administrators for federally regulated employee health benefit plans administer self-insured plans on behalf of clients.

178. Pursuant to 28 U.S.C. § 2201, the Court should enter an order declaring that ERISA allows UPMC Benefit Management Services, Inc., in its capacity as an administrator of self-insured commercial health plans, to refuse to contract with any provider, to offer restricted networks to self-insured plan sponsors, to negotiate payment rates with contracting parties, and to freely choose the contractual terms of its agreements.

179. The Court should also enter an order enjoining Defendant's interference with these rights as established by ERISA.

COUNT IV
15 U.S.C. § 1 / Sherman Act Hybrid Restraint
(by all Plaintiffs individually and on behalf of the Plaintiff Class)

180. Plaintiffs incorporate each of the foregoing paragraphs of this Complaint as if fully set forth herein.

181. General Shapiro's forced contracting enables anticompetitive conduct and alters the market for healthcare by requiring that nonprofit healthcare providers contract with any willing insurer and that nonprofit healthcare insurers contract with any willing provider, at rates established by private, interested, unsupervised, and nonpolitical market participants without any state action immunity.

182. General Shapiro's scheme tends to interfere with free bargaining, stabilize prices, insulate prices from the flexibility of the free market, and impede the ability to employ market strategies through pricing; leaves unsupervised regulatory power in the hands of nonpolitical, nonresponsive private actors; encourages interdependent prices set solely according to private marketing decisions of non-state actors; and imposes governmental trade restraints that enforce private pricing decisions with no ongoing state supervision. Shapiro's hybrid restraint will serve to stabilize prices and insulate prices from the free market, thereby removing incentives for market participants to compete on non-price factors; artificially depress reimbursement rates to providers, thereby sacrificing quality and access to care, stifling innovation and investment in state-of-the art facilities and technologies, and endangering charitable missions; and otherwise skew free bargaining and ordinary negotiation dynamics in anti-competitive ways.

183. General Shapiro is unreasonably restraining trade by enabling insurers to fix prices for non-emergency and commercial emergency care in violation of Section 1 of the Sherman Act.

184. General Shapiro's scheme constitutes a hybrid restraint and satisfies the concerted action requirement under Section 1 of the Sherman Act.

185. The relevant products include the provision of inpatient and outpatient primary, secondary, tertiary, and quaternary hospital healthcare services; all specialized and general physician healthcare services; and home healthcare services, as well as all health plans offered for sale in the Commonwealth of Pennsylvania.

186. The relevant geographic market is the Commonwealth of Pennsylvania.

187. General Shapiro's hybrid restraint will produce adverse, anti-competitive effects within the relevant product and geographic markets by allowing private parties to fix horizontal prices without any governmental oversight.

188. Price fixing is a *per se* violation of the Sherman Act

189. General Shapiro's hybrid restraint also violates the rule of reason.

190. UPMC Pinnacle, UPMC Somerset, and all other nonprofit healthcare providers will suffer antitrust injury due to the artificially fixed prices that General Shapiro's hybrid restraint will enable and enforce, which will deprive UPMC Pinnacle, UPMC Somerset, and all other nonprofit healthcare providers of revenue they would otherwise receive in a competitive marketplace.

191. UPMC Health Plan, Inc., UPMC Health Coverage, Inc., UPMC Health Network, Inc., UPMC Health Options, Inc., and UPMC Benefit Management Services, Inc., and the Nonprofit ACA Health Plan Subclass will suffer antitrust injury due to being forced to contract with any willing provider, regardless of the health plan's need to contract with those providers, alignment with the health plan's business model, and ability to reach agreement on rates, which

will increase the health plan's costs and impair its ability to obtain discounts they would otherwise receive in a competitive marketplace.

192. Such injuries are of the type the antitrust laws were intended to prevent and flows from General Shapiro's unlawful hybrid restraint, which also interferes with free bargaining, stabilizes prices, insulates prices from the flexibility of the free market, and impedes the ability to employ market strategies through pricing, all of which hurt competition, disincentivize quality and innovation in healthcare, and result in higher prices for consumers.

193. General Shapiro seeks to make the proposed hybrid restraint permanent, and the expected injury from his conduct would not be redressible by money damages alone and would therefore be irreparable.

194. An injunction is appropriate to remedy the continuing violation, prevent irreparable harm to Plaintiffs and the Plaintiff Class, and further the public interest in competitive provider and health insurance markets.

195. The Court should also enter an order declaring that General Shapiro's hybrid restraint is a violation of the Sherman Act.

COUNT V
42 U.S.C. § 1983 / Regulatory Taking
(by all Plaintiffs individually and on behalf of the Plaintiff Class)

196. Plaintiffs incorporate each of the foregoing paragraphs of this Complaint as if fully set forth herein.

197. But for General Shapiro's actions, Plaintiffs would have an undisputed right to determine what contract they enter and to end their current contracts, both as a matter of state and federal law.

198. General Shapiro's requirements take these rights from Plaintiffs and all other nonprofit entities organized under the laws of Pennsylvania. In doing so, General Shapiro's requirements effect a taking.

199. General Shapiro's new requirements severely harm UPMC, UPMC hospitals, UPMC-affiliated physician groups, and other members of the Plaintiff Class by preventing them from obtaining market rates for their services.

200. General Shapiro's new requirements harm members of the Plaintiff Class by reducing the collection of payments for relevant services and/or by imposing higher costs.

201. General Shapiro's new requirements interfere with the expectations of Plaintiffs and the Plaintiff Class. Plaintiffs have made business decisions and have invested significant resources in reliance on their understanding that they have the right to choose not to enter into contracts against their will.

202. For example, in the case of Plaintiff UPMC Pinnacle, General Shapiro's new requirements interfere with UPMC Pinnacle's expectations that it would have the right to make its own business and contracting decisions when investing in its property and managing its operations, and UPMC Pinnacle's expectations that it is permitted, under federal law, to engage in provider-based billing.

203. General Shapiro's new requirements do not merely regulate how members of the Plaintiff Class do business, but affirmatively require members of the Plaintiff Class to sell their property, goods, and services to entities with which they choose not to contract.

204. General Shapiro is taking property from members of the Plaintiff Class for the purpose of conferring a private benefit onto others.

205. Moreover, General Shapiro is retroactively imposing on the actions of the Plaintiff Class new legal consequences not required by any valid, state law and without any process or procedure to protect members of the Plaintiff Class.

206. As such, General Shapiro's requirements are private takings in violation of the Takings Clause of the Fifth Amendment to the United States Constitution and the Pennsylvania Constitution.

207. General Shapiro's actions also are a deprivation of liberty and property without due process of law, in violation of the Fourteenth Amendment to the United States Constitution and the Pennsylvania Constitution.

208. Even if the takings were for a public purpose, members of the Plaintiff Class would be entitled to just compensation pursuant to the Fifth Amendment to the United States Constitution and 26 Pa. Cons. Stat. § 701.

COUNT VI
42 U.S.C. § 1983 / Unconstitutional Condition
(by all Plaintiffs individually and on behalf of the Plaintiff Class)

209. Plaintiffs incorporate each of the foregoing paragraphs of this Complaint as if fully set forth herein.

210. General Shapiro is imposing unconstitutional conditions on the Plaintiff Class.

211. General Shapiro seeks to force members of the Plaintiff Class to give up their protected rights—including their federally guaranteed rights under the Medicare Act, ERISA, the ACA, and the Sherman Act—by threatening retaliatory action implicating their nonprofit status. General Shapiro cannot condition regulatory action, or the avoidance of same, on willingness of members of the Plaintiff Class to give up their protected constitutional rights.

212. General Shapiro's actions severely harm UPMC, UPMC hospitals, UPMC-affiliated physician groups, and other members of the Plaintiff Class.

213. General Shapiro's new requirements represent unreasoned, improper, and fundamentally unfair action under color of state law.

214. There is no nexus between General Shapiro's new requirements and his intended retaliation. Nor is there any proportionality between General Shapiro's new requirements and any purported benefit.

215. As alleged above, the requirements that General Shapiro seeks to impose through his unconstitutional demands also constitute a regulatory taking. General Shapiro has therefore conditioned his regulatory forbearance on Plaintiffs' consent to a taking.

216. The action has the improper purpose of placing an unconstitutional condition on members of the Plaintiff Class and coercing them into unwanted contractual relationships.

COUNT VII
42 U.S.C. § 1983 / Equal Protection
(by all Plaintiffs individually)

217. Plaintiffs incorporate each of the foregoing paragraphs of this Complaint as if fully set forth herein.

218. General Shapiro is seeking to force UPMC subsidiaries and acquisitions into sweeping contractual agreements and to impose on them novel legal requirements with regard to all insurers and providers.

219. While General Shapiro has made clear that his authority extends to all nonprofit entities organized under the laws of Pennsylvania, General Shapiro is, upon belief, not presently trying to force any other nonprofit healthcare entity in Pennsylvania outside of the UPMC-Highmark relationship to contract with any specific insurer or provider.

220. General Shapiro has no legitimate justification for his decision to single out UPMC and its subsidiaries for special regulatory burdens. To the contrary, General Shapiro has stated that the same requirements *ought* to apply to all nonprofit healthcare providers, although he has issued no regulation or rule and is currently only enforcing them against UPMC.

221. Coercing UPMC subsidiaries to agree to contracts with other insurers and providers also lacks any legitimate government interest and is irrational because it impedes federal determinations regarding operation of the MA program, as well as the efficiencies in the market for healthcare in the relevant area.

222. The federal government has determined that there should not be state interference with Plaintiffs' right to determine which insurers and providers they contract with for purposes of MA.

223. General Shapiro's selective proceeding also harms Plaintiffs and consumers generally by benefitting for-profit providers and insurers, which remain free to exercise their established rights to determine when and with whom they contract. General Shapiro's actions place UPMC affiliates, including Plaintiffs, at a competitive disadvantage, further inuring to their detriment and to the detriment of healthcare consumers in Pennsylvania.

224. General Shapiro's decision to single out Plaintiffs for special regulatory burdens bears no relationship—rational or otherwise—to and does not further any legitimate governmental interest. As such, General Shapiro's actions violate the Equal Protection clause of the Fourteenth Amendment of the United States Constitution and the Pennsylvania Constitution and impose an unconstitutional condition on Plaintiffs.

COUNT VIII
42 U.S.C. § 1983 / Due Process
(by all Plaintiffs individually)

225. Plaintiffs incorporate each of the foregoing paragraphs of this Complaint as if fully set forth herein.

226. Plaintiffs have a protected liberty interest in their right not to contract, as well as a protected property interest in their contracts and business relationships.

227. General Shapiro has invaded Plaintiffs' protected liberty and property interest without following *any* procedure at all, as he has simply imposed his new requirements through *ad hoc* decrees.

228. Plaintiffs also have a protected liberty and property interest in their right to determine the membership of their board and to set their corporate governance. General Shapiro has also invaded that protected liberty and property interest without any procedure at all.

229. General Shapiro's rule that Plaintiffs and other nonprofits enter into involuntary contracts—with rates set by him—further violates due process by invading the liberty and property rights of Pennsylvania nonprofits without any procedure.

230. General Shapiro also has violated the private nondelegation doctrine by delegating the power to set rates for medical services to private arbitrators. He provided no standard to guide those arbitrators and has retained no supervision over their decisions.

231. Accordingly, General Shapiro's actions violate the Due Process clause of the Fourteenth Amendment of the United States Constitution.

COUNT IX
42 U.S.C. § 1983 / Substantive Due Process
(by UPMC Pinnacle)

232. Plaintiffs incorporate each of the foregoing paragraphs of this Complaint as if fully set forth herein.

233. In a prior proceeding before this Court, the Attorney General cited the value of competition between narrow networks of providers to block a proposed merger involving UPMC Pinnacle.

234. In that prior litigation, the Attorney General explained that the ability *not* to contract results in lower prices and higher-quality services, as it promotes competition between providers.

235. Now, the Attorney General has taken the exact opposite position and is seeking to take away that very same right not to contract.

236. There is no legitimate basis for the Attorney General's arbitrary and irrational change in position. Rather, the Attorney General has adopted these inconsistent positions for purely political ends.

237. The Attorney General's decision to subject UPMC Pinnacle to fundamentally inconsistent legal positions, to UPMC's detriment, is so arbitrary and irrational that it shocks the conscience.

238. The Attorney General's arbitrary and irrational actions interfere with UPMC Pinnacle's protected property and liberty interests, including UPMC Pinnacle's protected liberty interest in its right *not* to contract, its protected property interest in its business and contractual relationships, and its protected property interest in rights created by federal and state law.

239. Accordingly, General Shapiro's actions violate the Due Process clause of the Fourteenth Amendment of the United States Constitution.

PRAYER FOR RELIEF

240. WHEREFORE, Plaintiffs respectfully request that this Court:

(a) Enter a declaratory judgment:

- declaring that federal MA law allows Plaintiffs to refuse to contract with another insurer or provider, to negotiate their payment rates with contracting parties, including for provider-based billing, to enforce their contract rights, to set reimbursement rates for services to out-of-network MA enrollees, and to be free from state regulation of advertising for MA purposes;

- declaring that the ACA preempts Defendant's attempt to impose different standards on nonprofit insurers as compared to for-profit insurers as it relates to ACA products, whether those products are offered on or off the exchange;

- declaring that ERISA, in the context of self-insured commercial health plans, allows the Plaintiffs to refuse to contract with any provider, to freely negotiate payment rates with contracting parties, and to enforce contract rights of their choosing;

- declaring that Defendant's interference with these rights is preempted by federal law;

- declaring that Defendant's hybrid restraint is a violation of the Sherman Act;

- declaring that Defendant's requirement that Plaintiffs give up their protected rights or else face retaliatory action implicating their nonprofit status imposes an unconstitutional condition;

- declaring that Defendant's selective proceeding against Plaintiffs violates the Equal Protection clause of the Fourteenth Amendment of the United States Constitution and the Pennsylvania Constitution and imposes and unconstitutional condition on Plaintiffs;

- declaring that Defendant's invasion of Plaintiffs' protected property and liberty rights without *any* procedure violates due process;

- declaring that Defendant's delegation of ratemaking authority to private arbitrators violates the private nondelegation doctrine;

- declaring that Defendant's arbitrary and irrational new standards, as applied to UPMC Pinnacle, violates substantive due process; and

- extending this declaratory relief to members of the Plaintiff Class, as appropriate.

(b) Preliminarily and permanently enjoin Defendant from:

- interfering with Plaintiffs' rights as established by the Medicare Act, the ACA, and ERISA;

- taking any action to force Plaintiffs to negotiate or contract with any insurer or provider or to set any terms for such compulsory contracting;

- taking any action to enforce any other term of General Shapiro's rules;

- taking any action to compel Plaintiffs against their consent to agree to any term of General Shapiro's rules; and

- extending this injunctive relief to members of the Plaintiff Class, as appropriate.

(c) Award Plaintiffs reasonable attorney's fees incurred for bringing its 42 U.S.C. § 1983 claims, pursuant to 42 U.S.C. § 1988, as well as its costs incurred on all claims; and

(d) Grant Plaintiffs any and all further relief, either in law or equity, that the Court deems just and proper.

Dated: February 21, 2019

Respectfully submitted,

/s/ *Leon F. DeJulius, Jr.,*

Leon F. DeJulius Jr. (Pa. No. 90383)
(pro hac motion to be filed)
Anderson T. Bailey (Pa. No. 206485)
(pro hac motion to be filed)
JONES DAY
500 Grant Street, Suite 4500
Pittsburgh, PA 15219
Ph: (412) 391-3939
Fx: (412) 394-7959
lfdejulius@jonesday.com
atbailey@jonesday.com

David S. Torborg
(pro hac motion to be filed)
JONES DAY
51 Louisiana Avenue, NW
Washington, DC 20001-2113
Ph: (202) 879-5562
Fx: (202) 626-1700
dstorborg@jonesday.com

Stephen A. Cozen (Pa. 03492)
James R. Potts (Pa. 73704)
Stephen A. Miller (Pa. 308590)
Jared D. Bayer (Pa. 201211)
COZEN O'CONNOR
One Liberty Place
1650 Market Street, Ste. 2800
Philadelphia, PA 19103
Ph: (215) 665-2000
Fx: (215) 701-2055

On behalf of Plaintiffs and All Other Members of the Plaintiff Class

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

UPMC Pinnacle; UPMC Pinnacle Hospitals; UPMC Pinnacle Carlisle; UPMC Pinnacle Hanover; UPMC Pinnacle Lititz; UPMC Pinnacle Memorial; UPMC Somerset; UPMC Health Plan, Inc.; UPMC Health Coverage, Inc.; UPMC Health Network, Inc.; UPMC Health Options, Inc.; UPMC Benefit Management Services, Inc.,

Plaintiffs, on their own and on behalf of all others similarly situated,

v.

Joshua D. Shapiro, in his official capacity as Attorney General of the Commonwealth of Pennsylvania,

Defendant.

Class Action

Civil Action No.

Electronically Filed

INDEX OF EXHIBITS TO COMPLAINT

EXHIBIT	DESCRIPTION
A	Draft Modified Consent Decree
B	01/02/2019 W. Thomas McGough letter to James A. Donahue, III
C	Complaint for Temporary Restraining Order and Preliminary Injunction, *Commonwealth v. Penn State Hershey Medical Center*, No. 15-cv-2362 (M.D. Pa. Apr. 8, 2016) (Doc. 101)
D	06/01/2016 Brief of FTC and the Commonwealth of Pennsylvania, *Commonwealth, Federal Trade Commission v. Penn State Hershey Medical Center*, No. 15-cv-2362 (3d Cir. June 1, 2016) (Doc. 003112313990)
E	10/10/2014 Public hearing transcript

Exhibit A

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA, By JOSH SHAPIRO, Attorney General; PENNSYLVANIA DEPARTMENT OF INSURANCE, By JESSICA ALTMAN, Insurance Commissioner; And PENNSYLVANIA DEPARTMENT OF HEALTH, By DR. RACHEL LEVINE, Secretary of Health, Petitioners, v. UPMC, A Nonprofit Corp.; UPE, a/k/a, HIGHMARK HEALTH, A Nonprofit Corp. And HIGHMARK INC., A Nonprofit Corp.; Respondents.	: : : : : : : : : : : : : : : : :	No. 334 M.D. 2014

MODIFIED CONSENT DECREE

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

INTERPRETIVE PRINCIPLES

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.18 "In-Network" means where a Health Care Provider has contracted with a Health Plan to provide specified services for reimbursement at a negotiated rate to treat the Health Plan's members. The member shall be charged no more than the Cost-Share required

pursuant to his or her Health Plan, the member shall not be refused treatment for the specified services in the contract based on his or her Health Plan and the negotiated rate paid under the contract by the Health Plan and the member shall be payment in full for the specified services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TERMS

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

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

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

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

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

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

3.4.2 Any Gag Clause, practice, term or condition;

3.4.3 Any Most Favored Nation practice, term or condition;

3.4.4 Any Must Have practice, term or condition;

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

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

3.4.7 Any Exclusive Contracts practice, term or condition;

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

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

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

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

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

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

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

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

CONTRACT RESOLUTION (LAST BEST OFFER ARBITRATION)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.8 During the above arbitration process:

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

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

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

MISCELLANEOUS TERMS

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

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

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

7. Release – This Modified Consent Decree releases any and all claims the OAG, PID or DOH brought or could have brought against Highmark or UPMC for violations of any laws or regulations within their respective jurisdictions, including claims under laws governing nonprofit corporations and charitable trusts, consumer protection laws, insurance laws and health laws relating to the facts alleged in the Petition for Review or encompassed within this Modified Consent Decree for the period of July 1, 2012 to the date of filing. Any other claims, including but not limited to violations of the crimes code, Medicaid fraud laws or tax laws are not released.

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

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

If to the Attorney General:

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

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

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

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

If to Highmark

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

Copies to:

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

If to UPMC:

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

Copies to:

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

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

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

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

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

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

15. Counterparts – This Modified Consent Decree may be executed in counterparts.

NOW THEREFORE, without trial or adjudication of the facts or law herein between the parties to this Modified Consent Decree, the respondents agree to the signing of this Modified

Consent Decree and this Court hereby orders that Highmark and UPMC shall be enjoined from breaching any and all of the aforementioned provisions.

WHEREFORE, and intending to be legally bound, the parties have hereto set their hands and seals to this Modified Consent Decree and submit the same to this Honorable Court for the making and entry of a Modified Consent Decree, Order or Judgment of the Court on the dates indicated below.

Exhibit B

UPMC LIFE CHANGING MEDICINE

W. Thomas McGough, Jr.
Executive Vice President, UPMC
Chief Legal Officer

U.S. Steel Tower, Suite 6241
600 Grant Street
Pittsburgh, PA 15219
T 412-647-9191
F 412-647-9193
mcgought@upmc.edu

January 2, 2019

Via Electronic Mail and US Mail

James A. Donahue, III
Executive Deputy Attorney General
Public Protection Division
Commonwealth of Pennsylvania
Office of Attorney General
Strawberry Square, 16th Floor
Harrisburg, PA 17120
jdonahue@attorneygeneral.gov

Re: *Commonwealth v. UPMC, et al., No. 334 M.D. 2014; Commonwealth Court; Modification of Consent Decrees*

Dear Jim:

First, I want to thank you for the informative telephone conference you and your team had with Steve Cozen, Mark Tamburri and me on December 28, during which we worked through the list of questions I sent you on December 20. Here are those questions with what we understand to be OAG's responses:

1. Which "principles" embodied in the proposed Modified Consent Decree would OAG announce as applicable to all nonprofit charitable health systems:
2.
    a. Health Care Provider Subsidiaries' Duty to Negotiate (¶3.2)?

    Yes.

    b. Health Plan Subsidiaries Duty to Negotiate (¶3.3)?

    Yes.

    c. Mandatory contracting for Medicare Advantage (¶¶3.2, 3.3)?

    Yes.

d. Regulation of employer-sponsored health plans (¶¶3.3, 3.4, 3.5, 3.7)?

Yes.

e. Prohibited Contract Terms (¶3.4)

Yes.

f. Limitations of Charges for Emergency Services (¶3.5)?

Yes.

g. Limitations on Terminations (¶3.6)?

Yes.

h. Direct Payments Required (¶3.7)?

Yes.

i. Non-Discrimination (¶3.8)?

Yes.

j. Communication (¶3.9)?

Yes.

k. Advertising (¶3.10)

Yes.

l. Changes to Corporate Governance (¶3.11)?

Yes, although OAG would clarify the meaning of "unaffiliated."

m. Contract Resolution (¶¶4.1-4.8)?

Yes.

3. How would OAG enforce those principles against other nonprofit charitable health systems?

OAG would engage in serial enforcement actions, starting with matters that OAG currently has under investigation or inquiry.

4. Would any of those principles apply to nonprofit charitable organizations other than those involved in health care, e.g., educational institutions, social services organizations, religious charities or charitable foundations?

OAG will enforce the charitable mission of all charities.

5. Would ¶3.2 (Health Care Provider Subsidiaries' Duty to Negotiate) apply to for-profit health care providers?

No.

6. Would ¶3.3 (Health Plan Subsidiaries' Duty to Negotiate) apply to for-profit Health Plans?

No, except for health plans owned by nonprofits.

7. One of the stated purposes of the proposed modification is to "enabl[e] open and affordable access to [UPMC's] health care services and products through negotiated contracts." How does the prohibition of anti-steering and tiering provisions (¶3.4.1) facilitate that?

Evidence suggests that any-willing-provider regimes like that in the proposed modification result in increases in rates between providers and insurers. Tiering and steering is one way to counteract that effect.

8. A Tiered Insurance Plan or a Tiered Network is defined as "a network of Health Care Providers ranked on cost and quality." (¶2.25) The Conflict Resolution process calls for arbitration that sets rates (i.e., cost) based in part on the "prices paid for comparable services[.]" (¶4.3.4.2) How would the arbitration panel's determination of cost and comparable quality affect a Health Plan's assessment of cost and quality for purposes of creating Tiered Networks?

The evaluation of cost and quality would be made by the health plan doing the tiering and steering.

9. Who if anyone would review or regulate a Health Plan's self-interested assessment of the "cost and quality" of services delivered by its captive providers to ensure that non-captive providers are tiered fairly?

The evaluation of cost and quality would be made by the health plan doing the tiering and steering. Fairness would be enforced by disclosing to consumers up front the cost to them of using particular providers.

10. The "Average In-Network Rate" includes government reimbursement. Has the OAG investigated the financial impact on providers of including government reimbursement in its methodology for establishing commercial reimbursement rates?

No.

11. Has OAG investigated the practicality and financial impact on providers of prohibiting "Any Provider-Based Billing practice, term, or condition"?

No.

12. Were UPMC to agree to the twin Duties to Negotiate (¶3.2 and ¶3.3), which contemplate compulsory negotiations and contracts between direct competitors with a binding process to decide any disagreement on reimbursement rates, wouldn't it run afoul of the Sherman Act's prohibition on hybrid restraints as described in, *e.g.*, *Anheuser-Busch, Inc. v. Goodman*, 745 F. Supp. 1048 (M.D. Pa. 1990)?

OAG acknowledges that the state-action exemption from antitrust scrutiny would not apply to the proposed arrangements between direct competitors like UPMC and Highmark but believes that the arrangements can be distinguished from those found unlawful in *Anheuser-Busch* and similar cases.

13. Does the OAG contend that its authority over nonprofit charitable health systems supersedes the non-interference provisions of the Social Security Act, 42 U.S.C. § 1395w-24(a)(6)(B)(iii), and permits OAG to require those health systems to enter into Medicare Advantage contracts with Health Plans?

Yes.

14. Does the OAG contend that its authority over Health Care Providers and Health Plans supersedes ERISA's preemption clause, 29 U.S.C. § 1144(a), and permits OAG to regulate the networks, rates, and terms of employer-sponsored health plans?

Yes.

15. How can any information not subject to a non-disclosure agreement with a third-party be "competitively sensitive" (¶3.1) when shared between two elements of an integrated health care enterprise where those elements don't—and can't—compete with each other and where close alignment of strategies, operations and incentives is fundamental to delivering high-value health care?

OAG would re-evaluate this provision.

16. The 2012 Consent Decrees were the product of consultation and collaboration among many parties, including then-Governor Tom Corbett, the Office of Attorney General, the Insurance Department, the Department of Health, and leaders of both parties in both chambers of the Pennsylvania Legislature. Has OAG determined whether Governor Wolf, the Insurance Department, the Department of Health, or any legislative leaders support the proposed modifications to the Consent Decree and the application of its principles to all nonprofit charitable health systems?

OAG believes that the Governor is supportive of both the proposed modification to the Consent Decrees and the enforcement of its principles on all nonprofit charitable health care providers. OAG will attempt, however, to confirm that support. As for the others mentioned, OAG is not aware of their positions.

17. Would the proposed modification bind UPMC in perpetuity, even if (for example) OAG was not successful in imposing similar principles on UPMC's competitors?

Yes, although UPMC could return to the Court to seek modification of the Consent Decree if after some unspecified time OAG had not been successful in imposing similar principles on UPMC's competitors.

18. What would be the effective date of the Modified Consent Decree? Would the Prohibited Contract Terms apply to contracts executed prior to the effective date?

The effective date would be July 1, 2019. The modified Consent Decree would not apply to existing contracts but would be phased in as those contracts expire. OAG will consider how this regime would apply to evergreen contracts.

If we have misunderstood or mispresented OAG's position on any of these questions, please let me know as soon as possible.

Considering the positions set forth above and other concerns we have with your proposed modification of the Consent Decrees—not least of which is that it would not be a modification at all but rather a complete abrogation of those decrees and the creation of a new, radical and supposedly perpetual regime for delivering health care in Pennsylvania—UPMC cannot consent to your proposal.

Please let me know if you have any questions.

Very truly yours,

W. Thomas McGough, Jr.

cc: (via electronic mail)

Victoria S. Madden
Deputy General Counsel
PA Office of General Counsel
vmadden@pa.gov

Kenneth L. Joel
Deputy General Counsel
PA Office of General Counsel
kennjoel@pa.gov

Amy Daubert
Chief Counsel
PA Department of Insurance
adaubert@pa.gov

Yvette Kostelac
Acting Chief Counsel
PA Department of Health
ykostelac@pa.gov

Tracy W. Wertz
Chief Deputy Attorney General
Antitrust Section
twertz@attorneygeneral.gov

Mark A. Pacella
Chief Deputy Attorney General
Charitable Trusts and Organizations Section
mpacella@attorneygeneral.gov

Exhibit C

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

FEDERAL TRADE COMMISSION and COMMONWEALTH OF PENNSYLVANIA, Plaintiffs, vs. PENN STATE HERSHEY MEDICAL CENTER and PINNACLEHEALTH SYSTEM, Defendants.	Civil Action No.: 1:15-CV-2362 ~~FILED UNDER SEAL~~

COMPLAINT FOR TEMPORARY RESTRAINING ORDER
AND PRELIMINARY INJUNCTION

Plaintiffs, the Federal Trade Commission ("FTC" or "Commission"), by its undersigned attorneys, and the Commonwealth of Pennsylvania, acting by and through its Office of Attorney General, petition this Court, pursuant to Section 13(b) of the Federal Trade Commission Act ("FTC Act"), 15 U.S.C. § 53(b), and Section 16 of the Clayton Act, 15 U.S.C. § 26, for a temporary restraining order

and preliminary injunction enjoining Penn State Hershey Medical Center ("Hershey") from consummating its proposed merger (the "Merger") with PinnacleHealth System ("Pinnacle"). Absent such provisional relief, Hershey and Pinnacle (collectively, "Defendants") would be free to consummate the Merger on 12:01 a.m. on December 10, 2015.

Plaintiffs require the aid of this Court to maintain the *status quo* during the pendency of an administrative proceeding on the merits scheduled to begin on May 17, 2016, which the Commission already has initiated pursuant to Sections 7 and 11 of the Clayton Act, 15 U.S.C. §§ 18, 21, and Section 5 of the FTC Act, 15 U.S.C. § 45. That administrative proceeding will determine the legality of the Merger, subject to judicial review by a federal Court of Appeals, and will provide the parties to this proceeding a full opportunity to conduct discovery and present testimony and other evidence regarding the likely competitive effects of the Merger.

NATURE OF THE CASE

1. This is an action to temporarily restrain and preliminarily enjoin the consummation of the merger between Hershey and Pinnacle, the two largest health systems in the greater Harrisburg, Pennsylvania area. If allowed to proceed, the Merger would create a dominant provider of general acute care ("GAC") inpatient

hospital services in the Harrisburg area. The Merger is likely to substantially lessen competition for healthcare services in Harrisburg, Pennsylvania, and its surrounding communities, leading to increased healthcare costs and reduced quality of care for over 500,000 local residents and patients.

2. Today, Hershey owns and operates one GAC hospital in the Harrisburg area, while Pinnacle operates three GAC hospitals. Hershey and Pinnacle operate the only three hospitals located in Dauphin County. Both Hershey and Pinnacle are high-quality health systems that, with limited exceptions, offer an overlapping range of GAC inpatient hospital services ("GAC services"), including primary, secondary, tertiary, and quaternary services.

3. Hershey and Pinnacle are close competitors for GAC services in the Harrisburg area. Hershey and Pinnacle vigorously compete on price, quality of care, and services provided, both for inclusion in commercial health plan networks and to attract patients from one another. The rivalry between Hershey and Pinnacle has benefited local patients with lower healthcare costs and increased quality of care. The Merger would eliminate this significant head-to-head competition between Hershey and Pinnacle and its related benefits.

4. The Merger would substantially lessen competition in the market for GAC services sold to commercial health plans in an area roughly equivalent to a

four-county region comprised of the Harrisburg Metropolitan Statistical Area (Dauphin, Cumberland, and Perry Counties) plus Lebanon County (the "Harrisburg Area").

5. The only significant competitor of the Defendants in the Harrisburg Area is Holy Spirit Hospital ("Holy Spirit"), which is a smaller community hospital located in eastern Cumberland County that offers a more limited range of services than Hershey or Pinnacle. There are two other hospitals located on the outskirts of the Harrisburg Area. They are even smaller community hospitals that offer a more limited range of services than Holy Spirit and a much more limited range of services than the Defendants. Neither of these hospitals meaningfully constrains Hershey or Pinnacle.

6. Post-Merger, the combined entity will account for approximately 64% of all GAC services in the Harrisburg Area. Using the Herfindahl-Hirschman Index ("HHI") to measure market concentration, the post-Merger HHI would be approximately 4,500 with an increase of approximately 2,000 points. This high market share and corresponding high concentration level render the Merger presumptively unlawful under the relevant case law and likely to increase market power—by a wide margin—under the 2010 U.S. Department of Justice and Federal Trade Commission Horizontal Merger Guidelines ("Merger Guidelines").

7. The Merger would substantially increase the combined entity's bargaining leverage in negotiations with commercial health plans. The combined entity would be able to exercise market power by raising prices and reducing quality and services, ultimately harming Harrisburg Area residents and patients.

8. Entry or expansion by other providers of the relevant services is unlikely to occur, much less in a manner that is timely, likely or sufficient to deter or mitigate the loss of price and non-price competition in the near future.

9. Finally, the Defendants' efficiency claims are overstated, speculative, unverifiable, not merger-specific, or result from an anticompetitive reduction in output, quality, or services, and are largely non-cognizable. Any cognizable efficiency claims are insufficient to offset the substantial competitive harm the Merger is likely to cause.

10. On December 7, 2015, by a 4-0 vote, the Commission found reason to believe that the Merger would violate Section 7 of the Clayton Act and Section 5 of the FTC Act.

11. A temporary restraining order enjoining the Merger is necessary to preserve the Court's ability to afford full and effective relief after considering the Commission's application for a preliminary injunction. Preliminary injunctive relief is imperative to preserve the *status quo* and protect competition during the

Commission's ongoing administrative proceeding. Allowing the Merger to proceed would harm consumers and undermine the Commission's ability to remedy the anticompetitive effects of the Merger if it is ultimately found unlawful after a full trial on the merits and any subsequent appeals.

JURISDICTION AND VENUE

12. This Court's jurisdiction arises under Section 13(b) of the FTC Act, 15 U.S.C. § 53(b); Section 16 of the Clayton Act, 15 U.S.C. § 26; and 28 U.S.C. §§ 1331, 1337, and 1345. This is a civil action arising under Acts of Congress protecting trade and commerce against restraints and monopolies, and is brought by an agency of the United States authorized by an Act of Congress to bring this action.

13. Section 13(b) of the FTC Act, 15 U.S.C. § 53(b), provides in pertinent part:

> Whenever the Commission has reason to believe –
>
> (1) that any person, partnership, or corporation is violating, or is about to violate, any provision of law enforced by the Federal Trade Commission, and
>
> (2) that the enjoining thereof pending the issuance of a complaint by the Commission and until such complaint is dismissed by the Commission or set aside by the court on review, or until the order of the Commission made thereon has become final, would be in the interest of the public – the Commission by any of its attorneys designated by it for such purpose may bring suit in a district court of the United States to enjoin any such

> act or practice. *Upon a proper showing that weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest*, and after notice to the defendant, a temporary restraining order or a preliminary injunction may be granted without bond . . . , (emphasis added).

14. In conjunction with the Commission, the Commonwealth of Pennsylvania brings this action for a preliminary injunction under Section 16 of the Clayton Act, 15 U.S.C. § 26, to prevent and restrain Hershey and Pinnacle from violating Section 7 of the Clayton Act, 15 U S C § 18, pending the Commission's administrative proceeding. The Commonwealth of Pennsylvania has the requisite standing to bring this action because the Merger would cause antitrust injury in the market for GAC services sold to customers within its state.

15. Defendants are, and at all relevant times have been, engaged in activities in or affecting "commerce" as defined in Section 4 of the FTC Act, 15 U.S.C. § 44, and Section 1 of the Clayton Act, 15 U.S.C. § 12. Defendants also are, and at all relevant times have been, engaged in commerce in the Commonwealth of Pennsylvania.

16. Defendants transact substantial business in this district and the Commonwealth of Pennsylvania and are subject to personal jurisdiction therein. Venue, therefore, is proper in this district under 28 U.S.C. § 1391(b) and (c) and 15 U.S.C. § 53(b).

17. The Merger constitutes a transaction subject to Section 7 of the Clayton Act, 15 U.S.C. § 18.

THE PARTIES AND THE PROPOSED MERGER

18. Defendant Hershey is a not-for-profit healthcare system headquartered in Hershey, Pennsylvania in Dauphin County. The system includes the Milton S. Hershey Medical Center ("Hershey Medical Center"), a GAC academic medical center affiliated with the Penn State College of Medicine, and the Penn State Hershey Children's Hospital (located on the Hershey Medical Center campus and the only children's hospital in the Harrisburg Area).

19. The Hershey Medical Center has 551 licensed beds (125 of which are located at the Children's Hospital). It employs approximately 804 physicians. Hershey offers a full range of GAC services, from primary care to quaternary services. It offers quaternary services such as heart transplants and operates a state-designated Level I Trauma Center for pediatrics and adults. In fiscal year 2014, on a system-wide basis, Hershey generated approximately $1.4 billion in revenue and had approximately 29,000 inpatient discharges.

20. Defendant Pinnacle is a not-for-profit healthcare system headquartered in Harrisburg, Pennsylvania. Pinnacle operates three GAC hospitals in the Harrisburg Area. Pinnacle's Harrisburg Hospital and Community General

Osteopathic Hospital are located in Dauphin County and Pinnacle's West Shore Hospital, which opened in May 2014, is located in eastern Cumberland County.

21. Pinnacle's combined system has 662 licensed beds, which are divided among its three GAC hospitals. Pinnacle offers a full range of GAC services, from primary care to quaternary services, excluding only a limited number of quaternary services. Harrisburg Hospital, which is Pinnacle's flagship teaching hospital, has a Level III neonatal intensive care unit and performs high-level services such as kidney transplants. Pinnacle's CardioVascular Institute is considered one of the leading cardiology programs in Pennsylvania. In 2014, Pinnacle generated approximately $850 million in revenue and had more than 35,000 inpatient discharges.

22. In June 2014, Hershey and Pinnacle signed a letter of intent pursuant to which they agreed to explore the possibility of combining their assets. In March 2015, the Defendants' boards approved moving forward with the transaction. Although the final merger documents have not yet been signed, pursuant to the letter of intent, the transaction would be structured as a membership substitution by which the new entity would become the sole member of both Hershey and Pinnacle, and Hershey and Pinnacle will have equal representation on the new entity's board of directors.

THE RELEVANT SERVICE MARKET

23. The relevant service market in which to analyze the effects of the Merger is GAC inpatient hospital services sold to commercial health plans and their members. This service market encompasses a broad cluster of medical and surgical diagnostic and treatment services offered by both Hershey and Pinnacle that require an overnight hospital stay.

24. Although the Merger's likely effect on competition could be analyzed separately for each of the hundreds of affected medical procedures and treatments, it is appropriate to evaluate the Merger's likely effects across this cluster of services because the services are offered to Harrisburg Area patients under similar competitive conditions, by similar market participants. There are no practical substitutes for this cluster of GAC services.

THE RELEVANT GEOGRAPHIC MARKET

25. The relevant geographic market in which to analyze the effects of the Merger is the Harrisburg Area, which is an area roughly equivalent to the Harrisburg Metropolitan Statistical Area (Dauphin, Cumberland, and Perry Counties) and Lebanon County.

26. The appropriate geographic market in which to analyze the Merger is the area in which consumers can practicably find alternative providers of the

service. The test from the Merger Guidelines used to determine the boundaries of the geographic market is whether a hypothetical monopolist of the relevant services within that geographic area could profitably negotiate a small but significant and non-transitory increase in price (here, reimbursement rates for GAC services). If so, the boundaries of that geographic area are an appropriate geographic market.

27. In general, patients choose to seek care close to their homes or workplaces for their own convenience and that of their families because it takes less time to travel to a hospital that is nearby and it is easier to arrange for transportation and visitation. Residents of the Harrisburg Area strongly prefer to, and do, obtain GAC services locally. Moreover, residents of the Harrisburg Area who require emergency hospital services seek such services within the Harrisburg Area. They would not travel outside of the Harrisburg Area for such emergency services without jeopardizing their health and well-being.

28. Evidence from multiple sources shows that an overwhelming percentage of commercially insured residents of the Harrisburg Area seek GAC services within the Harrisburg Area.

29. Hospitals outside the Harrisburg Area, such as those in York and Lancaster Counties, do not consider themselves as, and are not, meaningful

competitors of Hershey, Pinnacle, or other hospitals in the Harrisburg Area for the provision of GAC services to residents of the Harrisburg Area because they draw very few patients from the Harrisburg Area.

30. Health plans that offer health care networks in the Harrisburg Area do not consider hospitals outside of the Harrisburg Area to be viable substitutes for Harrisburg Area hospitals. Very few of their members leave the Harrisburg Area to obtain GAC services, even for tertiary and quaternary care.

31. Because residents of the Harrisburg Area strongly prefer to obtain GAC services in the Harrisburg Area, a health plan that did not have Harrisburg Area hospitals in its network would be very difficult to successfully market a network to employers and consumers in the area. Accordingly, a health plan would not exclude from its network a hypothetical monopolist of hospital services in the Harrisburg Area in response to a small but significant price increase.

MARKET STRUCTURE AND THE MERGER'S PRESUMPTIVE ILLEGALITY

32. Hershey currently accounts for approximately 26% of the relevant market. Pinnacle currently accounts for approximately 38% of the market. A combined Hershey/Pinnacle would own by far the largest GAC hospital system within the Harrisburg Area. Defendants' post-Merger market share would be overwhelming at approximately 64% of the relevant market.

33. Of the three other hospitals that provide GAC services to residents in the Harrisburg Area, only one – Holy Spirit Hospital – is of any competitive significance. Holy Spirit currently accounts for approximately 15% of the relevant market. The remaining two hospitals are Carlisle Regional Medical Center (in central Cumberland County), which accounts for approximately 5% of the market, and WellSpan Good Samaritan Hospital (in central Lebanon County), which accounts for approximately 6% of the market. These two hospitals are small community hospitals with limited service offerings and little appeal to residents of the Harrisburg Area. They do not compete to any significant degree with the Defendants. No other hospital accounts for more than 3% of the relevant market. Accordingly, the proposed Merger would reduce the number of meaningful competitors in the Harrisburg Area from three to two.

34. Under the relevant case law, including U.S. Supreme Court precedent and recent litigated hospital merger cases, the Merger is presumptively unlawful by a wide margin, as it would significantly increase concentration in an already highly concentrated market.

35. The Herfindahl-Hirschman Index ("HHI") is used to measure market concentration under the Merger Guidelines. A merger or acquisition is presumed likely to create or enhance market power under the Merger Guidelines, and thus, is

presumed illegal under relevant case law, when the post-merger HHI exceeds 2,500 points and the merger or acquisition increases the HHI by more than 200 points.

36. Here, the market concentration levels far exceed those HHI thresholds. The post-Merger HHI in the GAC services market will be over 4,400, an increase of approximately 2,000 points. The approximate HHI figures and market shares for the GAC services market in the Harrisburg Area are summarized in the table below.

GENERAL ACUTE CARE INPATIENT HOSPITAL SERVICES		
Hospital System	**Pre-Merger Market Share**	**Post-Merger Market Share**
Penn State Hershey Medical Center	26%	64%
PinnacleHealth System	38%	
Holy Spirit Health System – A Geisinger Affiliate (Cumberland County)	15%	15%
WellSpan Good Samaritan Hospital (Lebanon County)	6%	6%
Carlisle Regional Medical Center (Cumberland County)	5%	5%
Other (<3% share each)	10%	10%
HHI	**2,500**	**4,500**
Change in HHI	**+2,000**	

ANTICOMPETITIVE EFFECTS

A.

Hospital Competition Yields Lower Prices and Higher Quality

37. Competition between hospitals occurs in two distinct but related dimensions. First, hospitals compete to be selected as in-network providers for commercial health plans' members. Second, hospitals compete with each other on the basis of non-price features (*e.g.*, quality, amenities, etc.) to attract patients, including health plan members, to their facilities.

38. In the first dimension of hospital competition, hospitals compete to be included in health plan networks. To become an in-network provider, a hospital negotiates with a health plan and, if mutually agreeable terms can be reached, enters into a contract. Reimbursement rates (*i.e.*, prices), which the hospital charges to a health plan for services rendered to a health plan's members, are the primary contractual terms negotiated.

39. In-network status benefits the hospital by giving it preferential access to the health plan's members. Health plan members typically pay far less to access in-network hospitals than out-of-network hospitals. Thus, all else being equal, an in-network hospital will attract more patients from a particular health plan than an out-of-network hospital. This dynamic motivates hospitals to offer lower rates to

health plans to win inclusion in their networks.

40. From the health plan's perspective, having hospitals in-network is beneficial because it enables the health plan to create a healthcare provider network in a particular geographic area that is attractive to current and prospective members, typically local employers and their employees.

41. A critical determinant of the relative bargaining positions of a hospital and a health plan during negotiations is whether other, nearby comparable hospitals are available to the health plan and its members as alternatives in the event of a negotiating impasse. The presence of alternative hospitals limits a hospital's bargaining leverage and thus constrains its ability to obtain higher reimbursement rates from health plans. The more attractive these alternative hospitals are to a health plan's members in a local area, the greater the constraint on that hospital's bargaining leverage. Where there are few or no meaningful alternatives, a hospital will have greater bargaining leverage to demand and obtain higher reimbursement rates.

42. A merger between hospitals that are close substitutes from the perspective of health plans and their members therefore tends to produce increased bargaining leverage for the merged entity and, as a result, higher negotiated rates, because it eliminates a competitive alternative for health plans.

43. Increases in the reimbursement rates negotiated between a hospital and a health plan significantly impact the health plan's members. "Self-insured" employers rely on a health plan for access to its provider network and negotiated rates. These employers pay the cost of their employees' health care claims directly and thus bear the full and immediate burden of any rate increases in the healthcare services used by their employees. "Fully-insured" employers pay premiums to health plans—and employees pay premiums, co-pays, co-insurance and/or deductibles—in exchange for the health plan assuming financial responsibility for paying hospital costs generated by the employees' use of hospital services. When hospital rates increase, health plans pass on these increases to their fully-insured customers in the form of higher premiums, co-pays, co-insurance and/or deductibles.

44. In the second dimension of hospital competition, hospitals compete to attract patients to their facilities by offering higher quality care, amenities, convenience, and patient satisfaction than their competitors. This competition can be significant because health plan members often have a choice of in-network hospitals where they face similar out-of-pocket costs. Hospitals also compete on these non-price dimensions to attract patients covered by Medicare and Medicaid, as well as other patients without commercial insurance. A merger of competing

hospitals eliminates that non-price competition and reduces their incentive to improve and maintain quality.

B.

The Merger Would Eliminate Close Competition between Hershey and Pinnacle

45. Hershey and Pinnacle are vigorous competitors in the relevant market due to the similarity in services that they both offer and their geographic proximity. The Merger would eliminate direct and substantial competition between the Defendants and create a dominant health system that could increase reimbursement rates and/or reduce service levels for GAC inpatient services. Close competition in the relevant market is evident from a wide variety of evidence, including econometric analysis of the Defendants' patient draw data, ordinary-course documents, testimony, and information from health plans.

46. A standard economic analysis of the closeness of competition known as diversion analysis, which is based on data about where patients receive hospital services, confirms that Hershey and Pinnacle are very close competitors. More specifically, Pinnacle is the only significant competitor of Hershey and Hershey is the only significant competitor of Pinnacle other than Holy Spirit Hospital. Diversion analyses show that if Hershey were no longer available, over 40% of its patients would seek GAC services at Pinnacle. Similarly, if Pinnacle were no

longer available to patients, over 30% of its patients would seek GAC services at Hershey. The diversions between the Defendants are higher than those present in recent hospital merger cases where courts have found that the transaction at issue would substantially lessen competition and, therefore, violated the Clayton Act.

47. Hershey and Pinnacle offer a wide range of overlapping GAC inpatient service lines, from primary to higher-end tertiary and quaternary care, with the limited exceptions of major organ transplants and high-end trauma care, which are provided by Hershey but not by Pinnacle. Data show that the services offered by each of the Defendants substantially overlap with one another. Diagnosis-related groups ("DRGs") are categories of diagnoses used by Medicare and health plans to set reimbursement rates. 98% of Hershey's patients are in DRGs that are offered by Pinnacle. Similarly, 97% of Pinnacle's patients are in DRGs offered by Hershey.

48. According to the Defendants' documents, Pinnacle and Hershey "aggressively compete with one another in many areas" and view each other as close competitors. For example, in 2011, Hershey hired a consulting firm to conduct a detailed service line analysis, which concluded that Pinnacle was Hershey's most significant, and often the "dominant," local competitor in numerous key services lines, including neurosciences, heart and vascular,

orthopaedics, obstetrics and gynecology ("OB/GYN"), spine, and pediatrics. The analysis also states that within the local market, Hershey had increased its market share in orthopedic services by "taking away market share from Pinnacle." The same analysis also notes that Hershey is the "dominant player" in pediatrics while Pinnacle is the "second dominant player." Similarly, Pinnacle views Hershey as is its "main competitor" for OB/GYN services. A Pinnacle analysis lists the top inpatient services lines, for both Pinnacle and Hershey, as "OB/birthing services, general medicine, ortho/spine, and general surgery."

49. In addition, Pinnacle has been expanding its service offerings and is currently implementing its strategic Vision 2017 Plan, which includes renovating Pinnacle's Harrisburg Hospital to establish it as a "tertiary referral center" that would further enhance its competition with Hershey.

50. Pinnacle's ordinary course documents and business plans identify Hershey and Holy Spirit Hospital as its two principal competitors and frequently focus on Hershey as its main competitor. Pinnacle routinely generates reports tracking "leakage" of referrals from primary care physicians to Hershey, and it routinely tracks Hershey's market shares by service line. While Holy Spirit competes in the Harrisburg Area, Pinnacle's documents reveal that "[d]espite its efforts to become indispensable to the entire Harrisburg market, Holy Spirit

remains a medium-sized community hospital with a limited (West Shore) service area and few distinctions." Its service lines are "modest when compared to Pinnacle's."

51. Similarly, Hershey's internal documents reveal that Hershey identifies Pinnacle as being one of its principal competitors. Hershey focuses significant attention on Pinnacle's strategy, while focusing its own competitive strategies on capturing market share from Pinnacle.

52. The Defendants are also close competitors because of their geographic proximity. Competition between Hershey and Pinnacle is particularly intense in Dauphin County, where Hershey and Pinnacle operate the only GAC hospitals and the only emergency departments (where the Defendants draw approximately half of their inpatient admissions), and both draw more patients from Dauphin County than any other county. Post-Merger, the Defendants will operate the only two emergency rooms in Dauphin County and two of only three emergency rooms within 25 miles of downtown Harrisburg.

53. Competition between Hershey and Pinnacle also extends into Cumberland and Lebanon Counties. Hershey has expanded its primary care services in Cumberland County to drive referrals to Hershey Medical Center following Pinnacle's opening of West Shore Hospital in Cumberland County in

2014. Pinnacle has expanded its primary care services in Lebanon County, near Hershey Medical Center, in order to compete with Hershey and drive referrals to Pinnacle hospitals. Both Pinnacle and Hershey have both expanded their oncology services in Cumberland County.

54. Health plans that serve the Harrisburg Area confirm that Hershey and Pinnacle are large health systems that compete closely against one another by offering very similar services and high levels of quality. Because Holy Spirit's services are more limited, health plans consider it to be in a lower tier than Hershey and Pinnacle. Health plans do not view other hospitals in the Harrisburg Area—Carlisle Regional Medical Center or Good Samaritan Hospitals—as viable substitutes for the Defendants for Harrisburg Area residents due to their more limited service offerings and distance.

C.

The Merger Would Eliminate Price Competition and Increase the Merged Entity's Bargaining Leverage

55. Because the Merger would eliminate direct competition between Pinnacle and Hershey, a combined Hershey/Pinnacle would have increased bargaining leverage, allowing it to raise rates for GAC inpatient services in the Harrisburg Area. This increased leverage could manifest itself in multiple ways

including through an increase in rates across the entire combined hospital system or by raising Pinnacle's rates to Hershey's rate levels, which are higher. Such leverage could negatively affect agreements with traditional fee-for-service arrangements and/or new reimbursement models such as risk sharing, by, for example, allocating more risk to the health plan and less risk to a combined Hershey/Pinnacle.

56. Currently, health plans in the Harrisburg Area can negotiate lower rates by threatening to exclude Hershey or Pinnacle from their networks because the other hospital serves as a close alternative for patients living in the Harrisburg Area. For example, a large health plan that serves the Harrisburg Area recently resisted rate increases proposed by Pinnacle by threatening to exclude Pinnacle from its network and create a hospital network limited to Hershey and Holy Spirit. This threat resulted in Pinnacle accepting a more modest rate increase than it had demanded.

57. If Hershey and Pinnacle were to merge, health plans could no longer threaten to exclude the combined Hershey/Pinnacle from their networks or otherwise use competition between Hershey and Pinnacle to negotiate better reimbursement rates. In fact, one of Pinnacle's stated "transaction objectives" was to "establish a health care provider that is a 'must have' for payers."

58. Moreover, health plans have confirmed that a provider network that lacked the combined Hershey/Pinnacle would be very difficult, if not impossible, to market to Harrisburg Area residents. This is evidenced by the recent experience of one area health plan. For over a decade, this health plan was able to market a viable network in the Harrisburg Area that included Pinnacle and Holy Spirit, but did not include Hershey. However, in 2015, after Pinnacle terminated its provider agreement with the health plan, the health plan rapidly lost almost half of its members in the Harrisburg Area and is now unable to market a viable network in the area.

59. Numerous health plans have expressed concern that the proposed Merger will eliminate competition and result in price increases. For example, a representative of Capital BlueCross, the second large health plan in the Harrisburg Area, sent an email to the Defendants which stated that "[w]ith the proposed merger, the new entity would control greater than 50% of the market and without a strategic long-term partnership defined for Capital, we would have concerns that the new entity would ultimately have too much leverage and Capital would not be able to negotiate market appropriate pricing and terms." Indeed, the CEO of Hershey acknowledged that health plans had "a lot of anxiety" that the Defendants would use the Merger as a means to raise prices.

60. As confirmed by numerous area health plans, the Harrisburg Area currently benefits from competition between Hershey and Pinnacle and has lower reimbursement rates than those that prevail in more concentrated markets in Pennsylvania, most notably York and Lancaster Counties, where a single health system dominates each market.

61. Post-Merger, the transaction would eliminate this beneficial competition and create a dominant health system in the Harrisburg Area. Accordingly, if allowed to proceed, the Merger would substantially increase the combined entity's bargaining leverage in negotiations and result in higher rates.

D.

The Merger Eliminates Vital Quality Competition

62. In addition to price competition, Hershey and Pinnacle compete extensively on non-price dimensions, including expansion of services, quality of care, and the use of state-of-the-art facilities and technology. Patients in the Harrisburg Area have benefitted from this competition.

63. In order to further compete with Hershey, Pinnacle has expanded its tertiary services in recent years. For example, Pinnacle has expanded and modernized its facilities, and introduced new advanced service lines pursuant to its Vision 2017 Plan, all to the benefit of Harrisburg Area residents. Pinnacle recently

renovated Harrisburg Hospital and its other hospitals to modernize, increase the number of private rooms, and add clinical space. Pinnacle has also expanded its service line offerings and implemented numerous operational improvements and best practices to improve its quality metrics and patient satisfaction. These improvements were driven by Pinnacle's desire to improve the patient experience and attract additional patients to Pinnacle and away from Hershey.

64. Competition between Pinnacle and Hershey is particularly evident in their efforts to improve and expand their respective oncology services. Pinnacle's strategic plan for its new state-of-the-art Ortenzio Cancer Center in Cumberland County states that "[t]he one competitor that brings the biggest challenge to us is the University Hospital for the medical school at Penn State Milton S. Hershey Medical Center … In order for Pinnacle to be competitive we will have to assure that the patient experience is superior." An internal Hershey document about Pinnacle's Cancer Center notes "the future of the West Shore cancer market is at risk" and that Pinnacle is "making aggressive moves to grow its market share."

65. Pinnacle also has improved the quality of care at its hospitals to attract more patients from the Harrisburg Area. Pinnacle's internal documents show that it implemented operational improvements and best practices in order to improve its quality metrics and patient satisfaction.

66. Hershey has begun to implement strategic plans to expand its network of primary care practices and to construct a new outpatient ambulatory facility to increase access for patients in the Harrisburg Area and to compete with Pinnacle. It expanded outpatient services in Cumberland County to drive referrals to Hershey Medical Center and "steal market share from Pinnacle."

67. Hershey's documents also show its recognition that it needs to reduce costs and improve its quality and efficiency to remain competitive with Pinnacle and other competitors. It is "working to improve operational and cost performance" with specific initiatives on "quality & safety" and "cost efficiency."

68. The Merger would eliminate this beneficial competition between Hershey and Pinnacle on these vital non-price factors, thereby reducing incentives to improve quality, implement new medical technologies, and expand services in the Harrisburg Area. In addition, the Defendants intend, post-Merger, to move low acuity cases from Hershey to Pinnacle and high acuity cases from Pinnacle to Hershey. Such plans will further reduce the combined Hershey/Pinnacle's incentive to continue to invest in tertiary services at Pinnacle, and reduce costs and improve efficiency at Hershey. Losing these important benefits would affect all patients in the Harrisburg Area.

E.

Defendants' Recent Rate Agreements With Two Health Plans Would Not Prevent Competitive Harm

69. The Defendants have recently entered into multi-year agreements with the two largest health plans in the Harrisburg Area. These rate agreements – one is a term sheet, the other is letter agreement – purport to extend the Defendants' existing rate agreements with the health plans and commit to maintain the rate differential between Pinnacle and Hershey. The rate agreements were designed to forestall opposition to the Merger. One of these health plans requested the agreement "to ensure that [its] members are protected for a significantly long period of time from any adverse economic impact of the Pinnacle-Hershey merger." Accordingly, these rate agreements are strong evidence that the payors believe that the Merger would result in anticompetitive increases in reimbursement rates to health plans imposed by the combined Hershey/Pinnacle. However, these rate agreements do not alleviate the anticompetitive effects of the Merger.

70. First, the rate agreements are limited to only two health plans. The Defendants have not entered into similar agreements with other health plans in the Harrisburg Area. Accordingly, the combined Hershey/Pinnacle would be able to use its enhanced bargaining leverage to demand higher prices or better terms,

without any constraints, when negotiating with these other health plans.

71. Second, the rate agreements foreclose the possibility that, absent the Merger, competition could lead to rates that increase less quickly or even decrease. Similarly, they do not address that the change in bargaining dynamics due to the merged entity's increased leverage would also apply to different types of agreements, such as risk-sharing arrangements, which are purportedly contemplated by the letter agreements in the future. Under such newer reimbursement arrangements, the health plan and the provider must negotiate over the level of risk that each party bears. Here, the combined entity could use its increased bargaining leverage post-Merger to the detriment of health plans (and ultimately their members) when negotiating risk-sharing or value-based agreements.

72. Third, the rate agreements do nothing to preserve the service and quality competition between Pinnacle and Hershey that has benefitted Harrisburg Area residents and patients and that the Merger would eliminate.

73. Finally, the rate agreements are of limited duration. When they terminate, the Defendants will no longer be subject to any purported commitment to maintain the rate differential. Accordingly, the combined Hershey/Pinnacle would be able to use its enhanced bargaining leverage to demand higher prices or

better terms from the two health plans, without any constraints, when negotiating both traditional fee-for-service contracts as well as contracts with newer reimbursement models.

ENTRY BARRIERS

74. Neither entry by new healthcare providers into the relevant service market nor expansion by existing market participants will deter or counteract the Merger's likely serious competitive harm in the relevant service market.

75. New hospital entry in the Harrisburg Area would not be likely, timely, or sufficient to offset the Merger's harmful effects. Construction and operation of a new GAC inpatient hospital involves high costs and serious financial risk. The construction of a new hospital also would take much more than two years from the initial planning stage to opening, as evidenced by the significant time and expense involved in the building of Pinnacle's West Shore Hospital and Hershey's Children's Hospital.

76. Even if new hospital entry did occur, it likely would not be sufficient to offset the Merger's harm because a new hospital could not achieve the scale required to offer the broad cluster of GAC services comparable to those offered by the Defendants. Hershey and Pinnacle are both large, high-quality health systems, which offer a full range of GAC services and employ a significant number of

physicians. Their service capabilities, strong reputations, and significant share of the relevant market present significant barriers to entry and would be extremely challenging for a new entrant to replicate in a manner sufficient to counteract the likely anticompetitive effects of the Merger.

77. Moreover, hospitals both outside and within the Harrisburg Area have affirmed that they have no plans to enter or build new hospitals in the Harrisburg Area. In fact, the Defendants are the only healthcare providers that have constructed new hospitals in the relevant area (one each) in over a decade.

EFFICIENCIES

78. No court ever has found, without being reversed, that efficiencies rescue an otherwise illegal transaction. Here, in order to rebut the presumption that the Merger is unlawful, Defendants would need to present evidence that extraordinary merger-specific efficiencies, which will be passed on to consumers, outweigh the Merger's likely significant harm to competition in the Harrisburg Area. However, Defendants' efficiency claims are overstated, speculative, unverifiable, not merger-specific, or result from an anticompetitive reduction in output, quality, or services, and are largely non-cognizable. Overall, Defendants' efficiency claims, to the extent they are cognizable, are insufficient to offset the substantial competitive harm the Merger is likely to cause.

79. Defendants have claimed that Hershey is at capacity and the Merger will allow the Defendants to transfer patients suffering from less severe illnesses from Hershey to Pinnacle, which has the capacity to treat them. Defendants further claim that this will allow Hershey to avoid constructing a new inpatient bed tower to alleviate its capacity issues.

80. However, Hershey could alleviate its capacity constraints in a timely manner without the Merger. Moreover, the Defendants' alleged efficiency plans would result in competitive harm. Defendants' plans would force patients to go to a different hospital than the one they originally chose. Defendants' plans would also reduce output, capacity, and service compared to the but-for world without the Merger, thereby denying patients the benefits of new inpatient rooms at Hershey. Accordingly, these claims are not cognizable under the law.

81. The Defendants have also claimed that the Merger may achieve other operational efficiencies. However, these efficiency claims are speculative, overstated, and have not been substantiated by the Defendants.

LIKELIHOOD OF SUCCESS ON THE MERITS, BALANCE OF EQUITIES, AND NEED FOR RELIEF

82. Section 13(b) of the FTC Act, 15 U.S.C. § 53(b), authorizes the Commission, whenever it has reason to believe that a proposed merger is unlawful, to seek preliminary injunctive relief to prevent consummation of a merger until the

Commission has had an opportunity to adjudicate the merger's legality in an administrative proceeding. The Court may grant preliminary injunctive relief upon a proper showing that weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest. The principal public equity weighing in favor of issuance of preliminary injunctive relief is the public interest in effective enforcement of the antitrust laws. Private equities affecting only Defendants' interest cannot defeat a preliminary injunction.

83. The Commission is likely to succeed in proving that the effect of the Merger may be substantially to lessen competition or tend to create a monopoly in violation of Section 7 of the Clayton Act, 15 U.S.C. § 18, or Section 5 of the FTC Act, 15 U.S.C § 45.

84. Preliminary relief is warranted and necessary. Should the Commission rule, after the full administrative trial, that the Merger is unlawful, reestablishing the *status quo ante* of vigorous competition between Hershey and Pinnacle would be difficult, if not impossible, if the Merger has already occurred in the absence of preliminary relief. Moreover, in the absence of relief from this Court, substantial harm to competition would likely occur in the interim, even if suitable remedies were obtained later.

85. Accordingly, the equitable relief requested here is in the public

interest. WHEREFORE, the Commission and the Commonwealth of Pennsylvania respectfully request that the Court:

1. Temporarily restrain and preliminarily enjoin Defendants from taking any further steps to consummate the Merger, or any other acquisition of stock, assets, or other interests of one another, either directly or indirectly;

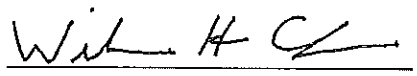
2. Retain jurisdiction and maintain the *status quo* until the administrative proceeding that the Commission has initiated is concluded;

3. That Plaintiffs be awarded their costs of this action, including attorneys' fees to the Commonwealth of Pennsylvania; and

4. Award such other and further relief as the Court may determine is appropriate, just, and proper.

Dated: December 9, 2015

Respectfully submitted,



WILLIAM H. EFRON
Director
Northeast Region
Federal Trade Commission

JARED P. NAGLEY
GERALYN J. TRUJILLO
RYAN F. HARSCH
JONATHAN W. PLATT
NANCY TURNBLACER
THEODORE ZANG
GERALD A. STEIN
Attorneys
Bureau of Competition
Federal Trade Commission
Northeast Region
One Bowling Green, Suite 318
New York, NY 10004
Telephone: (212) 607-2829
Email: wefron@ftc.gov
jnagley@ftc.gov

DEBORAH L. FEINSTEIN
Director
Bureau of Competition
Federal Trade Commission

JONATHAN NUECHTERLEIN
General Counsel
Federal Trade Commission

Attorneys for Plaintiff
Federal Trade Commission

Dated: December 9, 2015

Respectfully submitted,

Bruce Beemer
First Deputy Attorney General
James A. Donahue, III
Executive Deputy Attorney General
Public Protection Division
PA 42624

By: _____

Tracy W. Wertz
Chief Deputy Attorney General
Antitrust Section
14th Floor Strawberry Square
Harrisburg, PA 17120
(717) 787-4530 (phone)
(717) 705-1190 (fax)
twertz@attorneygeneral.gov
PA 69164

Jennifer A. Thomson
Senior Deputy Attorney General
Antitrust Section
jthomson@attorneygeneral.gov
PA 89360

Aaron L. Schwartz
Deputy Attorney General
Antitrust Section
aschwartz@attorneygeneral.gov
PA 319615

Attorneys for the Commonwealth of Pennsylvania

Exhibit D

No. 16-2365

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

FEDERAL TRADE COMMISSION *et al.*,
Appellants,

v.

PENN STATE HERSHEY MEDICAL CENTER *et al.*,
Appellees.

On Appeal from the United States District Court
for the Middle District of Pennsylvania
No. 1:15-cv-2362 Hon. John E. Jones III

BRIEF OF THE FEDERAL TRADE COMMISSION AND THE COMMONWEALTH OF PENNSYLVANIA

BRUCE L. CASTOR, JR.
Solicitor General
BRUCE BEEMER
First Deputy Attorney General
JAMES A. DONAHUE, III
Executive Deputy Attorney General
TRACY W. WERTZ
Chief Deputy Attorney General
JENNIFER THOMSON
AARON SCHWARTZ
Attorneys
PENNSYLVANIA OFFICE OF THE ATTORNEY GENERAL
Harrisburg, PA 17120

DAVID C. SHONKA
Acting General Counsel
JOEL MARCUS
Director of Litigation
DEBORAH L. FEINSTEIN
MICHELE ARINGTON
WILLIAM H. EFRON
JARED P. NAGLEY
GERALYN J. TRUJILLO
RYAN F. HARSCH
JONATHAN W. PLATT
PEGGY BAYER FEMENELLA
Attorneys
FEDERAL TRADE COMMISSION
600 Pennsylvania Avenue, N.W.
Washington, D.C. 20580
(202) 326-3157

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

STATUTES

OTHER AUTHORITIES

RULES

GLOSSARY

For ease of reference, the following abbreviations and citation forms are used in this brief:

App.	Appellants' appendix
PX	Plaintiffs' exhibit
Hrg.	Transcript of testimony from preliminary injunction hearing

JURISDICTION

The district court had jurisdiction over the FTC's request for a preliminary injunction to preserve the status quo under 15 U.S.C. § 53(b), and over Pennsylvania's request for a preliminary injunction under 15 U.S.C. § 26. The district court entered the order under review on May 9, 2016 (App. 4), and the Government plaintiffs filed a notice of appeal the following day (App. 1). This Court has jurisdiction because the order under review is final and disposed of all issues presented, 28 U.S.C. § 1291, and because the lower court denied an injunction, 28 U.S.C. § 1292(a)(1).

QUESTION PRESENTED

The Government plaintiffs sought a preliminary injunction blocking the merger of the two largest health systems in the Harrisburg, Pennsylvania area while the FTC conducts an administrative adjudication to determine whether the merger violates the antitrust laws. The hospitals are close rivals for inclusion in insurance company healthcare networks, and together they would control nearly 80 percent of the market for general acute care inpatient services sold to commercial health insurers in the Harrisburg area. The questions presented are:

1. Whether the district court improperly determined that the Government did not show that the four-county area around Harrisburg is a proper antitrust geographic market; and

2. Whether the district court improperly assessed the "equities" of the merger in declining to preliminarily enjoin it.

STATEMENT OF RELATED CASES AND PROCEEDINGS

This case has not been before the Court previously. An administrative proceeding challenging the merger and related directly to this case is pending before the Federal Trade Commission in FTC Docket No. 9368.

STATUTES AND REGULATIONS

Pertinent materials are attached.

STATEMENT OF THE CASE

This is an antitrust case under Section 7 of the Clayton Act, 15 U.S.C. § 18, involving the merger of the two largest hospital systems in the area around Harrisburg, Pennsylvania. The hospitals have long been close competitors, but in 2015 they decided to stop competing and agreed to combine into a single economic entity. The Federal Trade Commission found reason to believe that the merger would significantly reduce competition in the Harrisburg-area hospital market, and its Commissioners voted unanimously to issue an administrative complaint to block the merger. That matter will be tried before an agency administrative law judge later this year.

In the meantime, the FTC and the Commonwealth of Pennsylvania asked the district court below to issue a preliminary injunction preventing the merger from closing before the administrative adjudication is complete. Recognizing the need

to protect consumers from competitive harm until the adjudication is finished and to preserve the FTC's ability to secure effective relief if the merger is held unlawful, Congress authorized district courts to grant preliminary injunctions temporarily barring mergers in this type of case. 15 U.S.C. § 53(b).

The Government alleged that the merger will substantially lessen competition in the market for general acute care inpatient hospital services sold to commercial insurers in the Harrisburg, Pennsylvania area. The combined hospital systems would control 76% of the market, dramatically increasing their bargaining power over health insurers and enabling them to raise prices and reduce output, while reducing their incentives to improve patient care and service.

After a five-day hearing, at which 15 witnesses testified and numerous exhibits were introduced, the district court denied the Government's request for a preliminary injunction. The FTC and Pennsylvania appeal from that order. On May 24, 2016, this Court granted the Government's motion for an injunction pending appeal.

A. The Proposed Merger

Hershey and Pinnacle operate the two largest hospital systems in the four county area surrounding Harrisburg, which includes Dauphin, Cumberland, Perry, and Lebanon counties. Those counties have a combined population of almost

700,000. PX01062-37-38.[1] Hershey, which commands a 36 percent share of inpatient hospital services in the four-county area, owns the Penn State Milton S. Hershey Medical Center in Dauphin County, a 551-bed facility. Pinnacle, with a 40 percent share, operates three hospitals in the Harrisburg area, including two in Dauphin County, with a combined 646 beds. Defendants operate the only hospitals in Dauphin County, where the city of Harrisburg is located. The next largest hospital, Holy Spirit, located in Cumberland County, has a 15 percent market share. Each of the two remaining hospitals in the four-county area has a share of 5 percent or less. PX01062-21, 28, 116.

Pinnacle and Hershey offer an extensive range of inpatient hospital treatment and provide almost entirely overlapping services. PX01062-127-131. Approximately 98% of Hershey's patients could be treated at Pinnacle, and nearly all of Pinnacle's patients could be treated at Hershey. PX01062-131; Hrg. 334:17-21 (App. 81). Both hospitals are sophisticated health systems with teaching hospitals that offer highly complex treatments and innovative medical technology. Hrg. 523:15-530:12; PX00280-002; PX00027-081; PX00030-128; PX00253-009; PX00379-002-06.

[1] PX01062 is the report of the Government's expert economist, Dr. Nathan Wilson. PX01424 is his Rebuttal Report.

B. Economics Of Insurer/Hospital Price Negotiations

1. Understanding the competitive dynamics of hospital markets is essential for assessing the competitive effects of a hospital merger. Unlike the typical two-party market, the market for hospital services has four participants: *hospitals*, which provide healthcare services; *health insurance companies*, which negotiate the prices of hospital services and market health plans to employers and their employees; *employers*, who select among the competing health plans offered by insurance companies; and *employees*, who are the ultimate consumers of service and decide which hospital to use.[2]

Those four participants engage in a complex relationship. Because insurers compete with one another to sell policies, they must offer attractive health plans. Whether a policy is attractive depends not only on its price, but also on the desirability of the service providers, including hospitals, in the insurance "network." The network is the group of healthcare providers that have agreed to treat the insurer's policyholders at negotiated prices. Those prices are usually significantly lower than the prices charged by providers outside of the insurer's network. Insurers thus strive to assemble a desirable network at the lowest cost.

[2] We refer to employees as "policyholders," "consumers," and "patients" interchangeably. Insurance companies were referred to below as "payors."

Hrg. 305:12-22, 306:14-20 (App. 65-66); PX01062-55, 58-60, 65, 75; PX01424-061.

Because insurers rather than policyholders negotiate prices, they are the hospitals' direct customers. PX01062-59-60; Hrg. 306:10-13 (App. 66). Once the price that an insurer will pay a hospital for service has been established, policyholders who need hospital care typically face no significant price difference between in-network hospitals. PX01062-59-60. Instead, hospitals compete for their business on the basis of quality and convenience. In particular, patients typically demand access to local care. A hospital's proximity to policyholders therefore is a core consideration for insurers when assembling their provider network. PX01062-64-65, 93; PX01424-61; Hrg. 315:13-20, 320:11-22 (App. 72, 76). The Supreme Court has recognized that "in most service industries, convenience of location is essential to effective competition." *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 358 (1963).

At the same time, hospitals compete to be included in insurance company networks. Insured patients rarely choose providers outside their health plan's network. Health plans typically either do not cover the cost of out-of-network care at all or require patients to bear a significantly larger share of it. Thus, a hospital that is not included in an insurance company's network is likely to lose access to virtually all of that insurer's policyholders. Competition between hospitals leads to

both lower prices (as described immediately below) and to improvements in quality of care and service to patients. PX01062-55,68-69; Hrg. 305:23-306:09, 309:03-06 (App. 65-67).

2. Prices are negotiated between each hospital and health insurance company. Like any business deal, both sides have some amount of bargaining power, or "leverage," and the agreement reached depends on the relative strengths of that leverage. Leverage ultimately is a function of a party's ability to walk away from the negotiation and refuse to do business with its negotiating partner. Thus, in bargaining over hospital prices, if the hospital demands too high a price and the insurer abandons the negotiation, the hospital will lose access to most of that insurer's members. Hrg. 309:12-25 (App. 67). Conversely, if the insurer insists on an unacceptably low price and the hospital walks away, the insurer will be unable to include the hospital in its network and must offer a policy that does not cover the hospital. A hospital's leverage thus depends on how important it is to the insurer's network, which reflects both patient preferences for the hospital and the availability of desirable alternative substitute hospitals. PX01062-65-67; Hrg. 309:12-311:20 (App. 67-69). *See ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 562 (6th Cir. 2014); *St. Alphonsus Medical Center v. St. Luke's Health System*, 778 F.3d 775, 784-785 (9th Cir. 2015).

Greater hospital competition leads to lower hospital prices. The more hospitals that compete for inclusion in insurance networks, the more an insurer can plausibly substitute one hospital for the other when forming its network and the stronger its ability to resist price increases. PX01062-067-71; Hrg. 309:22-310:11 (App. 67-68); *see ProMedica*, 749 F.3d at 562. Competition between hospitals thus constrains their prices, which allows insurers to charge lower premiums, co-payments, and deductibles to employers and their employees. PX01062-55. And, as mentioned, competition between hospitals also spurs them to improve quality of care.

But less competition among hospitals for inclusion in insurance networks increases the hospital's leverage, leading to higher prices, higher policy costs, and lower quality of care. Hrg. 339:19-341:6 (App. 82-84); PX01062-73-76. An insurer facing a hospital with superior bargaining leverage will agree to pay higher prices because doing so is preferable to marketing a network that lacks the hospital. When hospitals that formerly competed for inclusion in the network merge, it diminishes the insurer's bargaining position. PX01062-65-67.

3. The record showed that the bargaining model described above accurately depicts the commercial reality of the Harrisburg market. Through sworn declarations and deposition testimony, area insurers repeatedly confirmed that the outcome of price negotiations turns on their relative bargaining leverage with

hospitals. The declaration of one area insurer, for example, stated that a hospital's leverage "is largely determined by the extent to which [policyholders] demand to receive care at that hospital." PX00701 ¶¶15-17 (App. 268-269). The insurer's leverage in turn depends on "how many competing providers are located in a particular area." *Id*. ¶15. Where alternatives are limited, "a [hospital] is generally able to negotiate higher reimbursement rates … because [it] could credibly threaten to terminate its contract with [insurer], which would result in [insurer] having a significantly less attractive network to offer to members." *Id*. ¶17. Other insurance company executives testified to the same effect. PX00700 ¶5; PX00704 ¶¶4-5; PX01062-076-78; PX01236, 38:10-40:15 (App. 490). One testified that the availability of competing hospitals affects a hospital's leverage because it determines the credibility of an insurer's threat "to walk away from a negotiation and yet still market an attractive network at competitive rates." PX00707 ¶16. Defendants do not disagree. *See* PX01382-004 (App. 515) (discussed in greater detail at page 15 below).

C. The Harrisburg Market

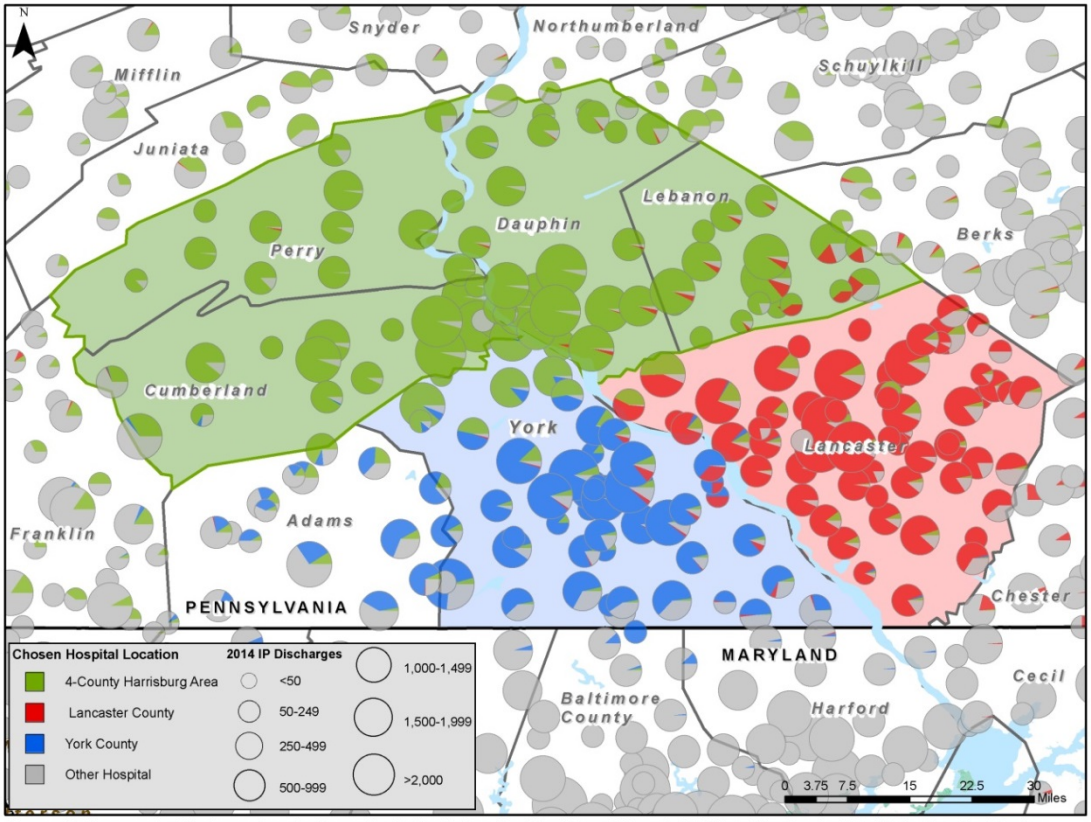
Hershey and Pinnacle compete against each other both for patients and for inclusion in insurers' hospital networks. Pinnacle's CFO testified that they compete closely on quality, price, and range of services offered. Hrg. 537:7-10, 540:17-541:8, 541:20-542:4 (App. 116-119). Indeed, Pinnacle identified Hershey

as "our main competitor," PX00527-001, and Hershey described Pinnacle as a "primary competitor," PX00140-008. Pinnacle indicated that the two systems "aggressively compete." PX00037-008. Other of defendants' documents and testimony show aggressive competition across a wide range of services including cancer treatment, PX00039-006; heart surgery, PX00940-001; breast surgery, PX00327-001-2; PX01473-001; and kidney transplants, PX01202, 74:5-13. As the hospitals' own expert testified, the evidence showed a "local rivalry" for cancer treatment and kidney transplants that is "particularly hot." PX01232, 252:25-255:18.

1. The two hospitals are especially close rivals in the Harrisburg area because consumers in the Harrisburg area overwhelmingly demand hospital care close to their homes. The evidence showed that 91% of Harrisburg area patients sought care at hospitals located in the four-county area, with a median travel time of 15 minutes. Hrg. 315:12-20, 319:22-320:22 (App. 72, 75-76); PX01062-97-102, 120. By contrast, the largest hospitals in York and Lancaster counties, which are each 30 to 45 minutes away, collectively provide care to fewer than 2 percent of Harrisburg area patients. PX01062-043, 122.

An economic analysis performed by the Government's expert graphically shows the strong preference of Harrisburg area patients for local hospitals. The chart below shows by color where patients who live within a given zip code go for

hospital care (each circle represents one zip code, and its size indicates the insured population). It indicates clearly that patients living in the Harrisburg area (shown in green) overwhelmingly prefer to receive care in hospitals inside the area. Similarly, residents of York (shown in blue) and Lancaster (shown in red) counties overwhelmingly receive care at hospitals in their own home counties.



Source: 2014 commerical discharges from the Pennsylvania Health Care Cost Containment Council (PHC4) and the Maryland Health Services Cost Review Commission (MD HSCRC).

PX01062-99-101. Put simply, patients use hospitals close to home.

Defendants' own analyses reached the same conclusion. A survey they conducted showed that 92% of Central Pennsylvania residents would go either to the closest or to a very convenient hospital to receive non-life threatening care, and

that convenient location was consumers' most important factor in selecting a hospital. Hrg. 320:16-321:16 (App. 76-77); PX01360-024 (App. 511).

Similarly, Hershey's CEO testified that the desire for local care is a "big determinant in people's choice of health care." Hrg. 474:7-10 (App. 100). Pinnacle's CFO testified likewise. Hrg. 521:17-522:6 (App. 106-107). Indeed, the President of PinnacleHealth's Medical Group said in an email that most Central Pennsylvania patients would not travel more than 10 miles or 20 minutes from home to receive hospital care. PX01277-001.

Area insurers also consistently affirmed that residents in the Harrisburg area strongly prefer to go to local hospitals. The director of provider contracting for one insurer stated that most of its Dauphin County policyholders used either Pinnacle or Hershey "[b]ecause of the proximity of these two quality health systems," and that "very few members who live in Dauphin County travel outside the county for general acute services." More broadly, "the vast majority of [insurer's] members in the four-county Harrisburg area utilize health systems locat[ed] within this area, with few members leaving for general acute care." PX00701 ¶¶7-8 (App. 266); *see also* PX00707 ¶9; PX00700 ¶¶12-13. The demand for local hospital care was further confirmed by the testimony of a former Harrisburg area hospital CEO explaining that most patients in Dauphin County receive care at either Pinnacle or Hershey. Hrg. 90:11-16 (App. 36).

The strong preference among Harrisburg-area residents for Hershey and Pinnacle specifically was confirmed by defendants' own brand study, which concluded that Pinnacle's Harrisburg Hospital "leads or is second to Penn State Hershey in the Primary market," which the study defined as the Harrisburg area. PX01360-11 (App. 510).

2. Because Harrisburg residents demand local hospital service, insurance company networks are marketable to them only if the network provides access to Harrisburg-area hospitals. Employers in the Harrisburg area provided sworn declarations that both they and their employees will consider using a health plan only if its provider network includes local hospitals.[3] Insurance company representatives recognize this strong preference and consistently affirmed the need to include local hospitals in their networks. PX00704 ¶¶6-8, 11; PX00707 ¶4; PX00701 ¶¶7-8 (App. 266-267).

A natural experiment described at the hearing vividly illustrates the need for either Hershey or Pinnacle in an insurance network marketed to Harrisburg-area employers. For more than a decade, one small insurer successfully marketed policies to those employers that included Pinnacle and Holy Spirit, but not Hershey, in the network. PX00704 ¶10; Hrg. 208:25-209:11 (App. 51-52). In

[3] PX00708 ¶¶5, 9; PX00717 ¶¶8, 13; PX00718 ¶¶5, 7, 10; PX00719 ¶¶5, 11; PX00720 ¶4.

2014, Pinnacle terminated its participation in the insurer's network. PX01533-001; Hrg. 209:18-210:13 (App. 52-53). Once Pinnacle withdrew, half of its commercial policyholders switched to other insurers even though its network included Holy Spirit and large hospitals in York and Lancaster counties and the insurer offered a substantial discount. PX01542; PX01608; Hrg. 223:20-226:19 (App. 54-57); PX01610; PX00704 ¶10. Brokers opined that the network without Hershey and Pinnacle was unmarketable at any price point. PX00704 ¶10; PX00708 ¶¶ 7-13; Hrg. 225:15-226:19 (App. 56-57).

The experience of that small insurer was confirmed by the two largest ones in the Harrisburg area. Their representatives testified at depositions that they too could not successfully market a network without either Hershey or Pinnacle. One stated that without the two hospitals, "[f]or all intents and purposes there would be no network." PX01236, 48:17-22 (App. 491). He predicted that a network without defendants' hospitals would lose half its membership in Dauphin County. PX01236, 144:6-16 (App. 494).

His counterpart at the other large insurer testified similarly. Asked, "When you market a plan in the Harrisburg area, would you need to include a combined Hershey and Pinnacle in your network to successfully market it?" he answered simply, "Yes." PX00804, 64:13-20 (App. 317). That testimony establishes that

even the largest insurers in the Harrisburg area would not try to sell a network that includes neither Hershey nor Pinnacle.

3. The evidence showed that competition between Hershey and Pinnacle for inclusion in insurers' networks has constrained their prices and that eliminating the competition would lead to increased prices. A real-world example demonstrates the constraint. In 2014, Pinnacle demanded a substantial price increase from one of the area's largest insurance companies. When the insurer responded by threatening to exclude Pinnacle from its network and instead rely on a network that included only Hershey and Holy Spirit, Pinnacle relented. PX00701 ¶18 (App. 269).

Defendants have explicitly acknowledged in this litigation how the separate existence of Hershey and Pinnacle has benefitted insurers in contract negotiations. Indeed, they sought (unsuccessfully) to keep Pinnacle's price capitulation, which was described in the Government's complaint, under seal. They argued that

> If this information is made public, health plans will learn that a competitor was able to resist Pinnacle's request for a rate increase by threatening to exclude Pinnacle from its network. As a result, health plans will have increased leverage in resisting future requests by Pinnacle for reasonable rate increases. Similarly, if other hospitals learn about this, they will know that health plans may be able to exclude Pinnacle from their networks, and those hospitals could thus seek to negotiate better deals for themselves by proposing plans that exclude Pinnacle.

PX01382-004 (App. 515).

Evidence from insurers likewise showed that the merger would eliminate this favorable bargaining dynamic and allow the combined entity to demand a price increase. An executive of one of the two largest area insurers emailed that the Harrisburg market "has been a very fortunate market" that has benefitted from competition among health systems, but he was concerned that a combined Hershey/Pinnacle "would ultimately have too much leverage and [the insurer] would not be able to negotiate market appropriate pricing and terms." PX00378-002 (App. 221); *accord* PX01200, 34:8-20 (App. 458). The executive responsible for hospital contracting at the other large area insurer testified at his deposition that if the merged hospitals demanded a price increase, his company "wouldn't have a whole lot of choice," but to pay it. PX01236, 49:3-19 (App. 492). He estimated that the company would have no realistic alternative but to pay prices 25 percent higher to keep them in the network. PX01236, 91:16-25,144:6-16, 48:23-49:19 (App. 491-494); *see also* PX01201, 70:21-71:18. Finally, in sworn declarations, other area insurers explained their concerns that the merger would increase defendants' bargaining leverage, resulting in higher prices for these insurers and their policy holders. PX00700 ¶19; PX00704 ¶14.

Hershey's own CEO acknowledged at his deposition that insurers had "a lot of anxiety" that defendants would increase prices post-merger and were particularly concerned that the merger would allow defendants to raise prices at

Pinnacle, whose prices are lower than Hershey's. PX00801, 103:24-105:9. A representative from one of the two largest area insurers, who analyzed the potential financial impact of the merger, estimated substantial price increases if defendants increased Pinnacle's prices. PX00612-003.

Pinnacle too recognized the potential for post-merger price increases. One of its stated "objectives" for the merger was to "establish a health care provider that is a 'must have' for [insurers]." PX00463-010. A Pinnacle executive even queried whether it would "make sense to put a charge increase in now while we can without it looking like we completed the merger, then raised charges?" PX00301-001.

4. The Government's expert testified that for antitrust purposes the four-county Harrisburg area is a relevant geographic market. Principally, the expert applied the "hypothetical monopolist" test, a standard tool of market definition used by economists, antitrust agencies, and courts. *See* U.S. Dep't of Justice & Federal Trade Commission, *Horizontal Merger Guidelines*, §§ 4.1.2, 4.2; *see Atlantic Exposition Servs. Inc. v. SMG*, 262 F. App'x 449, 452 (3d Cir. 2008); *see also St. Luke's Health Sys.*, 778 F.3d at 784-785. The test asks whether a hypothetical monopolist in a proposed geographic market—*i.e.*, a single owner of every hospital in that area—could profitably impose a small but significant (about 5 percent) non-transitory price increase (called a "SSNIP"). If the hypothetical

monopolist could profitably impose a SSNIP from at least one location of the merging firms, then the market is properly defined for antitrust purposes. The analysis showed that a monopolist in the four-county Harrisburg area could impose a SSNIP, which means that the Harrisburg area is a proper antitrust geographic market. PX01062-84-86, 91-92; Hrg. 313:17-314:21 (App. 70-71).

As shown above, insurers testified that, post-merger, they would pay a combined Hershey/Pinnacle in excess of a SSNIP in order to keep those hospitals in their network. Thus, as the Government's expert explained, a hypothetical monopolist of just these two Harrisburg area hospital systems could demand a SSNIP. PX01264-64-65; Hrg. 386:19-24 (App. 91). By necessary implication, a hypothetical monopolist of all Harrisburg-area hospitals would therefore also be able to demand a SSNIP. PX01062-092.

Additional fact witness testimony confirmed as much. Insurers uniformly view the Harrisburg area as a distinct market.[4] Indeed, when one large insurer calculated the financial impact of the merger, it measured defendants' post-merger market shares only in the four-county Harrisburg area and a narrower two-county Dauphin/Cumberland area. PX00613-002.

[4] PX00700 ¶¶2, 8; PX00704 ¶¶6-8, 11; PX00707 ¶4; PX00701 ¶¶3, 8; PX00804, 16:21-17:2 (App. 314-315); PX01201, 6:22-17:8; PX00784-004; PX01027-006; PX01062-101-06 (quoting the consistent views of market participants that the Harrisburg area is a distinct market).

The hospitals' own contemporaneous business documents show that they too see the Harrisburg area as a distinct market. Hershey's Chief Marketing Officer and Pinnacle's Director of Marketing agreed that the "[p]rimary" market for defendants' brand survey should be limited to the four counties in the Harrisburg area. PX00373-002. Hershey's COO testified that defendants' agreement with one large insurer defined their "Core Service Area" as the Harrisburg area and granted exclusive rights and competitive restrictions solely within this area. Hrg. 591:24-595:20; PX00029-008. Hershey identified the Harrisburg area as a distinct region reflecting "natural referral patterns" and requiring its own strategic plan. PX01198-001; PX00881-004; Hrg. 599:2-600:24. Pinnacle's CFO stated that Pinnacle's primary service area fell within the Harrisburg area and identified its closest competitors to be Hershey and Holy Spirit. Hrg. 537:4-10 (App. 116); PX00802, 63:9-13; PX00380-037; PX00006-001; PX00251-009.

D. Presumption That The Merger Is Anticompetitive

A merger that substantially increases market concentration in an already concentrated market is presumptively anticompetitive and unlawful. *See Philadelphia Nat'l Bank*, 374 U.S at 363. The *Merger Guidelines* measure market concentration using the "Herfindahl-Hirschman" Index ("HHI"), which is calculated by summing the squares of market share percentages. A transaction that increases the HHI by more than 200 points in a market that is already highly

concentrated (over 2,500) is presumed likely to enhance market power. *Merger Guidelines* § 5.3. Currently, the HHI of the Harrisburg market is 3,132—highly concentrated. The post-merger HHI would be 5,984, an increase of 2,852 points, which is *nearly fifteen times* greater than the *Merger Guidelines*' threshold for a presumptively anticompetitive merger. PX01062-115-16; Hrg. 323:22-324:10 (App. 79-80). That increase reflects the enormous 76 percent market share of the combined hospitals. *See Philadelphia Nat'l Bank*, 374 U.S. at 364 (30 percent market share unlawfully concentrated).

Consistent with the increase in market concentration, the Government's economic expert showed that the merger would likely allow the combined hospitals to raise their prices. Using common econometric techniques, the Government's expert concluded that the merger was likely to result in substantial price increases up to $178 million per year and insurance premium increases of as much as 33 percent. Hrg. 339:19-23 (App. 82); PX01062-148; PX01424-36. These estimates of harm were consistent with those provided by a large insurer. PX00612-003.

The Government's expert also testified that competition would be harmed by Hershey's cancellation of its plan to expand its facility by building a new "bed tower" should the merger take place. The bed tower would increase Hershey's ability to serve patients, and the increased capacity would lower prices. Hrg.

341:16-342:7 (App. 84-85), 988:16-990:1. Canceling the project would amount to a reduction in output, which would constrain supply and increase prices. Hrg. 341:5-15 (App. 84); PX01062-154-157. Defendants' own economic expert largely agreed that capacity expansion by Hershey would likely lower prices at both Hershey and Pinnacle. PX01232, 112:15-116:18.

Finally, the Government presented evidence that the merger would eliminate substantial competition between Hershey and Pinnacle on non-price dimensions such as quality of care and expanding access to services. For example, a Pinnacle document stated with respect to oncology services that "[i]n order for Pinnacle to be competitive we will have to assure that the patient experience is superior" to Hershey's. PX00039-006.

E. The District Court's Order

The district court denied the Government's request for an injunction. The parties had agreed that the relevant *product* market is general acute care services sold to commercial payors. App. 9. The court found that the Government had not shown the four-county Harrisburg area to be a properly defined antitrust *geographic* market, which was "dispositive to the outcome" of the proceeding. App. 11. The court believed the Government's proposed market to be a "starkly narrow view of the amount of hospitals patients could turn to if the combined Hospitals raised prices or let quality suffer." *Id*. at 13. It concluded that "19 other

hospitals within a 65 minute drive of Harrisburg provide a realistic alternative that patients would utilize." *Id*. at 12. The court based that conclusion on the fact that 43.5% of Hershey's patients travel to Hershey from outside the Harrisburg area. Because those patients travel to the Harrisburg area to receive care, the court held, the Government had failed to proffer a geographic market in which "'few' patients leave…and 'few' patients enter." *Id*. at 10 (quoting *Little Rock Cardiology Clinic PA v. Baptist Health*, 591 F.3d 591, 598 (8th Cir. 2009)).

The court also found it "extremely compelling" for purposes of geographic market definition that the hospitals have entered into long-term contracts with two large insurers that "maintain existing rate structures." App. 13-14. The court elaborated that, in applying the hypothetical monopolist test, it "simply cannot be blind to [the] reality" that defendants cannot increase prices to these two insurers for at least five years. *Id*. at 14. The court declined to make a "prediction" of what might happen to prices in 5 years, stating that doing so would be "imprudent." *Id*.

At no point in its analysis did the court discuss how hospital prices are established or describe the bargaining dynamic between hospitals and insurance companies. Nor did the court mention how insurers create their provider networks or what consumers require when they chose insurance networks and use hospital care. Instead, the court rested its consideration of the geographic market entirely on Hershey's out-of-area patients and the two temporary price agreements.

Because the court determined that the Government had not established a likelihood of success on the merits of its case, it did not engage in the ordinary antitrust burden-shifting regime. *See FTC v. H.J. Heinz Co.*, 246 F.3d 708, 715 (D.C. Cir. 2001). It therefore did not require the defendants to prove that the proposed transaction would not cause anticompetitive effects. The court nevertheless went on to address the "equities," stating that the hospitals "presented ample evidence demonstrating that anticompetitive effects would not arise" from their merger. App. 15. Although the court recognized that defendants' claimed efficiencies are not a "defense to illegality," it nevertheless found the merger "would provide beneficial effects to the public, such that equitable considerations weigh in favor of denying the injunction." App. 17-18.

That "weighing of the equities" considered several factors. First, the court found that the merger would alleviate capacity constraints at Hershey because patients could be shifted from Hershey to Pinnacle. That, in turn, would allow Hershey to avoid construction of the bed tower. Second, the court found that "repositioning" by other nearby hospitals—*i.e.*, their association with large hospital systems in an attempt to attract patients—"has already occurred" and will result in a meaningful constraint on prices. Third, the district court found that the merger would beneficially affect the defendants' ability to engage in "risk-based contracting," a method of payment in which the hospital accepts some of the risk

ordinarily borne by the insurer. The court reached that determination even though it also found that "Hershey and Pinnacle independently are capable of continuing to operate under the risk-based model." App. 26.

The FTC and the Commonwealth of Pennsylvania appeal from that decision. On May 24, 2016, a panel of this Court enjoined the merger pending appeal.

SUMMARY OF ARGUMENT

Hershey and Pinnacle are by far the two largest hospital systems in the Harrisburg area. Their merger will eliminate competition between them and result in a single dominant hospital system with a 76 percent market share. Insurers will be unable to successfully market a network without the merged hospitals, which will therefore enjoy greatly enhanced bargaining power. The upshot will be substantial price increases and lower incentives to improve quality of care.

The Clayton Act prohibits mergers that "*may* … substantially lessen competition." 15 U.S.C. § 18 (emphasis added). Section 13(b) of the FTC Act authorizes a court to enjoin a merger pending an administrative adjudication where the Government is "likely" to prove a merger unlawful. The Government satisfied both statutes here, and the district court therefore committed error when it declined to enjoin the merger.

1. The Government showed that the four-county Harrisburg area is a proper antitrust geographic market. The district court committed errors of both law and fact when it rejected that proposed market.

A geographic market is the area where buyers may "rationally look" to purchase services. Determining the relevant geographic market in an antitrust case must be grounded in the commercial realities faced by the relevant customers—here, insurers. Insurers bargain with hospitals over prices and they pay the bills directly. Defendants do not dispute this. The evidence clearly showed that insurers that wish to sell policies in the four-county Harrisburg area must purchase hospital services in that area because area residents overwhelmingly use Harrisburg-area hospitals and require policies that include local hospitals. As a result, insurers cannot rationally look to hospitals outside of the area if they wish to have a marketable product.

As the parties and the district court acknowledge, geographic markets are properly assessed using the "hypothetical monopolist test" set forth in the *Horizontal Merger Guidelines*. As that test applies here, the relevant question is whether a hypothetical owner of all Harrisburg area hospitals (*i.e.*, the monopolist) could successfully demand a price increase from insurers. If so, then the Harrisburg area is a properly defined antitrust market.

The Government submitted overwhelming evidence, including testimony from Central Pennsylvania's two largest insurers, that insurers would pay a demanded price increase rather than market a network without Harrisburg area hospitals. Nevertheless, the district court rejected the Harrisburg area as an antitrust market. In doing so, the district court committed three independent legal errors, all stemming from its failure to consider the commercial realities of the hospital marketplace and to properly formulate and apply the hypothetical monopolist test. Any one of those errors would justify reversal.

First, the court completely ignored both the role of insurers in negotiating hospital prices and the bargaining process through which hospital prices are set. Erasing the role of insurers in turn led the court to disregard the critical and conclusive evidence that an insurance network that does not include Harrisburg-area hospitals is not marketable to Harrisburg-area employers, and that an insurer would rather pay more than create a network without them. Instead, the district court based it analysis of the geographic market on the fact that a subset of Hershey's patients travel to Hershey from outside the area. The preferences of those patients have no bearing on the central question whether insurers can market a network to Harrisburg area employers without area hospitals. The district court's focus on out-of-area patients, rather than on the relevant insurance company

buyers, was unmoored from the "commercial reality" of the hospital marketplace, a basic error of law.

Second, the court misapplied the hypothetical monopolist test. The *Merger Guidelines* require analysis of whether the hypothetical monopolist could raise prices at *any* of the merging firms' hospitals. The court therefore should have asked whether a hypothetical monopolist of Harrisburg area hospitals could raise prices at either Hershey or Pinnacle. But the court completely failed to examine whether prices could be raised at Pinnacle. That too was legal error.

Third, the district court committed yet another fundamental error of law when it based its application of the hypothetical monopolist test on private price agreements between the hospitals and two large insurance companies. Such agreements have no proper place in the inquiry, as established by legal precedent. The insurers sought these agreements as protection from what they perceived as the likely price increases from the merger. Thus, if anything, the agreements prove that the Harrisburg area is a proper geographic market. Insurers would not need price protection if hospitals outside the Harrisburg area could constrain prices inside the area. Reliance on the agreements is also fundamentally inconsistent with the hypothetical monopolist test, which assumes that buyers actually face a price increase and asks how they would react. Insurers testified as to what they would

do if faced with a price increase demand from a combined Hershey and Pinnacle: they would accept it.

Reliance on such private agreements in defining a geographic market has troubling implications that go beyond this case. Under the district court's approach, merging parties with presumptively unlawful market shares would be able to stymie a proposed geographic market merely by privately agreeing not to raise prices

2. In light of the court's errors in assessing the geographic market, its consideration of the "equities" provides no independent basis to affirm its denial of the injunction. Had the court not erred about the market, it necessarily would have found the merger presumptively unlawful, and defendants would then have faced the heavy burden of proving either that the merger clearly was not anticompetitive or that it was nevertheless justified by extraordinary efficiencies. The court's cursory review of defendants' claimed benefits of the merger under the guise of equities in no way justifies the merger.

The principal efficiency defense examined by the court was defendants' claim that the merger would relieve overcrowding at Hershey by allowing it to shift patients to Pinnacle. The hospitals claimed that doing so would enable Hershey to avoid building a new 100-bed facility costing $277 million. But under the law, canceling the construction of a new facility is not an efficiency at all; it is

a reduction in output and therefore an anticompetitive harm. Moreover, the court did not undertake the rigorous analysis needed to evaluate and verify an efficiency claim. Instead, the court uncritically relied on the testimony of two of defendants' own executives that they would build the bed tower absent the merger. Such "speculation and promises about post-merger behavior" are badly insufficient under a proper antitrust analysis.

The court also wrongly analyzed defendants' "repositioning" defense. Defendants claim that affiliations between other hospitals in Central Pennsylvania and larger health care systems from out of the area will negate the anticompetitive effects of this merger. Much of the repositioning on which the district court relied has already occurred, however, yet the evidence showed that insurers *still* could not defeat a price increase demanded by a combined Hershey/Pinnacle. Repositioning therefore cannot possibly alleviate the price consequences of this merger. This merger is substantially likely to lessen competition in violation of the Clayton Act, and it should have been enjoined until the adjudicative process has run its course.

STANDARD OF REVIEW

This Court reviews a district court's denial of a preliminary injunction under three standards: findings of fact for clear error; conclusions of law de novo; and the ultimate decision to grant or deny the preliminary injunction for abuse of

discretion. *Miller v. Mitchell*, 598 F.3d 139, 145 (3d Cir. 2010) (*citing McTernan v. City of York*, 577 F.3d 521, 526 (3d Cir. 2009)). "Factual findings are clearly erroneous if the findings are unsupported by substantial evidence, lack adequate evidentiary support in the record, are against the clear weight of the evidence or where the district court has misapprehended the weight of the evidence." *United States v. 6.45 Acres of Land*, 409 F.3d 139, 145 n.10 (3d Cir. 2005) (quoting *United States v. Roman*, 121 F.3d 136, 140 (3d Cir. 1997)); *see also Lame v. U.S. Department of Justice*, 767 F.2d 66, 70-71 (3d Cir. 1981). A district court also commits clear error when its finding of fact is "completely devoid of a credible evidentiary basis or bears no rational relationship to the supporting data." *Shire U.S., Inc. v. Barr Labs., Inc.*, 329 F.3d 348, 352 (3d Cir. 2003) (quoting *American Home Prods. Corp. v. Barr Labs., Inc.*, 834 F.2d 368, 370-71 (3d Cir. 1987)).

A district court's definition of an antitrust geographic market is typically regarded as a question of fact reviewed for clear error. *E.g., Borough of Lansdale v. Phila. Elec. Co.*, 692 F.2d 307 (3d Cir. 1982). But review is de novo where the lower court is alleged to have erred "in formulating or applying legal principles," including analytical flaws. *Allen-Myland, Inc. v. International Business Machines Corp.*, 33 F.3d 194, 201-204 (3d Cir. 1994). *See* L.A.R. 28.1(b) (Court engages in "plenary review" where the district court "erred in formulating or applying a legal precept"). Thus, the Court will review de novo when a district court does not

"apply the correct legal standard" to analyze a case. *A.J. Canfield Co. v. Honickman*, 808 F.2d 291, 307 (3d Cir. 1986); *accord Sabinsa Corp. v. Creative Compounds, LLC*, 609 F.3d 175, 182 (3d Cir. 2010); *see also White & White, Inc. v. American Hospital Supply Corp.*, 723 F.2d 495, 499-500 (6th Cir. 1983) (in antitrust cases, court will "freely review[] … as a matter of law" district court's "formulation of the market tests").

As set forth below, the district court failed to properly formulate and apply the test used to define a relevant geographic market, and that determination should be reviewed de novo. But even if the Court determines to review under a more lenient standard, the district court clearly erred in its assessment of the market and the equities.

ARGUMENT

Section 7 of the Clayton Act prohibits mergers that "may" substantially lessen competition or tend to create a monopoly. 15 U.S.C. § 18. Congress used the word "may" deliberately, for its "concern was with probabilities, not certainties." *United States v. El Paso Natural Gas Co.*, 376 U.S. 651, 658 (1964); *accord Brown Shoe Co., Inc. v. United States*, 370 U.S. 294, 323 (1962). The Clayton Act thus creates an "expansive definition of antitrust liability." *California v. American Stores Co.*, 495 U.S. 271, 284 (1990).

Congress vested principal responsibility for enforcement of Section 7 with the FTC through an administrative adjudication. *See Heinz*, 246 F.3d at 714. But it recognized that agency proceedings take time and thus provided a mechanism to maintain the status quo pending the administrative process, thereby preventing interim harm to competition and preserving the Commission's ability to fashion effective relief. Specifically, Section 13(b) of the FTC Act authorizes a federal district court to grant a preliminary injunction "[u]pon a proper showing that, weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest." 15 U.S.C. § 53(b)(2); *Heinz*, 246 F.3d at 714 n.5.[5]

The Government met both prongs of that test, and this Court should either enjoin the merger itself or direct the district court to do so. In seeking a preliminary injunction, the Government is "not required to *establish* that the proposed merger would in fact violate Section 7." *Heinz*, 246 F.3d at 714 (emphasis in original). Rather, Section 13(b) requires only that the Government show a *likelihood* that the merger ultimately will be found unlawful. "[D]oubts are to be resolved against the transaction." *FTC v. Elders Grain, Inc.*, 868 F.2d 901, 906 (7th Cir. 1989).

[5] Section 16 of the Clayton Act also permits a State to seek injunctive relief against a threatened antitrust violation. 15 U.S.C. § 26.

I. THE GOVERNMENT IS LIKELY TO SUCCEED ON THE MERITS

The Government demonstrated that the merger will likely be found unlawful in the administrative adjudication. Setting aside for the moment the validity of the Government's proposed geographic market, the evidence shows that the combined hospital system would have a 76 percent market share and extraordinarily high HHI figures. Such concentration is "so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects." *Philadelphia Nat'l Bank*, 374 U.S at 363.

Had the district court properly found the Harrisburg area to be a relevant geographic market, it necessarily would have found the merger to be presumptively illegal. At that point, defendants would have borne the burden to "clearly show that their combination would not cause anticompetitive effects," App. 15, or to show "extraordinary efficiencies," *Heinz*, 246 F.3d at 720-21. The district court did not seriously assess these issues, but the record is clear that defendants would not have met their heavy burden. In the administrative adjudication, they are unlikely to overcome the presumption that the merger is unlawful.

The district court reached none of these issues because it found that the Government had not shown the four-county Harrisburg area to be a proper antitrust

geographic market. We show below that the court committed multiple fundamental errors in reaching that determination. In particular, it ignored entirely the commercial reality of the hospital market and the bargaining process by which prices are set.

The Government presented overwhelming evidence that the relevant geographic market is the Harrisburg area. As the Government's expert explained at the hearing, the relevant question to ask in determining the relevant geographic market is whether the direct purchasers—insurers—would pay a higher price to one of defendants' hospitals rather than attempt to market a network to Harrisburg-area consumers that includes no Harrisburg-area hospitals. Hrg. 306:11-13, 313:23-314:04 (App. 66, 70-71). The evidence conclusively established that because patients demand access to Harrisburg area hospitals, insurers could not offer a viable network without them. Insurers thus would pay at least a SSNIP to a Harrisburg area hypothetical monopolist rather than attempt to market a network with no Harrisburg area hospitals. In fact, the Government presented clear evidence that a hypothetical monopolist of defendants' hospitals alone would be able to impose a SSNIP on insurers, indicating that the Government's alleged geographic market is conservative.

A. The District Court Failed to Properly Formulate and Apply The Test For Defining A Geographic Market.

An antitrust geographic market is "the area in which a potential buyer may rationally look for the goods or services he or she seeks." *Pennsylvania Dental Ass'n v. Medical Service Ass'n of Pa.*, 745 F.2d 248, 260 (3d Cir. 1984). As this Court has recognized, "economic realities rather than a formalistic approach must govern." *United States v. Dentsply Int'l, Inc.*, 399 F.3d 181, 189 (3d Cir. 2005); *see Brown Shoe*, 370 U.S. at 336 (market definition must reflect "commercial reality"); *see also Philadelphia Nat'l Bank*, 374 U.S. at 357 (geographic market is "the area of competitive overlap" where "the effect of the merger on competition will be direct and immediate").

The district court committed three independent errors when it rejected the Government's proposed geographic market. Any of them would be sufficient in itself to overturn the ruling on review. First, and most basic, it utterly ignored the commercial reality of the hospital marketplace and how prices are set. Instead, by focusing on patients who live outside the Harrisburg area, it relied on an analysis untethered from market reality. Second, the court failed to assess whether, post-merger, the combined hospital system could raise prices at Pinnacle's hospitals. The unrebutted evidence showed that they could. Third, the court improperly rested its geographic market analysis on defendants' temporary price protection

agreements with two insurers. Such agreements play no proper role in a market determination.

1. The District Court Ignored the Commercial Reality of the Hospital Market.

The district court fundamentally erred by turning a blind eye to the role of the buyer when it rejected the Government's geographic market. There is no genuine dispute that the direct buyer in the market for hospital services is the insurance company. The parties agreed (and the district court found) that the product market was defined as general acute care services "*sold to commercial payors*." App. 9 (emphasis added). Defendants admitted in their opposition to the Government's motion for a preliminary injunction that insurers are the "relevant customers" in analyzing the markets for general acute care services. Dkt. No. 96 at 8.[6]

Yet in defining the area where buyers turn for services, the district court wholly ignored the role of the relevant buyers—insurers. Analyzing the geographic market without considering the relevant buyers was a basic error of

[6] Recent judicial and administrative decisions similarly recognize that health care mergers must be analyzed through the lens of contract negotiations between health care providers and health insurers. *See St. Luke's Health Sys.*, 778 F.3d at 784-85; *ProMedica*, 749 F.3d at 562-63; *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1083-84 (N.D. Ill. 2012); *In re Evanston*, 2007 WL 2286195, at *51-53. Even though insurers are the direct purchasers, individual consumers also suffer the adverse consequences of anticompetitive healthcare mergers.

law. In the face of considerable uncontested evidence about how insurers and hospitals negotiate prices, the role of provider networks, and the economic necessity of accommodating consumer demand for local care, the court said exactly nothing. The court thus wholly overlooked the "particular structure and circumstances" of the hospital market, *Verizon Comms. v. Law Offices of Curtis V. Trinko*, 540 U.S. 398, 411 (2004), and utterly ignored "commercial reality," *Brown Shoe*, 370 U.S. at 336.

Nor can the district court's ruling withstand factual scrutiny, because it "bears no rational relationship" to the evidence. *Shire*, 329 F.3d at 352. Both sides agreed that the market should be defined using the hypothetical monopolist test, which asks whether a buyer would pay a SSNIP to a monopoly provider in the proposed geographic area. *See Merger Guidelines* § 4.2.1; *St. Luke's Health Sys.*, 778 F.3d at 784-85. The district court seemingly agreed. App. 10. The Government presented considerable expert and fact evidence that any rational insurer would agree to pay 5 percent (or more) to keep a hypothetical Harrisburg-area monopolist in its network. Yet the court's geographic market determination is totally unmoored from both the proper analytical framework and any of that evidence.

In particular, the district court ignored the uncontested deposition testimony of Central Pennsylvania's two largest insurers that, without defendants' hospitals,

they could not successfully market a network to employers. PX01236, 48:17-22 (App. 491); PX00804, 64:13-20 (App. 317). The court ignored unrebutted testimony of one of these insurers that it would have no realistic alternative but to pay well in excess of a 5 percent increase to retain the defendants' hospitals (much less to retain a monopolist of all Harrisburg area hospitals). PX01236, 144:6-16 (App. 494); *see also* PX01201, 70:21-71:18. The court ignored unrebutted testimony of the other large insurer that it was concerned about post-merger price increases due to the defendants' increased bargaining leverage. PX00378-002 (App. 221). It also ignored deposition testimony from one of those large insurers that without either Hershey or Pinnacle in its network, it would lose half its membership in Dauphin County—and a natural experiment proving that would in fact happen. PX01236 (App. 494), 144:6-16; PX00704 ¶10. Indeed, the insurer that attempted to market a network without either Hershey or Pinnacle lost half of its customers even though its network contained many of the very hospitals outside the Harrisburg area that the district court deemed to be within a proper market. PX00704 ¶10; PX01542-002. The undisputed testimony that insurers, even the largest ones, were concerned that the merger would force them to pay increased prices, *e.g.*, PX01200, 34:8-20 (App. 458), cannot be reconciled with the court's view of the geographic market. Defendants' merger would have caused no consternation if hospitals outside the Harrisburg area could readily substitute in

insurer networks for Hershey and Pinnacle and thereby constrain their prices. All of these failures to address unrebutted evidence from the relevant customers affected by the merger render the court's decision "completely devoid of a credible evidentiary basis." *Shire*, 329 F.3d at 352.

Those basic analytical errors are not salvaged by the court's reliance on the statistic that 43.5 percent of Hershey patients reside outside of the Harrisburg area and travel up to an hour to get there. App. 13. In the court's view, those patients would go elsewhere if Hershey and Pinnacle raised prices post-merger, and the merged firm therefore would be constrained. But the court cited no record evidence that these patients would use other hospitals if Hershey and Pinnacle raised their prices, and there is none. The court's central conclusion is no more than sheer speculation.

To the contrary, the court's conclusion cannot be squared with the economic functioning of the insurance market. First, although Hershey attracts patients from Lancaster, Pittsburgh, and other distant places, its doing so does not alter the "commercial reality" that insurers wishing to sell policies to the substantial population of the four-county Harrisburg area must have Harrisburg-area hospitals in their networks—and would pay significantly increased prices in order to keep them. Harrisburg-area consumers demand local care and would not purchase an insurance policy that required them to drive 65 minutes away for hospital

treatment. Hrg. 314:12-316:4 (App. 71-73); 415:7-416:15; 474:7-10; 521:17-522:6 (App. 106-107); PX01277-001. Far beyond a mere SSNIP, one of the largest insurers in Central Pennsylvania testified that it would have no realistic alternative but to pay prices up to 25 percent higher rather than attempting to sell a policy without Hershey or Pinnacle in the network. PX01236, 91:16-25, 144:6-16 (App. 493-494).[7]

Furthermore, the district court was wrong that price increases at "a hypothetical monopolist such as the combined Hospitals" would cause consumers to seek care at other hospitals within the court's broader geographic market. App. 13. In fact, price plays little role when patients choose between in-network hospitals. Rather, insured patients pay roughly the same amount to go to any in-network hospital. PX01062-55; PX01424-061. As the Ninth Circuit thus recognized in directly analogous circumstances, the marketplace reality is that patients "would not change their behavior in the event of a SSNIP" because "the

[7] By defining the geographic market based on patient in-flow, the district court essentially applied the discredited "Elzinga-Hogarty" test, which has been rejected for use in analyzing hospital mergers by the FTC and by its own creator. The test was created for markets with posted prices like coal and accounts for neither the role of the insurer in setting prices nor the price-insensitivity of patients. *See In re Evanston*, 2007 WL 2286195 at **64-66; PX01062-110-115. No recent court has used the analysis; to the contrary recent judicial decisions recognize that health care mergers are properly analyzed by scrutinizing the relative bargaining power of healthcare providers and insurers. *See St. Luke's Health Sys.*, 778 F.3d at 784-85; *ProMedica*, 749 F.3d at 562-63; *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1083-84.

impact of a SSNIP likely would not register." *St. Luke's Health Sys.*, 778 F.3d at 785.

Even though consumers demand local care and insurers thus require local hospitals in their networks, the court's geographic market analysis leads inevitably to an absurdly large geographic market encompassing Harrisburg, Lancaster, York, and even more distant places. But unrebutted evidence (including the chart reproduced at page 11 above) showed that 91 percent of Harrisburg area residents seek care in the four-county area and that fewer than 2 percent of them go to the largest hospitals in Lancaster and York counties. PX01062-120-122. Similarly, residents of Lancaster and York overwhelmingly use hospitals in their own home counties. PX01062-100. Indeed, insurers testified that hospitals in York and Lancaster are able to demand higher prices because they face limited local competition. PX00704 ¶13; PX00701 ¶17 (App. 268); PX00700 ¶17; PX00804, 34-35, 102-103 (App. 316, 319); PX01201, 142:19-144:25. This commercial reality is undisturbed by the fact that some subset of patients have travelled beyond their local area for hospital care. *See Houser v. Fox Theatres Mgmt. Corp.*, 845 F.2d 1225, 1229-1230 n.10 (3d Cir. 1988) ("evidence that a minority of customers might travel to Harrisburg, Lancaster or even Philadelphia to attend a picture unavailable in Lebanon" does not show that "the relevant geographic market should be expanded to include those cities as a matter of law").

2. The District Court Failed To Assess Whether Pinnacle Could Impose A SSNIP

The court committed a second, and independent, error of law when it failed to apply the hypothetical monopolist test to Pinnacle's hospitals. The test requires an inquiry into whether the monopolist could impose a SSNIP "from at least one location" of the merging firms. *Merger Guidelines* § 4.2.1. As applied here, the geographic market is properly defined as the four-county Harrisburg area if a hypothetical monopolist of Harrisburg-area hospitals could profitably impose a post-merger SSNIP at *any* of Pinnacle's hospitals *or* at Hershey. The district court plainly did not engage in this analysis with respect to Pinnacle, which is barely mentioned in the opinion.

The failure to consider price increases at Pinnacle is especially striking in light of unrebutted evidence that: (a) insurers were specifically concerned that the merger would allow defendants to substantially raise prices at Pinnacle, PX00612-003; (b) one insurer successfully defeated Pinnacle's demand for a large price by threatening to construct a network that included Hershey but not Pinnacle; and (c) Pinnacle overwhelmingly draws its patients from within the Harrisburg area. PX01062-26-27. The linchpin of the district court's reasoning—that patients who currently travel long distances to Hershey will choose not to do so if it raises prices—therefore does not apply to Pinnacle. Even if the district court were right about Hershey (which it was not), the court's theory would not support a finding

that Pinnacle's prices will be constrained by hospitals closer to patients outside the Harrisburg area.

3. The District Court Improperly Based Its Geographic Market Analysis On Defendants' Temporary Price Protection Agreements with Two Insurers.

The court committed yet a third independent error of law when it based its analysis of the geographic market on private price agreements between defendants and two large insurers.

As described above, the proposed merger raised alarm among area insurers that the merged hospitals could successfully demand a price increase. In exchange for the promise of the two largest insurers not to complain to the FTC about the merger, defendants entered into contracts with those insurers promising limited price increases for several years. PX00029-001-02; PX00503-004; PX01000-001; PX01011-002; PX00664-001; PX00804, 77:23-78:8 (App. 318). Specifically, the agreements maintain the price differential between Hershey and the lower-cost Pinnacle and limit price increases to stated amounts for at least 5 years.

The court relied on the price agreements in its geographic market analysis. After reciting that it "heard hours of economic expert testimony regarding the hypothetical monopolist's ability to impose a SSNIP," the court stated it found the protection agreements to be "extremely compelling" evidence to the contrary. App. 13. The court reasoned that because the agreements restrict defendants from

raising prices for at least 5 years, it "simply cannot be blind to this reality when considering the import of the hypothetical monopolist test." *Id*. 14. The court then concluded that in light of the agreements, the relevant time period for performing the hypothetical monopolist test would be five years from now. *Id*. Yet the court refused to examine that time period, finding it speculative to do so. It then added that it did "not find that the outcome of the hypothetical monopolist test aids the FTC in this matter." *Id*.

That reasoning suffers from multiple serious flaws. To begin with, the court failed to acknowledge that the very existence of the price protection agreements reveals that insurers do not view hospitals outside the Harrisburg area as "realistic alternatives" to the defendants that would allow them to defeat a SSNIP. If they did, they would have had no need to enter into such agreements, but would have been able to constrain Hershey and Pinnacle's prices by threatening to use non-Harrisburg area hospitals in their networks. The insurers' need to enter into post-merger price protections is an admission of anticompetitive concern that "strongly supports the fears of impermissible monopolization." *FTC v. Cardinal Health*, 12 F. Supp. 2d 34, 67 (D.D.C. 1998).

More fundamentally, the price protection agreements have no proper place in a geographic market analysis. The hypothetical monopolist test is just that—hypothetical—and it asks how customers would react to a SSNIP. The court,

however, assumed that the agreements prevented the monopolist from imposing a SSNIP, App. 14, thus defeating the whole purpose of the inquiry, which *necessarily* assumes that customers face the SSNIP, unprotected by a contract. This assumption is explicit in the *Merger Guidelines*, which hinge market definition "solely on demand substitution factors, *i.e.*, on customers' ability and willingness to substitute away from one product to another in response to a price increase." *Merger Guidelines* § 4. The record is clear about how the two largest insurers would react to a SSNIP: one testified it would have no realistic alternative but to pay well in excess of a SSNIP (PX01236, 91:16-25,144:6-16 (App. 493-494)); and the other testified it could not successfully market a network without the merged firm and estimated substantial potential price increases as a result of the merger. PX00612-003; PX00613-001.

This Court has recognized the irrelevance of private contracts to antitrust market determination. In *Queen City Pizza v. Domino's Pizza*, 124 F.3d 430, 438-439 (3d Cir. 1997), the Court held that a plaintiff's particular contractual restraints did not alter the determination of a product market, which turns on whether the products are interchangeable. It explained that in making a market determination the Court does not "look[] … to the contractual restraints assumed by a particular plaintiff." The Court recognized that "no court has defined a relevant product

market with reference to the particular contractual restraints of the plaintiff." *Id*. at 438-439.

The court's refusal to assess a hypothetical monopolist's ability to impose price increases after the price agreements expire because doing so would be "imprudent" was also error. App. 14. The record was again clear about what would happen on expiration. One of the two insurers testified that at that point it would have no realistic choice but to give in to price increase demands. Indeed, the witness suggested that to keep the merged hospitals in its network, the company would be willing to pay as much as 25 percent more—five times higher than a SSNIP. PX01236, 91:16-25, 144:6-16 (App. 493-494). The future may be unpredictable, but the risk of anticompetitive price increases is not. The court's ruling thus cannot be squared with the underlying thrust of the Clayton Act that courts should protect against the *likelihood* of anticompetitive effects and that "doubts are to be resolved against the transaction." *Elders Grain*, 868 F.2d at 906.

The court's reliance on the price agreements is erroneous in several additional ways. It fails to consider the effect of the merger on insurers in the Harrisburg area that are *not* covered by the price agreements. Those companies would be immediately subject to price increases as a result of defendants' enhanced bargaining power. It fails to consider the limited scope of the agreements, which cover fee-for-service prices but do not apply to other types of

payment contracts, which the court viewed as becoming increasingly important in the modern era. App. 26. With respect to those prices, the hospitals are free to demand any increase they wish. And it fails to consider the harm to patients when hospitals no longer compete over quality of care.

Beyond mere error, the court's reliance on private price agreements to define a geographic market marks an unprecedented departure from legal precedent and from the standard framework of antitrust analysis employed by the nation's antitrust enforcers. The district court's ruling has troubling implications beyond this case, for it would empower merging parties with presumptively unlawful market shares to stymie a proposed geographic market by privately agreeing not to raise prices.

B. The District Court's Assessment Of The "Equities" Cannot Justify The Merger.

Defendants argued in response to the Government's motion for injunction pending appeal that the district court's determination of the "equities" supports its decision. Not so. Nothing about the court's discussion of the equities offers an independent basis to affirm its denial of the preliminary injunction. In fact, the court's erroneous assessment of the geographic market fatally infected its subsequent analysis. Had the court properly found the Harrisburg area to be a relevant geographic market, it necessarily would have found the merger to be presumptively illegal. The burden then would have shifted to defendants either to

"'clearly' show that their combination would not cause anticompetitive effects," App. 15, or to show "extraordinary efficiencies." *Heinz*, 246 F.3d at 720-21. The court never put defendants to the burden of crossing that hurdle. On the record before the district court, they could not have met that burden. Indeed, no court has ever found a presumptively unlawful merger to be saved by efficiencies.

An efficiency defense requires antitrust defendants to prove four elements. First, they must prove "extraordinary efficiencies" that offset the anticompetitive concerns in highly concentrated markets. *St. Luke's Health Sys.*, 778 F.3d 790 (citing *Heinz*, 246 F.3d at 720-22). Second, they must demonstrate that the claimed efficiencies are "merger-specific," *i.e.*, they can be achieved only via the merger. *St. Luke's Health Sys.*, 778 F.3d at 790 (citing *United States v. H & R Block, Inc.*, 833 F. Supp.2d 36, 89–90 (D.D.C. 2011)). Third, they must show that the efficiencies are "verifiable" and not "speculative." *St. Luke's Health Sys.*, 778 F.3d at 791. The analysis of those factors must be "rigorous" to ensure that alleged efficiencies "represent more than mere speculation and promises about post-merger behavior." *Heinz*, 246 F.3d at 721. Fourth, claimed efficiencies must "'not arise from anticompetitive reductions in output or service'." *H&R Block, Inc.*, 833 F. Supp. 2d at 89 (quoting *Merger Guidelines* § 10).

Because the district court found the geographic market issue dispositive of the Government's case, it did not engage in an efficiencies analysis, under which

defendants would have borne the substantial burden of proving each element of the defense. Instead of performing the rigorous inquiry required for an efficiencies defense, the court transformed it into a gratuitous discussion of the "equities" that lacked any analytical rigor.

Similarly, the district court failed to properly assess defendants' argument that repositioning by hospitals outside the Harrisburg area would fill the "competitive void" created by the merger and "clearly" prevent the likely anticompetitive harm.

1. Defendants' Plan to Reduce Capacity By Foregoing Construction Of Additional Facilities Is Neither An Efficiency Nor An "Equity."

Defendants claimed below that patient demand for service at Hershey exceeds the number of beds available, and that the merger increase its capacity, allowing Hershey to avoid construction of an expensive bed tower. The district court accepted those claims and determined that "the Hospitals have presented a compelling efficiencies argument … in that the merger would alleviate some of Hershey's capacity constraints." App. 17. The court also found that Hershey's avoidance of a large capital outlay to construct the new facility would also benefit consumers. App. 21-22.

As an initial matter, the court's analysis turns antitrust law on its head by converting a reduction in output—an anticompetitive *harm*—into a *benefit* of the

merger. A merging entity's pledge to cancel a planned capacity expansion as the result of the merger is not an "efficiency" that can somehow justify the deal. It is a classic reduction in output that will lead to higher prices. For that reason, a nearly identical claim was specifically rejected as non-cognizable by a federal district court enjoining a hospital merger. *FTC v. ProMedica Health Sys., Inc.*, WL 1219281 at *36 (N.D. Ohio Mar. 29, 2011); *see Merger Guidelines* § 10. Investment in businesses serve to "enhance consumer welfare" and when "competition-driven investments are 'avoided,' consumers are generally left worse off." *ProMedica*, *supra*. Yet the district court did not even consider that dimension of the issue, although the Government squarely raised it.

If Hershey and Pinnacle do not merge and Hershey constructs the bed tower, it will have both the additional ability to serve the public and the incentive to fill the new beds, in part by competing with Pinnacle on price and quality of care. Both outcomes would result in substantial consumer benefits. By contrast, if the hospitals merge and the tower project is canceled, there will be fewer beds to serve the public and a reduced incentive to lower prices and compete on quality. Consumers will be worse off. Hrg. 341:5-342:7 (App. 84-85).

Moreover, the district court's conclusion that the merger will add bed capacity is plainly wrong. The merger merely combines two existing facilities; it cannot add a single bed to the supply now available in the Harrisburg area. If

Hershey is currently full, it can refer patients to Pinnacle, where the vast majority of them can receive the very same high-quality treatments they seek at Hershey. Hrg. 716:7-15, 717:1-718:9.

In any event, the district court could not properly have found the bed tower claim to be a "compelling efficiencies argument" because the court failed to engage in the rigorous efficiencies analysis. The Government presented overwhelming evidence that defendants' capital avoidance claim failed because there is no relationship between Hershey's actual bed need and defendants' claim that Hershey could solve any capacity issues only by building a $277 million, 100-bed tower.[8]

Yet the court relied on the very sort of "speculation and promises about post-merger behavior" that *Heinz* rejected. It uncritically accepted the self-serving statements of defendants' executives that they would build the bed tower absent the merger. The court even chastised the Government for "impermissibly" asking it to "second guess Hershey's business decision in building the tower." App. 21. And although the court admitted that Hershey may have "partially overstated" the

[8] Defendants' efficiencies expert admitted that Hershey needs only 13 beds to alleviate its capacity constraints today, and only 36 beds in five years. PX01343-069; Hrg. 767:15-21. Defendants' contention that this modest need can be remedied only through the construction of a 100-bed tower or merger with Pinnacle cannot withstand scrutiny. *See, e.g.*, PX00258; PX00754-059; PX01238, 279:18-22.

cost of alleviating its capacity issues, it failed to make any attempt to determine the magnitude of that overstatement. App. 20. Indeed, the court wrongly stated that it was not within its "purview to question" these statements and concluded that defendants' testimony on this issue "is sufficiently reliable." *Id*. That is not the way a proper antitrust efficiency analysis is conducted.

The court's insistence that it must accept defendants' business decision to build a bed tower has troubling implications similar to its reliance on temporary rate agreements to find against the Government on geographic market. If the court's deference were proper, then any defendant could proffer any efficiency justification for a merger without having to show that it meets the strict requirements of an efficiency defense. That approach would upend decades of merger law.

2. The District Court Improperly Analyzed Defendants' Risk-Based Contracting Claim.

Risk-based contracting is a developing payment model in which healthcare providers bear some financial risk and share in financial upside based on the quality and value of the services they provide. Hrg. 128:13-20. It is an alternative to the traditional fee-for-service model in which the hospital receives a payment for every service performed and the insurer bears the risk. The district court found that the merger enhanced the hospitals' efforts to engage in risk-based contracting to the benefit of the public.

The district court found "persuasive" the testimony of Hershey's CEO that "there will be some advantages in terms of size of scale, in terms of being able to spread of costs [sic] of the infrastructure of population health over a larger health care system." App. 26. But the court did not analyze whether such a claim was verifiable—and it could not have done so since it relied not on extrinsic evidence but only on the self-interested testimony of Hershey's own chief executive.

Nor does the evidence support the claim that risk-based contracting is an "equity" that weighed against an injunction. The evidence showed that hospitals and insurers engage in the same bargaining process for risk-based contracts that they do for traditional ones. PX01422-016-017 (McWilliams Rebuttal Report); PX01062-065. The merger will enable the combined hospital system to use its market power to obtain higher reimbursement from insurers under a risk-based approach for the very same reasons it can obtain higher fee-for-service prices. Hrg. 348:21-349:6 (App. 86-87); PX01236, 165:21-166:2 (App. 495). Thus, allowing the creation of a near-monopoly hospital system no more serves "equity" with respect to risk-based contracting than it does with any other form of business dealing.

The court speculated that changing from fee-for-service to risk-based contracting would have a "beneficial impact" because it would allow Hershey to "continue to use its revenue to operate its College of Medicine and draw high-

quality medical students and professors into the region." App. 26. It then assumed, without any analysis, that additional post-merger revenue to Hershey from risk-based contracting would inure to the benefit of consumers. But for the reasons explained above, the combined hospitals will be able to obtain higher prices—and consumers will ultimately bear the increase. Hrg. 348:21-349:6 (App. 86-87); PX01236, 165:21-166:2 (App. 495). That is not an "equity."

3. "Repositioning" By Other Hospitals Will Not Negate The Anticompetitive Effects Of The Merger.

The district court stated in passing that "the Hospitals presented ample evidence demonstrating that anticompetitive effects would not arise through the merger of Hershey and Pinnacle." App. 15-16. But the only evidence it cited for this conclusion had to do with the affiliation of hospitals in and around the Harrisburg area with large outside health systems and a trauma center being developed at one hospital. App. 26-28. That evidence does not support the court's conclusion.

In antitrust law, "repositioning" refers to a response by competitors that is sufficient to deter or counteract the anticompetitive effects of a merger. *Merger Guidelines* § 6.1. *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 148-150 (D.D.C. 2004). To be credited as "repositioning," the expansion or development should be "equivalent to new entry" and "greatly reduce[] the anticompetitive effects of a merger." *FTC v. CCC Holdings, Inc.*, 605 F. Supp. 2d 26, 57 (D.D.C. 2009)

(citing *Arch Coal*, 329 F. Supp. 2d at 148). Antitrust defendants therefore must show that repositioning will be timely, likely, and sufficient to constrain market power. *Merger Guidelines* § 6.1; *see also FTC v. Sysco*, 113 F. Supp. 3d 1, 80 (D.D.C. 2015) (defendants bear the burden of demonstrating the ability of other competitors to "fill the competitive void" that will result from the proposed merger) (citing *FTC v. Swedish Match*, 131 F. Supp. 2d 151, 169 (D.D.C. 2000)).

First, the court credited as "repositioning" developments that had *already* occurred. But overwhelming evidence from insurers showed that, even considering all of the recent developments, they could not defeat a price increase if Hershey and Pinnacle merge. The district court ignored that evidence, which defeats any possible claim that past repositioning will constrain hospital prices in the Harrisburg area.

Indeed, although the court pointed to a number of affiliations, such as Geisinger's purchase of Holy Spirit Hospital, it failed to ask the critical question whether such "repositioned" hospitals could replace Pinnacle or Hershey *in an insurer's network* for Harrisburg area residents. For all the reasons discussed above, they plainly cannot. *See also* PX1201, 255:7-18 (deposition testimony of a large insurer explaining "we don't believe that we could create a Holy Spirit-centric product, we don't believe their scope of services is broad enough"). The court's analysis was also infected by its error in defining the geographic market.

Believing that the market included places outside the Harrisburg area, the court considered the repositioning of hospitals in places like Lancaster. Such hospitals could not replace Hershey or Pinnacle in an insurance network marketed to Harrisburg-area residents.

Second, the district court did not seriously consider whether future repositioning by hospital systems inside the Harrisburg area would be sufficient to counteract anticompetitive effects from the merger. For example, the court noted Holy Spirit's plans to develop a Level II trauma center, but it did not assess whether the trauma center would make Holy Spirit a suitable post-merger replacement for a combined Hershey/Pinnacle in an insurer network. It also ignored unrebutted evidence that the trauma center would have a negligible impact on competition with the merged parties (*see, e.g.*, PX01221, 56:25-59:3, 96:16-98:1). Repositioning by Holy Spirit would not have the constraining power of "new entry." *CCC Holdings*, 605 F. Supp. 2d at 57. The court also again ignored evidence from a large area insurer that it did not believe it would be able to defeat a substantial price increase five years from now if the combined entity raised rates –indicating future repositioning will not be sufficient to constrain defendants.

4. The Affordable Care Act Does Not Justify Anticompetitive Mergers.

The district court stated that its decision was informed by "a growing need" for hospitals "to adapt to an evolving landscape of health care that includes … the

institution of the Affordable Care Act." App. 28. The court found that the ACA "has created a climate that virtually compels institutions to seek alliances such as the Hospitals intend here." *Id.* In other words, the court determined that the perceived needs of the healthcare system must take precedence over the antitrust laws. That conclusion was legal error.

The Clayton Act contains no healthcare exception. To the contrary, the Supreme Court determined long ago that Congress declined to provide antitrust exceptions "for specific industries" and rejected the notion that "monopolistic arrangements will better promote trade and commerce than competition." *National Society of Professional Engineers v. United States*, 435 U.S. 679, 689-90 (1978). The antitrust laws thus "apply to hospitals in the same manner that they apply to all other sectors of the economy." *Boulware v. Nevada*, 960 F.2d 793, 797 (9th Cir. 1992). Indeed, Congress recognized as much in the Affordable Care Act itself, which provides that it "shall not be construed to modify, impair, or supersede the operation of any of the antitrust laws." 42 U.S.C. § 18118(a) (2010).

5. The District Court Regarded Healthy Hospitals As If They Were Failing Firms.

In passing, at the very end of its opinion, the district court surmised that "it is better for the people they treat that such hospitals unite and survive rather than remain divided and wither." App. 28. Instead of properly viewing the combination as a near-monopoly of the two close rivals, the court appears to have

incorrectly perceived Hershey and Pinnacle as embattled survivors hanging on for life.

Antitrust law recognizes a "failing firm" defense under which parties may undertake an otherwise unlawful merger if one of them is likely to go out of business anyway. *See Merger Guidelines* § 11. But defendants never asserted that the merger was necessary for their survival or that failure of either hospital system was imminent (or even likely), as the failing firm defense requires. Nor could they have. Both Pinnacle and Hershey enjoy success and robust financial health, and both continue to expand. PX01062-27, 31. Indeed, Pinnacle recently constructed West Shore Hospital, which opened in May of 2014 and has over 100 inpatient beds. They are precisely the type of firms that should be competing to the benefit of consumers, not merging to their detriment. The district court's perception of them as enfeebled underscores its deep misunderstanding of this case.

II. THE EQUITIES FAVOR AN INJUNCTION

An FTC showing of a likelihood of success on the merits creates "a presumption in favor of preliminary injunctive relief." *Heinz*, 246 F.3d at 726. No court has ever denied an injunction under Section 13(b) where the FTC has demonstrated a likelihood of success on the merits. *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1094-95 (quoting *FTC v. ProMedica Health Sys., Inc.*, No. 3:11-CV-47, 2011 WL1219281, at *60).

For the reasons set forth above, the district court improperly found the FTC unlikely to succeed in the administrative adjudication. The court's analysis of the equities was thus fatally flawed from the outset, because the court took no account of the strong "public interest in effective enforcement of the antitrust laws." *Id.*; *see FTC v. Whole Foods Market, Inc.*, 548 F.3d 1028, 1035 (D.C. Cir. 2008); *Arch Coal*, 329 F. Supp. 2d at 116. Instead, the court examined defendants' purported efficiencies as equities (and as shown above, its analysis was faulty there too) with no counterbalance.

"Congress enacted section 13(b) to preserve [the] status quo until [the] FTC can perform its function" in the adjudicative proceeding. *Heinz*, 246 F.3d at 726 (citation omitted). Thus, where the Government shows a likelihood of success on the merits in the adjudication, parties should not merge unless they show "public equities" that would "benefit their customers" "despite the likely anticompetitive effects of their proposed merger." *CCC Holdings*, 605 F. Supp. 2d at 75-76 (emphasis added).

The equities favor enjoining this merger pending the completion of the administrative adjudication. If "the merger is ultimately found to violate section 7 of the Clayton Act, it will be too late to preserve competition if no preliminary injunction has issued." *Heinz*, 246 F.3d at 727; *FTC v. Univ. Health*, 938 F.2d 1206, 1217 n.23 (11th Cir. 1991).

Indeed, the FTC has recently had unfortunate experiences trying to unwind recent unlawful healthcare mergers. In *Phoebe Putney*, the FTC attempted to enjoin the merger, but the courts denied an injunction. Two years later, after the Supreme Court ruled that the FTC could challenge the transaction, divestiture remained too difficult to achieve, and the FTC allowed the parties to remain merged. *See* https://www.ftc. gov/system/files/documents/public_statements/634181/150331phoebeputneycommstmt.pdf. In *St. Luke's*, divestiture has not yet occurred well over a year after the court of appeals found the merger unlawful—and nearly four years after the district court denied a preliminary injunction.

Granting preliminary relief therefore will both protect Harrisburg area residents who will otherwise face immediate competitive harm and enable the FTC to fashion any suitable remedy ultimately required. By contrast, if the district court's decision stands, and the merger is allowed to close, defendants will be free to integrate operations, share competitively sensitive information, and reorganize human and physical resources. It will be difficult, if not impossible, for the FTC to "unscramble the egg" and fashion effective relief to restore competition following the merits trial.

Hershey and Pinnacle showed little on the other side of the ledger. The district court characterized the purported efficiencies of the transaction as "public equities." App. 15-28. Even apart from the district court's errors in its assessment

of the alleged efficiencies, the law is clear that efficiencies cannot be deemed public equities unless there is reason to believe that they "will not still exist when the FTC completes its work." *Heinz*, 246 F.3d at 726-27; *see OSF Healthcare Sys.*, 852 F. Supp. 2d at 1088 n.16. Here, any of the alleged benefits of this merger will be available after the trial on the merits. The purported efficiencies therefore "do not constitute public equities weighing against a preliminary injunction." *OSF Healthcare Sys*., 852 F. Supp. 2d at 1095 (quotation marks and citation omitted). As the D.C Circuit put it, "[i]f the merger makes economic sense now," then absent specific evidence to the contrary, there is "no reason why it would not do so later." *Heinz*, 246 F.3d at 726.

CONCLUSION

For the foregoing reasons, this Court should reverse the decision below and enjoin the proposed merger between Hershey and Pinnacle pending the outcome of the administrative adjudication.

Respectfully submitted,

BRUCE L. CASTOR, JR.
Solicitor General

BRUCE BEEMER
First Deputy Attorney General

JAMES A. DONAHUE, III
Executive Deputy Attorney General
Public Protection Division

TRACY W. WERTZ
Chief Deputy Attorney General

JENNIFER THOMSON
AARON SCHWARTZ

PENNSYLVANIA OFFICE OF THE
ATTORNEY GENERAL
14th Floor, Strawberry Square
Harrisburg, PA 17120

DAVID C. SHONKA
Acting General Counsel

/s/ Joel Marcus
JOEL MARCUS
Director of Litigation

DEBORAH L. FEINSTEIN
MICHELE ARINGTON
WILLIAM H. EFRON
JARED P. NAGLEY
GERALYN J. TRUJILLO
RYAN F. HARSCH
JONATHAN W. PLATT
PEGGY BAYER FEMENELLA
Attorneys
FEDERAL TRADE COMMISSION
600 Pennsylvania Avenue, N.W.
Washington, D.C. 20580
(202) 326-3350
JMarcus@FTC.gov

June 1, 2016

CERTIFICATE OF COMPLIANCE WITH TYPE-VOLUME LIMITATION, TYPEFACE REQUIREMENTS, AND TYPE STYLE REQUIREMENTS

I. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because the brief contains 13,495 words.

II. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2010, in 14-point Times New Roman.

/s/ Joel Marcus

June 1, 2016

CERTIFICATE OF IDENTICAL COMPLIANCE OF BRIEFS

I certify that the text of the electronically filed brief is identical to the text of the original copies that were sent on June 1, 2016, to the Clerk of the Court of the United States Court of Appeals for the Third Circuit.

/s/ Joel Marcus

June 1, 2016

CERTIFICATE OF PERFORMANCE OF VIRUS CHECK

I certify that on June 1, 2016, I performed a virus check on the electronically filed copy of this brief using Symantec Endpoint Protection Version 12.1.6867.6400 (last updated May 31, 2016). No virus was detected.

/s/ Joel Marcus

June 1, 2016

CERTIFICATE OF SERVICE

I certify that on June 1, 2016, I filed the foregoing Brief for the Federal Trade Commission and the Commonwealth of Pennsylvania via the Court's electronic filing system. All parties have consented to receive electronic service and will be served by the ECF system.

/s/ Joel Marcus

STATUTORY APPENDIX

Contents:

United States Code Annotated
Title 15. Commerce and Trade
Chapter 1. Monopolies and Combinations in Restraint of Trade (Refs & Annos)

15 U.S.C.A. § 18

§ 18. Acquisition by one corporation of stock of another

Effective: February 8, 1996
Currentness

No person engaged in commerce or in any activity affecting commerce shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another person engaged also in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.

No person shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of one or more persons engaged in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition, of such stocks or assets, or of the use of such stock by the voting or granting of proxies or otherwise, may be substantially to lessen competition, or to tend to create a monopoly.

This section shall not apply to persons purchasing such stock solely for investment and not using the same by voting or otherwise to bring about, or in attempting to bring about, the substantial lessening of competition. Nor shall anything contained in this section prevent a corporation engaged in commerce or in any activity affecting commerce from causing the formation of subsidiary corporations for the actual carrying on of their immediate lawful business, or the natural and legitimate branches or extensions thereof, or from owning and holding all or a part of the stock of such subsidiary corporations, when the effect of such formation is not to substantially lessen competition.

Nor shall anything herein contained be construed to prohibit any common carrier subject to the laws to regulate commerce from aiding in the construction of branches or short lines so located as to become feeders to the main line of the company so aiding in such construction or from acquiring or owning all or any part of the stock of such branch lines, nor to prevent any such common carrier

from acquiring and owning all or any part of the stock of a branch or short line constructed by an independent company where there is no substantial competition between the company owning the branch line so constructed and the company owning the main line acquiring the property or an interest therein, nor to prevent such common carrier from extending any of its lines through the medium of the acquisition of stock or otherwise of any other common carrier where there is no substantial competition between the company extending its lines and the company whose stock, property, or an interest therein is so acquired.

Nothing contained in this section shall be held to affect or impair any right heretofore legally acquired: *Provided*, That nothing in this section shall be held or construed to authorize or make lawful anything heretofore prohibited or made illegal by the antitrust laws, nor to exempt any person from the penal provisions thereof or the civil remedies therein provided.

Nothing contained in this section shall apply to transactions duly consummated pursuant to authority given by the Secretary of Transportation, Federal Power Commission, Surface Transportation Board, the Securities and Exchange Commission in the exercise of its jurisdiction under section 79j of this title, the United States Maritime Commission, or the Secretary of Agriculture under any statutory provision vesting such power in such Commission, Board, or Secretary.

CREDIT(S)

(Oct. 15, 1914, c. 323, § 7, 38 Stat. 731; Dec. 29, 1950, c. 1184, 64 Stat. 1125; Sept. 12, 1980, Pub.L. 96-349, § 6(a), 94 Stat. 1157; Oct. 4, 1984, Pub.L. 98-443, § 9(l), 98 Stat. 1708; Dec. 29, 1995, Pub.L. 104-88, Title III, § 318(1), 109 Stat. 949; Feb. 8, 1996, Pub.L. 104-104, Title VI, § 601(b)(3), 110 Stat. 143.)

15 U.S.C.A. § 18, 15 USCA § 18
Current through P.L. 114-143. Also includes P.L. 114-145, 114-146, 114-148, and 114-151 to 114-154.

End of Document

15 U.S.C.A. § 53(b) (Section 13(b))

§ 53. False advertisements; injunctions and restraining orders

(b) Temporary restraining orders; preliminary injunctions

Whenever the Commission has reason to believe--

(1) that any person, partnership, or corporation is violating, or is about to violate, any provision of law enforced by the Federal Trade Commission, and

(2) that the enjoining thereof pending the issuance of a complaint by the Commission and until such complaint is dismissed by the Commission or set aside by the court on review, or until the order of the Commission made thereon has become final, would be in the interest of the public--

the Commission by any of its attorneys designated by it for such purpose may bring suit in a district court of the United States to enjoin any such act or practice. Upon a proper showing that, weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest, and after notice to the defendant, a temporary restraining order or a preliminary injunction may be granted without bond: *Provided, however*, That if a complaint is not filed within such period (not exceeding 20 days) as may be specified by the court after issuance of the temporary restraining order or preliminary injunction, the order or injunction shall be dissolved by the court and be of no further force and effect: *Provided further*, That in proper cases the Commission may seek, and after proper proof, the court may issue, a permanent injunction. Any suit may be brought where such person, partnership, or corporation resides or transacts business, or wherever venue is proper under section 1391 of Title 28. In addition, the court may, if the court determines that the interests of justice require that any other person, partnership, or corporation should be a party in such suit, cause such other person, partnership, or corporation to be added as a party without regard to whether venue is otherwise proper in the district in which the suit is brought. In any suit under this section, process may be served on any person, partnership, or corporation wherever it may be found.

CREDIT(S)

(Sept. 26, 1914, c. 311, § 13, as added Mar. 21, 1938, c. 49, § 4, 52 Stat. 114; amended Nov. 16, 1973, Pub.L. 93-153, Title IV, § 408(f), 87 Stat. 592; Aug. 26, 1994, Pub.L. 103-312, § 10, 108 Stat. 1695.)

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 16-2365

FEDERAL TRADE COMMISSION and
COMMONWEALTH OF PENNSYLVANIA,
Appellants,

v.

PENN STATE HERSHEY MEDICAL CENTER and
PINNACLEHEALTH SYSTEM,
Appellees.

APPENDIX VOLUME 1, Pages 1 - 29

Contents: **Page:**

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

FEDERAL TRADE COMMISSION and COMMONWEALTH OF PENNSYLVANIA, Plaintiffs, vs. PENN STATE HERSHEY MEDICAL CENTER and PINNACLEHEALTH SYSTEM, Defendants.	Civil Action No.: 1:15-cv-02362 Hon. John E. Jones III

NOTICE OF APPEAL

Notice is hereby given that Plaintiffs Federal Trade Commission and the Commonwealth of Pennsylvania appeal to the United States Court of Appeals for the Third Circuit from an Order of the United States District Court for the Middle District of Pennsylvania, entered on May 9, 2016 (Doc. No. 131), denying Plaintiffs' Motion For Preliminary Injunction in the above-captioned proceeding.

Dated: May 10, 2016

Respectfully submitted,

/s/ William H. Efron
WILLIAM H. EFRON
Director, Northeast Region

JARED P. NAGLEY
GERALYN J. TRUJILLO
RYAN F. HARSCH
JONATHAN W. PLATT
NANCY TURNBLACER
THEODORE ZANG
GERALD A. STEIN
PEGGY BAYER FEMENELLA
LYNDA LAO
Attorneys

Bureau of Competition
Federal Trade Commission
Northeast Region
One Bowling Green, Suite 318
New York, NY 10004
Telephone: (212) 607-2829
Fax: (212) 607-2832
Email: wefron@ftc.gov

DEBORAH L. FEINSTEIN
Director
Bureau of Competition
Federal Trade Commission

DAVID C. SHONKA
Acting General Counsel
Federal Trade Commission

Attorneys for Plaintiff Federal Trade Commission

BRUCE L. CASTOR, JR.
Solicitor General

BRUCE BEEMER
First Deputy Attorney General

JAMES A. DONAHUE, III
Executive Deputy Attorney General
Public Protection Division

/s/ Tracy W. Wertz
TRACY W. WERTZ
Chief Deputy Attorney General
Antitrust Section

JENNIFER A. THOMSON
Senior Deputy Attorney General

AARON SCHWARTZ
Deputy Attorney General

Pennsylvania Office of the Attorney General
Antitrust Section
14th Floor, Strawberry Square
Harrisburg, PA 17120
Telephone: (717) 787-4530
Email: twertz@attorneygeneral.gov

Attorneys for Plaintiff
Commonwealth of Pennsylvania

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

FEDERAL TRADE COMMISSION and COMMONWEALTH OF PENNSYLVANIA, Plaintiffs, vs. PENN STATE HERSHEY MEDICAL CENTER and PINNACLEHEALTH SYSTEM, Defendants.	Civil Action No.: 1:15-cv-2362 Hon. John E. Jones III

MEMORANDUM OPINION AND ORDER

May 9, 2016

Before the Court is a motion by Plaintiffs, Federal Trade Commission ("FTC") and the Commonwealth of Pennsylvania, pursuant to Section 13(b) of the FTC Act, 15 U.S.C. § 53(b), for a preliminary injunction enjoining Defendants, Penn State Hershey Medical Center ("Hershey") and PinnacleHealth System ("Pinnacle") (collectively, "the Hospitals"), from taking any steps towards

consummating their proposed merger pending the completion of the FTC's administrative trial on the merits of the underlying antitrust claims. For the reasons that follow, the Motion for Preliminary Injunction shall be denied.

I. BACKGROUND[1]

Penn State Hershey Medical Center is a 551-bed hospital located in Hershey, Pennsylvania. It is a leading academic medical center ("AMC") and the primary teaching hospital of the Penn State College of Medicine. (DX1160-009). Hershey offers a broad array of high-acuity services, and tertiary and quaternary care, including bone-marrow transplants, neurosurgery, and specialized oncologic surgery.[2] Hershey operates central Pennsylvania's only specialty children's hospital, one of the Commonwealth's three Level I trauma centers, and the only heart-transplant center outside Philadelphia and Pittsburgh. (DX0190-005; DX0527-010; DX1160-009; DX0803-002).

PinnacleHealth System is a not-for-profit health system with 646 licensed beds across three campuses: Harrisburg Hospital and Community General Osteopathic Hospital, both in Harrisburg, and West Shore Hospital in Cumberland

[1] Citations to the record are identified in the following ways: (1) documents already on file with the Court are cited as "Doc." followed by the docket number and any further pinpoint citation; (2) references to testimony from the evidentiary hearing are cited as "Tr." followed by the specific page numbers; and (3) exhibits are cited to by reference to their marked number, and where applicable, further pinpoint citation to the specific page, paragraph, or section.

[2] Tertiary care is sophisticated, complex, or high-tech care that includes, for example, open heart surgery, oncology surgery, neurosurgery, high-risk obstetrics, neonatal intensive care and trauma services. Quaternary care is even more sophisticated and includes organ transplants.

County, Pennsylvania. (DX0196-001-002). All three of Pinnacle's hospitals are community hospitals focused on cost-effective acute care, although Pinnacle offers some higher-level services including open-heart surgery, kidney transplants, chemotherapy and radiation oncology. (Tr., pp. 523:15-525:22).

The Hospitals signed a Letter of Intent of their proposed merger in June of 2014, and received final board approval in March of 2015. (PX00643). In April of 2015, the Hospitals notified the FTC of their proposed merger and executed a "Strategic Affiliation Agreement" one month later. (PX00390-011; PX01338).

Following an investigation, on December 7, 2015, the FTC issued an administrative complaint alleging that the Hospitals' proposed merger violates Section 7 of the Clayton Act and Section 5 of the FTC Act. A merits trial in the FTC administrative proceeding is scheduled to commence on May 17, 2016. On December 9, 2015, Plaintiffs filed their Complaint in this action. (Doc. 4). The Hospitals filed their Answer on January 11, 2016. (Doc. 41). The instant Motion for Preliminary Injunction was filed on March 7, 2016 and was subsequently briefed by the parties. (Docs. 82, 96, and 102).

Following a period of expedited discovery, the Court conducted a five-day evidentiary hearing commencing on April 11, 2016. The Court heard testimony from 16 witnesses, including two economists, and admitted thousands of pages of

exhibits into evidence. Following the hearing, both sides filed post-hearing briefs. (Docs. 129 and 130). This matter is thus fully ripe for our review.

II. ANALYSIS

A. Standard of Review for Preliminary Injunctive Relief

When the FTC has reason to believe that "any person, partnership, or corporation is violating, or is about to violate, any provision of law enforced by the Federal Trade Commission," including Section 7 of the Clayton Act, it is authorized by § 13(b) of the FTC Act to "bring suit in a district court of the United States to enjoin any such act or practice." 15 U.S.C. § 53(b). The district court may grant a request for preliminary injunctive relief "[u]pon a proper showing that, weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest." *Id*. Therefore, "in determining whether to grant a preliminary injunction under section 13(b), a district court must (1) determine the likelihood that the FTC will ultimately succeed on the merits and (2) balance the equities." *FTC v. United Health, Inc.*, 938 F.2d 1206, 1217 (11th Cir. 1991); *see also FTC v. Click4Support*, 2015 U.S. Dist. LEXIS 153945, *12-13 (E.D.Pa. Nov. 10, 2015) (noting that while the Third Circuit has not expressly adopted this standard, several other circuits have done so, as well as the District of New Jersey); *FTC v. Millennium Telecard, Inc.*, 2011 U.S. Dist. LEXIS 74951, *6-7 (D.N.J. Jul. 12, 2011).

B. Section 7 of the Clayton Act

Section 7 of the Clayton Act prohibits mergers whose effect "may be substantially to lessen competition, or to tend to create a monopoly." 15 U.S.C. § 18. Section 7 is "designed to arrest in its incipiency . . . the substantial lessening of competition from the acquisition by one corporation" of the assets of a competing corporation. *United States v. E.I. du Pont de Nemours & Co.*, 353 U.S. 586, 589 (1957). To be sure, "Congress used the words 'may be substantially to lessen competition' to indicate that its concern was with probabilities, not certainties." *Brown Shoe Co. v. United States*, 370 U.S. 294, 323 (1962). "Ephemeral possibilities" of anticompetitive effects are not sufficient to establish a violation of Section 7, *United States v. Marine Bancorp., Inc.*, 418 U.S. 602, 623 (1974) (quotation marks omitted), nor will "a fair or tenable chance of success on the merits . . . suffice for injunctive relief." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045 (8th Cir. 1999) (citation omitted).

The first step in a Clayton Act analysis is "[t]he determination of the relevant market." *E.I. du Pont*, 353 U.S. at 593. "A relevant market consists of two separate components: a product market and a geographic market." *Id.* (citing *Morgenstern v. Wilson*, 29 F.3d 1291, 1296) (8th Cir. 1994). "Without a well-defined relevant market, an examination of a transaction's competitive effects is without context or meaning." *FTC v. Freeman Hosp.*, 69 F.3d 260, 268 (8th Cir.

1995). Thus, "[i]t is . . . essential that the FTC identify a credible relevant market before a preliminary injunction may properly issue," because a merger's effect cannot be properly evaluated without a well-defined relevant market. *Tenet Health*, 186 F.3d at 1051. Courts have observed that "[a] monopolization claim often succeeds or fails strictly on the definition of the product or geographic market." *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1075 (N.D. Ill. 2012) (quoting *Tenet Health*, 186 F. 3d at 1052); *see also Morgenstern*,29 F. 3d at 1296. The FTC bears the burden of defining a valid market. *See FTC v. Lundbeck, Inc.*, 650 F. 3d 1236, 1239-40 (8th Cir. 2011).

A relevant product market is a "line of commerce" affected by a proposed merger, *see Brown Shoe Co.*, 370 U.S. at 324, and is defined by determining "whether two products can be used for the same purpose, and if so, whether and to what extent purchasers are willing to substitute one for the other." *U.S. v. H&R Block*,, 883 F. Supp. 2d 36, 51 (D.D.C. 2011) (citations and quotations omitted). In the matter *sub judice*, the parties agree that the relevant product market is general acuity services ("GAC") sold to commercial payors. GAC services comprise a broad cluster of medical and surgical services that require an overnight hospital stay. (Doc. 82, pp. 7-8; Doc. 96, p. 7).

"The relevant geographic market is the area in which a potential buyer may rationally look for the goods or services he or she seeks." *Hanover 3201 Realty*,

LLC v. Vill. Supermarkets, Inc., 806 F.3d 162, 183-84 (3d Cir. 2015) (quoting *Eichorn v. AT&T Corp.*, 248 F.3d 131, 147 (3d Cir. 2001) (citing *Pa. Dental Ass'n v. Med. Serv. Ass'n of Pa.*, 745 F.2d 248, 260 (3d Cir. 1984)). Determination of the relevant geographic market is highly fact sensitive. *Tenet Health*, 186 F. 3d at 1052 (citing *Freeman Hosp.*, 69 F.3d at 271, n. 16). "This geographic market must 'conform to commercial reality,'" *Eichorn*, 248 F.3d at 147 (quoting *Acme Mkts., Inc. v. Wharton Hardware & Supply Corp.*, 890 F. Supp. 1230, 1239 (D.N.J. 1995)(citing *Brown Shoe Co.*, 370 U.S. at 336)), and can be determined "only after a factual inquiry into the commercial realities faced by consumers." *Tenet Health*, 186 F.3d at 1052 (citing *Flegel v. Christian Hosp. Northeast-Northwest*, 4 F.3d 682, 690 (8th Cir. 1993). Further, the Department of Justice and Federal Trade Commission's *Horizontal Merger Guidelines* "provides guidance" in defining a geographic market. *Atl. Exposition Servs. Inc. v. SMG*, 262 F. App'x 449, 452 (3d Cir. 2008) The most recent version of the *Merger Guidelines* defines a relevant geographic market as the smallest area in which a hypothetical monopolist could profitably raise prices by a "small but significant amount" for a meaningful period of time (referred to as a "SSNIP"). *See* U.S. Dep't of Justice and Fed. Trade Comm'n, *Horizontal Merger Guidelines*, §§ 4.1, 4.2 (2010).

C. Relevant Geographic Market

The FTC contends that the relevant geographic market for purposes of our analysis is the "Harrisburg Area," which is "roughly equivalent to the Harrisburg Metropolitan Statistical Area (Dauphin, Cumberland and Perry Counties) and Lebanon County." (Doc. 82, pp. 8-9). The FTC contends that geographic markets for GAC services are inherently local because people want to be hospitalized near their families and homes. To support this contention, the FTC posits that patients who live in the Harrisburg Area overwhelmingly utilize hospitals close to home, primarily Hershey and Pinnacle, and very few patients travel to hospitals outside of the Harrisburg Area. The FTC further contends that the two main commercial health insurance payors in the Harrisburg Area, Capital Blue Cross ("CBC") and Highmark recognize the Harrisburg Area as a distinct market and would not exclude the proposed merged entity from their networks. The Hospitals heartily disagree, arguing that the FTC's four county relevant geographic market is far too narrowly drawn and is untethered to the commercial realities facing patients and payors. It is the resolution of this threshold dispute that is dispositive to the outcome of the instant Motion.

"Properly defined, a geographic market is a geographic area 'in which the seller operates, and to which . . . purchaser[s] can practicably turn for supplies.'" *Little Rock Cardiology Clinic PA v. Baptist Health*, 591 F.3d 591 (8th Cir. 2009)

(quoting *Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320, 327 (1961)); *see also Morgenstern*, 29 F.3d at 1291. "Broken down, the test requires a court to first determine whether a plaintiff has alleged a geographic market that includes the area in which a defendant supplier draws a sufficiently large percentage of its business – 'the market area in which the seller operates,' its trade area." *Id*. (citing *Morgenstern*, 29 F.3d at 1296). "A court must then determine whether a plaintiff has alleged a geographic market in which only a small percentage of purchasers have alternative suppliers to whom they could practicably turn in the event that a defendant supplier's anticompetitive actions result in a price increase." *Id*. "The end goal in this analysis is to delineate a geographic area where, in the medical setting, "'few' patients leave. . . and 'few' patients enter." *Id.* (quoting *U.S. v. Rockford Mem'l Corp.*, 717 F. Supp. 1251, 1267 (N.D. Ill. 1989), aff'd 898 F.2d 1278 (7th Cir. 1990)).

Of particular import to our analysis is the uncontroverted fact that, in 2014, 43.5% of Hershey's patients, 11,260 people, travel to Hershey from outside of the FTC's designated Harrisburg Area, and several thousand of Pinnacle's patients reside outside of the Harrisburg Area. (DX1698-0048). Further, half of Hershey's patients travel at least thirty minutes for care, and 20% travel over an hour to reach Hershey, resulting in over half of Hershey's revenue originating outside of the Harrisburg area. (DX 1698-0034-36; DX1698-0049). These salient facts

controvert the FTC's assertion that GAC services are "inherently local," and strongly indicate that the FTC has created a geographic market that is too narrow because it does not appropriately account for where the Hospitals, particularly Hershey, draw their business.

Next, the FTC presents a starkly narrow view of the amount of hospitals patients could turn to if the combined Hospitals raised prices or let quality suffer. There are 19 hospitals within a 65 minute drive of Harrisburg, and many of these hospitals are closer to patients who now come to Hershey. Thus, if a hypothetical monopolist such as the combined Hospitals imposed a SSNIP, these other hospitals would readily offer consumers an alternative. Further, given the realities of living in Central Pennsylvania, which is largely rural and requires driving distances for specific goods or services, it is our view that these 19 other hospitals within a 65 minute drive of Harrisburg provide a realistic alternative that patients would utilize. Thus, the relevant geographic market proffered by the FTC is not one in which "'few' patients leave. . . and 'few' patients enter." *Little Rock Cardiology*, 591 F. 3d at 591.

Finally, during the evidentiary hearing, the Court heard hours of economic expert testimony regarding the hypothetical monopolist's ability to impose a SSNIP in the context of this proposed merger. The Court finds it extremely compelling that the Hospitals have already taken steps to ensure that post-merger

rates do not increase with CBC and Highmark, central Pennsylvania's two largest payors, representing 75-80% of the Hospitals' commercial patients. (DX 1166-01; DX 1167-003; DX 1698-0120-0124). To wit, the Hospitals have executed a 5-year contract with Highmark and a 10-year contract with CBC that not only require the Hospitals to contract with these payors for those periods, but to maintain existing rate structures for fee-for-service contracts and preserve the existing rate-differential between the Hospitals. The result of these agreements is that the Hospitals cannot walk away from these payors and that rates cannot increase for at least 5 years. (DX 0095 ¶ 14). The Court simply cannot be blind to this reality when considering the import of the hypothetical monopolist test advanced by the *Merger Guidelines*. Thus, the FTC is essentially asking the Court prevent this merger based on a prediction of what might happen to negotiating position and rates in 5 years. In the rapidly-changing arena of healthcare and health insurance, to make such a prediction would be imprudent, and as such, we do not find that the outcome of the hypothetical monopolist test aids the FTC in this matter.

In sum, we find based on the hours of testimony and thousands of pages of exhibits presented by the parties and considered by this Court, that the FTC's four county "Harrisburg Area" relevant geographic market is unrealistically narrow and does not assume the commercial realities faced by consumers in the region. Because the Government has failed to set forth a relevant geographic market, it

cannot establish a *prima facie* case under the Clayton Act. Therefore, the FTC's request for injunctive relief must be denied because it has not demonstrated a likelihood of ultimate success on the merits. *See Tenet Health*, 186 F.3d at 1053-55 (denying a preliminary injunction on the grounds of failure to provide sufficient evidence of a relevant geographic market); *Freeman Hosp.*, 69 F.3d at 268-72 (same); *California v. Sutter Health Sys.*, 130 F. Supp.2d 1109, 1132 (N.D. Cal. 2001) (same).

D. **Equities**

The FTC's impermissibly narrow interpretation of the relevant geographic market has caused this Court to determine that the FTC has not established a likelihood of success on the merits. Had the FTC demonstrated a likelihood of ultimate success, however, the burden of proof would have shifted to the Hospitals to "clearly" show that their combination would not cause anticompetitive effects. *U.S. v. Citizens & S. Nat. Bank*, 422 U.S. 86, 120 (1975) (explaining that once the Government plainly made out a *prima facie* case establishing a violation of Section 7, it "was incumbent upon [the defendants] to show that the market-share statistics gave an inaccurate account of the acquisitions' probable effects on competition."). As a precaution, then, the Hospitals presented ample evidence demonstrating that anticompetitive effects would not arise through the merger of Hershey and

Pinnacle. This evidence warrants consideration in our weighing of the equities here.

As noted in the Standard of Review, *see* Section II.A, along with consideration of the FTC's likelihood of success, a weighing of the equities present in this case is required to determine whether enjoining the merger would be in the best interests of the public. *F.T.C. v. H.J. Heinz Co.*, 246 F.3d 708, 714 (D.C. Cir. 2001) ("Section 13(b) provides for the grant of a preliminary injunction where such action would be in the public interest—as determined by a weighing of the equities and a consideration of the Commission's likelihood of success on the merits."). "Absent a likelihood of success on the merits, however, equities alone will not justify an injunction." *F.T.C. v. Arch Coal, Inc.*, 329 F.Supp.2d 109, 159 (D.D.C. 2004) (citing *F.T.C. v. PPG Indus., Inc.*, 798 F.2d 1500, 1508 (D.C. Cir. 1986)). The Seventh Circuit has adopted a "sliding scale" approach to a consideration of the equities: "[t]he greater the plaintiff's likelihood of success on the merits . . . the less harm from denial of the preliminary injunction the plaintiff need show in relation to the harm that the defendant will suffer if the preliminary injunction is granted." *F.T.C. v. Elders Grain, Inc.*, 868 F.2d 901, 903 (7th Cir. 1989); *OSF Healthcare Sys.*, 852 F.Supp.2d at 1094-95 (also utilizing the sliding-scale standard). The inverse has also been adopted; where a defendant can demonstrate that a preliminary injunction would inflict "irreparable harm," a ruling

that a plaintiff would likely succeed on the merits is less probable. *Elders Grain*, 868 F.2d at 903 ("[T]he sliding scale approach just sketched is appropriate . . . in cases where defendants are able to show that a preliminary injunction would do them irreparable harm."). Because of this relationship, once a court has made a determination of the likelihood of success, discussions on equitable considerations are often scant. *See OSF*, 852 F.Supp.2d at 1094-95; *Arch Coal*, 329 F.Supp.2d at 159-60. However, as alluded to in the rationale above, there are several important equitable considerations that merit further elucidation here.

1. Hershey's Capacity Constraints

"The Supreme Court has not sanctioned the use of an efficiencies defense in a case brought under Section 7 of the Clayton Act. However, 'the trend among lower courts is to recognize the defense."' *Arch Coal*, 329 F.Supp.2d at 150 (internal citations omitted) (quoting *Heinz*, 246 F.3d at 720); *see FTC v. Procter & Gamble Co.*, 386 U.S. 568, 580 (1967) ("Possible economies cannot be used as a defense to illegality."). Here, the Hospitals have presented a compelling efficiencies argument in support of the merger, in that the merger would alleviate some of Hershey's capacity constraints. As we have already found the merger to be legal, this argument is not relevant as a defense to illegality. However, the efficiencies wrought by the merger would nonetheless provide beneficial effects to

the public, such that equitable considerations weigh in favor of denying the injunction.

Though the exact range is contested, both parties concur that a hospital's optimal occupancy rate is approximately 85%.[3] During the evidentiary hearing on this matter, Ms. Sherry Kwater, former Chief Nursing Officer at Hershey Medical Center, testified extensively to her experience with the overcrowding and capacity problems rampant at Hershey. (Tr., pp. 688-89). Specifically, Ms. Kwater testified that the average capacity percentage at Hershey in the last several years had hovered at approximately 89% during the daily midnight census,[4] and routinely climbed to as high as 112-115% occupancy during midday.[5] (Tr., p. 688). Ms. Kwater also testified to a variety of ongoing renovation projects at Hershey designed to procure more beds, including those in the maternity ward and in the emergency room, as well as a project to convert a large storage room into space for observation beds. (Tr., pp. 671-72, 675-76, 679, 685). Ultimately, however, Hershey's Chief Executive Officer Craig Hillemeier and Chief Operating

[3] (Doc. 96, p. 18 ("The consensus in medical literature is that a hospital's optimal occupancy rate is 80-85%.")); (Doc. 129, pp. 24-25).

[4] Efficiencies expert Brandon Klar later testified that an occupancy review excluding the pediatric beds and focusing only on the remaining adult beds yielded a midnight occupancy rate averaging 90.5%. (Tr., p. 737:25-738:1-7).

[5] Ms. Kwater's testimony indicates that a hospital may be at over 100% capacity by placing patients in beds that were not designed for inpatient care. (Tr., p. 689:3-6). Obviously, this overcrowding results in negative consequences for patients at Hershey, who may not be comfortable placed in the hallway beds described, or 4- and 6- bedded rooms. (Tr., p. 684:17-23).

Officer Robin Wittenstein both testified that the renovation projects have not been sufficient to keep pace with the demand for care. (Tr., pp. 443:15-20; 579:12-19). Thus, without the merger, Hershey intends to build a new bed tower, costing approximately $277 million and generating 100 inpatient beds (yielding a total net gain of 70-80 new beds after renovations are complete). (Doc. 130, p. 21); (Tr., p. 579:12-19 ("[W]e will immediately begin moving forward on the construction of a new bed tower.")).

In response, the FTC assembled a series of arguments designed to rebut Hershey's stated need to build the bed tower. Evidence was introduced indicating that as few as two and as many as thirteen beds could alleviate Hershey's capacity constraints, and that Hershey would need a total of just thirty-six (36) beds in five years to relieve its capacity issues. (Doc. 129, p. 26). Under this reasoning, Plaintiffs suggest that Hershey would not need to build a bed tower at all. (*Id*.). Furthermore, Plaintiffs argue that even if it were built, Hershey has artificially inflated the cost of constructing the bed tower, and the cost would not ultimately be passed on to patients as the tower would be funded by grants or by existing funds in Hershey's fixed cost budget. (Tr., pp. 779-82, 989:4-8 ("Such a capital expense [as the building of a bed tower] . . . is properly understood as a fixed cost. As such, economic theory would not predict that it would be passed on in the form of higher prices.")).

This line of reasoning defies logic. Even if the cost of the bed tower has been partially overstated, its construction would undoubtedly strain Hershey's financial resources, resulting in either increased charges for services or less investment in quality improvements. (Doc. 130, p. 23 (citing to testimony by Defendants' expert economic witness, Dr. Willig)). Both outcomes would negatively impact patients at least until the bed tower could be completed, fully paid for, and operational. By contrast, the merger would immediately make additional capacity available to Hershey, causing near instantaneous benefits to Hershey's patients. (*See* Tr., pp. 819:25-820:4 ("[T]he merger will immediately make more effective capacity available to alleviate Hershey's capacity problem. That's a relatively immediate, maybe instantly, but certainly within a few months, impact of the merger.")).

Further, for the Court to expect Hershey to rely on assumptions of grants for the construction would be to expect a reliance on unsound business practice, as the FTC has presented no evidence that such grants would definitively be forthcoming. (Tr., pp. 779:24-781:10 (cross examination of Brandon Klar, noting that the FTC's prediction of philanthropic donations is only assumed, and not guaranteed, and that donations for a bed-tower with no designated specialty like a children's ward or cancer facility are unlikely to accumulate in any great frequency)).

Finally, Plaintiffs impermissibly ask the Court to second guess Hershey's business decision in building the tower. It is not within our purview to question the CEO and COO's determination of this need, and their sworn testimony that they will embark upon this project absent the merger is sufficiently reliable. Further, as our nation's population continues to age and increasingly demand more complex and numerous medical treatments, it is entirely reasonable that Hershey would decide that, absent a merger, construction of a large bed tower is in its best interest.

Hershey has also presented testimony of the capital avoidance that will occur if the combination with Pinnacle is allowed to go forward and the bed tower is not built. Pinnacle has sufficient capacity available such that Hershey may transfer its lower-acuity patients to Pinnacle, simultaneously allowing both hospitals' physicians to treat more people while Hershey's capacity constraints are alleviated. (Tr., pp. 732-33, 748:13-18). Further, Hershey's facilities will be able to admit more high-acuity patients who will benefit from Hershey's greater offering of complex treatments and procedures. (*Id*. p. 737)[6]; (Doc. 96, p. 29). Of course, the ability of both hospitals to treat more patients at the locations best suited to their

[6] Here, Mr. Klar explained that "[site-of-service adjustments] will allow [Hershey] to reduce their occupancy rate . . . to 80 percent, which will allow space for patients that are currently being denied access within Central Pennsylvania to get the available access that they need locally and close to home." (Tr., p. 737:1-13).

healthcare needs will also generate more revenue.[7] Finally, the merger will prevent the outpouring of capital for the construction of the tower, allowing Hershey to forego this expenditure, serve more patients, and generate downward pricing pressure that greater efficiencies and a larger supply of services typically facilitates.[8]

Where, as here, "an injunction would deny consumers the procompetitive advantages of the merger," courts have found that the equities may weigh in favor of allowing the combination to go forward. *See Heinz*, 246 F.3d at 726-27 (citing *FTC v. Pharmtech Research, Inc*., 576 F.Supp. 294, 299 (D.D.C. 1983)). We find

[7] This increase in revenue was discussed in detail during the Hospitals' testimony, and relates primarily to a two-step savings process. First, because Pinnacle handles on average, lower-acuity care patients, there is an average price differential of $3,400 per case at Pinnacle as compared to Hershey. (Tr., p. 749:12-24). This, multiplied by the expected 2,000-3,000 cases that will be transferred over the next five years, yields a great deal of the expected savings, between approximately $31.3 and $46.2 million. (*Id*.). Second, because the patients transferred from Hershey to Pinnacle will be replaced by primarily higher-acuity care patients, the income that Hershey will generate from providing their treatment will drastically increase, by as much as $17,000 per case (Hershey stresses that other AMCs are routinely reimbursed at even higher commercial rates for high-acuity care procedures—approximately 15 percent higher). (*Id*., pp. 750:18-751:5). This two-step increase in revenue was presented as one of the main reasons for the Hospitals' desire to pursue the merger. It was also cited as a reason for why the Hospitals would have no need to impose a SSNIP on Harrisburg area payors, even if they could do so. While we certainly acknowledge the merit of the efficiencies argument, we find this secondary rationale regarding the SSNIP unpersuasive, as in the Court's experience it is rare that a company decides it has made enough money already, such that it does not need more. *See In the Matter of ProMedica Health Sys., Inc*., Docket No. 9346, 2012 WL 2450574, at *21 (F.T.C., June 25, 2012) (describing the lower court's holding that the evidence did not support that "excess hospital bed capacity in Toledo, repositioning by competitors, and steering patients away from high-priced hospitals . . . would constrain post-Joinder price increases."). Rather, it is for the reasons discussed *supra* that we feel the Hospitals are unlikely to be able to unreasonably raise costs for payors.

[8] (Doc. 96, p. 29 (noting that the adjustments will save patients and payors $49.5-82.7 million over five years); (Tr., pp.732-34 (same)).

that the efficiencies evidence overwhelmingly indicates that procompetitive advantages would be generated for the Hospitals' consumers such that the equities favor the denial of injunctive relief.

2. Repositioning by Competitors Will Constrain Hershey and Pinnacle

The 2010 *Horizontal Merger Guidelines* advise that "[i]n some cases, non-merging firms may be able to reposition . . . to offer close substitutes for the products offered by the merging firms." 2010 *Horizontal Merger Guidelines*, §6.1. "A merger is unlikely to generate substantial unilateral price increases if non-merging parties offer very close substitutes." *Id*. Where, as here, firms are already present in the market but are repositioning, that "[r]epositioning . . . is evaluated much like entry, with consideration given to timeliness, likelihood, and sufficiency." *Id*. Courts weighing the anticompetitive effects of a merge have considered such repositioning as a factor in whether to give great weight to predictions of a combined entity's ability to control the marketplace. *See ProMedica Health*, 2012 WL 2450574, *64-65 (discussing hospitals' competitors and concluding that they did not possess the significant competitive ability necessary to constrain the merged entity).

In the case *sub judice*, the market that Hershey and Pinnacle exist within has already been subject to extensive repositioning. Competition, in the form of

nearby hospitals' growing ability to offer close substitutes for Hershey and Pinnacles' advanced care, is escalating. Specifically, Geisinger Health System recently acquired Holy Spirit Hospital, with the intent to create a "regional referral center and tertiary care hospital" (DX0090-002); WellSpan Health has acquired Good Samaritan Hospital—with the specific goal of taking patients from Hershey (DX 0095 ¶ 6; DX0851); the University of Pennsylvania partnered with Lancaster General Hospital to "take more volume away from Hopkins, Hershey, and Philadelphia competitors" (DX0136-232; *see also* DX0095 ¶ 7); and Community Health Systems acquired Carlisle Regional Hospital. (Tr., p. 80:23-25). Notably, this repositioning would not happen in response to the combination of Hershey and Pinnacle—it has already occurred. Thus, in terms of a timeliness and likelihood analysis, there is no delay here that other courts have found to be a significant concern in a competitor's ability to constrain a merged entity. *ProMedica Health*, 2012 WL 2450574, *64-65 (expressing concern that a rival hospital, Mercy, had no location chosen or deadline implemented for the construction of its outpatient facility, which "casts doubt on whether Mercy is likely to accomplish such repositioning and suggests that its . . . strategy will not provide a timely constraint.").

Furthermore, this repositioning represents a direct and concerted effort to erode both hospitals', but mainly Hershey's, patient base. Far from being isolated

from service, other hospitals have realized and begun to capitalize on the large market of patients in the Harrisburg area.[9] The Office of the Attorney General cites to these hospitals, not as small community hospitals, but as "dominant providers" that demand high prices for their services. (Tr., p. 42:15-19). It neglects, however, to emphasize that these providers are located in York, Lancaster, Reading and Danville[10]—well within driving distance from the "Harrisburg Area." (Tr., p. 487:4-15). Rather than monopolizing a geographic space, merging allows Hershey and Pinnacle to remain competitive in a climate where nearby hospitals are routinely partnering to assist each other in achieving growth and dominance. The rival hospitals'' competitive strength will result in a meaningful constraint on competition, benefitting Harrisburg area residents in a manner consistent with the analysis set forth in the Guidelines.

3. Risk-Based Contracting

Over the course of the five-day hearing, a substantial amount of testimony on the increase in risk-based contracting was presented. Risk based contracting

[9] For example, Geisinger has already committed to invest $100 million in Holy Spirit to open a children's hospital and a Level II trauma center that Charles Chiampi, director of contracting for Highmark, submits shall directly compete with Hershey for complex emergency trauma care. DX0095-0001, ¶ 5. Further, the partnership between Geisinger and Holy Spirit allows for Geisinger to more easily refer higher-acuity patients from its Harrisburg location out to its larger facility in Danville. (Tr. 938:16-939:7).

[10] (Tr., p. 42:15-19). The Attorney General's Office simply cannot have its cake and eat it too. These hospitals cannot both be examples of behemoth institutions that have negatively impacted the Central Pennsylvania patient base but also be too small to meaningfully compete with a combined Hershey and Pinnacle entity.

"begins to introduce new concepts and terms that begin to transfer the risk for the cost of care for the individual to the provider." (Tr., 493:18-25). Over the ensuing three years, the government and various private payors intend to evoke a shift towards risk-based forms of contracting, and the payors with which Hershey and Pinnacle contract are no exception. (Tr. 254:17-255:3; Tr., p. 939:19-21 ("these agreements . . . between the payers and the hospitals . . . include a strong mutual assurance of movement toward . . . risk-based forms of contracting, and framework for doing that cooperatively.")). In fact, the government intends to shift 50-80% of payments into risk based contracts by 2018. (Tr., p. 498: 6-14). In order to perform best under risk-based contracting, hospitals must offer a "total continuum of care." (Doc. 130, p. 30). Though we agree with the FTC that Hershey and Pinnacle independently are capable of continuing to operate under the risk-based model, we find the testimony of Hershey CEO Craig Hillemeier to be persuasive in that "there will be some advantages in terms of size of scale, in terms of being able to spread of costs [sic] of the infrastructure of population health over a larger health care system." (Tr. 445:21-446:4). This adaptation to risk-based contracting will have a beneficial impact. One persuasive benefit involves Hershey's ability to continue to use its revenue to operate its College of Medicine and draw high-quality medical students and professors into the region. (*Id.*, 448:13-15 ("[P]art of the purpose of the Medical Center is, indeed, to support the College of Medicine . .

. . If patients don't fill the beds, then we can't do it.")). Particularly as the payment models continue to shift, the local populace has a continued interest in seeing its most closely situated medical center remain competitive.

4. Public Interest in Effective Enforcement of Antitrust Laws

"The principal public equity weighing in favor of issuance of preliminary injunctive relief is the public interest in effective enforcement of the antitrust laws. The Congress specifically had this public equity consideration in mind when it enacted Section 13(b)." *Heinz*, 246 F.3d at 726 (internal citations omitted). However, where an injunction would deny consumers the procompetitive advantages of the merger, this equity is no longer as compelling. These advantages have now been discussed at length, above. Further, though the FTC is correct to caution that "unscrambling" the assets of two merged entities is made more difficult after the combination has been completed, *see F.T.C. v. Univ. Health, Inc.*, 938 F.2d 1206, 1216 n. 23 ("once an anticompetitive acquisition is consummated, it is difficult to "unscramble the egg"), it is by no means unheard of that a merged entity would be asked to divest the assets of the previously separate institution. *See ProMedica Health*, 2012 WL 2450574, *66 ("Divestiture is the most appropriate remedy to restore the competition eliminated by the Joinder.").

Further we note that the parties have not emphasized, and we do not credit, any argument that "an injunction would 'kill this merger,'" as courts in the past

have found this line of reasoning to be unpersuasive and "at best a 'private' equity which does not affect [an] analysis of the impact on the market." *Heinz*, 246 F.3d at 726-27; *but see Freeman Hosp.*, 69 F.3d at 272 ("[A] district court may consider both public and private equities.").

After a thorough consideration of the equities in play, we find that the majority of these factors weigh in the public interest. The patients of Hershey and Pinnacle stand to gain much from a combined entity that is capable of competing with a variety of other merged and already growing hospital systems in the region. This decision further recognizes a growing need for all those involved to adapt to an evolving landscape of healthcare that includes, among other changes, the institution of the Affordable Care Act, fluctuations in Medicare and Medicaid reimbursement, and the adoption of risk-based contracting. Our determination reflects the healthcare world as it is, and not as the FTC wishes it to be. We find it no small irony that the same federal government under which the FTC operates has created a climate that virtually compels institutions to seek alliances such as the Hospitals intend here. Like the corner store, the community medical center is a charming but increasingly antiquated concept. It is better for the people they treat that such hospitals unite and survive rather than remain divided and wither.

III. CONCLUSION

Based on the foregoing analysis, the Court finds that the FTC failed to meet its burden to show a likelihood of ultimate success on the merits of their antitrust claim against the Hospitals. Accordingly, the Plaintiffs' Motion for a Preliminary Injunction shall be denied.

NOW, THEREFORE, IT IS HEREBY ORDERED THAT:

1. The Plaintiffs' Motion for Preliminary Injunction (Doc. 82) is **DENIED**.

s/ John E. Jones III
John E. Jones III
United States District Judge

Exhibit E

UPMC LIFE CHANGING MEDICINE

PENNSYLVANIA HOUSE OF REPRESENTATIVES
DEMOCRATIC POLICY COMMITTEE HEARING
AT POINT PARK UNIVERSITY
October 10, 2014

Rep. DeLuca

Good Morning everyone. Let me first of all thank Point Park for having us here, this is a beautiful facility here and I want to thank them for hosting this group today for us for this very important policy hearing regarding the Consent Decree with Highmark and UPMC. I also want to recognize Paul Costa who is a board member with Point Park and Paul you're doing a heck of a job here at Point Park, I just seen a big, a lot of money just came in, somebody just donated a lot of money so that means it's really moving ahead. I want to welcome everyone here today this morning to this democratic policy committee meeting on the impending Highmark/UPMC transition and their Consent Decree with the commonwealth. And I want to thank all of our testifiers for appearing here today. Everyone in this room is aware of the long standing dispute between Highmark and UPMC as well as the highly publicized break up that will begin January 1, 2015. Many of us hope for a different outcome and pushed hard to get a new contract. Several members of the General Assembly including Representative Frankel and myself introduced legislation to force a contract through binding arbitration. Unfortunately the republican majority in the legislator refused to bring that legislation up to the vote. As a result, Highmark and UPMC will be ending their contractual relationship at least in regards to the core UPMC facilities in the greater Pittsburgh area. Ladies and gentleman the past is the past. Now we need to start looking forward and do our best to inform the residents of Western Pennsylvania, particularly Highmark cardholders about the specifics of the Consent Decree. While we did not get a new contract, the Department of Health, Insurance Department and the Attorney General's office were able to get both parties to agree to sign a Consent Decree. These Consent Decrees contain some of the provisions that we in the House of democratic caucus fought so hard for. These are documents that will be governing the future of Highmark and UPMC's relationship and that is our focus here today.

We will be joined today by independent representatives of the Western Pennsylvania medical community as well as representatives from UPMC and Highmark. As I stated previously, the Consent Decrees were ultimately the work of three government agencies, The Department of Health, the Insurance Department and the Attorney General's office. While we invited all three agencies involved in the Consent Decrees to appear here, only the Attorney General's office was willing to come and testify. The Corbett administration declined an invitation on this important subject. It would have been helpful to hear from the Insurance Department and the Department of Health since they are the government regulators with prime oversight over both UPMC and Highmark. Testimony from the Department of Health would have been particularly useful given that it is the agency that will hear appeals on (inaudible) of medical treatment under the Consent Decree. However, I want to thank the Attorney General's office for testifying today. While the Attorney General's office is not an expert on the healthcare of insurance practices, its representatives will be able to speak to the enforcement of aspects of the Consent Decree. Again I would like to thank all the members who are participating here today and before I turn it over to Representative Frankel, I would like to have the members and the staff introduce themselves starting from my left.

Representative Chris Sainato, I represent the 9th Legislative District which is in Lawrence, County.

I'm Representative Harry Readshaw, 36th Legislative District, Allegheny County

Shawn Brennan I'm with Representative DeLuca's staff on the House Insurance Committee.

Alan Cohen with Chairman DeLuca, House Insurance Committee.

Chairman DeLuca of the Insurance Committee.

Representative Dan Frankel

Ann Kafricky from Representative Frankel's office

Good morning everybody I'm Representative Paul Costa and as Tony said I'm a board member here at Point Park, I'm also a proud alum and I want to thank President Hennigan and MaryAnn Geyer for always opening up their doors to not only the policy committee but all the committees in the House of Representatives to have meetings here in the Pittsburgh area. And I also want to thank Representative DeLuca and Frankel for keeping this issue in the forefront. I mean some people might want to ignore it and wish it would go away but these 2 have continued to keep it in the forefront and I want to thank you gentleman for that.

I'm Representative Dan Miller, 42nd District, essentially based in Mt. Lebanon here in Allegheny County.

Rep. DeLuca

I also want to, being that this is an important issue I want to thank the Auditor General for sending his staff here to sit in on this hearing today to report back to him on all the particulars that will be coming out on this hearing. Representative Frankel?

Rep. Frankel

Thank you Representative DeLuca and I want to thank also Point Park University for making this forum available for us, it's a great venue and a great part of, great asset of the city of Pittsburgh and particularly the revitalization of downtown.

Over the past several years I've spoken about very little as much as I've spoken about the conflict between UPMC and Highmark. The conflict is at the center of so many issues, healthcare value, the health of individual patients, and the economic health of our community. At the end of the day this Consent Decree does not address al those issues in a way that I would have wanted it to. However, it did bring some resolution to a nasty dispute that created important protections for vulnerable Western Pennsylvanians. Now our job is to make sure that the Consent Decree works for the only truly important stakeholders in this group, patients. The goal of this hearing is to understand exactly how that's going to happen to get beyond the claims and counter claims that are being played out in the media and to try and get clarity for the people who are actually seeking medical care.

I'm grateful that we have executives from both Highmark and UPMC in the same room at the same time so that we can actually get answers. I'm also grateful to the Allegheny county medical society for attending and representing physician concerns. And many thanks to the Attorney General's office who brokered this Consent Decree and will be doing some of the ongoing monitoring. To be clear, this hearing is not designed to find problems with or offer alternatives to the Consent Decree. These parties agreed to come here today to explain how the transition will occur and what patients in our region can expect. So we're limiting the focus here. Obviously many of us would have preferred a different alternative, we had legislative proposals, but we have what we have in front of us and that is the Consent Decree and our job is to make sure that it's laid out in a way that works best for our community and the patients that will be accessing these services, while holding down costs and promoting access and quality of healthcare. Thank you very much.

Rep. DeLuca

Thank you Representative Frankel and as Representative Frankel said that's the intent of this meeting. It's also the intent to clarify some of the confusion out there with the constituents. Everyday there's letters in the paper and I get constituents and I'm sure my colleagues get calls about the confusion coming from both sides. So that's what this hearing is about to try to clear up the confusion for the constituents in Allegheny county and Western Pennsylvania. Thank you. Our first testifier will be Jack Krah with the, he's the Executive Director of the Allegheny Medical Society. Jack?

Jack Krah

Good morning.

Rep. DeLuca

Jack if you could have your, I don't have her name, if you could have her identify herself it would be appreciated.

Good morning I'm Pat Rafael from Hospital Council of Western Pennsylvania.

Rep. DeLuca

Welcome Pat.

Pat Rafael

Thank you.

Rep. DeLuca

Whenever you're ready Jack.

Jack Krah

Thank you Chairman. I'm Jack Krah I'm the Executive Director of the Allegheny County Medical Society. I'd like to thank Representative DeLuca, Representative Frankel and the members of the House Democratic Policy Committee for providing the opportunity to testify regarding the transition agreement between the University of Pittsburgh Medical Center and Highmark. My colleague A.J. Harper, President of The Hospital Council of Western Pennsylvania is currently on medical leave and was not able to attend this morning but the testimony that I'm about to present is a joint effort and Ms .Rafael is here as Vice President of Council to represent Hospital Council in this. And the statement is a joint statement from Council and the Medical Society as we move through this critical transition with the exploration of the contract between Highmark and the University of Pittsburgh Medical Center on December 31st, 2014.

As you know The Medica Society represents physicians in the region and Hospital Council represents hospitals and other providers in the 30 counties of Western Pennsylvania. We'd like to first of all commend the Governor, the Attorney General, the Insurance Commissioner and the Secretary of Health for all of the work and leadership in crafting the Consent Decrees that govern the transition agreement. The Consent Decrees do provide a substantive framework to address critical issues of patient care and professional relationships. First and foremost all providers and payors want to protect and preserve the physician/patient relationship. We must ensure that patients and physicians have the security and confidence to maintain the relationships regardless of the transition particularly those patients experiencing serious and life threatening conditions who have long standing relationships with physicians. In fact, this transition should not be a factor in their ongoing relationship.

The Medical Society's board of directors has advocated that patients and physicians have the ability to maintain those relationship. Patients must have the utmost clarity regarding the circumstances of their treatment. It is also important to define continuity of care to be within the physician's judgement and a decision to be reached by the physician and patient when transitions occur. In those instances when a patient will be transitioning to a new physician it is impetrative that the following occur:

UPMC physicians must have access to a current physician panel that will allow their patient to select a physician within the Highmark network. That panel should identify physician office locations and admitting privileges at

Allegheny Health Network and independent community hospitals. UPMC physicians should also advise Highmark in a timely manner of those instances when a patient referral is made that the physician practice may be closed to new patients. UPMC physicians must also prioritize the copying and transmittal of the patient's medical record to the new physician of record when those situations occur.

Secondly the term out of network has come front and center in our healthcare vocabulary in Western Pennsylvania. Patients, physicians and hospitals have had or have to have clarity around exactly who is affected by the transition and what our of network actually means for those patients. It will and is becoming a prevalent term across the country as health plans create narrow networks and tiered products and in a strategy to reduce costs and improve outcomes. It is still unclear when UPMC physicians will be in network to Highmark subscribers due to different office locations. The two entities have apparently not reached final agreement on the specifics of those terms. This information must be finalized and provided to patients and to physicians in easily understandable formats.

While we need to clarify this for physicians and patients we also need to clarify this for the region's independent hospitals. Many physicians practice at one or more of the region's independent community hospitals and also at rural hospitals. Many of those physicians also have privileges at UPMC or Allegheny Health Network facilities. It is critical that the legislature also actively consider how to strengthen those independent hospitals and physician practices to remain community resources. One of our concerns is how all of this will be communicated to the patients who may have to pay out of network differentials. We have already seen articles and letters to the editor in the local media written about patients who have found themselves in the confusing state of referrals and concerns between networks. These types of issues will develop quickly especially during the early months of the contract termination. We must be prepared for the realtime 24/7 ability to resolve coverage problems. If a patient is in the hospital and has questions over the weekend, the patient should not wait for answers on coverage the following Monday or Tuesday. The patient is in a state of anxiety and concern and again clarity is of the utmost importance.

Both the Medical Society and the Hospital Council suggest that there be a way that physician and hospitals can get quick resolutions to these type of issues. We recommend an Ombudsman hotline be created and staffed specifically for these situations even if this was available for a few months during the beginning of the transition it would be extremely helpful and provide a level of security to patients. We do realize that there are measures in place in the Consent Decrees that if a violation occurs there is an opportunity for the party to correct the violation. However, there is a 20 day timeframe given for the correction of violation. That amount of time is simply too long to wait for a resolution to an issue of patient care. There will be questions and issues that are simple misunderstandings or due to poor miscommunication, poor communications. It's critical to anticipate that these will occur and be prepared to address and resolve them quickly. While we appreciate that this mechanism for the state to address violations in place we strongly believe in the need for a process and a policy that allows for quick resolution of patient, physician, and hospital issues concerning care.

Third, we also appreciate that there is a mechanism built into this transition plan that puts in place a communications effort that has been funded by the two entities. Patients, providers and purchasers are waiting for the communications plan to be unveiled by the Departments of Health and Insurance. Clear and consistent information must be available and provided in multiple mediums into multiple audiences including frontline office and hospital personnel. The business community also needs clear communications and information as they make decisions with respect to their employee benefit programs.

Again, clarity is the word of the moment and in this case the communications plan must include the following element. A strong message that must be communicated promptly is that our senior and most vulnerable populations are not impacted by the expiration of this contract. As you know Allegheny county and the surround areas have one of the largest populations of those 65 and older and also a large population of frail elderly. We need to make sure that those consumers understand that they are not impacted by this and relieve their concerns about access care and financial coverage.

Separate messaging is needed for our regions population covered by medicaid and CHIP programs that these consumers will not be affected by this change as well. This is even more important because of the introduction of Healthy PA. To ensure that these messages are appropriate that there is clarity for all consumers in this region we recommend continued communication and engagement, possibly through the creation of a regional work group that can assist in developing and testing these messages and communications during the transition period. We suggest that physicians, hospitals and employer organizations and consumers be part of this group. All messages whether they be provided through social medial, print media, print materials, consumer presentations and other messages should be tested and validated by established health literacy tools and techniques to make sure that these messages can be understood by all audiences.

From our testimony today you can see that physicians and hospitals are most concerned about the relationship between the physician and the patient and the communication strategies that will be needed to provide clarity to vulnerable population, to our region's businesses, to patients with commercial insurance and to the general public. Patient care is our first priority.

I want to once again thank Representative DeLuca, Representative Frankel and the committee for giving the Allegheny County Medical Society and The Hospital Council of Western Pennsylvania the opportunity to present remarks and Ms. Rafael and I would be happy to answer questions if we can.

Rep. DeLuca

Thank you Jack. Let me, since this hasn't played out let, let me as you how do you perceive since we have such a short time in this excellent testimony here, from January 1st how do perceive all those things will play out that you're advocating for?

Jack Kruh

Well that's a good question Chairman DeLuca. I think that everybody is going to have to work very hard to assure that as much as possible occurs before that January 1st deadline. It's also apparent from the testimony that there will be issues that occur during the transition time. So attention will need to continue to be focused on this for sometime into 2015.

Rep. DeLuca

Was the medical profession involved in the negotiations with this Consent Decree?

Jack Kruh

The Medical Society was not involved.

Rep. DeLuca

The Medical Society was not involved. Okay. Have you heard from any patents lately about their worry about being out of network and has your organization heard anything about the medical society or your physicians about individuals who are worried about the out of network since a lot of people don't understand what out of network is, especially with senior citizens.

Jack Kruh

We've received a modest number of calls. The inquiries that we receive really are primarily from physicians who are concerned about patients who have to change. We represent physicians who are employed both by AHN and by UPMC and I think it's a fair statement to say that those physicians wherever their employment or locales of

practice are concerned about the impact on the patients. UPMC physicians are concerned if they have to disrupt relationships because a patient's insurance coverage has changed, they are concerned that they can help them transition to a new physician. I don't think it's as much of an issue for AHN physicians because it's going that direction and of course I think that independent practices are also concerned. They would like to remain independent, they'd like to be able to participate in both insurance networks and they'd like to maintain their facilities and their relationships at the different hospitals that they have them. And one of the reasons they remain independent is they fell that allows them to best serve their patient base. So that is, we made a reference to it being an important factor for the legislature to consider that we do have, as large as these 2 entities are we do have community hospitals and we have independent physician practices and practices that are affiliated with other hospitals and smaller systems and it's important to remember those are vital community resources and we should make sure that we strengthen them and preserve their ability to care for patients in those communities.

Rep. DeLuca

I certainly agree with you Jack. Representative Franke?

Rep. Frankel

Thank you, thank you Jack. My understanding is that the Consent Decree gives an enormous amount of discretion to the individual physician independent of the kind of corporate structures that are out there and their interpretation. Issues with respect to continuity of care beyond January 1st issues such as one of the things that we do know from this Consent Decree is that somebody who goes to the emergency room at any hospital is in network if they're admitted then the physician themselves has an enormous amount of discretion as to how long that patient is there and how long remains in network. I mean there's some, I think understanding or misunderstanding that once a patient is admitted through the emergency room if it's a Highmark patient at a UPMC hospital that they'll be transferred to an Allegheny Health Network in network hospital but doesn't, that is not my understanding of the Consent Decree. My understanding of the Consent Decree is that the physician, the treating physician once there's an admission through the emergency room has the discretion as to when that patient is either transferred or discharged.

Jack Kruh

That would be the position that The Medical Society would advocate for that that decision on when it is appropriate to transfer, or when a patient may be transferred is within the judgement of the attending physician and our understanding is that is the case. I am not an attorney and I can't speak with thorough knowledge of the insurance contracts but I would also say that I think most insurance contracts provide that the judgement is within the attending physician's, when someone does go through an emergency department and if they're, that facility is not normally within the network, when the patient is considered medically stable they will be transferred to hospitals within that network. That's been a long standing practice and again I can't speak with a high level of expertise there but to come back to your original point, The Medical Society would advocate that the decision on when a patient may be transferred or transition to another physician should be within the judgement of the attending physician and with the agreement of the patient that they're ready to go.

Rep. Frankel.

So the issue is really in the hands of the physician not in terms of the kind of corporate interpretation of what stabilized is. They physician determines when a person is ready to be discharged or transferred. It's not a decision that is made at the corporate level of the healthcare system.

Jack Kruh

That is certainly the position that we would advocate and recommend that the decision be made by the attending physician on when that patient may be moved to the care of another physician.

Rep. Frankel
]
Thank you.

Rep. DeLuca

Representative Readshaw.

Rep. Readshaw

Executive Director I don't have a question but being a former member of the United States Marine Corp I want to give you a big Oorah on your testimony particularly page 6. "Again clarity is the word of the moment." I repeat, "Again clarity is the word of the moment and in this case the communications plan must include the following elements" and you go on to list those elements. As we have this hearing and previous conversation and I'll speak for my constituents, they've read about it in the newspaper, they've heard about it through a variety of media, and they're still as confused today as they were when this issue began. So you have no idea, in my humble opinion, about using that sentence, again clarity is the word of the moment, it is the word of the moment, decisions are made, prospective decisions are discussed and I'll go back to my district and the people will be in my office saying Harry what's going on? We read about it and we don't have a clue what's happening. So I just wanted to comment you're right ton the money there, clarity is the point. Thank you so much.

Rep. DeLuca

Representative Frankel has another question.

Rep. Frankel.

In your testimony you talked about trying to provide clarity to patients who may get confused or misdirected and talked about the potential of an Ombudsman program. How would you envision that playing out?

Jack Kruh

We would think that would be a hotline within either the Insurance Department or the Health Department that was staffed 24 hours a day, 7 days a week so that if there is a patient who is in a physician office of in an hospital and there are any questions, we would hope that there would be a minimal number of those situations but we think that we should be prepared for when they do occur. When you have a patient who's ill, they're concerned, they have a high level of anxiety about their treatment, we should be able to provide clarity to them on what their insurance coverage is and take care of their medical needs. The entire point of having insurance is to provide a level of financial security that they will be able to pay for the care that is provided to them. And that is I think among the least things that we ought to be able to do and our suggestion would be that part of the funds that are being provided by both UPMC and Highmark to fund the educational effort be used within one of those departments to staff that service and that they have the ability to reach the appropriate people or to make a decision that is binding with respect to the coverage.

Rep. Frankel.

Thank you. You also talked about medical data, transfer electronic medical records. What's the status of that in Western Pennsylvania? Because it seems to me a very critical part of making this Consent Decree work and

focusing on patients is the ability to transfer medical records in an accurate, efficient and timely way. What's the status and what do we need to do, are we ready for that?

Pat Rafael

I don't know if we can answer that last part of the question but there are several networks of hospitals that are sharing records within their own networks and also outside of their networks so there's a lot of work being done in that area, but I'm not sure if we're actually completely ready.

Jack Kruh

I think that's an accurate statement. There are some cases where the electronic record can be transferred but I think in many cases a paper file is still going with an ambulance crew.

Pat Rafael

Especially in the smaller hospitals.

Jack Kruh

Especially in rural and smaller hospitals. One of the things frankly that The Medical Society has looked at and has spoken about is there is not, to the best of my knowledge, a standard transfer form in the commonwealth. And it might be very helpful to hospitals and physicians if we had a standardized transfer protocol that was used by all entities to make sure that all appropriate lab and imaging procedures, physician notes etc., were transferred with the patient.

Rep. Frankel

Thank you.

Unidentified Speaker

Thank you for being here. I just want to follow up on Representative Frankel's question about the call center. Who's going actually going to be making, if this existed, who would be making the calls, the patients or the hospital staff, the doctor's staff?

Jack Kruh

We think it would be most likely that it would be a physician's office or a hospital staff calling. We think that if a patient does need to call that should be available but we would think it would be the care givers making the call.

Unidentified speaker

I just wanted to make sure because I'm thinking if someone is in the hospital they're already stressed enough and to be able to comprehend what someone is telling the procedures, the language they many not understand so thank you very much.

Jack Kruh

Exactly.

Rep. DeLuca

Any other questions? Jack let me ask you I think the key word I heard Representative Frankel state in this Consent Decree is stabilization in the ER. You mentioned the fact and Representative Frankel mentioned the fact that the physician should have the say so. What happens if the physician decides that the patient should be there longer, the insurance carrier says no they're not going to pay for it, and then the Consent Decree has got 20 days, that's why you say that's too long correct? To appeal or how does that work? How many days to correct the violation. Is that a violation then?

Jack Kruh

Well the 20 days applies to what the departments would consider violations of the Consent Decrees. We're more focused Mr. Chairman on the situations where the patient is in active care. I'm not sure that I can answer the question in full because obviously there's an insurance contract that the patient is a subscriber to and the physicians and the hospitals ascribe to, there's generally a medical necessity clause in there and a process for review. I think we would simply advocate that the physician's judgement should prevail and when there are disputes they should have access to physician reviewers within the insurance company so that they can review with them why they think the patient needs to continue where they are.

Rep. DeLuca

Okay very good thank you, excellent testimony thank you for participating today. Thank you very much.

Jack Kruh

Thank you very much.

Rep. DeLuca

The next panel will be UPMC W. Thomas McGough Jr., and Dr. Steven Shapiro. Tom is the Executive Vice President and Chief Legal Office and Dr. Shapiro is the Executive Vice President and Chief Medical and Scientific Officer and President of Physician services, welcome. Thank you very much for coming this morning to participate. Tom whoever is going to start first.

W. Thomas McGough, Jr.

Thank you very much. Steve Shapiro and I certainly appreciate the opportunity to address the committee this morning. I led the UPMC team that negotiated the Consent Decrees with the Patients First leadership team and I was on the stage on June 27th when that deal was announced. That was an extraordinary event with many, many people commenting on how amazing it was to see Governor Tom Corbett, Attorney General Kathleen Kane, Highmark and UPMC all in the same place at the same time agreeing on anything. Those Consent Decrees were indeed monumental accomplishments as Representative Frankel has noted and noted that same day. They addressed many of the biggest issues on the minds of the people in Western Pennsylvania about the end of the Highmark/UPMC contracts. They addressed the protection of vulnerable patients, the concerns of patients undergoing medical treatment, the concerns of patients living with cancer or cancer survivors, children, seniors, patients with chronic conditions and people in need of emergency care. They also addressed the high costs of out of network care and access to what Representative Frankel called unique community assets like Wester Psychiatric, Children's Hospital and the Cancer Center. Now as important and as comprehensive as those decrees were everyone knew that there was much work left to be done and many details of the transition that had yet to be hammered out. I can assure you on behalf of UPMC that we're working diligently on those details. Nevertheless, we all know that there is still a great deal of anxiety and confusion and concern about how all this is supposed to

work. Particularly what choices people will have, about how they're going to make those choices, and when they're going to have to make those choices.

Before addressing some of those concerns and anxieties I'd like to offer a little bit of context. Just 4 years ago Western Pennsylvania had one of the least competitive environments for healthcare in the country, with one dominant insurer, Highmark, and one increasingly dominant provider, UPMC. Today we have one of the most competitive environments and this is within 4 years. With at least 5 major insurers and at least 2 major health systems and numerous community hospitals striving to distinguish themselves by delivering the highest quality, highest value healthcare to as many of the region's residents as possible. Now that newly competitive environment is more than just an abstraction, much more. There is a real payoff to this region. Today the cost of healthcare in Western Pennsylvania ranks among the lowest in the country. For example a review in April of data compiled by the federal agency for healthcare research and quality showed that among the 25 most populous metropolitan areas Pittsburgh now has the lowest health insurance costs. Similarly a review of options being offered over the past year on the federal governments health exchange reveals that Western Pennsylvania has some of the lowest priced plans in the country. Even more remarkably, we have created this lower cost environment while maintaining the world class quality our region has come to expect, a subject that Dr. Shapiro will address in a moment. So while there is still much to do let me repeat myself, today the cost of healthcare in Western Pennsylvania is among the lowest in the country and that healthcare is world class. This newly competitive environment in Western Pennsylvania is unfamiliar and somewhat uncomfortable particularly for those who have to make important choices about healthcare for themselves, their families, or their employers. That's why it is so important to give them complete, accurate, and consistent information about those choices which brings me back to the Consent Decrees and the numerous questions they left unanswered.

Over the past 10 months UPMC has tried to provide clarity and precision whenever, wherever, and to whomever it can. We have been meeting and communicating ceaselessly with employers, doctors, patients, brokers, unions, reporters, government officials and legislative staffs to address their concerns and answer their questions. We have posted information on our website. We have prepared and circulated materials like the Fine Print to delve into the complex details of the Decrees. We have set up a dedicated call in number with representatives specially trained on the intricacies of the Consent Decrees. We have taken out full page newspaper advertisements and launched a complimentary internet based campaign. And of equal note, UPMC and Highmark have provided the commonwealth with $4 million dollars so that the Patient's First leadership team can do its own education and outreach during this transition. All that said there are still unanswered questions and concerns. The media and others for example have spent a great deal of time examining Highmark's claim that 80% of UPMC's doctors will be in its network in 2015. Now under the Consent Decrees whether a doctor is in network or out of network for a Highmark subscriber next year is determined largely by where the doctor performs the service. If the doctor sees a patient say at UPMC Altoona it will be in network. But if that same doctor sees the same patient in the greater Pittsburgh area those services will very likely be out of network. So we think it's misleading to the consumer or at least to consumers in the greater Pittsburgh area to suggest that the doctor they've been seeing in Pittsburgh is in network without also telling them that they'd have to go to Altoona if they want in network access to that doctor. As a result we've run our 1,600 reasons why series of advertisements to let consumers know that they need to be very careful about whether a Highmark plan will have their UPMC doctors in network where they want to see them after the end of the year.

Finally I'd like to turn to a development that has gotten a great deal of attention this last week. Highmark's attempt to sell seniors medicare advantage plans that are supposedly not covered by the Consent Decrees and include no in network access to UPMC whatsoever. The Attorney General, the Secretary of Health and the Insurance Commissioner have all notified Highmark that these plans do not comply with the Consent Decrees, that Highmark's marketing of these plans is a violation of those decrees and that they will be seeking to enforce the decrees against those plans in commonwealth court. Amazingly, Highmark's Chief Executive Officer, David Holmberg told the media as recently as yesterday that Highmark was moving forward with these plans, and in fact Highmark has now mailed to seniors a brochure promoting the plans with a $10.00 gift certificate without ever mentioning in that brochure that by signing up the subscriber will lose in network access to every UPMC facility,

physician and service. This is remarkable at any number of levels. Highmark and UPMC have spent the last 3 years telling seniors not to be concerned because their in network access to UPMC would not be affected when their contracts expired. In the immediate wake of the Consent Decrees moreover, within days Highmark saturated the media with advertisements proclaiming that all seniors will have access to UPMC providers on an in network basis. Even more definitively 3 weeks after the entry of the Consent Decrees Mr. Holmberg stated on KDKA TV that anyone over the age of 65 would have in network access to UPMC under any of the Highmark products. Earlier this week Chairman DeLuca condemned Highmark for the enormous rate hikes it is imposing on it's medicare advantage plans that do include UPMC, noting that it is all too convenient that these medicare rare increases come along with a new plan that completely eliminates access to UPMC facilities. In light of the 3 year set up of the seniors the recent blitz of all seniors are protected advertising and Mr. Holmberg's categorical assurances several weeks ago that anyone over 65 would have in network access to UPMC under any Highmark product what Chairman DeLuca sees as suspiciously convenient, we at UPMC see as a blatant bait and switch.

Highmark has not even tried to argue that the new no UPMC plans comply with the Consent Decrees. Instead, these plans supposedly exist in some parallel universe outside the Consent Decrees. Not only do they lack the broad UPMC access that the Consent Decrees guaranteed to the vulnerable populations including seniors, but they also lack any of the protections afforded by the Consent Decree to every other Highmark subscriber. That means no access to the Hillman Cancer Center, or Western Psychiatric Hospital and Clinic, no access to UPMC oncologists, no safety net protections, no physician driven continuity of care, and no in network access to any of the 3,500 UPMC physicians forget about 1,600 it's now 3,500 or hundreds of UPMC facilities. Ironically the vulnerable seniors at whom these plans are targeted would go from being the most protected Highmark subscribers under the Consent Decree to being the least protected.

UPMC knows how this gambit, if it is allowed to proceed, will play out, we've seen it. Come January 1st senior citizens who were unwittingly baited into these plans will begin presenting themselves at UPMC for treatment only to learn that the physician that they have been seeing for years or the hospital where they have always been treated is now out of network. UPMC will then face the painful choice of turning those seniors away or treating them at out of network rates with potentially disastrous financial consequences. If these plans were new drugs going on the market the FDA could at a minimum require a black box warning perhaps something like what we've displayed here on the easels.

But the bottom line is that these defective and illegal plans should not be in the market in the first place and UPMC welcomes the efforts of the Attorney General, The Department of Health, an the Insurance Department to bring this bait and switch to a halt.

Let me wrap up. UPMC remains committed framed out in the Consent Decrees and to working with the commonwealth and with Highmark on that transition. We understand the complexities of this newly competitive environment and we will do our absolute best to minimize any confusion or anxiety. We can only hope that Highmark will do the same. Thank you.

Rep. DeLuca

Thank you Tom. Dr. Shapiro?

Dr. Steven Shapiro

Mr. Chairman and members of the policy committee thank you for the opportunity to talk to you today about the healthcare landscape in Western Pennsylvania from a UPMC physician's perspective. As way of introduction I'm Steve Shapiro, Chief Medical and Scientific Officer of UPMC and distinguished professor of medicine University of Pittsburgh. I came to Pittsburgh 8 years ago from Boston where I was the Parker B. Francis Professor of medicine at Harvard Medical School and Chief of Pulmonary and Critical Care and Brigham and Women's Hospital. I came here because I thought UPMC was the future of medicine little did I know that it would come so quickly and so

dramatically. Although I still do basic bench research with lung cancer and lung disease, genetics and pathobiology, I'm most excited by our efforts with our UPMC colleagues and University of Pittsburgh and Carnegie Mellon to make Pittsburgh the center for big data that will fundamentally improve our understanding of diseases and care of our patients at the bedside as we create many local jobs along the way. I also remain an active clinician seeing patients both at UPMC and the Birmingham free clinic. I enjoy the free clinic because there is no in network or out of network.

I think it would be helpful to step back and look at this issue in terms of the healthcare revolution that's going on nationally driven in part by these improvements in science and technology that have directly raised healthcare costs and also indirectly by allowing patients to have longer life expectancies with an aging population with more chronic disease. If you combine this with the flattening of the global economy it's clear that our nation cannot sustain the high cost of healthcare relative to other countries. In addition, although I'm convinced that in the U.S. we provide the world's best acute care our system is fragmented with uneven access. We now can use this science and technology along with our will to improve quality in the most cost effective manner and indeed this big data that I've talked about will really be a game changer as long as we have healthy academic health systems. And while the Affordable Care Act is directionally geared to address costs and quality at the moment it's focused on access. Nevertheless, the payors for healthcare, big business, and the government along with insurers have rather silently addressed the cost problem by changing benefit design, pushing more costs to the consumer creating a price sensitive consumer and this really changes everything immediately. We must now move to value based healthcare providing the highest quality at affordable costs. In Western Pennsylvania we are actually better positioned for this new world than any other community. We have integrated payor provider systems that are structured to provide affordable, continuous, accountable healthcare. As Mr. McGough mentioned we are already one of if not the lowest priced region in the country. UPMC doctors are committed to providing affordable care to our patient since after all it is now our patients financial health that is at stake as our healthcare is commoditized.

And nothing is more important to UPMC than quality. With the top ranked medical school and training programs as well as a cadre of physicians that are not only trained here but come from all over the country from leading academic centers. We are proud to be among the nations' dozen best U.S. News and World Report best of the best hospitals. Independently CMS Hospital Compare ranks UPMC Presbyterian Hospital in the top 4 of the 30 hospitals in the region despite caring for the sickest and the poorest. Yet as an example of the issues with quality using the same hospital and the same CMS data a consultant after opaquely manipulating this data suggested that this hospital was a rather poor performer. I think there's several lessons here. One quality ratings are extremely important but it is an emerging science. Most of the metrics used to date are processed measures, did you check this test, is it in normal range, not the outcome measures that are important to physicians and our patients. And as public reporting and transparency becomes commonplace we must not only use the right metrics but the right statistics and they too must be transparent if not broadly agreed upon. And through there are certain things that are difficult to account for such as complexity of illness and socioeconomic status, we have some tools to risk adjust for severity of illness but none really to address the unique challenges of the poor. This puts academic medical centers at risk since they take care of a disproportionately high share of the poorest and the sickest, yet as academic health systems whose mission it is to perform research and educate, I would put the challenge back on us to help develop those meaningful quality metrics for the future.

The bottom line is that we cannot have black box quality measures being used to confuse the community about quality. And that's, this word confusion has come up a lot in this hearing and confusion is a key thing. But radical changes in healthcare delivery and the insurance benefit design are confusing and if the government intervenes it runs the risk of becoming even more confusing. However patients need protection and the Consent Decrees lead by the bipartisan Patients First task force do just that. The CD's successfully define the rules that establish network adequacy in Western Pennsylvania and protect our patients. Our challenge as a health system is to educate the public, to help them understand the rules of the road and their rights under the Consent Decrees. We must eliminate confusion and make sure that our patients are not surprised by large out of network charges or unknowingly find out that their doctor was not in their network.

Our clinicians really simply want to care for our patients and we don't relish all the anxiety associated with healthcare reform yet we also understood 3 years ago that our best chance of taking care of our patients and supporting our academic mission was to compete as a neural network integrated delivery and finance system. We understood that if we gave Highmark unfettered access to our commercial patients as subscribers they would flash UPMC, make it unaffordable and push patients to their hospitals system which badly needed and still needs patients. We never wanted to put vulnerable patients including senior citizens through the healthcare maze nor did we think we needed to since UPMC and Highmark had agreed to maintain full, in network access for all medicare advantage products long term not to mention it is now part of the law of the Consent Decree. So how ironic and unconscionable that our worst fears of having a contract with Highmark leading to bait and switch are playing themselves out with one population that we wanted to protect that cannot afford confusion in their healthcare. We applaud the state for taking action and as UPMC physicians along with our clinicians and frontline staff we are actively educating our patients about all the changes and choices that they have since black boxes can be dangerous to ones health. Thank you.

Rep. DeLuca

Thank you very much Dr. Shapiro and I want to thank you both for your excellent testimony. Tom I was at that news conference were at too, I was in the audience there, it was my understanding that 65 and over were not to, seniors were not be touched, they have access to all the facilities. It was never brought up about any medicare supplemental products, it's my understanding that was supposed to be part of the consent, part of the agreement. And it was a historic meeting between all you guys because I give you credit for all coming together. But it seems to me that a lot of these seniors in my opinion are going to be taken advantage if these products are rolled out and they do not have, some of these seniors are going to be just looking at price and not what these policies cover. They can't even afford to pay their prescription drugs and sometimes they go without their drugs because of the fact they don't have enough money to pay to eat. So I just don't understand, it was my understanding and everybody that I had talked to after that meeting has said thank God that these seniors were not going to be affected. Now they are going to be affected through a product that's a supplemental product, am I correct?

W. Thomas McGough, Jr.

It's a Medicare Advantage product, yes Mr. Chairman. We worked under the same understanding you did since the entry of the Consent Decree and indeed for 3 years prior to that, that the seniors were going to be protected and screened from the confusion and anxiety that would be involved in trying to figure out what was in network and what wasn't in network.

Rep. DeLuca

Now does UPMC have any medicare product that limits UPMC facilities or do they consider all Allegheny Health Network Hospitals and physicians in network providers?

W. Thomas McGough, Jr.

We've had that product, UPMC Health Plan has had that product I think for as long as the Medicare Advantage program has existed.

Rep. DeLuca

So it's still going to be in existence?

W. Thomas McGough, Jr.

It's still out there and you mentioned the price, the fact of the matter is this one of the plans is a 0 premium price if you look at the flyer that Highmark is distributing it has $0.00, $0.00. $0.00 dollars about 12 times in it, that's going to be a real eye catcher. That's not the only $0.00 plan Medicare Advantage plan in the market there are other $0.00 plans including one from The Health Plan in the market now. To be honest we don't understand what Highmark's argument is as to why this doesn't violate the Consent Decree.

Rep. DeLuca

Outside of that issue there, are there anything else that you and Highmark are disputing in the Consent Decree?

W. Thomas McGough, Jr.

There are-

Rep. DeLuca

I mean it'd have to be ironed out by the arbitration panel.

W. Thomas McGough, Jr.

The important thing, one of the aspects about the Consent Decree that's important for everyone to understand is that there are a lot of there is a lot of discretion permitted in the health plan or in the Consent Decree to the treating physician and there's a lot of discretion permitted to Highmark. I'll give you one example, continuity of care. For those plans with the protections of the Consent Decree, continuity of care is determined by the treating physician. But if Highmark disagrees with that determination they can take an appeal an expeditious appeal to the Department of Health, so we know those are the rules. We assume that if the treating physician is a UPMC physician that that physician is going to be in all likelihood expansive in their definition of continuity of care, they want to treat the patient. What we don't know and what nobody will know until we get there is how Highmark will treat that and that may depend on whether Highmark is trying to sell an insurance policy that includes supposedly broad access to UPMC or whether they're trying to move patients to Allegheny Health Network. That's one of the areas that' it's just going to be inherently have to evolve as things go along.

Rep. DeLuca

Okay, thank you. Representative Frankel?

Rep. Frankel

Thank you, and thank you for being here today. Let me ask you, do you agree with Jack Krah that basically the physician is the person who determines you know when somebody is prepared to be discharged if admitted through the emergency room?

W. Thomas McGough, Jr.

If we focus on the emergency room, etc. what the emergency room exception says, or emergency room provision says that a patient will be in network for emergency and trauma services, and that Highmark and UPMC will agree upon protocols to determine stabilization. Now this is against a backdrop and it's not uncommon, it happens all the time in healthcare where a patient will be admitted to an emergency room where their insurer doesn't have that emergency room in network. And what routinely happens in those situations is the patient is stabilized and then transferred to an in network facility. Now you say should it be the treating, under the Consent Decree is it the treating physician who makes that determination about whether transfer is appropriate or not, that sort of begs the question who is the treating physician. Is it the physician who is seeing that patient in the emergency room? Or if

that patient for example has a cardiologist or a PCP, primary care physician, who is an Allegheny Health Network physician who makes the determination as to whether that admission is in network or out of – further admission is in network or out of network at UPMC? All the Consent Decree says is that the services will be in network up to the point of stabilization. That's as far as the Consent Decree goes.

Rep. Frankel

I just want to – but is the physician the one who determiners stabilization?

W. Thomas McGough, Jr.

Yes, absolutely. The real question is who determines whether to transfer the patient or not, and there the question is which physician are you talking about? And the last thing any of us want, anybody wants is for this patient who unfortunately is in an emergency room has been stabilized and have AHN physicians arguing with UPMC physicians about where that patient ought to be, ought to be transferred or not transferred or nor transferred. So we are just going to have to work that out as time goes ahead.

Rep. Frankel

Thank you. The Consent Decree also has a directive informing patients about the out of network rates for procedures in advance, how do you expect that to work?

W. Thomas McGough, Jr.

We are working on that right now, Representative Frankel. As you know we can only give the patient the information that we have and we can advise them here is what is coming, what we believe is coming, here are the charges for that. The ultimate invoiced amount for that will be 60% of those charges under the Consent Decree. The piece that we don't necessarily have though is what portion of that is the patient responsible for and what portion is Highmark responsible for because that will be determined not only by the terms of the patient's benefit plan but also by where they may be on their annual deductible or their coinsurance or co-pays at that particular point in time. So about the best we think we're going to be able to do is to say to the patient this is what the total bill could be, 60% of that is what we expect to be paid promptly. And at that point there is obviously going to have to be a choice made by the patient and a dialogue that will involve Highmark.

Rep. Frankel

So if I'm a patient and I say I want X doctor at UPMC to do my hip replacement what's it going to cost? And can you tell me today what the cost of that procedure is, independent, not issuing the, you know you've got a charge master that's you know based on totally unreal numbers, it has no relationship to reality. You know the $25 aspirin, right? And I don't know – and I don't think this is just to UPMC, but you look at the issue nationally. Do you know what it costs to do a medical procedure? So if want, if I really want you know Dr. DiGioia to do my hip replacement and I want to know definitively this is what it's going to cost out of network to me, can you today tell me what that cost is?

W. Thomas McGough, Jr.

Prospectively we can tell you what it is likely to be.

Rep. Frankel

Well that's not going to be good enough I think.

W. Thomas McGough, Jr.

I know. We can tell you what it is likely to be but when Dr. DiGioia gets you, hopefully not you, hopefully a hypothetical person into the emergency room we don't necessarily know how that procedure is going to go. Are there complications, that sort of thing? So we can't say with precision it will cost you X and that's it. We don't know how the procedure will go. What we can say I believe, we believe is if everything goes according to plan this is what a person with your condition, what the charges would be for a person in your condition if it goes through the normal course. And under the Consent Decree you or somebody will be responsible for paying us 60% of that amount. Do you want to do that? And that's about as far as we can take the analysis. We can't say and you the patient will be responsible for this much of that because we don't – we don't know necessarily what the benefit plan is, where they stand with their deductibles and all that sort of thing.

Rep. Frankel

Do you view bundled payments as a kind of – a way to deal with the future in terms of payment?

W. Thomas McGough, Jr.

Let me turn – all the future questions go to Steve.

Rep. Frankel

I mean other systems are doing that and that when you have a bundled payment you know what it costs and it doesn't matter what kind of complications you have at the end of the day you are – that's what you are going to pay for that procedure. Why is that not possible here?

Dr. Steven Shapiro

It is possible, in fact for hip and knee replacements right now our orthopedic surgeons both our academic community and private have put together bundles that they are now working with our health plan and I think the future is to start to do this more broadly as well. But you are absolutely right, the future, this would simplify the situation tremendously.

Rep. Frankel

So I mean, so it sounds to me that on one hand there is – you are headed that direction but on the other hand going into this new world if somebody wants and out of network procedure done at UPMC there is no way that you can price that, you can give them a guaranty as this is what it's going to cost to do whatever procedure it is that they elect to do at a UPMC hospital? That it's – if somebody comes to UPMC to have a medical procedure out of – knowingly out of network it is an open ended question as to what that bill will be at the end of the day?

Dr. Steven Shapiro

It's not open ended, it's just that different hospitals have different rates and then there's the out of network.

Rep. Frankel

If I go buy you know a car I know what the cost is, right. If I go to get knee replacement, hip replacement, get treated for you know – do a transplant you know I can't, you can't give me that number? I mean that's a problem.

W. Thomas McGough, Jr.

We can give it to you more closer than any other health system in the country right now and we are working on ways and testing it to see if this is viable, yes.

Rep. Frankel

Well you are not doing bundled payments, I mean other hospital systems are so they do know, some systems do have a handle on what their exact cost is.

W. Thomas McGough, Jr.

We are experimenting with our own –

Rep. Frankel

Right, but you are not there. So it's not really – you are not ready for this kind of out of network environment in terms of consumers who want to be – go out and purchase healthcare at a UPMC hospital out of network by choice because you cannot tell that consumer what a procedure costs.

W. Thomas McGough, Jr.

Let me just go back for a second –

Rep. Frankel

It's really kind of perplexing, and it's not just an attack on you guys, this is –

W. Thomas McGough, Jr.

It's a very good question, I mean I'm not trying to fight the question, I think it is very appropriate and a very good question. And it comes down – at one level where we are now with our – with our systems and our charges list and that sort of thing there will be some procedures for which we're dead certain what it will cost. You want to go into your audiologist and have your ears cleaned, all right, and it's out of network we will probably have a high degree of certainty. If you want to come in and have a heart valve replaced, I'm not sure, Steve has said we are working on bundled payments that will essentially be guaranteed price no matter what happens to you and you know how you react or how long you are in the hospital. We are not quite there yet and so the come back to a patient who says how much will it cost may not be as precise as that patient might like. But we are working on the systems, we are working on the bundled payments and we are going to get them to the best place we can get them by January 1.

Rep. Frankel

You talked, I forget which one of you talked about information with respect to outcomes and pricing. You know we have a mechanism here in Pennsylvania PHC4 that would – that I think is clearly you know when it was conceived of it was probably state of the art and today needs to be updated, there is some flaws. But when you take a look at that data and I accept Dr. Shapiro's explanation with respect to acuity at UPMC hospitals and being an academic research hospital, but you look at those numbers three is – it's kind of disturbing when you take a look at costs at some of the most highly visible hospitals, UPMC hospitals, Allegheny General and then look at outcomes versus lower cost hospitals in our system. I mean how would you fix PHC4 in terms of giving – because I think it's an absolutely – given this new world we are going into you know with respect to trying to get a handle on what costs are and what value is in healthcare, which you talked about extensively, we need to be able to measure those things. So you know you are citing information I think from U.S. News and World Report.

W. Thomas McGough, Jr.

And CMS, and CMS hospital comparison.

Rep. Frankel

So I think ultimately how do we get a better metric?

W. Thomas McGough, Jr.

What we are having our physicians do is with the diseases that they care for to come up with their own pathways, protocols and determine the outcomes that are important to them and then we will monitor their adherence to the pathways and the outcomes and then try to get more general agreement through their national committees and do this at more of a national physician level. But we do need to get to true outcomes that are important and we need to standardize them and really have – we know transparency is coming, we know we are going to be measured and we welcome it, we just want to make sure that everyone is – we are measuring the right metrics the right way.

Rep. Frankel

As our healthcare systems move from you know an inpatient model to an increasingly outpatient model one of the things that is of interest to me is with respect to PHC4 one of the things that I would ask in terms of a modification is that we include outpatient data. Would you support that?

W. Thomas McGough, Jr.

Absolutely. The world is moving to outpatient, we take care of a lot of our patients and it matters.

Rep. Frankel

Thank you.

Rep. DeLuca

Any questions from (inaudible)?

Rep. Miller

Thank you, you might be able to help me with this, but the previous testifiers from the Medical Society came up with several ideas that would help in their mind with questions from the public as they move forward. I believe both of you were in the room during the testimony. One of the follow-up questions to that testimony talked about the shortness in time to implement. I know that – I believe there was some talk about some of your efforts to educate the public and to be cooperative in that process. I will tell you that the number one issue since I've in the last 16 months for my office has been the UPMC-Highmark concern, number one. So I just wanted to ask, knowing that there is a shortness of time for certain deadlines that will be coming up, I wonder from the testimony that you heard and hopefully received a copy of from the Medical Society is there anything that you found in their testimony that you believe would be a good supplement to your efforts or that you believe should be something that should be paramount for us to assist with in its creation?

Dr. Steven Shapiro.

We do agree that the shorter the timeframe the better, 20 days is a long time and I think we can work some of these issues out. We definitely – the onus is on us to give the patients the potential out of network charges immediately. And as you've heard about how some of the conversations will go between physicians and the state I

think once it gets to the state level it's a little bit out of our hands but we too would like to have things resolved as rapidly as possible for the patient's sake.

W. Thomas McGough, Jr.

And I'd just say Steve and I have met. With Jack and with the Allegheny County Medical Society, we are going to continue to meet with them. I was trying to write down the list, I didn't have a copy of his remarks but there is some – write down the list of the things that they suggested and I think there are some good suggestions and there the hot line being one of them. And some sort of attention to the level at which the communications and ads and disclosures are written I think is an excellent idea. So we'll continue that dialogue.

Dr. Steven Shapiro

And of course transferring records we always do, our physicians do want and Jack mentioned a say in the transfer of their patients to make sure they are getting the right care and the right physician, that's a little bit out of our hands. But we agree with the Allegheny Medical Society.

Rep. Miller

Thank you Mr. Chairman

Rep. DeLuca

Thank you Representative Miller. Any questions? Tom, let me just I want to clarify something, we know about the 60% of charges that's capped at. Now is that the charges that we receive on our statements without discounting? So just to give you an example, I get an operation, I get a $40,000 bill. It says the insurance company will only pay $8,000, so we've got $32,000. Is it going to be based on that $40,000?

W. Thomas McGough, Jr.

And as a matter of fact I think the thing you get specifically says this is not a bill and it has the charge amount and then it has what the insurance company will pay, what you guys charge. If it is in network it has your allowance. So the answer is yes, the out of network exposure would be 60% of that top line number.

Rep. DeLuca

Which could be pretty substantial as far as bankrupting a lot of people out there on their healthcare, am I correct? So we want to say well it's capped at 60%. That is going to cost a lot of people who are out of network a lot of money and the fact is we have to let them know 60% of the charge is on the left hand side, not the right hand side if you pay, am I correct?

W. Thomas McGough, Jr.

Correct. And 60% of a lot is still a lot in a lot of cases. There is no question about that.

Rep. DeLuca

Absolutely. I'd like to also recognize Brian O'Malley who is a representative of Adam Ravenstahl's office here, where is he at? He's out there. He's in the back. I want to thank him. Unfortunately Representative Ravenstahl had another commitment, but I want to thank him for sending his staff person. I want to thank you gentlemen for the – one more thing, Representative Frankel.

Rep. Frankel

Sorry about that. Let me expand on something between dialogue with Dr. Shapiro and Rep. Miller I want to flesh out a little bit. How prepared are you, UPMC, with respect to getting medical information to other doctors at Allegheny Health Network? Where is UPMC with respect to electronic medical records not just within your system but in terms of communicating to other healthcare systems?

Dr. Seven Shapiro.

Well we do have a health information network for several hospitals in the community that are on our systems and others with our interoperability. Allegheny Health Network isn't quite on their Epic yet but we definitely can get information to them in a very timely, immediate manner.

Rep. Frankel

And how would that happen actually?

Dr. Steven Shapiro.

Right now probably by paper, but we certainly will get the records to them.

Rep. Frankel

That's going to be an enormous, I mean we are talking about tens of thousands of patients that are going to be getting new physicians in all likelihood. You are prepared to get that information to new physicians today? I mean your system is prepared in a timely way, which is in some cases instantaneous right?

Dr. Steven Shapiro.

Yeah, we've always gotten records – we don't think in a day –

Rep. Frankel

You don't have an environment like this where you –

Dr. Steven Shapiro.

Well we'll see what happens but –

Rep. Frankel

But we want I think some assurance.-

Dr. Steven Shapiro

Of course, we will get the records in an extremely timely manner, within a day. I mean it's simple.

W. Thomas McGough, Jr.

And I should say we just this past week have had a telephone conference and we believe Highmark has too with the Department of Health on this very issue. I mean we all have our eye on this ball and we understand that it could be a challenge depending on how the numbers go and the timing goes, but we're –

Rep. Frankel

I hope you keep us updated because I do think that this is an extraordinarily important issue. I mean I've had my own issues within the system sometimes, I use UPMC in particular with my aging parents who I occasionally have to be in the emergency room with and dealing with looking just at their medications and inaccuracies there even within that system itself are really disturbing. So when we are talking about not only that but then try to transfer that information by paper to another healthcare system that is now you know in network for that patient I mean I think it's a serious concern that and possibility for medical errors resulting from it is something that we need to be absolutely focused on, it should be a top priority to both UPMC and Allegheny Health Network through this transition and I think we really want to hear some assurances that January 1 everybody is ready to go on this and I've got a feeling that we are not.

Dr. Steven Shapiro

We certainly think this is critically important, but in the older days before we had medical records for every admission we had in all of our systems you would call up the record and we could just as easily get it to the floor, Xerox it, ship it within a day. So it's not – transferring of the medical knowledge shouldn't be an issue although we realize it's critically important.

Rep. Frankel

Yeah, well it's an issue – I mean it is an issue nationally so the existing systems are not working, we know that. I can't speak directly towards what is going on here but we know that transferring medical information is a huge problem nationally. I don't think we are immune from it. So the existing system is not adequate and we need to be prepared particularly in this really kind of volatile environment of patients you know flying cross Western Pennsylvania that we are going to be assured that there is going to be the accurate transmission of accurate information, timely, should be instantaneous in my view and it doesn't sound like we are ready to do that as we enter this kind of new world that we are about to broach. So I mean I'm very concerned about it.

Rep. DeLuca

One more question from my Executive Director Alan Cohen. Alan?

Alan Cohen

Thank you, Chairman. Tom, you mentioned continuity of care and this question kind of drills down specifically on that and it's moving forward as we hit January. We have constituents that may present in a member's district in an outlier hospital that's in network and may need moved to a flagship facility, so let me just quickly read that example. Explain how you see the continuity of care provision in the Consent Decree applied to an individual who presents at an outlier UPMC facility like Hamot that is considered in network who then might need to be transferred to receive a service at a core UPMC facility, Presby or Shadyside that is out of network?

W. Thomas McGough, Jr.

Transfers from outside the 5 county area into the 5 county area are not covered by the Consent Decree, they are not in network just because they are going from a UPMC facility or a UPMC facility. If you add on top of that a continuity of care possibility, That is that this is related to the same treatment or condition I think that – I believe the physician and UPMC would have an argument that just because the doctor is making a handoff for the same condition that it would be within the continuity of care exception.

Alan Cohen

Could it be an example where the doctor practices at both facilities and feels he can't treat at the outlier and needs to see the individual at the flagship facility.

W. Thomas McGough, Jr.

Right, the continuity of care provisions do cover related – treatments related to the condition for which you are seeing a UPMC physician. So obviously there is some gray areas there, but it seems to me at least that the continuity of care would involve, certainly if the physician was moving from one facility to another, that would be within the continuity of care. I would think we could argue, we could assert that the physician - transferring from one transferring from one physician to another for that same condition would be under continuity of care. But Highmark has a say in this as well.

Rep. DeLuca

Thank you very much gentlemen and I want to thank you for your testimony and thank you for coming out. The next panel will be Highmark, Thomas Fitzpatrick, Senior Vice President, Provider Contracting Relations and Tony Farah, Chief Medical Officer, Allegheny Health Network. Thank you very much gentlemen for coming.

Thomas Fitzpatrick

Thank you, Chairman DeLuca and Representative Frankel and good morning to the others participating in today's hearing. I am Tom Fitzpatrick, Senior Vice President of Provider Contracting Relations at Highmark. Joining me at the table today is Dr. Tony Farah, Chief Medical Officer of the Allegheny Health Network. We appreciate the opportunity to be with you this morning to discuss the initiatives that the Highmark Health enterprise have undertaken to provide stability to our customers and to ensure that Highmark members have access to the world class healthcare they deserve. I think we can all agree that patients should come first. At Highmark we are committed to removing patients from the middle, we are committed to the best interest of our customers and the community by minimizing confusion in the market. Highmark is taking the lead in deploying resources to provide stability to our customers whether through the protections offered by the Consent Decree, through new insurance product offerings that provide choices for consumers, through enhanced customer service capabilities outlined in the transition plan Highmark will continue to ensure that our members have access to the bets healthcare in Pennsylvania.

You have already heard some of the details of the Consent Decree and Transition Plan from those who have testified earlier. In order to make the best use of our time I would like to address some of the areas that Chairman DeLuca has requested that we comment on. The Consent Decree gives protections for vulnerable populations including consumers age 65 or older who are eligible for or covered by Medicare, Medicare Advantage, Medicaid and/or Chip. This includes members who are eligible for but are actually enrolled in a Highmark commercial product like Signature 65, Medigap or some of the other retiree (inaudible) programs that we offer. Also any Highmark member who has commercial coverage or is considered an active aged individual who are 65 years of age and older and covered will have acces to UPMC providers on an in network basis. In Medicare Advantage members have full access to UPMC through our Security Blue and Freedom Blue products. This protection also includes those under age 65 that qualify for Medicare based on disability.

One of the other provisions that Chairman DeLuca has requested that we comment on is the ER and trauma services provision. Highmark members presenting at a UPMC emergency room will receive care on an in network benefit level. If the member needs to be admitted to the hospital the inpatient care will be covered at the in network benefit level through discharge. Under all circumstances before care to a Highmark members can be deemed as out of network UPMC must inform that member of their financial liability prior to that care being provided. Several UPMC facilities and physicians will remain in network for Highmark members. These facilities include Children's,

Mercy, Hamot and its affiliate Kane Community Hospital, Altoona, Northwest, Horizon, Bedford, Hillman Cancer Center and Western Psych Institute and Clinic. In addition to these facilities all UPMC emergency medicine physicians, pediatricians, oncologists and behavioral health providers are also in network. Any UPMC physician that practices outside of the 5 country Greater Pittsburgh service area, any physician that practices at any exception facility that we just mentioned as well as any UPMC physician practicing at the community hospitals is considered in network when they are practicing at those sites.

While the spirit of the Consent Decree and Highmark's Transition Plan have attempted to provide clarity to Highmark members the best way for members to protect themselves against being out of network is to ensure that their provider is part of our outstanding network prior to receiving services. Our network includes over 10,000 physicians and includes not only the Allegheny Health Network physicians but also more than 6,000 physicians that are either employed by community hospitals or are independent. In recognition of the new dynamic healthcare landscape Highmark is offering many health insurance products that continue to meet the expectations of employers and individuals. We understand that each consumer has different needs and budgets, therefore Highmark offers innovative products with an extensive provider network to meet the needs of our members. These products include both traditional broad networks as well as tiered benefit plans.

As an example of our innovative product offerings Highmark has recently launched Community Blue Flex PPO, a new tiered benefit that will offer Western Pennsylvania consumers two levels of in network care. This product will allow members to choose doctors and facilities near where they live and also allow them to choose care based on the cost that is right for them. Also Highmark has introduced Community Blue Medicare HMO in Western Pennsylvania. Community Blue Medicare HMO is a low cost select network option that complements our broad Security HMO and Freedom Blue PPO products.

In order to answer questions from the community regarding which physician or hospital is in network or to assist with the transfer of care to other high quality in network physicians Highmark has launched several platforms to assist our customers. To assist Highmark members we have our traditional provider directory that shows the current status of our network. We have also recently launched a new web based tool that will help members navigate what the new healthcare landscape will look like in 2015. It should be noted that there is a longstanding process for terminating physicians that we have historically followed and it is out hope that this practice will continue as we move closer to the end of this year. Once we receive notice that certain physicians are actually terminating we will have our provider directories updated. Our new tool, yournetwork2015.com will allow Highmark members and members of the public to view which doctors we believe will be in network beginning next year. Additional functionality on the website will permit users to find new doctors and will include cross-functionality with other Highmark customer service tools. Highmark members also have the option to talk to member service representatives by calling a new division of our customer service group called My Care Navigator. This service is designed to help consumers navigate the healthcare system. Representatives can answer member questions, help them find new doctors, transfer medical records and even schedule appointments. Highmark is interacting with our members in new and nontraditional ways. Members who use Facebook, Twitter and other social media platforms can visit our pages to stay on top of changes, learn what other members are saying and obtain helpful information to make the most of their healthcare coverage.

In closing I'd like to reiterate that Highmark is taking the lead in providing stability for our customers. The Highmark network will continue to provide access to affordable, world class and comprehensive primary and specialty care from thousands of physicians and at dozens of community hospitals, speciality hospitals and renowned medical centers in Western Pennsylvania and across the country. Highmark stands ready to help the community with the appropriate resources to answer questions and provide clarity during this time of transition.

I'd like to know turn the conversation over to Dr. Tony Farah from the Allegheny Health Network to provide you with insight on how the Allegheny Health Network is prepared to seamlessly meet the needs of Highmark members in the community at large.

UPMC LIFE CHANGING MEDICINE

PENNSYLVANIA HOUSE OF REPRESENTATIVES
DEMOCRATIC POLICY COMMITTEE HEARING
AT POINT PARK UNIVERSITY
October 10, 2014

Dr. Tony Farah

Good afternoon Chairman DeLuca, Committee members. On behalf of the Allegheny Health Network, its 17,000 employees and 2100 affiliated physicians I would like to thank both the Committee and the members of the community who have joined us today for the opportunity to talk briefly about the Allegheny Health Network and the tremendous value that we bring to the region as the healthcare provider arm of Highmark Health.

One of the most pressing questions that we receive on a regular basis with the many changes taking place in the local healthcare market and the anticipated impact of the Consent Decree between Highmark and UPMC is are we as a network capable of meeting the healthcare needs of a growing patient population with the same high level of quality, innovation and service excellence that our patients have come to expect from us. And the answer to that question I'm happy to say is a resounding yes. For more than a century the physicians and hospitals of Allegheny Health Network have proudly served the Western Pennsylvania community with great distinction and a steadfast commitment to our charitable mission. Even in the midst of the tumultuous financial difficulties many of our facilities have weathered over the past decade the one consistency that saw us through those challenging times and led us to the bright future we now have as part of Highmark Health has been the exceptional quality of care that we have always provided and the personalized approach to care that we bring to every patient. The resilience that we have shown and the remarkable growth and success that we have achieved in just 16 months since joining the Highmark family is a reflection on the immensely talented and dedicated group of physicians, nurses and support staff who have stayed loyal to us and are now leading us so capably in to the future.

At AHN and Highmark we are bringing a new approach to healthcare in Western Pennsylvania with a focus on making high quality healthcare more accessible, convenient and affordable to consumers. We are focused not only on filling the beds of our hospitals but on best we can promote wellness, prevent disease and meet the changing needs of patients as more and more care shifts to an outpatient model. Keeping care in the communities where people live and work is how we plan to make a difference and set a new standard for healthcare delivery in our region.

So how are we achieving this vision? First and foremost it's important o impress upon the community in no uncertain terms that we are more than capable of meeting the comprehensive healthcare needs of any and all patients in our region who seek care within our network. AHN has both the inpatient and outpatient program capacity to ensure that all patients are cared for in an effective, timely and personalized manner. We provide advanced high quality preventive, diagnostic and treatment programs across every single medical discipline. We employ more than 1100 physicians and have a total of 2100 affiliated physicians on our medical staff. We've added more than 100 new physicians to our medical staff over the past 2 years. We have more than 250 employed primary care physicians based at more than 75 locations across the region. AHN offers a complete scope of medical, diagnostic and surgical specialty care and in addition to our more than 750 employed specialists there are more than 500 independent but closely affiliated specialists who are available to provide care.

Within the OB/GYN space AHN employes 110 OB/GYN physicians with more than 50 office locations across the region. In obstetrics in just one month we will open a new obstetrical unit at Jefferson Hospital, the first OB program in this region in more than 30 years. While many others around the country are shutting down OB obstetrics programs or consolidating them, we are keeping care in the community where women live. When it opens Jefferson will be the fourth obstetrics program we offer. The convenience will allow thousands of expecting women to access high level obstetric care without having to travel miles into the city. AHN's capabilities for women's healthcare are as sophisticated as those found anywhere in the country with a complete spectrum of health needs including uro-gynecology, pelvic floor reconstruction, gynecologic oncology, minimally invasive gynecologic surgery, breast disease, bone health, women's heart centers, integrated and complementary medicine and all medical subspecialties.

With respect to cancer AHN has a comprehensive multidisciplinary regional cancer network with more than 150 oncologists who practice at nearly 50 sites across the region. Our doctors are leaders or more than 200 cancer

clinical trials exploring novel therapies for many cancers. Earlier this year we established a formal relationship with Johns Hopkins National Cancer Institute Designated Kimmel Cancer Center to further advance the level of care we provide to the region. It is the first relationship of its kind for Johns Hopkins and they chose AHN because of the quality of care we provide.

Within cardiovascular care AHN's history as a pioneering center for heart care innovation is no secret. The network has a comprehensive multidisciplinary team of nationally recognized cardiologists, cardiothoracic and vascular surgeons, nurses in Allied Health Professionals who see patients at over 25 sites throughout the region. Our Cardiovascular Institute offers patients every possible treatment option including many cutting edge therapies available at only select medical centers in the country.

In orthopedics AHN is also a national leader in orthopedic surgery, sports medicine and rehab care with 17 orthopedic and rehab centers across the region. This year we were selected by the U.S. Olympic Committee to serve as a regional Olympic Medical Center, one of only a select few in the nation and trusted to care for the nation's elite Olympic athletes. We are also the official sports medicine providers for the Pittsburgh Pirates.

In the newer sciences space AHN's neurosurgical and neurology programs are nationally recognized and second to none in Western Pennsylvania. We have leading centers for movement disorders, epilepsy, stroke, traumatic brain injury, concussion management and brain tumors. Our doctors see patients at dozens of locations across the region.

These are just but a few good examples of the impressive scope of resources and options that Allegheny Health Network offers to the people of Western Pennsylvania. And most importantly from a quality of care standpoint patients who access these and our other services can be assured they are in the very best of hands. The quality of care at AHN and safety of care provided is as good if not better than you will find anywhere in this community or across the country.

In the highly specialized field of organ transplantation for example AGH has posted 3 year outcomes for both heart and liver transplantation over the past several years that are not only the best in Western Pennsylvania but among the best in the nation. AGH's 1 and 3 year liver transplant outcomes are the best of any transplant center in the state.

Thanks to Highmark we are making significant investments in our facilities and programs to ensure that we continue to provide patients with such high quality, state of the art care. In addition to the new Jefferson OB program we are investing more than $30 million to expand and modernize the obstetrics and neonatal facilities at West Penn Hospital. We are the first in the country to install GE's new cutting edge 3-D mammography tomosynthesis units and will do so at 5 of our locations. We've just opened one of the nation's largest most innovative and comprehensive outpatient care facilities in Wexford to better meet the needs of those who live north of the city. We've also invested in similar facilities across the region with our Health and Wellness Pavilions in Bethel Park and Peters Township, and in a few months we'll be opening an Urgent Care Center in Braddock to help fill the void and provide needed services in a community left to fend for itself after the closing of its hospital. Why? Because our charitable mission compels us to do so.

Again these are just a few examples of the commitment Highmark and AHN have made to advancing the delivery of high quality, more accessible and affordable healthcare services in our region. We are also helping to keep care in the community and enhance access to care by having our physicians establish and expand on clinical programs based at independent community hospitals in the region allowing us to partner with those hospitals to help them provide better access, leading care and more affordable options. At AHN we understand that change can be extremely stressful and difficult under any circumstance, but particularly when it comes to one's health and wellbeing. I'm here today to assure both the Committee and those in the community who are faced with finding a new physician or program after January 1st that you have great options available to you both at AHN and at our

many outstanding independent hospitals in the region to receive the exceptional care that you need and deserve. Thank you.

Rep. DeLuca

Thank you doctor, thank you for telling us everything AHN has, everything Allegheny Health Network has so now let's get down to some of what we are here for, what we are here for, get some information on the Consent Decree. I'd like to know your answer to the question about what UPMC has identified as one of the Medicare products that you are rolling out which they believe is illegal and that will only have access to your facility. And if we want to protect the seniors then how are we protecting them and giving them choices if they only have choices to your facilities?

Thomas Fitzpatrick

Well just to be clear, that product has – offers access to more than just the AHN facilities, that product was offered to all of the hospitals in Western Pennsylvania including UPMC. A number of them including UPMC did decline to participate in addition to other systems like Butler and Excela in Westmoreland County and Washington Hospital. But the rest of the Keystone Health Plan Network and the independent physicians are a part of that, that product. And we were clear as we were going through the transition plan with the state that we were getting ready to launch this product and that this product was approved by CMS.

Rep. DeLuca

So in other words after the news conference when seniors were told that they would not be touched they in fact will be touched, am I correct, because as I look – and they will be touched because as I look here you have raised most of your products and just lowered a couple of them, so naturally with seniors on fixed income they're going to look at price not knowing what's inside that policy. Now I understand you are launching some high tech networks where you can get information and that there, but a lot of seniors don't have access to them computers and don't have access to being able to navigate them systems to find out that kind of information. A lot of seniors don't have family around because we are a mobile society and the fact is if they don't have anybody giving them advice they could be caught off guard using all their savings for out of network products. Am I correct?

Thomas Fitzpatrick

We are absolutely dedicated and committed to meeting with and making sure that any senior that chooses this product is well aware of the constraints that this product brings.

Rep. DeLuca

So what you are saying is the fact that under the Consent Decree you have the authority to come out with this product and it will not go into the courts, is that what you are saying?

Thomas Fitzpatrick

Our belief is that we reserve the right to offer this product. The Consent Decrees were done in cooperation with a number of other Agreements, the mediated Agreement from 2012 as well as our Affiliation Order from West Penn Allegheny Health System acquisition and in that Affiliating Order one of the conditions was that we offer consumer choice initiatives. And so we believe that we are complying with that Order by offering these kinds of products to the seniors who we know very well and we know that they need options.

Rep. DeLuca

But this product will only be available for in network, am I correct, your hospital? This new product you are rolling out is only pertaining to Allegheny General am I correct on that? No? They'll go where?
Thomas Fitzpatrick

This product has an expansive network of all of our Keystone Health Plan West Network, so Highmark's existing network minus the UPMC facilities, minus Butler Hospital, Excela and Washington Hospital and St. Clair Hospital.

Rep. DeLuca

Which is quite a lot of facilities right?

Thomas Fitzpatrick

They were all offered participation in the product in an effort for us to meet certain price points and they had declined to participate in the product. But it is not a closed network product to just AHN and again these products are currently in the network as was described earlier. There are these narrow network product offerings in the market today, seniors do choose them and there is an education effort that needs to go on along with those and we are prepared to meet that obligation.

Rep. DeLuca

All right, let me ask you another one, based on the Consent Decree please explain to us whether Highmark's subscribers would be in network or out of network once treated and stabilized in an emergency room at a core UPMC hospital? If they need further treatment could they stay at that UPMC hospital as an in network patient or would they need to be transported to an in network facility?

Thomas Fitzpatrick

Those members will be covered as in network and that's what we negotiated for throughout that emergency episode including the inpatient mission through discharge.

Rep. DeLuca

So that will be in network?

Thomas Fitzpatrick

That's correct.

Rep. DeLuca

Okay. And I have one more here, can you explain the continuing care provision in the Consent Decree applying to Highmark subscribers who present at outlying or a UPMC facility like Hamot that is considered in network who then might need to be transferred to receive a service at a core UPMC facility like Presbyterian and Shadyside that was out of network, the same question we asked UPMC.

Thomas Fitzpatrick

So what we were interested in as we negotiated through the Consent Decree was absolute patient protection. And so we made it a point and we wanted to make sure that we protected our members so that if they were to be transferred from a satellite – satellite in network facility that they would have to be referred to an in network facility.

Again we wanted to take patients and members out of the middle and we wanted to make sure that they could maintain continuity of in network coverage, and that's what we negotiated for.

Rep. DeLuca

Okay, just one more, as I read their comment and I want you to comment on it. On July 20, 2014 Mr. Holmberg stated on KDKA TV that anyone over the age of 65 would have in network access to UPMC under any of the Highmark products. Is that true?

Thomas Fitzpatrick

Well I believe that those individuals will have access to UPMC under the Freedom Blue and Security Blue products. It was our hope that UPMC would have agreed to participate in the Community Blue Medicare Advantage product and they decided not to. So therefore in that particular product those individuals would not have access, in network access to those UPMC facilities.

Rep. DeLuca

So was that product rolled out after he spoke on KDKA TV, or was – is that something after the July 20 something Press Conference he had at KDKA, that product came afterwards is that correct?

Thomas Fitzpatrick

Yeah, I don't know the exact timing of our approval, Chairman, but I can tell you that the marketing of that product did not occur until a couple of weeks ago.

Rep. DeLuca

Okay, thank you. Representative Frankel.

Rep. Frankel

Thank you. The Community Blue Medicare product, I mean it's a narrow network product and I'm all for having product different choices for folks but ultimately what I'm hearing from a lot of my constituents is that you've raised the price of the traditional Medicare products substantially, which would seem to be an effort to drive business to the Community Blue product. Can you talk about that? I mean what the rationale for A, the increase in some cases I've been told 70% in the traditional Medicare product?

Thomas Fitzpatrick

I can tell you that is not the strategy to drive people into this product. As you know there are a lot of factors that go into rate setting, a fair amount has to do with the risk profile so the current membership we have in those products as well as the revenue that we receive from CMS for those products. So you know we believe that our rates are actuarially sound and that's what we've produced and had approved and that's what we've rolled out into the marketplace. Again knowing this population and knowing the choice and knowing how important it is you know to have a product that meets certain price points that's why we feel so strongly that we had to get this zero dollar premium product into the marketplace to provide the choice for these seniors who make the decision knowingly and willingly that they do not have or want access to some certain facilities.

Rep. Frankel

What community hospitals are in the narrow network product?

Thomas Fitzpatrick

There is well over you know 50 community hospitals you know in and around the 29 county service areas, so places like you know Heritage Valley and Ohio Valley, you know when you get into the outer ring you've got places like Armstrong in Indiana and you know up the 79 corridor like Grove City and you know all of the other hospitals within you know our Keystone Health Plan West network agreed to the price that we had put out there from a reimbursement perspective and that has enabled us to price that product you know where it's priced.

Rep. Frankel

Let me pursue some of the questions I had for UPMC. So if I come to Allegheny General for a procedure and I'm – and you are out of network, I've got UPMC insurance, can you tell me what the cost of that procedure will be out of network?

Dr. Tony Farah

No, I don't believe we are any different from UPMC in that regard in terms of giving patients an exact cost. That being said Highmark is introducing transparency tools which we as physicians are fully supportive of so that the consumer can through multiple means access that type of information ahead of time so they are better informed about making those choices.

Rep. Frankel

But there is no real certainty. I mean you could have – I mean you have transparency without you know – transparency about basically uncertainty in the marketplace. That seems to me again I mean where are you looking towards new models with respect to things like bundled payments which require you to know what it costs to provide a certain procedure and guaranty to the patient that that's the cost no matter whether there are complications, a readmission, an infection. I mean we need to be doing better here and particularly in an environment where folks are going to be looking, coming if you have some specialty that is unique in the community and want to do, take buy it out of network you know how do we know what that is? So transparency without that kind of information is not particularly valuable.

Dr. Tony Farah

So actually I'm glad you are asking that question, this is – this is a problem that's not unique to us as you pointed out earlier. I mean throughout the country very few centers, there are few centers who have introduced precise cost data to the consumer, primarily to large employers, national employers. For instance you know Cleveland Clinic has introduced fixed costs for bypass surgery to a number of national employers, large employers. They come in, they get the procedure done no matter what happens it's a fixed cost to that employer. We at the Integrated Delivery Network, which is now Highmark along with Allegheny Health Network, our goal is to drive toward exactly what you are asking for. Our goal is to get to the point where consumers have complete transparency as to the cost, not only cost of insurance but cost of the care in addition to the quality that you pointed out earlier. What we have today that isn't yet available to the consumer is we are bundling a whole number of common procedures, they are mostly surgical and medical surgeries and procedures that are very common that we believe we will be able to provide that type of cost data on in a very transparent manner. We are not yet – we are not there yet but that is our goal.

Rep. Frankel

Where are you with respect to medical records, electronic medical records, where is your system?

Dr. Tony Farah

Within Allegheny Health Network?

Rep. Frankel

Within and then in this environment where are you – what would be your understanding of what the relationship is with UPMC and other health systems and your ability to access medical information about a new patient coming into your system and the difficulties I kind of outlined in the questioning I had with UPMC.

Dr. Tony Farah

So as you very well pointed out earlier that is a nationwide problem, systems don't talk to each other and every time I see a patient in the office who may have seen a different provider or been to a different hospital whether it's local or out of state it has not been easy to obtain those records in as seamless a manner as you ask for. Within Allegheny Health Network we are rolling out one system, it's the Epic system, that connects all inpatient and outpatient facilities together, so all 1100 physicians, their practices, all 7 hospitals in this region. That's one of the reasons we chose that system is because as long as other healthcare systems across the country including Pittsburgh choose to opt in, as long as they have that system and this is one of the most commonly adopted system across the country, electronic health record systems, then this allows any provider to access the medical record of an individual patient as long as this other system has opted in. That is not the case with UPMC and we already have had patients who have transitioned their care from UPMC physicians to Allegheny Health Network physicians and this has occurred primarily by – through fax.

Thomas Fitzpatrick

So Representative, we would absolutely welcome the opportunity to work collaboratively through the Allegheny County Medical Society and UPMC to come up with a standard form to transfer these medical records. That has been requested as we've continued our efforts and if we could arrive at a place where we actually got patient medical records transferred in one day as it was referred in previous testimony we would absolutely support that and welcome that and do everything we can to get to that place.

Rep. Frankel

Does that happen now?

Thomas Fitzpatrick

It is not happening right now.

Rep. Frankel

So in an environment with you know an enormous amount of volatility and dislocation of patients that we are about to face that's not likely to improve and probably deteriorate?

Thomas Fitzpatrick

Again in the perfect world we would love for that exchange to happen electronically, but as you heard from previous testimony this is happening via fax machines and you know this is happening in weeks not days.

Rep. Frankel

It doesn't sound like we are ready for prime time here with respect to what we are about to face. And we were talking about patients and the interest of patients in this environment and the volume of change that our healthcare systems are looking at this next year. We are not ready to ensure patients that they are going to have their information safely transferred, accurately transferred to give physicians in either healthcare system the information they need to treat their patients as they, as the marketing that takes place between these two entities and switching around of providers takes place. We aren't ready would be my assessment and that patients could be at risk, certainly greater risk than we are at at this point.

Thomas Fitzpatrick

So we again are working with UPMC in an effort to arrive at a place that it's much more seamless. We are doing everything that we can possibly do through the patients in working with them through release forms and then using their claims data in an effort to try to get at a minimum a patient summary that we can get to the new physician. It is not –

Rep. Frankel

I would like a request on behalf of you know of us who represent this community that as soon as possible we get a outline of exactly how that information is going to be transferred, where you are headed with this, how it's going to be done so that we can protect patients. So I would like some collaboration between the two systems to come up with a proposal that makes sense, that protects patients first and make sure that we have accurate transfer of medical information that is absolutely essential to the safety of patients in this community. And that – so I think that would be a great indication of the new day that seem to be in the offing when as Mr. McGough talked about that Press Conference where everybody stood on the dais at the – in the Media Center at the Capital, that there is actual collaboration. This is a critical issue, we need to make sure that you and UPMC are prepared and that our patients aren't going to get lost in the shuffle in an environment that's going to create peril and the possibility of more medical errors than we see today because of this lack of transferred information. So I would say that before January 1 I'd like to see a plan. Obviously maybe not something that's going to be completely ready to go but some way that you are going to lay out how the two systems are going to work together to get the information to doctors that they need in order to treat patients adequately and well. So I make that request.

Dr. Tony Farah

Thank you Representative Frankel, I'm glad you brought that up. I can tell you the technology is available today to allow seamless and immediate transfer of records from one physician practice to another, from an Emergency Dept. to another, and we would welcome that level of collaboration.

Rep. Frankel

Finally let me ask you with respect to Pennsylvania Healthcare Cost Containment Council you know I asked about endorsing the issue of broadening the mandate for PHC4 to give us more transparency and with respect to the fact that we are looking at more healthcare being provided in the outpatient setting as opposed to inpatient setting and we don't collect data today with respect to outpatient costs and outcomes that I'd like to see PHC4's mandate include outpatient information and data. Would you support that?

Dr. Tony Farah

Absolutely, and you are absolutely correct when you state that the outpatient quality data have not been reported for the most part across the country. You know despite its limitations PHC4 has gotten us you know one step in the right direction, but as you know it's been around for a long time and there hasn't been a whole lot of advances when it comes to measuring and reporting the types of quality metrics that the patients, the subscribers are looking for. So we would more than welcome that.

Rep. Frankel

I think this is very important so that people understand. I mean as I said at the outset of my remarks, the outcome that was negotiated in this Consent Decree is not how I would envision healthcare taking place in Western Pennsylvania. I want competition not just between insurance companies but I want direct competition between providers. I don't think we are getting that with this Agreement. However if we have a tool that provides very good and accurate information about costs and quality including outpatient information consumers will be empowered to make intelligent choices that will create the competition that we want. So I would say that as folks out in the audience understand this we need to have the kind of information and transparency that creates that environment that will only improve our healthcare systems. And we have the opportunity to do that. So I appreciate both UPMC and Allegheny Health Network and Highmark endorsing a broadening of that tool and because I know it will be a discussion as we move into the next legislative session so that we empower consumers to help improve the quality of care and give them the information they need to make intelligent choices among healthcare systems. Thank you.

Rep. DeLuca

Thank you. Representative Costa.

Rep. Costa

Actually my question is going to be very easy. You mentioned the Urgent Care Center in Braddock, what actually is it going to be called, an Urgent Care Center?

Dr. Tony Farah

Actually I'm not sure what the name is but it will provide the same level of services as Urgent Care Centers in the region provide.

Rep. Costs

Thank you. Well the reason why I ask I am also moving into that building, as a matter of fact we are moving next week and I've been telling people that we are on the first floor, the second floor is an Urgent Care Center but I never knew what the name – but I do while you guys are here I do want to thank you.

Dr. Tony Farah

We can get back to you on that.

Rep. Costs

Thank you. I'm thankful that you are putting that in the Braddock area and I want to thank Dan Onorato, I know he was here somewhere in the back, but Dan had worked on this when he was the County Executive and continued in his capacity today to make sure that that actually happened. And I want to thank you guys for coming back to Braddock, so thank you.

Dr. Tony Farah

Sure.

Rep. DeLuca

Thank you. I have another question. Can you describe how you are handling the safety net issue when a subscriber has not transitioned to a doctor of their choice in your network? Are you pushing them to find a doctor or are you giving the subscribers the full year grace period until they have a new doctor in your network as the Transition Plan and the Consent Decree specifies?

Thomas Fitzpatrick

We certainly intend to comply with the Consent Decree. We have taken a very broad approach to the safety net. In fact we have communicated that extensively to our existing members, to our clients, to our brokers, etc. And we believe that if members are unable to find a physician they are covered by the safety net and they are never going to run into a situation where the insurer is debating that decision, especially in 2015.

Rep. DeLuca

Good. Let me also read a little bit on and October, and I'm sure you are familiar with this letter, it came from the Insurance Commissioner, the Attorney General and the Secretary of the Department of Health. On October 1, 2014 we provided Highmark with notice that we believe the Consent Decree has been violated with respect to the Community Blue Zero Dollar Medicare Advantage product. It provided Highmark with 20 days to cure it. Unfortunately you confirmed in your October 2, 2014 response that Highmark intends to go forward with this Medicare Advantage product thereby refusing to cure under this Consent Decree. Please be advised, and it goes on to say other stuff, please be advised until this matter is resolved we view Highmark continued marketing of Medicare Advantage to be a violation of the Consent Decree which we will be going to Commonwealth Court. Finally we are extremely disappointed that both companies appear to have lost sight of the spirit in which you entered into the Consent Decrees, which was to protect the insurance consuming public, specifically the vulnerable population that all parties agreed needed the most protection and continued access. Moreover both parties seem more motivated to using the Consent Decree as a mechanism to gain leverage in contract negotiations than a platform to move forward for the transition that puts the consumers and patients first. They are intending to take you to court, you are familiar with that right? Okay. So we are going to have a court problem on this situation with this product and I guess the courts are going to be deciding some of this stuff that we can't do with arbitration. So I just wonder what would happen if the courts rule that this product is not permissible and people have signed up for it? What happens in a situation like that?

Thomas Fitzpatrick

Yeah, so in the unlikely event that the product is removed from the marketplace there is a, CMS has a special open enrollment period that we are very familiar with, again being you know one of the largest players in the country in that space. So members who have chosen that product would have the opportunity to choose another Highmark product or a product from another competitor. And they would have enough time to be able to accommodate for that.

Dr. Tony Farah

May I just add something?

Rep. DeLuca

Go ahead doctor.

Dr. Tony Farah

So I just wanted to give you a perspective from both physicians and patients. Over the last number of years thousands of patients that used to either see myself or many of my colleagues, not necessarily just at Allegheny Health Network, had to transition away from our practices to UPMC physician practices for exactly the same reason that this product is being introduced. So my whole point is this is not a unique product, there has been a UPMC Health Plan Medicare Advantage product that's been in existence. Our patients have had to transition out over many years and we've actually facilitated that access because we have to, right. And I just want to make the point that it's been in existence and we, many of us, physicians and patients, have had to deal with this over a period of time.

Rep. DeLuca

Doctor, I don't doubt it's been in existence, but according to the three individuals on that panel they are taking you to court with this product because they disagree with you, okay? John Brennan, do you have a question?

John Brennan

One of the Chairman's biggest issues has been transparency with the Consent Decree and there has been some back and forth regarding the list of physicians that are going to be in network starting next year. Now you talked a bit about the new tool your Network 2015, is that going to clarify for anyone going on there that there are certain physicians that they are say practicing at Altoona, they'll be in network then but when they are primarily they are at say Presbyterian they will not be? Is that going to be clear?

Thomas Fitzpatrick

Yes, the tool was created in cooperation with UPMC. We had exchanged lists of doctors and we had agreed upon a footnote that is prevalent on the website so there are certain physicians on the – your Network 2015 site that have an asterisk but then call to the member to look at that footnote. That again was agreed upon between the two organizations that clearly spells out that these physicians are only in network when they are practicing at in network facilities, and it lists all of those exceptions that I just laid out. So again we want to be as clear as possible, we want to eliminate as much confusion as possible. And again we welcome you know the opportunity to clarify. Our position going in with respect to physicians was we believed that they should be either always in or always out, and we had communicated this to the state, to UPMC and we knew that there was an opportunity for this confusion. So we will do everything that we can, again taking you know updates and working in cooperation with UPMC to update the site and make sure that it is as accurate as possible.

John Brennan

Thank you.
Rep. DeLuca

Thank you gentlemen, I want to thank you for your time in taking the questions and thank you very much and we look forward to working with you and UPMC in the future. Thank you very much. Our next individual to testify will be the James Donahue with the Executive Deputy Attorney General, Pennsylvania Office of Attorney General. James? I want to thank you for coming and I want to thank Attorney General Kane for permitting you to come to testify here at this meeting today. Thank you very much.

James Donahue III

You are welcome, Chairman DeLuca. Chairman DeLuca, member of the Committee thank you for the opportunity to talk to you today about our efforts regarding the disputes between UPMC and Highmark and the Consent Decree we entered into with them on June 27, 2014. I will address three main points today. First is how we came to the Decree as the appropriate resolution of the dispute between Highmark and UPMC, the underlying principles under

the Decree and how the Decree is going so far. 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. 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. Other states like Maryland have such a mechanism for resolving price disputes between hospitals and health plans, but we don't have that statutory tool here.

So we looked at the core issues and we had two nonprofit corporations that had certain unique assets that were not available anywhere else. In addition consumers could suffer dramatic consequences if they only had access to healthcare on an out of network basis. So we looked to do two things, protect those who were vulnerable and who would be objects of charity; and to ensure that consumers who had Highmark insurance would not be out of network when they absolutely had to seek care from UPMC. So the principles that guided us were these. First, that UPMC and Highmark had to have a contract with each other, in those circumstances when contact between the two was unavoidable, specifically Highmark subscribers had to be treated on an in network basis when they had to do things like go to the ER. Second, we had to protect the most vulnerable members of the community, the poor, the elderly and children. The Consent Decree we, with the Departments of Insurance and Health, entered into achieves these goals. Vulnerable populations, children, the poor and elderly have access to UPMC assets. Consumers who need emergency room care, cancer care or services where UPMC is the only provider such as the case in Bedford or with Western Psychiatric Institute have in network access. The Consent Decree means that some consumers who have been using UPMC and have Highmark insurance will need to switch their doctor, if they do not fall within one of the protected categories. We believe that the categories we protected address the circumstances where an access to UPMC is most important.

The Consent Decrees are admittedly very complicated and I know here are a lot of questions. Consequently I can't say things have gone as smoothly as we would have liked. One of the things that has come up has been this new Medicare Advantage plan that Highmark has launched recently that has a very narrow network that excludes UPMC hospitals. We are going to make a filing with the Commonwealth Court later today seeking an injunction to make that plan comply with the Consent Decree. We have a couple of problems with what Highmark has done. One is, as has been pointed out earlier today, immediately after the Consent Decree was signed they took out advertising throughout Western Pennsylvania saying that all seniors will have access to UPMC. Secondly, we have a vulnerable population provision which specifically says seniors will have access to UPMC. And thirdly, there is some broad protections for ER, oncology and the exception hospitals that are included in the Consent Decree that aren't being followed either. You know we are not happy about this. You know as Highmark has indicated they have – they believe they have good reasons for doing what they are doing, and we expect that they will fight our efforts vigorously. And I also want to be clear is our effort is not to remove a zero dollar product from the market, our effort will be to make sure that zero dollar product complies with the Consent Decree.

The – you know as was noted in the letter that I think you read, Chairman DeLuca, that was sent by the Attorney General and the Commissioner of Insurance and the Secretary of Health there has been considerable frustration among our agencies with both of these organizations, both before we entered into the Consent Decree and with all of the many issues that have come up between the two organizations since then. You know it's unfortunate that there is that frustration with us but that's – you know we are prepared to enforce the Decree and stand by the principles that we tried to protect. I'd be happy to answer any questions that I can.

Rep. DeLuca

Dan, do you have a question? Let me ask you, Jim, under paragraph 4 of the Consent Decree the Insurance Department, the Department of Health and the Attorney General have exclusive jurisdiction over enforcement, anyone including Highmark or UPMC can file a complaint with any of these agencies if they believe the Consent Decree has been violated. My question is a practical one, how does someone file a complaint? Will there be one standard complaint form? Will each agency have its own complaint form? Or can a person simply send a complaint letter to one of the agencies?

James Donahue III

A person can simply, you know a regular consumer can send a complaint letter to the agencies.

Rep. DeLuca

So they could just their self send a letter to one? Okay. And you -

Rep. Frankel

In the Consent Decree in the discussion on out of network services you heard the conversation that I had with both Allegheny Health Network and UPMC. In this Consent Decree it talks about out of network charges that Highmark subscribers shall be no more than 60% of charges paid promptly and provided that UPMC informs consumers of such charge before rendering services. That would indicate to me that at the outset the provider has got to set the price with certainty, my interpretation of that.

James Donahue III

The – you know the example that we've been using you know this morning has been the knee replacement and I think both you know Mr. McGough and Mr. Fitzpatrick had noted that yeah there is some, you know there is a standard knee replacement and there is a – they have a good idea what that's going to cost and they can tell the consumer ahead of time what that knee replacement is going to cost. The question is and we didn't answer this in the Consent Decree is okay so you are having a knee replacement and while you are on the table you have a stroke or you have a heart attack and that mandates you get a second procedure of some type to – you know to save your life. That, and I'm not a medical doctor so I don't know whether strokes or heart attacks routinely occur during a knee replacement, but yes that sort of thing can happen and the consumer then could face a bill that is larger than they were told about in the first place.

Rep. Frankel

That just seems to me to be not a very good approach. I mean there ought to be at that point some guaranty to the consumer that they are not going to get gouged if there is a complication. I mean such as guarantying at least beyond that if there is a complication an in network charge or something. You know I don't think anybody even if you know the most wonderful doctor in the world that you want to access at one of these systems would go in there with an open ended possibility that you'd be out of pocket based on 60% of charges if there is any kind of complication. I mean what happens under you know another healthcare systems where you bundle services and

there is a complication? My understanding is that that's the charge. And there ought to be some clarity here it seems to me, because I interpret this as saying informs of such charges before rendering services. It doesn't matter what the complications are, you know complications happen, they've got to be included in – the consumer is not going to be exposed to additional charges. I mean sometimes there are complications that are because of somebody's health condition, sometimes there are complications because of mistakes made, infections, etc. that may not be necessarily a result of the patient's condition but the care provided, how do you draw those lines? There needs to be some clarity here it seems to me, and my interpretation is that there is clarity here, that basically if you are told that knee replacement is $35,000 that's what you are going to pay no matter what happens at the end of the day beyond that coverage. Otherwise why would anybody even consider going out of network even for –

James Donahue III

We looked at the out of network you know from a pragmatic standpoint. When we were considering the out of network we considered that there would be three situations where people would go out of network. The first is to get a diagnostic test and the second is to get a second opinion and the third is to have a procedure done like you know like some type of surgery. In the first two I don't see that there is going to be any problem with UPMC being able to tell you how much an MRI is going to cost or how much it's going to cost to get a second opinion as to whether you in fact need a knee replacement. The surgery thing is trickier but you know even if they are, you know let's use the example again that we've been using here this morning, so you go to UPMC and they tell you okay, our charge, our normal charge for this procedure in most cases is $40,000, 60% of that is $24,000, that's what your bill is going to be. And then your insurance plan will say what percentage of that $24,000 you are going to pay, what percentage of the balance will be your responsibility. As Chairman DeLuca pointed out at that point a lot of consumers are not going to make that choice. And I think as you've pointed out one of the things that makes the PHC4 information so important is if you are in network and you need a knee replacement, and I don't have all of you know Highmark's copayments memorized, but I mean there are a lot of Highmark plans where your out of pocket costs for surgery is like $100. So you have on the one hand it's going to cost me $100, or some multiple of or some portion of $24,000. So the decision the consumer has to make then is okay, what quality data is there out there about knee replacements versus the in network place and the out of network place so they can make an informed decision. And that's why I think what you've said about the PHC4 is very important because they have to then provide robust information to consumers so they can make that informed choice. And maybe some consumers rightly see there is no quality difference between the two, or the quality difference is so slight that it's not worth the thousands of dollars of extra cost. This is going to be a dynamic process. We couldn't you know these organizations, UPMC and the Allegheny Health Network, as they both have said do not have perfect information about how to price these products now. And you know we don't have the authority even as the government to make them put in place financial controls to give you a bundled price. As we move to a more transparent market you know I think both organizations have said that bundled pricing is the way of the future, and but that's going to transition. It probably is not going to happen by January 1 but it will happen over time.

Rep. Frankel

Speaking of January 1, I mean I think it's really unfortunate that the Corbett administration did not allow the Department of Health and the Insurance Commissioner to be part of this program today because I think the information that we heard with respect to the readiness of these two systems to enter this new world based on a complete lack of capacity to share accurate and timely medical information is problematic. But based on what you – hey, let me ask you, was that a discussion as this Consent Decree was being negotiated about how prepared the two systems were for this parting of the way?

James Donahue III

Yes, you mean on the exchange of medical records, yes. And the response was this was something that both organizations would be able to achieve.

Rep. Frankel

And is there a mechanism for you and the Attorney General, the Department of Health to evaluate that? I mean is three – and if it's not in place by January 1 what are you prepared to do or not do?

James Donahue III

Well the medical records part of this as Mr. McGough noted is something that both our parties have been working with the Secretary of Health so I really can't answer that question in terms of where they are and what hurdles they have to overcome.

Rep. Frankel

But would you acknowledge that's a real obstacle to having an effective implementation of this Consent Decree if they aren't prepared to do that? And that patients are put at risk if they aren't prepared to do that?

James Donahue III

We don't have any information now that they are not prepared to do that, but you know so we'll have to see.

Rep. Frankel

Well you heard it here, I mean they are not prepared to do it, quite clearly. And there is limited collaboration. They committed to coming to us with a proposal but I think that that has to be put into the mix and that the parties from Harrisburg who were engaged in this, Attorney General, Department of Health, Insurance Commissioner, Governor be policing this. And I do think that if they are not ready to have this timely sharing of information, accurate information I think it's a problem with respect to the implementation of the Consent Decree and the separation that we are anticipating in that patients could be in jeopardy if they aren't prepared.

James Donahue III

We would have to, if there is a breakdown in the transfer of information between these two organizations that is something we would look at.

Rep. Frankel

Thank you.

Rep. DeLuca

Thank you, Jim and I want to commend you and the Attorney General for staying on top of the arbitration, staying on top of the Consent Decree as I heard here today, I read your letter. You are going to hold both parties accountable, both you and the Secretary of Health Administration and maybe I suggest Representative Frankel that we send a letter to all three individuals to ask them questions and see if we get answers to maybe expand on that agreement. But I want to thank all those who are participating in our Democratic Policy Hearing today, I appreciate your testimony and candid discussions about serious healthcare access issues that affect the constituents of Western Pennsylvania. My colleagues and I in the Legislature all worked very hard to come up with the best possible solution for Western Pennsylvania short of another contact or law directing UPMC and Highmark to contract. We now have a signed Consent Decree which needs to be followed and enforced by the regulators and we have seen today the Attorney General is ready to act and at the same time I would ask both UPMC and Highmark to not lose sight of their mission to serve the healthcare needs of the public. The last thing our constituents need to experience is more bickering and misguided information. To UPMC and Highmark you have a

responsibility to get this right and carry out the Consent Decree for the communities you serve and I'm sure you will do that. Thank you. Again I want to thank Jim and the rest of your testimonies for attending here. Have a great weekend everybody, thank you.