Testimony of the

Office of Attorney General

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Public Hearing Before the

Health Committee

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G050 Irvis Office Building

Harrisburg, PA

Thank you for the opportunity to [submit testimony / appear today] on what powers the Office of Attorney General has in reviewing hospital transactions and what tools would help strengthen its oversight authority.

The Office of Attorney General reviews hospital transactions and investigates certain conduct in healthcare markets in the Commonwealth. The access to affordable, quality healthcare is of paramount importance in Pennsylvania.

As this Committee and others explore the regulatory and oversight role of the Attorney General in these matters, please allow us to explain the jurisdiction and authority of the Office of Attorney General.

The Attorney General's jurisdiction in these matters is grounded upon the Commonwealth's *parens patriae*[1] responsibility to protect the public's health, safety and welfare, primarily through three areas of law set forth in the Commonwealth Attorneys Act:

> a) The Attorney General shall represent the Commonwealth and its citizens in any action brought for violation of the antitrust laws of the United States and the Commonwealth;
>
> b) The Attorney General shall represent the Commonwealth and … may intervene in any other action, including those involving charitable bequests and trusts …; and
>
> c) The Attorney General shall administer the provisions relating to consumer protection ….
>
> Commonwealth Attorneys Act, 71 P.S. §§ 732-204(c) and (d).

[1] *Parens patriae* refers to the traditional role of the state in protecting quasi-sovereign interests such as the health, safety and welfare of the people.

Under federal antitrust laws, the Attorney General has the ability to bring an action as *parens patriae* to protect the general economy. *Georgia v. Pennsylvania Railroad*, 324 U.S. 439 (1945); *Hawaii v. Standard Oil*, 405 U.S. 251 (1972); *California v. American Stores*, 495 U.S. 271 (1990); and *Pennsylvania v. Mid-Atl. Toyota Distributors, Inc.*, 704 F.2d 125 (4th Cir. 1983). Using this authority, the Office of Attorney General has investigated dozens of hospital mergers over the years. In some cases, we have concluded that the transaction posed no competitive risk or that one of the institutions was in such poor financial shape it had no choice other than to merge. In other cases, we have advised hospitals we would sue to block their transactions and have sued to block. In other instances, we have entered into consent decrees.

In analyzing hospital transactions, we look to see whether the proposed transaction will substantially lessen competition or tend to create a monopoly. When investigating conduct in healthcare markets, we look at whether any of the players in the market are trying to acquire market power through their actions; and, if they have acquired market power, we look at whether they are taking unlawful steps to maintain it.

The Office's charitable trust *parens patriae* focus is different from antitrust — it is intended to ensure that our charitable institutions lawfully pursue their charitable missions for the benefit of the public, their ultimate beneficiary. Any nonprofit corporation formed for charitable purposes under state law, is subject to the charitable oversight of the Office of Attorney General. "[A]ll property held by a nonprofit corporation is held in trust to carry out its charitable purposes. All property

held by a charitable nonprofit including the operating revenues, grants, donations, bequests, etc. generated therefrom, constitute property committed to charitable purposes." *In Re Roxborough Memorial Hospital*, 17 Fiduc.Rep.2d 412 (O.C. Phila. 1997). The "Attorney General . . . by virtue of the powers of [the] office, is authorized to inquire into the status, activities and functioning of public charities." *Commonwealth v. Barnes Foundation*, 398 Pa. 458, 467, 159 A.2d 500, 505 (1960). It has been held "[t]hat such powers, *parens patriae*, are broad and sweeping powers there can be no dispute. For it is of the essence of a public charity that it be subject to the visitorial powers of the sovereign." *Commonwealth v Barnes Foundation (No. 2)*, 11 Fiduc. Rep. 29, 31 (O.C. Montg. 1961).

As such, our Office regularly investigates allegations of misconduct by officers and directors of nonprofit corporations and other fiduciaries administering charitable assets through whatever form. The Attorney General's office is not empowered to substitute our judgment for a board's lawful exercise of its discretion. So, unless we uncover a violation of law, we are obliged to acquiesce in the board's decision.

The Office's *Review Protocol for Fundamental Change Transactions Affecting Health Care Nonprofits*, attached, was created as a guide for reviewing mergers, divisions, conversions, sales, and affiliations, among health care nonprofits. As mentioned above, this Office has reviewed dozens of such transactions over the past two decades. The scope of review varies with the specifics of each transaction, but generally seeks to ensure that the transaction is the product of due diligence after consideration of all other available alternatives;

that it is free of private inurement; that full and fair value is being paid when any sale of charitable assets is implicated; that any restricted assets will remain segregated and committed to the intended charitable purposes; and that the transaction will not unduly impact the community's access and availability to health care.

Past reviews have strengthened the enforceability of a buyer's pledge to make post-closing capital improvements, increased the purchase price ultimately obtained from a sale, and avoided the closing of a community hospital. It is important to note that the review protocol has never been signed into law and lacks the statutory authority requiring compliance with its notification and other provisions. Absent the transaction parties' voluntary compliance, the office needs to initiate a legal action to compel their compliance.

Finally, the Office of Attorney General has the authority to investigate unfair or deceptive practices in the advertising, sale, and provision of goods and services – including healthcare and insurance services – to consumers under the Administrative Code and the Commonwealth Attorneys Act. Our Office provides assistance to constituents through our Bureau of Consumer Protection and the Office's Health Care Section. The Office has jurisdiction to enjoin unfair methods of competition and unfair or deceptive acts or practices by persons engaged in trade or commerce within the Commonwealth of Pennsylvania. That authority is contained in Pennsylvania's Unfair Trade Practices and Consumer Protection Law which can be found at 73 P.S. §§ 201-1, *et seq*.(UTPCPL). The healthcare systems in question are persons engaged in trade and commerce with respect to consumer healthcare transactions. *See*, *Chalfin v. Beverly Enterprises, Inc*., 741 F. Supp.

1162 (E.D. Pa 1989), *reconsideration denied* 745 F. Supp. 1117. Consequently, those healthcare systems come within the ambit of the UTPCPL.

The general purpose of the UTPCPL is "designed to 'benefit the public at large by eradicating unfair or deceptive business practices [and] to ensure fairness of market transactions.'" *Danganan v. Guardian Prot. Servs.*, 645 Pa. 181, 187, 179 A.3d 9, 12 (2018) (citing *Commonwealth v. Monumental Props.*, 459 Pa. 450 (1974)). The remedies available under the UTPCPL for violations include injunctive relief, disgorgement and restitution. In addition, the UTPCPL provides for up $1,000.00 in penalties per violation and up to $3,000.00 per violation perpetrated against victims 60 years of age or older. Moreover, the violation of an injunctive order or an assurance of voluntary compliance (a court filed settlement agreement) under the UTPCPL can result in the disenfranchisement of a business from further activities in Pennsylvania and additional civil penalties.

While the Office of Attorney General has been very active in reviewing hospitals transactions and other healthcare matters, there are additional tools and authority the legislature could provide which would strengthen our ability to protect the public and its access to high quality affordable healthcare services.

First, as previously mentioned the Office of Attorney General has authority under the Commonwealth Attorneys Act to represent the Commonwealth and its citizens in any action brought for violation of the antitrust laws of the United States and the Commonwealth. The Commonwealth, however, does not have an antitrust statute, so our Office must rely on state common law, some of which dates back to the 1800's, to pursue state causes of action in addition to our federal causes of

action. It is worth noting that Pennsylvania is the only state that does not have an antitrust law.

A state antitrust statute could provide for pre-merger notification to our Office of mergers and transactions, including healthcare transactions. It could also provide our Office with better tools to conduct investigations and to recover damages and monetary equitable relief for Commonwealth Agencies and consumers. It could provide for the repayment of fees and costs. Finally, it would make clear that unfair methods of competition[2] such as monopolization, price fixing and market allocation are illegal in Pennsylvania.

Currently without a state antitrust statute, we rely on parties to notify us of their plans to merge or we learn about a transaction through press reports or complaints filed with our Office. A state antitrust statute with a pre-merger notification provision for transactions would ensure that our Office is notified in advance before parties enter into a transaction. While we have reviewed a steady stream of hospital mergers and affiliations as well as physician acquisitions and mergers over the last twenty plus years, there are also many that have occurred without our knowledge. Given that healthcare consolidation continues and the importance of maintaining competitive healthcare markets, the Office of Attorney General and the public would benefit from pre-merger notification of healthcare

[2] The UTPCPL makes unfair methods of competition unlawful in Section 3. However, its definition in Section 2 (4) does not include anticompetitive practices with which the term is traditionally associated.

transactions involving hospitals, physicians, and other ancillary healthcare providers.[3]

A state antitrust statute with pre-complaint subpoena power would enable us to get the necessary information from parties and third parties in a timely and efficient manner and to preserve the confidentiality of the information. Currently, the Attorney General's subpoena power under the Administrative Code is very limited and the Commonwealth Court has now ruled twice that information obtained through an Administrative Code subpoena may not be used for enforcement purposes, even in court. So, without an antitrust statute, we have limited pre-complaint subpoena power and have to rely on targets of investigations to voluntarily provide information regarding their proposed transactions or evidence of their wrong-doing. A state antitrust statue would also better enable us to recover damages and monetary equitable relief for Commonwealth Agencies and consumers, provide for civil penalties and enable us to recover our fees and costs.

Second, the legislature could enact legislation targeting anticompetitive provider-payer contract provisions. Other states have already enacted statutes directed at anticompetitive healthcare contract provisions and there currently is pending federal legislation.[4] There are six contract clauses that have raised the most concern and have been addressed by other states: 1) Most Favored Nation

[3] The Commonwealth would not be the first state to impose pre-merger notification for healthcare transactions. Rather, several states including Connecticut, Massachusetts, Oregon, Minnesota and Washington already require pre-notification of certain healthcare transactions.

[4] S 2840 – Bipartisan Primary Care and Health Workforce Act and H 3120 – Health Competition for Better Care Act.

Clauses[5] in which another party cannot be offered better terms than that given to the contracting parties; 2) All or Nothing Provisions[6] in which a party is required to contract with all of a system's facilities and providers in order to contract with any part of the system; 3) Anti-Tiering/Anti-Steering Provisions[7] which either require an insurer to place all of a system's facilities and providers in the most favorable tier or prohibit an insurer from directing patients to other lower cost facilities and providers; 4) Gag Clauses[8] which prevent patients or employers from knowing the negotiated rates and other costs of healthcare services; 5) System-Wide Contracting which require insurers to pay the same prices for all parts of a system and its providers; and 6) Exclusive Contracting Clauses[9] which prevent an insurer from contracting with other competitive healthcare providers.

Legislation targeting anticompetitive contract provisions in provider-payer contracts is necessary given the consolidation that has already occurred in healthcare markets across the Commonwealth. This consolidation has resulted in the creation of large vertically integrated health systems with multiple hospitals, their

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[5] Other states which restrict the use of MFN's include Arkansas, Connecticut, Georgia, Hawaii, Idaho, Indiana, Kentucky, Massachusetts, Maryland, Maine, Michigan, Minnesota, North Carolina, North Dakota, New Hampshire, New Jersey, New York, Ohio, Texas and Vermont. California and Washington have legislation pending. *See* https://sourceonhealthcare.org/provider-contracts/#:~:text=All%2Dor%2Dnothing%20Clause%3A,of%20their%20must%2Dhave%20facilities.

[6] Connecticut, Massachusetts, Nevada and Texas restrict the use of All or Nothing Provisions and legislation is pending in California, Maine, New Jersey, New York and Washington. *Id*.

[7] Connecticut, Massachusetts, Nevada and Texas restrict the use of Anti-Tiering/Anti-Steering provisions and California, Maine, New Jersey, New York and Washington have legislation pending. *Id*.

[8] California, Connecticut, Indiana, Massachusetts, Minnesota, New York, Ohio and Texas restrict the use of Gag Clauses. *Id*.

[9] Minnesota, New Hampshire, New York, Nevada and Wisconsin restrict the use of Exclusive Contracting Clauses. *Id*.

own health plans, employed physicians, and ancillary services that service large regions of the Commonwealth. We have experienced firsthand what this means for consumers who do not carry the right insurance card. They are told to switch insurance plans in order to access their trusted physicians, local hospitals and life-saving medical care, something which is not possible for many consumers to do. We have also seen healthcare costs increase without corresponding improvements in quality.

Finally, in addition to enacting a statute targeted at anticompetitive contract provisions, the legislature could impose a duty to negotiate in good faith for healthcare providers and insurers similar to the relief[10] the Attorney General's Office requested in its 2019 UPMC Litigation, *Commonwealth of Pennsylvania, et al., v. UPMC, et al.*, No. 334 M.D. 2014 (Pa.Comwlth. Feb. 7, 2019). This would require that healthcare providers and insurers negotiate in good faith with one another for contracts and submit to last best offer arbitration after 90 days to determine all unresolved material terms.

While the Office of Attorney General has been very active in reviewing hospital transactions and other healthcare matters for quite some time, providing the Office with additional tools would strengthen our authority and oversight of healthcare markets. These tools include a state antitrust statute with a pre-merger notification requirement, pre-complaint subpoena power, the ability to recover

[10] See attached Modified Consent Decree which was attached as Exhibit G to the Commonwealth's 2019 Petition to Modify Consent Decrees. The Proposed Modified Consent Decree imposed a duty to negotiate or UPMC and Highmark healthcare providers and health plan subsidiaries. It also prohibited certain contract terms including the six common concerning contract provisions referenced previously.

damages and monetary equitable relief for Commonwealth Agencies and consumers, civil penalties and the ability to recover fees and costs. They also include legislation targeted at common anticompetitive provider-payer contract provisions and imposing a duty to negotiate in good faith for healthcare providers and insurers. These tools would enable us to better investigate and challenge anticompetitive hospital transactions and other healthcare provider mergers as well as address anticompetitive conduct in the marketplace to protect consumers and market participants.

Thank you again for the opportunity to [testify / comment] on these important issues. We would be happy to meet with you to discuss our existing authority over healthcare mergers and acquisitions and our need for additional tools to better protect consumers and ensure access to high quality affordable healthcare services and provide a level playing field for market participants.

Review Protocol for Fundamental change transactions affecting health care nonprofits

Underlying Principle

Whenever a nonprofit, charitable health care entity enters into a transaction effecting a fundamental corporate change which involves a transfer of ownership or control of charitable assets, regardless of the form of the transaction contemplated (i.e., sale, merger, consolidation, lease, option, conveyance, exchange, transfer, joint venture, affiliation, management agreement or collaboration arrangement, or other method of disposition); unless the transaction is in the usual and regular course of the nonprofit's activities; and regardless of whether the other party or parties to the transaction are a nonprofit, mutual benefit or for-profit organization; the Office of Attorney General, as parens patriae, must review each transaction to ensure that the public interest in the charitable assets of the nonprofit organization is fully protected. Consequently, to review each transaction, the OAG must be provided relevant financial, corporate, and transactional information, in order to reach a decision on whether or not to object to or withhold objection to the proposed transaction. This decision will determine the Attorney General's position relative to Orphans' Court proceedings required in fundamental change transactions under the Nonprofit Corporations Law.

Review Protocol

This Protocol was developed to be used as a guide by attorneys and reviewers in the Charitable Trusts & Organizations Section, and its outside experts, in reviewing fundamental transactions affecting nonprofit, charitable health care entities. It provides broad, general guidelines with respect to issues that routinely appear in such transactions and is not intended to be an exhaustive or exclusive list of items to be reviewed and investigated, as these will vary on a case-to-case basis.

1. Notice to the Attorney General

The parties to the transaction shall provide written notice of same to the Attorney General at least 90 days prior to the contemplated date of its consummation. The Attorney General shall be given sufficient time from the receipt of the written notice within which to review and evaluate adequately and fully the proposed transaction. This notice shall include any and/or all of the following documents as the Attorney General may determine to be necessary:Continue Reading

a. all information, including organic documents such as Articles of Incorporation, bylaws, endowment fund documentation, trust restrictions, expenditure history, and other information necessary to define the trust upon which the charitable assets are held;

b. all complete transaction documents with attachments, including collateral or ancillary agreements involving officers, directors or employees (i.e., employment contracts, stock option agreements in the acquiring entity, etc.);
c. all documents signed by the principals or their agents which are necessary to determine the proposed transaction's effect, if any, on related or subsidiary business entities, whether nonprofit or for-profit;
d. all asset contribution agreements, operating agreements, and management contracts, if any, which comprise part or all of the transaction;
e. all financial information and organic documents regarding the post-transaction successor or resulting charitable entity (foundation), including the information detailed in Item (a), supra; and including relevant information with respect to officers, directors, and employees (current and post-transaction), in order to determine independence, board composition, charitable purpose, and to review any financial arrangements with officers, directors, or employees which may be affected by the transaction, particularly those which have the potential of affecting an individual's objectivity in supporting or approving the transaction;
f. all information necessary to evaluate the effects of the transaction on each component of an integrated delivery system, where transactions involve hospitals, including any changes in contracts between the integrated delivery system entities and related physician groups;
g. all financial documents of the transaction parties and related entities, where applicable, including audited financial statements, any fiduciary accounts whether or not filed with the various Orphans' Courts of the Commonwealth, ownership records, business projection data, current capital asset valuation data (assessed at market value), and any records upon which future earnings, existing asset values and fair market value analysis can be based;
h. all fairness opinions and independent valuation reports of the assets and liabilities of the parties, prepared on their behalf;
i. all relevant contracts (assets and liabilities) which may affect value, including, but not limited to, business contracts, employee contracts such as buy-out provisions, profit-sharing agreements, severance packages, etc.;
j. all information and/or representations disclosing related party transactions, which are necessary to assess whether or not the transaction is at arms length or involves self-dealing;
k. all documents relating to non-cash elements of the transaction, including pertinent valuations of security for loans, stock restrictions, etc.;
l. all tax-related information, including the existence of tax-free debt subject to redemption, disqualified person transactions yielding tax liability, etc.;
m. a listing of ongoing litigation, including full court captions, involving the transaction parties or their related entities, which may affect the interests of the parties and the valuation of charitable assets;
n. all information in the possession of the transaction parties relative to the perspective of the nonprofit's beneficiary class or representatives thereof (e.g., the community);

o. all information, including internal and external reports and studies, bearing on the effect of the proposed transaction on the availability or accessibility of health care in the affected community;
p. organizational charts of the parties to the transaction, as they exist both pre- and post- consummation of the transaction involved, detailing the relationship between the principal parties and any and all subsidiaries thereof; and
q. any and all additional documents that the Office of Attorney General deems necessary for its review purposes.

Any and all confidential information provided in the course of the review will be held in confidence by the Office of Attorney General as a part of its investigative files and, as such, will not be returned to the transaction parties. Only information that is a public record will be privately or publicly disseminated concerning any transaction that is not objected to by the Attorney General, unless such a dissemination is ordered by a court of competent jurisdiction. The Attorney General will notify all transaction parties of any formal or informal request seeking access to the information provided.

2. The Review Process

The Attorney General is entitled to retain outside experts and consultants for the purpose of evaluating information detailed in Item 1, supra. This is more likely to occur in a nonprofit to for-profit transaction. These consultants may be either from state agencies, the private sector, or both. They shall be retained pursuant to written contracts, and the costs for retaining such consultants shall be paid by the parties requesting transaction approval.

The review of the transaction shall include, among other components:

a. information gathering;
b. review of fiduciary responsibilities of directors, particularly relative to the exercise of due diligence, the assessment of self-dealing and whether or not the transaction is at arms length;
c. fair market valuation analysis;
d. inurement inquiry, including stock options, pension plans and perquisites, performance bonuses, consulting contracts or other post-transaction employment agreements, corporate loans, golden parachute provisions and severance packages, salaries, and related party transactions;
e. public interest review to evaluate the transaction’s effect upon the availability and accessibility of health care in the affected community, to include community involvement and antitrust review; and
f. appropriate cy pres determination, to ensure that all restricted funds remain segregated and used for their restricted purposes; and that the remaining or successor charitable organization competently and efficiently utilizes the assets for a like charitable purpose benefitting the same class of beneficiaries. The analysis is particularly important when the transaction results in the reallocation of charitable funds from operational use to grant-making use, to ensure that a

constancy of charitable purpose is maintained. It is critical to evaluate whether the acquiring entity will maintain control of the charitable assets, post-transaction, through the creation of a newly controlled foundation or through appointments to the existing charity's board.

3. Notice to the Public

The role of the Office of Attorney General in its review of the proposed transaction is to ensure that the actions of nonprofit directors satisfied their fiduciary duties to the public beneficiaries of the health care entity, and to ensure that the charitable assets thereof are preserved and used for their proper charitable purpose. Further, the Attorney General will consider the broad public policy issue of whether the transaction is in the public interest, specifically whether the proposed transaction will adversely affect the availability or accessibility of health care in the affected community or region.

Implicit in this review is that reasonable public notice of a proposed transaction shall be provided by the parties to the affected community or region, along with reasonable and timely opportunity for such community to contribute to the deliberations of the parties and the Attorney General relative to the health care and charitable trust issues.

In this way, a thorough and complete review of the transaction can be accomplished in a manner that is open to public scrutiny, and the interest of public beneficiaries of nonprofit health care entities may best be protected.

4. Response of Attorney General

Upon completion of its review of the transaction, the Office of Attorney General may: issue a letter indicating that it has no objection to the transaction; bring judicial proceedings to enjoin consummation of any disputed transaction; seek to void any transaction consummated as being in derogation of the law or contrary to public policy; or take any other action it deems appropriate. If, in the opinion of the Office of Attorney General the public interest will be best served thereby, the Office of Attorney General may request that the parties to the transaction seek approval of the Orphans' Court in the county of the nonprofit charitable corporation's registered office. This is more likely to occur in a nonprofit to for-profit transaction.

The procedures set forth in this protocol are in addition to all other powers conferred on the Office of Attorney General by statute or common law.

5. Post-transaction Oversight

The Office of Attorney General will maintain oversight of the transaction after its consummation to ensure that no subsequently executed contracts or arrangements between the parties or their agents effect a denigration of its terms. This oversight may mandate that the resulting entity or surviving charity report on some basis to the OAG to ensure that the terms of the transaction are fulfilled.

EXHIBIT

G

PROPOSED
MODIFIED CONSENT DECREE

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

MODIFIED CONSENT DECREE

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

INTERPRETIVE PRINCIPLES

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TERMS

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

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

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

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

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

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

3.4.2 Any Gag Clause, practice, term or condition;

3.4.3 Any Most Favored Nation practice, term or condition;

3.4.4 Any Must Have practice, term or condition;

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

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

3.4.7 Any Exclusive Contracts practice, term or condition;

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

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

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

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

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

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

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

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

CONTRACT RESOLUTION (LAST BEST OFFER ARBITRATION)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.8 During the above arbitration process:

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

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

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

MISCELLANEOUS TERMS

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

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

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

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

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

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

If to the Attorney General:

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

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

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

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

If to Highmark

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

Copies to:

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

If to UPMC:

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

Copies to:

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

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

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

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

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

BY THE COURT:

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, J.