IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

COMMONWEALTH'S PETITION TO MODIFY CONSENT DECREES

A. INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

The Commonwealth offers the following in support.

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

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

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

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

2. At all times relevant and material hereto, UPMC has operated as the parent and controlling member of a nonprofit academic medical center and

integrated health care delivery system supporting the health care, research and educational services of its constituent hospitals and providers.

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

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

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

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

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

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

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

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

> **It is our mission to provide outstanding patient care and to shape tomorrow's health care through clinical innovation, biomedical and health services research, and education.**
>
> **No matter the size or type, all gifts are meaningful and provide important support for all of the programs at UPMC. Please consider giving today** (emphasis added)**.**[2]

C. PUBLIC FINANCIAL SUPPORT FOR UPMC

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. HISTORY

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

Conduct Leading Up to Consent Decrees

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Second Mediated Agreement

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

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

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

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

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

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

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

E. UPMC'S DEPARTURE FROM ITS CHARITABLE PURPOSES

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

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

Disputed Payments Concerning Highmark's Out of Network Riders

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

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

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

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

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

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

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

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

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

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

Refusal to Contract and Practices to Increase Revenue

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

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

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

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

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

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

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

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

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

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

Unfair and Misleading Marketing

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

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

34. The promotional flyer represented that:

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

See Exhibit E attached.

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

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

Access and Treatment Denials

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

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

Individuals:

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

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

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

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

Employers:

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

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

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

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

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

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

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

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

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

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

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

See Exhibit F attached.

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

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

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

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

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

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

Medicare and Older Pennsylvanians:

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

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

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

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

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

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

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

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

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

Emergency:

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

46. UPMC acquires more than 60% of its patient admissions through its emergency rooms and when a patient is treated for an emergency condition or admitted for an emergency, the patient's health plan is obligated to pay for the patient's care.

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

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

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

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

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

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

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

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

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

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

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

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

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

Assets, Spending and Compensation Practices

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

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

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

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

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

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

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

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

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

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

calling into question whether the compensation is unreasonably excessive;

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

Wasteful Expenditures of Charitable Resources

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

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

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

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

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

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

F. UPMC'S EXPANSION

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

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

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

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

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

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

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

f. Somerset Hospital in Somerset, PA.

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

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

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

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

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

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

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

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

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

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

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

G. COUNTS

COUNT I

[18] Sunbury Hospital and Lock Haven Hospital.

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

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

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

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

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

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

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

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

b. Protect against the respondents' unjust enrichment;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COUNT II

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

used for charitable purposes when such is not the fact.

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

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

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

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

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

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

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

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

(1) the appointment of a master or receiver;

(2) the sequestration of assets;

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

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

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

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

(7) the granting of other appropriate relief.

WHEREFORE, the Commonwealth respectfully requests that this Honorable Court:

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

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

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

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

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

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

g. Order any other relief the Court deems appropriate.

COUNT III

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

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

99. Section 5712 of the Nonprofit Corporation Law provides:

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

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

15 Pa.C.S. § 5712.

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

> (a) General rule. -- Every nonprofit corporation incorporated for a charitable purpose or purposes may take, receive and hold such real and personal property as may be given, devised to, or otherwise vested in such corporation, in trust, for the purpose or purposes set forth in its articles. The board of directors or other body of the corporation shall, as trustees of such property, be held to the same degree of responsibility and accountability as if not incorporated, . .

15 Pa.C.S. § 5547(a).

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

> (b) Nondiversion of certain property. -- Property committed to charitable purposes shall not . . . be diverted from the objects to which it was donated, granted or

devised, unless and until the board of directors or other body obtains from the court an order under 20 Pa.C.S. Ch. 77 Subch. D (relating to creation, validity, modification and termination of trust) specifying the disposition of the property (footnote omitted).

15 Pa.C.S. § 5547(b).

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

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

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

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

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

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

(4) Ordering a trustee to file an account.

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

. . .

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

(8) Reducing or denying compensation to the trustee.

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

20 Pa.C.S. § 7781.

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

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

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

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

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

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

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

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

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

108. The discriminatory policies pursued by UPMC are:

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

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

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

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

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

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

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

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

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

WHEREFORE, the Commonwealth respectfully requests that this Honorable Court:

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

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

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

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

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

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

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

h. Order UPMC to substantiate the reasonableness of:

A) UPMC's executive staff compensation;

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

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

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

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

j. Order any other relief this Court deems appropriate.

COUNT IV

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

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

112. At all times relevant and material, UPMC engaged in and continues to engage in trade or commerce within Pennsylvania by advertising, marketing, promoting, soliciting, and selling an array of medical products and services, including acute inpatient hospital care, outpatient care, physician services and the UPMC Health Plan insurance products and services directly and indirectly to consumers, within the meaning of 73 P.S. §§ 201-1, *et seq*.

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

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

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

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

> In any action brought under section 4 of this act, if the court finds that a person, firm or corporation is willfully using or has willfully used a method, act or practice declared unlawful by section 3 of the act, the Attorney General . . . may recover, on

> behalf of the Commonwealth of Pennsylvania, a civil penalty of not exceeding one thousand dollars ($1,000) per violation, which civil penalty shall be in addition to other relief which may be granted under sections 4 and 4.1 of this act. Where the victim of the willful use of a method, act or practice declared unlawful by section 3 of this act is sixty years of age or older, the civil penalty shall not exceed three thousand dollars ($3,000) per violation, which penalty shall be in addition to other relief which may be granted under section 2 and 4.1 of this act.

73 P.S. §201-8(b).

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

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

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

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

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

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

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

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

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

119. More recently as alleged:

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

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

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

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

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

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

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

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

June 30, 2019 and its premature termination

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

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

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

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

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

(iii) Causing likelihood of confusion or of misunderstanding as to affiliation, connection or association with, or certification by, another;

. . .

(v) Representing that goods or services have sponsorship, approval, characteristics, ingredients, uses, benefits or quantities that they do not have or that a person has a sponsorship, approval, status, affiliation or connection that he does not have;

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

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

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

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

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

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

WHEREFORE, the Commonwealth respectfully requests that as an additional alternative to the relief requested under Count I, this Honorable Court:

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

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

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

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

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

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

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

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

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

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

j. Order any other relief the Court deems appropriate.

Respectfully submitted,
COMONWEALTH OF PENNSYLVANIA,
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Date: February 7, 2019

CERTIFICATE OF COMPLIANCE

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

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

February 7, 2019

CERTIFICATE OF SERVICE

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

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