

# **Highmark Health**

## **UPMC Contract Transition Plan**

**August 29, 2014 (revised)**

### **I. INTRODUCTION**

Under the Approving Determination and Order of the Pennsylvania Department of Insurance (“Department” or “PID”), dated April 29, 2013 (the “PID Order”), a copy of which is attached as Exhibit 1, recognizing that most of the hospital contracts between Highmark and UPMC are terminating on December 31, 2014<sup>1</sup>, the Department directed that if Highmark and UPMC did not secure a new contract by July 1, 2014, Highmark should provide the PID and the Department of Health with a status update, including the reasons why the parties have been unable to enter into a new UPMC contract, and a formal Transition Plan, by July 31, 2014. The Transition Plan was filed on that date on a confidential basis. The current filing reflects additional direction and discussion with the PID and Department of Health.

The PID Order specifies that the Transition Plan include at least the following information:

“(ii) a formal transition plan (the “UPMC Contract Transition Plan”) . . . that sets forth such information as shall be required by the Department and the Department of Health and which addresses such issues as continuation of care; options available to subscribers to access Health Care Providers; appropriate communication, as necessary, to subscribers, providers and others regarding adequacy and changes in cost or scope of coverage. The UPE Entities shall fully cooperate with the Department and the Department of Health in coordinating with UPMC for the further development and, if necessary, implementation of the UPMC Contract Transition Plan with the goal of minimizing any disruption to consumers and the marketplace and ensuring that such consumers continue to have access to quality health care in a competitive marketplace.” Exhibit 1, PID Order, Condition No. 22, B., p. 16.

Highmark appreciates the initiative of the Governor’s Office, the Pennsylvania Attorney General, the Pennsylvania Insurance Department (PID) and the Department of Health (DOH) resulting in the June 27, 2014 Consent Decrees (referred to generally as the “Consent Decrees”) because as a result, Highmark members<sup>2</sup> now have some very

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<sup>1</sup> The UPMC – Highmark contracts which will not be terminated as of December 31, 2014 include The Children’s Hospital of Pittsburgh of the UPMC, with which Highmark is contracted through June 30, 2022, and UPMC Mercy, which is contracted through June 30, 2015. Contracts with the Exception Hospitals referenced below will be amended to extend the terms until December 31, 2019.

<sup>2</sup> The term “Highmark members” used throughout the Transition Plan is intended to refer both to Highmark members and to BlueCard members. BlueCard members are members of other Blue Cross and Blue Shield plans whose benefit agreements allow access to healthcare providers in other Plans’ networks. The terms of the Consent Decrees apply in the same way to BlueCard members as they do to Highmark members.

important protections regarding access to UPMC providers and more reasonable payment for services obtained from UPMC providers after the current contracts terminate on December 31, 2014. While these Consent Decrees in no way address all issues, they have led to more constructive dialogue and greater cooperation with UPMC on several long outstanding issues. We are hopeful that this new attitude will continue as we work towards the transition of our members who currently rely on UPMC providers for much of their healthcare and thus are most significantly impacted by the termination of the contracts at the end of this year. Determination of all the details and full implementation of the terms of the Consent Decrees will require additional discussion with UPMC over the next several months. Copies of the Consent Decrees, the provisions of which are incorporated into this Transition Plan, are attached as Exhibits 2 and 3.

What follows is Highmark's formal Transition Plan setting forth our program to address the issues raised in Condition No. 22.

## **II. HIGHMARK'S UPMC CONTRACT TRANSITION PLAN**

Highmark believes that this Transition Plan, as contemplated under the PID Order that specifically directs its filing, is an opportunity to advise the public of how we are addressing the consequences of UPMC's termination of its contracts with Highmark and should be focused on the persons most impacted by the contract terminations who are primarily members currently in our broad network products. However, recognizing that other circumstances may occur, and given the modification we are making to our Community Blue products, we are also addressing these members.

Highmark's UPMC Transition Plan is divided into four (4) sections:

- **Provider Networks (Section One)**: Highmark has assessed the capacity of its provider networks to demonstrate that we have the capacity necessary to serve our members in both our broad and narrow network products. Highmark will continue to meet or exceed all state and federal network adequacy requirements.
- **Affordable Access (Section Two)**: Highmark members will continue to have in-network access to an extensive network of providers, including the seven hospitals in the Allegheny Health Network and over 40 independent Community Hospitals and over 9,000 independent or community hospital-owned physicians. Highmark's network will also include many UPMC facilities as well as over 80% of UPMC-owned physicians when performing services at an Exception Hospital or at, or on behalf of, a community hospital. This means Highmark's network will include all UPMC owned oncologists, pediatricians, behavioral health specialists, and emergency medicine physicians and any other UPMC physicians working at any Highmark contracted in-network facility.
- **Continuation of Care (Section Three)**: Highmark will coordinate continuation of care for members continuing treatment with UPMC providers and for members transitioning from UPMC providers. For new members or for members needing

transition from UPMC providers, Highmark is prepared to assist. We have a number of tools and other resources that will allow members to seamlessly transition to non-UPMC facilities and physicians, if they so desire.

- **Communication (Section Four)**: Highmark has developed a timeline for appropriate communications to clients and members in an effort to keep them informed regarding provider access, choice, and changes in cost or scope of coverage issues with UPMC providers. Highmark will also work with UPMC to develop a process for prompt resolution of any member issue arising out of this transition so as to reduce member stress and confusion.

### **III. PROVIDER NETWORKS (Transition Plan, Section One)**

#### **1. General**

Highmark and its subsidiaries maintain robust and comprehensive hospital, physician and ancillary provider networks. We have traditionally offered products that include a broad network that assures wide access to hospital, physician and ancillary providers. These products, for example, Keystone Blue HMO and PPO Blue, offer consumers maximum choice in their selection of health care providers. We offer our customers traditional indemnity products with broad access to participating providers.

We also offer narrow network products, such as Community Blue, which utilize a narrower network of high quality providers. These narrow network products can typically be offered at a lower cost thus providing a much needed alternative for cost conscious employer groups and individuals. For 2015 we are modifying these products to allow access to UPMC providers as described under the Consent Decrees, but, in many cases at a higher member cost sharing obligation.<sup>3</sup>

Highmark continues to develop products and network options designed to address customer needs and preferences. These products and network options will be rolled out in a number of different ways. Some are the more traditional “home host” type arrangements which focus on a hospital system and its physicians, primarily for the benefit of the hospital employees. Other products we have recently filed focus on a group of hospitals (The Pennsylvania Mountain Health Alliance) and certain groups of physicians. We intend to continue to expand these offerings by partnering with a number of community hospitals (Penn Highlands) and independent physicians to create products that would be of particular interest to employers who have large segments of employees in one locale.

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<sup>3</sup> The majority of the Community Blue products in western Pennsylvania will be modified to tiered benefit designs under which access to specified UPMC providers on an in-network basis, as described under the Consent Decrees, will be available at a different in-network benefit level. In western Pennsylvania this new product will be called Community Blue Flex. When Community Blue members utilize UPMC providers at the standard benefit level, they will be subject to higher member cost sharing. When members choose to use UPMC providers for services not treated as in-network under the Consent Decrees, these will be available on an out-of-network basis, but subject to the cap on balance billing. Inclusion of in-network access to UPMC providers will result in this product being more costly than the original Community Blue narrow network products.

## **2. Non-UPMC Network Composition**

Both Highmark's broad and narrow networks include the following:

### **A. Allegheny Health Network**

Highmark Health's AHN is a dynamic, patient-centered and physician-led academic healthcare system based in Pittsburgh, Pennsylvania that provides services to patients throughout Western Pennsylvania and the adjacent multi-state region of Ohio, West Virginia, New York and Maryland. As part of the eight hospital network (including AGH, a quaternary academic medical center), more than 200 healthcare sites with outpatient care centers and physician offices, the Allegheny Singer Research Institute and a 700+ member physician organization, these AHN facilities provide the full array of general and advanced medical services:

- Allegheny General Hospital
- Allegheny Valley Hospital
- Canonsburg General Hospital
- Forbes Hospital
- Jefferson Hospital
- Saint Vincent Hospital
- West Penn Hospital
- Westfield Memorial Hospital (NY)

ahn provides a complete spectrum of advanced diagnostic, medical and surgical care across all medical specialties, including emergency, trauma and burn care, general surgery, diabetes, digestive diseases, pulmonary, hospice care and rehabilitation services. AHN is anchored by nationally and internationally recognized clinical and research programs in such areas as Bone and Joint Care, Sports Medicine, Cardiology, and Neurosciences, with leading programs in Transplantation (leading center for advanced heart, liver, kidney and pancreas transplantation including kidney/pancreas and heart/kidney double transplants), Cancer Care (nationally recognized cancer treatment and research program with advanced medical, hematological, surgical and radiation oncology services, state-of-the-art diagnostics, robust cancer clinical trials and formal collaborative relationship with the Johns Hopkins Comprehensive Kimmel Cancer Center) and Women's Care (110 OBGYNs with more than 50 offices across the region offering maternity services and advanced obstetrical specialties in high risk pregnancy, infertility and high risk genetic testing, along with advanced gynecologic services including uro-gynecology, pelvic floor reconstruction, gynecologic oncology, breast disease and bone health).

Each year, the hospitals of Allegheny Health Network together admit nearly 100,000 patients, log over 285,000 emergency room visits, deliver approximately 5,000 babies and perform 21,400 orthopedic, 7,800 neurosurgical, 16,500 cardiovascular and 120,000 cancer procedures. For more information about AHN's ample capacity to meet the needs of Highmark members and a comprehensive description of its services, see Exhibit 4.

### **B. Community Hospitals and other Providers**

Beyond the Allegheny Health Network, Highmark's independent provider networks continue to be robust and well situated to provide Highmark members with ample access to a wide variety of health care providers, even without UPMC in the network. In the 29 counties of Western Pennsylvania, Highmark's network of various provider types includes 53 acute care community hospitals, 55 ambulatory surgery centers and 249 skilled nursing facilities, along with 8000 community hospital affiliated and independent physicians. Network specialists represent every kind of care specialty, including cancer, cardiology, behavioral health, dermatology, pediatrics, physical and occupational therapies, gastroenterology, neurology, neurosurgery, obstetrics and gynecology. Highmark maintains a strong community hospital network in the Western region, with many facilities earning recognition as Blue Distinction Centers for specialty care including Dubois Regional (Penn Highlands) and Westmoreland Regional (Excela) for cardiac care, Heritage Valley Beaver and Conemaugh Memorial for cardiac care and knee and hip replacement, Heritage Valley Sewickley for bariatric surgery and knee and hip replacement, St. Clair Hospital for cardiac care, knee and hip replacement and spine surgery, Washington Hospital for knee and hip replacement and spine surgery, and Jameson Memorial, Monongahela Valley and Uniontown for knee and hip replacement. Highmark remains committed to supporting these hospitals in the Western region as they continue providing health care in their local communities:

Advanced Surgical Hospital	Latrobe Area Hospital (Excela)
Armstrong County Memorial Hospital	Meadville Medical Center
Bradford Regional Medical Center	Millcreek Community Hospital
Brookville Hospital	Miners Medical Center
Butler Memorial Hospital	Meyersdale Medical Center
Charles Cole Memorial Hospital	Monongahela Valley Hospital
Clarion Hospital	Nason Hospital
Clarion Psychiatric Center	Ohio Valley General Hospital
Clearfield Hospital	Olean General Hospital
Conemaugh Memorial Medical Center	Punxsutawney Area Hospital
Corry Memorial Hospital	Sharon Regional Health System
Dubois Regional Medical Center	Somerset Hospital
Edgewood Surgical Center	Southwest Regional
Elk Regional Medical Center	Southwood Psychiatric Hospital
Ellwood City Hospital	St. Clair Memorial Hospital
Frick Hospital (Excela)	Titusville Area Hospital
Grove City Medical Center	Tyrone Hospital
Heritage Valley Health System, Beaver	Uniontown Hospital
Heritage Valley Health System, Sewickley	Warren General Hospital
Highlands Hospital	Washington Hospital
Indiana Regional Medical Center	Westmoreland Regional Hospital (Excela)
Jameson Hospital	
J.C. Blair Memorial Hospital	Windber Medical Center

For more information about the clinical excellence of these Highmark network community hospitals, please refer to Exhibit 5.

### **C. Providers Outside Western Pennsylvania**

In the 21 counties that make up Highmark's Central Pennsylvania region, we have a network of 43 acute care hospitals, 76 ambulatory surgery centers and 167 skilled nursing facilities, in addition to 9400 physicians. Highmark members have access to the providers at Geisinger Health System, Penn State Hershey and many other independent providers. In addition, all healthcare providers contracted with Blue Cross of Northeastern Pennsylvania (NEPA) and Independence Blue Cross (IBC), the two Blues plans operating in Northeastern and Eastern Pennsylvania, are available to Highmark members, thus ensuring a wealth of access for Highmark members.

Outside of Pennsylvania, Highmark members also have access to a national network of Blue participating providers under the BlueCard program. BlueCard gives Blue members seamless national access to the 92 percent of physicians and 96 percent of hospitals that participate in Blue networks. The program links participating healthcare providers with the independent Blue Cross and Blue Shield Plans through a single electronic network for claims processing and reimbursement. No matter where they live, work, or travel, Highmark members, through BlueCard, can receive care at consistent in-network benefit levels.

### **3. Effect of UPMC Contract Terminations**

UPMC intends to terminate the following facility contracts on December 31, 2014: UPMC McKeesport, UPMC East, UPMC Magee, UPMC Passavant, UPMC Saint Margaret and UPMC Presbyterian-Shadyside. It is important to note that the UPMC Contract Terminations do not impact Highmark's current contract with Children's Hospital of Pittsburgh of UPMC, which runs until at least 2022. Nor does it have an immediate impact on Highmark's contract with UPMC Mercy Hospital which runs until June, 2015, with a one year run-out.

During the 2012 mediation, Highmark and UPMC identified certain providers which, because of geographic location or specialty care, addressed specific community needs and should remain accessible to Highmark members after the UPMC Contract Terminations, namely, Western Psychiatric Institute and Clinic (WPIC), UPMC Bedford and UPMC Northwest. These are referred to as Exception Hospitals.

This group of exception providers was expanded after the July 1, 2013 acquisition by UPMC of Altoona Hospital, and now under the Consent Decrees the list of Exception Hospitals further includes UPMC Hamot (and its affiliate Kane Community Hospital) and UPMC Horizon, bringing the total number of Exception Hospitals to seven.

Highmark and UPMC have been engaging in negotiation to set in-network rates and terms for the initial Exception Hospitals and reached agreement on terms with Bedford,

Northwest and WPIC in January, 2014 although as of the date of this filing UPMC has not executed proposed amendments to these contracts. Highmark also has a verbal agreement with UPMC for UPMC Altoona<sup>4</sup> for 2015 rates and will attempt to reach agreement with UPMC on rates and terms for Hamot, Kane and Horizon. If the parties are unable to agree upon contract rates or other terms, the dispute resolution process included in the 2014 Consent Decree sets forth a mechanism for resolution. UPMC hospitals covered under previous consent decrees (Children's & Mercy) plus all of the Exception Hospitals described above will be in-network for Highmark's broad network products in 2015. For Highmark's narrow network products, Children's, Bedford, Northwest, WPIC, Kane, and Altoona will be considered in-network. In-network access to Hamot, Horizon will also be available, but at a higher member cost sharing in the Community Blue Flex products.

#### **4. Effect of Consent Decrees**

Our broad network products, built on the Keystone Health Plan West network, will provide in-network access to the full Highmark provider network as described in detail above, including in-network access to UPMC as outlined in the Consent Decrees. Member cost sharing will be at in-network levels.

The narrow network products will utilize our Community Blue network, and will also include access to Children's Hospital, WPIC, Altoona, Bedford, Hamot, Horizon, Kane and Northwest. It will also include in-network access to emergency and trauma services at any UPMC facility. In addition, Highmark members will have the opportunity to access other UPMC providers on an in-network basis, but at higher member cost sharing in the Community Blue Flex products for other situations identified in the Consent Decrees.

And under all products, for services not specified in the Consent Decree, Highmark members will be treated by UPMC providers on an out-of-network basis and will have the consumer protection from balance billing beyond 60% of UPMC's charges for out-of-network services.

Highmark believes that this overall structure accomplishes our goals of minimizing the disruptions caused by UPMC's termination of its contracts with Highmark while ensuring quality healthcare, customer choice and affordability.

#### **5. Sufficiency of Highmark's Networks**

Highmark's network of providers in the Western and Central Pennsylvania regions includes over 100 hospitals and thousands of physicians and specialists. Members have

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<sup>4</sup> Note that under the terms of the current contract between Highmark and UPMC Altoona the contract renews annually unless either party gives the other 90 days' notice. The next soonest date either party can terminate that contract is effective June 30, 2015. The contract also includes a six (6) month run out period. As of the date of this filing, the parties have a verbal agreement for an extension amendment that keeps UPMC Altoona in Highmark's network through June 30, 2019.

access to superior care close to home at AHN and community hospitals which provide a wide range of healthcare ranging from transplant services and advanced cancer care to rehabilitation services, behavioral health, emergency care, women's health care, pediatrics and podiatry. Highmark members can also access participating physicians, hospitals and caregivers all across the country including a broad choice of quality providers like Cleveland Clinic and Johns Hopkins.

#### **A. Highmark's Provider Network Capacity without UPMC**

Highmark's commercial networks in most cases meet and/or exceed state required accessibility standards without those UPMC providers who will be out of network January 1, 2015. In July of 2014 the Highmark Quality Management Department conducted a practitioner/provider availability analysis including AHN, our community hospitals and professional provider network to ensure enrollee access to primary care providers, specialty care providers, and other health care facilities and services necessary to provide covered benefits in the 29 counties of the Western Pennsylvania region<sup>5</sup>. The analysis showed that for Highmark's commercial HMO and PPO products, Highmark members in most counties will still have ample access to all required facilities and practitioner types. In the few cases where a coverage gap was identified, the gap was usually a previously existing gap not caused by UPMC's exit from the Highmark network. Further, for the few gaps that do exist where Highmark has no available network practitioners/providers to provide covered services within the travel standard, Highmark members will be authorized to receive care from other non-network providers at the in-network level of benefit to ensure access.

#### **B. AHN Capacity**

AHN conducted a capacity analysis of its network and confirmed that AHN hospitals have the necessary capacity to meet the needs of those Highmark members who may need to transition from UPMC providers. AHN has provided "new patient" slot schedules to Highmark's MyCare Navigator Team, adding several new half hour appointments per day to physician schedules, and is expanding operating hours, adding Physician Extenders to practices, and continuing its recruiting efforts. More than 70 physicians will be joining the network in summer 2014 to ensure access.

### **IV. AFFORDABLE ACCESS (Transition Plan, Section Two)**

Highmark's extensive provider networks ensure comprehensive access to high quality providers of all types. While the Consent Decrees provide a broad framework to address

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<sup>5</sup> For an in-depth discussion of the geo access methodology used in the analysis, including a county-by-county summary showing all provider types and potential access gaps, please see COMMERCIAL HMO AND PPO PRACTITIONER/PROVIDER AVAILABILITY ANALYSIS (Without UPMC Affiliated Practitioners/Provider Consistent With Consent Decree), attached hereto as Exhibit 6.

some of these issues, the provisions of the Consent Decrees must be considered in relation to Highmark's product designs to ensure members who choose to use UPMC providers, will understand the scope of access on both an in- and out-of-network basis and their financial liability.

## A. Emergency Services

1. **ER Access.** All Highmark members will continue to have in-network access to all UPMC hospital facilities for emergency treatment. All hospital, physician, and appropriate continuity of care services provided pursuant to the ER episode of care shall be in-network, including related inpatient admission, through discharge.
2. **Member Liability for Emergency Services.** Members will pay in-network cost sharing, according to the terms of their benefit plan, for emergency services at UPMC. UPMC shall not balance bill Highmark members for the difference between UPMC charges for emergency services (hospital, physician, and continuity of care services) and the amount paid by Highmark and member cost sharing.
3. **ER Rates.** As of the date of this filing, Highmark and UPMC have been unable to agree upon rates for ER services. According to the terms of the Consent Decrees, the rates for Jan. 1, 2015 – Dec. 31, 2015 shall be the last mutually agreed upon rates (July 1, 2014) with medical MBI applied on January 1, 2015. For the period January 1, 2016 through the end of the Consent Decree, if Highmark and UPMC cannot agree on a negotiated rate, such rate shall be determined by binding arbitration.
4. **ER Transition of Care.** If a Highmark member needs inpatient admission following emergency or trauma treatment at a UPMC facility, the patient will be admitted and all services during that admission will be treated as in-network up through the patient's discharge. Where transfer to another hospital is necessary, Highmark will work with UPMC to establish an agreed-upon protocol for transfer of members from UPMC to Highmark network facilities.

## B. Hospital Services<sup>6</sup>

1. Highmark members will have access to the services from the UPMC providers as described in the Consent Decrees on an in-network basis.
2. Highmark members will have access to all UPMC providers on an in-network basis as necessary to provide continuity of care, treat oncology and provide the safety net protection as described in the Consent Decrees.

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<sup>6</sup> Sections IV, B and C pertain to Highmark's non-Medicare Advantage members. Medicare Advantage is dealt with specifically at Section E.

3. Highmark members within the Consent Decrees definitions of “Vulnerable Populations” will have in-network access to all UPMC providers;
  4. Highmark members will have access to UPMC hospitals on an in-network basis for services provided locally only by UPMC and which a member’s treating physician believes the patient needs and the Department of Health (DOH) has determined the services are not available from another source (“local community needs”);
  5. For care that is not otherwise governed by the Consent Decrees, UPMC will treat the member on an out-of-network basis.
6. Member Liability.
- a. For in-network access at UPMC hospitals, members will pay cost sharing, according to the terms of their benefit plan, for services. UPMC providers shall not balance bill Highmark members for the difference between UPMC charges for services and the amount paid by Highmark and cost sharing received from members;
  - b. Members may access UPMC Exception providers and other UPMC providers for continuity of care, oncology treatment safety net coverage, vulnerable populations and local community needs as those terms are used in the Consent Decrees, according to the member cost sharing provisions of their benefit plan;
  - c. Member liability to UPMC for out-of-network care will include member out-of-network cost sharing, but the total liability relative to balance billing will be no more than 60% of UPMC charges, subject to prior notice to the consumer of the charges and prompt payment by the member.
7. Hospital Rates.
- a. As of the date of this filing, Highmark and UPMC have been unable to agree upon rates for services at the Exception Hospitals, except for Bedford, Northwest, WPIC and UPMC Altoona.
  - b. Rates for services rendered at UPMC hospitals under the continuity of care, oncology, and safety net provisions will be determined under the provisions of the Consent Decrees.

## C. Physician Services

UPMC has not given Highmark notice of its intention to terminate its physician contracts with Highmark; however, we are planning for UPMC’s termination of the physician contracts.

The Consent Decrees also contemplated UPMC's termination of the physicians' contracts and provided for continued access in many instances.

## **1. Access to Physician Services**

- a. Highmark members will have access to the services from UPMC physicians as described in the Consent Decrees on an in-network basis;
- b. Highmark members will have access to all UPMC physicians on an in-network basis as necessary to provide continuity of care, treat oncology and provide the safety net protection as described in the Consent Decrees;
- c. Highmark members within the Consent Decrees' definitions of "Vulnerable Populations" will have in-network access to all UPMC physicians;
- d. Highmark members will have access to UPMC hospitals physicians on an in-network basis for services for local community needs, as that term is used in the Consent Decrees;
- e. For all other Highmark members whose care is not otherwise covered under the Consent Decrees, UPMC physicians must treat the member, on an out-of-network basis, if requested by the member.

## **2. Member Liability**

- a. Similar to Hospital Services, Highmark members with access to UPMC providers, as described in the Consent Decrees, will pay cost sharing, according to the terms of their benefit plan, for services. UPMC shall not balance bill Highmark members for the difference between UPMC physician charges for services and the amount paid by Highmark and cost sharing received from members;

## **3. UPMC Physicians Still in Network as of January 1, 2015**

Highmark members will continue to receive in-network services from many UPMC physicians after January 1, 2015. Highmark conducted an analysis which demonstrated that a total of 81% of UPMC physicians will continue to remain in the broad Highmark network as of January 1, 2015. Highmark has shared this analysis with UPMC and on August 14, 2014 obtained UPMC's concurrence with the analysis. See Exhibit 7 for further details including a chart depicting Highmark's determination of continuing in-network UPMC physicians.

#### **D. Other Exception Providers**

1. **Other Exception Providers.** In addition to facility and physician services at Exception Hospitals described above, “any other provider services located or delivered outside the Greater Pittsburgh Area currently owned or acquired in the future by UPMC” shall also be provided as in-network in Highmark’s broad network products during the term of the Consent Decrees at in-network cost sharing level. These providers will also be in-network for narrow network tiered products.

#### **E. Access for Vulnerable Populations**

1. **Access for Seniors.** UPMC has publicly stated that seniors will continue to have access to its facilities after December 31, 2014. Under the Consent Decrees Highmark and UPMC agreed that UPMC would continue to contract with Highmark at in-network rates for senior care.
  - a. **Current Medicare Advantage Products.** Under the Consent Decrees, seniors in the current broad network Medicare Advantage products will continue to have in-network access to UPMC facilities and physicians after December 31, 2014. The current broad network contracts with UPMC extend until December 31, 2015 and renew annually unless either party provides prior notice. Approximately 206,000 area seniors are currently covered under Highmark’s two broad network Medicare Advantage products, Freedom Blue and Security Blue.
  - b. **Other Senior Products.** Under the Consent Decrees, Highmark and UPMC agreed that UPMC would continue to contract with Highmark at in-network rates for care at UPMC facilities and physicians for seniors in Signature 65, Medigap (29,000 enrollees) and retiree carve out products and seniors covered in employer group products after December 31, 2014.
2. **Access for CHIP and Medicaid.** Under the Consent Decrees, members in CHIP and Medicaid products will continue to have in-network access to UPMC facilities and physicians after December 31, 2014.

### **V. CONTINUATION OF CARE (Transition Plan, Section Three)**

Under the terms of the Consent Decrees, many Highmark members currently under treatment with UPMC providers will have continuing in-network access.

#### **A. Continuing Care Provisions**

1. All Highmark members who are inpatient at any UPMC facility on January 1, 2015 shall continue to have in-network access to UPMC providers for the duration of their inpatient episode of care through discharge.
2. Highmark members have the choice to transition to in-network providers now or continue with UPMC providers on an in-network basis:
  - a. Members in the midst of a course of treatment, in consultation with treating UPMC physician will be able to continue with that physician;
  - b. Members who may not be currently in treatment, but who used UPMC providers on an in-network basis in 2014 and have been unable to find alternative services in their locality may use UPMC providers during 2015.
  - c. Members may also access UPMC providers on an in-network basis for cancer treatment if the member and their treating physician agree that the member should be treated by a UPMC oncologist. This in-network access also includes illnesses resulting from cancer treatment.
  - d. Members may also access UPMC providers for the other circumstances as described in the Consent Decree.
3. For members in narrow network products, Highmark has traditionally provided members coming into our plans and using out-of-network providers an opportunity to ease the transition into another network and time to find appropriate in network care.
  - a. For members initially enrolling in Highmark's Community Blue HMO product as of January 1, 2015, and who are receiving care from an out-of-network provider, Highmark will afford the member a 60 day Transition of Care period, at the member's option and request, to continue an ongoing course of treatment with that out-of-network provider. This 60 day period may be extended if deemed medically appropriate by Highmark after consultation with the member and the provider. For members in the second or third trimester of pregnancy, care may continue through postpartum care related to the delivery.
  - b. For members initially enrolling in Highmark's Community Blue PPO product as of January 1, 2015, and who are receiving care for specified conditions from an out-of-network provider, Highmark will afford the member a 60 day Extension of Out-of-Network Care period, at the member's option and request, to continue an ongoing course of treatment with that out-of-network provider. This 60 day period may be extended if deemed medically appropriate by Highmark after consultation with the member and the provider. For members in the second or third trimester of pregnancy, care may continue

through postpartum care related to the delivery. A list of the conditions considered for this extension of out of network care is attached as Exhibit 8.

- c. For Community Blue HMO members the services will be covered under the same terms as those for network providers. For Community Blue PPO members, Highmark will pay the provider for the services at an in-network level of benefits. If the provider is unwilling to accept this amount as payment in full, the member may be balance billed by the provider subject to prior notice to the member of the charges. The balance billing cap of 60%, under the Consent Decrees will apply.

## B. Medical Record Transfer

Over the next few years, many Highmark members will be transitioning from UPMC providers to in-network providers for their health care needs. In addition Highmark members may receive emergency or trauma treatment at UPMC and later obtain additional care with an in-network provider. To facilitate the necessary transfer of patient information with the least amount of disruption to the patient, a HIPAA compliant, secure, efficient and affordable procedure must be established for the transfer of patient medical records.

Highmark recommends that UPMC and Highmark agree to comply with a single procedure for transferring medical records to and from hospitals, physicians and patients to ensure expedient, complete and accurate record transfers that prioritize patients and the quality of their care through a coordinated, seamless medical record transfer process. Highmark and UPMC should jointly agree upon and develop a standard authorization form for patients to use when requesting the transfer of their medical records or copies of their records for personal use. A uniformly accepted form will avoid patient confusion, minimize risk of error and will eliminate unnecessary and burdensome legal and compliance analysis of “foreign” forms, to ensure a seamless and patient-friendly transition process. Such medical record transfer is best accomplished using an electronic format.

1. **Hospital Transfer.** When a Highmark patient transfers from a UPMC facility to an in-network facility, or vice versa, if both health systems use a compatible electronic medical record system, such as EPIC, transfer of the patient's medical record should be accomplished electronically via a secure Web-based portal. UPMC has formed and is a participant in ClinicalConnect, a Health Information Exchange (HIE) in Western Pennsylvania that creates a unique network of electronic medical records to securely connect clinicians with patients' vital medical information whenever it's needed. Highmark hopes that any in-network provider who requests to join that HIE will be permitted to do so. Hospitals may not charge the patient for hospital transfer medical records.
2. **Continuity of Care Transfer.** a) When a patient requests the transfer of their medical records to another provider for the purpose of continuity of care, the

physician must produce and deliver the records, in the medium requested by the patient to the new provider no later than 30 days from the date that the request was submitted. In the event that the physician cannot produce the records within 30 days, the physician must submit notice of the delay in writing to the patient and may then obtain an additional 30 days. The physician may not charge the patient for continuity of care record transfers. b) When a physician requests the transfer of medical records from a patient's previous provider for the purpose of continuity of care, the previous provider must produce the records (electronic format preferred) with all deliberate speed and without unreasonable delay. Patients may not be charged for the production and transfer of such records.

3. **Records for Personal Use.** When a patient requests access to their medical records from their physician for personal use, the physician must produce and deliver the records, in the medium requested by the patient, to the patient no later than 30 days from the date that the request was submitted. In the event that the physician cannot produce the records within 30 days, the physician must submit notice of the delay in writing to the patient, and may then obtain an additional 30 days. The physician may charge the patient for reproducing the records for personal use. Amounts shall not exceed the amounts prescribed under Pennsylvania law.

## **VI. COMMUNICATION (Transition Plan, Section Four)**

Clear, comprehensive and understandable communication is critical if Highmark is to accomplish its goal of minimizing the disruption to our members and others caused by the UPMC Contract Terminations. Highmark will utilize a variety of means of communication through 2014 and beyond in order to assure that relevant, accurate and complete information is properly disseminated.

1. Highmark has developed a timeline, attached as Exhibit 9, for communications to members on what to expect and how to prepare for 2015. These communications will address concerns regarding provider access, benefit plan choice and 2015 product offerings and changes in cost or scope of coverage with UPMC providers.
2. Highmark is determined to help our members, clients, producers and the community at large understand and adjust to the changes in our Provider Network as easily as possible. Our comprehensive, multi-channel, layered communications strategy will use simple, member-friendly explanations to communicate the facts and convey the details of the Consent Decree and how it applies to different Highmark members.
3. Highmark has identified all members currently treating with UPMC providers and will soon begin member outreach efforts to educate members regarding their options for access to care. Where appropriate, we will assist members in transitioning to non-UPMC providers. Highmark will use several communication tools for this outreach effort,

including written communications, 412-DOCTORS, My Care Navigator, and Nurse Coaches to address members' concerns.

4. Using several Highmark communication tools and channels, including social media as appropriate, we will advise members about changes to Highmark's networks in 2015 and provide support to members who are interested in transitioning providers. We will convey the general message that access has been maintained and our Provider Network is strong, robust and comprehensive. Tailored messaging will be delivered to those with specific situations or needs, including members enrolling in Community Blue Flex and small groups and individuals who currently use a UPMC physician. With regard to social media inquiries, we will ensure that our social media team is equipped with the information they need to respond to member questions and concerns.
5. Our plan commits to maintaining ongoing communications well into 2015 to ensure that members and clients have the best service experience possible. We have taken measures to provide members with as much information as possible about which providers will be in our network as of January 1, 2015.
  - a. We are targeting September 1, 2014 for the launch of a microsite ([YourNetwork2015.com](http://YourNetwork2015.com)) that will provide a forward look of the physicians and hospitals that are likely to be in the Highmark Provider Network in 2015. It will allow members to search for a provider based on network assumptions for 2015. This site will be available until December 31, 2014.
  - b. On January 1, 2015 and beyond, our regular member site ([highmarkbcbs.com](http://highmarkbcbs.com)) will roll out messaging regarding the impact of the Consent Decrees on the Provider Network and products for 2015. Our regular online Provider Directory, which includes a search tool, will reflect the new Provider Network makeup for 2015.

## VII. CONCLUSION

Highmark is pleased to have the opportunity to submit this Transition Plan to the Pennsylvania Insurance Department and Department of Health. Preparation of the Transition Plan has enabled Highmark to evaluate our members' needs, adjust our product offerings, and identify and prepare the response strategies, policies and procedures necessary to maintain consumer choice and affordable access to high quality healthcare while safeguarding healthcare consumers and minimizing disruption to the citizens of the region currently relying on UPMC providers. Highmark looks forward to continuing this work together with the PID and DOH for 2015.

Respectfully submitted,

HIGHMARK HEALTH

August 29, 2014

## **LIST OF EXHIBITS**

1. *In Re: Application of UPE, No. ID-RC-13-06 (Pa. Insur. Dept. 2013)* (PID Order).
2. *In Re: Commonwealth of Pennsylvania v. UPMC and HIGHMARK, INC.*, No. 334 of 2014 (M.D. 2014) (Highmark).
3. *In Re: Commonwealth of Pennsylvania v. UPMC and HIGHMARK, INC.*, No. 334 of 2014 (M.D. 2014) (UPMC).
4. Allegheny Health Network Overview.
5. Highmark's Western Region Community Hospitals.
6. COMMERCIAL HMO AND PPO PRACTITIONER/PROVIDER AVAILABILITY ANALYSIS (Without UPMC Affiliated Practitioners/Provider Consistent With Consent Decree) [CONFIDENTIAL].
7. Highmark Disruption Analysis Methodology and Chart of UPMC Physicians In-Network as of 2015.
8. Community Blue PPO 60 Day Extension of Out-of-Network Care “List of Conditions”.
9. Member Transition Communication Timeline [CONFIDENTIAL].

# **Exhibit**

**1**

## EXHIBIT 1

**BEFORE THE INSURANCE DEPARTMENT  
OF THE  
COMMONWEALTH OF PENNSYLVANIA**

IN RE:

Application of UPE for Approval of the Request by UPE to Acquire Control of Highmark Inc.; First Priority Life Insurance Company, Inc.; Gateway Health Plan, Inc.; Highmark Casualty Insurance Company; Highmark Senior Resources Inc.; HM Casualty Insurance Company; HM Health Insurance Company, d/b/a Highmark Health Insurance Company; HM Life Insurance Company; HMO of Northeastern Pennsylvania, Inc., d/b/a First Priority Health; Inter-County Health Plan, Inc.; Inter-County Hospitalization Plan, Inc.; Keystone Health Plan West, Inc.; United Concordia Companies, Inc.; United Concordia Dental Plans of Pennsylvania, Inc.; and United Concordia Life and Health Insurance Company	:	Pursuant to Sections 1401, 1402 and 1403 of the Insurance Holding Companies Act, Article XIV of the Insurance Company Law of 1921, Act of May 17, 1921, P.L. 682, <u>as amended</u> , 40 P.S. §§ 991.1401 - 991.1403; 40 Pa.C.S. Chapter 61 (relating to hospital plan corporations); 40 Pa.C.S. Chapter 63 (relating to professional health services plan corporations); and Chapter 25 of Title 31 of The Pennsylvania Code, 31 Pa. Code §§ 25.1-25.23
		Order No. ID-RC-13-06

**APPROVING DETERMINATION AND ORDER**

Upon consideration of the information, presentations, reports, documents and comments received, as well as other inquiries, investigations, materials, and studies permitted by law,<sup>1</sup> the application (the "Application") of UPE (the "Applicant") to acquire control (the "Change of Control") of Highmark Inc.; First Priority Life Insurance Company, Inc.; Gateway Health Plan, Inc.; Highmark Casualty Insurance Company; Highmark Senior Resources Inc.; HM Casualty Insurance Company; HM Health Insurance Company, d/b/a Highmark Health Insurance Company; HM Life Insurance Company; HMO of Northeastern Pennsylvania, Inc., d/b/a First

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<sup>1</sup> These materials include, but are not limited to, information submitted to the Department by UPE and members of the public, and the reports prepared for the Department by The Blackstone Group, L.P. (the "Blackstone Report") and Margaret E. Guerin-Calvert, Senior Consultant, Compass Lexecon (the "Guerin-Calvert Report"). All of the publicly available materials submitted to the Department are available on the Department's website at: [http://www.portal.state.pa.us/portal/server.pt/community/industry\\_activity/9276/highmark\\_west\\_penn\\_allegheny\\_health\\_system/982185](http://www.portal.state.pa.us/portal/server.pt/community/industry_activity/9276/highmark_west_penn_allegheny_health_system/982185)

Priority Health; Inter-County Health Plan, Inc.; Inter-County Hospitalization Plan, Inc.; Keystone Health Plan West, Inc.; United Concordia Companies, Inc.; United Concordia Dental Plans of Pennsylvania, Inc.; and United Concordia Life and Health Insurance Company (the "Highmark Insurance Companies") and all other transactions included in the Form A which are subject to the Department's jurisdiction and require approval of the Department are hereby approved, subject to the conditions set forth below (collectively the "Conditions").

Section 1402 of the Insurance Holding Companies Act requires the Department to approve an application for a change in control unless the Department has found that:

- (i) After the Change of Control, the Highmark Insurance Companies would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which they are presently licensed;
- (ii) The effect of the Change of Control would be to substantially lessen competition in insurance in this Commonwealth or tend to create a monopoly therein;
- (iii) The financial condition of the Applicant is such as might jeopardize the financial stability of a one or more of the Highmark Insurance Companies or prejudice the interests of any policyholders;
- (iv) The Change of Control, including but not limited to any material change in the business or corporate structure or management of the Applicant or the Highmark Insurance Companies as described in the Application is unfair and unreasonable to policyholders of the Highmark Insurance Companies and not in the public interest;
- (v) The competence, experience and integrity of those Persons who would control the operation of any of the Highmark Insurance Companies are such that it would not be in the interest of the policyholders of the Highmark Insurance Companies and the public to permit the Change of Control;
- (vi) The Change of Control is likely to be hazardous or prejudicial to the insurance buying public; and
- (vii) The Change of Control is not in compliance with laws of the Commonwealth.

The burden is on the Department to show a violation of the standards. The standards are phrased in the negative and the Department is required to approve a transaction unless it finds that any of the standards are met.

The Department finds that, with the imposition of the Conditions set forth below to preserve and promote competition in insurance in the Commonwealth of Pennsylvania, to protect the public interest, and to protect the financial stability of the Highmark Insurance Companies, the Change of Control (and all other transactions included in the Application which are subject to the Department's jurisdiction and require approval of the Department) do not violate Section 1402 of the Insurance Holding Companies Act.

The form of the Second Amended and Restated Bylaws of Highmark Inc., as submitted to the Department in connection with the Application, meet the statutory standards of 40 Pa.C.S. § 6328(b).

This Approving Determination and Order shall be subject to the following Conditions, all of which must be complied with in order for the approval of the Application to be valid. This Approving Determination and Order is effective immediately.<sup>2</sup> The Department will issue further full written findings and conclusions on or before May 31, 2013 that substantially reflect the factual conclusions reached in the Blackstone Report and the Guerin-Calvert Report.

### **Competitive Conditions**

*Preamble: Both the WPAHS Entities and the Domestic Insurers engage in confidential and competitively sensitive contract negotiations with each other's rivals that involve price and non-price terms and product design. Common ownership of the Domestic Insurers and the WPAHS Entities provides the opportunity for each to obtain and make use of Competitively Sensitive Information from rivals that could be used to the potential detriment of consumers and competition. The ability of rival insurers in the Western Pennsylvania area to develop and obtain the benefits of innovative products and pricing depend on their ability to contract with UPE-affiliated providers without risk of disclosure to the Domestic Insurers. A risk to competition exists if a Domestic Insurer can adversely affect any rival's price and non-price contract terms or deter innovation or access or limit gains to innovation by obtaining and acting upon any rival's Competitively Sensitive Information. A risk to competition also exists if Health Care Insurers or Health Care Providers enter into contractual arrangements, including but not limited to arrangements (known as "most-favored nation" arrangements) that guarantee receipt of the best payment rate and/or terms*

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<sup>2</sup> The captions, headings and preambles in this Approving Determination and Order are for convenience and general reference only and shall not be construed to describe, define or limit the scope, intent or meaning of any of the terms or conditions of this Approving Determination and Order.

*offered to any other Health Care Insurer or Health Care Provider. The following Competitive Conditions are designed to mitigate potential adverse competitive effects on competition and on rivals contracting with the Domestic Insurers and/or the WPAHS Entities when under common ownership and to maximize market-based access opportunities of unrelated providers and community hospitals to the IDN and insurers to UPE Health Care Providers.*

#### **Prohibition On Exclusive Contracting**

1. No Domestic Insurer shall enter into a contract or arrangement with any UPE Health Care Provider which contract or arrangement requires the UPE Health Care Provider to exclusively contract with one or more Health Care Insurers with respect to any Health Care Service.
2. No UPE Entity shall, directly or indirectly, prohibit or limit the authority of any other UPE Entity that is a Health Care Provider from entering into any contract or arrangement with any Health Care Insurer. Exclusive contracts with specialized providers, such as anesthesiologists or emergency room physicians, may be entered into by a UPE Entity that is a Health Care Insurer with at least thirty (30) days' prior written notice to the Department, so long as the Department does not advise the requesting Health Care Insurer that the Department either disapproves the request for approval or requests any further information or explanation regarding the request for approval within such thirty (30) day period.

#### **Provider/Insurer Payment Contract Length Limitation**

3. No Domestic Insurer shall enter into any contract or arrangement with any Health Care Provider where the length of the contract (including but not limited to the initial term and all renewal terms) is in excess of five (5) years, without the prior Approval of the Department. No UPE Entity that is a Health Care Insurer domiciled in Pennsylvania shall enter into any contract or arrangement with any Health Care Provider where the length of the contract (including but not limited to the initial term together with all renewal terms) is in excess of five (5) years, without the Approval of the Department.

#### **Termination Of Current Health Care Insurer Contracts Other Than For Cause**

4. Until December 31, 2015, no UPE Entity that is a Health Care Provider shall terminate a Health Care Service reimbursement contract with any Health Care Insurer for a reason other than for cause.

#### **Prohibition On Most Favored Nation Contracts Or Arrangements**

5. No Domestic Insurer shall enter into any contract or arrangement with any Health Care Provider on terms which include a "most favored nation" or similar clause that guarantees or provides that a Domestic Insurer will receive the best payment rate and/or terms that such Health Care Provider gives any other purchaser or payor of the same or substantially the same product or service.

6. No UPE Entity that is a Health Care Provider shall enter into any contract or arrangement with any Health Care Insurer which includes a “most favored nation” or similar clause that guarantees or provides that the Health Care Insurer will receive the best payment rate and/or terms that such UPE Entity gives any other purchaser or payor of the same or substantially the same product or service.

#### **Firewall Policy**

7. UPE shall develop, implement, monitor the operation of and enforce strict compliance with a Firewall Policy for UPE, UPE Provider Sub, and each UPE Entity that is a Health Care Provider or a Health Care Insurer (and for such other UPE Entities as the Department may require). The Firewall Policy shall be in a form and substance acceptable to the Department. Within thirty (30) days after the issuance of this Approving Determination and Order, UPE shall file with the Department, for the review and Approval of the Department, a comprehensive Firewall Policy that includes but is not limited to the elements set forth in Appendix 2 (Firewall Policy), which is attached hereto and is incorporated herein by reference. Different Firewall Policies may be submitted for separate UPE Entities or types of UPE Entities, provided that each such separate policy shall substantially include all of the elements set forth in Appendix 2 (Firewall Policy) and be accompanied by an explanation that describes the need for a separate policy. Once Approved by the Department, each Firewall Policy (“Approved Firewall Policy”) shall be made publicly available in accordance with the requirements of the Department. After Approval of the Department of the Approved Firewall Policy, UPE shall cause each applicable UPE Entity to maintain in full force the applicable Approved Firewall Policy. No UPE Entity may make any material amendment, waive enforcement of or terminate any material provision of its Approved Firewall Policy without the Approval of the Department. Each UPE Entity required to have and to maintain an Approved Firewall Policy shall give prompt notice to the Department of any other amendment, waiver or termination of its Approved Firewall Policy.
8. On or before May 1 of each year, UPE shall file with the Department a report executed by UPE’s President and its Chief Privacy Officer. The report shall be a public record, shall be in a form and substance satisfactory to the Department and shall include the following certification to the best of the President’s and Chief Privacy Officer’s information, knowledge and belief: (i) at all times during the immediately preceding calendar year, each UPE Entity subject to Condition 7 was governed by and operated in accordance with a Department Approved Firewall Policy; (ii) at all times in the prior calendar year each Approved Firewall Policy was fully implemented, monitored and enforced in accordance with its terms, except as fully described in subsection (vi) below; (iii) mandatory training of employees with access to any Competitively Sensitive Information (including both current employees and all new hires) has occurred in accordance with the terms of the applicable Approved Firewall Policy; (iv) each UPE Entity that is subject to Condition 7 has obtained recertification biannually of each of its employees with access to any Competitively Sensitive Information stating that the employee has received a copy of the Approved Firewall Policy, understands the Approved Firewall Policy and agrees to abide by the Firewall Policy; (v) no individual with management oversight over all or part of both UPE’s provider and insurer business

segments has used Competitively Sensitive Information obtained as part of his or her oversight function to competitively disadvantage a rival Health Care Provider or Health Care Insurer; (vi) each UPE Entity that is subject to Condition 7 has undertaken an annual good faith review of the UPE Entity's Approved Firewall Policy compliance for the prior calendar year and that either (a) there were no violations or other breaches of the applicable Approved Firewall Policy other than those for which the UPE Entity had previously provided notice to the Department in accordance with the Approved Firewall Policy, or (b) the Department has been provided with the non-reported breaches report and corrective action plan required in Condition 9; and (vii) such other information as the Department shall require.

9. UPE, UPE Provider Sub, and each UPE Entity that is a Health Care Provider or a Health Care Insurer shall provide the Department with such information regarding its Approved Firewall Policy and its implementation and enforcement as the Department shall from time to time request. In addition to other information to be provided to the Department, a report of non-reported breaches of the applicable Approved Firewall Policy, which shall not be a public record, shall accompany the annual certification along with a corrective action plan (which shall be satisfactory in form and substance to the Department) to assure the Department of future, timely compliance with the Approved Firewall Policy and to provide an explanation as to why prior notice of such breach had not been provided to the Department. Approved Firewall Policy implementation and enforcement shall be subject to review and/or examination by the Department, or consultants retained by the Department at the expense of the UPE Entity, to the extent that the Department believes that such review and/or examination is in the public interest.

### **Financial Conditions**

*Preamble: The following financial conditions are intended to:*

*(i) limit the amount of policyholder funds that may be transferred to any Domestic Insurer's new parent entity or other Affiliates of the parent; (ii) establish an enhanced standard of review and assessment that is required to be undertaken prior to any Domestic Insurer entering into additional material financial commitments; (iii) implement ongoing reporting and monitoring requirements related to a Domestic Insurer's investments into the WPAHS Entities; (iv) establish criteria for a plan of corrective action to be prepared by UPE if the turnaround of WPAHS falls short of certain targets; and (v) enhance the level of transparency and accountability with respect to Highmark's stated goal of deriving tangible policyholder benefits, in the form of relative premium and cost of care savings, related to financial commitments made in connection with the Transaction.*

### **Limitations On Donations**

10. Without the Approval of the Department, no Domestic Insurer shall make, or agree to make, directly or indirectly, any Donation, which together with all other Donations made or agreed to be made by that Domestic Insurer within the twelve (12) consecutive months immediately preceding such Donation equals or exceeds the lesser of: (i) 3% of the Domestic Insurer's surplus as regards policyholders, as shown on its latest annual statement on file with the Department; or (ii) 25% of the Domestic Insurer's net income as shown on its latest annual statement; provided, however, if UPE has filed pursuant to Condition 15 a WPAHS Corrective Action Plan, any Donation made or agreed to be made by any Domestic Insurer to any UPE Entity shall be restricted solely for use in connection with implementing the Financial Commitments under and to the extent provided in the WPAHS Corrective Action Plan, until such time as all Financial Commitments related to the WPAHS Corrective Action Plan are satisfied. A Domestic Insurer may not make or agree to make a Donation which is part of a plan or series of like Donations and/or other transactions with other UPE Entities, the purpose, design or intent of which is, or could reasonably be construed to be, to evade the threshold amount set forth in this Condition and thus avoid the review that would occur otherwise. Notwithstanding the foregoing, and in addition to the requirements of (i) and (ii) of this Condition 10, in no event shall Highmark have any right, directly or indirectly, to make any Donation under this Condition if the RBC Rating of Highmark is, or as a result of the Donation is likely to be, 525% or below. This Condition 10 shall not apply to a Donation made from a Domestic Insurer that is a direct or indirect subsidiary of Highmark to Highmark or any subsidiary of Highmark. No Approval of the Department shall be required under this Condition if Department approval for the Financial Commitment has been obtained under 40 P.S. § 991.1405.

### **Financial Commitment Limitations**

11. Any Financial Commitment made or agreed to be made to or for any Person by any of the UPE Entities designated in this Condition, directly or indirectly, shall satisfy the following requirements:
- A. **Due Diligence Standard.** For all Financial Commitments: (i) the UPE Entity making or agreeing to make any Financial Commitment shall conduct a Commercially Reasonable Process to evaluate and assess the benefits and risks to policyholders, subscribers or other stakeholders, as applicable, and whether the Financial Commitment furthers and is consistent with the UPE Entity's nonprofit mission, if the UPE Entity is exempt from Federal taxation pursuant to Section 501(c)(3) of the Internal Revenue Code; and (ii) the terms of any Financial Commitment shall satisfy the provisions of 40 P.S. § 991.1405, as if the Financial Commitment transaction were made or agreed to be made between or among members of the holding company system.
- B. **Transactions Requiring Only Notice.** If the amount of any Financial Commitment made or agreed to be made by one or more of the Domestic Insurers equals or exceeds \$100,000,000 in the aggregate (or if such Financial

Commitment, together with all other Financial Commitments made by one or more of the Domestic Insurers, directly or indirectly, within twelve (12) consecutive months immediately preceding the making of the Financial Commitment causes the total to exceed \$100,000,000), the Domestic Insurer(s) making or agreeing to make such Financial Commitment shall deliver to the Department written notice 30 days in advance of making or agreeing to make such Financial Commitment (the "Financial Commitment Notice"). The Financial Commitment Notice shall describe such Financial Commitment, and provide such information as is required by 31 Pa. Code § 27.3 relating to material transactions, together with such other information as the Department shall request. No notice is required under this Condition if notice of the Financial Commitment is provided to the Department pursuant to 40 P.S. § 991.1405.

- C. **Transactions Requiring Department Approval.** Without the Approval of the Department, no Domestic Insurer shall make or agree, directly or indirectly, to make any Financial Commitment if: (i) the amount thereof, together with all other Financial Commitments made or agreed to be made directly or indirectly by all of the Domestic Insurers within the immediately preceding consecutive twelve (12) months, equals or exceeds \$250,000,000; (ii) the amount thereof is made in connection with a Financial Commitment made or agreed to be made to a Person (including but not limited to any Affiliates), together with all other Financial Commitments between or among one or more of the UPE Entities, on the one hand, and such Person (including but not limited to any Affiliates), on the other hand, aggregate \$250,000,000 or more; or (iii) the RBC Rating of Highmark is, or as a result of the Financial Commitment is likely to be, 525% or below.
- D. **No Circumvention Mechanism.** No Domestic Insurer may undertake any action to delay any Financial Commitment or perform or agree to perform any Financial Commitment in stages or steps, or take any other action with respect to any Financial Commitment, the purpose, design or intent of which is, or could reasonably be construed to be, to evade any of the foregoing requirements.

#### **Disclosure Of Financial Commitments And Financial And Operational Information**

- 12. On or before May 1 of each year, UPE shall file with the Department a report setting forth: (i) all Financial Commitments made or agreed to be made by any UPE Entity within the immediately preceding calendar year; and (ii) specifying the section of this Condition pursuant to which such Financial Commitments were permitted to be made or agreed to be made. UPE shall promptly and fully respond to questions or requests of the Department for information in connection with such report.
- 13. Each year, no later than the date on which the financial statements are required to be filed for the holding company system under Form B or otherwise filed pursuant to 40 P.S. § 991.1404 (a), UPE shall file with the Department, as a public record, audited financial statements (including but not limited to all footnotes) of UPE prepared in accordance with GAAP, for the immediately preceding calendar year. In addition, UPE shall file with

the Department any letters from auditor(s) to management and any other information requested by the Department.

14. UPE shall file with the Department a report setting forth the below listed financial and operational information for the WPAHS Entities (the "Required WPAHS Financial and Operational Information"). The Required WPAHS Financial and Operational Information shall be filed quarterly for each quarter through the period ended June 30, 2015 (within 30 days after the end of the quarter) and thereafter annually on July 1 of each year.
  - A. The Required WPAHS Financial and Operational Information shall be presented on the same basis as the information was presented for the immediately preceding three (3) month period through the quarter ended June 30, 2015, or for each annual report on the same basis the information was presented for the preceding four (4) quarters of each year for which the annual report is required to be delivered. For each quarterly report, the information shall be compared to the WPAHS budget or forecast for such quarter and for each annual report, the information shall be compared to the WPAHS budget or forecast for such year and the Base Case financial projections. UPE shall make members of its management team available to the Department on a timely basis for purposes of reviewing the Required WPAHS Financial and Operational Information with the Department and any consultants retained by the Department.
  - B. The Required WPAHS Financial and Operational Information shall include for the WPAHS Entities:
    - (1) An income statement displaying a level of detail consistent with the Base Case Financial Projections for the WPAHS Entities as submitted by UPE to the Department as part of UPE's Form A filings (the "Base Case Financial Projections"). To the extent that the income statement submitted to the Department pursuant to this Condition differs from GAAP, a reconciliation shall be submitted as well.
    - (2) A cash flow statement displaying a level of detail consistent with the Base Case Financial Projections for the WPAHS Entities submitted by UPE to the Department as part of UPE's Form A. To the extent that the income statement and cash flow statements submitted to the Department pursuant to this Condition differ from GAAP, a reconciliation shall be submitted as well.
    - (3) A calculation of the WPAHS Entities' Days Cash on Hand as defined in the Master Trust Indenture (the "DCOH"), which shall present a level of detail sufficient to reconcile the components of the calculation to the income statement and balance sheets submitted as part of this Condition.
    - (4) A calculation of WPAHS Entities' Debt Service Coverage Ratio, as defined in the Master Trust Indenture, which shall present a level of detail

sufficient to reconcile the components of the calculation to the income statement and balance sheets submitted as part of this Condition.

- (5) A schedule of capital expenditures for all WPAHS Entities, and for each WPAHS Entity for which information is requested by the Department, during the applicable calendar quarter in question and grouped by significant project categories.
- (6) A schedule of inpatient and outpatient discharge volume for the WPAHS Entities in total and for each primary WPAHS Entity facility.
- (7) A schedule of occupancy rates for the WPAHS Entities in total and for each primary WPAHS facility.
- (8) A schedule of salaried and non-salaried employees, including but not limited to physicians, on an FTE basis for the WPAHS Entities in total and for each primary WPAHS Entity operating segment (hospitals, physician organization, etc.).
- (9) A schedule of occupied beds by each primary WPAHS Entity facility.
- (10) A schedule of FTEs per occupied bed by each primary WPAHS Entity facility.
- (11) Audited financial statements (including but not limited to all footnotes) of WPAHS and WPAHS Affiliates specified by the Department prepared in accordance with GAAP, for the immediately preceding calendar year along with any letters from auditors to management.
- (12) If WPAHS files consolidated financial statements with any UPE Entity other than WPAHS Affiliates specified by the Department, then UPE shall deliver WPAHS' consolidating financial statements showing its financial position, results of operations, changes in cash flow and related footnotes thereto of WPAHS and such specified WPAHS Affiliates on a standalone basis.
- (13) Such other financial and operational information related to WPAHS and the IDN Strategy as may be requested, from time to time, by the Department.

#### **WPAHS Corrective Action Plan**

- 15. UPE shall prepare and produce to the Department a plan of financial and operational corrective action for WPAHS (the "WPAHS Corrective Action Plan") if either:
  - A. (i) From the date hereof through June 30, 2015, the aggregate amount of Financial Commitments made or agreed to be made directly or indirectly by all UPE Entities to the WPAHS Entities equals or exceeds \$100,000,000 and (ii) the

WPAHS Entities have issuer ratings from two (2) of the Credit Rating Agencies of less than investment grade; or

- B. As of the quarter ended June 30, 2015, either (i) the WPAHS Entities' net income, as determined in accordance with GAAP ("Net Income"), has not been greater than \$0.00 after adjusting for any material non-recurring or unusual income, including but not limited to all payments received from any UPE Entity outside of the normal course of business and any Financial Commitments to the extent included in such Net Income, for two (2) out of the previous four (4) consecutive quarters; or (ii) DCOH, after adjusting for any material non-recurring or unusual cash receipts and Financial Commitments, including but not limited to all payments received from any UPE Entity outside of the normal course of business, has not been equal to or greater than a value of sixty-five (65) days for two (2) of the previous four (4) consecutive quarters.
- 16. If a WPAHS Corrective Action Plan is required to be prepared and produced to the Department pursuant to Condition 15A or 15B, it shall be produced promptly upon request or order of the Department to UPE and all such information when produced shall be treated as confidential pursuant to an examination process or proceeding under 40 PS § 991.1406.
- 17. The WPAHS Corrective Action Plan shall specify, in reasonable detail, UPE's intended actions to be taken over the subsequent twelve to twenty-four (12–24) months that are designed and anticipated to: (i) facilitate repayment or refinancing of the bond obligations of the WPAHS Entities payable to Highmark (or any UPE Entity) and on terms that would not require any Credit Enhancement Device from Highmark or other UPE Entities; (ii) generate DCOH of at least sixty-five (65) days within eighteen (18) months and for the foreseeable future thereafter; and (iii) generate net income of no less than \$0 within eighteen (18) months and for the foreseeable future thereafter.
  - A. In addition, the WPAHS Corrective Action Plan shall specify the intended corrective actions that are proposed to be implemented, including but not limited to the following potential actions that were referenced in UPE's Form A filing: (i) efficiency improvements and revenue opportunities; (ii) changes in employment, including but not limited to in the number of employed physicians; (iii) modifications to capital expenditure plans; (iv) reductions in unfunded research; (v) non-core asset sales; (vi) restructuring of compensation and benefits; and (vii) outsourcing.
  - B. The WPAHS Corrective Action Plan shall include but not be limited to: (i) an estimate of total cost to adopt, implement and consummate the WPAHS Corrective Action Plan—including but not limited to write-downs, one-time or ongoing restructuring costs, anticipated litigation, consulting, legal and other advisory fees and any future capital commitments—specifying UPE's estimated value for any WPAHS Entity-related investments held by Highmark or any other UPE Entity, including but not limited to loans or bonds receivable, at the time of the WPAHS Corrective Action Plan's implementation and without consideration

of potential contingency actions; and (ii) the amount of any funding needed by the WPAHS Entities to fully pay for and carry out the WPAHS Corrective Action Plan (the “WPAHS Required Funding”) and an acknowledgement that any Donations made pursuant to Condition 10 will be restricted for use in paying the WPAHS Required Funding to the extent of the amount of the WPAHS Required Funding.

- C. Prior to submission, UPE shall have the WPAHS Corrective Action Plan reviewed at its sole expense by an external financial expert, who shall conclude as to the reasonableness of the plan and the sufficiency of the WPAHS Required Funding and UPE’s stated actions for the purposes of limiting future WPAHS, Highmark and/or UPE losses and/or the need for additional Financial Commitments. The financial expert also shall assess the specific level of benefits and costs to be borne by Highmark’s policyholders, as distinct from any franchise benefits accruing to Highmark in the form of higher enrollment, revenue and market share, and shall conclude as to the reasonableness of the value assigned by UPE to Highmark’s investments in WPAHS.

#### **Executive Compensation**

18. UPE and Highmark shall ensure and maintain in effect a policy that any senior executives of any UPE Entity who have been responsible for designing, recommending and/or implementing the IDN Strategy have a meaningful portion of their long-term compensation tied to the achievement of quantifiable and tangible benefits to policyholders, if any, or to the charitable nonprofit entity, if the UPE Entity is exempt from Federal taxation pursuant to Section 501(c)(3) of the Internal Revenue Code (the “IDN Compensation Policy”). Within ninety (90) days after the date hereof, UPE shall deliver to the Department a copy of the IDN Compensation Policy which satisfies the foregoing requirements in a form and substance acceptable to the Department. Any amendments to the IDN Compensation Policy shall be submitted to the Department accompanied by a certification by the President of UPE that, to the best of his or her information, knowledge and belief, the amendment to the IDN Compensation Policy satisfies the requirements of this Condition. UPE shall report annually by May 1 of each year the amount of the compensation paid to such senior executives and describe the manner in which such compensation is consistent with the IDN Compensation Policy.

#### **Meeting IDN Savings Benchmarks**

19. On or before May 1 of each year, UPE shall file with the Department a report describing in detail whether each Benchmark contained in Appendix 3 (Benchmarks), which Appendix 3 is attached hereto and incorporated herein by reference, has been met or what progress has been made toward meeting each Benchmark. The report shall include but not be limited to a statement of savings achieved through implementation of the IDN Strategy (the “IDN Savings”) during (i) the preceding calendar year; and (ii) in total since consummation of the Affiliation Agreement. Each annual report shall quantify: (i) the total savings realized by policyholders across all products and consumers compared to the estimate of the cost of care that would have been incurred by policyholders if the

Affiliation Agreement had not been consummated (the "Total IDN Savings"); (ii) the relative savings realized by consumers on a per-member-per-month claims basis (the "PMPM IDN Savings"); (iii) a comparison of the Total IDN Savings and PMPM IDN Savings to the relevant projections provided in the Form A filing and shall provide a detailed description of variances between the projections and actual savings achieved; (iv) the annual and cumulative savings actually achieved by policyholders in the eight categories for which projected savings were provided to the Department in the Form A, which categories are set forth in Attachment 4 (Total IDN Savings Categories) or such other categories as the Department may approve. UPE shall have the quantification of savings and related explanations of variances reviewed by an external actuarial consulting firm, which shall conclude as to the reasonableness of the methodologies used for quantifying the savings. Within ninety (90) days of closing of the Affiliation Agreement, UPE shall submit to the Department a detailed plan for the measurement and reporting methodologies to be followed for compliance with this Condition. If the Benchmark has not been met or if satisfactory progress has not been made toward achievement of the Benchmark, the report shall specify what corrective actions will be taken in order to assure that the Benchmark is met in a timely fashion. Specifically, if, as of December 31, 2016, either the Total IDN Savings or the PMPM IDN Savings are less than the amounts projected as part of the Form A filing, then, by April 1, 2017, UPE shall file with the Department a detailed corrective action plan to maximize IDN Savings in the future or otherwise generate tangible policyholder benefits in amounts sufficient to justify the continued investment of policyholder funds in the IDN Strategy.

## Public Interest/Policyholder Protection Conditions

### **Consumer Choice Initiatives**

*Preamble: Consumer choice and other member cost-sharing initiatives, including but not limited to tiered network products based upon transparent, objective criteria that include quality and cost, are procompetitive. These initiatives are consistent with efforts to provide consumers with informed healthcare choices and to incentivize consumers to consider the costs of healthcare and quality of outcomes in choosing providers. The following consumer choice initiative Condition is designed to prohibit provider and insurer contracts that would prohibit or limit the ability of Health Care Insurers to implement such consumer choice initiatives.*

20. After the issuance of this Approving Determination and Order, no Domestic Insurer shall enter into a contract or arrangement with a Health Care Provider that prohibits and/or limits the ability of any Domestic Insurer to implement Consumer Choice Initiatives, without the prior Approval of the Department. After the issuance of this Approving Determination and Order, no UPE Entity that is a Health Care Provider shall enter into a contract or arrangement with a Health Care Insurer that prohibits and/or limits the ability of the UPE Entity to implement Consumer Choice Initiatives, without the prior Approval of the Department. This Condition does not prohibit a Domestic Insurer or a UPE Entity that is a Health Care Provider from entering into a contract that provides volume

discounts, provided that such volume discounts are not conditioned upon or related to commitments not to implement Consumer Choice Initiatives.

### Affiliation And IDN Impact On Community Hospitals

*Preamble: UPE indicates in its filings that vibrant and financially healthy community hospitals are a key component of the IDN Strategy. Community hospitals are viewed as high quality, lower cost alternatives for healthcare delivery; and, thus, are projected to be key partners. UPE acknowledges that its efforts to reinvigorate the WPAHS Entities may result in some draw of inpatients away from community hospitals to the WPAHS Entities, but states that the IDN Strategy and UPE's "Accountable Care Alliance" strategy overall will increase inpatient admissions at community hospitals, thereby resulting in a net increase in community hospital inpatient admissions. To address concerns that the Affiliation Agreement will adversely impact inpatient admissions at community hospitals and risk the financial viability of these community assets, the Department imposes Conditions that require the monitoring and reporting of Affiliation Agreement and IDN Strategy implementation impacts on community hospital discharges, and Conditions requiring UPE to report any financial commitments and other efforts to deliver more cost-effective healthcare at community hospitals to further healthcare choices in the Western Pennsylvania area.*

21. On or before May 1 of each year, UPE shall submit a document (the "IDN-Community Hospital Report"), which IDN-Community Hospital Report shall describe in detail for the immediately preceding calendar year: (a) the number of discharges for each Domestic Insurer at each hospital in the WPA service area, as such area is defined in connection with the Form A (the "WPA Service Area"); (b) the number of discharges for each Domestic Insurer at each hospital in its WPA Service Area for calendar year ended 2012 ("Base Year Discharge Data"); (c) a comparison of the discharge information in the current IDN Certification against: (i) the discharge information provided by UPE under the IDN Certification for the immediately preceding year, if any was required to be provided; and (ii) the Base Year Discharge Data; (d) an analysis of whether and to what extent Highmark's affiliation with WPAHS and the implementation of the IDN Strategy resulted in a net decrease in the Domestic Insurers' discharges at its WPA Service Area community hospitals; and (e) the amount and nature of any Financial Commitments by any and all UPE Entities in community-based facilities and service in community hospitals that any such UPE Entities have undertaken with each hospital (excluding any hospitals of WPAHS and UPMC or their respective subsidiaries), including but not limited to efforts to identify opportunities to deliver more cost-effective healthcare to ensure a robust and vibrant network with meaningful choice in key service lines.
  - A. Within sixty (60) days after the date of an IDN-Community Hospital Report, the Domestic Insurers shall submit to the Department a plan of operational corrective action ("IDN Corrective Action Plan") if the analysis set forth in the IDN-Community Hospital Report for the year in question reflects a net decrease of

10% or more in all of the Domestic Insurers' discharges at their WPA Service Area community hospitals with which they have a contract or arrangement. The IDN Corrective Action Plan shall specify, in reasonable detail, the Domestic Insurers' intended commercially reasonable actions to be taken over the subsequent twelve (12) months that are designed and anticipated to address the reasons for the decrease in discharges relating to the Affiliation Agreement and the IDN Strategy. The IDN Corrective Action Plan shall include but not be limited to an estimate of total cost to adopt, implement and consummate the IDN Corrective Action Plan.

- B. The Domestic Insurers shall use commercially reasonable efforts to implement the IDN Strategy in a manner that utilizes and enhances the role of community hospitals in their respective WPA Service Areas to provide continued services to the communities they serve.

#### **Transition Plan Regarding UPMC Contract**

*Preamble: The Department recognizes that Highmark's contract with UPMC is scheduled to terminate on December 31, 2014, and new or extended provider contracts may or may not be entered into between the parties. The Department also recognizes that the Application's Base Case is premised on a non-continuation of the UPMC Contract and that continuation of such contract may, based on the Applicant's projections, delay WPAHS' financial recovery. The potential termination of these provider contracts may be disruptive to the Domestic Insurers' enrollees and consumers of UPMC healthcare services as that termination date is reached. In the event of a contract termination and to minimize any adverse impact on healthcare consumers and protect the public interest, the Department imposes a transition plan condition on all Domestic Insurers that have contract(s) with UPMC. The Condition focuses on issues such as continuation of care and access options available to the Domestic Insurers' enrollees; adequacy of the Domestic Insurers' remaining provider networks; and appropriate communications, as necessary, to inform healthcare consumers of any issues with continued access to certain UPMC facilities and practice areas.*

22. With respect to the possibility of a contract between or among one or more of the Domestic Insurers and UPMC after December 31, 2014, the following shall apply:
- A. If a Domestic Insurer secures UPMC's assent to a new contract, combination, affiliation, or arrangement (or an extension of the current contract that expires on December 31, 2014) ("New UPMC Contract"), UPE shall notify the Department in advance of the execution of the New UPMC Contract and provide the Department with updated information, based on reasonable assumptions and credible projections, on the impact of the terms of any New UPMC Contract on the financial performance of WPAHS, as well as an independent analysis of an expert on the impact of the New UPMC Contract on both the insurance and

provider markets in the region including but not limited to any effects on competition.

- B. If, however, one or more of the Domestic Insurers and UPMC do not enter into a New UPMC Contract by July 1, 2014, then UPE shall file with the Department and with the Pennsylvania Department of Health: (i) an update of the status of negotiations between UPMC and such Domestic Insurer(s), including but not limited to reasons that the parties have been unable to enter into a New UPMC Contract; and (ii) a formal transition plan (the "UPMC Contract Transition Plan") no later than July 31, 2014 that sets forth such information as shall be required by the Department and the Department of Health and which addresses such issues as continuation of care; options available to subscribers to access Health Care Providers; appropriate communication, as necessary, to subscribers, providers and others regarding adequacy and changes in cost or scope of coverage. The UPE Entities shall fully cooperate with the Department and the Department of Health in coordinating with UPMC for the further development and, if necessary, implementation of the UPMC Contract Transition Plan with the goal of minimizing any disruption to consumers and the marketplace and ensuring that such consumers continue to have access to quality healthcare in a competitive marketplace.

#### **Community Health Reinvestment**

*Preamble: Preamble: This Condition requires Highmark to continue its commitment to non-profit activities directed to the betterment of overall community healthcare by fixing and expressly making permanent a percentage of Highmark's direct written premiums that will be dedicated to Community Health Reinvestment endeavors.*

23. Commencing with calendar year 2014, Highmark shall annually dedicate to and pay for Community Health Reinvestment Activities ("CHR") an amount equal to 1.25% of all of Highmark's aggregate direct written premiums, as reported in the annual statement filed by Highmark pursuant to Condition 23B (the "Annual CHR Payment Obligation") for the immediately preceding year.
- A. The Annual CHR Payment Obligation shall be calculated on a calendar year basis. Notwithstanding the foregoing, (i) Highmark's minimum Annual CHR Payment Obligation (the "Minimum Annual CHR Payment Obligation") shall be equal to 1.25% of all of Highmark's aggregate direct written premiums for the 2013 calendar year; and (ii) Highmark shall not be required to fund or commit to fund Community Health Reinvestment Activities for 2014 in an amount in excess of 105% of the Minimum Annual CHR Payment Obligation, and thereafter in an amount in excess of 105% of the actual CHR Payment made (but in no event less than the Minimum Annual CHR Payment Obligation) for the immediately preceding calendar year. Highmark shall not be required to fund or commit to fund any Community Health Reinvestment Activities to the extent that, at the time of such funding or commitment, or after giving effect thereto, its RBC

Rating level is, or is reasonably expected to be, less than 525%. If Highmark fails to meet its Annual CHR Payment Obligation in any calendar year, the deficiency in such payment obligation shall be paid by Highmark by May 1 of the following calendar year into the Insurance Restructuring Restricted Receipt Account.

- B. On or before March 31 of each calendar year, Highmark shall provide to the Department a report, in form and substance acceptable to the Department, of Highmark's Community Health Reinvestment Activities for the prior calendar year.
- C. The provisions of this Condition supersede and replace in their entirety any obligation by Highmark pursuant to Condition 4 of the Department's Decision and Order dated November 27, 1996 (Docket No. MS96-04-098) (the "1996 Department Order").

### **Miscellaneous Conditions**

#### **Modification Of Prior Orders**

- 24. Except as expressly provided in this Approving Determination and Order, nothing in this Approving Determination and Order shall be construed to modify or repeal any term or condition of any prior order or approval of the Department, including, but not limited to, the 1996 Department Order.
- 25. The Department shall determine whether and to what extent any conflict or inconsistency exists between or among this Approving Determination and Order and any term or condition in any prior order(s) or approval(s) of the Department, and the Department shall have the authority to determine what term or condition controls.

#### **Department Costs And Expenses**

- 26. The Department may retain at the reasonable expense of the UPE Entities, as determined by the Department, any attorneys, actuaries, accountants and other experts not otherwise part of the Department's staff as, in the judgment of the Department, may be necessary to assist the Department, regardless whether retained before, on or after the date of this Approving Determination and Order, in or with respect to: (i) evaluation and assessment of any certifications, reports submissions, or notices given or required to be given in connection with this Approving Determination and Order; (ii) compliance by any of the UPE Entities with this Approving Determination and Order; (iii) the enforcement, or any challenge or contest to enforcement or validity, of the Conditions or otherwise of this Approving Determination and Order, including, but not limited to, reviewing and analyzing any certifications, reports, submissions or notices by or for any UPE Entity or auditing and reviewing any books and records of any UPE Entity to determine compliance with any of the Conditions; (iv) litigation, threatened litigation or inquiries or investigations regarding, arising from or related to the Form A filing, the process surrounding the approval of the Form A filing and/or this Approving Determination and Order; and/or (v) the defense of any request or action to require public disclosure of

information that UPE or the Department deems confidential. The obligations of the UPE Entities to the Department for all such costs and expenses shall be joint and several obligations.

#### **Modification Of Approving Determination And Order**

27. Upon written request by a UPE Entity setting forth: (a) the specific Condition(s) for which such UPE Entity seeks relief; (b) the reason for which such relief is necessary and (c) an undertaking by such UPE Entity to provide all such further information as the Department shall require to evaluate the request, the Department may evaluate and, after evaluation of the request, the Commissioner, in the Commissioner's sole discretion, may grant relief, in whole or in part, from one or more of the Conditions as the Commissioner may be deem appropriate.
28. The Commissioner reserves the right to impose additional conditions upon the approval of the Transaction or modify the Conditions in this Approving Determination and Order if, in his reasonable judgment (i) the consolidated financial position or results of operation of the WPAHS Entities suffer or incur, or are reasonably likely to suffer or incur, a material deterioration or material adverse change and the Commissioner finds that such material deterioration or material adverse change might jeopardize the financial stability of a Domestic Insurer or prejudice the interest of the policyholders of a Domestic Insurer; (ii) the Commissioner finds that actions taken or proposed to be taken by any UPE Entity might jeopardize the financial stability of a Domestic Insurer or prejudice the interest of policyholders of a Domestic Insurer; and/or (iii) the Commissioner finds that actions taken or proposed to be taken by any UPE Entity would substantially lessen competition in insurance in this Commonwealth or tend to create a monopoly therein.

#### **Settlement Of Litigation**

29. Without the prior approval of the Commissioner, UPE and each UPE Entity agrees that it will not settle, enter into a settlement agreement or otherwise consent to terminate litigation where the result of such settlement or termination of litigation will be to affect or impair in any way the objective or purpose sought by the Department in imposing or establishing any Condition in this Approving Determination and Order.

#### **Modification Of Affiliation Agreement**

30. No UPE Entity which is a party to the Affiliation Agreement may amend, waive enforcement of, modify, or enter into any other agreement or arrangement having the effect of terminating, waiving or modifying, in any material respect, the terms or conditions of the Affiliation Agreement, without the prior approval by the Commissioner.

#### **Sunset Of Conditions**

31. The Conditions contained in this Approving Determination and Order shall expire as follows:

- A. The following Conditions shall not expire: Conditions 1 and 2 (Prohibition on Exclusive Contracting); 3 (Provider/Insurer Contract Length); 5 and 6 (Prohibition on Most Favored Nation Contracts or Arrangements); 7, 8, and 9 (Firewall Policy); 10 (Donations); 11 (Financial Commitment Limitations); 13 (one of the Public Disclosure of Financial Commitments and Financial and Operational Information Conditions); 20 (Consumer Choice Initiatives); 23 (Community Health Reinvestment); 26 (Department Cost and Expenses); 27 and 28 (Modification of Approving Determination and Order); 29 (Settlement of Litigation); 32 (Required Record Retention); 33, 34, and 35 (Enforcement); and 36 (Post Closing Obligations).
- B. Unless a Condition is listed in Condition 31A or contains a specific expiration date, the Condition shall expire on December 31, 2018, provided that the Department may extend any of these Conditions for up to an additional five (5) years if, in the judgment of the Department, such an extension is in the public interest, and further provided that any expiration of any Condition shall not affect or limit the obligations arising under such Condition prior to its expiration.

#### **Required Record Retention**

- 32. The books, accounts and records of each UPE Entity shall be so maintained and be accessible to the Department as to clearly and accurately disclose the precise nature and details of the transactions between and/or among any UPE Entity and/or other Person, and to permit the Department to establish compliance with the Conditions or otherwise of this Approving Determination and Order, including, but not limited to, such accounting information as is necessary to support the reasonableness of any charges or fees to a Person.

#### **Enforcement**

- 33. Each of the UPE Entities shall be subject to the jurisdiction of the Department for the purpose of enforcing the terms or the Conditions or otherwise of this Approving Determination and Order. Nothing in this Approving Determination and Order is intended to create or enlarge the right of any Person to enforce, seek enforcement of, and/or seek compliance by the UPE Entities with the terms and conditions of this Approving Determination and Order.
- 34. To the maximum extent provided by law, a violation of any Condition shall constitute a violation of 40 Pa.C.S. § 6105 (relating to penalties), which provides that any person who violates a Department order made pursuant to 40 Pa.C.S. Chapter 61 (relating to hospital plan corporations) or hinders or prevents the Department in the discharge of its duties under that statute shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine of not more than \$ 3,000 or to be imprisoned for not more than six months, or both, in the discretion of the court. This statute also provides that any act or default by any corporation, association, or common law trust who violates a Department order made pursuant to 40 Pa.C.S. Chapter 61 (relating to hospital plan corporations)

shall be deemed to be the act or default of the officers or directors who participated in authorizing or effecting such act or default or who knowingly permitted it.

35. In addition to its powers otherwise available under applicable law, the Department may apply to the Commonwealth Court for an order enjoining any UPE Entity or any director, officer, employee or agent thereof from violating or continuing to violate any term or condition of this Approving Determination and Order and for such other equitable relief as the nature of the case and the interest of any Domestic Insurer's policyholders, creditors, shareholders, members or the public may require.

#### **Post Closing Obligations Of UPE**

36. If UPE proceeds with closing the Transaction and implements the Change of Control as contemplated by Form A, UPE shall have been deemed to have agreed expressly to fully and promptly comply with each Condition set forth in this Approving Determination and Order. UPE shall have the obligation and responsibility to cause all UPE Entities to comply with their respective obligations under this Approving Determination and Order, including but not limited to the Conditions.
37. Highmark shall provide to the Department a list of closing documents for the Affiliation Agreement and the JRMC Affiliation Agreement within five (5) days after consummation of the Transaction and shall maintain the listed documents and make them available to the Department for a period of not less than five (5) years from the date of this Approval Determination and Order.

This Approving Determination and Order is effective immediately. The Department will issue further full written findings and conclusions on or before May 31, 2013 that substantially reflect the factual conclusions reached in the Blackstone Report and the Guerin-Calvert Report.



Michael F. Consedine  
Insurance Commissioner  
Commonwealth of Pennsylvania

Date: April 29, 2013



## Appendix 1 (Definitions)

In addition to the words or terms otherwise defined in the Approving Determination and Order, as used in this Approving Determination and Order and the appendices thereto, the following terms have the following meanings:

“1996 Department Order” shall have the meaning set forth in Condition 23C.

“Addendum 1” means Addendum No. 1 to Amendment No. 1 to Form A dated August 24, 2012.

“Affiliate” means any present Person or any Future Person that, directly or indirectly through one or more intermediaries, Controls, is Controlled by, or is under Common Control with any other UPE Entity and their successors and assigns. “Affiliate” includes but is not limited to all Persons in which any UPE Entity, directly or indirectly, has a membership interest.

“Affiliation Agreement” means the contract entered into between UPE, UPE Provider Sub, Highmark, WPAHS and certain subsidiaries of WPAHS as specified therein dated October 31, 2011, as amended by that certain Amendment No. 1 to Affiliation Agreement entered into as of January 22, 2013, relating to the affiliation between or among the parties thereto.

“Annual CHR Payment Obligation” shall have the meaning set forth in Condition 23A.

“Approval of the Department” or “Approved by the Department” means, except as otherwise provided in this definition: either (1) the Department expressly grants its written approval to a written request by the applicable requesting party for Department approval; or (2) within thirty (30) days after the receipt by the Department of the written request for approval, the Department does not advise the requesting party that the Department either disapproves the request for approval or requests any further information or explanation regarding the request for approval. With respect to Condition 3 (Provider/Insurer Payment Contract Length Limitation), Condition 7 (Firewall Policy) and Condition 21 (Consumer Choice Initiatives), “Approval of the Department” means when the Department expressly grants its written approval to a written request by the applicable requesting party for Department approval.

“Approved Firewall Policy” shall have the meaning set forth in Condition 7.

“Base Case Financial Projections” means the WPAHS financial projections for fiscal years 2013–2017 as prepared by Highmark, dated January 16, 2013 and submitted by UPE to the Department as Exhibit K to Amendment No. 2 to Form A.

“Base Year Discharge Data” shall have the meaning set forth in Condition 21.

“Benchmark” shall have the meaning set forth in Appendix 3 (Benchmarks).

“Commercially Reasonable Process” means such due diligence and evaluative process that would be customarily performed by parties to an arm’s length transaction in the geographic

area in which the Financial Commitment is to be made in order to assess the merits and risks of a Financial Commitment and the financial, operational and policy effects to the involved UPE Entity. This includes but is not limited to obtaining, where commercially appropriate and reasonable or to the extent required by law, of a third party fairness opinion or fair market value analysis of such Financial Commitment or other financial analysis and/or stakeholder cost-benefit assessment as may be customarily or reasonably expected to be performed in connection with such a transaction.

“Competitively Sensitive Information” means any information that is not available publicly that could potentially affect competitive innovation and/or pricing between or among one or more UPE Entities and the rivals of such UPE Entities at the provider and/or insurer levels. At a minimum, “Competitively Sensitive Information” includes but is not limited to: (i) present and future reimbursement rates by payor; (ii) payor-provider reimbursement contracts; (iii) terms and conditions included in agreements or arrangements between payors and providers, including but not limited to discounts in reimbursements in agreements; (iv) reimbursement methodologies including but not limited to provisions relating to performance, pay for performance, pay for value, tiering of providers; and (v) specific cost and member information, and revenue or discharge information specific to the payor.

“Community Health Reinvestment Activity” means community health services and projects that improve health care or make health care more accessible. The term includes funding, subsidization or provision of the following: (i) health care coverage for persons who are determined by recognized standards as determined by the Department to be unable to pay for coverage; (ii) health care services for persons who are determined by recognized standards to be uninsured and unable to pay for services; (iii) programs for the prevention and treatment of disease or injury, including but not limited to mental retardation, mental disorders, mental health counseling or the promotion of health or wellness; and (iv) such other services or programs as the Department may approve, including but not limited to health or mental health services for veterans, and the prevention of other conditions, behaviors or activities that are adverse to good health as well as donations to or for the benefit of health care providers in furtherance of any of the foregoing purposes. “Community Health Reinvestment Activity” does not include expenditures for advertising, public relations, sponsorships, bad debt, administrative costs associated with any Domestic Insurer, programs provided as an employee benefit, use of facilities for meetings held by community groups, or expenses for in-service training, continuing education, orientation or mentoring of employees.

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

“Control,” “Controlling,” “Controlled by” or “under Common Control with” have the meaning given to those terms in 40 P.S. § 991.1401.

“Credit Enhancement Device” means any letter of credit, guaranty, line of credit, insurance or any other device, arrangement or method, financial or otherwise, given or provided as security or assurance for the payment of the principal of, premium, if any, or interest on, the applicable debt.

“Department” means the Insurance Department of the Commonwealth of Pennsylvania.

“Domestic Insurers” means the following Pennsylvania domestic insurers to which the Form A applies: Highmark Inc.; Highmark Casualty Insurance Company, a Pennsylvania stock insurance company; Highmark Senior Resources Inc., a Pennsylvania stock insurance company; HM Casualty Insurance Company, a Pennsylvania stock insurance company; HM Health Insurance Company, d/b/a Highmark Health Insurance Company, a Pennsylvania stock insurance company; HM Life Insurance Company, a Pennsylvania stock insurance company; Keystone Health Plan West, Inc., a Pennsylvania business corporation and licensed health maintenance organization; United Concordia Companies, Inc., a Pennsylvania stock insurance company; United Concordia Dental Plans of Pennsylvania, Inc., a Pennsylvania business corporation and licensed risk-assuming PPO; and United Concordia Life And Health Insurance Company, a Pennsylvania stock insurance company. “Domestic Insurers” also includes but is not limited to any Health Care Insurer hereafter formed, acquired or organized directly or indirectly by or for any of the foregoing or by any other UPE Entity. The term “Domestic Insurers” shall not include First Priority Life Insurance Company, Inc.; Gateway Health Plan, Inc.; HMO of Northeastern Pennsylvania, Inc., d/b/a First Priority Health; Inter-County Health Plan, Inc.; or Inter-County Hospitalization Plan, Inc. to the extent that those entities are not used, directly or indirectly, to circumvent, affect or impair the purpose or intent of any Condition.

“Domestic Insurer Competitively Sensitive Information” means Competitively Sensitive Information originated by, received and/or held, directly or indirectly, in any form by or for any Domestic Insurer.

“Donation” means any contribution, grant, donation, distributions under 40 P.S. § 991.1405 or other transfer or payment of funds, property or services (or a commitment to make a Donation), whether made directly or indirectly, in cash or in kind, by any UPE Entity to any other UPE Entity or to any other Person; provided, however, that “Donation” shall not include any transfer or payment made in exchange for the fair value of goods or services received by the transferring or paying Person. An expenditure made for a Community Health Reinvestment Activity is not a “Donation”, so long as the expenditures are for the direct provision of community health services and direct funding of projects that improve health care or make health care more accessible. Donations that are in furtherance of the Affiliation Agreement, the JRMC Affiliation Agreement and any affiliation agreement with SVHS; and/or are capital expenditures related to the IDN or the IDN Strategy are not to be considered as Community Health Reinvestment Activity for the purposes of this definition of “Donation.”

“Financial Commitment” means any direct or indirect payment or transfer of any cash or other property, any Donation, provision of services, encumbrance upon or granting of any security interest in or to any assets or properties, or the direct or indirect guaranty or incurrence of any contractual obligation or liability. The term “Financial Commitment” includes, but is not limited to, the acquisition of any assets or properties of or interests in, the merger, consolidation or affiliation with, or the entering into of any financial or contractual relationship with, any Person, except for: (i) any Financial Commitment made in the ordinary and usual course of the UPE Entity’s business; or (ii) any amounts expressly required to be paid without any further consent of any Person and pursuant to the current provisions of the Affiliation Agreement, JRMC Affiliation Agreement and/or any affiliation agreement between Highmark and SVHS acceptable to the Department. Without limiting the generality of the foregoing, (i) until June 30, 2017, a Financial Commitment shall include but is not limited to (A) any advance payment by a Domestic Insurer to a WPAHS Entity pursuant to or in connection with a contract or arrangement for the payment or reimbursement for Health Care Services; or (B) an increase in contractual rates pursuant to or in connection with a contract or arrangement for the payment or reimbursement for Health Care Services between or among any Domestic Insurer and any WPAHS Entity in excess of the level of increase set forth in the Base Case Financial Projections; and (ii) in no event shall any Financial Commitment relating to the acquisition of any assets or properties of or interests in, the merger, consolidation or affiliation with, or any Donation to or investment in, any Person in connection with the IDN Strategy, as it may be renamed, modified or replaced, be considered to be in the ordinary course of business.

“Financial Commitment Notice” shall have the meaning set forth in Condition 11B.

“Firewall Policy” means a written course of action that governs the use, disclosure, release, dissemination or sharing of Competitively Sensitive Information between and/or among each UPE Entity and the employees, contractors, officers, directors, managers or other personnel of other UPE Entities. Without limiting the scope of any Firewall Policy, a Firewall Policy shall restrict each Domestic Insurer’s and its directors’, officers’, employees’ and agents’ knowledge and ability to influence, directly or indirectly, the negotiations of other UPE Entities with rival insurers, and, conversely, shall restrict other UPE Entities’ and their directors’, officers’, employees’ and agents’ knowledge and ability to influence, directly or indirectly, any Domestic Insurer’s negotiations with rival Health Care Providers.

“Form A” means the Form A filed by UPE, as applicant, with the Department on November 7, 2011, as amended and supplemented by filings made by UPE with the Department.

“GAAP” means generally accepted accounting principles, consistently applied.

“Health Care Insurer” means the Highmark Insurance Companies or any other related or unrelated insurance company, health plan corporation, professional health services plan corporation, health maintenance organization, preferred provider organization or other Person in the business of insurance that finances or pays for health care goods and/or services.

“Health Care Provider” means a Person licensed, certified or otherwise authorized or permitted by the laws of the Commonwealth of Pennsylvania or any other state to provide or

perform a Health Care Service in the ordinary course of business or practice of a profession and any other Person who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to a physician, dentist, hospital, nursing home, assisted living provider, home health agency or any other Person that would constitute a "health care provider" pursuant to Federal HIPAA privacy laws (45 C.F.R. § 160.103).

"Health Care Service" means any medical or health care service including but not limited to the treatment or care of an individual or administration of any medical service or medical goods or supplies or dispensing of any medical goods or supplies.

"Highmark" means Highmark Inc., a Pennsylvania nonprofit corporation licensed to operate a hospital plan and a professional health services plan and its successors and assigns.

"Highmark Affiliates" means all Affiliates of Highmark. The term includes but is not limited to all of the Domestic Insurers (other than Highmark).

"Highmark Entities" or "Highmark Entity" means, individually and/or collectively, Highmark and Highmark Affiliates.

"Highmark Insurance Companies" shall have the meaning as set forth in the first paragraph of this Approving Determination and Order.

"IDN" means all aspects of and all Persons involved or to be involved with the integrated delivery network proposed by UPE referred to in Addendum 1 and which is referenced on page 1 of Addendum 1 (wherein UPE states that "... UPE proposed the change in control as part of a strategy to implement an integrated delivery network (IDN)"). The IDN is further described throughout the Form A and elsewhere in documents filed by UPE. The IDN includes but it's not limited to the Affiliation Agreement, the JRMC Affiliation Agreement, and proposed affiliation agreement with SVHS, the expansion of the provider network (physicians, community hospitals and medical malls), infrastructure development (including but not limited to the acquisition, expansion, development, improvement or construction of Health Care Services, Health Care Providers, facilities, physician practice management companies and group purchasing organizations), other relationships with individuals or Persons included in the Provider Group and any other activity that has been, is being or is expected to be included in the IDN when the IDN is fully implemented.

"IDN Compensation Policy" shall have the meaning set forth in Condition 18.

"IDN Savings" shall have the meaning set forth in Condition 19.

"IDN Strategy" refers to UPE's strategy to implement the IDN.

"Insurance Restructuring Restricted Receipt Account" means the restricted receipt account in the Pennsylvania State Treasury established by Section 7 of Act 62, 40 P.S. § 991.1403b.

“JRMC” means Jefferson Regional Medical Center, its successors and assigns.

“JRMC Affiliates” means all Affiliates of JRMC.

“JRMC Affiliation Agreement” means that certain affiliation agreement by, between and among UPE, UPE Provider Sub, Highmark, JRMC, the subsidiaries of JRMC and Jefferson Regional Medical Center Foundation dated as of August 13, 2012.

“Master Trust Indenture” shall have the meaning set forth in the Affiliation Agreement.

“Minimum Annual CHR Payments Obligation” shall have the meaning set forth in Condition 23A.

“Net Income” shall have the meaning set forth in Condition 15B.

“New UPMC Contract” shall have the meaning set forth in Condition 22A.

“Person” means any individual, corporation, partnership, limited liability company, trust, association, employee pension plan or stock trust or other entity or organization, including but not limited to any governmental or political subdivision or any agency or instrumentality thereof.

“PMPM IDN Savings” shall have the meaning set forth in Condition 19.

“Provider Group” refers to the Persons included or to be included in the “Provider Group” shown on the Proposed Corporate Structure after Tab N to Addendum 1.

“RBC Rating” means the risk-based capital level of a Health Care Insurer determined in accordance with the insurance laws and requirements of the Commonwealth of Pennsylvania as amended from time to time and in a manner acceptable to the Department.

“Required WPAHS Financial and Operational Information” shall have the meaning set forth in Condition 14.

“Steering” means any practice, process or arrangement the effect of which is directly or indirectly to encourage, direct or maneuver a Person into a course of action, e.g., choice of healthcare, by offering structured economic incentives that vary by their value to the consumer or other Person.

“SVHS” means Saint Vincent Health System, a Pennsylvania nonprofit corporation, its successors and assigns.

“SVHS Affiliates” means all Affiliates of SVHS.

“SVHS Entities” or “SVHS Entity” means SVHS and all SVHS Affiliates, collectively and individually.

“Tiering” means a method or design of a health care plan in which a Health Care Providers are assigned to different benefit tiers based on the Health Care Insurer’s application of criteria to Health Care Providers’ relative costs and/or quality, and in which enrollees pay the cost-sharing (co-payment, co-insurance or deductible) associated with a Health Care Provider’s assigned benefit tier(s).

“Total IDN Savings” shall have the meaning set forth in Condition 19.

“Transaction” means the proposed Change of Control relating to the Highmark Insurance Companies as reflected in the Form A, together with all other related transactions and all aspects of the IDN Strategy, including but not limited to the Affiliation Agreement, the JRMC Affiliation Agreement, the expansion of the provider network (physicians, community hospitals and medical malls), the development of infrastructure (physician practice management companies and group purchasing organizations), formation of other relationships with individuals or entities included in the Provider Group, and any other activity that has been, is being or is expected to be included in the IDN when the IDN Strategy is fully implemented.

“UPE” means the Pennsylvania nonprofit corporation of that name formed on October 20, 2011, being the ultimate parent entity, and its successors and assigns.

“UPE Entity” or “UPE Entities” means individually and/or collectively UPE and Affiliates of UPE, including, but not limited to, UPE Provider Sub, Highmark, all Highmark Affiliates, WPAHS, and all WPAHS Affiliates, JRMC, and all of JRMC Affiliates, SVHS and all SVHS Affiliates, any entity Controlled by any of the foregoing, and their respective successors and assigns.

“UPE Health Care Provider Competitively Sensitive Information” means Competitively Sensitive Information originated by and/or held in any form by each business unit, e.g., each hospital (including, but not limited to, WPAHS and JRMC), each physician group, and other UPE Entities on the IDN side of UPE’s business.

“UPE Provider Sub” means the Pennsylvania nonprofit corporation of that name formed on October 20, 2011 as referenced on page 7 of the Form A, its successors and assigns.

“UPMC” means University of Pittsburgh Medical Center and/or any and/or all of its Affiliates, its successors and assigns.

“UPMC Contract Transition Plan” shall have the meaning set forth in Condition 22B.

“WPA Service Area” shall have the meaning set forth in Condition 21.

“WPAHS” means West Penn Allegheny Health System, Inc., a Pennsylvania nonprofit corporation, its successors and assigns.

“WPAHS Affiliates” means all Affiliates of WPAHS.

“WPAHS Corrective Action Plan” shall have the meaning set forth in Condition 15.

“WPAHS Due Diligence Information” shall have the meaning set forth in the Affiliation Agreement.

“WPAHS Entities” or “WPAHS Entity” means, individually and/or collectively, WPAHS and all WPAHS Affiliates.

“WPAHS Tax-Exempt Bonds” shall have the meaning set forth in the Affiliation Agreement.

## **Appendix 2 (Firewall Policy)**

Firewalls are a class of provisions that govern both the dissemination and/or sharing of Competitively Sensitive Information between and/or among the formerly independent operations of each UPE Entity and the personnel from each such entity that can be involved in decision-making and engaged with its rivals (who are suppliers or customers) at other UPE Entities. The purpose of developing and implementing a firewall policy is to avoid the inadvertent or intentional disclosure of Competitively Sensitive Information that could potentially reduce substantially competitive innovation or pricing between and/or among the vertically integrated entities and their rivals at the provider and insurer levels.

With respect to each UPE Entity, it is also imperative from a competitive perspective to establish firewalls that prevent persons with influence over managed care contracts and related reimbursements on the health plan side from obtaining information on rival managed contracts and related reimbursements on the provider side.

With this Condition, each UPE Entity shall develop and submit a firewall policy to the Department for approval. Different Firewall Policies may be submitted for separate UPE Entities or types of UPE Entities.

At a minimum, the Firewall Policy shall incorporate each of the following factors:

- UPE, UPE Provider Sub, Highmark, WPAHS, JRMC, and SVHS senior management involvement and support;
- Corporate firewall compliance policies and procedures;
- Mandatory training and education of current and new employees;
- Monitoring, auditing and reporting mechanisms;
- Consistent disciplinary procedures for violation of the Firewall Policy and incentives to ensure compliance; and
- A recusal policy to reduce the risk of senior management's involvement in the review and approval of contracts or arrangements containing Competitively Sensitive Information to which they should otherwise not have access.

From a competitive perspective, the following principles shall guide the development and implementation of an effective Firewall Policy among the UPE Entities' vertically integrated hospitals/providers and its insurers relating to personnel and decision-making:

- Separate managed care contracting information and activity of the hospital and of the insurer segments, including but not limited to the personnel who engage in decision-making and contracting with suppliers (customers);

- Firewall mechanisms that prevent sharing of Competitively Sensitive Information among persons at the hospital and insurer entities, with clear definition of what constitutes Competitively Sensitive Information; and
- Clear confidentiality policies, procedures and protocols that describe the specific persons and positions that can have access to Competitively Sensitive Information with clear policies and procedures for monitoring or auditing compliance with established firewalls, reporting of violations, and remedial actions taken in the event of a violation of the firewall.

Firewalls to prevent the dissemination of competitively sensitive information are common among vertically integrated firms, particularly integrated hospitals and insurance entities. At a minimum, each UPE Entity's Firewall Policy shall prohibit the exchange of Competitively Sensitive Information, including but not limited to:

- Present and future reimbursement rates by payor;
- Payor-provider reimbursement contracts;
- Terms and conditions included in agreements or contracts between payors and providers including but not limited to discounts in reimbursements in agreements;
- Reimbursement methodologies including but not limited to provisions relating to performance, pay for performance, pay for value, tiering of providers; and
- Specific cost and member information and revenue or discharge information specific to the payor.

Each UPE Entity's Firewall Policy shall incorporate monitoring, auditing and reporting mechanisms and provide consistent disciplinary procedures for violation of the Firewall Policy and incentives to ensure compliance, including but not limited to acknowledgement and certification by each employee or independent contractor with access to Competitively Sensitive Information of the employee's or independent contractor's responsibility to report actual or potential violations with the understanding that such reporting will not result in retribution. Employees also shall be required to affirmatively acknowledge that failure to report such information may subject the employee to disciplinary action and independent contractors shall be required to acknowledge that failure to report such information shall constitute cause for termination of such independent contractor's contract.

UPE's Firewall Policy shall include but not be limited to a whistleblower protection/anti-retaliation policy acceptable to the Department that specifically includes but is not limited to reports of Firewall Policy violations. The Firewall Policy may reference a whistleblower protection/anti-retaliation policy of UPE or another UPE Entity so long as that whistleblower/anti-retaliation policy is acceptable to the Department.

### Appendix 3 (Benchmarks)

The following are the benchmarks (the “Benchmarks”) referred to in Condition 19:

- \$3,000 lower yearly premiums for a family of four by Fiscal Year 2016 relative to a “no transaction scenario” as described in the Form A.
- 10% cost savings on inpatient spend on enrollees that remain with the Domestic Insurers that are Health Care Insurers.
- 10% cost savings on outpatient spend on enrollees that remain with the Domestic Insurers that are Health Care Insurers.
- Achieve estimated IDN cost savings relative to a “no transaction scenario” as described in the Form A in the following amounts:

Period	With UPMC at Non-Par after 12/31/2014			With UPMC at Par after 12/31/2014		
	TOTAL	Utilization Shift	IDN Implementation	TOTAL	Utilization Shift	IDN Implementation
*CY14	\$12M	\$80M	(\$68M)	(\$91M)	\$33M	(\$215M)
*CY15	(\$233M)	\$4M	(\$238M)	(\$298M)	(\$15M)	(\$283M)
*CY16	(\$261M)	\$14M	(\$275M)	(\$447M)	(\$15M)	(\$432M)

\* “CY” means calendar year

Attachment 4 (Total IDN Savings Categories)

- 1) Oncology Shift
- 2) Utilization Shift
- 3) Reimbursement
- 4) Healthier Population
- 5) Right Setting
- 6) Right Treatment
- 7) Cost/Quality
- 8) Other

# **Exhibit**

**2**

## EXHIBIT 2

### IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA,  
By KATHLEEN G. KANE, Attorney General;  
PENNSYLVANIA DEPARTMENT OF INSURANCE,  
By MICHAEL CONSEDINE, Insurance Commissioner  
and  
PENNSYLVANIA DEPARTMENT OF HEALTH,  
By MICHAEL WOLF, Secretary of Health,

Petitioners,

v.

UPMC, A Nonprofit Corp.;  
UPE, a/k/a, HIGHMARK HEALTH, A Nonprofit Corp.  
and  
HIGHMARK, INC., A Nonprofit Corp.;

Respondents.

No. 334 M.D. 2014

### MOTION TO APPROVE CONSENT DECREE WITH RESPONDENT HIGHMARK

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

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

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

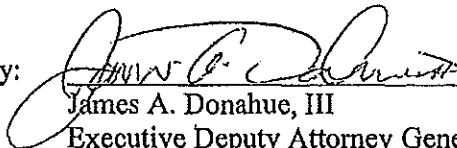
Respectfully submitted

COMMONWEALTH OF PENNSYLVANIA

KATHLEEN G. KANE  
Attorney General

Date: 6/27/2014

By:

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

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA,  
By KATHLEEN G. KANE, Attorney General;  
PENNSYLVANIA DEPARTMENT OF INSURANCE,  
By MICHAEL CONSEDINE, Insurance Commissioner  
and  
PENNSYLVANIA DEPARTMENT OF HEALTH,  
By MICHAEL WOLF, Secretary of Health,

Petitioners,

v.

No. \_\_\_\_\_ M.D. 2014

UPMC , A Nonprofit Corp.;  
UPE, a/k/a, HIGHMARK HEALTH, A Nonprofit Corp.  
and  
HIGHMARK, INC., A Nonprofit Corp.;

Respondents.

**CONSENT DECREE**

AND NOW, this \_\_\_\_\_ day of \_\_\_\_\_, 2014, upon the

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

**SETTLEMENT TERMS**

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

## **I. INTERPRETATIVE PRINCIPLES**

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

## **II. DEFINITIONS**

- A. "Allegheny Health Network" ("AHN") means the domestic, nonprofit corporation, incorporated on October 20, 2011 with its registered office located at Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, PA 15222. Allegheny Health Network is a health care system with seven hospitals serving Western Pennsylvania. Allegheny Health Network's sole controlling member is Highmark Health
- B. "Balance Billing" means when a Health Care Provider bills or otherwise attempts to recover the difference between the provider's charge and the amount paid by a patient's insurer and through member cost-shares.
- C. "Children's Final Order" means the Final Order in the matter of *In Re: Children's Hospital of Pittsburgh and Children's Hospital of Pittsburgh Foundation*, No. 6425 of 2001 (All. Co. 2001).

- D. "Emergency Services/ER Services" means medical services provided in a hospital emergency department in response to the sudden onset of a medical condition requiring intervention to sustain the life of a person or to prevent damage to a person's health and which the recipient secures immediately after the onset or as soon thereafter as the care can be made available, but in no case later than 72 hours after the onset.
- E. "Greater Pittsburgh Area" means the counties of Allegheny, Beaver, Butler, Washington and Westmoreland.
- F. "Health Plan" means all types of organized health-service purchasing programs, including, but not limited to, health insurance or managed-care plans, offered by government, for-profit or non-profit third-party payors, health care providers or any other entity.
- G. "Health Care Provider" means hospitals, skilled nursing facilities, ambulatory surgery centers, laboratories, physicians, physician networks and other health care professionals and health care facilities.
- H. "Highmark" means Highmark, Inc., the domestic nonprofit corporation incorporated on December 6, 1996, with a registered office at Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, Pennsylvania 15222. Unless otherwise specified, all references to Highmark include UPE and all of the controlled non-profit and for-profit subsidiaries, partnerships, trusts, foundations, associations or other entities however styled.
- I. "Hospital" means a health care facility, licensed as a hospital, having a duly organized governing body with overall administrative and professional responsibility

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

- J. "In-Network" means where a Health Care Provider has contracted with a Health Plan to provide specified services for reimbursement at a negotiated rate to treat the Health Plan's members. The member shall be charged no more than the co-pay, co-insurance or deductible charged by his or her Health Plan, the member shall not be refused treatment for the specified services in the contract based on his or her Health Plan and the negotiated rate paid under the contract by the Health Plan and the member shall be payment in full for the specified services.
- K. "Mediated Agreement" means the Mediated Agreement entered into by Highmark and UPMC on May 1, 2012 with assistance of a mediator appointed by the Governor and all agreements implementing the Mediated Agreement.
- L. "Out-of-Network" means where a Health Care Provider has not contracted with a Health Plan for reimbursement for treatment of the Health Plan's members.
- M. "Payor Contract" means a contract between a Health Care Provider and a Health Plan for reimbursement for the Health Care Provider's treatment of the Health Plan's members.
- N. "Trauma" means medical services that are provided to an individual with a severe, life threatening injury which is likely to produce mortality or permanent disability and which are provided at the designated Trauma Center in a facility that provides specialized medical services and resources to patients suffering from traumatic,

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

- O. "UPE", also known as Highmark Health, means the entity incorporated on October 20, 2011, on a non-stock, non-membership basis, with its registered office located at Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, Pennsylvania 15222. UPE serves as the controlling member of Highmark.
- P. "UPE Order" means the Pennsylvania Insurance Department's April 29, 2013 Approving Determination and Order of the Highmark/West Penn Allegheny Health System Affiliation, *In Re Application of UPE*, No. ID-RC-13-06 (Pa. Insur. Dept. 2013).
- Q. "UPMC" means the non-profit, tax-exempt corporation organized under the laws of the Commonwealth of Pennsylvania having its principal address at: 200 Lothrop Street, Pittsburgh, PA 15213. Unless otherwise specified, all references to UPMC include all of its controlled non-profit and for-profit subsidiaries, partnerships, trusts, foundations, associations or other entities however styled.
- R. "UPMC Health Plan" means the Health Plan owned by UPMC which is licensed by the Pennsylvania Department of Insurance.
- S. "UPMC Hospitals" means the Hospitals operated by the following UPMC subsidiaries: UPMC Presbyterian-Shadyside, Children's Hospital of Pittsburgh of UPMC, Magee Women's Hospital of UPMC, UPMC McKeesport, UPMC Passavant, UPMC St. Margaret, UPMC Bedford Memorial, UPMC Horizon, UPMC Northwest, UPMC Mercy, UPMC East, UPMC Hamot, UPMC Hamot affiliate – Kane Community Hospital, UPMC Altoona, Western Psychiatric Institute and Clinic of

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

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

**IV. TERMS**

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

**A. Access**

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

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

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

3. **Local Community Needs** – Where UPMC is the provider of services provided locally that the patient's treating physician believes the patient needs and DOH has determined such services are not available from another source, and member is Out-of-Network, UPMC will not Balance Bill the member, and Highmark and UPMC shall negotiate a payment that shall not be greater than the Out-of-Network rates established by this Consent Decree.
4. **Oncology** – Highmark subscribers may access, as if In-Network, UPMC services, providers facilities and physicians involved in the treatment of cancer, if a patient's treating physician determines that a patient who is diagnosed with cancer should be treated by a UPMC oncologist and the patient agrees to be so treated. In addition, UPMC and Highmark shall negotiate an agreement for treatment of illnesses which result from cancer treatment. These resulting illnesses may

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

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

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

6. **Out-of-Network Services** – For all other Highmark subscribers whose care is not otherwise governed by other provisions in this Consent Decree, beginning January 1, 2015, UPMC will provide services to all such subscribers on an Out-of-Network basis. UPMC's reimbursement rates for Out-of-Network services for Highmark subscribers shall be no more than 60% of charges if paid promptly and provided that UPMC informs consumers of such charge before rendering services.
7. **Continuity of Care** – Highmark and UPMC mutually agree that the continuation of care of a Highmark member in the midst of a course of treatment at UPMC shall be on an In-Network basis at In-Network rates. The need for a continuing course of treatment shall be determined, in the first instance, by the patient's treating physician acting in consultation with and in accordance with the wishes of the patient or the patient's representative. While undergoing a continuing course of treatment with UPMC the services covered In-Network will include all services reasonably related to that treatment, including but not limited to testing and follow-up care. In the event that Highmark disputes the opinion of the treating physician that a continuation of care is medically appropriate, or disputes the scope of that care, the DOH or its designated representative will review the matter and make a final, non-appealable determination.

8. **Transfer of Services** - If any services covered by this Consent Decree are transferred or consolidated at one or more AHN Hospitals, the terms of this Consent Decree shall apply to those transferred services where such services are transferred or consolidated.
9. **Referrals and Highmark Transfer of Patients** – (a) Highmark shall not require its physicians to refer patients to an AHN Hospital in situations where the patient is covered by a Health Plan that does not participate with such AHN Hospital or otherwise expresses a preference to be referred to a non-AHN Hospital; (b) AHN shall not refuse to transfer a patient, whether for diagnosis or treatment, to a non-AHN Hospital or Health-Care Provider if such transfer is requested by the patient, the patient's representative when such representative is authorized to make care decisions for the patient, or the patient's physician; provided the patient is stable and that the transfer is medically appropriate and legally permissible. (c) When a patient in need of transfer is covered by a Health Plan with which the AHN Hospital does not contract, AHN shall transfer the patient to the Health Plan's participating non-AHN facility (provided the patient is stable and that the transfer is medically appropriate and legally permissible) unless, (i) the patient or the patient's representative expresses a contrary preference after having been informed of the financial consequences of such a decision, or (ii) is otherwise approved by the patient's Health Plan.
10. **Safety Net** – Highmark and UPMC mutually agree to establish a one year safety net beginning January 1, 2015, for any existing UPMC patient who is, a Highmark subscriber (i) who used UPMC physicians and services In-Network during the

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

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

#### B. Monetary Terms

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

#### C. Miscellaneous Terms

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

- a. Rates –

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

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

- ii. For rates currently being arbitrated, in the event that the current arbitration between UPMC and Highmark and finds in favor of UPMC, then the rates and fees under the Consent Decree will revert to the rates in effect before April 1, 2014 as of the date of the arbitral award and shall remain in place through December 31, 2015. If as a consequence of the arbitral award, Highmark owes UPMC for underpayments, Highmark shall pay UPMC appropriate interest. UPMC and Highmark will use their best efforts to conclude their current arbitration before the end of December 31, 2014. If as a consequence of the arbitral award, UPMC owes Highmark for overpayments, UPMC shall pay Highmark appropriate interest. If an arbitral award is not decided before January 1, 2015, Highmark shall increase its payments by one-half the difference between Highmark's April 1, 2014 schedule and its rate schedule in effect before April 1, 2014 for the period January 1, 2015 to December 31, 2015.
- iii. For the period beginning January 1, 2016 to the expiration of the Consent Decree or the expiration of any agreements between UPMC and Highmark for all In-Network services, whichever is

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

- iv. Any agreement or award as to rates and fees will be binding on both UPMC and Highmark, meaning that each will bill and make payments consistent with the agreement or award.
  - v. For rates for UPMC Health Plan patients at Allegheny Health Network hospitals, if those rates are not resolved by current litigation between the Allegheny Health Network and the UPMC Health Plan in the Allegheny Court of Common Pleas, or by agreement between Highmark and UPMC, Allegheny Health Network and the UPMC Health Plan shall engage in last best offer arbitration to determine those rates for the period not covered by the current litigation to the termination of the Consent Decree.
- b. Non-Rate Term – Disputed terms set forth in this Consent Decree and related to the Consent Decree and unrelated to rate and reimbursement shall be subject to mediation before the OAG, PID and DOH. If mediation does not result in resolution within thirty (30) days, Highmark and UPMC shall engage in binding arbitration to resolve the dispute as to terms.

2. **Binding Arbitration**
  - a. The Parties will file a joint plan with this court for a single last best offer binding arbitration before independent and neutral parties by August 14, 2014 or seek court intervention to resolve any disputes over such process.
3. **Binding on Successors and Assigns** – The terms of this Consent Decree are binding on Highmark, its directors, officers, managers, employees (in their respective capacities as such) and to its successors and assigns, including, but not limited to, any person or entity to whom Highmark may be sold, leased or otherwise transferred, during the term of this Consent Decree. Highmark shall not permit any substantial part of Highmark to be acquired by any other entity unless that entity agrees in writing to be bound by the provisions of this Consent Decree.
4. **Enforcement of the Consent Decree** - The OAG, PID and DOH shall have exclusive jurisdiction to enforce the Consent Decree.
  - (a) If the OAG, PID or DOH believe that a violation of the Consent Decree has taken place, they shall so advise Highmark and give Highmark twenty (20) days to cure the violation. If after that time the violation is not cured, the OAG, PID and DOH may seek enforcement of the Consent Decree in the Commonwealth Court; (b) Any person who believes they have been aggrieved by a violation of this Consent Decree may file a complaint with the OAG, PID or DOH for review. If after that review, the OAG, PID or DOH believes either a violation of the Consent Decree has occurred or they need additional information to evaluate the complaint, the complaint shall be forwarded to Highmark for a response within thirty (30) days. If after receiving the

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

5. **Release** – This Consent Decree will release any and all claims the OAG, PID or DOH brought or could have brought against Highmark for violations of any laws or regulations within their respective jurisdictions, including claims under laws governing non-profit corporations and charitable trusts, consumer protection laws, insurance laws and health laws relating to the facts alleged in the Petition for Review or encompassed within this Consent Decree for the period of July 1, 2012 to the date of filing. Any other claims, including but not limited violations of the crimes code, Medicaid fraud laws or tax laws are not released.
6. **Compliance with Other Laws** - The Parties agree that the terms and agreements encompassed within this Consent Decree do not conflict with Highmark's obligations under the laws governing non-profit corporations and charitable trusts, consumer protection laws, antitrust laws, insurance laws and health laws.
7. **Notices** – All notices required by this Consent Decree shall be sent by certified or registered mail, return receipt requested, postage prepaid or by hand delivery to:

**If to the Attorney General:**

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

**If to Highmark:**

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

**Copies to:**

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

8. **Averment of Truth** – Highmark avers that, to the best of its knowledge, the information it has provided to the OAG, PID and DOH in connection with this Consent Decree is true.
9. **Termination** – This Consent Decree shall expire five (5) years from the date of entry.
10. **Modification** – If the OAG, PID, DOH or Highmark believes that modification of this Consent Decree would be in the public interest, that party shall give notice to the other and the parties shall attempt to agree on a modification. If the parties agree on a modification, they shall jointly petition the Court to modify the Consent Decree. If the parties cannot agree on a modification, the party seeking modification may petition the Court for modification and shall bear the burden of persuasion that the requested modification is in the public interest.

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

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

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

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

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

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

**BY THE PETITIONERS**

**COMMONWEALTH OF PENNSYLVANIA  
KATHLEEN G. KANE  
Attorney General**

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

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

Date: \_\_\_\_\_ By: \_\_\_\_\_  
**MICHAEL F. CONSEDINE, COMMISSIONER  
PENNSYLVANIA INSURANCE DEPARTMENT**

Date: \_\_\_\_\_ By: \_\_\_\_\_  
**MICHAEL WOLF, SECRETARY  
PENNSYLVANIA DEPARTMENT OF HEALTH**

Date: \_\_\_\_\_ By: \_\_\_\_\_  
**JAMES D. SCHULTZ, GENERAL COUNSEL**

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

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

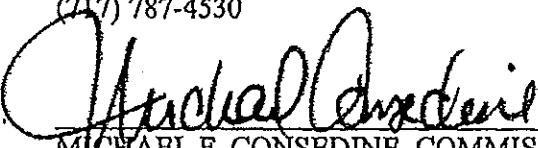
**BY THE PETITIONERS**

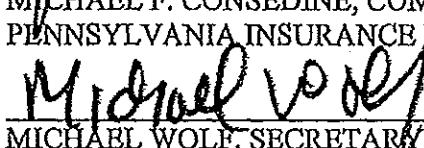
**COMMONWEALTH OF PENNSYLVANIA  
KATHLEEN G. KANE  
Attorney General**

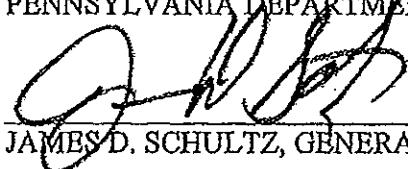
Date: \_\_\_\_\_ By: \_\_\_\_\_

Date: \_\_\_\_\_ By: \_\_\_\_\_

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

Date: 6/27/14 By:   
MICHAEL F. CONSEDINE, COMMISSIONER  
PENNSYLVANIA INSURANCE DEPARTMENT

Date: 6/27/14 By:   
MICHAEL WOLF, SECRETARY  
PENNSYLVANIA DEPARTMENT OF HEALTH

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

Date: \_\_\_\_\_ By: \_\_\_\_\_  
Yen Lucas  
Chief Counsel  
Insurance Department  
13<sup>th</sup> Floor, Strawberry Square  
Harrisburg, PA 17120  
Counsel for the Commonwealth of Pennsylvania

Counsel for the Commonwealth of Pennsylvania

**BY THE RESPONDENTS**

**UPE, a/k/a, HIGHMARK HEALTH**

Date: 6/27/2014

By:

Thomas L. VanKirk

**HIGHMARK, INC.**

Date: 6/27/2014

By:

Thomas L. VanKirk, Sec.

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

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA,  
By KATHLEEN G. KANE, Attorney General;  
PENNSYLVANIA DEPARTMENT OF INSURANCE,  
By MICHAEL CONSEDINE, Insurance Commissioner;  
and  
PENNSYLVANIA DEPARTMENT OF HEALTH,  
By MICHAEL WOLF, Secretary of Health;

Petitioners,

v.

No. \_\_\_\_ M.D. 2014

UPMC, A Nonprofit Corp.;  
UPE, a/k/a, HIGHMARK HEALTH, A Nonprofit Corp.;  
and  
HIGHMARK, INC., A Nonprofit Corp.;

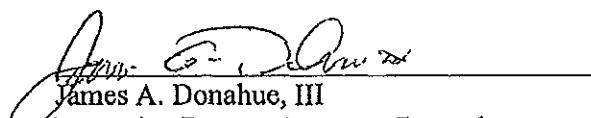
Respondents.

**CERTIFICATE OF SERVICE**

I, James A. Donahue, III, hereby certify that on June , 2014, I caused to be served a true and correct copy of the foregoing Motion to Approve Consent Decree with Respondent Highmark and Consent Decree via first class mail, postage prepaid, on counsel for Respondents as follows:

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

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

  
\_\_\_\_\_  
James A. Donahue, III  
Executive Deputy Attorney General  
Public Protection Division



# **Exhibit**

**3**

## EXHIBIT 3

### IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA,  
By KATHLEEN G. KANE, Attorney General;  
PENNSYLVANIA DEPARTMENT OF INSURANCE,  
By MICHAEL CONSEDINE, Insurance Commissioner  
and  
PENNSYLVANIA DEPARTMENT OF HEALTH,  
By MICHAEL WOLF, Secretary of Health,

Petitioners,

v.

No. 334 M.D. 2014

UPMC , A Nonprofit Corp.;  
UPE, a/k/a, HIGHMARK HEALTH, A Nonprofit Corp.  
and  
HIGHMARK, INC., A Nonprofit Corp.;

Respondents.

#### MOTION TO APPROVE CONSENT DECREE WITH RESPONDENT UPMC

1. The Commonwealth of Pennsylvania acting through its Attorney General, Kathleen G. Kane, its Insurance Commissioner, Michael F. Consedine, and its Secretary of Health, Michael Wolf (Petitioners), initiated an action by filing a Petition for Review on June 27, 2014, against the Respondent UPMC, the allegations of which are incorporated herein by reference.
  
2. The Petitioners and Respondent, UPMC, have resolved the allegations in the Petition for Review subject to this Court's approval of the terms and conditions contained in the proposed Consent Decree attached.

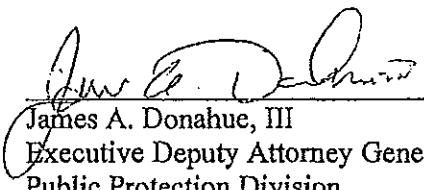
WHEREFORE, Petitioners respectfully request that this Honorable Court approve the proposed Consent Decree.

Respectfully submitted

COMMONWEALTH OF PENNSYLVANIA

KATHLEEN G. KANE  
Attorney General

Date: 6/27/2014 By:

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

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA, :  
By KATHLEEN G. KANE, Attorney General; :  
PENNSYLVANIA DEPARTMENT OF INSURANCE, :  
By MICHAEL CONSEDINE, Insurance Commissioner :  
and :  
PENNSYLVANIA DEPARTMENT OF HEALTH, :  
By MICHAEL WOLF, Secretary of Health, :

Petitioners, :

v. : No. \_\_\_\_\_ M.D. 2014

UPMC, A Nonprofit Corp.; :  
UPE, a/k/a, HIGHMARK HEALTH, A Nonprofit Corp. :  
and :  
HIGHMARK, INC., A Nonprofit Corp.; :

Respondents. :

CONSENT DECREE

AND NOW, this \_\_\_\_\_ day of \_\_\_\_\_, 2014, upon the

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

SETTLEMENT TERMS

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

## I. INTERPRETATIVE PRINCIPLES

A. The Court's Consent Decree shall be interpreted consistently with the Insurance Department's UPE Order in the Highmark/West Penn Allegheny Health System matter, *In Re Application of UPE*, No. ID-RC-13-06 (Pa. Insur. Dept. 2013), and the 2012 Mediated Agreement and to protect consumers and UPMC'S charitable mission. The outcome of the actions embodied in the Consent Decree shall be incorporated in the Transition Plan to be filed by Highmark by July 31, 2014, as provided under Condition 22 of the UPE order. The Consent Decree is not a contract extension and shall not be characterized as such.

## II. DEFINITIONS

- A. "Balance Billing" means when a Health Care Provider bills or otherwise attempts to recover the difference between the provider's charge and the amount paid by a patient's insurer and through member cost-shares.
- B. "Children's Final Order" means the Final Order in the matter of *In Re: Children's Hospital of Pittsburgh and Children's Hospital of Pittsburgh Foundation*, No. 6425 of 2001 (All. Co. 2001).
- C. "Emergency Services/ER Services" means medical services provided in a hospital emergency department in response to the sudden onset of a medical condition requiring intervention to sustain the life of a person or to prevent damage to a person's health and which the recipient secures immediately after the onset or as soon thereafter as the care can be made available, but in no case later than 72 hours after the onset.

- D. "Greater Pittsburgh Area" means the counties of Allegheny, Beaver, Butler, Washington and Westmoreland.
- E. "Health Plan" means all types of organized health-service purchasing programs, including, but not limited to, health insurance or managed-care plans, offered by government, for-profit or non-profit third-party payors, health care providers or any other entity.
- F. "Health Care Provider" means hospitals, skilled nursing facilities, ambulatory surgery centers, laboratories, physicians, physician networks and other health care professionals and health care facilities.
- G. "Highmark" means Highmark, Inc., the domestic nonprofit corporation incorporated on December 6, 1996, with a registered office at Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, Pennsylvania 15222. Unless otherwise specified, all references to Highmark include UPE and all of its controlled nonprofit and for-profit subsidiaries, partnerships, trusts, foundations, associations or other entities however styled.
- H. "Hospital" means a health care facility, licensed as a hospital, having a duly organized governing body with overall administrative and professional responsibility and an organized professional staff that provides 24-hour inpatient care, that may also provide outpatient services, and that has, as a primary function, the provision of inpatient services for medical diagnosis, treatment and care of physically injured or sick persons with short-term or episodic health problems or infirmities.
- I. "In-Network" means where a health care provider has contracted with a Health Plan to provide specified services for reimbursement at a negotiated rate to treat the Health

Plan's members. The member shall be charged no more than the co-pay, co-insurance or deductible charged by his or her Health Plan, the member shall not be refused treatment for the specified services in the contract based on his or her Health Plan and the negotiated rate paid under the contract by the Health Plan and the member shall be payment in full for the specified services.

- J. "Mediated Agreement" means the Mediated Agreement entered into by UPMC and Highmark on May 1, 2012, with assistance of a mediator appointed by the Governor and all agreements implementing the Mediated Agreement.
- K. "Out-of-Network" means where a Health Care Provider has not contracted with a Health Plan for reimbursement for treatment of the Health Plan's members.
- L. "Payor Contract" means a contract between a Health Care Provider and a Health Plan for reimbursement for the Health Care Provider's treatment of the Health Plan's members.
- M. "Trauma" means medical services that are provided to an individual with a severe, life threatening injury which is likely to produce mortality or permanent disability and which are provided at the designated Trauma Center in a facility that provides specialized medical services and resources to patients suffering from traumatic, serious or critical bodily injuries and which is accredited by the Pennsylvania Trauma Systems Foundation and services needed for appropriate continuity of care.
- N. "UPE", also known as Highmark Health, means the entity incorporated on October 20, 2011, on a non-stock, non-membership basis, with its registered office located at Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, Pennsylvania 15222. UPE serves as the controlling member of Highmark.

- O. “UPE Order” means the Pennsylvania Insurance Department’s April 29, 2013 Approving Determination and Order of the Highmark/West Penn Allegheny Health System Affiliation, *In Re Application of UPE*, No. ID-RC-13-06 (Pa. Insur. Dept. 2013).
- P. “UPMC” means the non-profit, tax-exempt corporation organized under the laws of the Commonwealth of Pennsylvania having its principal address at: 200 Lothrop Street, Pittsburgh, PA 15213. Unless otherwise specified, all references to UPMC include all of its controlled nonprofit and for-profit subsidiaries, partnerships, trusts, foundations, associations or other entities however styled.
- Q. “UPMC Health Plan” means the Health Plan owned by UPMC which is licensed by the Pennsylvania Department of Insurance.
- R. “UPMC Hospitals” means the Hospitals operated by the following UPMC subsidiaries: UPMC Presbyterian-Shadyside, Children’s Hospital of Pittsburgh of UPMC, Magee Women’s Hospital of UPMC, UPMC McKeesport, UPMC Passavant, UPMC St. Margaret, UPMC Bedford Memorial, UPMC Horizon, UPMC Northwest, UPMC Mercy, UPMC East, UPMC Hamot, UPMC Hamot, affiliate - Kane Community Hospital, UPMC Altoona, Western Psychiatric Institute and Clinic of UPMC and any other Hospital acquired by UPMC following the entry of the Court’s Consent Decree.
- S. “Western Pennsylvania” means the 29-county area designated by the Blue Cross Blue Shield Association in which Highmark does business as Highmark Blue Cross Blue Shield.

#### **IV. TERMS**

UPMC shall comply with the following terms:

##### **A. Access**

1. **ER/Trauma Services** - UPMC shall negotiate in good faith to reach an agreement with Highmark on In-Network rates and patient transfer protocols for emergency and trauma services for hospital, physician and appropriate continuity of care services at all UPMC and Allegheny Health Network hospitals by July 15, 2014 or be subject to the Dispute Resolution Process set forth in paragraph C (1) below. This does not mean that Hospitals or physicians rendering emergency or trauma services to a patient are In-Network for purposes or services other than treating the emergency condition for which a patient is admitted or the treating physicians are otherwise In-Network under other terms of this Consent Decree including, but not limited to, the Continuity of Care, Unique/Exception Hospitals or Oncology. The agreement shall be for a commercially reasonable period of time as provided in Condition 3 of the UPE Order. UPMC shall not Balance Bill consumers until the ER services agreement is resolved.
2. **Vulnerable Populations** – UPMC and Highmark mutually agree that vulnerable populations include: (i) consumers age 65 or older who are eligible or covered by Medicare, Medicare Advantage, (ii) Medigap health plans, (iii) Medicaid and/or (iv) CHIP. With respect to Highmark's covered vulnerable populations, UPMC shall continue to contract with Highmark at in-network rates for all of its hospital, physician and appropriate continuity of care services for CHIP, Highmark Signature 65, Medigap and commercial retiree carve out as long as Highmark

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

3. **Local Community Needs** – Where UPMC is the provider of services provided locally that the patient's treating physician believes the patient needs and DOH has determined such services are not available from another source, and member is Out-of-Network, UPMC will not Balance Bill the member, and UPMC and Highmark shall negotiate a payment that shall not be greater than the Out-of-Network rates established by this Consent Decree.
4. **Oncology/Cancer Services** – Highmark subscribers may access, as if In-Network, UPMC services, providers, facilities, and physicians involved in the treatment of cancer, if a patient's treating physician determines that a patient who is diagnosed with cancer should be treated by a UPMC oncologist and the patient agrees to be so treated. In addition, UPMC and Highmark shall negotiate an agreement for treatment of illnesses which result from cancer treatment. These resulting illnesses may include, but not be limited to, mental health, endocrinology, orthopedics and cardiology. The need for a treatment of a resulting illness shall be determined, in the first instance, by the patient's treating physician acting in consultation with and in accordance with the wishes of the patient or the patient's representative. Moreover, all UPMC joint ventures and physician services

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

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

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

7. **Continuity of Care** – UPMC and Highmark mutually agree that the continuation of care of a Highmark member in the midst of a course of treatment at UPMC shall be on an In-Network basis at In-Network rates. The need for a continuing course of treatment shall be determined, in the first instance, by the patient's treating physician acting in consultation with and in accordance with the wishes of the patient or the patient's representative. While undergoing a continuing course of treatment with UPMC, the services covered In-Network will include all services reasonably related to that treatment, including, but not limited to, testing and follow-up care. In the event that Highmark disputes the opinion of the treating physician that a continuation of care is medically appropriate, or disputes the scope of that care, the DOH or its designated representative will review the matter and make a final, non-appealable determination.
8. **Transfer of Services** – If any services covered by this Consent Decree are transferred or consolidated at one or more UPMC Hospitals, the terms of this Consent Decree shall apply to those transferred services where such services are transferred or consolidated.
9. **Referrals and UPMC Transfer of Patients** - (a) UPMC shall not require its physicians to refer patients to a UPMC Hospital in situations where the patient is

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

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

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

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

#### B. **Monetary Terms**

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

#### C. **Miscellaneous Terms**

1. **Dispute Resolution Process** - Where required in this Consent Decree, UPMC and Highmark shall negotiate in good faith. If the parties are unable to reach agreement on any of the issues raised in this Consent Decree by July 15, 2014, or such other date as may be set by OAG, PID and DOH, then the terms or rates shall be subject to the following:
  - a. Rates
    - i. For the period, January 1, 2015 to December 31, 2015, rates for all In-Network services covered in this Consent Decree, except for those rates currently being arbitrated by UPMC and Highmark, shall revert to the last mutually agreed upon rates or fees by UPMC and Highmark with the applicable medical market basket index (MBI) increase applied January 1, 2015.

- ii. For rates currently being arbitrated, in the event that the current arbitration between UPMC and Highmark finds in favor of UPMC, then the rates and fees under the Consent Decree will revert to the rates in effect before April 1, 2014 as of the date of the arbitral award and shall remain in place through December 31, 2015. If as a consequence of the arbitral award, Highmark owes UPMC for underpayments, Highmark shall pay UPMC appropriate interest. If as a consequence of the arbitral award, UPMC owes Highmark for overpayments, UPMC shall pay Highmark appropriate interest. If an arbitral award is not decided before January 1, 2015, Highmark shall increase its payments by one-half the difference between Highmark's April 1, 2014 schedule and its rate schedule in effect before April 1, 2014 for the period January 1, 2015 to December 31, 2015.
- iii. For the period beginning January 1, 2016 to the expiration of the Consent Decree or the expiration of any agreements between UPMC and Highmark for all In-Network services, whichever is later, the rates shall be the rates mutually agreed to by Highmark and UPMC, or UPMC and Highmark shall engage in a single last best offer binding arbitration to resolve any dispute as to rates after December 31, 2015 as set forth in paragraph C (2) below.
- iv. Any agreement or award as to rates and fees will be binding on both UPMC and Highmark, meaning that each will bill and make payments consistent with the agreement or award.

- b. Non-Rate Term – Disputed terms set forth in this Consent Decree and unrelated to rate and reimbursement shall be subject to mediation before the OAG, PID and DOH. If mediation does not result in resolution within 30 days or such other time set by the OAG, PID and DOH, UPMC and Highmark shall engage in binding arbitration to resolve the dispute as to terms as set forth in Paragraph C (2) below.
2. **Binding Arbitration**
- a. The Parties will file a joint plan with this court for a single last best offer binding arbitration before independent and neutral parties by August 14, 2014 or seek court intervention to resolve any disputes over such process.
3. **Binding on Successors and Assigns** – The terms of this Consent Decree are binding on UPMC, its directors, officers, managers, employees (in their respective capacities as such) and to its successors and assigns, including, but not limited to, any person or entity to whom UPMC may be sold, leased or otherwise transferred, during the term of the Consent Decree. UPMC shall not permit any substantial part of UPMC to be acquired by any other entity unless that entity agrees in writing to be bound by the provisions of this Consent Decree.
4. **Enforcement** - The OAG, PID and DOH shall have exclusive jurisdiction to enforce the Consent Decree. If the OAG, PID or DOH believe that a violation of the Final Decree has taken place, they shall so advise UPMC and give UPMC 20 days to cure the violation. If after that time the violation is not cured, the OAG, PID or DOH may seek enforcement of the Consent Decree in the Commonwealth Court. Any person who believes they have been aggrieved by a violation of this

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

5. **Release** –This Consent Decree will release any and all claims the OAG, PID or DOH brought or could have brought against UPMC for violations of any laws or regulations within their respective jurisdictions, including claims under laws governing non-profit corporations and charitable trusts, consumer protection laws, insurance laws and health laws relating to the facts alleged in the Petition for Review or encompassed within this Consent Decree for the period of July 1, 2012 to the date of filing. Any other claims, including but not limited violations of the crimes code, Medicaid fraud laws or tax laws are not released.
6. **Compliance with Other Laws** - The Parties agree that the terms and agreements encompassed within this Consent Decree do not conflict with UPMC's obligations under the laws governing non-profit corporations and charitable trusts, consumer protection laws, antitrust laws, insurance laws and health laws.

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

**If to the Attorney General:**

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

**If to UPMC:**

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

**Copies to:**

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

8. Averment of Truth – UPMC avers that, to the best of its knowledge, the information it has provided to the OAG, PID and DOH in connection with this Consent Decree is true.
9. Termination – This Consent Decree shall expire five (5) years from the date of entry.
10. Modification – If the OAG, PID, DOH or UPMC believes that modification of this Consent Decree would be in the public interest, that party shall give notice to the other and the parties shall attempt to agree on a modification. If the parties

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

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

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

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

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

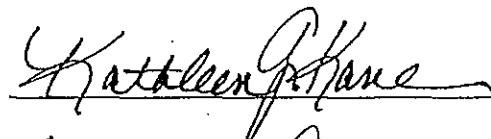
WE HEREBY consent to this Consent Decree and submit the same to this Honorable Court for the making and entry of a Consent Decree, Order or Judgment of the Court on the dates indicated below.

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

BY THE PETITIONERS

COMMONWEALTH OF PENNSYLVANIA  
KATHLEEN G. KANE  
Attorney General

Date: June 27, 2014 By:



Date: 6/27/2014 By:



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

Date: \_\_\_\_\_ By:

MICHAEL F. CONSEDINE, COMMISSIONER  
PENNSYLVANIA INSURANCE DEPARTMENT

Date: \_\_\_\_\_ By:

MICHAEL WOLF, SECRETARY  
PENNSYLVANIA DEPARTMENT OF HEALTH

Date: \_\_\_\_\_ By:

JAMES D. SCHULTZ, GENERAL COUNSEL

Date: 6/27/14 By:

  
Yen Lucas  
Chief Counsel  
Insurance Department  
13<sup>th</sup> Floor, Strawberry Square  
Harrisburg, PA 17120

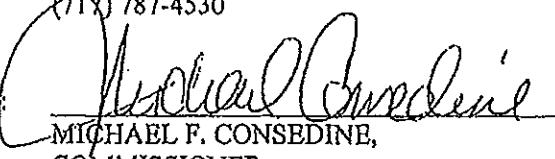
WHEREFORE, and intending to be legally bound, the parties have hereto set their hands and seals.

BY THE PETITIONERS

COMMONWEALTH OF PENNSYLVANIA  
KATHLEEN G. KANE  
Attorney General

Date: \_\_\_\_\_ By: \_\_\_\_\_

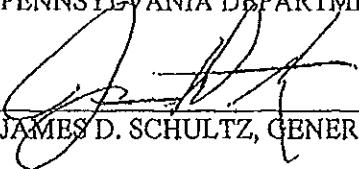
James A. Donahue, III  
Executive Deputy Attorney General  
Public Protection Division  
Attorney I.D. No.: 82620  
14<sup>th</sup> Floor Strawberry Square,  
Harrisburg, PA 17120  
(717) 787-4530

Date: 6/27/14 By: 

MICHAEL F. CONSEDINE,  
COMMISSIONER  
PENNSYLVANIA INSURANCE DEPARTMENT

Date: 6/27/14 By: 

MICHAEL WOLF  
SECRETARY  
PENNSYLVANIA DEPARTMENT OF HEALTH

Date: 6/27/14 By: 

JAMES D. SCHULTZ, GENERAL COUNSEL

Date: \_\_\_\_\_ By: \_\_\_\_\_

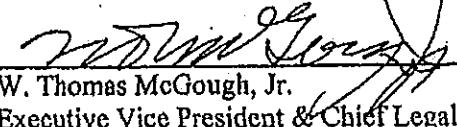
Yen Lucas  
Chief Counsel  
Insurance Department  
13<sup>th</sup> Floor, Strawberry Square  
Harrisburg, PA 17120

Counsel for the Commonwealth of Pennsylvania

BY THE RESPONDENT  
UPMC

Date: June 27, 2014

By:

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

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA,  
By KATHLEEN G. KANE, Attorney General;  
PENNSYLVANIA DEPARTMENT OF INSURANCE,  
By MICHAEL CONSEDINE, Insurance Commissioner  
and  
PENNSYLVANIA DEPARTMENT OF HEALTH,  
By MICHAEL WOLF, Secretary of Health,

Petitioners,

v.

No. \_\_\_\_\_ M.D. 2014

UPMC, A Nonprofit Corp.;  
UPE, a/k/a, HIGHMARK HEALTH, A Nonprofit Corp.  
and  
HIGHMARK, INC., A Nonprofit Corp.;

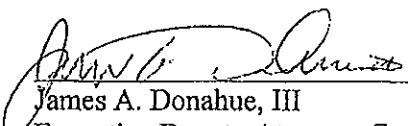
Respondents.

**CERTIFICATE OF SERVICE**

I, James A. Donahue, III, hereby certify that on June , 2014, I caused to be served a true and correct copy of the foregoing Motion to Approve Consent Decree with Respondent UPMC and Consent Decree via first class mail, postage prepaid, on counsel for Respondents as follows:

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

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

  
\_\_\_\_\_  
James A. Donahue, III  
Executive Deputy Attorney General  
Public Protection Division

# **Exhibit**

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## **EXHIBIT 4**

### **Allegheny Health Network Overview**

Allegheny Health Network ("AHN") is a dynamic, patient-centered and physician-led academic, healthcare system based in Pittsburgh, Pennsylvania that provides services to patients throughout western Pennsylvania and the adjacent multi-state region of Ohio, West Virginia, New York and Maryland.

Allegheny Health Network is comprised of eight hospitals, more than 200 healthcare sites – including outpatient care centers and physician offices, the Allegheny Singer Research Institute and a 700+ member physician organization. The Network's hospitals include one quaternary academic medical center (Allegheny General Hospital, 630 beds, Pittsburgh), and seven tertiary/community hospitals that provide an array of general and advanced medical services, including Allegheny Valley Hospital, 228 beds, Natrona Heights, PA; Canonsburg General Hospital, 104 beds; Forbes Hospital, 349 beds, Monroeville, PA; Jefferson Hospital, 369 beds, Jefferson Hills, PA; Saint Vincent Hospital, 385 beds, Erie PA; West Penn Hospital, 308 beds, Pittsburgh; and Westfield Memorial Hospital, Westfield, NY. In addition to the full range of inpatient and outpatient programs offered at the Network's eight hospitals, comprehensive services are provided at dozens of conveniently located outpatient centers throughout the region, including broad scale Health + Wellness Pavilions in Peters Township, Bethel Park and Wexford, opening soon. These pavilions offer a multi-disciplinary array of clinical and support services close to home.

Allegheny Health Network is anchored by nationally and internationally recognized clinical and research programs in the areas of Bone and Joint Care, Sports Medicine, Cardiology, Neurosciences, Women's Health and Cancer. Allegheny Health Network provides a complete spectrum of advanced diagnostic, medical and surgical care across all medical specialties, including emergency, trauma and burn care, general surgery, diabetes, digestive diseases, pulmonary, hospice care and rehabilitation services. The Network is also a leading center for advanced heart, liver, kidney and pancreas transplantation.

Allegheny Health Network's sports medicine program is the official medical provider of the Pittsburgh Pirates professional baseball team, the Pittsburgh Riverhounds soccer team, Robert Morris University and 20 Pittsburgh area high schools. The program is also an official medical provider of the Professional Golfers Association.

Each year, the hospitals of Allegheny Health Network together admit nearly 100,000 patients, log over 285,000 emergency room visits, deliver approximately 5,000 babies and perform 21,400 orthopaedic, 7,800 neurosurgical, 16,500 cardiovascular and 120,000 cancer procedures.

The hospitals of Allegheny Health Network have earned many accolades for superior quality and service excellence, including recognition from respected independent analysts such as US News, Thomson Reuters/Truven Analytics, Consumer Reports, Healthgrades and Becker's Hospital Review. In the most recent US News Best Hospitals Report, four of the Network's hospitals were lauded as "High Performing" institutions, including Allegheny General Hospital (10 categories), West Penn (6 categories) Forbes Regional (7 categories) and Saint Vincent (5 categories).

Allegheny Health Network also plays a pivotal role in the training of future generations of healthcare professionals by offering 46 graduate medical programs, three medical school affiliations and two nursing schools. Allegheny General and West Penn Hospital serve as clinical campuses for the medical schools of Drexel University and Temple University, respectively and Saint Vincent serves as a campus of

## **EXHIBIT 4**

the Lake Erie College of Osteopathic Medicine (LECOM). Nearly 280 students are also currently enrolled in nursing programs at The Western Pennsylvania Hospital School of Nursing in Bloomfield and the Citizens School of Nursing in Natrona Heights and more than 500 residents and fellows are on staff at the Network's hospitals.

Physicians and scientists at Allegheny Health Network are often on the cutting edge of advanced treatments and new technologies. Innovative medical research across all of the Networks programs is a critical component of the organization's mission. The Network's Allegheny-Singer Research Institute coordinates private and federally funded interdisciplinary programs designed to better understand, treat and prevent disease, and the Network's hospitals are frequently involved in clinical trials of breast, prostate and bowel cancer, burn and traumatic injuries, gene therapy, cardiovascular disease, leukemia and lymphoma, autoimmune diseases, neurological diseases, and more. The Network is currently home to more than 340 active clinical trials.

AHN is committed to ensuring that all patients have seamless, timely access to its programs and physicians. Some steps taken to meet this charge, include:

- **Our New Call Center.** Allegheny Health Network has established a centralized call center to triage patient appointment requests coming into the system. Both the Network's 412-Doctors hotline and online physician directory lead patients to the Call Center for assistance in making appointments or to provide information about the services or programs of the network .
- **New Online Physician Directory.** A key feature of Allegheny Health Network's new web site is the completely revamped, more user friendly online physician directory. Users can search under a specific doctor's name or specialty group and look for physicians with offices located in areas convenient to them. Once a doctor is selected, the Call Center will do the rest to set the appointment up.
- **Welcome Kits.** Allegheny Health Network and Highmark have developed information packets that will be distributed to all patients whose care will be impacted by the separation of Highmark and UPMC. The kits will include forms to assist patients in transitioning their care and medical records to a new provider, as well as the AHN physician directory.

**Women's Care**-AHN, its affiliates and community partners are fully capable of meeting the obstetric and gynecologic needs of women in the Pittsburgh region who seeks care within our system. We have both the capacity to care for more women and, most importantly, capabilities that are every bit as sophisticated as those found at Magee for the care of women and infants.

- AHN employs 110 OBGYNs, with more than 50 office locations across the region.
- When Jefferson Hospital's obstetrics program starts in the fall, we will deliver babies at four hospitals in our system, including:
  - Forbes Hospital, Monroeville

## EXHIBIT 4

- Jefferson Hospital, Jefferson Hills
- West Penn Hospital, Pittsburgh
- Saint Vincent Hospital, Erie
- AHN also has the highest level of neonatology services available at West Penn and Saint Vincent and level two capabilities at Forbes and Jefferson. Our existing programs delivered 5,000 babies last year and have the capacity to deliver many more, including the new capacity we will bring to the region at Jefferson.
- AHN's advanced obstetrical specialties including high risk pregnancy , infertility and high risk genetic testing and counseling
- AHN has comprehensive Women's Health Centers in numerous community locations, including:
  - Peters Township
  - Bethel Park
  - Murrysville in progress
  - Wexford (Heath + Wellness Pavilion, opening Fall 2014)
- Advanced gynecologic services available at AHN include uro-gynecology and pelvic floor reconstruction, gynecologic oncology, minimally invasive gynecologic surgery, breast disease, bone health, women's heart centers, integrated and complementary medicine, and all medical subspecialties

**Cancer Care** -AHN is home to a nationally recognized cancer treatment and research program that provides patients a complete spectrum of oncology care, including advanced medical, hematological, surgical and radiation oncology services, state-of-the –art diagnostics and a robust cancer clinical trials program.

- AHN has an official collaborative relationship with the world renowned Johns Hopkins Comprehensive Kimmel Cancer Center for research, medical education and clinical services.
- AHN has launched an expansion of its Comprehensive Cancer Care into communities around the Pittsburgh region through its AHN Cancer Institutes that include:
  - Allegheny General Hospital- Tertiary Center
  - Forbes Hospital
  - West Penn Hospital-FACT Accredited Stem Cell Transplant Center
  - Peters Township Outpatient Care Center
  - Jefferson Hospital
  - Wexford Health + Wellness Pavilion (opening 10/2014)
  - Allegheny Valley Hospital
  - Armstrong Hospital
  - Somerset

## EXHIBIT 4

- Butler
  - New Castle
  - New Kensington
  - Punxsutawney
  - Robinson
  - Steubenville (Trinity Health System)- Radiation Oncology
  - Clarion –Radiation Oncology
- AHN has a comprehensive, multidisciplinary regional cancer network with more than 150 oncologists who practice at nearly 50 locations across the region.
  - AHN is active in more than 200 cancer clinical trials exploring novel therapies for many cancers. The Network is also headquarters for the primary leadership of the National Surgical Adjuvant Breast and Bowel Project, the world's preeminent, NCI funded breast and bowel cancer research program.
  - AHN's radiation oncology program, with 12 locations throughout the region, is the nation's largest program accredited by the American College of Radiology and the American Society of Radiation Oncology, signifying the highest level of cancer care quality, safety and patient outcomes. UPMC does not have this dual accreditation.
  - AHN's Bone Marrow and Stem Cell Transplantation program for hematologic cancers is one of the most advanced in research and clinical trials, is FACT certified and has the highest accreditation for quality care. The Stem Cell Transplant Program is a designated Center of Excellence (COE) by Optum, Blue Distinction, Cigna, Aetna(Coventry / Health America).

**Heart and Vascular:** AHN's doctors have earned worldwide recognition in the medical and surgical care of cardiac, thoracic and vascular disease. Among the program highlights include:

- Comprehensive, multidisciplinary team of cardiologists, cardio-thoracic and vascular surgeons, nurses and allied health professionals with over 25 office locations throughout the region to facilitate easy access for patients
- Specialty centers that focus on valve disease, heart failure, pulmonary hypertension, atrial fibrillation, advanced open and minimally invasive heart surgery, vascular disease, heart transplantation, lung and esophageal surgery, coronary artery disease, and preventative cardiology with lifestyle management.
- Leading Expertise in cardiovascular innovation with patient access to over 75 clinical trials in cardiovascular medicine and surgery.

## **EXHIBIT 4**

- AHN heart transplantation program has the region's best three year patient outcomes

**Orthopaedic Care:** AHN is a national leader in orthopaedic surgery, sports medicine and rehabilitation care. The program includes specific divisions for:

- Sports medicine care and concussion management
  - Orthopaedic trauma
  - Spine Injury
  - Foot and ankle,
  - Joint Reconstruction
  - Pediatric orthopaedic surgery
- Through Allegheny Health Network's seven hospitals and 17 orthopedic and rehabilitation centers across western Pennsylvania and eastern Ohio, athletes are able to receive advanced testing, treatment and rehabilitation in close to home settings.
  - For highly specialized and advanced levels of orthopedic care, the Network's hospitals offer innovative surgeries and minimally invasive procedures that help athletes recover faster and with less post-operative pain
  - AHN's orthopaedic surgeons access the latest treatment modalities and research protocols to maximize our patients' potential for full mobility. AHN programs include advanced diagnostic services, repair and rehabilitation through follow-up, and the development of new devices and procedures that advance the treatment of the musculoskeletal system.
  - AHN serves as the official medical provider of the Pittsburgh Pirates Major League Baseball Club as well as the Pittsburgh Riverhounds soccer team.
  - AHN provides orthopedic and sports medicine services to Robert Morris University and 18 Pittsburgh area high school athletic programs.
  - In 2014, AHN became designated as an official U.S. Olympic Regional Medical Center by the U.S. Olympic Committee, one of just seven such facilities in the country.
  - Allegheny Health Network is also home to a leading athletic concussion management program and is one of just a few medical centers in the country using a groundbreaking new concussion evaluation and management system called C3 Logix.

**Neurosciences:** AHN's neurosurgeons and neurologists rank among the nation's best for the treatment of diseases related to the brain and spine.

## **EXHIBIT 4**

- The Network's neurosurgical department offers leading expertise in treatment of:
  - Spinal cord disease and injuries
  - Brain tumors and brain blood vessel malformations
  - Head injuries
  - Cranial nerve disease
  - Parkinson's and other Movement Disorders
  - Stroke
  - Brain Cancer
- AHN Neurosurgeons provide pioneering treatments for conditions that include trigeminal neuralgia, brain tumors, skull base tumors, lumbar conditions and Parkinson's disease.
- AHN's neuroscience researchers are involved in landmark studies exploring novel treatments for diseases of the brain and spine. They also implant deep brain stimulation devices to improve treatment of epileptic seizures, tremors and movement disorders and have devised new therapies to combat tissue damage from lack of arterial blood inflow to the brain.
- AHN's neurologists established the region's first dedicated Comprehensive Stroke Unit and the Network is currently home to a Joint Commission designated Comprehensive Stroke Center and multiple primary stroke centers based at community hospitals.
- AHN is home to the area's largest epilepsy program and its neurologists lead other comprehensive disease specific centers for the treatment of:
  - Stroke
  - Parkinson's Disease and Movement Disorders
  - Neuromuscular Disease
  - Multiple Sclerosis
  - Myasthenia Gravis
  - Neuro-oncology

**Transplantation:** AHN's organ transplantation program is certified by Medicare and the United Network for Organ Sharing (UNOS). Among the program highlights:

- AHN's transplant surgeons are on the forefront of the latest advances in surgical procedures and medical care designed to improve survival rates after transplant.
- AHN is a center for heart, liver, kidney and pancreas transplantation, as well as kidney/ pancreas and heart/kidney double transplants.
- According to the latest data from the Scientific Registry of Transplant Recipients, AHN has the best one and three year liver transplant outcomes in the region and the best three year outcomes in the region for heart transplant.

# **Exhibit**

**5**

## **EXHIBIT 5**

### **Highmark's Western Region Community Hospitals**

#### **Allegheny County**

##### **Heritage Valley Sewickley**

- \* Designated a fully accredited center by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) and The American College of Surgeons
- \* Earned the Gold Seal of Approval™ from The Joint Commission for Primary Stroke Centers (2013)

##### **Ohio Valley**

- \* Awarded a 2014 Accreditation from The Joint Commission

##### **St. Clair**

- \* Received the 2014 Gynecologic Surgery Excellence Award™ from Healthgrades
- \* Received an "A" Hospital Safety Score<sup>SM</sup> from The Leapfrog Group in Spring 2014
- \* Named (for a third time) one of the nation's 100 Top Hospitals in 2014 by Truven Health Analytics
- \* Comprehensive Community Cancer Program continuously accredited since 1996 by the Commission on Cancer® (CoC) and The American College of Surgeons
- \* Received the 2014 Healthgrades Outstanding Patient Experience Award™

#### **Armstrong County**

##### **Armstrong County Memorial Hospital**

- \* Received an "A" Hospital Safety Score<sup>SM</sup> from The Leapfrog Group in Spring 2014
- \* Again noted to have one of the lowest infection rates of any hospital in Pennsylvania according to a recent report from the Pennsylvania Department of Health
- \* Proficient in rotator cuff and ACL injuries, Orthopedic Surgeon Dr. Hasan Baydoun completed his fellowship in Sports Medicine and Shoulder Surgery at Harvard University and was the assistant team physician for the New England Patriots, the Boston Red Sox and the Boston Bruins.

#### **Beaver County**

##### **Heritage Valley Beaver**

- \* Earned the Gold Seal of Approval™ from The Joint Commission for Primary Stroke Centers (2013)
- \* Opened the first inpatient hospice unit in Beaver County as a joint venture with Good Samaritan Hospice (2013)

#### **Butler County**

##### **Butler Memorial**

- \* Received the latest American Stroke Association's Get With The Guidelines® - Stroke Gold Plus Quality Achievement Award (2013)
- \* Comprehensive Community Cancer Program continuously accredited since 2008 by the Commission on Cancer® (CoC) and The American College of Surgeons
- \* A recipient of Healthgrades Patient Safety Excellence Award™ (2013)

## **EXHIBIT 5**

### **Washington County**

#### **Mon Valley**

- \* Received the latest American Stroke Association's Get With The Guidelines® - Stroke Silver Plus Quality Achievement Award (2013)
- \* Community Cancer Program continuously accredited since 1992 by the Commission on Cancer® (CoC) and The American College of Surgeons
- \* Received the 2014 Healthgrades Outstanding Patient Experience Award™
- \* Recent accreditation by The Joint Commission (2012)
- \* Recent certification (2012) by The Joint Commission in the following programs: Inpatient Diabetes, Primary Stroke Center, Joint Replacement – Hip and Joint Replacement – Knee

#### **Washington Hospital**

- \* Received the latest American Stroke Association's Get With The Guidelines® - Stroke Gold Plus Quality Achievement Award (2013)
- \* 2014 certification by The Joint Commission in the following programs: Primary Stroke Center, Joint Replacement – Hip, Joint Replacement – Knee and Spinal Fusion
- \* A recipient of Healthgrades Patient Safety Excellence Award™ (2013)

### **Westmoreland County**

#### **Frick Hospital**

- \* Recent accreditation by The Joint Commission (2012)
- \* A recipient of Healthgrades Patient Safety Excellence Award™ (2013)
- \* Received the Healthgrades Patient Safety Excellence Award™ 2014
- \* Received the latest American Stroke Association's Get With The Guidelines® - Stroke Gold Plus Quality Achievement Award (2013)

#### **Ltrobe Hospital**

- \* Community Cancer Program continuously accredited since 1977 by the Commission on Cancer® (CoC) and The American College of Surgeons
- \* Recent accreditation by The Joint Commission (2012)
- \* Home to the family medicine residency program, affiliated with Jefferson Medical College of Thomas Jefferson University
- \* A recipient of Healthgrades Patient Safety Excellence Award™ (2013)
- \* Received the Healthgrades Patient Safety Excellence Award™ 2014
- \* Received the latest American Stroke Association's Get With The Guidelines® - Stroke Gold Plus Quality Achievement Award (2013)

#### **Westmoreland Hospital**

- \* Recent accreditation by The Joint Commission (2011)
- \* By using Hyperbaric Oxygen Therapy at its Advanced Wound Center, healing rates for patients have reached 93% in a 49-day average
- \* Received the latest American Stroke Association's Get With The Guidelines® - Stroke Gold Quality Achievement Award (2013)

## **EXHIBIT 5**

### **Additional Hospitals**

#### **Erie County**

##### **Corry Memorial**

- \* Its Diabetes Education Program has been awarded the American Diabetes Association Education Recognition Certificate
- \* Providing in-patient, out-patient and home-health care testing, their full-service Laboratory has been accredited by the Pennsylvania Department of Health

##### **Millcreek**

- \* Received a three-year accreditation (2012) from the American Osteopathic Association (AOA) Bureau of Healthcare Facilities Accreditation Program (HFAP)
- \* Opened The Lake Erie College of Osteopathic Medicine (LECOM) in 1992 which has grown to be the nation's largest medical college and the only Academic Health Center in the osteopathic profession
- \* Located here is the region's largest Behavioral Health Care unit, with special units for seniors, adults and children
- \* Home to the region's only ACE unit (Acute Care for the Elderly)

##### **Saint Vincent**

- \* Received the latest American Heart Association's Get With The Guidelines® - Heart Failure Silver Plus Quality Achievement Award (2013)
- \* Received the latest American Stroke Association's Get With The Guidelines® - Stroke Gold Plus Quality Achievement Award (2013)
- \* Recent accreditation by The Joint Commission (2013)
- \* Comprehensive Community Cancer Program continuously accredited since 2007 by the Commission on Cancer® (CoC) and The American College of Surgeons
- \* Received the 2014 Healthgrades Distinguished Hospital Award for Clinical Excellence™
- \* Designated by Healthgrades as one of *America's 100 Best Hospitals™ 2014*
- \* A recipient of Healthgrades Women's Health Excellence Award™ (2013)
- \* Received the Healthgrades Patient Safety Excellence Award™ 2014

# **Exhibit**

**6**

**REDACTED**

# **Exhibit**

**7**

## **EXHIBIT 7**

### **HIGHMARK DISRUPTION ANALYSIS**

#### **UPMC Disruption Analytics Methodology:**

##### **1) Identification of Disrupted UPMC Providers**

The first step of the analyses to identify potentially disrupted members was to identifying all contracted UPMC billing providers (inclusive of facilities, physician practices and ancillary care providers). Each of the UPMC billing providers was then categorized into one of three (3) categories based on Highmark's understanding of the 6/27/2014 Consent Decree Terms. The categories utilized were 1) in-network, 2) out-of-network, or 3) in-and-out-of-network. The in-and-out-of-network category was applied to physician practices containing a mix of physicians that met criteria for being in-network and included other physicians that did not meet any criteria and thus are considered out-of-network. For the physician practices identified as being in the in-and-out-of-network category each individual physician was evaluated to determine if the physician met any one of the criteria for being in-network. Physicians determined to be in-network under at least one criteria were considered to be in-network all of the time for the purposes of the Highmark analysis. Appendix 1 provides additional details on the categorization of the UPMC providers into the aforementioned categories.

Criteria for classifying a UPMC billing provider as being in-network (any one of the following):

- Community Hospital-UPMC JV practices
- UPMC Practices with specialty of pediatrics and/or pediatric subspecialties
- UPMC Practices with specialty behavioral health (psychology, psychiatry, clinical social work)
- UPMC Oncology practices
- UPMC Emergency Medicine practices (does not include Urgent Care)
- UPMC Exception Hospital practices
- UPMC Practices with locations EXCLUSIVELY outside Greater Pittsburgh Area

Criteria for classifying individual UPMC physician as in-network when the physician is part of a UPMC billing provider that has been classified as being in-and-out-of-network (any one of the following):

- Physician has one or more practice location(s) outside of Greater Pittsburgh Area
- Physician provides services at any UPMC exception hospital(s)
- Physician provides services at any community hospital(s)

##### **2) Summary of Disrupted UPMC Providers**

The results of the Identification of Disrupted UPMC Providers analysis are summarized in [Appendix 1](#). This analysis identified that, based on Highmark data a total of 647 (19%) UPMC employed physicians are identified as being out-of-network based on the physician being part of an in-and-out-of-network practice and not meeting any criteria for classifying the individual UPMC physician as in-network. In contrast, 1,309 (37%) UPMC employed physicians were identified as in-network as they are part of a physician practice that was considered as in-network plus an additional 1,550 (44%) of UPMC employed physicians classified as being in-and-out-of-network were considered to be in-network based on meeting one the criteria described above. As of 7/31/2014 Highmark and UPMC are working thru the specific physician lists and at this time that reconciliation is not complete, thus the aforementioned approach and results were used to determine potential member disruption.

## EXHIBIT 7

### Appendix 1 to the HIGHMARK DISRUPTION ANALYSIS

*As of 7/1/2014, CPR data as of 7/1, claims data for CY2013 utilized for provider analysis  
Greater Pittsburgh is defined as Allegheny, Beaver, Butler, Washington and Westmoreland counties*

#### **Product Types Included in Analysis: Commercial, FEP, Blue Card ONLY**

*\*UPMC remains INN for all "vulnerable population" members: This includes Medicare Advantage, Medigap, CHIP and Medicare participating members (including any members 65+ year old in commercial retiree carve outs or Medicare as primary or secondary)*

	<b>Contracted 2015+ Providers IN</b>	<b>Exception Hospitals/Services and Outside of Greater Pittsburgh Area Providers IN</b>	<b>Exception Services IN</b> <i>(Apply to all Provider Types)</i>	<b>Additional UPMC Greater Pittsburgh Area Providers "Likely IN"</b>	<b>UPMC Providers OUT</b> <i>(*Not accounting for exception services, Continuity of Care, or 2015 Safety Net conditions making the member's services INN for 2015)</i>	
<b>Hospitals</b>	UPMC Children's UPMC Mercy	UPMC Altoona UPMC Bedford UPMC Northwest UPMC Western Psych	UPMC Hamot UPMC Horizon UPMC Kane	<b>All Oncology and Related Care</b> <i>(Assumption: Any member with primary or secondary diagnosis of cancer on UPMC claim is INN for ALL UPMC services)</i>  <b>ER Services</b> <i>(Assumption: All ER and same episode related services for IP, OP and Prof. with an ER Services indicator on the claim are considered INN)</i>  <b>Local Community Needs Services</b>	UPMC East UPMC McKeesport UPMC Passavant	UPMC Presby/Shadyside UPMC Magee UPMC St. Margaret
<b>Physician</b>	<i>*Technically, none of the required termination notices have been received from UPMC (90 days req in most cases)</i>	1,309 (37%) UPMC Physicians in primary practices meeting any one of the following <ul style="list-style-type: none"> <li>• Community Hospital-UPMC JV practices</li> <li>• UPMC Practices with specialty of pediatrics and/or pediatric subspecialties</li> <li>• UPMC Practices with specialty behavioral health (psychology, psychiatry, clinical social work)</li> <li>• UPMC Oncology practices</li> <li>• UPMC Emergency Medicine practices (does not include Urgent Care)</li> <li>• UPMC Exception Hospital practices</li> <li>• UPMC Practices with locations EXCLUSIVELY outside Greater Pittsburgh Area</li> </ul>	<i>(Assumption: Any member with primary or secondary diagnosis of cancer on UPMC claim is INN for ALL UPMC services)</i>  <b>ER Services</b> <i>(Assumption: All ER and same episode related services for IP, OP and Prof. with an ER Services indicator on the claim are considered INN)</i>  <b>Local Community Needs Services</b>	1,550 (44%) UPMC Greater Pittsburgh Area physicians meeting any one of the following criteria are considered INN 100% of the time <ul style="list-style-type: none"> <li>• Physician has one or more practice location(s) outside of Greater Pittsburgh Area</li> <li>• Physician provides services at any UPMC exception hospital(s)</li> <li>• Physician provides services at any community hospital(s)</li> </ul>	647 (19%) Greater Pittsburgh Area UPMC physicians working at UPMC Out facilities ONLY <i>(i.e. Physician did not meet any of the inclusion criteria)</i>	
<b>Ancillary</b>		UPMC Ambulance Provider (ER Services Condition)  UPMC Ancillary Providers with locations EXCLUSIVELY outside of Greater Pittsburgh Area	<i>(Assumption: ALL UPMC care is INN for members with Lung Transplant, Small Bowel Transplant, Pregnancy Termination after 22 weeks)</i>		<b>UPMC Ancillary Providers with only locations inside the Greater Pittsburgh Area will be considered OUT</b>  <b>UPMC Ancillary Providers with locations inside &amp; outside of the Greater Pittsburgh Area will be OUT, until determined</b>	

# **Exhibit**

**8**

## **EXHIBIT 8**

### **Community Blue PPO 60 Day Extension of Out-of-Network Care**

#### **List of Conditions**

Medical Conditions that Qualify for Extension of Out of Network Care:

- a. 2nd and 3rd trimester of pregnancy
- b. Active medical/surgical/therapeutic radiation oncology management
- c. Transplants (within one (1) year prior to the Member's effective date of coverage)
- d. Surgery/Procedure performed within 60 days prior to the Member's effective date of coverage, including staged procedures in progress
- e. Physical Therapy/Occupational Therapy/Speech Therapy (Treatment plans/visits that began within the month prior to the Member's effective date of coverage)
- f. Cardiac and Pulmonary Rehab (Treatment plans/visits that began within the month prior to the Member's effective date of coverage)
- g. Medical services which are in active treatment within 60 days prior to the Member's effective date of coverage
- h. Individual consideration for a clinical scenario not identified above

# **Exhibit**

**9**

**REDACTED**