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

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

# COMPLAINT

## NATURE OF ACTION

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

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

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

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

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

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

**PARTIES**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**JURISDICTION AND VENUE**

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

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

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

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

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

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

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

## BACKGROUND

### I. GENERAL SHAPIRO ASSUMES CONTROL OVER NONPROFIT HEALTHCARE.

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

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

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

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

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

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

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

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

(f) nonprofit healthcare providers are prohibited from utilizing Provider-Based Billing, defined to mean "charging a fee for the use of the … building or facility at which a patient is seen";

(g) nonprofit healthcare providers are prohibited from including six other types of non-rate provisions in any of its contracts, including a provision that limits the dissemination of cost information;

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

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

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

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

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

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

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

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

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

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

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

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

39. General Shapiro has not yet identified to Plaintiffs what specific actions he intends to take to ensure that his new rules apply to all nonprofits.

40. General Shapiro also has not yet identified to Plaintiffs what specific actions he intends to take to force Plaintiffs to open their doors to insurers and providers who do not agree to be bound by his arbitration procedures.

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

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

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

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

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

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

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

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

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

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

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

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

**A. Federal Law Prohibits State Interference with Medicare Advantage.**

49. General Shapiro's new requirements directly conflict with the federal MA program in multiple ways. The Medicare Act, enacted as Title XVIII of the Social Security Act and codified at 42 U.S.C. §§ 1395 – 1395lll, creates a federally funded health insurance program for elderly and disabled individuals. Part C of the Act, 42 U.S.C. §§ 1395w-21 – 1395w-28, creates the MA program, through which beneficiaries may receive Medicare benefits through plans provided by private entities called MA organizations ("MAOs"). *See* 42 C.F.R. § 422.2.

50. The MA program is the subject of comprehensive federal statutory and regulatory authority. *See, e.g.*, 42 U.S.C. §§ 1395w-21 – 1395w-28; *see also* 42 C.F.R. § 422 *et seq*.

51. Congress has made clear that federal standards shall exclusively govern the MA program and preempt all state law requirements. Part C contains an express preemption clause, which states: "The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part." 42 U.S.C. § 1395w-26(b)(3).

52. The Centers for Medicare & Medicaid Services ("CMS"), the federal agency that oversees the MA program, has confirmed the broad scope of federal preemption: "[A]ll State standards, including those established through case law, are preempted to the extent that they specifically would regulate MA plans, with exceptions of State licensing and solvency laws." 70 Fed. Reg. 4665.

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

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

55. In the interest of fostering competition as an integral part of the MA program, Congress enacted a "noninterference" provision, which states:

> Noninterference. In order to promote competition under this part and part D of this subchapter and in carrying out such parts, the Secretary may not require any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services under this subchapter or require a particular price structure for payment under such a contract to the extent consistent with the Secretary's authority under this part.

42 U.S.C. § 1395w-24(a)(6)(B)(iii); *see also* 42 C.F.R. § 422.256(a)(2).

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

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

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

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

60. Provider-based billing refers to the exercise of a right under federal regulations that permit providers that meet specific criteria to bill a facility fee for services to MA enrollees. *See generally* 42 C.F.R. § 413.65. This kind of facility fee is common throughout the healthcare industry and represents, for instance, a hospital's cost of providing the facilities and equipment when a patient sees a doctor in a location owned by the hospital.

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

62. Section 413.65 and the noninterference provision's prohibition on imposing a particular price structure bar General Shapiro from precluding provider-based billing among Pennsylvania nonprofit healthcare providers.

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

64. Congress has established the amount to be accepted as payment in full for authorized services and emergency services to out-of-network MA patients. That amount is the reimbursement that would be available if the patient were enrolled in traditional Medicare. *See* 42 U.S.C. § 1395w-22(k)(1). No state court or actor, including General Shapiro, can supplant those determinations with its own assessment of what the public interest requires.

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

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

67. Nonprofit MAOs that offer MA plans must submit proposed advertising to CMS for the agency's review. Under 42 U.S.C. §1395w-21(h)(2), any marketing material which is "materially inaccurate or misleading or otherwise makes a material misrepresentation" shall be disapproved by CMS.

68. Courts have broadly held that this review process and the MA program's express preemption provision bar states from imposing their own standards on the accuracy of advertising for MA plans. *See, e.g.*, *Commonwealth v. UPMC*, No. 334 MD 2014 (Oct. 30, 2014); *see also Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134, 1152, 1157 (9th Cir. 2010); *Morrison v. Health Plan of Nev.*, 328 P.3d 1165, 1170 (Nev. 2014).

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

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

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

71. The ACA contains an express preemption clause, pursuant to which any state regulatory actions "that 'hinder or impede' the implementation of the ACA run afoul of the Supremacy Clause." *St. Louis Effort for AIDS v. Huff*, 782 F.3d 1016, 1022 (8th Cir. 2015) (applying 42 U.S.C. § 18041(d)).

72. Among other things, the ACA created health insurance exchanges in all 50 states. These exchanges are thoroughly regulated, largely online marketplaces, where individuals and small businesses can purchase private insurance plans. The exchange in Pennsylvania is administered by the federal government.

73. The ACA requires health plans to prove each year that they meet a detailed set of requirements, including but not limited to requirements with respect to benefits, network adequacy and rating. The ACA's requirements ensure that the plans all meet the same standards, and to protect the consistency of those standards, the ACA prohibits states from imposing regulations on some health plans that it does not impose on others. 42 U.S.C. § 18012 requires that any state "standard or requirement" for health plans offering insurance products "shall be

applied uniformly to all health plans in each insurance market to which the standard and requirements apply."

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

75. Specifically, nonprofit health insurers that market ACA insurance plans — including Plaintiff UPMC Health Coverage, Inc. — are subject to General Shapiro's new requirements and must incur the cost and harm associated with compulsory provider contracting and transfer of ultimate control over rates from the plan and its actuaries to a private arbitration panel. For-profit competitors offering substantially similar plans, however, are exempt from General Shapiro's new rules and free to manage their networks and establish rates as they see fit.

76. The ACA intended a level playing field for *all* insurers when designing and setting premiums for health plans to be offered on the exchanges. Section 18012 preempts General Shapiro's disparate treatment of nonprofit insurers offering products in the ACA marketplaces.

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

77. ERISA, 29 U.S.C. § 1001 *et seq.*, is a comprehensive federal statutory and regulatory scheme that governs, *inter alia*, the administration of "self-insured" health plans, *i.e.*, health plans that are administered by insurers but in which an employer assumes the financial risk of providing health care benefits to its employees.

78. Congress has made clear that the federal standards of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan…." 29 U.S.C. § 1144(a).

79. "State law" includes "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State." *Id*. § 1144(c)(1). The definition of "State" includes "a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans…." *Id*. § 1144(c)(2).

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

81. General Shapiro's new rules do not carve out any exceptions for self-insured benefit plans. That is, there is no indication that employers or third-party administrators can preclude certain providers from their networks and thus structure benefit plans around preferred provider arrangements. General Shapiro's new rules are therefore preempted. *See e.g*., *Kentucky Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 366 (6th Cir. 2000) (finding that all willing provider laws cannot be enforced "against the employer who has a self-insured ERISA plan nor against the administrator of such a plan").

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

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

specific regulatory requirements require UPMC Benefit Management Services, Inc. to tailor its plans to the peculiarities of each jurisdiction, in contravention of the letter and intent of ERISA.

84. ERISA preempts General Shapiro's interference with administration of self-insured health plans. ERISA's "savings clause" does not exempt General Shapiro from preemption. That clause does not apply, both on its face and pursuant to ERISA's "deemer clause," 29 U.S. Code § 1142(b)(2)(b).

**D. General Shapiro is Unreasonably Restraining Trade.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**G. General Shapiro's Rules Violate Due Process.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> Competition between hospitals leads to both lower prices (as described immediately below) and to improvements in quality of care and service to patients. . . . Prices are negotiated between each hospital and health insurance company. Like any business deal,

> both sides have some amount of bargaining power, or "leverage," and the agreement reached depends on the relative strengths of that leverage. ***Leverage ultimately is a function of a party's ability to walk away from the negotiation and refuse to do business with its negotiating partner***. Thus, in bargaining over hospital prices, if the hospital demands too high a price and the insurer abandons the negotiation, the hospital will lose access to most of that insurer's members. . . . Conversely, if the insurer insists on an unacceptably low price and the hospital walks away, the insurer will be unable to include the hospital in its network and must offer a policy that does not cover the hospital. A hospital's leverage thus depends on how important it is to the insurer's network, which reflects both patient preferences for the hospital and the availability of desirable alternative substitute hospitals.

Exhibit D at 6–7 (emphasis added).

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

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

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

140. Furthermore, senior representatives from the Attorney General's Office *publicly testified* before the Pennsylvania House of Representatives, on October 14, 2014, as follows:

> ***The simple question we faced was could we force UPMC and Highmark to contract with each other? We concluded that we***

> ***could not for several reasons***. First, there is no statutory basis to make UPMC and Highmark contract with each other. . . . Second, the disputes that we see here that exist between Highmark and UPMC are similar to although less publicly known than disputes between health plans and hospitals around the country. These disputes over how, what the terms of contracts are go on every day and there are very vigorous and acrimonious disputes going on with many hospital systems and many health plans throughout the Commonwealth. If we forced a resolution in this case we really could not avoid trying to force a similar resolution in all those other situations and that is just simply an unworkable method of dealing with these problems. Third, the contracting process involves two parties willingly coming to an agreement. By us trying to force the parties to enter into an agreement we would be putting our finger on the scale so to speak and having effects that we aren't quite sure what those effects would be. And in particular we wouldn't be sure about what the price effects that we would impose would be. ***In contract negotiations one of the key things is that each party has the ability to walk away from the negotiations. That ability to walk away forces each side to be reasonable in most circumstances, putting our finger on the scale in favor of one side or the other changes that dynamic in ways that are unpredictable.*** And one of the key things here in most contract negotiations is price, and price is at the heart of the dispute between Highmark and UPMC, and there is no mechanism in Pennsylvania for resolving this price dispute.

Exhibit E, at 35 (emphasis added).

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

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

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

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

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

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

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

## III. CLASS ACTION ALLEGATIONS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**COUNT II**
**Declaratory Judgment / ACA**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## PRAYER FOR RELIEF

240. WHEREFORE, Plaintiffs respectfully request that this Court:

(a) Enter a declaratory judgment:

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

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

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

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

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

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

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

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

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

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

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

(b) Preliminarily and permanently enjoin Defendant from:

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

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

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

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

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

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

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

Dated: February 21, 2019

Respectfully submitted,

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

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

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

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

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