Appendix 1:
UPMC Market Share Analysis

University of Pittsburgh Medical Center (UPMC) is a Pittsburgh, PA based health system which claims $26 billion in operating revenue and 92,000 employees.[1]

This analysis uses hospital-submitted cost reports and other CMS data to calculate UPMC's hospital market share in the context of the system's geographic markets. It analyzed market share based on two measures, described in more detail below: 1) number of Medicare cases and 2) net patient service revenue (NPSR).

The analysis, conducted in February 2023, identified 29 UPMC facilities active as inpatient hospitals with the Centers for Medicare and Medicaid Services, or CMS. Three UPMC hospitals, UPMC Williamsport Divine Providence Campus, UPMC Shadyside and UPMC Community Osteopathic, currently report in a consolidated fashion under other UPMC inpatient hospitals, but previously reported under independent Medicare provider numbers. These consolidated facilities' provider numbers are enclosed in parentheses below.

Table 1 lists every identified UPMC hospital with its total Net Patient Service Revenue, or NPSR. The facilities are sorted from north to south, so that the table can be compared to maps in following sections.

Table 1. UPMC Facility List with NPSR, sorted north to south

Medicare ID	Facility Name	City	County	State	Facility NPSR 2020
390063	UPMC Hamot	Erie	Erie	PA	$ 464,816,224
330239	UPMC Chatauqua	Jamestown	Chautauqua	NY	$ 93,295,119
391313	UPMC Cole	Coudersport	Potter	PA	$ 85,307,167
391316	UPMC Wellsboro	Wellsboro	Tioga	PA	$ 70,129,002
390104	UPMC Kane	Kane	Mckean	PA	$ 19,524,077
390178	UPMC Horizon	Greenville	Mercer	PA	$ 123,059,193
390091	UPMC Northwest - Seneca	Seneca	Venango	PA	$ 117,820,003
(394048)[A]	UPMC Williamsport Divine Providence Campus	Williamsport	Lycoming	PA	
390045	UPMC Williamsport	Williamsport	Lycoming	PA	$ 406,015,739
391301	UPMC Muncy	Muncy	Lycoming	PA	$ 53,004,373
390071	UPMC Lock Haven	Lock Haven	Clinton	PA	$ 29,591,359
390016	UPMC Jameson	New Castle	Lawrence	PA	$ 98,305,077
390107	UPMC Passavant	Pittsburgh	Allegheny	PA	$ 361,680,703
390073	UPMC Altoona	Altoona	Blair	PA	$ 515,776,424
390102	UPMC St Margaret	Pittsburgh	Allegheny	PA	$ 219,253,237
393302	UPMC Children's Hospital Of Pittsburgh	Pittsburgh	Allegheny	PA	$ 663,784,447
(390055)[B]	UPMC Shadyside	Pittsburgh	Allegheny	PA	
390164	UPMC Presbyterian Shadyside	Pittsburgh	Allegheny	PA	$ 1,986,215,592
390114	UPMC Magee-Womens Hospital	Pittsburgh	Allegheny	PA	$ 943,692,635
390328	UPMC East	Monroeville	Allegheny	PA	$ 156,080,097
390028	UPMC Mercy	Pittsburgh	Allegheny	PA	$ 383,394,724
390002	UPMC Mckeesport	Mckeesport	Allegheny	PA	$ 125,531,191
(390206)[C]	UPMC Community Osteopathic	Harrisburg	Dauphin	PA	
390067	UPMC Harrisburg	Harrisburg	Dauphin	PA	$ 990,213,319
390058	UPMC Carlisle	Carlisle	Cumberland	PA	$ 124,148,127
390068	UPMC Lititz	Lititz	Lancaster	PA	$ 95,712,321
390117	UPMC Bedford	Everett	Bedford	PA	$44,198,550 (2021)[D]
390039	UPMC Somerset	Somerset	Somerset	PA	$ 68,709,505
390101	UPMC Memorial	York	York	PA	$ 120,127,842
390233	UPMC Hanover	Hanover	York	PA	$ 150,716,222
210027	UPMC Western Maryland	Cumberland	Allegany	MD	$ 326,175,570

[A] UPMC Williamsport Divine Providence Campus reports in a consolidated manner with UPMC Susquehanna Williamsport Regional Medical Center (Provider ID 390045).
[B] UPMC Shadyside currently reports in a consolidated fashion with University of Pittsburgh Medical Center Presbyterian (Provider ID 390164).
[C] UPMC Community Osteopathic currently reports in a consolidated fashion with UPMC Pinnacle Harrisburg (Provider ID 390067).
[D] UPMC Bedford appears not to have submitted a cost report with NPSR in FY 2020. The facility's 2021 NPSR was $44,198,550.

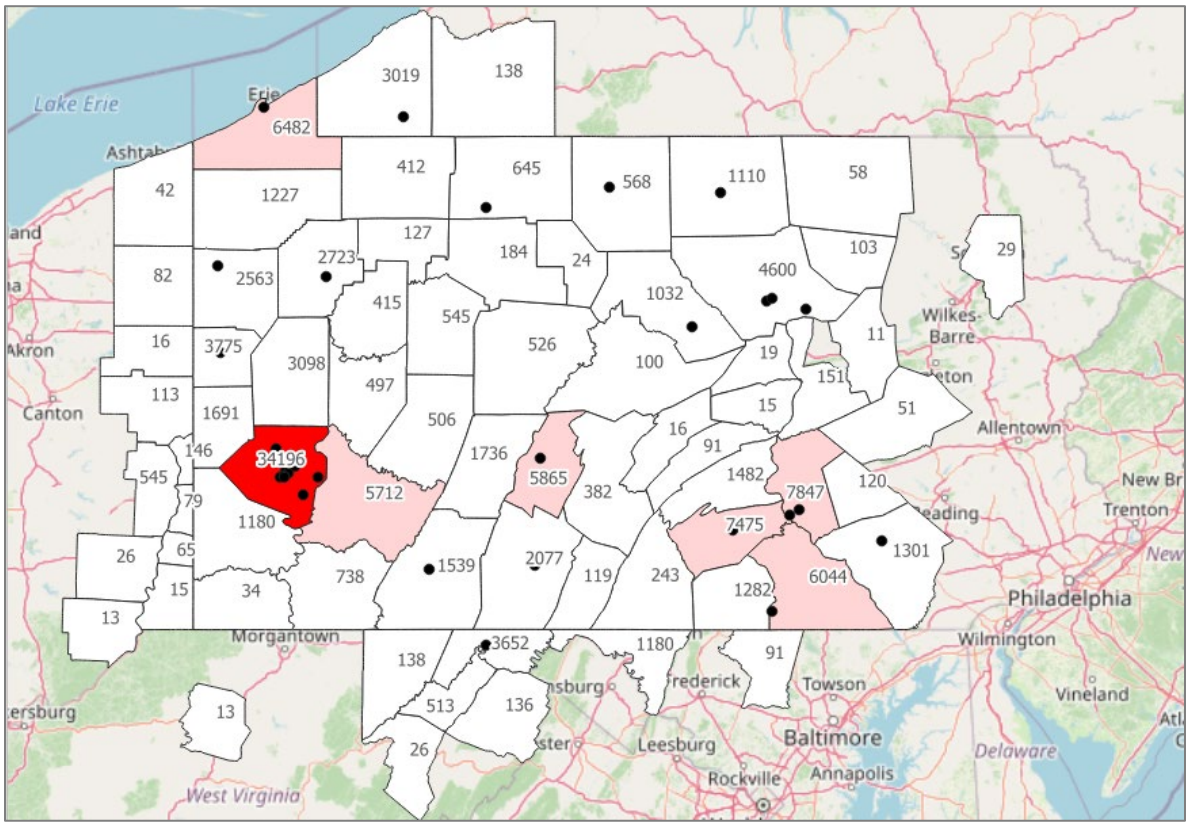
UPMC Market Share According to Hospital Service Area File Market Share

The following maps illustrate the UPMC system's market share from the CMS Hospital Service Area File, which provides the number of Medicare cases originating from every zip code for every hospital. These maps therefore show where UPMC's hospital patients live.

This data source includes only inpatient visits by Medicare beneficiaries.[2] According to CMS, the HSA file is drawn from fee-for-service Medicare claims.[3] 87% of Medicare beneficiaries are older than age 65 so the HSA files may not be exactly representative of patient visits by the general population. Additionally, the HSA file suppresses data for all rows with less than 11 cases to preserve patients' privacy,[4] so this analysis does not include the number of cases from a hospital in a particular ZIP code if the number of cases is less than 11.

Figure 1 shows the total number of HSAF cases for the UPMC system for each county. The numbers on the map are the total cases for all zip codes within each county, and counties are shaded darker red if they have more cases. The locations of UPMC facilities are represented by black dots.

Figure 1. Total HSAF Cases by County for all UPMC facilities



It is clear from Figure 1 that the county with the highest number of UPMC cases in the HSAF data is Allegheny County, colored bright red. In fact, Allegheny County residents accounted for 28% of all cases at UPMC hospitals in this data.

Many counties are shaded the lightest colors in this total cases map, despite UPMC having a high market as many HSAF cases as counties that contain larger cities.

Figure 2 shows UPMC's total market share in every zip code in Pennsylvania and the surrounding area. Zip codes are shaded darker where UPMC has a higher percentage of all HSAF cases in each zip code. Zip codes that are not shaded either have no UPMC cases, or have a number of cases below the minimum threshold of 11.

Figure 2. Total UPMC Market Share by ZIP Code

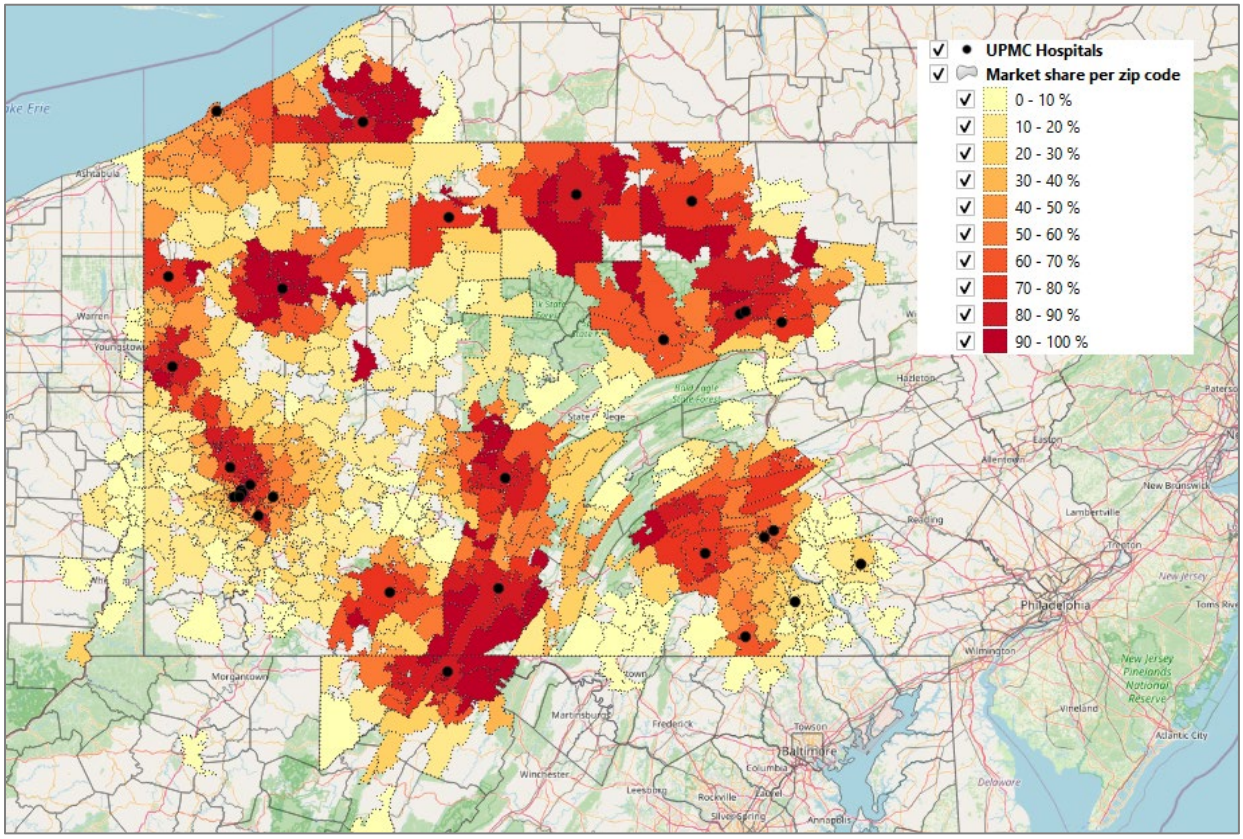
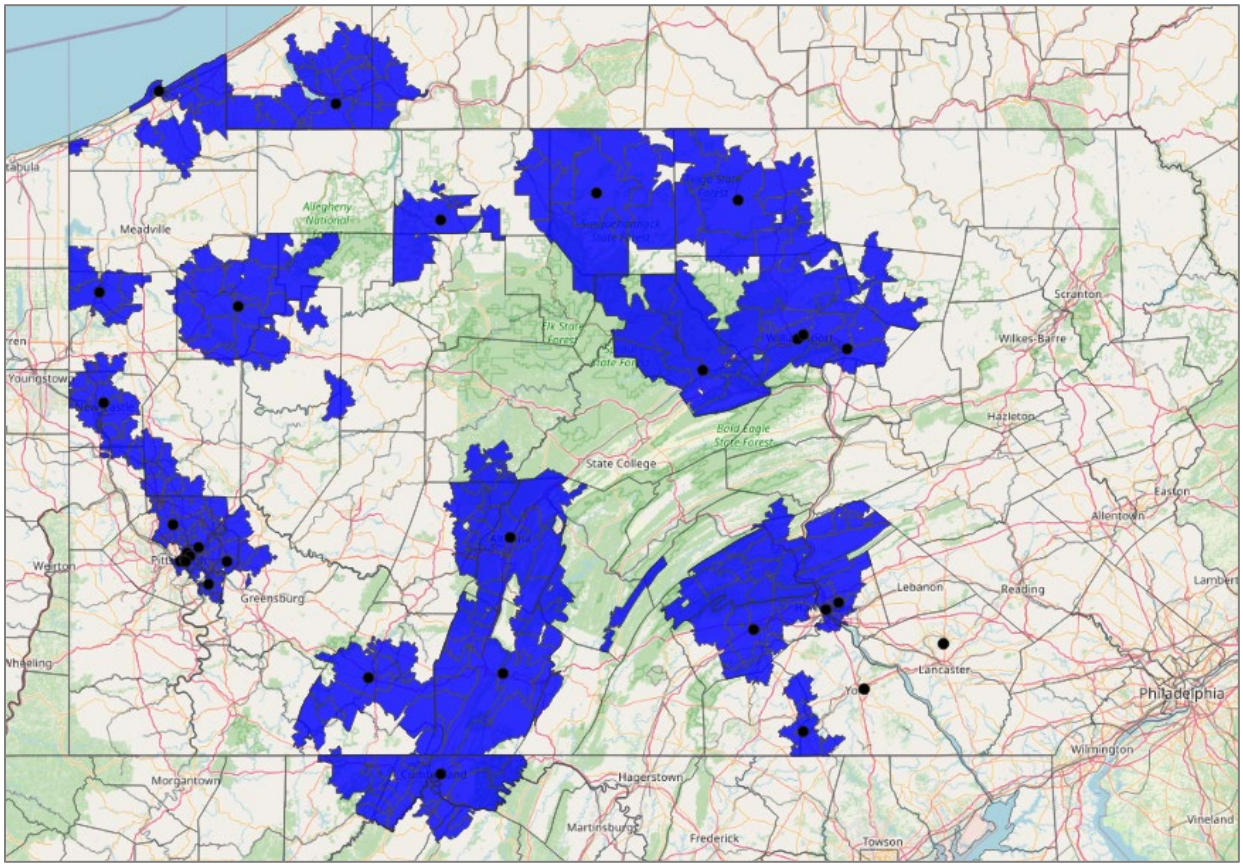


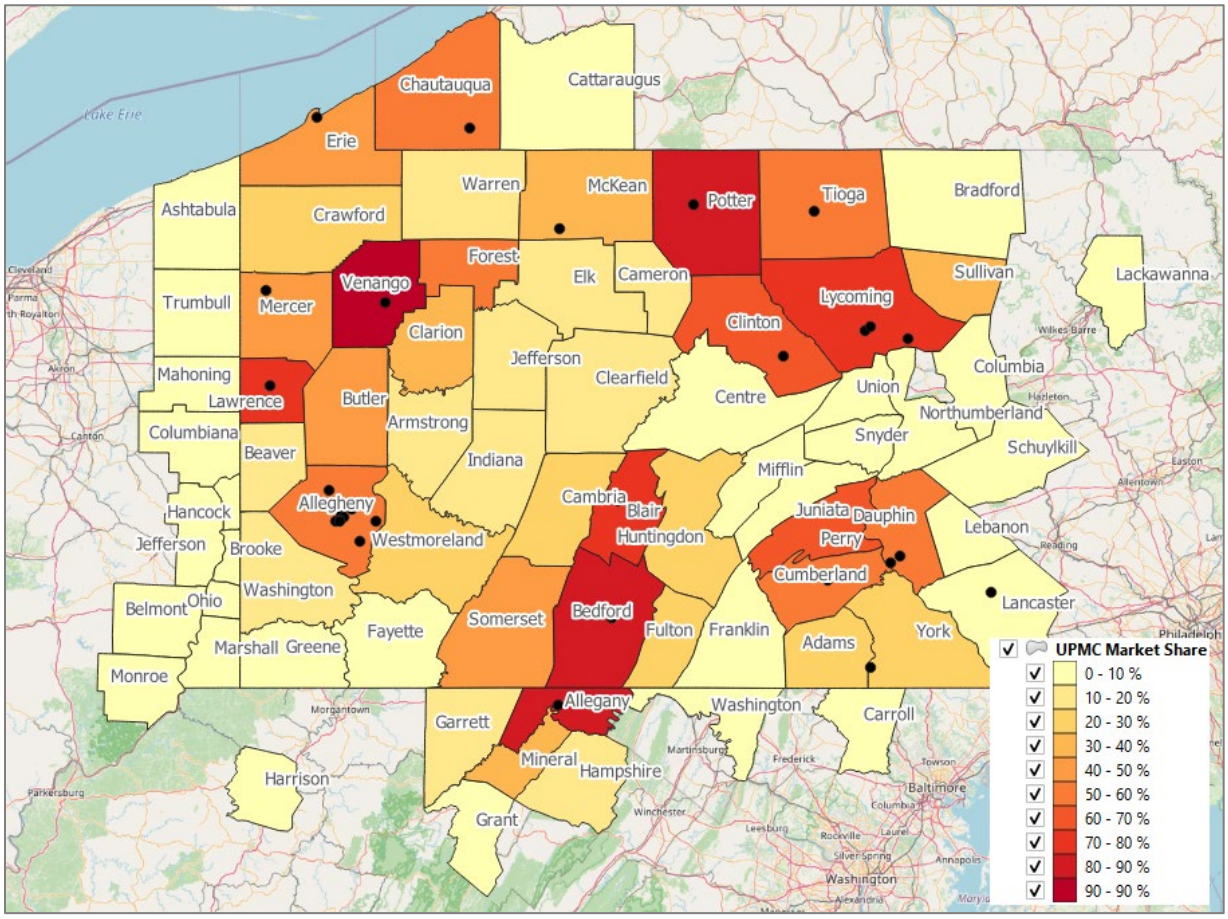
Figure 3 highlights only the zip codes where UPMC has more than 50% of all HSAF cases. In blue-shaded zip codes, more than half of all hospital visits by eligible residents were to hospitals in the UPMC system.

Figure 3. Zip Codes where UPMC has more than 50% Market Share



In the Pittsburgh area, UPMC has over 50% market share in a band of zip codes surrounding its facilities but not in every zip code in the area. On the other hand, in rural areas of Pennsylvania UPMC's market dominance extends across larger geographic areas.

Figure 4. UPMC HSAF Market Share by County



In Figure 4, the market share analysis is tabulated at the county level, rather than zip code. UPMC has the highest market share (indicated by red shading) in counties outside the system's highest-volume service area of Pittsburgh. Figure 4 can be cross-referenced with Figure 1 to compare market share in each county with the number of cases. HSAF market share per county is also listed in Appendix A below.

Table 2 shows, for each listed CBSA, the total UPMC cases for patients residing in those zip codes, the total cases in the HSAF for patients residing in a zip code in that CBSA, and UPMC market share of those cases. CBSAs in this table are those containing zip codes with UPMC hospital patients in the HSAF. To compare this to UPMC's NPSR market share in CBSA's, see Table 4. Note that there are more CBSAs in Table 2 than in Table 4. This is because there are (obviously) non-significant numbers of patients in CBSAs that do not have a UPMC hospital facility in that CBSA who are treated in UPMC hospitals located in different CBSAs.

Table 2. HSAF Market Share by CBSA, sorted by UPMC Cases, descending

CBSA Name	UPMC Cases	Total Cases	UPMC HSAF Market Share
Pittsburgh, PA	47,098	116,505	40%
Harrisburg-Carlisle, PA	16,804	28,379	59%
Erie, PA	6,482	13,067	50%
York-Hanover, PA	6,044	21,275	28%
Altoona, PA	5,865	7,378	79%
Williamsport, PA	4,600	5,760	80%
Cumberland, MD-WV	4,165	5,565	75%
New Castle, PA	3,775	4,980	76%
Jamestown-Dunkirk-Fredonia, NY	3,019	5,027	60%
Oil City, PA	2,723	3,002	91%
Youngstown-Warren-Boardman, OH-PA	2,661	33,125	8%
Johnstown, PA	1,736	8,292	21%
Somerset, PA	1,539	3,436	45%
Lancaster, PA	1,301	19,598	7%
Gettysburg, PA	1,282	4,875	26%
Meadville, PA	1,227	4,521	27%
Lock Haven, PA	1,032	1,642	63%
Bradford, PA	645	1,756	37%
Weirton-Steubenville, WV-OH	530	7,172	7%
DuBois, PA	526	3,714	14%
Indiana, PA	506	4,238	12%
Warren, PA	412	2,063	20%
Huntingdon, PA	382	1,534	25%
Chambersburg-Waynesboro, PA	243	6,941	4%
St. Marys, PA	184	1,332	14%
Sunbury, PA	151	5,730	3%
Olean, NY	138	3,017	5%
Winchester, VA-WV	136	1,059	13%
Lebanon, PA	120	6,431	2%
Salem, OH	113	6,021	2%
Wheeling, WV-OH	106	7,549	1%
State College, PA	100	4,863	2%
Baltimore-Columbia-Towson, MD	91	5,387	2%
Sayre, PA	58	3,381	2%
Pottsville, PA	51	9,160	1%
Ashtabula, OH	42	4,883	1%
Scranton--Wilkes-Barre, PA	29	12,223	0%
Lewisburg, PA	19	1,571	1%
Lewistown, PA	16	2,655	1%
Selinsgrove, PA	15	1,678	1%

Tampa-St. Petersburg-Clearwater, FL	15	58,048	0%
Hagerstown-Martinsburg, MD-WV	14	6,692	0%
Syracuse, NY	14	19,973	0%
Clarksburg, WV	13	4,129	0%
Bloomsburg-Berwick, PA	11	3,430	0%

UPMC Market Share According to Net Patient Service Revenue

Market Share for 2020

The analysis also examined UPMC's market share by revenue. The revenue figured used is Net Patient Service Revenue (NPSR), which is a standard measure of revenue in the hospital industry. NSPR can be understood as "the amount of money the hospital expects to actually collect after deducting charity care, provisions for bad debt, and contractual adjustments from [Gross Patient Service Revenue]."[5] Contractual adjustments reflect the difference between GPSR (i.e., list prices that are often inflated and largely internal to the hospital) and actual payment amounts from Medicare, Medicaid, and commercial plans. NPSR is accordingly considered better than gross revenue for comparing hospitals and calculating market share. All NPSR figures in this memo are from cost reports that end in calendar year 2020.

The hospitals included in this analysis are short term acute care, children's and critical access hospitals. This differs from the HSAF analysis, which does not include data from children's hospitals. Long term care, rehabilitation, and psychiatric hospitals are excluded from both methods. Cost reports are also excluded if the Medicare ID includes the letter F, indicating federal hospitals. Consolidated facilities are included with the location of the parent hospital. Each UPMC hospital's 2020 NPSR can be found in Table 1 above.

Table 3 lists UPMC's total NPSR and NPSR market share for each county with a UPMC hospital for the year 2020. NPSR market share is based on the location of hospitals, rather than the residence of patients as in Table 2 above and Appendix A below (HSAF). For this reason UPMC has NPSR market share in a smaller number of counties and states than HSAF market share.

Table 3. UPMC 2020 NPSR Market Share per County, sorted by largest UPMC NPSR to smallest

County Name	State	UPMC NPSR in this County 2020	Total NPSR in this County 2020	UPMC NPSR Market Share for this county
Allegheny	PA	$ 4,839,632,626	$ 7,378,340,375	66%
Dauphin	PA	$ 990,213,319	$ 2,658,692,677	37%
Blair	PA	$ 515,776,424	$ 581,451,049	89%
Erie	PA	$ 464,816,224	$ 863,400,767	54%
Lycoming	PA	$ 459,020,112	$ 488,995,538	94%
Allegany	MD	$ 326,175,570	$ 326,175,570	100%
York	PA	$ 270,844,064	$ 1,611,200,499	17%
Cumberland	PA	$ 124,148,127	$ 416,663,596	30%
Mercer	PA	$ 123,059,193	$ 300,553,563	41%
Venango	PA	$ 117,820,003	$ 117,820,003	100%
Lawrence	PA	$ 98,305,077	$ 98,305,077	100%
Lancaster	PA	$ 95,712,321	$ 1,373,337,427	7%
Chautauqua	NY	$ 93,295,119	$ 129,986,535	72%
Potter	PA	$ 85,307,167	$ 85,307,167	100%
Tioga	PA	$ 70,129,002	$ 70,129,002	100%
Somerset	PA	$ 68,709,505	$ 123,141,412	56%
***Bedford (2021)*[E]**	*PA*	*$ 44,198,550*	*$ 44,198,550*	*100%*
Clinton	PA	$ 29,591,359	$ 34,871,848	85%
McKean	PA	$ 19,524,077	$ 19,524,077	100%

Of note, UPMC's NPSR market share is 66% in Allegheny County, where Pittsburgh is located, and greater than 50% in 4 of its top 5 counties by total UPMC NPSR. There is a significant difference in Allegheny County market share between NPSR (66% in Table 3) and HSAF (57% in Appendix A below). One difference between these data sets is that HSAF does not include children's hospitals, and UPMC Children's Hospital of Pittsburgh contributes a significant $663.8 million in NPSR (see Table 1 above). When UPMC's Children's Hospital is eliminated from the numerator and denominator, UPMC still had 62% NPSR market share in Allegheny County in 2020.

Table 4 shows total NPSR and market share of the UPMC system tabulated by the core-based statistical area, or CBSA where hospitals are located.

[E] UPMC Bedford's 2020 cost report is missing from the database used for this analysis. In order to show UPMC's market share in Bedford County, we include the NPSR from the facility's 2021 cost report. There are no other short term acute care, critical access, or children's hospitals in Bedford County, PA.

Table 4. UPMC Market Share per CBSA, sorted by total UPMC NPSR in CBSA

CBSA	State	UPMC NPSR in CBSA	Total NPSR in CBSA	UPMC NPSR Market Share for CBSA
Oil City, PA	PA	$ 117,820,003	$ 117,820,003	100%
New Castle, PA	PA	$ 98,305,077	$ 98,305,077	100%
Bradford, PA	PA	$ 19,524,077	$ 19,524,077	100%
Williamsport, PA	PA	$ 459,020,112	$ 488,995,538	94%
Cumberland, MD-WV	MD	$ 326,175,570	$ 360,404,571	91%
Altoona, PA	PA	$ 515,776,424	$ 581,451,049	89%
Lock Haven, PA	PA	$ 29,591,359	$ 34,871,848	85%
Jamestown-Dunkirk-Fredonia, NY	NY	$ 93,295,119	$ 129,986,535	72%
Somerset, PA	PA	$ 68,709,505	$ 123,141,412	56%
Pittsburgh, PA	PA	$ 4,839,632,626	$ 8,845,139,204	55%
Erie, PA	PA	$ 464,816,224	$ 863,400,767	54%
Harrisburg-Carlisle, PA	PA	$ 1,114,361,446	$ 3,075,356,273	36%
York-Hanover, PA	PA	$ 270,844,064	$ 1,611,200,499	17%
Youngstown-Warren-Boardman, OH-PA	PA	$ 123,059,193	$ 1,339,830,232	9%
Lancaster, PA	PA	$ 95,712,321	$ 1,373,337,427	7%

By CBSA, UPMC's NPSR market share is also well above 50 percent in several markets. These include Altoona, where UPMC has 89 percent market share, and Williamsport, where UPMC has 94 percent market share. Its market share in the Pittsburgh CBSA is 55 percent.

Market Share 2011-2020

The analysis also calculated UPMC's market share by year between 2011 and 2020 using the NPSR methodology described above.[6] The results are shown in Table 5. The CBSAs shown in the table are those in which UPMC had significant market share as of 2020. As the table shows, UPMC's market share increased rapidly in the 10 years from 2011 to 2020. Of the fifteen CBSAs shown, UPMC had a presence in just four CBSAs at the beginning of the period in 2011, but by 2020 it had more than a 50 percent market share in eleven CBSAs as well as having a substantial presence in three additional CBSAs.

Table 5: UPMC NPSR Market Share by CBSA, 2011-2020

	Fiscal Year									
CBSA	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Bradford, PA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	13.2%	100.0%	100.0%
New Castle, PA	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oil City, PA	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Williamsport, PA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	93.9%	94.2%	94.5%	93.9%
Cumberland, MD-WV	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	90.5%
Altoona, PA	0.0%	0.0%	0.0%	87.2%	90.0%	85.4%	86.4%	87.5%	87.8%	88.7%
Lock Haven, PA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	77.5%	82.3%	84.9%
Jamestown-Dunkirk-Fredonia, NY	0.0%	0.0%	0.0%	0.0%	0.0%	67.8%	70.6%	64.7%	65.1%	71.8%
Somerset, PA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	59.2%	57.6%	55.8%
Pittsburgh, PA	54.8%	55.3%	56.3%	56.0%	54.9%	53.9%	53.2%	52.8%	52.8%	54.7%
Erie, PA	48.1%	50.4%	49.9%	50.2%	51.5%	51.6%	52.8%	53.9%	53.5%	53.8%
Harrisburg-Carlisle, PA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	37.3%	37.2%	36.2%
York-Hanover, PA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	16.6%	16.5%	16.8%
Youngstown-Warren-Boardman, OH-PA	10.7%	12.2%	12.8%	14.0%	12.2%	12.0%	13.2%	10.1%	9.1%	9.2%
Lancaster, PA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.7%	5.8%	7.0%

Because major medical centers may serve an area larger than a CBSA, the analysis also examined UPMC market share by region, again using NPSR data. All Pennsylvania counties were divided into six regions using Pennsylvania Department of Health regionalization. NPSR market share was then calculated by region, as shown in Table 6.[7] The Southeast and Northeast regions are excluded from the table because UPMC has a limited presence there.

Table 6: UPMC Market Share by Pennsylvania Region, 2011-2020

	Fiscal Year									
Pennsylvania Region	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Southwest	50.2%	50.7%	51.8%	53.7%	50.6%	49.4%	48.9%	49.3%	49.4%	51.2%
Northwest	28.4%	29.8%	30.0%	32.7%	31.2%	35.4%	39.1%	35.7%	35.9%	36.8%
South Central	1.0%	0.9%	0.8%	8.3%	8.1%	8.3%	8.5%	30.8%	30.5%	30.0%
North Central	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	14.5%	18.5%	20.2%	22.0%

As Table 6 shows, UPMC's market share in several Pennsylvania regions is significant and has grown substantially over the last ten years. Thus UPMC has held a dominant market share in Southwest Pennsylvania for over a decade. In Northwest Pennsylvania, UPMC has substantially increased its market share over the decade covered by the data, from 28.4 percent to 36.8 percent – an increase of nearly 30 percent. In the South Central and North Central regions, UPMC is experiencing dramatic growth in market share: While as recently as 2013 the health system had virtually no presence in either region, it has now achieved substantial market share of 30 percent and 22 percent respectively, with most of that growth occurring in the period after 2017.

Appendix A:

UPMC Total HSAF Cases and Market Share by State and County, sorted alphabetically by state and county

State	County	UPMC Cases in County	Total cases in county	UPMC County market share
FL	Pinellas	15	58048	0%
MD	Allegany	3652	4161	88%
MD	Carroll	91	5387	2%
MD	Garrett	138	1287	11%
MD	Washington	14	6692	0%
NY	Cattaraugus	138	3017	5%
NY	Chautauqua	3019	5027	60%
NY	Onondaga	14	19973	0%
OH	Ashtabula	42	4883	1%
OH	Belmont	26	3196	1%
OH	Columbiana	113	6021	2%
OH	Jefferson	305	3717	8%
OH	Mahoning	16	13811	0%
OH	Monroe	13	625	2%
OH	Trumbull	82	13386	1%
PA	Adams	1282	4875	26%
PA	Allegheny	34196	59697	57%
PA	Armstrong	497	2660	19%
PA	Beaver	1691	9643	18%
PA	Bedford	2077	2542	82%
PA	Blair	5865	7378	79%
PA	Bradford	58	3381	2%
PA	Butler	3098	7567	41%
PA	Cambria	1736	8292	21%
PA	Cameron	24	184	13%
PA	Centre	100	4863	2%
PA	Clarion	415	1273	33%
PA	Clearfield	526	3714	14%
PA	Clinton	1032	1642	63%
PA	Columbia	11	3430	0%
PA	Crawford	1227	4521	27%
PA	Cumberland	7475	12964	58%
PA	Dauphin	7847	13140	60%
PA	Elk	184	1332	14%
PA	Erie	6482	13067	50%
PA	Fayette	738	7359	10%

State	County	UPMC Cases in County	Total cases in county	UPMC County market share
PA	Forest	127	231	55%
PA	Franklin	243	6941	4%
PA	Fulton	119	473	25%
PA	Greene	34	1389	2%
PA	Huntingdon	382	1534	25%
PA	Indiana	506	4238	12%
PA	Jefferson	240	2042	12%
PA	Juniata	91	1024	9%
PA	Lackawanna	29	12223	0%
PA	Lancaster	1301	19598	7%
PA	Lawrence	3775	4980	76%
PA	Lebanon	120	6431	2%
PA	Lycoming	4600	5760	80%
PA	McKean	645	1756	37%
PA	Mercer	2563	5928	43%
PA	Mifflin	16	2655	1%
PA	Northumberland	151	5730	3%
PA	Perry	1482	2275	65%
PA	Potter	568	693	82%
PA	Schuylkill	51	9160	1%
PA	Snyder	15	1678	1%
PA	Somerset	1539	3436	45%
PA	Sullivan	103	255	40%
PA	Tioga	1110	1848	60%
PA	Union	19	1571	1%
PA	Venango	2723	3002	91%
PA	Warren	412	2063	20%
PA	Washington	1166	10246	11%
PA	Westmoreland	5712	19333	30%
PA	York	6044	21275	28%
WV	Brooke	79	1172	7%
WV	Grant	26	501	5%
WV	Hampshire	136	1059	13%
WV	Hancock	146	2283	6%
WV	Harrison	13	4129	0%
WV	Marshall	15	1566	1%
WV	Mineral	513	1404	37%
WV	Ohio	65	2787	2%

[1] UPMC Fast Facts. Retrieved February 6, 2023 from https://www.upmc.com/about/facts
[2] https://data.cms.gov/provider-summary-by-type-of-service/medicare-inpatient-hospitals/hospital-service-area
[3] https://www.hhs.gov/guidance/document/hospital-service-area; https://data.cms.gov/resources/hospital-service-area-methodology. The first of these CMS website sources unambiguously describes the data as drawn from FFS claims only. The second source states that the file may also contain data drawn from Medicare Advantage claims "if applicable." There is no information on the percentage of rows in the HSA file that may in fact be drawn in part from MA claims data. This "if applicable" language may have been added just to cover a remote possibility in which claim-level data on a small number of MA patients might appear in the FFS claims files.
[4] https://www.hhs.gov/guidance/document/hospital-service-area
[5] https://www.nashp.org/wp-content/uploads/2020/07/A-Community-Leaders-Guide-to-Hospital-Finance2.pdf
[6] This analysis did not attempt to perform this analysis using HSAF data because HSAF captures only Medicare fee-for-service revenue, and the rapid expansion of non-fee-for-service Medicare Advantage programs, which has been uneven across counties and beneficiary types, renders direct comparison over time impractical.
[7] Accessed at https://www.health.pa.gov/topics/programs/Patient-Advocacy/Pages/County-Regional-Resources.aspx.

Appendix 2: UPMC Impact on Market Concentration and Utilization of Hospital Beds, 2013-2021

Since 2013, the University of Pittsburgh Medical Center (UPMC) has pursued an aggressive expansion strategy, which has led the hospital system to become one of the largest integrated healthcare systems in the United States. In 2013, UPMC had facilities in only five counties within the state: Pittsburgh, Erie, Mercer County, Oil City, and Bedford counties. Since 2013, UPMC's growth has been driven almost exclusively by acquisitions of existing hospitals throughout Pennsylvania. Between 2013 and 2021, UPMC acquired 15 general acute care hospitals and entered 11 new markets.

This appendix quantifies UPMC's Impact on Market Concentration and Utilization of Inpatient Hospital Beds at Acute Care General Hospitals in Pennsylvania from 2013-2021.

Methodology

The Market Concentration and Utilization study analyzed UPMC's market concentration and hospital bed utilization rates based on hospital reports data published by Pennsylvania's Department of Health (PDOH) for fiscal years 2013 through 2021. These hospital reports are based on information collected via an annual PDOH questionnaire. The PDOH data include information about hospitals that operate in the state, including licensed beds, services, utilization, and staffing. The number of beds reported in PDOH's annual hospital data corresponds to the number of inpatient beds licensed to the hospital on the last day of the reporting period. Before 2016, reporting periods for annual hospital reports aligned with a fiscal year that ended on June 30. From 2016 onwards, the reporting period was changed to align with the calendar year. Thus, there is an 18-month span between the 2015 and 2016 figures.

The analysis assessed market concentration by calculating the Herfindahl-Hirschman Index (HHI) for acute care general hospitals, including children's and women's hospitals, in 16 local markets in Pennsylvania where UPMC operated at least one general acute care hospital as of 2021.

The market definition used in the analysis consists of twelve Core Based Statistical Areas (CBSAs), three rural counties that did not belong to any CBSA, and one county belonging to a CBSA primarily located in Ohio. CBSAs comprise one or more counties with strong social and economic integration to a core urbanized area; thus, they provide a useful way to capture the competitive environment for healthcare services in each market. The CBSAs in this analysis include Altoona, Bradford, Erie, Harrisburg-Carlisle, Lancaster, Lock Haven, New Castle, Oil City, Pittsburgh, Somerset, Williamsport, and York-Hanover. The three rural counties that are part of this analysis are Bedford, Potter, and Tioga. This analysis also includes Mercer County, which is part of the Youngstown-Warren-Boardman, OH-PA; however, the analysis only includes hospitals in Mercer County, which is located in Pennsylvania.

Market concentration was analyzed by calculating the Herfindahl-Hirschman Index (HHI) for each market. The HHI, a measure of market concentration used to evaluate the competitive environment in a defined market, is calculated by summing the squares of the market shares of all firms in a market. HHI can range from 0 to 10,000. A value of zero indicates perfect competition and a value of 10,000 implies pure monopoly (single firm with 100% market share). In this analysis, HHI figures were calculated using the number of hospital beds licensed to each hospital system in each market in each year. Before calculating HHI, hospital ownership information was confirmed using online resources such as press releases and data provided by each hospital to the PDOH in its annual questionnaire.

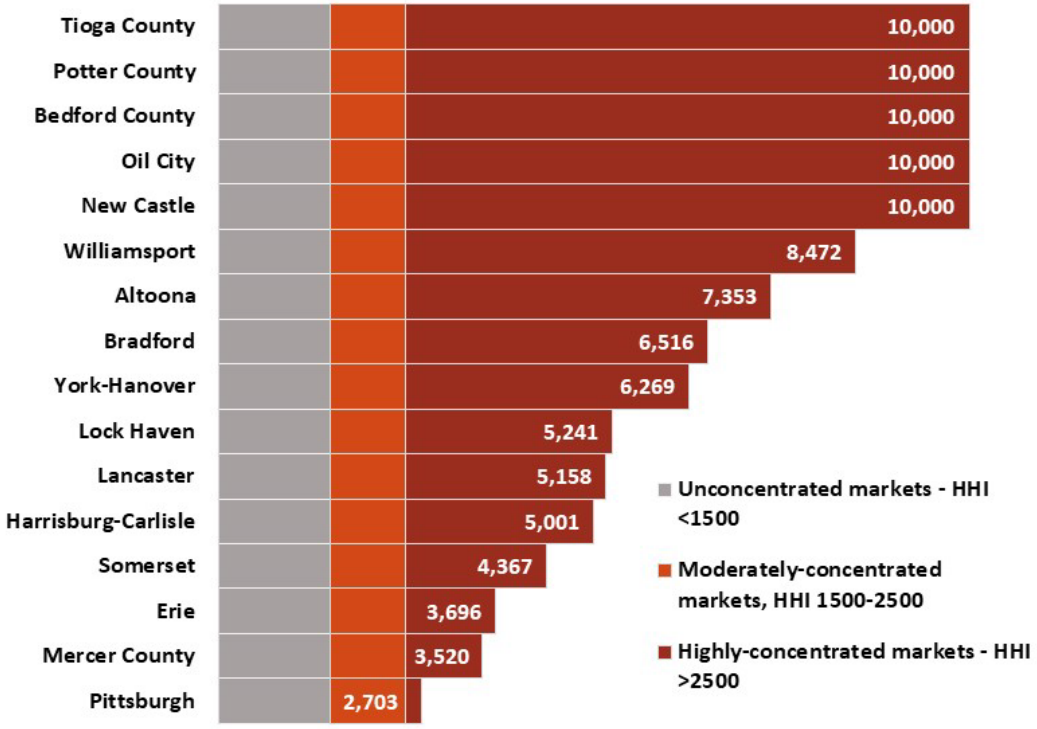
According to the Horizontal Merger Guidelines issued by the Department of Justice (DOJ) and the Federal Trade Commission (FTC), markets with an HHI that exceeds 2,500 are considered "highly concentrated."[1] Further, the FTC considers any mergers that lead to an increase of over 100 points in highly concentrated markets as potentially raising "significant competitive concerns" and "often warrant scrutiny." [2]

2021 Market Concentration

As shown in Figure A, in each of the 16 markets where UPMC currently operates, the HHI figures exceeded 2,500 in 2021. According to the DOJ and FTC, these HHI levels indicate a high level of concentration.

Among the sixteen markets, there are five markets where UPMC has no acute care hospital competitors, hence the HHI in those markets is 10,000. In another seven markets, the HHI exceeds 5,000, double the value that is deemed highly concentrated.

Figure A: HHI in Markets with at Least one UPMC Acute Hospital, 2021



[1] U.S. Dep't of Justice & Fed. Trade Comm'n, Horizontal Merger Guidelines (Aug. 19, 2010), at 19.
[2] *Id.*

Market Concentration Changes

A more granular view of the change in HHI in the markets impacted by UPMC's acquisition activity by examining changes in market share for particular markets. For example, in 2017, UPMC's acquisitions of six different hospitals in the Harrisburg-Carlisle, Lock Haven, and York-Hanover markets resulted in HHI increases of 780, 480 and 311 points, respectively.[3] The sharp increases in these three markets' HHIs from 2016 to 2017 are presented in Figure B. In each of these cases, the HHI figures in these already concentrated markets in 2016 increased by over 100 points in 2017, which should trigger significant concerns about competitiveness under the DOJ's guidelines.

Figure B: Acute Hospital HHI in Various Markets, 2016 and 2017

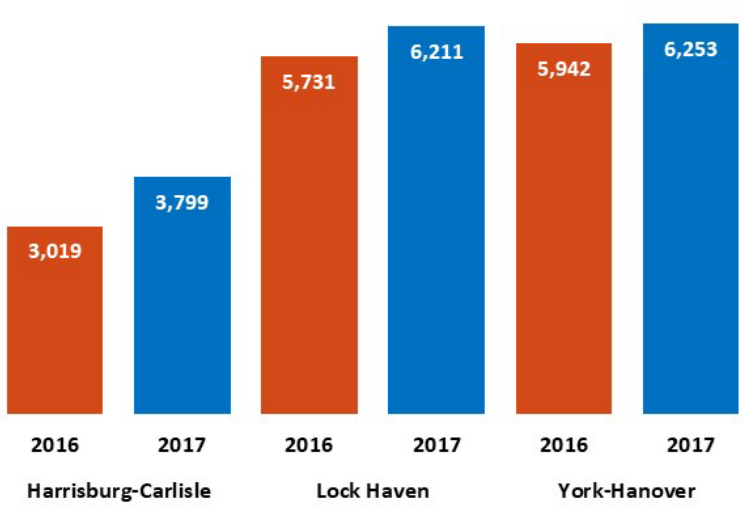
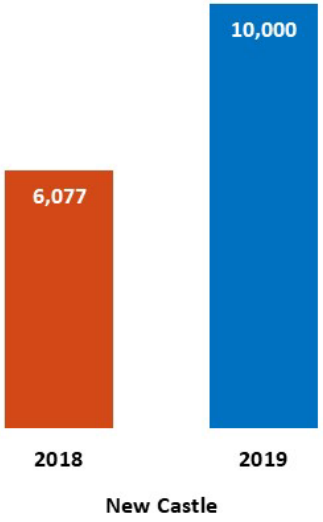


Figure C: Acute Hospital HHI in New Castle, 2018 and 2019



These patterns play out in many of the markets in which UPMC operates an acute care hospital. Table 1 displays the annual HHI value in all sixteen markets.

[3] In 2017, the following six hospitals were acquired by UPMC: Pinnacle Harrisburg (Harrisburg-Carlisle CBSE), Carlisle (Harrisburg-Carlisle CBSE), Lancaster Regional (Lancaster CBSE), Heart of Lancaster (Lancaster CBSE), York Memorial (York-Hanover CBSE), and Hanover (York-Hanover CBSE).

Table 1: Acute Hospital HHI and Year-Over-Year Changes by Market, 2013-2021

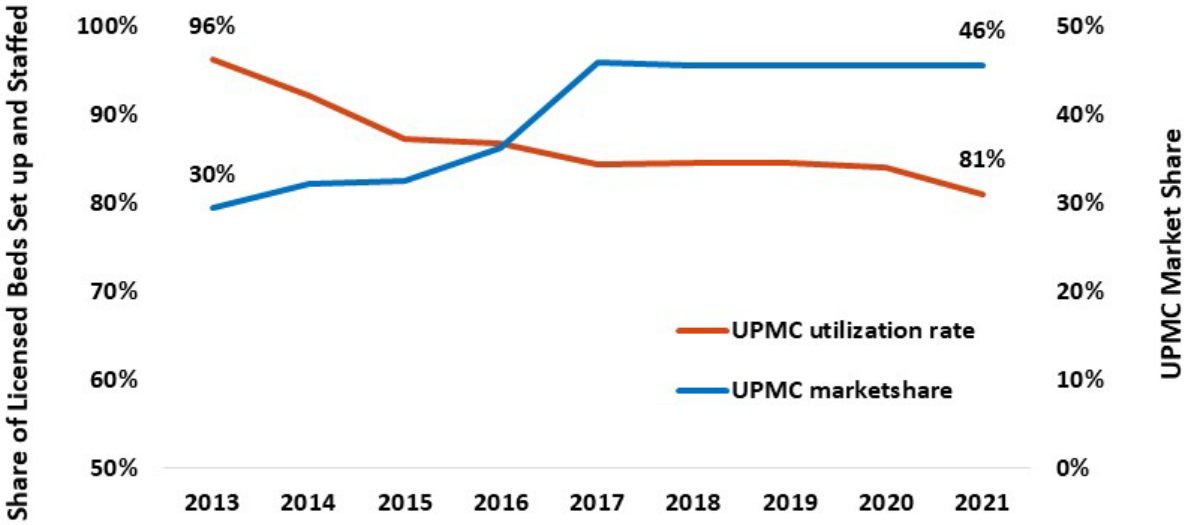
Market	2013	2014	2015	2016	2017	2018	2019	2020	2021
Altoona CBSA									
HHI	7,241	7,241	7,235	7,158	7,197	7,197	7,353	7,353	7,353
YoY change in HHI	-	-	-5	-77	39	-	156	-	-
Bradford CBSA									
HHI	6,516	6,516	6,516	6,516	6,516	6,516	6,516	6,387	6,516
YoY change in HHI	-	-	-	-	-	-	-	-129	129
Erie CBSA									
HHI	3,712	3,720	3,757	3,742	3,742	3,653	3,675	3,672	3,696
YoY change in HHI	-	8	37	-14	-	-90	22	-3	24
Harrisburg-Carlisle CBSA									
HHI	2,978	3,096	3,034	3,019	3,799	3,796	3,803	5,007	5,001
YoY change in HHI	-	118	-62	-15	780	-3	7	1,204	-5
Lancaster CBSA									
HHI	7,953	7,951	4,328	4,269	4,200	4,272	5,158	5,158	5,158
YoY change in HHI	-	-2	-3,623	-59	-69	73	886	-	-
Lock Haven CBSA									
HHI	5,731	5,731	5,731	5,731	6,211	6,211	5,241	5,241	5,241
YoY change in HHI	-	-	-	-	480	-	-970	-	-
New Castle CBSA									
HHI	6,320	6,320	6,552	6,453	6,310	6,077	10,000	10,000	10,000
YoY change in HHI	-	-	232	-99	-143	-233	3,923	-	-
Oil City CBSA									
HHI	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000
YoY change in HHI	-	-	-	-	-	-	-	-	-
Pittsburgh									
HHI	2,577	2,622	2,635	2,721	2,742	2,677	2,701	2,700	2,703
YoY change in HHI	-	45	13	85	21	-65	24	-1	3
Allgheny County									
HHI	4,469	4,500	4,514	4,575	4,619	4,531	4,519	4,563	4,488
YoY change in HHI	-	31	14	61	44	-88	-12	44	-75
City of Pittsburgh									
HHI	5,230	5,293	5,261	5,318	5,313	5,256	5,195	5,915	5,987
YoY change in HHI	-	63	-32	57	-5	-57	-60	719	72
Somerset									
HHI	4,569	4,569	4,569	4,569	4,569	4,569	4,569	4,569	4,367
YoY change in HHI	-	-	-	-	-	-	-	-	-202
Williamsport									
HHI	8,213	8,314	8,314	8,314	8,314	8,472	8,472	8,472	8,472
YoY change in HHI	-	101	-	-	-	158	-	-	-
York-Hanover									
HHI	5,756	5,734	5,934	5,942	6,253	6,269	6,324	6,266	6,269
YoY change in HHI	-	-22	200	8	311	16	55	-58	3
Bedford County									
HHI	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000
YoY change in HHI	-	-	-	-	-	-	-	-	-
Mercer County									
HHI	3,561	3,561	3,570	3,570	3,577	3,813	3,875	3,652	3,520
YoY change in HHI	-	-	9	-	7	236	63	-224	-131
Potter County									
HHI	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000
YoY change in HHI	-	-	-	-	-	-	-	-	-
Tioga County									
HHI	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000
YoY change in HHI	-	-	-	-	-	-	-	-	-

Hospital Market Concentration and Bed Utilization

During the same period that UPMC expanded and increased its market share across Western and Central Pennsylvania, the proportion of licensed beds that were set up and staffed declined. Between 2013 and 2017, UPMC acquired 13 hospitals, which significantly impacted its aggregate market share, raising it from 30 percent to 48 percent. Hospital reports data show that seven of the 13 acquired hospitals between 2013 and 2017 had a reduction in utilization of licensed beds, with an average reduction of 18 percent the year following the acquisition. Of the remaining six, four had no changes in utilization, and two had small increases.

As illustrated in Figure D, UPMC's rapid expansion coincided with an aggregate decline in its utilization rate of licensed hospital beds, which dropped from 96 percent to 85 percent in 2017 and further decreased to 81 percent by 2021. This downward trend suggests that as UPMC grew, it reduced the number of beds set up and staffed, despite having the license to operate additional inpatient beds.

Figure D: UPMC Market Share and Licensed Bed Utilization Rate, 2013-2021



These data imply a worrisome correlation between UPMC's increasing market share and a reduction in the utilization rate of licensed hospital beds. This pattern might indicate a strategic decision by UPMC to restrict the availability of beds, potentially reducing patient access to healthcare services or undermining the quality of care.

Note on Beds and Market Share

The annual number of UPMC beds in licensed acute care hospital beds used in the HHI analysis are presented in Table 2a from 2013 to 2021. Table 2b displays the corresponding market share of UPMC hospitals in each market. Over the eight-year period, the number of beds in UPMC acute care general hospitals increased by 50 percent, from 4,559 licensed beds in 2013 to 6,856 in 2021. UPMC's market share increased from 30 to 46 percent over the same period.

Table 2a: UPMC Licensed Hospital Beds in Acute Hospitals, by Local Market, 2013 to 2021

Market	2013	2014	2015	2016	2017	2018	2019	2020	2021
Altoona		376	375	361	368	368	398	398	398
Bradford					31	31	31	31	31
Erie	413	446	433	423	423	423	423	423	458
Harrisburg-Carlisle					824	820	818	879	1,009
Lancaster					362	362	148	148	148
Lock Haven					47	47	25	25	25
New Castle				207	192	153	148	146	146
Oil City	164	164	164	158	158	158	158	151	167
Pittsburgh	3,762	3,756	3,800	3,818	3,806	3,686	3,682	3,676	3,674
Allegheny County	3,762	3,756	3,800	3,818	3,806	3,686	3,682	3,676	3,674
City of Pittsburgh	3,408	3,403	3,447	3,441	3,432	3,336	3,314	3,308	3,315
Somerset							111	111	98
Williamsport				244	244	275	275	275	275
York-Hanover					193	193	191	197	197
Bedford County	49	49	49	49	40	40	40	40	40
Mercer County	171	171	158	158	158	136	120	116	116
Potter County						49	49	49	49
Tioga County				25	25	25	25	25	25
Total licensed beds	**4,559**	**4,962**	**4,979**	**5,443**	**6,871**	**6,766**	**6,642**	**6,690**	**6,856**

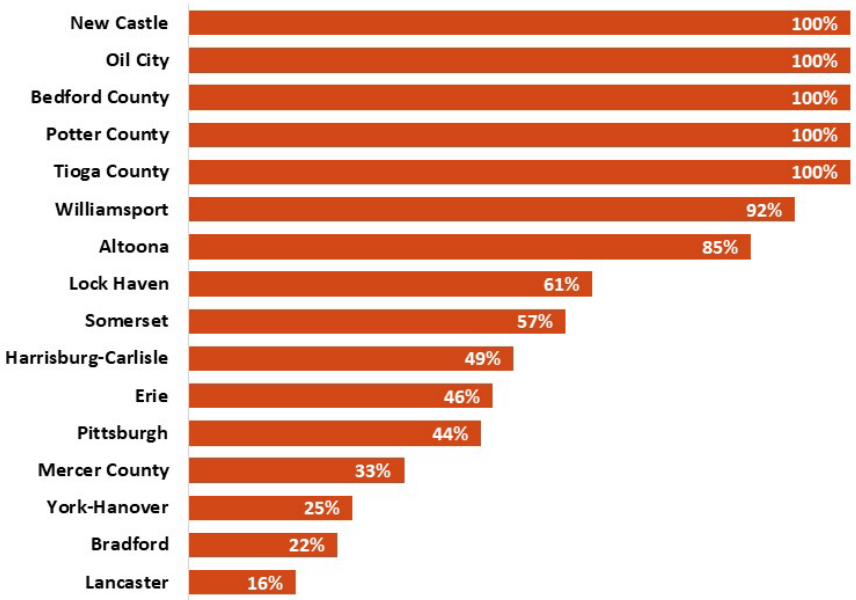
Table 2b: UPMC Market Share of Licensed Hospital Beds in Acute Hospitals, by Local Market, 2013 to 2021

Market	2013	2014	2015	2016	2017	2018	2019	2020	2021
Altoona		84%	84%	84%	84%	84%	85%	85%	85%
Bradford					22%	22%	22%	24%	22%
Erie	41%	45%	45%	44%	44%	43%	43%	44%	46%
Harrisburg-Carlisle					49%	49%	49%	48%	49%
Lancaster					33%	32%	16%	16%	16%
Lock Haven					75%	75%	61%	61%	61%
New Castle				77%	76%	73%	100%	100%	100%
Oil City	100%	100%	100%	100%	100%	100%	100%	100%	100%
Pittsburgh	44%	44%	44%	46%	46%	45%	45%	45%	44%
Allegheny County	59%	60%	60%	61%	62%	61%	60%	61%	59%
City of Pittsburgh	68%	68%	68%	69%	69%	68%	67%	67%	68%
Somerset							60%	60%	57%
Williamsport				91%	91%	92%	92%	92%	92%
York-Hanover					25%	25%	24%	25%	25%
Bedford County	100%	100%	100%	100%	100%	100%	100%	100%	100%
Mercer County	35%	35%	33%	33%	33%	31%	29%	31%	33%
Potter County						100%	100%	100%	100%
Tioga County				100%	100%	100%	100%	100%	100%
Total market share	**30%**	**32%**	**33%**	**36%**	**46%**	**46%**	**46%**	**46%**	**46%**

* Market share is based on the aggregate of beds licensed to UPMC in the analyzed markets.

As depicted in Figure E below, in 2021, UPMC held over fifty percent market share in nine of the sixteen markets in which it has an acute care hospital based on number of licensed beds. In five markets, UPMC has no competitors.

Figure E: UPMC's Market Share of Licensed Hospital Beds by market, 2021



APPENDIX 3:

Monopsony Power Over Hospital Workers: Evidence of a UPMC "Wage Penalty"

Monopsony Power Over Hospital Workers – Evidence of a UPMC "Wage Penalty"

Hal J. Singer and Ted Tatos[1]

Abstract

Over the last approximately four decades, antitrust enforcement in the United States has focused almost exclusively on anticompetitive injury to consumers via price and output effects. Recent developments in research and litigation have shone a spotlight on the existence and exercise of market power in input markets as well. While economic research has long acknowledged the injury that flows from the exercise of power over labor input providers in sports, the economic literature now approaches consensus on the breadth and scope of such monopsony power over workers in a much wider array of industries and positions. This paper focuses on one such industry where recent work has evinced market power over labor: healthcare. We investigate the existence and possible exercise of monopsony power by the University of Pittsburgh Medical Center (UPMC) conglomerate over hospital workers in a broad range of occupations. We find evidence of a nexus between UPMC's market power and lower wages at UPMC hospitals when compared to facilities in commuting zones with a comparable cost of living. Our results provide direct evidence that (1) UPMC has market power in labor markets where it operates, and (2) UPMC has leveraged its market power to artificially suppress wages for its workers, thus injuring competition.

[1] Hal Singer is a Managing Director at Econ One Research and Economics Professor at the University of Utah. Ted Tatos is an adjunct professor of economics at the University of Utah and is an affiliated consultant with Econ One Research. He is also the Associate Economics Editor of the *Antitrust Bulletin* journal. Service Employees International Union provided funding for this research.

The Service Employees International Union (SEIU) commissioned this study to investigate whether the UPMC has market power over labor input providers and whether it has exercised that power to suppress wages. We compared wages UPMC paid its workers in various healthcare occupations in a given commuting zone, a commonly-used proxy for the geographic market, to the corresponding wages paid by other hospitals and systems in commuting zones with a comparable cost of living in four nearby states. We found direct evidence supporting the conclusions that (1) UPMC has market power in labor markets where it operates, and (2) UPMC has leveraged its market power to artificially suppress wages for its workers, thus injuring competition.

Across all general hospital worker job categories, we found that UPMC paid workers two percent less than comparable hospital systems. This disparity, which we call the UPMC "wage penalty," varies by occupational group and particularly affects hospital workers with direct patient care responsibilities. Considering nurse wages specifically, we also observed a wage penalty for nurses.

We then explored the relationship between market concentration and this wage penalty. Our econometric analysis finds an economically and statistically significant relationship between both market concentration in commuting zones where UPMC owns hospitals (as proxied by the Herfindahl-Hirschman Index) and UPMC's own market share and the wage penalty. Higher HHI and UPMC market share are both associated with a greater wage penalty (UPMC wages being lower than the comparison entities). These results provide direct evidence supporting the conclusions that (1) UPMC has market power in labor markets where it operates, and (2) increases in UPMC's market share (which may be the result of exclusionary conduct and its acquisition of

dozens of rival hospitals) have resulted in suppressed wages for its workers, thus injuring competition.

INTRODUCTION

Concerns over depressed wages, particularly in the nursing sector, and the attendant deleterious effects on patient care are by no means novel. The healthcare sector struggled with this problem for much of the twentieth century.[2] Indeed, by early to mid-1900s, reports began to document the dearth of nurses at prevailing wages and the deficient working conditions and mediocre compensation that contributed to it. Josephine Goldmark's landmark 1923 report, "Nursing and Nursing Education in the United States," illuminated this conundrum and presaged increasing awareness of the need to alleviate the problem that would follow in the next several decades.[3] The report asked the same question that remains relevant to this day: What material inducements would convince prospective nurses to embark on such a career with such demanding physical and mental requirements?[4]

Unfortunately, the next twenty-five years following Goldmark's report did little to alleviate the predicament facing the nursing sector. A 1947 report by the United States Department of Labor reiterated the same concerns.[5] Soliciting responses from nurses regarding their working conditions

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[2] Penn Nursing, *Where did all the nurses go*? University of Pennsylvania, available at https://www.nursing.upenn.edu/nhhc/workforce-issues/where-did-all-the-nurses-go/.

[3] Josephine Goldmark, *Nursing and Nursing Education in the United States* (New York: The Macmillan Co., 1923).

[4] Id. at 101. "Many organizations have set a definite scale with a minimum initial salary and a fixed upper limit beyond which no staff nurse can pass, no matter how long she remains in that capacity in the agency. Some have no minimum and maximum but pay all members of the staff at the same rate, regardless of experience or length of service." Also see Id. at 102, describing the wages offered at two hospitals on the east coast: "In both, the minimum beginning salary was also the maximum, and unless a staff nurse was promoted to the position of supervisor she had no prospect of an advance in salary no matter how long her period of service with the organization."

[5] United States Department of Labor, *The Economic Status of Registered Professional Nurses 1946-1947.*

and pay, the Department of Labor observed that "Lack of provision for retirement or illness and salaries that do not permit nurses to save toward retirement or for emergencies were frequently mentioned together."[6] The report further noted that "The leading complaints were related to financial returns both during nursing employment and after retirement. Specifically they referred to lack of retirement and employment security, rates of pay, and opportunities for and methods of awarding promotions."[7]

The University of Pennsylvania's School of Nursing penned a short, but detailed, exegesis of the problems that have plagued the U.S. nursing sector, and identified the obvious solution to the poor wage and working conditions affecting nurses, as detailed in the Department of Labor's report: "Given the consistent findings of the 1947 investigation, it seemed obvious that efforts to improve employment conditions for nurses would lessen the shortage. This presented a logical course of action. And key among those improvements was higher wages."[8] Of course, this obvious solution called for fair compensation to nurses, which would in turn cut into institutional profits. It should perhaps come as no surprise to those familiar with corporate history in the United States that hospitals declined to adopt this course of action. Instead, they increased recruitment efforts and broadened the use of "assistive personnel."[9]

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[6] *Id.* at 37.
[7] *Id.* at 36.
[8] Penn Nursing, *Where did all the nurses go*?
[9] *Id.*

Predictably, the imbalance in the nursing market and concomitant problems persisted. The 1961 Surgeon General's report succinctly detailed wage deficiencies, identified nearly forty years earlier in the Goldmark report. [10] The Surgeon General's Consultancy observed:[11]

> Economic rewards are important in attracting and holding members of a profession. Deficiencies in economic incentives for nurses must be eliminated as to both salaries and fringe benefits. Nursing does not compare favorably in this respect with other careers requiring equivalent capabilities and education…Salaries of hospital staff nurses are lower, on the average, than those of secretaries. There is little opportunity for advancement for the nurse who wants to continue to give direct patient care. Even in top administrative positions, monetary compensation is not commensurate with responsibility.

The solution appears as obvious now as it was in 1923, 1947, and 1961. A shortage of nurses at prevailing wages generally evinces a compensation deficiency; to attract more workers, economists commonly prescribe an increase in wages. This incentivization principle reveals itself in nearly every facet of the economy: (1) to compensate non-exempt workers for extra hours, the Department of Labor requires overtime pay; (2) higher pay and better conditions attract more teachers; (3) the Department of Agriculture subsidizes certain crops deemed economically valuable, and so on. Yet, this rudimentary economic concept has largely failed to gain traction in certain economic sectors, particularly where workers have little countervailing economic power. Of course, this same phenomenon has manifested itself in other industries characterized by economic exploitation, defined in the Pigouvian sense as the difference between labor's marginal product and real wages.[12]

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[10] Toward Quality in Nursing; Needs and Goals; Report of the Surgeon Generals' Consultant Group on Nursing. Public Health Service Publication No. 922, available at https://files.eric.ed.gov/fulltext/ED021994.pdf.

[11] *Id.* at 36-37. Also, ("In today's society, salaries and related benefits not only determine standards of living but also influence the prestige of an occupation. Until the economic status of the nursing profession is improved, nursing will be unable to compete successfully with other fields where pay and benefits are more attractive.").

[12] Joseph Persky and Herbert Tsang, Pigouvian Exploitation of Labor, The Review of Economics and Statistics , Feb., 1974, Vol. 56, No. 1 (Feb., 1974), pp. 52-57 [hereafter "Persky & Tsang"].

The role of market concentration in output and input markets, and its leverage through the exercise of monopoly and monopsony power, respectively, has drawn increasing attention as a contributing, if not determining, factor in wage suppression. While the previously largely somnambulant field of industrial organization has begun to awaken to this epiphany, labor and sports economists have long pointed to such power over labor input providers through vehicles such as the reserve clause in professional sports (baseball, football, basketball, and hockey) that restricted wages below competitive levels.[13] Even more recently, the long-standing battle to curtail if not outright eliminate monopsony power over college athletes reached a denouement (albeit a limited one) in the *NCAA v. Alston* case, a 9-0 unanimous Supreme Court decision in favor of athletes.[14]

As Krueger and Posner explained in 2018, "Until recently economists assumed that labor markets are fairly competitive… recent events—including agreements among technology companies not to poach engineers and among hospitals not to poach nurses—have led many economists and government officials to question this assumption."[15] Indeed, the Council of Economic Advisors' 2016 Report proffered some indication of this newfound realization on the

[13] The same general obliviousness to the exercise of market power to suppress wages that plagued the subfield of industrial organization thankfully did not extend to other fields (e.g., labor and sports economics) that acknowledged this nexus. For example, Persky and Tsang explain, "For empirical purposes it seems plausible to assume that the more concentrated an industry (and the more conscious firms are of their influence on price) the greater will be the divergence be- tween actual wages and marginal productivity. Hence, we expect that industries with higher concentration ratios should show higher levels of Pigouvian exploitation… Labor economists have increasingly treated corporations and other administrative units as internal labor markets in which employees have little mobility and hence employers have substantial monopsonistic power.") Likewise, Rodney Fort and James Quirk detail the wage effects of the reserve clause. See Rodney Fort and James Quirk, Journal of Economic Literature, Vol. 33, No. 3 (Sep., 1995), pp. 1265-1299 at 1275, ("To summarize, the effects of a reserve clause system with unrestricted cash sale of players are to decrease player salaries, increase league-wide profits, and in- crease profits for all teams…")

[14] 141 S. Ct. 2141 (2021).

[15] Alan Krueger and Eric Posner, A Proposal for Protecting Low-Income Workers from Monopsony and Collusion, The Hamilton Project, February 2018, at 5-6.

role of market concentration and its potential attendant exercise to suppress wages below competitive levels.[16] The report explained:

> There is also growing concern about an additional cause of inequity—a general reduction in competition among firms, shifting the balance of bargaining power towards employers. Such a shift could explain not only the redistribution of revenues from worker wages to managerial earnings and profits, but also the rising disparity in pay among workers with similar skills. These trends also have broader implications for the economy as a whole: instead of promoting growth, forces that undermine competition tend to reduce efficiency, and can lead to lower output, employment, and social welfare.

The implication of market concentration and monopsony power in the healthcare sector reflects the focus of this report. We begin with a simple descriptive statistical analysis aimed at investigating evidence of a "wage penalty" facing workers at UPMC facilities compared to workers at hospitals in commuting zones with a comparable standard of living. Finding such evidence, we perform an econometric analysis to explore whether changes in UPMC's market power have impacted this wage differential. As we explain in the subsequent section, the reasons for concern over UPMC's potential exercise of monopsony power are well-founded. We find a relationship between UPMC's market share and the wage penalty, indicating that the wage penalty likely reflects the exercise of increasing monopsony power. Together, these analyses indicate not only that UPMC has monopsony power, but that increases in that power (potentially as a result of exclusionary conduct and anticompetitive acquisitions) have enabled UPMC to suppression healthcare worker wages below competitive levels

RELEVANT LITERATURE

The recent interest in how monopsony power contributes to wage suppression and rising inequality represents a welcome change from the assumption of competitive labor markets that

[16] Council of Economic Advisers Issue Brief, Labor Market Monopsony: Trends, Consequences, and Policy Responses, October 2016, *available at* https://obamawhitehouse.archives.gov/sites/default/files/page/files/20161025_monopsony_labor_mrkt_cea.pdf.

prevailed for much of the 20th century. Recent literature reflects this realization. In his review of the monopsony literature, labor economist Alan Manning observed that "The bottom line from these studies is that there seems to be a large amount of monopsony power. If anything, there seems to be much more monopsony in the labor market than one might have expected a priori."[17] The aforementioned 2016 CEA report explored several factors that can contribute to the exercise of power over labor input providers:

> …larger size of employers relative to individual workers tends to give employers a natural advantage in bargaining leverage over workers in the labor market.
>
> Limited competition in a labor market also may facilitate implicit or explicit collusion among employers that allows a small number of them to act as one. Collusion can take the form of agreements not to hire each other's workers or the coordination of wage offers and raises in order to avoid competitive bidding.[18]

As a result of these developments, the U.S. Department of Justice has assumed an increasingly interventionist role in policing such anticompetitive behavior in input markets.[19] Moreover, recent worker harm arising from the widespread use of non-compete agreements has drawn the attention of the Federal Trade Commission. Under Chair Lina Khan, the FTC has commenced efforts to impose a ban on such agreements, an effort that has garnered overwhelming worker support. The FTC's solicitation of comments on its proposed rulemaking has drawn attention to the restraints non-competes place on hospital workers. A recent study found 98 percent of workers in the medical profession favor the ban on non-competes.[20]

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[17] Alan Manning, *Monopsony in Labor Markets: A Review*, 74(1), ILR REVIEW 3-26, 6 (January 2021).

[18] 2016 CEA Report at 6.

[19] *See, e.g.*, United States and the State of Arizona v. Arizona Hospital and Healthcare Association and AzHHA Service Corporation.

[20] Ted Tatos, *Prohibiting Non-Compete Agreements Isn't Just Procompetitive, It's Extremely Popular Public Policy*, THE SLING, February 1, 2023, *available at* https://www.thesling.org/prohibiting-non-compete-agreements-isnt-just-procompetitive-its-extremely-popular-public-policy/.

The tepid attention that monopsony power had received in competition circles prior to the current overdue epiphany should not be misconstrued as applying to other fields in economics, which had long raised alarm. Donald Sullivan explained in his 1989 paper that "The market for hospital nurses is literally the textbook example of monopsony in the labor market."[21] Simultaneously tipping the hat to sports and labor economists and noting the silence from those in the industrial organization field, Sullivan further observes that "only other example cited with any regularity in intermediate microeconomics or labor economics textbooks is the market for professional athletes."[22]

The exercise of monopsony power as an explanation for suppressed nurse wages and working conditions predates Sullivan by nearly twenty years. Health economist Donald Yett advanced this argument in his 1975 book, *An Economic Analysis of the Nurse Shortage*, explaining that:[23]

> Most local nurse markets are variants of two prototypes—one characterized by monopsony, and the other by oligopsony—with respect to their hospital sectors. Although diversity exists in terms of their non-hospital sectors, it exerts only minor influence on the general level of nurse salaries because hospitals, which employ 70 percent of all active nurses, are the dominant employers.

Studying the determinants of the dearth of nurses in the 1970s, Fagin explained that "Using principles of supply and demand alone and examining average nursing salaries at the staff-nurse level-the level considered at national crisis proportions, we must conclude that the nursing shortage

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[21] Donald Sullivan, Monopsony Power in the Market for Nurses, NBER Working Paper #3031, July 1989 at 1.

[22] *Id.* at n. 1

[23] DONALD YETT, AN ECONOMIC ANALYSIS OF THE NURSE SHORTAGE 224 (Lexington Books 1975). Yett further presaged the current nurse shortage conditions, ("When nurse demand is increasing relative to supply wages will not rise as much under conditions of monopsony or oligopsony as they would in more competitive labor markets.") *Id.* at 225.

is a *shortage at a price*."[24] In other words, the seeming shortage resulted in a reduction in the number of nurses as hospitals exercised their wage-setting power to over labor. To wit, we emphasize the distinction between an absolute shortage in nurses and an artificial shortage caused by nurses unwilling to accept sub-market wages that result from monopsony power.

Despite these warnings, the United States currently faces both an artificial shortage at prevailing wages and widespread geographic market concentration in healthcare. Recent research has documented the attendant results. Prager and Schmitt (2021) examined whether wage growth slowed due to increases in consolidation following hospital mergers.[25] They found that when mergers resulted in a high degree of concentration, the effects were most pronounced for medically skilled workers (including nursing jobs), but less so for a group of other skilled, mostly white collar, non-medical workers.[26] Allegretto and Graham-Squire (2023) found that increased hospital system consolidation in smaller Metropolitan Statistical Areas (MSAs) (i.e. MSAs with less than five hospitals, excluding the smallest not in the study) is adversely related to nurse wage growth.[27] In particular, they find a wage penalty for nurses of $0.70 to $0.90 per hour for every 0.1 increase in the HHI consolidation measure.[28] Schubert, Stansbury, and Taska (2022) found that "For occupations in the bottom quartile of occupational mobility, like registered nurses and security

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[24] Claire Fagin, *The Shortage of Nurses in the United States*, 1(4) PUBLIC HEALTH POLICY, 293-311, 295 (Dec. 1980) (emphasis added). *Id*. ("However, the national average remains low ($13,000 in 1977), and the salary progression for nurses in patient care is noncompetitive. It is important to identify possible reasons for the fact that nurses' salaries have not risen sufficiently to create a balance of supply and demand. Among the possibilities are the following:…that employers are, de facto, united as one although numerous (the market for nurses has been called a monopsony since it is dominated by one employer, the hospital)."

[25] Elena Prager and Matt Schmitt, *Employer consolidation and wages: Evidence from Hospitals,* 111(2) AMERICAN ECONOMIC REVIEW 397-427 (2021).

[26] *Id*.

[27] Sylvia A. Allegretto and Dave Graham-Squire, Monopsony in Professional Labor Markets: Hospital System Concentration and Nurse Wages, INET Working Paper No. 197, January 5, 2023, *available at* https://www.ineteconomics.org/uploads/papers/WP_197-Allegretto-HospCons.pdf.

[28] *Id*. The authors use a HHI of 1 to indicate a fully consolidated market rather than the usual, 10,000. This reporting convention does not affect their results or conclusions.

guards, moving from the median to 95th percentile HHI is associated with on average 7.3 log points lower wages."[29] The FTC has also noted the wage-depressive effects of market concentration. In its September 2020 public comment on a hospital merger in Hendrick, Texas, the FTC cautioned that "The impact of hospital consolidation on labor markets has garnered particular attention during recent merger reviews and is highly relevant to HHSC's analysis, as this can affect worker pay and community access to healthcare services."[30]

Our current study evaluates the potential nexus between such concentration and the exercise of monopsony power over labor input providers. UPMC's actions have come under the scrutiny of both researchers and lawmakers. In a recent report, the American Economic Liberties Project detailed the injurious effects of UPMC's monopoly power over workers and patients.[31] Congresswoman Summer Lee and State Representative Sara Innamorato have both focused attention on the healthcare workforce crisis in Pittsburgh hospitals and UPMC role therein. We hope this study sheds further light into the economic issues that impact both workers and patients.

DATA SOURCES

Data limitations frequently impede independent investigations of monopsony power, as much of the specific wage information rests with private employers and outside of the public domain. Fortunately, the federal government collects substantial data on workers through various

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[29] Gregor Schubert, Anna Stansbury, and Bledi Taska. Employer Concentration and Outside Options, Washington Center for Equitable Growth, March 2022 at 3.

[30] Federal Trade Commission, Federal Trade Commission Staff Submission to Texas Health and Human Services Commission Regarding the Certificate of Public Advantage Applications of Hendrick Health System and Shannon Health System, September 11, 2020 "FTC staff defined a potentially relevant geographic market for calculating labor concentration as the commuting zone for nursing labor, as developed by the U.S. Department of Agriculture.) Id. at 36-37. Available at https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-texas-health-human-services-commission-regarding-certificate-public-advantage/20100902010119texashhsccopacomment.pdf.

[31] American Economic Liberties Project, Critical Condition: How UPMC's Monopoly Power Harms Workers and Patients, January 2023, available at http://www.economicliberties.us/wp-content/uploads/2023/01/AELP_2022_UPMC_Report_R2-3.pdf.

instruments such as the American Community Survey (ACS) and statutory reporting requirements that can provide significant insight into wage and occupational information. Previous research has leveraged these data to investigate the connection between increasing concentration and wage suppression. For example, Prager and Schmitt (2019) used data from the Center for Medicare Statistics (CMS) Healthcare Cost Report Information System (HCRIS), which includes the Hospital Cost Report Public Use Files. Allegretto and Graham-Squire (2023) used data from the American Community Survey to analyze the relationship between hospital concentration and nurse wages.

In this report, we leverage two publicly-available data sources for hospital workers' wages: (1) the annual Hospital Cost Report Public Use Files (i.e., the HCRIS data) and (2) the wage index files from the CMS Acute Inpatient Prospective Payment System. Specifically, with respect to the latter, we used the results of the triennial Occupational Mix Survey.[32] The HCRIS data contains data for a broad range of hospital workers organized into job categories, including cafeteria employees, nurse administration, and direct patient care workers. We analyzed the HCRIS data for years 2011 through 2020, the latest year for which data are available.

However, the HCRIS data do not contain wage information specifically for nurse categories other than the category "nurse administrators." Other researchers, such as Prager and Schmitt, have observed the same shortcoming. To address this gap, we also analyzed data available on a triennial basis from the CMS Occupational Mix Survey from 2008 to 2019, the latest year the survey was conducted. These data provide average wages by hospital for the following nurse

[32] Section 304(c) of Public Law 106-554 amended section 1886(d)(3)(E) of the Social Security Act and requires CMS to collect data every 3 years on occupational mix of employees for each short-term, acute care hospital participating in the Medicare program.

categories: (1) nurse assistants and orderlies, (2) medical assistants, (3) licensed practicing nurses (LPNs), (4) nurses, and (5) registered nurses (RNs).

While both data sources cover the United States, we limited our analysis to areas in Pennsylvania – where UPMC primarily operates – and to the nearby states of New York, Maryland, Ohio, and West Virginia for comparison purposes. In doing so, we sought to select geographic locations that were comparable to the areas containing one or more UPMC facilities. SEIU also provided additional information on HCRIS facilities that we used to supplement our data. These data included geocoding for hospital in the cost report (i.e., latitude and longitude coordinates) as well as county and state FIPS codes. We required FIPS codes to place hospitals into their corresponding commuting zones. Consistent with the literature, we used commuting zones to delineate the boundaries of labor input markets.[33]

Of 560 hospitals within the five-state dataset that we analyzed, only 421 contained FIPS codes. Because such missing data presented an impediment to any attempts to analyze geographic market concentration, we attempted to mitigate this issue in two ways. First, we extracted the provider information from the CMS database. These data included county and state names, which we could match to the FIPS code using a county-level crosswalk table from the U.S. Census Bureau. Second, for the hospitals where the above process did not result in a match but we had latitude and longitude coordinates for the hospital, we matched the latitude and longitude of the

[33] "The commuting zone is based on journey-to-work data and defines clusters of counties with strong commuting ties." https://usa.ipums.org/usa-action/variables/COMZONE#description_section. Research shows workers seeking jobs make no more than 20% of their applications outside their commuting zone and multiple studies of labor market concentration have used commuting zones as the boundaries of for relevant geographic labor markets. Ioana Marinescu & Eric A. Posner, *Why Has Antitrust Law Failed Workers?* 105 CORNELL L. REV. 1343, 1389 (2020) (proposing commuting zones should be presumptively valid geographic labor market definition); Elena Prager & Matt Schmitt, *Employer Consolidation and Wages: Evidence from Hospitals*, AM. ECON. REV. 111(2), at 10-11 & n.6 (Aug. 23, 2020) (relying on commuting zones as a "coarse measure" that was checked against a broader and narrower market definition for robustness).

hospital to the county boundary in which they were located.[34] These matching tools enabled us to successfully assign FIPS codes to 551 of the 560 hospitals in our dataset.

Next, we placed each hospital in its year 2000 commuting zone, data for which we obtained from the U.S. Department of Agriculture.[35] The commuting zone information also included population information for the commuting zone, as well as each county within it. In addition, if the commuting zone included a metropolitan area, the data provided its corresponding name. Some commuting zones covered a metropolitan statistical area (MSA), while other smaller ones did not. Each of the five commuting zones with a UPMC facility were located within a Pennsylvania MSA: Pittsburgh, Erie, Lancaster, Williamsport, and Johnstown.[36] To limit any potentially confounding effects of comparing wages within commuting zones of different sizes, we limited our analysis to only those commuting zones that include an MSA.

As a penultimate step, with assistance from SEIU, we calculated the cost of living for each commuting zone as the population-weighted contribution of each county within that zone.[37] This calculation permitted us to compare average hospital workers' wages in each commuting zone with a UPMC facility only to hospitals in commuting zones with a similar cost of living. We defined the term "similar cost of living" as within ten percent of the cost-of-living in a given UPMC-containing commuting zone. In other words, if a commuting zone's cost of living fell within ten percent of the cost of living within a given commuting zone where UPMC operates, we included it as a comparison group for that commuting zone containing UPMC. Thus, the same

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[34] To accomplish this matching, we translated the latitude/longitude coordinates to radians and used the GINSIDE procedure available in SAS Software.

[35] The specific file is available at https://www.ers.usda.gov/webdocs/DataFiles/48457/cz00_eqv_v1.xls?v=0.

[36] To the extent that one commuting zone encompassed more than one MSA, we assigned the name of the MSA with the largest population.

[37] Cost-of-living was calculated as of 2020, reflecting our assumption that changes in cost-of-living among commuting zones over the period of analysis occurred in parallel fashion leaving the relative positions unchanged.

commuting zone can serve as a comparison for multiple UPMC-containing commuting zones. Of course, other hospitals and systems also exist within the same commuting zone as UPMC. To effectuate the comparison, we considered only wages for workers at UPMC-owned facilities and eliminated wages from all other hospitals within a commuting zone containing a UPMC facility.

ANTICOMPETITIVE HYPOTHESES

Because our research aimed to investigate any relationship that may exist between wage differences and market concentration, we calculated the Herfindahl-Hirschman Index (HHI).[38] We calculated the HHI by first calculating the market share of each hospital system (or stand-alone hospital for unaffiliated entities) in each job category, by year, and by commuting zone using both HCRIS data for general hospital worker wages and CMS data for nurse wages. Concurrently, we computed UPMC's share of the market at each level mentioned above. As noted previously, we used the commuting zone to delineate geographic market boundaries. With respect to occupations, we treated each job category (e.g., cafeteria workers, nursing administration, various nursing levels) as its own labor input market within a given commuting zones. For example, registered nurses within the Pittsburgh, PA commuting zone were considered a relevant market for purposes of this analysis and used as a basis for calculating UPMC's market share for that job category. Both the HHI and UPMC market share were based on the total hours worked by employees in a given job category in a given year in a commuting zone.

The data organization detailed above resulted in two datasets, one for nurses for the 2010, 2013, 2016, and 2019 survey years, and another for general hospital workers in the job categories

[38] The HHI is simply the sum of the squared market shares of each buyer in the relevant labor market, multiplied by 10,000. Thus, a market with shares of 70 percent, 20 percent, and 10 percent would yield an HHI of 5,400 (equal to (.7^2 + .2^2 + .1^2) x 10,000). The antitrust agencies have established ranges of what they consider concentrated markets. *See* Department of Justice and Federal Trade Commission, Horizontal Merger Guidelines, Section 5.3, released Aug. 19, 2010.

contained in the Hospital Cost Reports annually from 2011 to 2020. Each dataset contained average wages, HHI, and UPMC market share by year, commuting zone, hospital category (UPMC v. Non-UPMC) and job category. We set out to test several anticompetitive hypotheses, including whether UPMC uniformly pays nurses lower wages than hospital systems in comparable commuting zones, and whether such a "wage penalty," assuming one exists, increases with UPMC's buying power in the relevant labor market.

RESULTS

We begin with a tabular analysis for various categories of nurses as reported in the CMS nurse wage data and for all other hospital employee categories as reported in the HCRIS data, comparing average wages at UPMC hospital facilities to average wages at non-UPMC facilities by year and commuting zone. We next present econometric models explaining hourly average wage differences between UPMC and other hospitals in commuting zones with comparable standards of living as a function of either UPMC's market share or the HHI. We present all hourly wage differences in this report as UPMC minus the comparison. Thus, negative numbers mean that UPMC pays less than non-UPMC facilities in comparable commuting zones while positive numbers represent the reverse.

Nurse Wage Comparison – Descriptive Statistics

First, as Table 1 below indicates, UPMC uniformly pays nurses lower average hourly wages than non-UPMC hospital systems in comparable commuting zones.[39] Such differences are

[39] The final analysis dataset consisted of UPMC vs. non-UPMC commuting zone pairings by job category, survey year, and commuting zone. For example, for nurses, average hourly wages were calculated as total nurse pay divided by total nurse hours by nurse classification (LPN, RN, etc.), survey year, and commuting zone. These averages by commuting zone that contained a UPMC hospital were compared with the corresponding non-UPMC hospital average in each commuting zone considered comparable to that specific commuting zone with a UPMC hospital.

particularly pronounced at lower wage categories. For example, LPNs at UPMC locations in the five commuting zones where UPMC has a presence received on average $1.31 per hour less than LPNs at hospitals in commuting zones with a comparable cost of living over the entire time period of analysis. Other categories of nurses also indicate significant wage penalties, including Nurses, with a $0.62 per hour wage difference, RNs with a $0.37 per hour wage difference, and Medical Assistants with a $0.56 per hour wage difference. These wage penalties are significant: Assuming full-time employment – a 40-hour work week and a 52-week work year – UPMC Nurses, for example, experience a penalty of, on average, $1,289.60 in annual income.

Table 1: Average Nurse Wages at UPMC and Non-UPMC Hospitals by Nurse Category, Survey Years 2008-2019

Nurse Category	UPMC Average Wage	Non-UPMC Average Wage	Wage Differential
LPNs	$19.97	$21.28	($1.31)
Nurses	$27.18	$27.80	($0.62)
Medical Assistants	$14.93	$15.49	($0.56)
RNs	$31.78	$32.15	($0.37)
Nurse Asst./Orderlies	$13.89	$14.10	($0.21)

***Note**: Wage differentials equal to average UPMC wage minus average non-UPMC wage; negative numbers imply average UPMC wages below average non-UPMC wages.*

Table 2 identifies the differences by the commuting zone where UPMC has a presence. In the four MSAs where UPMC has a least a 33 percent market share, average UPMC wages are below non-UPMC hospitals in nearly every instance; specifically, in 12 of the 15 nurse category-MSA combinations, UPMC nurses experience a wage penalty compared to nurses in non-UPMC facilities. Further, in the one MSA with UPMC market share below 33 percent – the Lancaster, PA

These data were subsequently averaged to arrive at further aggregated levels. For example, to arrive at the average across years, the averages in the pairing described above were again averaged. In other words, in this case, simple averages over the years were computed.

market – the opposite is true: UPMC offers higher wages relative to hospitals in comparable commuting zones for each of the five nurse categories.

Table 2: Average Wage Differentials between UPMC and Non-UPMC Nurses by Nurse Category in Select Pennsylvania Commuting Zones, Survey Years 2008-2019

Nurse Category	Williamsport CZ	Pittsburgh CZ	Erie CZ	Johnstown CZ	Lancaster CZ
UPMC Market Share	***91%***	***50%***	***43%***	***33%***	***25%***
LPNs	($0.58)	($1.51)	($4.07)	($1.71)	$2.07
Nurses	$1.74	($1.40)	($3.22)	($0.71)	$0.79
Medical Assistants	($0.88)	($0.47)	($1.51)	($1.46)	$1.66
RNs	$3.47	($1.54)	($3.40)	($1.05)	$0.89
Nurse Asst./Orderlies	($0.15)	$0.20	($1.72)	($0.15)	$1.07

***Notes**: Wage differentials equal to average UPMC wage minus average non-UPMC wage; negative numbers imply average UPMC wages below average non-UPMC wages. UPMC market shares were calculated based on UPMC's portion of workers in each job category as reported in HCRIS data as described above.*

Next, we inquired as to whether (and how) any wage disparities may have changed over time. Table 3 reports wage disparities at UPMC facilities by each survey year spanning 2008 through 2019. The results show that durable longitudinal pattern of underpayment by UPMC. Of the 25 nurse category-year combinations, 22 exhibit a wage penalty for UPMC hospital workers. In the most recent year available – 2019 – the Licensed Practical Nurses experience the most pronounced wage penalty of over $2 dollars.

Table 3: Average Annual Wage Differentials between UPMC and Non-UPMC Nurses by Nurse Category, Survey Years 2008-2019

Year	Nurse Asst. / Orderlies	Medical Assistants	Nurses	LPNs	RNs
2008	($0.16)	$0.16	($0.44)	($1.08)	($0.22)
2010	($0.57)	($1.17)	($0.54)	($1.22)	($0.06)
2013	($0.38)	($0.47)	($0.75)	($0.99)	($0.26)
2016	($0.41)	($1.35)	($0.85)	($0.98)	($0.85)
2019	$0.44	$0.03	($0.50)	($2.26)	($0.47)

Note: *Wage differentials equal to average UPMC wage minus average non-UPMC wage; negative numbers imply average UPMC wages below average non-UPMC wages.*

The results are consistent with other anecdotal evidence of a UPMC "wage penalty." For example, hospital workers have testified as to the dire economic straits in which they find themselves despite 1) their qualifications and 2) UPMC's solid financial position.[40] Further, employee reviews that reference the low wages that UPMC pays are commonplace.[41] Thus, the persistence of an economically significant UPMC wage penalty over time suggests that UPMC has some degree of market power that enables it to suppress wages for nurses in commuting zones where it operates.

General Hospital Worker Wage Comparison – Descriptive Statistics

The HCRIS data, which have formed the basis for analysis in previous literature, permit more granular historical analysis of hospital workers wages as the data are collected on an annual basis. However, in addition to omitting most nurse wage data as explained above, these data sacrifice the positional specificity of the nurse data since the HCRIS data aggregates positions that we would have preferred to analyze separately. For example, contracted hospital workers who

[40] Kim Lyons, UPMC has grown too big; Pa. lawmakers need to support its workers, new report finds, Pennsylvania Capital-Star, January 23, 2023, available at https://www.penncapital-star.com/government-politics/upmc-has-grown-too-big-pa-lawmakers-need-to-support-its-workers-new-report-finds/.

[41] For example, see Glassdoor reviews: https://www.glassdoor.com/Reviews/UPMC-Reviews-E14679.htm.

interact directly in the care of patients are grouped into a single "Contract Labor – Direct Patient Care" category. Nonetheless, these data have the important advantage of providing insight into the compensation to lower-wage workers such as those in housekeeping and cafeteria positions.

Using the HCRIS data, we also examined wages for general hospital workers overall and by occupation. First, considering wages across all job categories contained in the HCRIS data across all years 2011 to 2020, we find that UPMC paid workers approximately two percent less than comparable hospital systems. Next, our analysis by job category shows notable disparities between UPMC wages and wages at hospitals in comparable markets over the time period 2011-2020.[42] Table 4 presents these results.

[42] We removed the following job categories as too aggregated and/or not directly relevant to our analysis: "Total salaries", "Related organization salaries", "Home office and/or related organization personnel", "Home office and/or related organization salaries and wage-related costs", "Home office salaries".

Table 4: Average Hospital Worker Wages at UPMC and Non-UPMC Hospitals by Job Category, Survey Years 2011-2020

Job Category	UPMC Average Wage	Non-UPMC Average Wage	Wage Differential
Physician Administrative (under contract) (Part A Medicare)	$125.17	$135.79	($10.61)
Direct Patient Care (under contract)	$53.22	$61.90	($8.68)
Dietary (under contract)	$23.05	$29.05	($6.00)
Home office and Contract Physicians - Teaching (Part A Medicare)	$111.87	$116.69	($4.82)
Physician - Administrative (Part A Medicare)	$140.62	$145.38	($4.77)
Housekeeping (under contract)	$18.95	$23.12	($4.17)
Employee Benefits	$31.70	$34.12	($2.42)
Social Service	$27.59	$29.80	($2.21)
Nursing Administration	$35.55	$37.03	($1.48)
Pharmacy	$36.82	$37.66	($0.84)
Maintenance and Repairs	$23.91	$24.53	($0.62)
Laundry and Linen Service	$13.09	$13.64	($0.55)
Physician - Teaching (Part A Medicare)	$119.30	$119.33	($0.03)
Dietary	$15.30	$15.29	$0.01
Housekeeping	$13.61	$13.44	$0.16
Cafeteria	$14.98	$14.47	$0.51
Skilled Nursing Facility	$22.82	$22.30	$0.52
Physician and Non-Physician (Part B Medicare)	$126.63	$119.85	$6.78

***Note** : Wage differentials equal to average UPMC wage minus average non-UPMC wage; negative numbers imply average UPMC wages below average non-UPMC wages.*

Of the eighteen job categories analyzed, UPMC pays less on average in thirteen of these categories, and in twelve of those thirteen categories workers experienced more than a $.50 per hour wage penalty, or at least a $1,040 annual pay penalty for full-time workers.[43] Thus for example, UPMC contracted workers providing direct patient care experience, on average, a $8.68 per hour wage penalty compared to contracted workers at other hospitals, an $18,054 annual disparity assuming full-time work. UPMC Nursing Administrators are paid $1.48 per hour less, on average, compared

[43] Based on 40-hour work week and working 52 weeks per year.

to nursing administrators at comparable hospitals, which translates to an annual loss of $3,078 assuming full-time work.

Similar to the approach taken by Prager and Schmitt, we then grouped the positions above into broader occupational groupings: low-wage positions, maintenance, patient care, physician/nurse administration and teaching. We examined the dollar wage difference between UPMC and hospital wages in comparable commuting zones by commuting zone where UPMC has a presence. The overall results appear in Table 5. For each occupational grouping, UPMC workers experience a wage penalty ranging from $0.62 for Maintenance to $5.70 for Physician and Nurse administrative positions.

Table 5: Average Hospital Worker Wages at UPMC and Non-UPMC Hospitals by Occupational Grouping, Survey Years 2011-2020

Occupational Grouping	UPMC Average Wage	Non-UPMC Average Wage	Wage Differential
Low Wage	$15.92	$17.04	($1.12)
Maintenance	$23.91	$24.53	($0.62)
Patient Care	$57.85	$60.01	($2.16)
Phys/Nurse Admin	$93.73	$99.43	($5.70)
Teaching	$116.72	$118.41	($1.69)

Note: *Wage differentials equal to average UPMC wage minus average non-UPMC wage; negative numbers imply average UPMC wages below average non-UPMC wages.*

Table 6 below provides a further breakdown by commuting zone where UPMC operates a facility.

Table 6: Average Wage Differentials between UPMC and Non-UPMC Hospital Workers by Occupations Groupings in Select Pennsylvania Commuting Zones, Survey Years 2011-2020

Occupational Grouping	Williamsport CZ	Pittsburgh CZ	Erie CZ	Johnstown CZ	Lancaster CZ
UPMC Market Share	***88%***	***52%***	***51%***	***36%***	***27%***
Low Wage	($8.96)	$0.03	($0.89)	$0.91	($2.11)
Maintenance	($5.91)	$3.52	($3.05)	($2.00)	$3.85
Patient Care	($4.61)	($7.09)	$5.54	($5.49)	($1.05)
Phys/Nurse Admin	($14.20)	($4.33)	($3.27)	($4.68)	($3.88)
Teaching	($10.26)	($0.53)	($0.54)	$2.66	($4.02)

Notes *: Wage differentials equal to average UPMC wage minus average non-UPMC wage; negative numbers imply average UPMC wages below average non-UPMC wages. UPMC market shares were calculated based on UPMC's portion of workers in each job category as reported in HCRIS data as described above.*

The results raise reason for concern about UPMC's market dominance and its harm to competition and labor in the hospital sector. In Williamsport, UPMC enjoys a dominant market share of approximately 88 percent, and this commuting zone reveals a consistently high UPMC wage penalty across all wage categories. Notably, we found a nearly nine-dollar hourly wage difference for low-wage workers; much of this difference stems from the use of contract workers, who UPMC consistently underpays relative to comparison hospitals. We find this result particularly worrisome: To the extent that UPMC can leverage the use of contract workers as a tool to dampen employee wages, this can reflect an exercise of monopsony power.

Econometric Analysis – General Hospital Workers

We next investigated the critical question of whether market concentration—and UPMC's market share in particular—plays a role in any wage disparities between UPMC and other similarly situated hospitals. To do so, we relied on the HCRIS data, which contain annual information from 2011-2020 by wage category and hospital for general hospital workers. We aggregated these data at the commuting zone level by calculating the average wage by commuting zone and year and

hospital category (UPMC vs. Non-UPMC). The outcome variable of interest was the wage difference between UPMC and comparison hospitals within commuting zones with a similar cost of living. We posited two key independent variables, which we analyzed separately: the HHI (by year and occupation category) in UPMC's commuting zone and UPMC's market share in that commuting zone.

We estimated the following models:[44]

1. Pooled regression – aggregated effect of HHI across all occupations, years, and commuting zones.
2. Two-way fixed effects (TWFE) – fixed effects for occupations and years.
3. Pooled regression – occupation-clustered standard errors.
4. Two-way fixed effects (TWFE) – fixed effects for occupations and years, clustered standard errors at the job category level.
5. One-way fixed effects for job category.

Table 7 below provides the results for the equation regressing the wage difference in levels against the HHI in UPMC's commuting zone.

[44] All estimation performed using SAS. Clustered standard errors were estimated using the Surveyreg procedure. We excluded any instances reflecting an HHI of 10,000 or UPMC market share of 100%. After investigating these instances, these appear to be artifacts of data reporting rather than indicators of a fully-consolidated market. Removing these instances did not change our conclusions.

Table 7: HHI Regression Results Predicting General Hospital Worker Wage Differentials, 2011-2020

Model	HHI Coefficient Estimate	t-Value	P-Value
Pooled Reg.	-0.00159	-15.17	<.0001
TWFE	-0.00150	-13.33	<.0001
Pooled (Occupation Clustered SE)	-0.00160	-3.28	0.0042
TWFE (Occupation Clustered SE)	-0.00147	-2.80	0.0118
Year Fixed Effects	-0.00163	-17.65	<.0001
Occupation Fixed Effects	-0.00143	-13.02	<.0001

***Dependent Variable** : UPMC minus Comparison Group Wages*
***Independent Variable** : HHI in UPMC Commuting Zone*

Our results remain robust across these specifications. In each case, we find a negative, economically, and statistically significant effect on the wage differential from market concentration. In other words, as the market in which UPMC operates became more concentrated, UPMC paid workers lower wages relative to its comparison hospitals. The "estimate" column represents the regression coefficient, interpreted as the change in the wage penalty (UPMC minus comparison) associated with a one-point change in the HHI. For example, for every 1,000 increase in the HHI, UPMC wages fell by between $1.43 and $1.63 per hour relative to the comparison groups.

Next, we performed the same analysis using UPMC's market share as the treatment variable of interest. We begin with the overall results, shown in Table 8 below. The "estimate" column, which measures the correlation between increasing UPMC market share and UPMC's wage penalty under the five different regression specifications indicates that, as UPMC's market share increases, UPMC pays lower wages relative to comparison hospitals. For example, a ten-percent increase in UPMC's market share would yield a $0.30 to $0.57 increase (obtained by

multiplying the figures in the estimate column by ten) in the wage penalty that UPMC workers experienced.

Table 8: UPMC Market Share Regression Results Predicting General Hospital Worker Wage Differentials, 2011-2020

Model	UPMC Mkt Share Coeffi-cient Estimate	t-Value	P-Value	Implied UPMC Wage Impact per 10% UPMC Market Share Increase
Pooled Reg.	-0.05664	-7.07	<.0001	-$0.57
TWFE	-0.03083	-4.13	<.0001	-$0.31
Pooled (Occupation Clustered SE)	-0.05664	-2.20	0.0409	-$0.57
TWFE (Occupation Clustered SE)	-0.03078	-0.96	0.3482	-$0.31
Year Fixed Effects	-0.05736	-8.56	<.0001	-$0.57
Occupation Fixed Effects	-0.02989	-4.04	<.0001	-$0.30

Dependent Variable: *UPMC minus Comparison Group Wages*
Independent Variable: *UPMC Market Share*

Given the greater longitudinal scope of the HCRIS data, we also performed an analysis at the individual job category level, calculating market share by job category and year for each commuting zone with UPMC facilities, as shown in Table 9. These results offer some explanation for the earlier descriptive results showing pronounced wage disparities, particularly among contract workers. Our results demonstrate a consistent pattern across wage categories of UPMC underpaying contract workers relative to other hospitals, and an economically and statistically significant relationship between such underpayment and UPMC's market share. For example, the Housekeeping category shows a coefficient of -0.14215, indicating that for every ten percent increase in UPMC's market share, UPMC pays approximately $1.40 per hour less than the comparison group hospitals in commuting zones with a comparable cost of living.

Results are also concerning in the direct patient care categories. The coefficient on Contract Labor-Direct Patient Care equals -0.15761, meaning that a ten percent increase in UPMC's market share is associated with UPMC paying approximately $1.60 less than comparable hospitals. Further, we observe economically significant effects in Nursing Administration and Physician categories, although the effects of UPMC's market share on Part A Physician wage differentials did not meet standard thresholds of statistical significance. Nonetheless, the observed effect sizes are economically significant in both cases.[45]

Table 9: UPMC Market Share Regression Results Predicting General Hospital Worker Wage Differentials by Job Category, 2011-2020

Job Category	UPMC Mkt Share Coeffi-cient Estimate	t-Value	P-Value	Wage Impact per 10% UPMC Market Share Increase
Cafeteria	-0.00238	-0.68	0.4991	-$0.02
Direct Patient Care (under contract)	-0.15761	-9.92	<.0001	-$1.58
Physician Adminstrative (under contract) (Part A Medicare)	-0.09203	-2.98	0.003	-$0.92
Dietary	-0.01442	-4.46	<.0001	-$0.14
Dietary under contract	-0.16575	-6.46	<.0001	-$1.66
Employee Benefits Department	0.07641	3.36	0.0008	$0.76
Home office contract Physicians - Teaching (Part A Medicare)	0.38241	4.56	<.0001	$3.82
Housekeeping	-0.00581	-1.90	0.0578	-$0.06
Housekeeping (under contract)	-0.14215	-4.72	<.0001	-$1.42
Laundry and Linen Service	-0.02669	-6.22	<.0001	-$0.27
Maintenance and Repairs	0.01695	2.27	0.0232	$0.17
Nursing Administration	-0.04317	-6.65	<.0001	-$0.43
Pharmacy	-0.07065	-8.74	<.0001	-$0.71
Physician - Administrative (Part A Medicare)	-0.05403	-1.21	0.2252	-$0.54
Physician - Teaching (Part A Medicare)	-0.07985	-0.82	0.4118	-$0.80
Skilled Nursing Facilities	0.01077	1.24	0.2176	$0.11
Social Service	-0.08224	-11.54	<.0001	-$0.82

Dependent Variable: *UPMC minus Comparison Group Wages*
Independent Variable: *UPMC Market Share*

[45] For a distilled discussion of the difference between economic (i.e., practical) and statistical significance, see Ronald L. Wasserstein & Nicole A. Lazar. The ASA Statement on p-Values: Context, Process, and Purpose, The American Statistician, 70:2, (2016), 129-133, ("Statistical significance is not equivalent to scientific, human, or economic significance. Smaller *p*-values do not necessarily imply the presence of larger or more important effects, and larger *p*-values do not imply a lack of importance or even lack of effect.")

These results indicate that conduct that precipitated increases in UPMC's market share also enabled UPMC to suppress wages for its workers. Our fundings also provide strong support for the hypothesis that the UPMC wage penalty has resulted from UPMC's leverage of monopsony power, as opposed to other confounding variables, whether observable or unobservable. In particular, a variable that could plausibly confound the relationship between the *outcome* (the wage penalty, i.e., the wage differential between UPMC and the comparison hospitals) and the *treatment* (UPMC's market share in the commuting zone where it operates) would have to be correlated with both treatment and outcome.

Theoretical support for a confounding variable does not readily present itself, and we observe no such variable. For example, one might hypothesize that lower relative demand for hospitals services in UPMC's markets than in the comparison markets could explain the UPMC wage penalty. However, such a hypothesis would fail on two fronts. First, no apparent reason exists to posit any correlation between overall demand for hospital services in UPMC's market and its market share therein. Lacking such a relationship, demand would only serve to further explain variation in the wage penalty but would not confound the relationship between the market share and the wage penalty.[46] Second, record evidence does not support the depressed relative demand hypothesis. On the contrary, UPMC has further increased employee workloads.[47]

Finally, we emphasize that the focus should not rest on wage differentials alone but also the increasing workload, and in this respect the analysis of wages alone may understate the compensation disparities between UPMC and other hospitals. Increases in workload with no

[46] In other words, demand would be an explanatory variable but not a confounder, because it would not create a separate back door path between the treatment and the outcome.

[47] Courtney Murphy, UPMC nurses and patients still concerned over unsafe conditions, WTAJ, May 23, 2022, available at https://www.wtaj.com/news/local-news/upmc-nurses-and-patients-still-concerned-over-unsafe-conditions/.

commensurate pay adjustments represent an effective decrease in pay, but one that may remain unobserved in a wage analysis that does not account for such compositional changes. Currie et al. explain that such effects may explain the moderate or small effects of monopsony power in some earlier research papers, particularly when juxtaposed against actual worker experiences: "[S]urveys of nurses indicate that they associate takeovers primarily with increases in workload rather than with reductions in wages. We extend the standard monopsony model by considering an employer who sets minimum effort levels as well as wages and employment."[48] The authors found ambiguous effects of market power on wages but that increases in market power were associated with increases in effort. This suggests the conservative nature of our results, particularly in light of UPMC's reported plans to increase the patient workload nurses face from an earlier level of 4-1 to as much as 8-1.[49]

CONCLUSION

Our results evince cause for concern regarding UPMC's apparent "wage penalty" as well as its relationship with UPMC's increasing market power. Over the last twenty-two years, UPMC has acquired twenty-eight hospitals in Pennsylvania. This acquisition spree has increased of late; in 2016 and 2017 alone, UPMC acquired thirteen hospitals. We hope that the results presented herein will assist regulators in taking the appropriate action to protect both hospital workers and patients from the injury that has resulted from UPMC's increasing market power.

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[48] Janet Currie, Meddi Farsi, W. Bentley MacLeod, Cut to the Bone? Hospital Takeovers and Nurse Employment Contracts, NBER Working Paper #9428, December 2002.

[49] Shira Li Bartov, Nurses Allegedly Threatened for Refusal to Take 'Unsafe' Number of Patients, Newsweek, May 11, 2022, available at https://www.newsweek.com/nurses-allegedly-threatened-refusal-take-unsafe-number-patients-viral-tiktok-pennsylvania-1705671.

Appendix 4:
UPMC Survey Results

Introduction

The Strategic Organizing Center and SEIU Healthcare Pennsylvania administered an online survey, advertised via Facebook and Instagram, to hospital workers in Southwest Pennsylvania. Conducted between December 12, 2022, and January 23, 2023, the survey asked respondents about their commitment to the healthcare field, their working conditions and the impact of those conditions on patient care, as well as about their concerns about employer control and retaliation.

A total of 555 UPMC employees completed the online survey, and this memo summarizes the survey's findings.

Of the UPMC respondents who provided demographic information, 81 percent identify as female, 18 percent identify as male, and one percent identify as non-binary. In terms of racial makeup, 92 percent of respondents who answered this demographic question identified as Caucasian/White, four percent Black/African-American with the remainder Asian or of multiple races. Less than two percent of respondents identified as Hispanic/Latino.

COMMITMENT TO HEALTHCARE

The survey asked respondents about their commitment to the healthcare field. Table 1a displays the level of agreement with three statements indicating desire and commitment to healthcare-related work. In general, respondents expressed a high level of agreement with each of the three statements. For example, there was near unanimity among UPMC respondents (97%) that they chose the health care field over other fields of work and that working in health care is important to them (94%). In addition, five of six (84%) of UPMC respondents agreed with the statement: "I hope to advance in the health care field."

Table 1a: Levels of UPMC Respondent Agreement with Healthcare Commitment Statements

Healthcare Commitment Statement	Agree	Disagree	n
I chose the health care field over other fields of work.	97%	3%	483
Working in the health care field is important to me.	94%	6%	481
I hope to advance in the health care field.	84%	16%	409

Table 1b displays levels of agreement with the same statements broken down by wage category. UPMC respondents who provided hourly wage information (N=471) were divided into three wage groups: (1)

low-wage, defined as those that earn $20 or less per hour; (2) mid-wage, defined as between $20 and $35 per hour; and (3) high-wage, defined as greater than $35 per hour. Respondents who indicated they were salaried and hence did not provide an hourly wage rate (N=82) were excluded from this analysis.

Regardless of wage level, UPMC hospital worker respondents demonstrated a high level of commitment to the health care field. For example, even among the UPMC respondents in the low-wage category, worker commitment to the health care field was strongly indicated. For example, 88 percent of low-wage UPMC respondents agreed with the statements "I chose the health care field over other fields of work" and an even higher proportion (92%) agreed with the statement "Working in the health care field is important to me."

Table 1b: Levels of UPMC Respondent Agreement with Healthcare Commitment Statements, by Wage Group

Healthcare Commitment Statement	Low-Wage			Mid-Wage			High-Wage		
	Agree	Disagree	n	Agree	Disagree	n	Agree	Disagree	n
I chose the health care field over other fields of work.	88%	12%	77	96%	4%	195	93%	7%	138
Working in the health care field is important to me.	92%	8%	84	95%	5%	192	93%	7%	127
I hope to advance in the health care field.	86%	14%	76	89%	11%	168	70%	30%	96

Notes: Low-Wage = $20 or less per hour, Mid-Wage = $20.01-$35/hour, High-Wage = More than $35/hour

Lastly, and perhaps most importantly, a full 86 percent of low-wage UPMC respondents indicated a desire to advance in the health care field, proportions greater than those in the comparable high-wage categories.

WORKLOAD AND STAFFING LEVELS

The survey included two questions about workload changes. The first question asked if respondents' workloads increased since they began working in their primary hospital department. **An overwhelming majority of UPMC survey respondents – 92 percent – reported that their workload increased (n=548).**

For respondents who reported increased workloads, a follow-up question asked about the reasons for the workload increase. As shown in Table 2, 84 percent of UPMC hospital worker respondents selected loss of staff/chronic understaffing as the reason for their workload increases.

Table 2: Share of UPMC Respondents Indicating Reasons for Workload Increase

Reasons for Workload Increase	%
Loss of staff/Chronic understaffing	84%
Increase in the kinds of work required to be completed	68%
Job merging/Additional tasks added previously done in different departments	60%
Increase in number of patients	58%
n	511

The second most commonly-cited reason – increases in the kinds of work required to be completed – was cited by 68 percent of UPMC respondents. Job merging and/or additional tasks added that were previously done in different departments were cited by more than half of UPMC respondents.

UPMC respondents were also asked directly about whether staffing levels at their hospitals had gotten better, worse or were unchanged. Specifically, **84 percent of UPMC hospital respondents indicated that staff levels had gotten worse while only four percent indicated that staffing levels had gotten better.**

PATIENT CARE QUALITY

The survey also asked UPMC respondents about the changes in quality of patient care in their hospital facilities.

More than three-in-four UPMC respondents (77%) reported that the quality of patient care had gotten worse in the last year compared to a mere two percent who said the quality of care had gotten better; the remaining 21 percent said patient quality remained the same.

In addition**,** UPMC respondents who indicated that they worked in an intensive care unit (ICU) were asked how frequently patient to caregiver ratios exceeded mandated standards in the last year. As shown in Table 3, nearly a third of UPMC respondents reported that ICU ratios exceeded mandated standards ***daily*** **and another third reported that ICU ratios exceeded mandated standards on a weekly basis**. Only 2 percent reported that ICU staff ratios never exceeded mandated standards.

Table 3: Share of UPMC Respondents Reporting Frequency of ICU Ratios Exceeding Mandated Standards in Last Year

Daily	Weekly	Monthly	Very Rarely	Never	n
32%	30%	18%	18%	2%	89

HEALTH CARE BENEFITS AND MEDICAL DEBT

The survey asked UPMC respondents whether they are enrolled in UPMC's health care plan. Of those who responded, 80 percent of UPMC workers reported that they are enrolled in UPMC's health care plan.

Table 4: Share of UPMC Respondents that Owe Medical Debt to UPMC, by Wage Group

Wage Goup	%
All Respondents	36%
Low-Wage Respondents	51%
Mid-Wage Respondents	34%
High-Wage Respondents	32%

Notes: Low-Wage = $20 or less per hour, Mid-Wage = $20.01-$35/hour, High-Wage = More than $35/hour

The survey also asked UPMC respondents whether they owed medical debt to UPMC. In response, more than one-third – 36 percent – of UPMC workers reported owing medical debt to UPMC. However, the proportion of low-wage UPMC workers – those who earn $20 or less per hour – is much larger than for higher wage UPMC respondents. Specifically, a majority (51%) reported owing medical debt to UPMC compared to about a third of mid-wage and high-wage UPMC respondents.

JOB MOBILITY

UPMC respondents were asked about whether they had concerns with their ability to be rehired in the future at a facility operated by their current employer if they chose to leave their current job and, most importantly, if these concerns impacted their job mobility.

Table 5a displays levels of agreement with three statements indicating various levels of these concerns and whether their job mobility was impacted by these concerns. Half of UPMC respondents indicated

that they believed that if they left their current hospital job, they may be barred from being rehired by UPMC in the future. Even more serious, over four in ten respondents altered their job seeking behavior – by not applying for jobs outside of UPMC – out of fear that they may be barred from being rehired by UPMC in the future. Lastly, 35 percent of respondents indicated they had actually declined job opportunities out of fear that they may be barred from being rehired by UPMC in the future if they left their current jobs.

Table 5a: Levels of UPMC Respondent Agreement with Rehire and Job Mobility Statements

Rehire and Job Mobility Statements	Agree	Disagree	n
I believe that if I left my current hospital job, I may be barred from being rehired by my current employer in the future.	50%	50%	372
I have not applied for jobs outside of my hospital system out of fear that I may be barred from returning to work at that system in the future.	47%	53%	405
I have declined job opportunities outside of my hospital system out of fear that I may be barred from returning to work at that system in the future.	35%	65%	380

Table 5b displays the levels of agreement with the same statements by wage category. Low-wage UPMC respondents indicated even higher levels of agreement with each of the three statements relative to high-wage respondents. In some cases, these differences were large.

Table 5b: Levels of UPMC Respondent Agreement with Rehire and Job Mobility Statements, by Wage Group

Rehire and Job Mobility Statements	Low-Wage			Mid-Wage			High-Wage		
	Agree	Disagree	n	Agree	Disagree	n	Agree	Disagree	n
I believe that if I left my current hospital job, I may be barred from being rehired by my current employer in the future.	55%	45%	77	67%	33%	163	48%	52%	119
I have not applied for jobs outside of my hospital system out of fear that I may be barred from returning to work at that system in the future.	49%	51%	73	55%	45%	164	39%	61%	109
I have declined job opportunities outside of my hospital system out of fear that I may be barred from returning to work at that system in the future.	36%	64%	69	41%	59%	147	32%	68%	109

Notes: Low-Wage = $20 or less per hour, Mid-Wage = $20.01-$35/hour, High-Wage = More than $35/hour

For example, a majority of UPMC respondents (55%) in the low-wage category expressed concern about being barred from returning to work in their respective systems if they left their current jobs, exceeding the share of UPMC respondents (48%) in the high-wage category. Similarly, nearly half of UPMC respondents (49%) in the low-wage category indicated they did not apply to jobs out of concern about being barred from returning to work in their respective systems, again shares that exceeded those of UPMC respondents (39%) in the high-wage category.

FEAR OF EMPLOYER RETALIATION

Lastly, UPMC respondents were asked about their fear of suffering negative consequences or experiencing retaliation from UPMC if they brought a safety issue to the attention of management, spoke up about working conditions, or showed support at their workplace for organizing a union. Table 6a displays the level of agreement with three statements about these concerns.

As shown in Table 6a, a majority of UPMC respondents indicated concerns that they would suffer negative consequences at work or that their employer would retaliate against them for raising safety issues to management.

Table 6a: Levels of UPMC Respondent Agreement with Employer Retaliation Statements

Fear of Employer Retaliation Statements	Agree	Disagree	n
I believe that if I bring a safety issue to the attention of management, I may suffer negative consequences at work/my employer may retaliate against me.	51%	49%	446
I believe that if I speak up about working conditions, I may suffer negative consequences at work/my employer may retaliate against me.	74%	26%	483
I believe that if I show support at my workplace for organizing a union, I may suffer negative consequences at work/my employer may retaliate against me.	92%	8%	461

Nearly three quarters (74%) of respondents indicated that they would suffer negative consequences at work or that their employer would retaliate against them if they spoke up about working conditions (74%). Most significantly, nearly all UPMC respondents (92%) believed that they may experience negative consequences or that UPMC may retaliate against them if they show support for organizing a union at their job.

Table 6b: Levels of UPMC Respondent Agreement with Fear of Employer Retaliation Statements, by Wage Group

Fear of Employer Retaliation Statements	Low-Wage			Mid-Wage			High-Wage		
	Agree	Disagree	n	Agree	Disagree	n	Agree	Disagree	n
I believe that if I bring a safety issue to the attention of management, I may suffer negative consequences at work/my employer may retaliate against me.	48%	52%	83	56%	44%	160	59%	41%	131
I believe that if I speak up about working conditions, I may suffer negative consequences at work/my employer may retaliate against me.	73%	27%	92	84%	16%	179	74%	26%	136
I believe that if I show support at my workplace for organizing a union, I may suffer negative consequences at work/my employer may retaliate against me.	89%	11%	82	95%	5%	182	95%	5%	130

Notes: Low-Wage = $20 or less per hour, Mid-Wage = $20.01-$35/hr, High-Wage = More than $35/hr

Table 6b displays levels of agreement with the same statements by hospital system and wage category. The differences were relatively minor between low- and high- wage respondents.

APPENDIX 5:

Statements of UPMC Current and Former Workers

Friday, April 14, 2023

[Redacted] Statement

I was a travel nurse with Cross Country Medical Staffing and was first contracted as a travel nurse with UPMC Altoona beginning in September 2020. My contracts were 8 and 13 weeks long and continuous from September 2020 until my contract was terminated early on May 31, 2022, without a contract payout of any kind. My contract would not otherwise have expired until June 18, and at the time of my termination, I had already signed a renewal agreement that would have employed me through September 18, 2022. I believe I was an outstanding employee. I had leadership and training roles within the unit that I was working on. I received multiple awards and commendations for my work, including Guardian Angel and Daisy Awards at UPMC Altoona.

On May 15, 2022, I was working as charge nurse on the trauma unit with four other nurses--two travel nurses and two UPMC Altoona staff nurses. Each nurse on their floor that day already had seven patients, but I saw on the "bed board" that there would be more patients incoming. I contacted the Administrator on Duty (AOD), Susy Blackstone to tell her that everyone already had seven patients. All the nurses communicated to me that they could not take an eighth patient because the workload was too great, so I texted AOD Blackstone to say that everyone each was protesting taking an eighth patient. AOD Blackstone then came up to the unit to speak with each nurse. The three patients on the bed board remained there as potential assignments.

I spoke with AOD Blackstone alone and said that my reasons for not taking an eighth patient included concerns about patient safety, the high acuity of my current patients, and the possibility of medication errors or falls which would become a problem for me. The AOD said she wanted to speak with everyone else, so I informed those nurses, but I was not present for their conversations. After these conversations, AOD Blackstone stayed on the unit, shadowing nurses, and pushing for them to take an eighth patient. AOD Blackstone informed the nurses that she turned in their names to the state board of nursing for "patient abandonment" because they refused to take another patient. I told Blackstone that abandonment was not possible because the patients were not present on the unit nor were they assumed under our care. AOD Blackstone told nurses that in that case it was a violation of UPMC policy about refusing work assignments, but she refused to cite a specific policy.

After this shift, I sent emails to the Human Resources Representative and my Unit Manager, Joyce Haney, explaining my side of the situation. I reached out to a Representative from Human Resources for Cross Country Staffing Agency at the corporate level. I also reached out to the Healthcare Pennsylvania Organizer for this unit, Gillian Kratzer. Kratzer put me in touch with HCPA's media relations representatives.

The next day, May 16, 2022, I received a 13-week contract extension offer from Cross Country Staffing that would have extended my contract with UPMC Altoona from June 18, 2022, to September 18, 2022.

On May 23, 2022, I spoke with a WTAJ report, Courtney Brown, about the staffing shortages at UPMC Altoona. That interview was part of an article that aired on WTAJ-TV news on approximately March 23, 2022.

On May 26, 2022, I texted my recruiter at Cross Country Staffing, Christine Yauneridge (a.k.a. Christine Will) to accept the contract extension. Yauneridge replied by text, saying "UPMC accepted your extension and it has been processed." It was my intention at that time to continue to work at UPMC Altoona to for the foreseeable future. I worked the Memorial Day Weekend without incident.

On Tuesday, May 31, I received a phone call from Yaunderidge. Yauneridge told me that she had received an email from UPMC terminating my contract. I asked if this was the current or future contract. Yauneridge clarified that my current contract was terminated effective immediately, as well as the new contract was terminated, and that UPMC had placed a "do not hire" on my file. Her words to me were that I was not welcome to apply for any jobs within the UPMC system. I understood this to mean I could not be hired at any UPMC facilities whatsoever. I asked if they had given a reason, and Recruiter Yauneridge responded that the only reason given was that I had "failed to follow policy," but did not

provide any specific policy.
After my termination, I tried without success to find comparable employment through Cross Country staffing. My Recruiter Yaueridge informed me that a significant volume of their work came from UPMC and the “do not rehire” on my file was corporate-wide at UPMC, not just UPMC Altoona. Yauneridge also told me that she was having a very hard time finding me non-UPMC work because almost all medical work in the Altoona area is associated with UPMC in one way or another. Yauneridge offered to refer me to Cross Country’s long distance/travel division, but long distance is not an option for me, so I declined and started seeking jobs outside Cross Country’s network.
On about June 8, 2022, I tried to apply for UPMC’s Travel Staffing program. I applied through a link on the UPMC Travel Staffing website for jobs in Pittsburgh or McKeesport. If I had been accepted I could have been placed/offered throughout UPMC network, not just Pittsburgh or McKeesport. I was initially contacted by email by Kalie Warmbein, who said I was accepted and wanted to schedule an interview. Less than two hours later, I received an automated email stating my account status had changed. When I logged into the application portal, it informed me that the application was no longer being considered. Around 10:15, I received an email message that Warmbein recalled the email offer to interview.
On July 7, 2022, I began working at Penn Highlands hospital in the oncology department. This was a 98-mile roundtrip from my home and the closest work I was able to find after having my contract terminated by UPMC. By September 2022, I was able to find work through the Geisinger healthcare network, and I have been working in Wilkes-Barre, which is 165 miles one-way from my home. I am still working in this position.

Signature

[Redacted]

Date Friday, April 14, 2023

Sunday, March 26, 2023

[Redacted] Statement

[Redacted] worked in the GI Lab at UPMC Presbyterian for 17 Years. Previous to that he worked as a Patient Care Technician, starting at UPMC in January 2000 making 22 years of service in total. Early on in his career at UPMC [Redacted] felt like he was the target of many racist actions from management and co-workers. This mistreatment really ramped up when [Redacted] began supporting the unionization effort in 2012, so much so that coworkers, nurses, and doctors across the GI Lab signed onto a letter supporting his work ethic and value to the team in response to retaliation from a manager. The manager was finally fired. However, the cycle repeated itself and in early 2022 [Redacted] started noticing that his pattern of obvious mistreatment was negatively impacting his mental health, and he decided to put in his two weeks' notice. Almost immediately after giving notice, his supervisors stopped talking to him, and he heard from his coworkers that they were explicitly told not to have a goodbye party and cake for him. Although he finished his two weeks without incident, UPMC sent a letter in July 2022, after he had left UPMC, informing him that he was terminated, even though he had quit voluntarily. [Redacted] no longer has the letter.

In November 2022 [Redacted] decided to get back into healthcare and applied at UPMC's biggest competitor, Allegheny Health Network (AHN). He applied in November 2022, was offered an interview within a week, accepted the job, and started December 22, 2022. He makes roughly $6 more per hour at AHN Wexford as a brand new employee than he did at UPMC after close to two decades.

[Redacted] wanted to see if UPMC would ever hire him again or whether he would be barred from being rehired, so in December 2022 and January 2023 he applied to jobs he's qualified for at other UPMC hospitals in the area. In most cases he received rejection emails within a few hours, stating they've "decided to move on with another candidate." He did get a phone call from UPMC's Human Resources office offering him an interview in January 2023 and was told he should expect to receive an email with the zoom link, but he never received an email or link and was never interviewed. He believes in this last case UPMC started to reach out to him but then realized this was a mistake because he was on their "do not rehire" list and this is why they just didn't follow up.

Signature [Redacted]

Date Sunday, March 26, 2023

Monday, March 27, 2023

[Redacted] Statement

I have worked as a nurse at UPMC Presbyterian for 1 year. Before that I worked in the medical field for 5 years.
Many of my coworkers have some fear of retaliation. People are afraid because you can find a way to fire someone if you want. And then, what if you aren't able to come back to any UPMC hospital? I've heard a lot of people say "I don't want to burn this bridge". The majority of your options in Pittsburgh are through UPMC. If you want to work at a big hospital, you basically need to work at UPMC. If you want to work at a trauma center, there's only one option that's not UPMC.
Because I fear retaliation I can't share additional details, but I once spoke up about an unsafe staffing situation and shortly thereafter started being given the worst assignments. I was tripled - meaning I was given 3 patients when the standard is 2 patients - on 5 out of 6 shifts, when I had only been a nurse for around 6 months.
This kind of retaliation affects my decisions. I also worry about speaking out about the unfair treatment because I think "well, if I leave on a bad note here, they won't let me come back as casual". So I believe if I don't stay on good terms and I leave, I won't be able to come back because I'll be blacklisted. If I ever want to work in the area - which is where I am from – I can't be on bad terms with UPMC. It impacts your decisions.
This is the opposite of what our profession is supposed to be. It makes staff members miserable, and makes it harder to care about your patients. It's hard to have passion for nursing, when you're beaten down and don't have enough support.
I love nursing. I am very passionate about my job. But when I was being treated like that, I was so defeated. I did what I had to do to be able to go home. I couldn't go above and beyond. I was so beaten down, I was only able to do the minimum. Good care comes from being treated well.

Signature [Redacted]

Date Monday, March 27, 2023

Monday, March 27, 2023

[Redacted] Statement

I work as a Registered Nurse at UPMC McKeesport. Prior to this I worked at Braddock Hospital starting in 1982, before UPMC even owned Braddock, but I had to leave when UPMC closed Braddock in January 2010, and then I came to work at McKeesport.

When UPMC bought Braddock in 1996, they really came in and turned things on its ear. After UPMC bought Braddock, we were way more often short staffed on a medical-surgical (med-surg) unit. On the 3 p.m. to 11 p.m., shift there were 35 beds and 2 nurses. It was a family hospital, and it became a corporate hospital. That was before there even was a "nursing shortage." We were so short-staffed that we couldn't even start charting till after midnight and often didn't leave until 2-3 in the morning.

The year before they closed Braddock, 2009, my son was working at Commonplace coffee shop at IUPUI and would pick up shifts at their Penn Ave shop. He said that one day in the spring there were a whole bunch of UPMC attorneys in to get coffee who were talking about how they were going to close Braddock. A few months later UPMC had a big town hall where they reassured everyone that everything was fine, they weren't going anywhere. Then in November that same year I turned on KDKA radio and heard that UPMC Braddock was closing and that's how I found out. They weren't going to tell us until after Christmas because they didn't want to ruin anybody's Christmas.

Over the next couple of months, Dan Onorato came out with architect drawings for what they'd do with the Braddock building and the surrounding campus, now that it was closing. He spoke about how great it was going to be for the community, We knew then how long they had known because those drawings take at least six months to draw up.

I don't know how many millions of Allegheny tax dollars they used to build a new entrance at Braddock. UPMC also bought new windows, and they got about a third of them in when it was leaked to the press that they were closing. They never bothered to finish the job of installing them. They just closed and boarded it up on January 30th. They had a small amount of time before they closed when UPMC had other systems come through and tag physical materials like IV poles etc. Like selling us off for parts, like they did with the staff.

UPMC told us that we could apply to any opening within the system but I am pretty sure I was discriminated against because I was an officer in the union at Braddock. OPEIU represented the nurses at the Braddock hospital. I applied to 12 jobs. I got four interviews, but then two of those I never heard back from. Magee and St Margaret got back to me but said the jobs went to "someone more qualified" in the same day surgery unit. I worked in CCU and I was technically qualified, but they said they found an internal applicant who they wanted. I think they didn't want me because I was very involved in the Union.

UPMC brought the manager for the McKeesport observation unit over to Braddock and called several of us down to do an interview. It was clearly planned and it sure did feel like they knew who they were going to take over to McKeesport. I knew some people that bid into St Margaret, Shadyside, and a couple other places. Those folks might have been union supporters but they weren't officers like I was. I feel my prospects were affected by my involvement in the union.

My last day at Braddock and my first day of McKeesport were pretty close. The job I wound up getting wasn't one of the jobs that I applied to, it was in the new observation unit they opened up: You come in, you get tested, and if your tests are negative then you go home. If there are issues then we keep you on

the unit. They mostly came in through the ER, chest pain, diabetics, mostly. For billing and cost savings it does make sense, for community safety it also makes sense. Allows us to move folks through the system and not clog the ER, but keep folks safe. We started out with 12 beds, two nurses and a secretary. We ended up getting folks that needed more direct care, and more bedside care. We started seeing folks who had strokes, chest pain, and they progressively expanded this unit.

They transferred 10 nurses and a handful secretaries from Braddock to the new observation unit at Mckeesport. All of us nurses that transferred there were strong with the union. Even though most of us had critical care experience, it felt like we weren't going to get a job anywhere else. Now only two of us are left. One died, one is on permanent medical leave, a couple retired, some work casual. Val and I are the only ones left.

McKeesport was already unionized so when we went over there we had to figure that out. There were three of us with 28 years of experience and we were hired at the 15-year rate, where we got a $1 increase. We will never reach that top tier rate. It's a 3-4 dollar difference and we'll just never get there.

If UPMC fires you for something, especially if it was their fault, they don't want to hear from you ever again. For example, we had a guy who came from another state. He and his family moved to Pittsburgh after he graduated Nursing School. He went to a testing center and took his boards. In the state he came from, you could work for one year as a graduate nurse before you pass your test. In Pennsylvania if you fail your boards, you can't work as a graduate nurse until you pass. Whatever he did, he didn't pass them; he told his manager, he told his clinician, they didn't take him off the schedule. In July/August he took them again, and same thing, he didn't pass. He told his manager, he told his clinician and they brought him in for a conversation. I was present on the phone and they explained to him that he had been deceptive by working without a license. It was their fault, not his because he self-reported. They said that he was not meeting UPMC standards, etc. The meeting was to discuss the process and what happened with him.

At the end of the meeting I asked them to summarize and I repeated it back to them: I said, "You hired him in December, he reported that he wasn't passing his boards. You let him continue to work. He failed his boards again, self-reported again. And now you're firing him for deception? How are you all not responsible?"

He's got some sort of lawyer now and is pushing back because his termination letter will get in the way of him doing work in the market. He's blacklisted from UPMC, and that letter will get in the way of him getting his PA licensure.

We had a Labor Management meeting a few months ago, and we were talking about what other systems are doing like AGH raising their start rate to $30 an hour. UPMC's attorney told us that UPMC has 90,000 employees in Pennsylvania and that if UPMC increased everyone's wages, it would be detrimental to the economy of all of Pennsylvania and that other health care systems look up to UPMC for guidance. That was right before I got COVID, that's why I remember it so well.

Lastly, I'll just say: I'm near retirement, and I do fear retaliation for sharing all of the above information. Please use my story with discretion.

Signature [Redacted]

Date Monday, March 27, 2023

Monday, April 10, 2023

[Redacted] Statement

I began working as a staff nurse at UPMC Presbyterian in February 2018, in the 5G/Neuro Trauma Step-down. I later began working as a nurse in 6F/G which is the Trauma ICU. Around March of 2021, I noticed conditions for patients and staff were going from bad to what I felt were wildly unsafe. Unable to stand by and watch my coworkers struggle to keep up with the demands of management, I decided to reach out to my unit director. I was met with the same old story that I'd heard before-- that hospital administration took our concerns seriously and was working on solutions. In typical UPMC fashion, nothing changed and after six months, I knew it was time to move on from my role for the sake of my mental health.

On September 22, 2021, I resigned my position on 6F/G after giving two weeks' notice. When I resigned, I sent an email to upper management detailing problems on the floor that I felt put patients in danger and staff at grave risk, including severe understaffing and lack of management and supervision, which resulted in some egregious issues with patient care.

I believe that as a result of my email to management, I was blacklisted. Before my resignation, I had arranged with the Doug, unit supervisor of the Surgical ICU (which is now CTICU), to take a "casual" position in his unit, where I had previously picked up overtime. He verbally confirmed I would get the position about one week before I sent the email, saying it would just have to be processed through HR but everything was ready to go.

However, about a week after I sent my email, around September 29, 2021, I was told by Doug that the position was no longer mine, and he said to me, "you aren't allowed to work for UPMC anymore."

I thought maybe it was just Presbyterian Hospital, so about a week after sending the letter I interviewed for a casual position at UPMC East, and was told "HR will be reaching out, it's yours." But I called HR three times after this and they never responded.

To make matters worse, I also found out that my former coworkers were being threatened with termination if they spoke with me. Unfortunately, this sort of behavior by UPMC is not unique to my situation. There are other former employees who have dealt with the exact same thing.

My experience getting blacklisted from UPMC totally disrupted my career plans and changed my trajectory. I had planned on going to get certified as a Nurse Practitioner (NP) and become an NP on Doug's [CTICU] unit. After I resigned and then was blacklisted, I decided to work as a travel nurse. I had to work as a travel nurse because I was on the Do Not Rehire list. It was never my intention.

I can't have children while traveling. I pay my own insurance. I absolutely would have preferred to stay. But I have had to make this move, to travel nursing, and now I am working far away in Seattle. This has upended the course of my career and even my life.

Other people have told me they were also afraid they'd get fired and then be put on DNR lists, so they didn't speak out. I know people who stay at UPMC just because they're cornered and they have to. I have friends who can't afford to lose their insurance, they are literally trapped there.

It is hard to work at UPMC for other reasons. When you work there, you have to accept their insurance and see their doctors, and the insurance is terrible. You pay for so much. I had a friend who had to pay 1700 dollars for an ultrasound, even though she is a UPMC employee. It got significantly worse in my

time there. I went from paying a $10/copay to having to use Good Rx because otherwise I would have had to pay $50-75 dollars. It's their insurance, their hospitals, their employees. It's like being a coal miner back in the day — only being able to use the money you make at the general store.

The email to management follows this statement.

Signature

[Redacted]

Date Monday, April 10, 2023

Statement of Dr. [redacted]

Dr. [redacted] moved to Pittsburgh in 1999 and attended both college and medical school there; she views Pittsburgh as her home. She decided while in medical school that she wanted to work as a gynecologist who provided specialized gynecological care including reproductive health services, abortions, and treatment and care for transgender people. She completed her internship at Cleveland Clinic and her residency at Johns Hopkins. Treatment and care of transgender people was not covered in her medical school so she taught herself this specialty.

She took a job as a gynecologist in September 2013 at University of Pittsburgh Medical Center (UPMC) Magee Women's Hospital as an employee of United Pittsburgh Physicians, an affiliate of UPMC, as her first job as a doctor out of medical school after her residency. When she agreed to be employed she knew she was also agreeing to a non-compete agreement; she also believed virtually all doctors are subject to non-compete restrictions.

The non-compete agreement to which Dr. [redacted] was subject at UPMC required that she provide 6 months' notice prior to leaving her position at UPMC, and that after leaving the position she was prohibited from practicing obstetrics or gynecology services within Alleghany County for 12 months from her date of separation. [redacted] was also prohibited from communicating with her patients before or after she left the position. The contract further provided that if Dr. [redacted] violated the non-compete provision, UPMC was entitled to enjoin her from working and to liquidated damages.

At UPMC Magee, [redacted] provided gynecological services, complex family planning including abortions, and trans-care. When she began her job, there were seven doctors, including her, who provided these services. Although there are many doctors in the Magee Women's Hospital who provide gynecological services, the hospital decided that only this group of seven doctors could perform emergency abortions and other emergency gynecological services. As a result the seven doctors were required to effectively be on-call every night and weekend, and wound up working an average of one night per week and one weekend every six to seven weeks, without additional compensation in the form of paid time off or pay.

The situation was worse by 2017 because four doctors had left, so [redacted] was one of only three doctors performing these services. As a result she and her colleagues were on call once every three evenings and every third weekend, again without any additional compensation. There are many doctors at Magee Women's Hospital who are capable of performing the services [redacted] and her two colleagues performed, but the hospital refused to require any other doctors to perform these services, resulting in [redacted] and her two colleagues together being required to cover all such patient issues that arose on evenings and weekends. [redacted] noted that all of the doctors providing the after-hours gynecological care were women, and her supervisors who made the decision that only three women doctors should provide emergency gynecological care were all men, as were many of the doctors who were exempted from evening and weekend on-call work.

Around 2018, [redacted] requested that UPMC either pay her additional money, give her additional paid time off, or assign additional doctors to be available on evenings and weekends for emergency abortions and similar emergency gynecological services. UPMC refused. Her supervising doctors at the hospital

knew that she felt strongly about providing reproductive health care and related gynecological care to patients, and told her that if she was “really pro-choice” she would be willing to work all of the extra hours. As a result [redacted] had to continue to work every third evening and every third weekend in addition to a full time daily schedule. If she was called to the hospital in the middle of the night, which happened regularly, it meant that she was often working a full week in which she had stayed up all night one night or even two and then also had to cover weekend shifts. She believes that this not only was unfair to her, but unfair to patients because she could have been too tired to provide the compassionate care that her patients deserved.

Starting in 2017, [redacted] wanted to leave her job at UPMC because of the uncompensated work, but she delayed doing so for three or four years because of the non-compete restriction. Specifically, she was extremely concerned that many patients had come to rely on her services, in particular transgender care, and was concerned some patients might not be willing to see other doctors and receive the care they wanted or needed. As stated above, [redacted] was prohibited from informing her patients she was leaving before she left (or notifying them afterwards); she also knew that once she was gone, if patients asked the office where she had gone the office was instructed to say they did not know. She fully complied with the non-disclosure provisions of her contract but feels a lot of guilt about leaving her patients without telling them anything.

Eventually [redacted] decided that because of the conditions at UPMC she either needed to work at a different health care facility or stop practicing medicine. In 2022 she decided to take a job at Alleghany Health Network (AHN) at a clinic in Beaver County. She notified UPMC at the end of April 2022 she intended to leave by August 31, 2022. At the time she did not realize she was require to give six months’ notice before leaving. Rather than stay an additional two months until October 31, [redacted] agreed to be subject to the non-compete restrictions for 14 months after her departure instead of the usual 12 months. She left UPMC on August 31, 2022. Accordingly she is prohibited from working as a doctor within Allegheny County until after August 31, 2023.

[redacted] began work at the Alleghany Health Network (AHN) Beaver County clinic on or about October 3, 2022. She currently works there providing gynecological and complex family planning services, as she did at UPMC. Her working conditions and compensation are significantly improved: She earns 50% additional pay, and works only 4 days a week and no evenings or weekends. One reason [redacted]’s pay is higher is that AHN regards [redacted] as a specialist. UPMC refused to recognize [redacted] as a specialist and her compensation reflected that, even though UPMC effectively treated her as a specialist by refusing to have any other general acute care doctors perform the treatment that she and her two colleagues performed. This is evidence that UPMC was substantially underpaying [redacted] for the work she performed.

However, as a result of the non-compete restriction, [redacted] has to commute between 1.5 hours and 3 hours each day (45-90 minutes each way) compared to her 12-18 minute one-way commute to UPMC. If she were permitted to work at the AHN hospital in Pittsburgh in Alleghany County, she would have an even shorter commute of 1.5 miles. She pays a substantially greater amount for care of her dogs because of her longer commutes and believes that if she had children the cost of child care would be exorbitant or unaffordable.

In addition, [redacted] made the difficult decision not to perform surgeries for her current patients. This is because the nearest AHN hospital where she is permitted to practice under the terms of the non-compete agreement is in Grove City, which is two hours away from where she lives. She is concerned that if she performed surgeries in Grove City and a patient later had complications, she would not be able to get to those patients in a timely way. The hospital has other doctors, but only on an emergency basis and patients would not receive from [redacted] the full range of care she provided while at UPMC.

[redacted] is also concerned about the impact on her prior patients. She believes some of them may not seek care because she is no longer their doctor. A few prior patients have found her and started seeing her, but in order to do so they either had to switch insurance plans or pay substantially more out of pocket for treatment from her now that she works for AHN; in addition they have to travel much further.

PHYSICIAN EMPLOYMENT AGREEMENT

A. NATURE OF AGREEMENT

THIS IS AN EMPLOYMENT AGREEMENT ("Agreement").

University of Pittsburgh Physicians ("UPP") is the Employer.

[redacted] M.D. is the employee ("Physician").

B. REASONS FOR AGREEMENT

UPP is a group medical practice which employs faculty physicians. UPP is affiliated with UPMC, a Pennsylvania nonprofit corporation. UPP employs other faculty physicians to provide patient care at UPMC Hospitals, satellite facilities, Children's Hospital of Pittsburgh, and at other hospitals, facilities and locations in Allegheny County and surrounding counties ("community").

UPP seeks to retain the services of Physician in order to better serve the health care needs of the community.

Physician is being recommended for a faculty appointment at a rank to be determined by the University in the Department of Obstetrics. Gynecology and Reproductive Sciences (the "Department") of the School of Medicine ("School of Medicine") of the University of Pittsburgh (the "University").

This Employment Agreement is intended by UPP and by the Physician to be a binding legal agreement, and for that reason they have exchanged certain promises as described in the following terms and conditions. References herein to "Department Chair" shall refer to the UPP clinical department chair, who is the highest management level UPP employee in the Department and who is, by definition, the academic Chair of the Obstetrics. Gynecology and Reproductive Sciences Department of the School of Medicine of the University of Pittsburgh.

C. TERMS AND CONDITIONS OF THE EMPLOYMENT RELATIONSHIP

1.0 EMPLOYMENT

UPP employs Physician and Physician hereby accepts employment from UPP, beginning September 15, 2013, or other mutually agreeable date (the "Effective Date") for the period of time agreed upon by the parties and stated in Section 8.0 below. Physician acknowledges that a precondition of starting employment hereunder is Physician's successful completion of a pre-employment health assessment, the components of which have been communicated to Physician in writing.

2.0 PHYSICIAN'S DUTIES

2.1 Physician agrees to make an exclusive commitment of his/her clinical efforts to UPP, except for clinical efforts otherwise approved by the Department Chair. Physician's clinical duties include but are not limited to services in the specialty of Gynecological Oncology, ambulatory care services, teaching fellows and residents, providing on-call coverage, caring for hospital patients, participating in quality improvement, utilization review, making inventions related to the health care field or to the Physician's other duties, and/or such other duties assigned from time to time within the Department Chair's sound judgment. The amount of clinical time required of Physician under this Agreement shall be determined in the discretion of the Department Chair, taking into account Physician's teaching, research and other obligations as a faculty member and employee of the University. Academic duties including academic time will be set at the discretion of the Chair acting under the supervision of the Dean of the School of Medicine. Physician will not be required to perform duties which are contrary to appropriate medical practice or contrary to the best interest of any patient, and Physician shall be free to exercise independent medical judgment in a manner consistent with approved methods and practices in Physician's profession and in the best interest of the patient.

2.2 Physician is required to provide appropriate medical, time, financial and/or other records about the professional services made by him/her under this Agreement consistent with UPP's policies, Joint Commission standards, the Medicare program and other payors, and by law. All such documentation shall belong to and be maintained by UPP.

2.3 Consistent with the charitable purposes and policies of UPP, Physician may be expected to give medical treatment to persons in need of care without regard to their ability to pay for medical care. Physician will provide medical care without regard to whether his/her patients can pay the costs of medical care through private health insurance, or with the help of public programs such as Medicare and Medicaid.

2.4 Physician must obtain and maintain the following credentials throughout the period of time (s)he is employed by UPP:

2.4.1 An unconditional license (also known as a license without restriction) to practice medicine in the Commonwealth of Pennsylvania and any other state as required by the Department Chair;

2.4.2 full active or consulting medical staff membership with privileges at certain hospitals identified and approved by the Department Chair. Department Chair's advance approval will be required in order for the Physician to apply for and maintain medical staff appointments and privileges at any hospitals other than those identified by Department Chair;

2.4.3 a faculty appointment in the Department of Obstetrics, Gynecology and Reproductive Sciences of the School of Medicine of the University of Pittsburgh;

2.4.4 registration with the Federal Drug Enforcement Administration (DEA) which permits Physician to prescribe controlled substances without sanction, restriction or limitation. A sanction or restriction shall include, among other things:

2.4.4.1 revocation or termination of physician's DEA registration;

2.4.4.2 any other type of disciplinary or corrective action taken;

2.4.4.3 the imposition of a monetary fine by the registering authority;

2.4.4.4 any reprimand or monetary fine or penalty imposed by such authority.

2.4.5 good faith efforts to participate and maintain participation status with all medical insurance carriers or managed care programs in which UPP is enrolled, including, among others, Medicare, Medicaid, Blue Cross/Blue Shield insurance programs and UPMC Health Plan and/or other UPMC affiliated-programs, and any others as required by UPP;

2.4.6 present appropriate documentation to establish that physician is permitted to work in the United States of America consistent with the regulations of the United States Citizenship and Immigration Services, and

2.4.7 within ninety (90) days of Effective Date, obtain and maintain clearances issued by the responsible state and/or federal authorities certifying that Physician has not been named in the central register as a perpetrator of a founded report of child abuse committed within a five (5) year period immediately preceding Effective Date.

2.5 To remain an employee of UPP, the Physician is required to read, and agrees to be legally bound by, the following rules and policies in all material respects:

2.5.1 UPP's Corporate Compliance Plan, including all practice and documentation standards. Physician agrees that (s)he may be assessed and required to pay financial fees under UPP's Compliance Plan if (s)he fails to meet UPP's Compliance Plan standards;

2.5.2 the intellectual property policies of UPMC, including but not limited to the UPMC Intellectual Property Policy;

2.5.3 the operating standards and other policies established by UPP as well as by the Department Chair; and

2.5.4 the applicable bylaws, medical staff bylaws, rules and regulations of all hospitals where Physician is a staff member.

2.6 Physician's faculty appointment is subject to University policy. Physician must follow the policies of the University and other agreements between UPP and the University. If this Agreement ends for any reason, Physician agrees that his/her University faculty appointment may end and/or not be renewed in the University's discretion, under the University's policies.

2.7 UPP will be the only entity with the right to bill for services Physician provides to patients of the physicians employed by UPP. Physician will follow UPP's procedures regarding patient billing and will sign any agreements required to create an assignment (in other words, transfer of ownership of patient or other revenues) from or create any contractual relationship with any insurance companies, third-party payors or managed care entities. Physician agrees to take all reasonable actions requested by UPP to assist in the collection of accounts receivable for services provided by Physician.

2.8 Physician represents that (s)he is not currently subject to, or threatened with, any investigation, censure, probation, suspension, or other adverse action with respect to his/her medical license in any jurisdiction or with respect to his/her medical staff privileges at any hospital, nursing home or other institution. To the best of his/her knowledge, Physician is not currently under investigation with respect to his/her participation in the Medicare or Medicaid programs. Physician shall notify UPP immediately if (s)he becomes subject to such investigation, censure, probation or suspension.

2.9 Physician must notify UPP, in writing, within twenty-four (24) hours following notice of any incident which in the reasonable judgment of Physician might lead to a liability claim against Physician or UPP, lead to a lawsuit, or in some other way might affect insurance coverage provided under this Agreement. UPP will likewise notify Physician within twenty-four (24) hours of any incident involving Physician that in its reasonable judgment may result in a professional liability claim against Physician.

3.0 PHYSICIAN'S SCOPE OF COMMITMENT

3.1 Commitment. Physician shall devote his/her professional clinical time, skill, energy and attention to being an employee of UPP and recognize that Physician shall devote his/her professional academic time, skill, energy and attention to duties as an employee of UPP and as a faculty member of the University of Pittsburgh. Physician's clinical schedule will be set by the Department Chair, who shall take into account Physician's teaching and research obligations, if any, as a faculty member of the University. The only exceptions to Physician's exclusive commitment of clinical effort for UPP must be in writing and consented to in advance by the Department Chair.

All monies received for professional services (with exceptions as defined as approved "outside work" in Section 3.2 below) provided by Physician, including, without limitation, all medical practice involving patient care or clinical skills, as well as all UPP patient-related legal testimony, clinical consulting, medical practice administrative services, and independent medical examinations, shall be for the account of UPP. The only exception to this exclusive commitment of Physician's work to UPP shall occur when the Department Chair consents in advance in writing to a different arrangement.

3.2 Outside Work. "Outside work" is defined as clinical, medical and/or teaching activity, including related consulting activities, by Physician on behalf of anyone other than UPP and/or the University of Pittsburgh.

3.2.1 Retention of Fees for Approved Outside Work. For approved outside work, (such as honoraria for speaking engagements, royalties, publication revenues, consulting, record reviews or legal testimony unrelated to a patient of UPP; UPMC; Children's Hospital of Pittsburgh; UPMC Health Plan or any of their owned entities or affiliates; payment for teaching at an educational institution other than one affiliated with the University of Pittsburgh, UPMC or related affiliated hospitals), the Physician may collect and retain such fees.

3.2.2 Advance Approval. All outside work, including serving as a medical expert for legal purposes, must be approved in advance by the Department Chair. All outside work activities must comply with UPMC policy, including but not limited to Policy on Conflicts of Interest and Interactions between Representatives of Certain Industries and Faculty, Staff and Students of the Schools of the Health Sciences and Personnel Employed by UPMC at all United States based Locations. The Department Chair may withhold or revoke approval of outside work, in accordance with UPP's policies and procedures, at any time.

3.2.3 Disclosure Requirements. Physician must disclose the nature and income of all outside work to the Department Chair in accordance with UPP's disclosure and conflict of interest policies. Such disclosures include but are not limited to wages paid to Physician by the U.S. Department of Veterans Affairs and any non-UPMC hospital during Physician's employment by UPP.

3.2.4 Physician shall not use any facilities, staff, equipment or other resources of UPP, UPMC, the University or any of their affiliates in performing outside activities permitted under this Section 3.0 (including permitted outside activities set forth in Section 3.0).

4.0 COMPENSATION. For the services and duties described in Sections 2.0 and 3.0 above, UPP will pay the Physician compensation as described in this Section, below.

4.1 UPP Base Salary. To earn the annual base salary amount set forth in Exhibit A, Physician must perform all of the duties in this Agreement and in the attached Exhibit A. If Physician is employed less than a full calendar year, the annual base salary amount will be prorated. If Physician does not meet the minimum mandatory clinical productivity requirements set forth in Exhibit A, UPP may in its sole discretion reduce the UPP base salary amount paid to Physician. Such reduction, if any, may be implemented no more often than once per contract year, and shall be implemented prospectively upon ninety (90) days written notice to Physician. The adjusted base salary amount shall be commensurate with Physician's clinical productivity, as determined by UPP.

4.2 UPP Annual Incentive Salary. Physician will be eligible for the incentive salary plan identified on the attached Exhibit A. The incentive salary plan is determined in the sole discretion of the Department Chair in accordance with UPP guidelines. To be counted in the calculation of any Department incentive salary program, patient services must be medically necessary, be properly documented, and be consistent with any utilization review, case management, best practices or similar guidelines adopted by UPP. Department's incentive salary program shall include both clinical and academic productivity.

4.3 UPP Payroll Practices. Base salary and incentive salary are payable according to the normal payroll procedures and on the payroll schedule established by UPP. Physician will be paid base salary payments on at least a monthly basis. Incentive salary payments, if any, will be paid on a schedule to be determined by UPP and the Department Chair, but not less frequently than annually. UPP may, in its sole discretion, change payroll procedures at any time, and shall notify Physician of such changes as far in advance as is reasonably practicable under the circumstances. UPP shall report and deduct from all salary payments all required local, state and federal taxes and withholding amounts.

4.4 UPP Fringe Benefits and Pension Plan. Physician shall be entitled to participate in certain UPP fringe benefit and UPP pension benefit plans which are generally provided to all of the other UPP physician employees subject to the terms and conditions of such plans. Part-time or casual physicians' eligibility for UPP fringe and/or UPP pension benefits is limited consistent with the terms and conditions of each plan. UPP may, in its sole discretion, change these benefits programs at any time during any contract year, and shall notify Physician of such changes as far in advance as is reasonably practicable under the circumstances.

4.5 UPP Total Compensation. The total annualized amount of UPP compensation paid to Physician for the initial Contract Year covered by this Agreement, including base salary, incentives/supplemental salary/administrative salary (if any), professional liability insurance premiums, UPP fringe and UPP pension benefits costs, shall not exceed the annualized rate of Four Hundred Fifty Eight Thousand Two Hundred Eighty Three Dollars ($458,283), under any circumstances. The total compensation limit for future contract years, if applicable, shall be determined in accordance with available market data for similarly-situated professionals and consistent with then-current IRS Guidelines.

4.6 Compliance with Law. If UPP determines that the amount or manner of the compensation or any other benefit provided to Physician under this Agreement becomes in violation of rules, regulations or reimbursement policies of any third-party reimbursement program, any federal or state statute, rule or regulation, or administrative or judicial decision, or jeopardizes UPP's tax-exempt status, UPP may, at its option, reduce the amount paid or change the terms of this Agreement to the extent necessary such that it no longer violates the same or jeopardizes UPP's tax-exempt status. If UPP reduces the amount paid or changes the terms of this Agreement for the reasons described in this paragraph, Physician shall have the option of terminating the Agreement by giving written notice to UPP.

5.0 PROFESSIONAL LIABILITY INSURANCE. In Pennsylvania, physicians must carry professional liability insurance in amounts prescribed by law.

5.1 Beginning on the Effective Date of this Agreement, UPP shall carry and pay the premiums for professional liability insurance for Physician or, instead, UPP shall provide self-insurance, through an affiliate with occurrence-based coverage for Physician, as determined by UPP. UPP will only provide for professional liability insurance to cover services provided by Physician within the scope of employment by UPP. (Physician's scope of employment is described above in Section 3.1.) UPP will not provide professional liability insurance coverage for activities which are considered outside work, either approved or unapproved, and for which Physician directly retains fees. UPP will make reasonable efforts to participate in the defense of all professional liability claims.

5.2 Coverage terms and the amount of any deductibles for such insurance, if any, will be in UPP's sole discretion and Physician agrees to be responsible for payment of a portion or all such deductibles, pursuant to then-current UPP policy. Insurance coverage will meet Commonwealth of Pennsylvania limits.

5.3 Physician will sign and deliver in a timely fashion any and all applications, forms and documents concerning the professional liability insurance as UPP requests during the term of this Agreement or after this Agreement ends.

6.0 RELATIONSHIP TO PATIENTS AND RECORDS

All patients for whom Physician provides medical care are the patients of UPP with respect to all other matters. All patients seen by Physician during his/her employment with UPP and all patients seen by other employees of UPP are the patients of UPP in the same manner. All patient records shall at all times belong to and remain in the custody and control of UPP in UPP's or a hospital's premises unless reasonably required for patient care or specifically authorized in writing to be removed from said premises by UPP's President.

7.0 CONFIDENTIAL INFORMATION

7.1 Definition. All business information relating to UPP, UPMC or its affiliates, their employees and operations, specifically including information created by or revealed to Physician during his/her employment, shall be considered confidential UPP information. For purposes of this Section 7.0 and its subparts, confidential UPP information shall include only information designated as "confidential" by UPP Confidential UPP information shall not include information that is available to the public generally, in the public knowledge or available because UPP has disclosed it without confidentiality restrictions. Confidential UPP information does not include patient medical records. Patient records are subject to the separate legal requirements of patient confidentiality, however.

7.2 Disclosure. While employed by UPP or anytime thereafter, Physician will not disclose to any third-party or use for any purpose adverse to the interests of UPP any confidential UPP information. Disclosure of confidential UPP information may only occur with the written authorization of UPP's President or as required by law.

7.3 Access. UPP alone will decide if Physician shall have access to confidential UPP information, and Physician's access shall be limited to confidential information needed to carry out Physician's duties and obligations under this Agreement. No confidential UPP information shall be removed from UPP's premises or from UPP's custody and control unless reasonably required for patient care or unless UPP's President or his/her delegate specifically authorizes Physician in writing to remove such information from the premises.

8.0 TERM AND TERMINATION

8.1 Term. The initial period covered by this Agreement is two (2) years, nine (9) months and fifteen (15) days from the Effective Date. Physician's continued employment under this Agreement can be changed or ended as described in the termination provisions of this Agreement. The initial Contract Year shall be September 15, 2013 through June 30, 2014; thereafter, each twelve (12) month period beginning on July 1, will be referred to as a "Contract Year". This Agreement will automatically renew for successive one-year periods unless otherwise agreed upon or unless a written notice of non-renewal is provided to Physician, on or before 105-days prior to the termination date of the Agreement. The initial term of this Agreement will end on June 30, 2016.

8.2 Automatic Termination. Physician's employment with UPP will end without UPP or Physician taking any further action if and when any of the following events occur:

8.2.1 Physician's death; or

8.2.2 Revocation or suspension of the Physician's license to practice medicine in the Commonwealth of Pennsylvania or any state as required by the Department Chair; provided that if Physician's license or certification has been fully reinstated to Physician, UPP may consider reinstating this Agreement under its original terms or under such other terms as agreed upon by the parties. In no event will this Agreement automatically renew as described in Section 8.1, however, during or after a revocation or suspension period.

8.3 UPP's Immediate Termination for Cause. UPP shall have the absolute right at any time to immediately terminate Physician's employment for cause by giving written notice to Physician if any one or more of the following events related to Physician happens:

8.3.1 Physician materially fails to comply with any provision of Section 2.4 or 2.5 of this Agreement, provided Physician has been provided an opportunity to cure said material failure, when appropriate as determined by UPP, in accordance with Section 8.4 of this Agreement;

8.3.2 Physician is expelled, suspended or disciplined by any professional licensing or certifying body or a specialty board; provided that if Physician's license or certification has been fully reinstated to Physician, UPP may consider reinstating this Agreement under its original terms or under such other terms as agreed upon by the parties. In no event will this Agreement automatically renew as described in Section 8.1, however, during or after a revocation or suspension period;

8.3.3 Physician commits gross professional misconduct or gross professional negligence;

8.3.4 Physician fails to pay to UPP all monies belonging to UPP within fifteen (15) days of Physician's receipt of such practice monies, if in the determination of UPP, the failure to pay UPP was deliberate or gross negligence;

8.3.5 Physician's participation in the Medicare or Medicaid program is revoked or suspended; provided that if Physician is reinstated in such program, UPP may consider reinstating this Agreement under its original terms or under such other terms as agreed upon by the parties. In no event will this Agreement automatically renew as described in Section 8.1, however, during or after a revocation or suspension period;

8.3.6 Physician resigns from any professional medical organization after being threatened with disciplinary action for professional misconduct;

8.3.7 Physician's faculty appointment with the University of Pittsburgh School of Medicine ends, either due to resignation, non-renewal or termination; or

8.3.8 Physician commits fraud; misappropriation, embezzlement or is convicted of a criminal offense other than a summary offense.

8.4 UPP May Terminate Physician's Employment for Cause after Providing Him/Her an Opportunity to Cure. UPP may terminate this Agreement by giving thirty (30) days written notice to Physician if there is a material violation of any term or condition of this Agreement which can be reasonably cured and which remains uncured for thirty (30) days after Physician receives written notice of the violation. The written notice of violation must contain a description of the violation.

8.5 Physician May Terminate Physician's Employment:

8.5.1 For Cause After Opportunity to Cure. Physician may terminate this Agreement by giving thirty (30) days written notice to UPP if there is a material violation by UPP of any term or condition of this Agreement which remains uncured for thirty (30) days after receipt of written notice of such violation. The written notice of violation must contain a description of the violation.

8.5.2 Upon Written Notice. Physician may terminate this Agreement without cause by giving no less than six (6) months written notice to UPP unless a shorter notice period is mutually agreed upon by both parties.

8.6 Other Terminations. This Agreement shall end if the following events occur:

8.6.1 UPP may, in its sole discretion and consistent with UPMC disability accommodation policy, decide to terminate the Agreement by giving written notice to Physician, if in the event of the Physician's disability, whether physical or psychological or otherwise, which is of such a nature that Physician is unable to perform the essential functions of his/her employment. The decision to end the Agreement in these circumstances will be in UPP's reasonable and good faith judgment, taking into account whether Physician is eligible for leave under UPMC policy and, in such case, whether Physician has exhausted family medical leave, as calculated pursuant to UPP policy, during any rolling twelve-month period, and the essential functions of Physician's job will include his/her duties as described in this Agreement, with or without reasonable accommodation. During any such leave period, Physician's compensation shall be discontinued during the time Physician does not perform his/her duties hereunder (except for any sick leave or disability plan benefits including, if applicable, health plan premiums, or workers' or unemployment compensation benefits applicable to such time period), and Physician shall not accrue vacation or sick leave during such period of disability. UPP will engage in an interactive process with the physician and will make reasonable accommodations for Physician's disability in accordance with applicable laws and UPMC policy; nothing in this Agreement is intended to violate or supersede the definitions and/or requirements of the Americans with Disabilities Act.

8.6.2 If Physician's medical practice falls materially below the standard of medical care required of licensed and board-certified Gynecologists practicing in the Commonwealth of Pennsylvania, UPP may end the Agreement under the following procedure. UPP must give Physician notice in writing that UPP believes that Physician's medical practice is below standard for a licensed and board-certified Pennsylvania Gynecologist. If Physician fails to bring his/her methods of practice up to such standard or standards within sixty (60) days after UPP gives Physician this written notice, UPP may end the Agreement. If Physician wants an outside review of his/her performance, (s)he will have ten (10) business days from UPP's 60-day notice to demand a review of his/her performance by a licensed, board certified Gynecologist who practices in the Commonwealth of Pennsylvania or by a physician with recognized expertise in quality assurance and utilization review, as the case may be, acceptable to both Physician and UPP. UPP shall pay for the cost of such review, which shall be completed within thirty (30) days of the giving of said notice. If the reviewer determines the Physician's performance is below the applicable standard, Physician shall have the opportunity to correct his/her performance within the balance of said sixty (60) day period and to have the reviewer re-examine his/her performance at the end of the sixty (60) day period. If the reviewer determines that Physician continues to practice below the applicable standard, Physician's employment shall terminate ten (10) days after the expiration of said sixty (60) day period. Any such review shall be separate and distinct from any reviews otherwise conducted as part of the normal medical staff credentialing or quality assurance processes of UPP or an affiliate of UPP.

Regardless of this procedure, if UPP determines in good faith that continued practice by Physician during said sixty (60) day period would jeopardize the health, safety or welfare of UPP's patients, then UPP may suspend

Physician with pay during such period while awaiting the determination of the reviewer(s) and no opportunity to cure shall apply if the reviewer(s) determine that continued practice would jeopardize the health, safety or welfare of UPP's patients.

8.6.3 If Physician's medical practice falls materially below the standard of medical care required by the National Committee on Quality Assurance or its successor or any comparable managed care organization accrediting body or the standards set out by the Medicare Peer Review Organization with jurisdiction over the Commonwealth of Pennsylvania at such time, the same procedure described in subsection 8.6.2, above, applies.

Regardless of this procedure, if UPP determines in good faith that continued practice by Physician during said sixty (60) day period would jeopardize the health, safety or welfare of UPP's patients, then UPP may suspend Physician with pay during such period while awaiting the determination of the reviewer(s) and no opportunity to cure shall apply if the reviewer(s) determine that continued practice would jeopardize the health, safety or welfare of UPP's patients.

8.7 Covenants Regarding Adverse or Competing Conduct

This section addresses conduct by the Physician not based on medical judgment. In exchange for the compensation, fringe benefits and other related overhead and development costs UPP is paying to Physician or on Physician's behalf, Physician agrees that during the period of time (s)he is employed by UPP and for a period of one (1) year immediately following the end of this Agreement, Physician will not directly or indirectly do any of the acts described in subsections 8 7.1 through 8.7.4 below, unless (s)he has the written authorization in advance of UPP's Department Chair and the UPP President.

8.7.1 recruit or solicit any patient of UPMC to seek or receive medical care from any person, group or corporation that is not then employed or owned by UPMC;

8.7.2 interfere with or attempt to disrupt the relationship between UPMC and any of its patients;

8.7.3 interfere with or attempt to disrupt UPMC's relationship with other entities with which UPMC does business; and/or

8.7.4 recruit or solicit an employee or "borrowed servant" (including an employee who has been loaned to UPMC by the University or any other employer) of UPMC to end his/her relationship with UPMC or to become self-employed or employed by or in association with the Physician.

Physician agrees that the covenants in this subsection 8.7 apply following the voluntary or involuntary separation of Physician's employment with UPP. Physician is not prohibited during employment with UPP from referring patients to receive medical care from providers not affiliated with UPP or UPMC if in the medical judgment of the Physician such is in the best interest of the patient, the patient expresses a preference for a specific provider, or the patient's insurer determines the provider.

8.8 Post-Termination Covenant

8.8.1 Physician further agrees that for a period of one (1) year immediately following the end of Physician's employment with UPP, Physician, either on his/her own account or on behalf of another whether in the capacity as an employee, partner, owner or in any other capacity whatsoever, will not practice Obstetrics/Gynecology on an inpatient or outpatient basis, within Allegheny County and a radius of ten (10) miles from any principal location from which Physician provides Obstetrics and/or Gynecology services during the term of this Agreement. For purposes of this Section, a principal location is defined as one or more locations at which Physician has worked thirty percent (30%) or more of his/her clinical time, not including time scheduled in the operating room or on call, including in-house and pager call, during the term of the Agreement, including any extensions and or renewals thereof.

8.8.2 Remedies. Physician acknowledges and agrees that a violation of the covenants in Section 8.7 and 8.8 will cause irreparable material and adverse harm to UPP, meaning that UPP cannot be adequately compensated in damages, and that actual monetary damages arising from such breach may be difficult to ascertain. Therefore, in addition to any other remedies at law or equity for such breach, Physician agrees that UPP at UPP's sole discretion shall:

8.8.2.1 have the right to an injunction enjoining Physician's breach of such covenant. An injunction is a legal order of court forbidding the Physician from the act of violating the Agreement; and

8.8.2.2 direct Physician to pay UPP as stipulated, or liquidated, damages for any breach of such covenant a sum equal to the greater of

8.8.2.2.1 net collected revenues generated by Physician and collected by UPP over the Physician's last twelve (12) months of employment with UPP; or

8.8.2.2.2 the total cash and non-cash compensation, fringe benefits, other related overhead and development costs paid to or on behalf of Physician or the solicited employee or borrowed servant by UPP during the Physician's or solicited employee's and/or borrowed servant's last twelve (12) months of employment with UPP.

8.8.3 Reasonableness of Covenants - Physician has read and understands this Agreement. Physician has had the opportunity to review this Agreement with his/her advisor(s) prior to execution of the document. Physician agrees that the covenants contained in Subsections 8.7 and 8.8 of this Agreement are reasonable and necessary to protect the legitimate business interests of UPP.

8.8.4 Independent Nature of Covenants - Each covenant contained in this section is read or construed as independent of any other provision of this agreement or any other agreement. The existence of any claim, dispute or cause of action of Physician against UPP, whether predicated on this Agreement or otherwise, will not constitute a defense to the enforcement by UPP of any covenant.

8.8.5 Survival Beyond Agreement - Physician acknowledges and agrees that it is reasonable and necessary that each covenant contained in this Section 8.0 and its subparts will continue in full force for a period of one (1) year following the termination or expiration of this Agreement for any reason.

8.8.6 If any provision in this Section 8.8 is deemed by a court to be unenforceable because of its scope in terms of territory, time or business activities, but that court determines that it may be enforceable by reducing or limiting the scope of the covenant, then the court may make the necessary reductions or limitations so that this Section 8.8 of the Agreement shall be enforceable to the fullest extent permissible under the laws and public policies applied in the jurisdiction in which such court sits.

8.8.7 Physician agrees that the covenants in this subsection 8.8 apply following the voluntary or involuntary end of Physician's employment with UPP.

8.9 Dispute Resolution. For terminations effectuated prior to the originally defined termination date of this Agreement (as defined in Section 8.1), under Section 8.0 and its subparts, and for disputes between UPP and Physician concerning the interpretation of Section 8.7 during the one-year period immediately following the end of this Agreement, Physician may appeal the UPP decision in accordance with UPP's internal grievance procedure provided Physician provides written notice of his/her election to appeal within thirty (30) days receipt of Physician's notice of separation from employment from the employer.

9.0 Physician's Representations that this Agreement Does Not Interfere with Other Contracts. Physician represents and guarantees to UPP that (s)he is not breaching any pre-existing or co-existing agreement between Physician and another Employer or any other person or entity by entering into this Agreement. None of the following acts by the Physician will breach or violate any other contractual obligation of the Physician:

a) Physician's signing of this Agreement;

b) Physician's entering into an employment or professional relationship with UPP; or

c) Physician's performance of any duties or obligations under the terms of this Agreement.

As an employee of UPP, Physician will not enter into any agreement, either written or oral, which would be in violation of or in conflict with this Agreement.

9.1 Indemnification for Claims by Prior Employers, Associations, Patients. Physician agrees to indemnify UPP if any prior employer, co-employee, hospital at which Physician had privileges, School, Association or patient brings any kind of claim or action for loss, damages, injuries, suits, proceedings and/or judgments against UPP due to:

9.1.1 the termination of Physician's employment with any prior employer;

9.1.2 Physician's employment by UPP;

9.1.3 Any professional or other action or inaction on the part of Physician prior to Physician's employment with UPP; or

9.1.4 Physician's use of any skills, knowledge, materials or information in the scope of his/her employment with UPP which are, may be considered to be or are alleged to be a breach of any other agreement or legal duty or in violation of any law.

Physician's indemnification of UPP is an obligation to restore fully any loss created by any of the liabilities, claims, actions, losses, damages, injuries, suits, proceedings and judgments, including all costs, expenses and reasonable counsel fees, paid by UPP to resolve the matter(s) described in subparts 9.1.1 through 9.1.4 above.

10.0 OPERATIONS

The parties hereby agree that the day-to-day operations of UPP will be conducted in the sole good judgment of UPP, and according to UPP's Bylaws and policies now, or hereafter effective.

11.0 CONTRACTS

Physician shall have no authority to contract for or obligate UPP in any way unless the Board of Directors specifically gives such authority to Physician in writing.

12.0 GENERAL PROVISIONS

A. Severability and Reformation. The provisions of this Agreement shall be severable. In other words, if any portion of this Agreement is held to be unlawful or unenforceable, the contract is not dissolved but instead the remaining terms and conditions will remain in effect.

B. Assignability and Successors. This Agreement requires the personal services of Physician, and no portion of this Agreement may be assigned or delegated by Physician. The obligations of Sections 6 and 7, and their subparts, of this Agreement shall be binding upon the heirs and/or personal representative(s) of Physician, meaning that the obligations regarding the ownership and maintenance of records and confidentiality of business information continue to be binding on the estates and heirs of Physician. In the event of an alleged breach of Section 6 or 7 of this Agreement, the heirs or estate of Physician shall not be liable for damages, but shall be liable only for specific performance in the form of return of medical records or other documents containing confidential UPP information. UPP may assign all or any part of its obligations or rights under this Agreement, including the post-termination covenants set forth in subsections 8.7 and 8.8 (including subparts), above, to an affiliate of UPP or UPMC, and all rights and obligations of UPP shall automatically be vested in any such assignee.

C. Survival Beyond Agreement. Physician agrees that the obligations of Sections 5.0 (Professional Liability Insurance), 6.0 (Relationship to Patients and Records), 7.0 (Confidential Information) and 8.0 (Term and Termination) of this Agreement and their subsections will survive the end date of this Agreement because in each of those Sections there are specific promises that extend beyond the time period of the Agreement itself.

D. Governing Law. This Agreement will be governed by the laws of the Commonwealth of Pennsylvania without regard to the choice of law provisions of Pennsylvania. Any action or lawsuit brought to enforce or interpret this Agreement shall be brought only in federal or state court having jurisdiction and sitting in Allegheny County, Pennsylvania.

E. Amendments. No amendments, changes or additions to this Agreement will be binding upon either UPP or Physician unless reduced to writing and signed by both parties.

F. Notices. Any notice or other communications required or permitted under this Agreement shall be sufficiently given if sent by certified mail, return receipt requested, postage prepaid, to the addresses set forth below or such other addresses as may be furnished in writing by any such party. Such notice or communication shall be considered to have been received by the addressee on the earlier of the date received or on the date three (3) business days after the date notice was actually mailed.

If to UPP:

Chair, Department of Obstetrics, Gynecology
and Women's Health
University of Pittsburgh Physicians
2225 Magee-Womens Hospital
Pittsburgh, PA 15213

Vice President, Administration Services & Physician Relations
University of Pittsburgh Physicians
9035 Forbes Tower
200 Lothrop Street
Pittsburgh, PA 15213

If to Physician: The address set forth on the signature page.

With a copy to: [redacted]

G. Access to Records. If this Agreement is subject to the provisions of Section 1861(v)(I) of the Social Security Act, 42 U.S.C. § 1395x(v)(I), or the valid regulations issued thereunder, Physician agrees to make this Agreement, and any books, documents and records then in Physician's possession and control that are necessary to verify the nature and extent of the payments made by UPP hereunder, available to the Secretary of the U.S. Department of Health and Human Services, the U.S. Comptroller General, or their duly authorized representatives, upon written request made within four (4) years after the furnishing of services hereunder. Physician shall immediately notify UPP in the event of any request for any such information.

H. Integration. This Agreement contains all agreements between UPP and the Physician. By signing this Agreement, both UPP and the Physician agree to do what the Agreement says. Nothing which UPP said to the Physician orally, or the Physician has said orally to UPP changes the terms of this Agreement. This Agreement supersedes and takes the place of all prior agreements and negotiations, either oral, written or implied. This Agreement may be modified only by an agreement in writing signed by both parties.

I. Waiver. If either UPP or the Physician refrains from acting on any breach of this Agreement, the decision to so refrain in one instance shall not impair that party's rights to enforce the Agreement with respect to any other breach of the Agreement.

J. Approval and Signature of UPP. The parties to this Agreement acknowledge and understand that this contract is not binding on UPP until and unless the contract is approved and signed by the UPP President.

IN WITNESS WHEREOF, the parties have executed this Agreement effective as of the date above written.

University of Pittsburgh Physicians

By: [signature]
Name: Steven D. Shapiro, M.D.
Title: President
Date: 8/15/13

By: [signature]
Name: W. Allen Hogge, M.D.
Title: Chair, Department of Obstetrics, Gynecology And Women's Health
Date: 7/18/13

[redacted] M.D.

[signature]
Name:
Date: 8/5/13

Address for Notices: [redacted] Pittsburgh, PA [redacted]

UNIVERSITY OF PITTSBURGH PHYSICIANS
DEPARTMENT OF OBSTETRICS, GYNECOLOGY
& WOMEN'S HEALTH
Division of Gynecologic Specialties
EXHIBIT A for [redacted]
September 15, 2013 through June 30, 2016

I EFFORT AND PRODUCTIVITY REQUIREMENTS

The concept of the productivity standard is that the Physician is compensated with the expectation that Physician will perform at a level sufficient to contribute to the departmental goals and sufficiently generate revenue. Physician shall perform services consistent with the standards of practice established by the Department of Obstetrics, Gynecology & Women's Health, including but not limited to the requirements outlined below.

BASE SALARY

Minimum Mandatory Clinical Productivity Requirements

- Physician agrees to devote a minimum of 80% effort to providing clinical services in the Division of Gynecologic Specialties. This level of clinical effort equates to 4 days per week.

Clinical Requirements

- Physician's clinical time will include coverage of the private office, outpatient clinics, operating room, and other clinical assignments as determined by the Division Director and/or the Department Chairman.
- Additionally, Physician will participate fully in the Division of Gynecologic Specialties night call rotation and the Family Planning on-call rotation.
- Attendance at 90% of division meetings (not counting vacation or academic travel days), unless otherwise excused by the Division Director.
- Physician agrees to provide such office coverage, on call availability, and other services as may be reasonably requested by the Department Chair, or his/her designee.
- Physician is expected to be a productive team member of the Division of Gynecologic Specialties, which implies that Physician put team effectiveness and quality of care before personal preferences. Likewise, this means that Physician accept the clinical protocols as established by the Division and that Physician's behavior does not disrupt the smooth operation of the office, the clinic, or the in-patient setting.
- Attend and participate in academic conferences unless committed to other academic duties.
- Appropriate and timely charting and coding for hospital and practice medical records. Appropriate and timely is defined as "within 24 hours of event."
- Timely completion of billing material and chart notation.
- Timely dictation of operating cases, outpatient visits and processing of discharge materials.

- Physician will be active in the educational mission of the department commensurate with his/her effort allocation.
- Physician will be active in the research mission of the department commensurate with his/her effort allocation.
- Duties will be assigned and/or altered consistent with Section 2.1 of the Physician Employment Agreement.
- Participates in all Annual Training Requirements for Physician/Faculty.
- Full compliance with the UPP Compliance Plan annual training requirements and all internal and compliance audits.
- OSHA, Patient Safety, Bio-Terrorism Training (and any others as mandated by Corporate during the course of the fiscal year) to be completed within the established timelines.
- Maintaining a current unrestricted PA medical license, DEA certificate, Medicare & other third party payor provider numbers as deemed necessary by UPP.
- Completion of the SOM/UPP Annual Faculty Performance Evaluation within established time frame and maintaining a minimum overall rating of Satisfactory.
- Completion of the MWH/UPMC Time Allocation Form quarterly and other similar departmental or hospital forms within established time frames.
- Execution of an individual UPP employment agreement; signed and updated contract amendments (if applicable).
- Meet State Board of Medicine CME requirements – Over 2 year period, proposed requirements are: 20 hours of Category 1
  10 hours of patient safety/risk management (Category 1 or 2)
  70 hours of Category 1 or 2

II COMPENSATION (amount stated as annual rate based on a twelve month year)

Total Base Salary: $ 130,000

Incentive Salary: Physician is eligible to earn incentive salary not to exceed an annual rate of Thirty Six Thousand Dollars ($36,000) based on participation in the Gynecologic Specialties Divisional Incentive Plan. For the period September 15, 2013 through June 30, 2014, Physician's minimum annual incentive salary rate shall be at least Ten Thousand Dollars ($10,000). If Physician is employed less than a full year, the guaranteed annual incentive amount will be prorated.

Supplemental Salary: In UPP's sole discretion, Physician may receive supplemental salary for moonlighting services or providing call coverage, or other approved activities. For purposes of Section 4.5 of the Agreement, Supplemental Pay/Administrative Supplement (if any), shall be included in the calculation of total compensation.

9/11/13
UPP Review/ Date

Appendix 6:

Testimony of UPMC Workers
Pittsburgh Hospital Workers Task Force Hearing
September 26, 2022

Testimony of Ian Saunders

Hello, my name is Ian Saunders. I work as a host in the Food and Nutrition Department at UPMC Presbyterian. I meet with patients and make sure they have the nutrition they need - when they need it - to heal. Because my job takes me all over the hospital, I see what's happening everywhere. I gotta tell you, things are not good.

We're underpaid, overworked, and undervalued so people don't stay long. I've been here for just eleven months, and already I'm an old-timer because our turnover is so high.

So far, I've seen more than ten people get hired and quit. Sometimes they work part of a shift and quit because everything is so crazy. People are so stressed out they're crying through their shifts. I've begged people to stay; talking them through tough days, only to come back the next week and find out they walked out over the weekend. Every time someone quits, it makes things harder for the rest of us - workers and patients.

We're all trying to help the patients and our co-workers throughout the hospital but we physically can't do it all when management pulls us every which way.

People get upset when it takes too long to get their food at a restaurant, but in a hospital the timing really matters.

For example, patients who need dialysis have to have their meals before their four-hour procedure. If the schedule is off because we're being pulled to service other floors or being pulled to work the food line, some patients can go eight to twelve, or sometimes even 16 hours without a meal. That is not ok. That should not happen. It doesn't need to happen. UPMC is making that choice.

When we ask management for help, they don't take our input. They tell us they're desperate and that no one wants to work, but don't take any responsibility for the things they do that make people leave. This is the kind of turnover you see at temp jobs. Maybe it's good for UPMC's profits, but it's not good for us or for our patients.

We know we're caring for someone's mother, father, child, or brother or sister. We take that seriously so we end up killing ourselves to cover up management's lack of care and responsibility to our patients. It doesn't have to be this way. We deserve better and our patients deserve better.

Testimony of Quincy Shlosser

My name is Quincy Shlosser. I have worked as a Patient Care Technician on the surgical oncology and GI unit at Montefiore since 2019. Thank you for giving me the opportunity to speak today.

My job is hard. Physically, mentally and emotionally. You can't be squeamish working on the oncology unit. We are treating patients who are in one of the worst times of their lives. They are dealing with the terror of cancer or the pain of GI surgery. Even though challenge is the norm, short staffing should not be. On my unit, one PCT can be expected to care for up to 24 patients. This is a nightmare scenario. You receive a cascade of calls. When you are responding to the first call, you receive another; then you have to abandon THAT call to deal with an emergency situation. By that time, I've already lost an hour and a half. You are drowning. You can't treat your patients as human beings. They are only their medical issues or room numbers. Recently I was able to address a long term patient's personal concerns beyond just her physical needs. It was humanizing for her and it reminded me why I originally wanted to be a caregiver. But that glimpse of hope quickly disappeared when I had to run off to the next patient.

I used to have a positive outlook on what this job could mean for my career development. I don't have that anymore. A lot of my coworkers feel the same way. Again and again, they see the futility of expressing their frustration with our higher-ups. Nothing happens. They don't listen to us and workers know what happens if you keep pushing. They continue to let us suffer, accepting the turnover rates, the burnout rates as the norm. They are ok with the acceptability of chewing up people and turning our healthcare system into a gig economy.

It's no surprise then that caregivers are burning out and leaving the field. The field of bedside care is dying. It used to be that nurses would want to stay there for their entire careers because they earned enough to take care of their families and were given the support they needed. But every year it gets worse and worse. Decisions from the top make it harder and harder to find reasons to stay.

Short term solutions are band aids. The only solution is to allocate funding toward wages and staffing to attract people to stay. We need the resources to hire staff nurses instead of pushing all the funds toward travel nurses. The unit ***must*** have adequate staffing with caregivers who have experience treating cancer patients. You can't expect travel ENT or cardiac nurses to show up and succeed. It's pretty simple, if you have issues attracting staff, pay them better. Adjust to the market and reality we live in. We need to drastically change how we treat healthcare workers if we are going to keep our system afloat. Instead of accepting that 93% of caregivers want to leave, give them reasons to stay. Instead of squeezing every last drop from us, treat us like human beings. This is the only way we are going to create sustainability in our healthcare system.

Thank you.

Testimony of Mo Gordon, RN

Hello, my name is Mo Gordon and I'm a former staff nurse at Presby. I worked at the hospital for nearly three-and-a-half years before resigning in late 2021. I served in several different roles including charge nurse and as a preceptor, responsible for training nursing students. My last two years at UPMC Presbyterian were spent in the Trauma ICU, where things went completely off the rails during the COVID-19 pandemic.

I spent my time in the Trauma ICU as a bedside nurse. Around March of 2021, I noticed conditions for patients and staff were going from bad to what I felt were wildly unsafe. Unable to stand by and watch my coworkers struggle to keep up with the demands of management, I decided to reach out to my unit director. I was met with the same old story that I'd heard before – that hospital administration took our concerns seriously and was working on solutions. In typical UPMC fashion, nothing changed and after six months, I knew it was time to move on from my role for the sake of my mental health. In September of 2021, I put in my notice and I reached out to upper management for the final time to express my worries over conditions in the Trauma ICU. I went public with my concerns shortly after.

I later accepted a casual position back with UPMC but shortly before my start date, management went completely dark, not returning my calls or emails. I reached out to my former unit director and found out through them that I had been blacklisted – not to be rehired at any UPMC facility. To make matters worse, I also found out that my former coworkers were being threatened with termination if they spoke with me. Unfortunately, this sort of behavior by UPMC is not unique to my situation. There are other former employees who have dealt with the exact same thing.

Since leaving UPMC, I've started a new assignment as a travel nurse. I never had any intention of traveling, in fact, I intended to stay at Presby long-term and eventually become a Nurse Practitioner. But the conditions I witnessed caused me to rethink my career plan and it's safe to say my time at Presby has changed the trajectory of my entire life.

The way UPMC operates doesn't work for staff or patients. Instead of using their powers for good, UPMC uses their influence as the largest employer in the region to scare workers into silence by threatening their jobs and shadow banning them from working at any other UPMC facility ever again. But we're here today and won't be silent anymore.

Thank you.

Testimony of Jackie Stange, RN

Hi, my name is Jackie Stange, I have been an RN for about 7 years. I've spent the last 5 of them in the Emergency Department at UPMC Presbyterian.

Most people who go into nursing aren't doing it because of the money, they're doing it because they feel like they have a calling to it.

I am a third generation nurse. Becoming a nurse is one of the greatest things I have ever done.

When I first started, I was so proud to be working at Presby [UPMC Presbyterian Hospital] in a Level 1 trauma center. I would tell everyone — I work with the best team of physicians and nurses, I learn something new every day, I love what I do.

But all of that has changed. In my seven years of nursing, staffing has never been this bad.

The emergency room has become one of the largest in-patient departments in the entire hospital. Patients are spending days on end in ED beds because there are not enough beds due to staff shortages in every single department.

When a majority of our beds are filled by what should be inpatients, we run out of beds for emergency department patients. That means we have to start putting patients in hallways.

Just last weekend, I was the primary trauma nurse in the ED. Our check-in list in the waiting room was four hours long, techs were crying, patients were lining the halls, and then we had a cardiac arrest patient come in. We had no open beds.

These kinds of days used to be exciting. They were so few and far between, you almost got a rush from it. But now it's every single day.

We're already firing on all cylinders, and then we're getting three more traumas. When your staff is overworked like this, they're going to miss something. The stress is detrimental, and my coworkers and I leave feeling completely devastated.

Our patients don't deserve this. No one does.

We work at one of the biggest and best hospitals in the city — we should have the resources we need to care for our patients.

I want to make a change for future nursing generations.

My own daughter has said she wants to be a nurse or a paramedic. Two years ago that would have made me so proud. But now, the thought of her getting into the field breaks my heart. No one should have to experience this. We need to make this right for future generations of nurses and for the well-being of our patients.

Thank you.

Testimony of Dana Duncombe

Hello, my name is Dana Duncombe, and I am an Outpatient Social Worker at UPMC Magee-Women's Hospital. I have been in my current position at Magee for a year and a half.

In my role, I assist patients in navigating their perinatal period by promoting their access to community resources and supports such as housing, food, supplies, transportation, and mental health services. I focus specifically on higher-risk pregnancies, as well as abortion care.

I am humbled by and passionate about working with patients to explore how we can collaboratively meet their multifaceted needs with integrity and creativity. It is difficult to do this, however, when we are chronically understaffed and under-resourced at UPMC.

Within my first year at UPMC, one coworker left their position, along with two managers and my long-term director. The managerial position has yet to be filled. This gap has left me feeling persistently unsupported and has negatively impacted both me and the patients I serve.

For example, earlier this year, two members of our four-person team were out for nearly two weeks–doubling my workload. I covered extra units without supplemental support or compensation, frequently missed lunch, and worked longer hours. I had less time with each patient or missed patients altogether. While patients will continue to direct their journeys through healthcare, a missed social work consultation can sometimes result in a delayed surgery due to a lack of transportation or foregone prenatal testing for fear of upfront cost. The stakes could not be more real for people's health and medical decision-making.

The expectation for social workers to step up, do more with less, and maintain quality is concerning. My large caseload and lack of meaningful managerial support have at times contributed to a crushing sense of self-doubt, anxiety, and exhaustion–only worsened by hospital leadership telling me that my job is "easy and controllable" compared to inpatient settings.

Working under these conditions is not sustainable. I fear that the sense of urgency and need to "triage" crises result in social workers reaching for quick, often outdated solutions rather than having the space to evaluate how we can best respond to our patients' needs. Without the time to reflect and innovate–and without the support of experienced supervisors to guide that reflection–we risk replicating oppressive and racist care practices. Meaningful change comes from intentionality, a luxury we are not afforded in our fast-paced, understaffed work setting.

Ultimately, when social workers are not adequately staffed and supported, our patients are delaying life-affirming medicine or being deprived of services. We desperately need adequate staffing, resources, and a voice to advocate for our patients and profession–especially within hospital leadership committees and in the rooms where decisions about our patients and work responsibilities are made. UPMC must do better for us and our communities. Thank you.

Testimony of Sarah Smith

Good afternoon, my name is Sarah Smith. I am a Speech and Language Pathologist at UPMC.

Speech Language Pathologists, like many others in the field of healthcare, are widely undervalued. Many people don't really understand what we do — the mentality is that because we don't do the "life-saving work," it must be easy. It's not.

SLPs play a critical role in patient care — from providing therapy and education to diagnostic testing to helping inform and make surgical decisions in the OR.

The work is highly demanding and highly technical. The state of PA requires by law that I have a master's degree to practice in this field.

I trained for seven years to be in this position. I feel like I was built for this, I love my job, I get to help people.

It's hard to describe, but when you love what you do — when you really love your job — it is so fulfilling. You're excited to go to work, learn new things, and use the skills and knowledge you dedicated years to developing to help improve people's quality of life. It feels incredible.

But no matter how much I love the work I, just like many of my coworkers, am being pushed away from it.

I have invested so much into this career, into being able to help patients. Last year, I was in the top 20 percent of the country for continued education in my specialty.

For reference, my brother-in-law works at Costco and makes just as much as me, with no degree and better healthcare and retirement benefits. Right now, I don't know if I will ever be able to retire or pay off the loans I took out to get here. If nothing changes, I am planning to leave the field.

If hospitals aren't going to compensate people in this specialty appropriately, no one is going to see this as a viable career for themselves, and fewer people will pursue it. Fewer speech pathologists means fewer patients have access to the quality-of-life care they deserve.

For many patients, this can be the difference between eating and drinking after treatment or getting nourishment from a tube in their stomach for the rest of their lives. For others, it makes the difference in their ability to share a glass of champagne at a wedding or sit quietly while everyone else celebrates.

We help to educate and prepare patients who may have to permanently lose their ability to speak. Patients without this education and intervention, often come out of surgery feeling something was stolen from them and bitter about their outcome.

While the hospital will still "run" without us, patients will suffer immeasurably.

When you fail to invest in your workforce, you're failing to invest in patients. Patients shouldn't have to suffer because hospitals are unwilling to do what it takes to ensure they have access to the care they need.

Testimony of Kya Humphries

My name is Kya Humphries, I have been working as a Patient Care Technician at UPMC for about a year now, but I began my journey as a caregiver almost eight years ago caring for my father.

I am really passionate about providing quality patient care. However, it's incredibly hard to do when every single person involved in care is stretched to their breaking point.

When we're providing care without enough staff, we know patients aren't getting meals on time or waiting too long to use the bathroom. We know that more falls will happen. We know we're not going to be able to provide the kind of care that we want to. That's not fair to the patients, and it's not fair to the workers who are doing everything they can to give their patients the best care they can.

When I have to step away from work to start crying because I see how you're treating people, there's a problem.

On top of all of this, we are not paid enough for the type of work that we do. Despite the essential role care techs like myself play, many of us are barely making enough to make ends meet.

Right now, I am making about $1800 a month. Rent is $1175, I have a car payment and utilities, and a family. Often, I will drive for Uber to make sure I can meet all my essential expenses.

I am delivering a vital service to my community; I shouldn't have to take another job to pay my rent. I can honestly say that if it weren't for the landlord I have who works with me through this, I would probably be homeless.

What's worse is I can't even afford UPMC's employee health insurance plan, I have to get my insurance through the state.

I work for an incredibly wealthy health care company and I can't afford their insurance.

Why would anyone stay at this job when it puts their ability to care for their family in jeopardy?

If you want to keep people, if you want to recruit people who care about this job and are ready to do it well — you need to pay them.

Testimony of Gracie Mauro

Hello, my name is Gracie and I am a Pittsburgh native who studies at the University of Pittsburgh. I have been a PCT with UPMC since I was eighteen. As soon as I graduated high school in June 2020, I entered the workforce. I was extremely motivated to be a part of a company who performed 'Life Changing Medicine' and be recognized as a healthcare hero working on the frontlines of Covid. As a representative of the next generation of healthcare workers, I was eager to just be a part of it all. However, as months went on, the eagerness for each shift turned into anxiety.

The only way I can conceptualize the mindset that I have going through a 12-hour shift reminds me of the five stages of grief. Denial, Anger, Bargaining, Depression and Acceptance.

The first stage is denial. I want to believe that I am making a difference. I want to believe that this company is invested in me, as much as I am invested in it. I want to believe that if I just work hard enough things will change.

I then experience the second stage, anger. At UPMC, quality and safety are two of the core values. It is our responsibility as healthcare workers to keep our patients safe while delivering individualized quality care. It seems that recently more responsibility is placed on existing staff to make up for the lack of staff which in turn leads to a decrease in both quality and safety of care. When a patient falls—even with all fall precautions in place—it is simply because there was no one available to physically be with that patient. It is extremely frustrating that the expectation is for us to be everywhere at once.

The third stage is bargaining. After years of critically low staffing and low wages, we are pleading for change. The only way to retain staff, boost morale, and prevent future burnout is by recognizing the strength it takes to work at the bedside and compensate appropriately. With these changes in place, we could be more united than ever, but without them the foundation will eventually crumble.

The last two stages are depression and acceptance. From 7-7 whether day or night, every worker depletes all of their physical and emotional energy by giving patients compassionate care. These feelings of burnout and depression were catalyzed by the pandemic but were always present before it. Burnout causes you to feel like giving up on this job and this field in general.

I am here today as an advocate for change and a better future for UPMC. This company has always created life changing medicine as well as set the standard of innovation and excellence. We, as the frontline workers, are the ones who implement and execute this vision in everyday practice. UPMC has a reputation as one of the most successful healthcare systems nationwide and I think it is time that success applies to every employee.

Testimony of Meredith Amour, RN

Hi, my name is Meredith Amour. I've worked as a Registered Nurse for seven years at Montefiore [part of UPMC Presbyterian]. Thank you for allowing me to speak with you today.

I want to share my experience with how staffing has changed for the worse and the impact it has had on patients and nurses. When I first started, each nurse was responsible for four patients. This was especially important for our step-down patients because they require a high degree of monitoring. For the last year and a half, that number has risen to six patients per nurse and there's talk of raising it to seven.

We simply wouldn't have time to assess our patients properly with seven-to-one ratios. Already, we don't have the time to participate in daily rounds, which allowed us to have a deeper understanding of patients' needs. Now, because of short staffing, we're reduced to a reading a post-it note on our medicine cart.

We know at Mercy nurses are expected to care for eight or nine patients. These are sick people, in Level 1 Trauma centers. I worry that patients aren't getting the level of care we want to provide for them. Many people aren't even getting bathed as soon as they should. It's not just about medicine, it's also about patients' dignity.

Our mental health is suffering. I am one of the happiest nurses on the floor, and I've seen it take a toll on everyone, including me. I became a nurse to help people and now I go home every single day knowing my best wasn't good enough. Twice a week, there are nurses crying in the hallways in front of patients. It's embarrassing. My Unit Director is forced to work six or seven days a week. Everyone is so mentally drained.

We have people who have been there seven or eight years, and every single one of them are months away from leaving. It's becoming too much for everyone.

You're not just doing your job anymore. You're doing pharmacy and physician's work. We are not being paid for all the jobs we are doing.

Low pay is creating a revolving door of nurses. Travel nurses make three times what a bedside nurse makes and there's no continuity of care.

We have tried to address grievances with our supervisors. We have sent direct emails to our higher ups asking, what's the plan? But we never get a response.

Staffing shortages create a culture of people detached and disconnected. Instead of offering us 50 dollar visa gift cards or pizza parties, we need management to respect us, staff us, and invest in us. We need better pay and we need to have our voices heard. It is the ONLY way to change the culture and heal our broken system. If we continue to be ignored, I'm concerned of what the implications will be for all of us.

Testimony of Joanna Neikirk

Hello, my name is Joanna Neikirk and I'm a NICU RN at UPMC Children's Hospital. I've known that nursing was my calling since I was 12 years old, and even then, I knew I wanted to care for babies. I've been at Children's for over a year, and since then the conditions I've endured are bad enough to turn what was once my dream job into a nightmare.

In my department, we care for the newest and most vulnerable humans you can imagine – preemies, babies who survive complicated births, and some with debilitating conditions. These special patients require a level of care and attentiveness that we often struggle to provide due to chronic understaffing in the NICU.

In my year plus at Children's, I've seen countless nurses come and go. From my initial orientation group, I'm the only one still working at the hospital and we've even had senior nurses leave because of the overwhelming pressure. Some leave for the promise of higher wages as an agency nurse, but most leave due to burnout from unreasonable workloads.

My coworkers and I have brought our concerns about patient safety to our unit managers but have been met with combativeness and inaction in most cases. With no formal grievance procedure in place to resolve workplace issues, our pleas for change are easily ignored by upper management. I don't cry after *every* shift, but the frustration I feel for myself and our patients leaves me in tears more often than not. My job has tested my resolve as a caregiver, but has also pushed me to fight for a voice for nurses and our patients.

Working and living through the pandemic has taken a toll on everyone, and UPMC's failure to support the mental well-being of their workforce has made the already stressful nature of life in the healthcare profession amid a global health crisis almost unbearable. Knowing 93% percent of the city's hospital workers have considered leaving their jobs, Pittsburgh's healthcare systems have nowhere to hide from the reality of our situation.

The most upsetting part of UPMC's ongoing refusal to invest in staffing and a healthy work environment is their disregard for the people that depend on us most – our patients.

Providing the highest quality care requires fielding the strongest workforce. It's beyond time that our hospital systems listen to workers and prioritize the safety and well-being of patients and workers over profit. UPMC preaches "life changing medicine," but in reality, they need a life-changing dose of humanity.

Thank you.

Testimony of Nila Payton

My name is Nila Payton. I have worked as an Administrative Assistant at UPMC Presbyterian for nearly 17 years.

I and many of my fellow coworkers are hundreds and thousands of dollars in debt to UPMC. UPMC is my employer, my insurer, and the place where I see my doctors. Like my co-workers, I work long and hard hours every day to keep UPMC hospitals running so they can continue to provide some of the best healthcare in the country.

Four years ago, I gave birth to my third baby. I assumed as in the past that my prenatal care was covered only to discover that I was being billed for my prenatal care. While my son spent the first week of his life in the NICU, I was being billed every day.

Three months after having my baby I had to have my gallbladder removed; I was billed a $150 copay, which is now $250, for the ER visit and I was charged for my few-days stay and the surgery. I owed just over $2,000. Just this past December I had an MRI done and the charge was $9,269.50. With the UPMC Network Discount the balance owed was $965.35. UPMC paid $338.95, leaving me with a balance of $593.85. When you include the bill for the contrast with the MRI my total bill is $626.40. That's more than half of my monthly rent payment and about what I spend on groceries each month to feed my family. Yes, I am on Medical assistance, and thankfully, Pennsylvania reimburses the cost of employer-provided healthcare because I make so little, to be able to qualify for Medicaid.

Unfortunately, so many of my coworkers who are struggling with medical debt, make just too much to qualify, but not enough to cover the cost of the medical care, insurance and debt. The scary thought in the back of my mind is: when I get a raise next year is it going to be just enough to get me kicked off of Medicaid, which is the only thing that’s helping me get by, especially with two young children at home?

I am still paying the pre- and postnatal debt off every month as diligently as I can. I’m on a payment plan for that debt now, but before I started the payment plan, I was getting multiple collection calls at work, which was really disruptive – and quite disturbing. I'm sure I'll be getting more calls soon, in regards to the recent medical debts incurred.

I’m working at UPMC, while getting calls from UPMC collections telling me, that I owe UPMC money.

Something is very wrong with a system where you can spend all day helping to provide quality healthcare to people in your communities, and then not be able to stay healthy yourself, or keep your family healthy, because you can't afford it. And since Covid, our worries to stay healthy have only increased. We didn't even get hazard pay.

UPMC knows full well how much they pay me. They know that me and my family depend on UPMC doctors for our care. And they know when they structure our insurance how much I can afford and how much would be beyond my capacity to pay.

Despite the billions in profits, massive tax breaks and ceaseless expansions, UPMC is reluctant to shell out a single cent to support the health of the workers that keep their hospitals running. Instead, UPMC pushes this cost to the taxpayers, all so they can continue to line their own pockets.

Thank you for listening to us today. I hope you can help. Our health depends on it. Have a good rest of your day.

Walter Gates Testimony

Hello, my name is Walter Gates. I've been a MRI tech at UPMC Shadyside for eight years. Despite having a Bachelor's Degree and advanced training for my specialty, my years of experience, and working at a hospital system that saw over a billion dollars in excess revenue, my family's financial security balances on a knife's edge.

I moved to Pittsburgh from rural Pennsylvania for opportunity. Where I'm from, open MRI tech positions don't come along very often. When I got a job at UPMC I jumped on it. I imagined that working at such a large and wealthy hospital system would mean a good job with the chance for growth and the ability to live a middle-class life. That hasn't been the case.

Over the course of eight years at UPMC, I've received about a dollar-an-hour raise a year. I don't have to be an economist to know that the cost of living in Pittsburgh has gone up far higher than that in the last eight years. Every time UPMC does a survey of the market rate for pay, I am ALWAYS at the bottom of the market when it comes to pay scale. For instance, at AGH, the people who do my job using the same equipment on the same patients make $4 an hour more than I do. That comes to $600 a month. That is a huge difference for my family.

Then there is the cost of working at UPMC. Because my job includes on-call shifts, I am required by the hospital to live within 30-45 minutes of the hospital. My wife and I wanted to find a house that allowed us to walk, bike, or bus to work to save money on cars and gas, but it was impossible on our budget.

We eventually found a house in West Mifflin that just barely scrapes under the distance requirement. Being so far from Pittsburgh also means we have the added expense of two cars. And when gas prices go up, well, that comes out of our grocery budget or emergency savings. Oh, and then I have to pay $80 a month to pay UPMC for the pleasure of parking in a lot they own.

My wife and I both grew up in working class families that didn't have a lot of money. We're very frugal and make a lot of sacrifices. After we pay our mortgage, day care for our seven-month old daughter, utilities, and other expenses, we have about $150 left for everything else. We would like to have another child, but we can't afford daycare for two children, so we're not sure when we'll be able to grow our family.

It's a very precarious existence. I'm not asking to be a wealthy man, I'm simply asking to not have to worry so much about the basic survival of my family and my little girl's future.

Knowing how much money UPMC makes on the backs of its workers and patients - and the taxpayers - and the struggle and stress of trying to stay afloat, it makes me angry. It's a grotesque abuse of power and lack of responsibility. Like so many other people, I am trying to raise a family here, at what point is UPMC going to be held accountable?

Testimony of Danielle Hudson

Hello, my name is Danielle Hudson. I've worked in UPMC's billing department since October 2019. Every day, I take calls from people with questions about their bills. I field close to 900 calls a month. I spend a LOT of time trying to help people understand why they're being charged for things and referring them to UPMC's financial assistance program when they say they can't pay.

I like helping people, but I hate having to refer people to financial assistance. People think they're having a covered procedure only to get bills for thousands of dollars. I feel like UPMC should be able to tell people their procedure won't be covered before they get it done and save people lots of time, money, and stress. And many people don't even qualify for the assistance programs.

UPMC likes to talk about their payment plans, but quite often they are far more than I think patients can afford to pay, and even if you manage to get a payment plan you can afford, your troubles aren't over. Regardless if you are making your payments on time as agreed, the system can automatically cancel your payment plan and your debt will go to collections. Nine times out of ten, people don't realize their payment plan has been canceled until they've been called by the collections agency.

We work for a giant, world-class healthcare system, and yet employees are having to apply for assistance or end up going into medical debt. They force us to choose their health insurance plan - a plan that keeps our healthcare costs high. My premiums alone are $780 more a year than when I had Highmark insurance and my actual out-of-pocket costs are thousands of dollars more per year. It takes very little for us to end up with massive medical debt to our own boss. It's just like the old company store days.

I have to have botox treatments for my debilitating migraines. With my Highmark insurance it was completely covered. With UPMC it's $360 every three months when they order the drug. I get that four times a year ($1,140). The total out-of-pocket for the visit itself after I've met my deductible is $131. Just to see the doctor – four times a year. Out of all of that, our FSA only allows us to have $2500 total. So every year the list of things we can't afford to pay for grows.

Every day I think about leaving my job. But part of me wants to stay because no matter what I go through working for UPMC, there are patients, real people - mothers, daughters, grandmothers - who call me and find someone willing to listen to them. The good calls - the ones where you actually get to help people are the ones that keep you going.

UPMC cares only about their bottom line. They act like a bank and want to be treated like a church. They act like I'm supposed to be proud to work there, but I have so many terrible stories of billing nightmares. UPMC could do so much more for workers AND our communities. Thank you for listening to our stories.

Testimony of Juilia Centofanti

Hello, my name is Juilia Centofanti. I am currently a nursing student at a UPMC proprietary school.

Two years ago, I was rushed to Magee Women's Hospital from Indiana PA, where I gave birth to my daughter seven weeks premature. Seeing the difference the nurses at Magee NICU and the staff at the Children's Hospital made in people's lives inspired me to leave the restaurant industry to become a nurse. But I didn't want to be a nurse just anywhere. I wanted to be a nurse at UPMC.

My partner and I were convinced by all the talk about how Pittsburgh - and UPMC - was the place to find our American dream. We moved to Pittsburgh specifically so I could work at UPMC and take advantage of their tuition reimbursement, then work out my career there. So I took lower wage jobs as an environmental services worker and then later as a pharmacy assistant.

I thought the sacrifice would be worth it when I got to nursing school though, because as a full-time UPMC employee I would be eligible for $4,000 a semester of tuition assistance at a UPMC nursing school.

That's when I discovered the dirty secret behind this program.

To get that help, you agree to work at UPMC for two years following graduation. That seems reasonable until you read the small print. If you drop down to part-time working hours, quit working at UPMC altogether, **or fail any of your classes, you must pay the money back - at a 27% interest rate.**

And not only are you trapped in a predatory loan, but from talking to other nurses, this pipeline seems to depend on us being too afraid to speak up or rock the boat in any way. And God help you if you're fired - for any reason at all thanks to at-will hiring - because UPMC controls most of the healthcare industry in the region, nurses can find themselves unable to get a job at all - while being in deep debt to their former employer. As nurses, we have been taught that speaking out against UPMC can torpedo your whole career.

Fortunately for me, someone at the school - I don't want to say who for fear they will lose their job for protecting me against these predatory practices - told me the truth. So I decided to not take their so-called help. I quit my job and borrowed more in federal and private student loans to make up the difference. That means I will be carrying a greater load of debt when I graduate, but the risk of owing that same amount at a 27% interest rate wasn't worth it.

Still, through all of this, I want to be at UPMC. But I want UPMC to be better. For the people who work there and for the people who go there for their healthcare. And UPMC can be better, but they won't unless we - all of us - demand it and hold them accountable.

Testimony of Tosha Lindsey

My name is Tosha Lindsey. I work in environmental services at UPMC Presbyterian. I sweep, mop, pull trash, clean and prep rooms for surgery patients. Being in EVS is also patient care – I'm the one person who comes into patient rooms who doesn't want to poke or prod them. I help patients put their socks on, get them water, whatever they need. I do it because it helps them, and it helps my co-workers who are short staffed and running ragged.

Workers like me care about our jobs. But our wages are so low and our benefits so terrible that we have to visit the foodbank just to survive. Many of us are in medical debt to our own employer - a hospital. How ironic is that?

I'm not able to support my family. I live in public housing and cannot afford a vehicle. I work for the largest health system in the state taking care of other people and still owe $20,000 for my own health care. I can't afford to call off, no matter how sick I am or how much pain I'm in.

Earlier this year I stepped off the bus into a pothole and landed on my foot funny - ended up in a boot and walking shoe. I took some time off, I went back with special orthotics, but couldn't wear the boot at work, and now I need surgery. They told me that I could lose my foot if I don't take care of it. And while I wait for this surgery UPMC put me on short-term disability making 60% of my already low pay.

When I started working at UPMC, I was on Medicaid and I didn't have co-pays and all the other little things that add up that they don't tell you about when you get on UPMC's insurance - which everyone has to do. On Medicaid, everything was covered. Now, I have $30 co-pays for life-sustaining medications. Specialists are $60 each. This surgery is going to cost me $500-$600.

UPMC does not care what your circumstances are. They just want their money. UPMC keeps talking about their core values but they don't value the people who make sure their patients are ok and get the care they need.

I want to be able to enjoy my hard work. I want better for my children. I don't want to live in subsidized housing. I work full time, I should be able to live a decent life rather than decide which bill I can afford to pay this month. Which medicine I need to skip, which meals I can't afford to eat.

I know my worth, and I want my children to always know their worth too. I'm excited about this hearing because I hope it will help the public and our elected representatives better understand all the reasons behind what's going on with me and other workers in these hospitals. There is a crisis, and we need help.

Thank you.

Testimony of Jodi Faltin, RN

Hello, my name is Jodi Faltin. I have been a registered nurse for eight years, and like many nurses in Pittsburgh, my entire career has been with UPMC because of the clear stronghold they have on healthcare jobs in our state.

Thank you for holding this hearing today and for actually listening to workers. More than 500 hospital workers have submitted testimony since this process began. While they can't all be here today because they're at work caring for our patients, they have stories that deserve to be heard.

Saying we've been through hell these past few years doesn't come close to covering the reality. We've been running on pure adrenaline, fear, and love for our patients - just trying to make it through at a great cost to our physical and mental health. Despite what the banners say, we are not super heroes- just human beings with limits like any other workers.

The workforce crisis is especially acute in Pittsburgh because of the sheer amount of healthcare workers. One in five hospital workers in Pennsylvania works in our region, so this is a burden on the shoulders of so many workers and patients right here at home. Where I work at UPMC Shadyside, I believe the crisis continues because UPMC discovered during COVID that they can maximize profits by keeping us understaffed and underpaid. They are making COVID conditions the new normal.

Most of our patients in the neuro ICU are neurosurgical oncology patients or those with critical illness as the result of a stroke or brain bleed. We care for patients with respiratory failure or kidney failure who require machines and continuous medication to keep them alive. They need a great deal of one-on-one care and critical decision making that can't wait. This work is highly-specialized, and during the best of times is mentally, physically, and emotionally intensive. Not just anyone can walk in and do our jobs.

When the pandemic started, like healthcare workers everywhere, we pulled together here in Pittsburgh to do whatever it took to care for our patients.

We volunteered for extra shifts. We took on additional critical patients. We floated to other floors. We treated patients who had COVID as well as our patients whose surgeries couldn't wait. We held their hands and comforted them when they received bad news or when they passed away because their families couldn't. We carry the memories of these patients like our own shadows, always there.

Throughout all of this, UPMC administration made it apparent we were on our own.

Having enough nurses each shift is a thing of the past, and I want to be clear about what happens when we are chronically short-staffed. You struggle to monitor and care for critical patients, because they don't get less sick or need less care just because you have less help. You are rushed to complete tasks, answer questions, and make decisions. You don't stop moving or thinking for over 12 hours. After a while, your mind isn't as sharp. You're less resilient and less able to handle emergencies.

When you're not at work, you can't turn off your brain. You can't sleep, you can't recover, you can only worry about how you're going to make it through your next shift. On your days off, you're constantly asked to come in and help and if you say no, you feel immense guilt for not being there for patients and your colleagues who desperately need a break. It never ends.

I didn’t become a nurse to maximize UPMC’s billion-dollar profits. This is a choice UPMC is making and it’s not one that we have to live with. We can’t live with it.

So today, we are asking for your help. We need you - our elected leaders - to truly hear us and amplify what we’re saying, and to act. This crisis was created. It didn’t just happen, and it won’t go away without action. It’s threatening our health, our patients' health, and the health of our city. We need you to rein in our healthcare systems - especially UPMC - and hold them accountable.

Testimony of Joel Gundy, RN

Hello, I'm Joel Gundy, a registered nurse in the Neuro ICU at UPMC Shadyside. You heard my colleagues speak about how chronic understaffing impacts healthcare providers and patients, so I want to focus on the way UPMC management has refused to take responsibility or be accountable for the conditions they create in their facilities.

UPMC likes to say staffing is out of their control. When we ask for help, they say, "we'll pass on your concerns." When we ask for solutions, they tell us there is nothing they can do and push blame up the ladder. They set up a corporate structure that keeps us from getting answers or solutions.

I put together an evidence-based presentation for the head of Shadyside ICUs showing how UPMC's treatment amid the short-staffing crisis creates higher rates of RN and staff burnout, increased turnover, and the loss of senior-level knowledge and expertise. Which directly leads to higher patient mortality and higher readmission rates. I then had the concept of "perspective" explained to me.

Management had no response other than "we'll pass along your concerns." Nothing improves, things just keep getting worse.

Desperate for help and solutions, my colleagues and I had a meeting with the Chief Nursing Officer and the Director of Nursing at Shadyside. There were nurses crying at the meeting because they were so exhausted and demoralized by management's lack of care about us and our patients.

Management's response? They told us we were lucky to work at UPMC and that this is the best we're going to get. When one of my colleagues who came from California respectfully shared some of the improvements hospitals had made after listening to frontline nurses; including investing in raises, reducing ratios, and other smart solutions - management cut him off and ended the call. At that point, our morale hit bottom and we all had pits in our stomachs.

UPMC administration also doesn't care about our physical or mental health. It's no joke, but UPMC management treats it like one. When we're feeling overwhelmed or are experiencing a trauma response, we're supposed to call something called, "Code Lavender" (but only Monday through Friday from 9-5.) Then we'll be treated with a visit from someone who rubs our hands with lavender-scented lotion and gives us a small piece of chocolate to eat mindfully.

It's only funny because it's so awful. And it's a grotesque slap in the face to those of us who daily hold people's lives in our hands. We are serious people who do serious work. We fight through every shift to make sure our patients and their families are supported during the hardest days of their lives.

UPMC has shown us over and over again that they will not do the right thing on their own. When we leave UPMC to its own devices, things change, but only for the worse. That's why we must have a voice to protect ourselves and our patients. If we don't, no one else will.

Testimony of Jessica Guan, RN

Hello, my name is Jessica Guan. I am a registered nurse in the Cardio Thoracic ICU at UPMC Presbyterian Hospital. I graduated from nursing school in August of 2020 and started working at the height of the pandemic. I'm the daughter of Chinese immigrants and I spent my growing up years helping family members navigate the American healthcare system. I studied advanced science in high school, became an EMT and knew my future was in nursing. I wanted to use my skills and talent to help people.

My unit was one of the units that had COVID patients and we had the sickest ones. It was not unusual to spend a full 12-hour shift desperately trying to save one patient's life. In full PPE with no breaks, no water, no time to breathe. Not only did very few COVID patients survive, we had the added emotional toll of having to give terrible news to the families of our patients who couldn't be with them in the end.

Not too long ago I had a double assignment. One was a CMO (Comfort Measures Only; end of life) patient where my role was to help them pass peacefully with medications and physical care, talking to their family, and then doing post mortem care.

My other patient was very unstable on a ventilator, multiple IV meds, and a device helping pump their heart to keep them alive. They were agitated and confused and constantly calling my name. Both deserved a lot of attention but didn't receive it when I was tied up in one room, and we were too short staffed to have coworkers or a charge nurse available to help.

The whole time I was stressed out and tired, but kept putting pressure on myself to work faster. But at the end of the day, it falls on the nurse's responsibility and license. If I work too quickly and make a med error, or upset the CMO patient's family by not keeping them comfortable enough, or if the confused patient managed to pull out a jugular IV, then I've got to carry the fear and guilt.

That was just one day at work.

We never get a break. On our few days off managers are constantly calling and texting asking you to come in. It feels terrible to say no, because we know our colleagues are suffering and need a break. We know if we don't go in our patients will suffer.

My colleagues and I talk with each other a lot about our depression and anxiety. We can't sleep because we have nightmares about work. And for me personally, during all of this, both my mother and grandmother passed away.

When I finally got to my breaking point and tried to get help, UPMC was essentially useless. Three counseling sessions was all they offered to employees suffering the effects of work-related traumatic stress.

That's why I feel so guilty about leaving in January to go back to school. I feel guilty knowing I'm leaving them in an unsafe situation. I'm not the only one who is leaving at the same time. The nurses who will be left are young and inexperienced and they're scared about what's going to happen to them - and the patients - but I have to look out for my own health too.

UPMC has billions of dollars, but it’s not being spent to improve staffing. We’re making all the sacrifices to be there for our patients and our colleagues, but UPMC will do anything to avoid sharing that load and make billions while they leave us alone on the front lines.

Testimony of Diana Thompson

Good morning. My name is Diana Thompson. Up until last year, I was a medical assistant at UPMC Presbyterian.

In April of last year, we were only a year into COVID-19. The vaccine had just come out but cases and hospitalizations were still high. We were still in the worst parts of the pandemic and we were regularly short-staffed. Staff in the hospital were leaving left and right.

When he had departmental meetings, I'd ask what management was doing to fix the staffing situation and never got any clear answers. I guess they got tired of me questioning them because at the end of April, I was fired and told that I would never be able to work for UPMC again.

I was angry but also depressed. I had never been fired before and I didn't do anything to deserve this. On top of that, with UPMC being the largest healthcare system and employer, I was shut out of a lot of work. Where was I going to be able to get a job? Ultimately, I decided to go to nursing school.

I feel like this is what UPMC tries to do to people that speak up. They say you can speak up, but when you do, it seems like they come down on you. I was simply standing up for my co-workers and wanted to improve staffing for us and our patients.

My situation certainly isn't the first time something like this has happened either. More than 100 unfair labor practice charges have been filed against UPMC since Pittsburgh hospital workers started organizing.

I decided to stand up for myself and filed an unfair labor practice complaint with the National Labor Relations Board. It took months of work and negotiations, but recently I won a settlement with $36,000 in back pay, and I'm eligible to be rehired in January.

It's also the second time in the last few years that UPMC has had to publicly post notices in the hospital telling workers that they will respect their rights.

Right now, I don't know if I want to go back to UPMC. Who's to say they wouldn't try this again? But like I said, the choices are limited so I'm glad that I stood up and at least have the option. How many other people didn't do that and are essentially blacklisted from the majority of healthcare jobs in our area? That's what we need to change the system overall. No employer should have this kind of power.

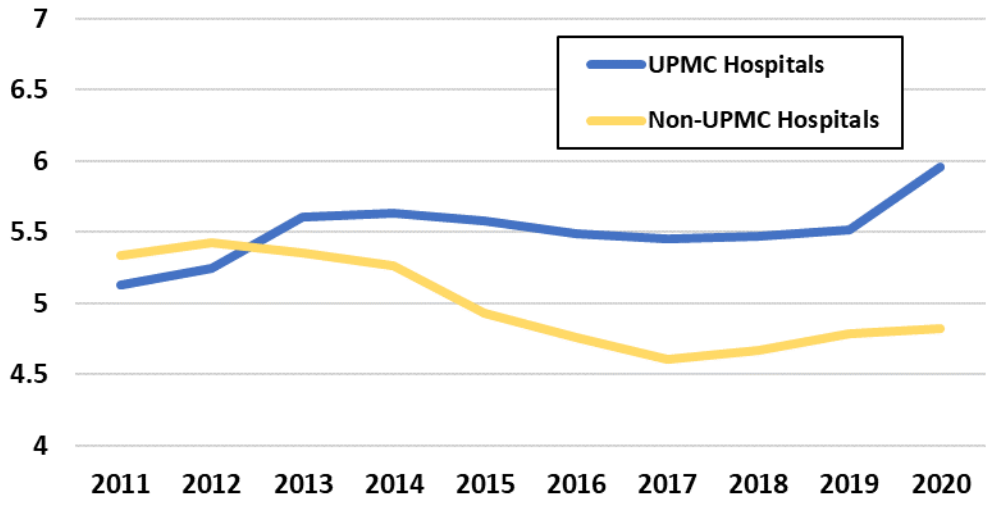
Appendix 7: Analysis of UPMC Staffing Ratios

SEIU has analyzed Medicare cost report data[1] to find whole-facility staffing ratios at short term acute care and critical access hospitals using an industry standard metric known as FTE's per adjusted occupied bed. We call this the FTE Staffing Ratio, which compares the number of staff (full time equivalents) to the volume of patients at each hospital. The formula is: Full Time Equivalents/ (Adjusted Inpatient Days/ Days in period). The adjustment to inpatient days accounts for outpatient utilization at the facilities, and all averages cited are weighted averages.

Results

Figure 1 below shows the FTE Staffing Ratio at all UPMC-owned hospitals in Pennsylvania compared to all non-UPMC hospitals in the state for each fiscal year between 2011 and 2020. Hospitals recently acquired by UPMC are counted as part of the system starting in the fiscal year that begins after the date of acquisition.

Figure A: Staff to Patient Ratios, UPMC and Non-UPMC Pennsylvania Hospitals, 2011-2020



As Figure A shows, the FTE Staffing Ratio at UPMC's Pennsylvania hospitals steadily decreased between 2011 and 2020, while the FTE Staffing Ratio at non-UPMC Pennsylvania hospitals increased over the same period.

Table 1 below similarly shows the decrease in UPMC's staffing ratios while other Pennsylvania hospitals' staffing ratios increased over the same period.

[1] *See* Additional Methodology, below, for more information regarding Medicare cost reports and how the calculations were performed.

Table 1: FTE Staffing to Patient Ratios, UPMC and Non-UPMC Hospitals in Pennsylvania, 2011-2020

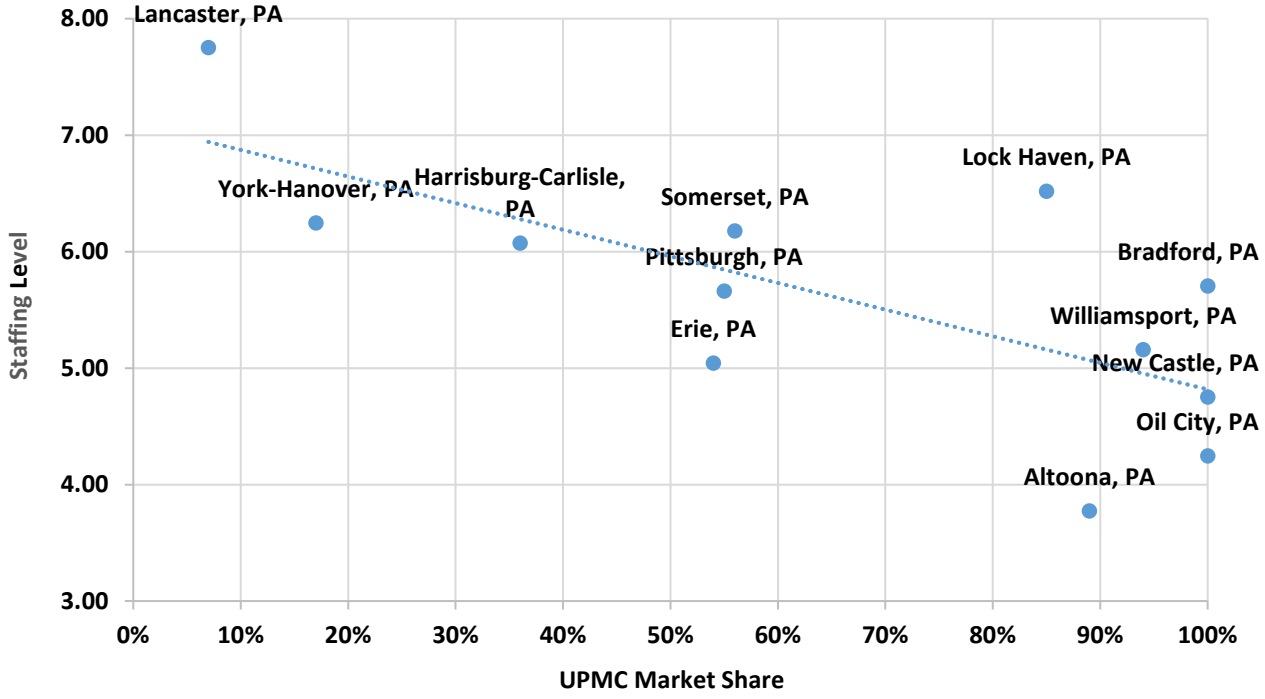
Year	UPMC Hospitals	Non-UPMC Hospitals	% Difference
2011	5.34	5.13	4%
2012	5.42	5.24	3%
2013	5.35	5.61	-5%
2014	5.27	5.64	-7%
2015	4.93	5.58	-12%
2016	4.76	5.49	-13%
2017	4.60	5.45	-16%
2018	4.67	5.47	-15%
2019	4.79	5.52	-13%
2020	4.83	5.96	-19%

The data show a dramatic decrease in UPMC's staffing ratio over time, both in absolute terms and relative to other hospitals in Pennsylvania. While FTE Staffing Ratios at non-UPMC Pennsylvania hospitals increased by 16.2% over the period covered, UPMC's staffing ratios *decreased* by 9.6 percent. The result is a dramatic divergence between UPMC staffing ratios and those of the rest of the industry: While in 2011 UPMC had an FTE Staffing Ratio level 4 percent above the non-UPMC state average, by 2020 its average was ***19 percent lower*** than the non-UPMC state average.

The analysis also included a simple comparison of the two largest CBSAs in Pennsylvania, Pittsburgh and Philadelphia. The average staffing ratio in the Pittsburgh CBSA, where UPMC has many hospitals, is lower than the average staffing ratio in the Philadelphia CBSA, where UPMC has no facilities.

The analysis also compared UPMC staffing levels to UPMC market shares for Pennsylvania CBSAs in which UPMC is active for 2020, the most recent year available. The results are plotted in Figure B.

Figure B: Staffing Level and UPMC Market Share



A clear pattern emerges: As UPMC market share increases, the staffing ratio decreases. Areas where UPMC is very dominant, such as the Oil City and New Castle CBSAs, show extremely low levels of staffing relative to the statewide average and to UPMC CBSAs with lower market share. Areas in which UPMC is much less dominant, such as Lancaster, have staffing ratios that are much higher, and that even substantially exceed the 2020 state average.

Table 2 presents the data used to plot Figure 2, comparing UPMC's market share (as reflected in net patient service revenue) to staffing levels in the Pennsylvania CBSAs where UPMC is active.

Table 2: UPMC FTE Staff to Patient Ratio and Market Share, by Pennsylvania CBSA, 2020

Pennsylvania CBSA	UPMC Market Share (NPSR)	FTE Staffing Ratio
Oil City	100%	4.24
New Castle	100%	4.75
Bradford	100%	5.70
Williamsport	94%	5.16
Altoona	89%	3.77
Lock Haven	85%	6.52
Somerset	56%	6.18
Pittsburgh	55%	5.66
Erie	54%	5.04
Harrisburg-Carlisle	36%	6.07
York-Hanover	17%	6.25
Lancaster	7%	7.75

Note: Market share based on net service revenue from Medicare claims.

The data indicate that the three CBSAs with 100% UPMC market share (meaning that UPMC owns the sole hospital in these CBSAs) have staffing ratios far below the non-UPMC average staffing ratio of 5.96. And in the market where UPMC's hospital has the ***lowest*** staffing ratio of 3.77, Altoona, UPMC has ***89 percent*** market share.

Additional Methodology:

Each hospital that participates in the Medicare program is required to file an annual cost report with the Centers for Medicare and Medicaid Services. These cost reports contain extensive information on hospital finances and utilization. While the data is not audited, it is relied on heavily by CMS and the Medicare Payment Advisory Commission in arriving at Medicare payment policies, and is also relied on widely by health services researchers.

Data were pulled from the raw cost report data (available for public download here) via a series of SQL queries. Certain conditions were attached to the SQL queries to limit the universe of cost reports for analysis as follows:

- Include general acute-care hospitals and critical access hospitals in the 50 states and DC; exclude children's hospitals, psychiatric hospitals, rehabilitation hospitals, and long-term acute-care hospitals.
- Include cost reports filed for the years 2011-2020. This period was chosen because CMS changed the cost report format in 2010, for cost reports filed starting in 2011.
- Exclude all federally owned hospitals (such as VA facilities).
- Exclude all hospitals that lack one or more of the data points necessary for calculation of the FTE ratio.
- Exclude outliers (hospitals with an FTE ratio 16 or greater).

Appendix 8:
Analysis of Unfair Labor Practices by UPMC

The University of Pittsburgh Medical Center employs 92,000 workers.[1] Below is an analysis of UPMC's record of the unfair labor practice (ULP) charges filed against UPMC in the past decade.

Methodology

The dataset of ULP charges was drawn from the National Labor Relations Board's case search tool[2] by filtering for Unfair Labor Practice (type C) cases and searching with the keyword "UPMC." This search generated a dataset of 166 cases. Of those cases, 14 were charges against other entities besides UPMC; these were excluded from further analysis. 19 cases from prior to 2012 were also excluded, leaving 133 ULP charges against UPMC since 2012.

The NLRB case dataset typically includes information on the specific allegations for each ULP charge. For some charges, no allegations are listed, while for others, multiple allegations are listed. Of the 133 ULP cases against UPMC since 2012, allegation data was available for 103 charges (77.4%), and those charges included 159 separate allegations.

ULP allegations vary widely in seriousness; for example, dismissal of employees in retaliation for an effort to organize is a more serious charge and a greater threat to workers' right to collective action than refusal to furnish information during bargaining. This analysis classifies ULP allegations into "Serious" and "Less Serious" based on categories developed by Kate Bronfenbrenner and Dorian Warren.[3] Examples of charges classified as "serious" include interrogation, and discipline or discharge in response to organizing activity/exercising rights under the NLRA. Charges classified as "less serious" included violations of employees' Weingarten rights, denial of access, and refusal to furnish information during bargaining. In general, in Bronfenbrenner and Warren's classification, "serious" allegations are those that might significantly deter or impede workers' effort to form a union.

Results

The most striking result of this analysis was the very large number of unfair labor practice cases brought against UPMC. From 2012 to 2022, UPMC faced ***133 ULP*** charges—an average of over 12 per year. Information on the underlying allegations was available for 103 of the charges. Those 103 charges involved 159 separate allegations.

The proportion of serious violations in each year is shown in Table 1a.

[1] https://www.upmc.com/about/facts.
[2] Available at https://www.nlrb.gov/search/case/, accessed on 9/9/22.
[3] Kate Bronfenbrenner & Dorian Warren, The Empirical Case for Streamlining the NLRB Certification Process: The Role of Date of Unfair Labor Practice Occurrence, ISERP Working Papers (June 2011),, https://academiccommons.columbia.edu/doi/10.7916/D8W38452, at 5.

Table 1a: Unfair Labor Practice Allegations Against UPMC, by Allegation Type, 2012-2022

Year	Total	Serious Allegations		Other Allegations	
		N	% of total	N	% of total
2012	9	8	89%	1	11%
2013	47	44	94%	3	6%
2014	23	15	65%	8	35%
2015	7	5	71%	2	29%
2016	11	7	64%	4	36%
2017	10	6	60%	4	40%
2018	18	8	44%	10	56%
2019	15	11	73%	4	27%
2020	6	4	67%	2	33%
2021	7	6	86%	1	14%
2022	6	4	67%	2	33%
Total	159	118	74%	41	26%

The overwhelming majority of ULPs brought against UPMC were serious—***74%*** in the period covered. In only one of the 11 years covered in our analysis did the rate of serious allegations fall below 50%. Serious allegations, including discipline, coercive actions, coercive statements, and discipline in violation of the NLRA, constitute the majority of allegations against UPMC in each of the remaining years.

A breakdown of the most common types of serious allegations against UPMC is provided in Table 1(b), below.

Table 1b: Share of Serious Unfair Labor Practice Allegations by Allegation Category, 2012-2022

Allegation Category	Serious Allegations	
	N	%
Coercive Statements or Actions	**45**	38%
Retaliation/ Discipline for Concerted Activity	**29**	25%
Terms of Employment Change	**22**	19%
Discharge	**15**	13%
Interrogation	**7**	6%

Thus UPMC was charged with coercive statements or actions ***45 times*** between 2012 and 2022 and with retaliation for concerted activity 29 times. Perhaps most concerning, UPMC was charged with discharging employees for concerted activity ***15 times*** during the period.

These charges reflect violations of core elements of employees' right to organize under the National Labor Relations Act. The analysis shows a very high volume of charges overall, and that those charges frequently involve the most serious violations of the NLRA – those with the most significant potentially chilling effect on workers' right to organize.