

Social Networking Sites Present Legal Risks for Health Care Providers

Hospitals and health care professionals have quickly embraced social networking as a way to interact with patients, market their practices and share information with the health care community. Every day more providers are going online to connect with colleagues, post updates on medical topics, share health tips with patients, attract participants for research studies, track medical trends, issue press releases and announce exciting developments in their practices. The explosion of social networking has built online communities for people to communicate, interact and share information.

Some of the more popular of the social networking sites include:

- *YouTube.com* – A number of hospitals have created channels on YouTube, the video sharing site that allows users to upload videos.
- *Facebook.com, LinkedIn.com* – These social networking sites allow users to create personal pages where they can upload messages, pictures, videos and other content and connect with friends and groups. Facebook has been deemed more social, while LinkedIn's intent is professional networking.
- *Blogs* – Doctors and patients are using these online diaries and journals to talk about their medical experiences and share their thoughts on health care issues and treatments.

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New FTC Studies Challenge Hospital Mergers

In the 1990s, antitrust regulators—including the Federal Trade Commission (FTC) and various state attorneys general—racked up a string of consecutive defeats in court as they regularly lost antitrust challenges to proposed hospital mergers. These cases turned upon how the market was defined: the broader the market geographically, the more competitors present to challenge a post-merger hospital, and thus a far smaller likelihood that the merger would reduce competition by limiting patient choice. Courts in the 1990s took an expansive view of hospital markets, reasoning that patients will travel long distances

to obtain their care and that even a small shift in patients between facilities could render a price increase self-defeating.

Over the past several years, the FTC has attempted to mount a challenge to the courts' broad view of hospital markets. The FTC has pursued a strategy of studying the effects of mergers after the fact, to see if hospital competition was truly restricted. In performing these analyses, the FTC has focused on the ability of post-merger hospitals to squeeze greater price concessions out of commercial third-party payors. One result of the FTC's new initiative was its successful enforcement action against a completed hospital merger in Evanston, Illinois.¹

Similarly, the FTC commissioned a series of economic case studies regarding the effects that hospital mergers had on prices. Over the past twelve months, the FTC

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- *Twitter.com* – This micro-blogging service allows users to send 140-character messages (called “tweets”) to their personal home page, where they can be read by followers. Earlier this year, surgeons at Henry Ford Hospital in Detroit tweeted real-time updates about a surgical procedure; video of the surgery was later posted on the hospital’s YouTube page.

However, when using such technology, health care providers must be aware of certain legal risks. The most obvious challenge for networking providers is compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which provides for the protection of the privacy of health information and regulates how certain covered entities use and disclose patients’ protected health information (PHI). HIPAA-covered entities are obligated to develop and implement appropriate safeguards designed to ensure that patients’ or clients’ PHI is adequately protected and is not used for any purposes in violation of the Privacy Rule.

In certain circumstances PHI disclosure is permitted, including: if the information is used to advance the patient’s treatment, if the information is related to the payment for the service, or if the patient consents to the specific disclosure. Additionally, a covered entity may determine that health information is not individually identifiable health information if certain identifiers are removed, including the patient’s name, address, birth date, admission date, discharge date, e-mail address and photographic images.

Providers should be extremely cautious in deciding what information to share on their social networking sites, as violations of the Privacy Rule often incur severe civil and criminal penalties. The risk of improper PHI disclosure is especially high where many employees are permitted to post to the sites or where visitors to the sites are permitted to ask detailed, personal questions or add anonymous comments to the postings.

Health care providers looking to increase their online presence should consider taking the following steps to help safeguard their online interactions:

The risk of improper PHI disclosure is especially high where many employees are permitted to post to the sites or where visitors to the sites are permitted to ask detailed, personal questions or add anonymous comments to the postings.

Create Internal Social Media Policies

Providers should enact policies with guidelines and requirements for their employees’ online interactions. These policies should make employees aware of the risks of posting confidential or proprietary information and should set standards for appropriate and professional communications.

Include Appropriate Disclaimers

Providers who blog should be sure that their postings cannot be interpreted by visitors as providing diagnosis or treatment, which could violate the prohibition against unlicensed practice of medicine as well as restrictions on corporate practice of medicine. All Web pages should therefore contain appropriate, noticeable disclaimers informing visitors that the Web sites are for informational purposes only and do not provide medical advice, diagnosis or treatment. Site visitors also should be instructed to contact the physician directly for personal questions or to call 911 for medical emergencies.

Enact Networking Safeguards

Facebook and other social networking sites allow users to regulate the security features on their individual pages. Users should be careful about accepting “friend requests” and other invitations to connect with users or groups. Additionally, physicians with Facebook pages should be wary of accepting invitations from patients or posting personal images and videos, and all providers should closely monitor, or disable altogether, the comment feature on their YouTube, Facebook and Twitter sites.

Train Employees on Proper Usage

Providers also should be aware that their employees' personal pages can be linked to their practice's official sites. See Pepper Hamilton's recent *Labor and Employment Law Update* for further guidance on monitoring employees' online conduct: http://www.pepperlaw.com/publications_update.aspx?ArticleKey=1573.

As social networking continues to grow as a valuable health care marketing and educational tool, it becomes increasingly vital for health care professionals to remain aware of the related legal risks.

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has published Working Papers Nos. 293, 294, and 295, which provide retrospective analyses of the price effects of the Sutter/Summit merger (Paper No. 293), the Evanston Northwestern Healthcare/Highland Park and St. Therese/Victory mergers (No. 294), and the New Hanover/Cape Fear transaction (No. 295).² Below are summaries of the findings presented by these FTC case studies. These published papers will likely be used as ammunition by the FTC (and possibly private plaintiffs) in future antitrust investigations of the hospital industry, and the papers signal the FTC's continued commitment to aggressive antitrust enforcement in health care.

FTC Analysis of the Sutter/Summit Merger (Working Paper No. 293, Nov. 2008)

The Sutter/Summit transaction concerned a merger between Sutter, a network of nonprofit hospitals, and Summit, an Oakland, California-based nonprofit hospital. Pursuant to the merger, Summit, which was experiencing financial distress, combined with Sutter's Alta Bates Hospital in Berkeley, California. The FTC took no action to prevent the Sutter/Summit merger; however, the California attorney general brought suit in an effort to enjoin the combination. Following a four-day trial, the Federal District Court for the Northern District of California denied the attorney general's motion for preliminary injunction, holding that the attorney general failed to identify the relevant geographic market for analyzing the anticompetitive effects of the Sutter/Summit merger.³ In its opinion, the court noted that the attorney general's proposed relevant geographic market excluded a number of hospitals that served as practical alternatives for patients seeking acute inpatient services at Summit or

Alta Bates and which could therefore provide a check on any anticompetitive price increases imposed by the merged entity.

In FTC Working Paper No. 293, Steven Tenn of the FTC performed a retrospective study in order to compare the post-merger price changes for the Sutter/Summit merging hospitals to the price changes for other hospitals in the area. In performing his analysis, Mr. Tenn relied on commercial claims data provided by Summit, Alta Bates, and three large health insurers. According to the FTC, the data demonstrated that both Summit and Alta Bates raised prices following the merger, and that Summit's prices, which were traditionally much lower than Alta Bates's prices, began to mirror the prices charged by Alta Bates. The data also demonstrated that Alta Bates's post-merger price change was consistent with the price changes experienced by the other hospitals, but that Summit's post-merger price increase was among the largest of any comparable hospital in California. Mr. Tenn concluded that the Sutter/Summit merger led to Summit's large price increase, and that the merger therefore may have been anticompetitive. He also contends that the ability of patients to travel to other hospitals in the vicinity of Summit and Alta Bates did not hinder the merged hospital's ability to impose anticompetitive price increases.

The Evanston Northwestern Healthcare/Highland Park and St. Therese/Victory Mergers (Working Paper No. 294, Jan. 2009)

FTC Working Paper No. 294 provides a detailed analysis of two hospital mergers that took place in the north shore suburbs of Chicago in 2000: the merger of St. Therese

While not all of the results showed that hospital mergers hurt competition, the evidence adduced by the FTC certainly cuts both ways.

Medical Center (STMC) and Victory Memorial Hospital (VMH), and Evanston Northwestern Healthcare's (ENH) purchase of Highland Park Hospital (HPH). Both mergers were significant, and in 2002, the FTC investigated the mergers as part of its Hospital Merger Retrospectives Project to determine whether enforcement actions against consummated, anticompetitive hospital mergers should proceed. The FTC's investigation of the STMC/VMH merged entity, Vista Health, found little evidence of anticompetitive effects, and the FTC therefore closed its investigation. However, for the ENH/HPH transaction, the FTC filed an administrative complaint challenging the merger as anticompetitive. At trial in 2005, the administrative law judge concluded that the acquisition violated antitrust law, that decision was affirmed by the FTC on appeal, and in 2008 ENH elected to forego additional appeals and accept the FTC's remedy—separate contracting with third-party payors for ENH and HPH.

In Working Paper No. 294, Deborah Haas-Wilson of Smith College and Christopher Garmon of the FTC estimated the effects the ENH/HPH and STMC/VMH mergers had on the prices the merging hospitals negotiated with managed care organizations. To estimate the post-merger price changes for the merging entities relative to a group of control hospitals, Haas-Wilson and Garmon collected and analyzed data from various sources, including claims data from five large managed care organizations in the Chicago area. For the ENH/HPH transaction, Haas-Wilson and Garmon found that four of the five managed care organizations experienced large and statistically significant relative price increases after the merger, with one payor experiencing a relative price increase of more than 50 percentage points. Further, Haas-Wilson and Garmon found that the relative post-merger price changes at STMC/VMH were mixed, in that three of the managed care organizations experienced a relative price decrease after the merger, one MCO experienced an increase that was substantially greater than at comparable hospitals, and that the other MCO experienced a fairly inconsequential price increase.

Based on their findings, Haas-Wilson and Garmon evidently agree with the FTC's decisions to pursue an enforcement action challenging the ENH/HPH transaction and to terminate the investigation into the STMC/VMH merger. As stated in their conclusion, the results of their paper "strongly suggest" that ENH/HPH increased its market power with the merger, "giving it

the ability to negotiate higher prices with MCOs" and that "the results for STMC/VMH, if anything, show the opposite effect with three MCOs receiving price decreases and only one MCO receiving a significant relative price increase post-merger."

The New Hanover/Cape Fear Transaction (Working Paper No. 295, Jan. 2009)

In 1998, New Hanover Regional Medical Center acquired Columbia Cape Fear Memorial, a small community hospital located six miles away from New Hanover in Wilmington, North Carolina. Both hospitals provided general acute care services, and patients therefore likely viewed the hospitals as close substitutes. Further, because the next closest hospital is more than 20 miles from New Hanover and Cape Fear, the author of Working Paper No. 295, the FTC's Aileen Thompson, notes that it is plausible that the merger enabled one or both of the merged parties to increase prices. Nevertheless, no government regulator instituted formal proceedings to stop the merger.

In order to assess whether the New Hanover/Cape Fear transaction may have hurt competition, Ms. Thompson analyzed patient-level claims data from New Hanover and four different insurers that paid claims for hospitals throughout North Carolina to estimate the effects of the merger on prices. Specifically, Ms. Thompson estimated the post-merger price changes at New Hanover relative to those at a control group of 11 similar hospitals. Her analysis provided mixed results, as two of the insurers experienced large price increases relative to the control group (one exceeding 100 percent), one experienced a fairly small relative price increase, and the final insurer had a large relative price decrease of nearly 30 percent. Given these divergent results, Ms. Thompson notes that it is difficult to draw a conclusion about the impact of the New Hanover/Cape Fear merger on inpatient pricing. It

also is unclear whether the merger had any anticompetitive effects, at least in light of Ms. Thompson's analysis.

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Conclusion

These Working Papers are part of a continuing campaign by the FTC to reverse its losses in the hospital merger battles of the 1990s. While not all of the results showed that hospital mergers hurt competition, the evidence adduced by the FTC certainly cuts both ways. Moreover, these studies show the FTC's strong emphasis on the effect of mergers on prices charged to third-party payors—a trend that is likely to continue.

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Endnotes

- 1 See *In the matter of Evanston Northwestern Healthcare Corporation, a corporation, and ENH Medical Group, Inc., a corporation*, 2004 WL 827782 (F.T.C. Mar. 17, 2004) (No. 9315).
- 2 Electronic copies of FTC Working Papers 293, 294, and 295 are available at www.ftc.gov/be/econwork.shtm.
- 3 See *California v. Sutter Health System*, 130 F. Supp. 2d 1109 (N.D. Cal. 2001).

Are You Aware of Antitrust Issues in Medical Staff Cases?

Peer review and credentialing processes are generally accepted methods hospitals use to evaluate the performance of their medical staff and to determine whether a doctor's privileges should be granted or maintained. However, the Fifth Circuit's recent decision in *Benson v. St. Joseph Regional Health Center*, 575 F.3d 542 (5th Cir. July 10, 2009) is a reminder that when determining whether to grant, suspend, revoke, or terminate a doctor's privileges, health care institutions must be conscious of the antitrust laws.

Background

In *Benson*, a doctor specializing in obstetrics and gynecology brought suit against the hospital where he worked and the individual doctors who participated in his peer review after they terminated his privileges at the hospital. He asserted claims under the Texas Medical Practice Act and Section 1 of the Sherman Act. With respect to the Sherman Act claim, he alleged that the defendants' refusal to renew his privileges constituted an illegal agreement in restraint of trade because it adversely affected OB/GYN services in the county where the hospital was located.

The district court rejected Benson's arguments and granted summary judgment in the defendants' favor because it

concluded that Benson had not presented any evidence that suggested competition for OB/GYN services was adversely affected by the refusal to renew his privileges. The Fifth Circuit affirmed the district court's judgment, noting that Benson's "inability to service patients at the hospital of his choice does not demonstrate an adverse impact on OB/GYN services for the entire county." Because Benson failed to show any effect on the quantity, quality, or price of health care services available to consumers, the court found no restraint on competition and, therefore, no violation of the Sherman Act.

The *Benson* decision is consistent with the result in other cases brought by doctors aggrieved by hospitals' decisions to deny, suspend, terminate, or revoke privileges. Faced with an adverse privileges decision, doctors frequently assert claims under Section 1 of the Sherman Act and similar state antitrust laws, alleging that the hospital and the reviewing doctors conspired or agreed to deny or terminate his or her privileges and that such a decision negatively affected or reduced competition in that doctor's specialty.

The majority of these cases resolve before the trial stage because they suffer from the same fatal flaw. While the doctor may be able to show that he or she has been injured personally, he or she is unable to demonstrate injury to

competition in a relevant market. Requiring a party to demonstrate an “antitrust injury” is not unique to these privilege suits. The hallmark of the Sherman Act is the protection of competition in a defined marketplace, not the protection of individual competitors.

Examples of injuries alleged by doctors but rejected by courts as insufficient antitrust injuries include loss of revenue, loss of patients, loss of referrals, increase in travel time, increase in expenses, and inability to service patients at the hospital of the doctor’s choice. Denial or termination of a doctor’s privileges has been held to inflict antitrust injury only when the decision results in injury to health care consumers, typically in the form of an increase in the price of health care services to consumers, a decrease in the quality of care, or a reduction in the choice of services available.

A related defect in doctors’ claims that often proves fatal is that the doctor is not considered the proper or appropriate party to pursue potential antitrust violations resulting from a privileges decision. Courts evaluate these factors to determine whether a party is the appropriate plaintiff: (1) how direct the relationship between the injury and alleged improper conduct is, (2) the nature of the injury, (3) the speculativeness of the injury, and (4) the causal connection between the alleged improper conduct and the injury. Consumers of the doctor’s services, whether they be patients, referring physicians or third-party payors, have been deemed by courts to be more “efficient enforcers” of the antitrust laws because they, and not doctors themselves, are directly injured by the harm to competition that the antitrust laws are designed to protect, i.e., a decrease in quality of care or quantity of services or an increase in the price of services. While a doctor may be concerned about the quality, quantity or price of care, the doctor is motivated primarily by his or her own financial gain, which often is inconsistent, economically, with consumers’ interest in low-priced, readily available, high-quality care.

The Antitrust Division of the Department of Justice agrees with the view of the majority of courts in recognizing the importance of the peer review process when undertaken in good faith. In response to an inquiry from the American Medical Association, the DOJ has said that “there is no reason to expect a clash between antitrust laws and peer review conducted to eliminate incompetence in the delivery of health care services.”

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Practical Considerations and Recommendations

Even though the scales appear to be tipped in hospitals’ favor, hospitals and other medical institutions cannot assume that peer review and privileges decisions will never invite antitrust scrutiny. Institutions must have valid procompetitive reasons for their staffing decisions. Generally, a decision to deny, suspend, revoke or terminate a doctor’s privileges is not considered anticompetitive if the decision is based on the doctor’s medical incompetence, unprofessional conduct, disruptive behavior, or failure to adhere to hospital policies. Excluding practitioners who are deemed unqualified promotes competition for competent, skilled doctors and quality care. At the same time, if a staffing decision results in an increase in the price of services or a decrease in the quantity or quality of care available, the staffing decision may be cast as an attempt to increase the incumbents’ profits and as evidence that the market for those services is not competitive.

In cases that do mature, factors that may insulate the hospital and its medical staff from antitrust liability include the affected doctor’s ability to admit patients to other hospitals, the hospital’s grant of privileges to other doctors in the same specialty, and the hospital’s replacement of the terminated doctor. Granting privileges to another doctor or replacing the terminated doctor often is viewed as procompetitive because the addition or substitution ensures that the quantity of health care services available is unchanged or increased, and suggests that the quality of care is improved.

In making staffing decisions, a hospital may consider economic factors such as the number of admissions generated by the doctor and the profitability of the doctor’s practice without inviting antitrust scrutiny. Evaluating whether a doctor promotes the hospital’s strategic plan or institutional goals may inform the institution’s privileges decision so long as the plan itself has a rational business justification and is applied evenhandedly.

Hospitals also may consider a doctor's loyalty to the institution when making a privileges decision, although in so doing they must carefully balance the procompetitive benefits of such consideration against any anticompetitive effects. For example, a hospital may evaluate whether a doctor admits a large percentage of his or her patients to a competing facility or whether the doctor has an investment interest in another facility to determine whether granting or continuing the doctor's privileges will best serve the hospital's patients and meets its long-term strategic development goals. The hospital, however, must be careful not to condition the grant of privileges on a doctor's loyalty because granting a doctor privileges based on the doctor's agreement that he or she will not compete with other hospitals or not admit patients to other hospitals may be deemed anticompetitive. Forbidding a doctor to admit patients at other hospitals could foreclose other hospitals' access to patients and interfere with their ability to compete. Similarly, threatening to terminate the privileges of a doctor who intends to open a competing outpatient facility or specialty hospital could be anticompetitive if the threat prevents the facility from opening. Without the competition from the new facility, the existing facilities may not have an incentive to keep prices at a competitive level, to seek out the most qualified physicians or to provide a wide array of services in sufficient quantity to serve the patient population.

Hospitals in smaller markets where there are fewer options for care, particularly in specialty areas, must be even more conscious of the potential anticompetitive and procompetitive effects of their staffing decisions. In smaller markets, it is more likely that staffing decisions will increase the price of services and affect the quantity and quality of care and, therefore, it is more likely that both the anticompetitive and procompetitive effects of such decisions will be scrutinized closely under the antitrust laws.

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Restrictions on Commercial Use Of Prescription Data Upheld

The U.S. Supreme Court recently declined to hear an appeal by IMS Health and other data aggregating companies regarding their challenge to a New Hampshire law prohibiting the sale of prescription information that contains data that could be used to identify prescribing physicians. The decision may significantly affect businesses that buy, sell, or use such information for commercial purposes in New Hampshire and in other jurisdictions that may now follow New Hampshire's lead.

The sale of prescription information for use in marketing activity is a significant business. In a typical transaction, data aggregating companies such as IMS Health purchase de-identified prescription information from pharmacies and then combine that information with the AMA Masterfile or other data in a manner that can reveal the prescriber's identity and their prescribing practices. Such information is valuable to the marketing departments of pharmaceutical companies who use the information to target their "detailing" activities.

There is vigorous debate concerning the risks and rewards involved in the sale of this information. On the one hand, data aggregation companies compile and package data related to health care that would otherwise not be readily available. The commercial sale of such information underwrites the availability of this data for other less profitable (but highly beneficial) activities such as research, education, and formulary compliance monitoring. On the other hand, the availability of detailed reports of the prescribing practices of individual physicians, and the use of such reports in pharmaceutical marketing activity, are seen by some as both contributing to an increase in drug prices and potentially interfering with medical judgment.

In an effort to control costs and improve care, some states are looking to curb the sale of this data in the belief that the use of such data for marketing purposes drives up the cost of prescription drugs. New privacy laws in New Hampshire, Maine, and Vermont seek to restrict or prohibit the sale for prescription information that contains prescriber identifiable data, and also patient identifiable data. Data aggregation companies claim the new laws are an impermissible restraint on free speech. Litigation related to these new laws, brought by IMS Health and other data

aggregation companies, had reached the U.S. Supreme Court.

On June 29, the Supreme Court declined to grant *certiorari* to IMS Health regarding its appeal of a U.S. Court of Appeals decision upholding the validity of New Hampshire's prescription data privacy law. The Supreme Court's decision in *IMS v. Ayotte* not only lets the appeals court's validation of the New Hampshire law stand, but may mean validation for similar laws in Maine and Vermont. Both the Maine and Vermont laws are undergoing similar legal challenges.

In general, the three laws prohibit the same activity—the sale of prescriber-identifiable and patient-identifiable *prescription data* for commercial purposes. New Hampshire prohibits the sale of records relating to prescription information containing patient- or prescriber-identifiable data for any commercial purpose. Maine prohibits the sale of prescription drug information that identifies the patient, and the sale of prescription drug information that identifies the prescriber *if* such prescriber has registered to opt out of the prescription data mining activity. Vermont prohibits the use of prescriber-identifiable prescription data for marketing and promotional purposes *unless* a prescriber has registered to opt in to such activity.

In summary, New Hampshire and Maine prohibit the sale of any patient-identifiable prescribing information for commercial purposes; Vermont does not address patient-identifiable prescribing information. All three states prohibit the sale of prescriber-identifiable prescribing information, with Maine and Vermont providing exceptions allowing physicians to opt in or out of the restrictions, respectively.

For reasons of public policy, with only slight variation the statutes in all three states exempt activities that serve the interests of patients and/or public health and safety. Towards this end, while all three statutes define the prohibited activity broadly, each state exempts from restriction most commercial activity that is not associated with for-profit sales and marketing. For example, in all three jurisdictions the sale of data for reimbursement purposes, educational programs and formulary compliance monitoring remains legal.

In all three states, violations of the statutes are deemed unfair trade practices and may involve penalties of as much

as \$10,000 for *each* violation. Such unfair trade practices laws also provide a private cause of action.

Companies with existing agreements to purchase, sell, or use prescription information that contains prescriber- or patient-identifiable data in these jurisdictions should look closely at their arrangements to ensure that the data being purchased or used for commercial activities complies with the new requirements.

During the past several years, more than a dozen states have considered legislation to restrict or prohibit the sale of prescription information. Such legislative activity appears to have been suspended pending the outcome of *IMS v. Ayotte*. If challenges to the Maine and Vermont laws also are unsuccessful, we could see a number of other states enacting similar prescription data laws in short order.

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