June 16, 2021

Brian Thompson
Chief Executive Officer
UnitedHealthcare
P.O. Box 1459
Minneapolis, MN 55440-1459

Dear Mr. Thompson:

The undersigned organizations write to express deep concerns about UnitedHealthcare's (UHC) new policy to allow for the retroactive denial of coverage for emergency care, which will have serious medical consequences for patients. While we understand that UHC has since announced a temporary delay of implementation for it until at least the end of the COVID-19 public health emergency, we write to urge you to rescind these policies permanently, and to express our belief that there is a better way to ensure that patients access the right care, in the right place, at the right time. We invite you to work together with us on these efforts.

Patients do not have the full set of knowledge and tools to assess the level of care they may need. In fact, most clinicians cannot make a diagnosis with confidence without the support of a wide range of tools and tests. A 2013 JAMA study[1] found that patients who receive a diagnosis of a low-acuity condition often present with initial complaints similar to patients with more serious conditions. Examining a dataset of over 34,900 unique emergency department (ED) visits found that 6.3% of visits were determined to have primary care–treatable diagnoses based on discharge diagnosis, yet the chief complaints reported for these ED visits were the same chief complaints reported for 88.7% of all ED visits. Of these visits, 11.1% were serious enough to be identified at ED triage as needing immediate emergency care, and 12.5% required hospital admission (with 3.4% of these going directly from the ED to the operating room).

Even before the COVID-19 pandemic, the need for access to mental health care and substance use services was reaching crisis levels. In 2019, less than half of adults with mental health conditions received services[2], and nearly 90% of those with a substance use disorder did not receive treatment.[3] EDs around the country often serve as the only safety net for a fragmented mental health infrastructure. For those in crisis for whom the ED is a lifeline for care, an added threat of a retroactive denial of coverage under this policy can be devastating.

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[1] Raven MC, Lowe RA, Maselli J, Hsia RY. Comparison of Presenting Complaint vs Discharge Diagnosis for Identifying "Nonemergency" Emergency Department Visits. JAMA. 2013;309(11):1145-1153. doi:10.1001/jama.2013.1948

[2] Substance Abuse and Mental Health Services Administration, "Mental Health and Substance Use Disorders," April, 30, 2020. Available at: https://www.samhsa.gov/findhelp/disorders.

[3] "The National Survey on Drug Use and Health: 2019," PowerPoint presentation, September 2020. Available at: https://www.samhsa. gov/data/sites/default/files/reports/rpt29392/Assistant-Secretary-nsduh2019_ presentation/Assistant-Secretary-nsduh2019_presentation.pdf.

In addition to shifting the responsibility for determining the difference between an emergent or non-emergent situation to the patient before any clinical evaluation, we believe the new coverage denial policy to be a violation of federal patient protection laws, specifically the "prudent layperson" (PLP) standard. This critical law allows people who reasonably think they are having an emergency to come to the ED without worrying about whether the services they receive will be covered by their insurance. Specifically, under the PLP, payors must cover any medical condition "manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the individual (or a pregnant woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part." Payors cannot deny reimbursement to providers based on the patient's final diagnosis.

Although the new policy claims to take into account the PLP standard, it does so by including an attestation process after an initial claim is denied. A policy of "deny first," "attest later" is in itself a clear violation of the PLP standard and will undoubtedly harm patients. It will have a chilling effect on patients' decisions to seek care, whether for themselves or for a loved one. It will take hearing only a few stories of neighbors, friends, or co-workers who were unexpectedly left with paying an entire ED bill after coverage was denied by UHC to make policyholders think twice about seeking care in an emergency. Such hesitation could be life-threatening or result in even greater costs to the healthcare system down the road.

Only full and permanent rescission of the policy will ensure the safety of our patients and your enrollees, and we urge you to take such action immediately.

Signed,

American College of Emergency Physicians

Alabama Arise

Alliance of Specialty Medicine

American Academy of Dermatology Association

American Academy of Ophthalmology

American Association of Neurological Surgeons

American Association of Orthopaedic Surgeons

American College of Obstetricians and Gynecologists

American College of Osteopathic Surgeons

American College of Radiology

American College of Surgeons

American Medical Association

American Osteopathic Association

(Continued)

American Society of Echocardiography

American Society of Plastic Surgeons

America's Essential Hospitals

Ann & Robert H. Lurie Children's Hospital of Chicago

Association of American Medical Colleges

California Medical Association

Center for Health & Democracy

Congress of Neurological Surgeons

Consumers for Quality Care

Emergency Department Practice Management Association (EDPMA)

Emergency Nurses Association

Federation of American Hospitals

Michigan State Medical Society

National Alliance on Mental Illness

National Association for Behavioral Healthcare

Pennsylvania Medical Society (PAMED)

Texas Medical Association

The Kennedy Forum

Well Being Trust