Coverage and Cost-Sharing of COVID-19 Testing

Broad access to the COVID-19 diagnostic test will enable the Centers for Disease Control and Prevention (CDC) as well as local and State public health departments to accurately track the course of the pandemic in our country, which will in turn lead to more aggressive treatment and the ability to identify when confirmed cases begin to reduce. One key element of the Family First Coronavirus Response Act (H.R. 6201) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act (H.R. 748), was ensuring appropriate coverage, without cost-sharing, for the COVID-19 test. The goal of this primer is to detail the specific coverage and cost-sharing elements within the Federal legislation, identify any gaps in coverage, and detail current State responses.

Who’s Covered
The Family First Coronavirus included provisions to extend coverage, without cost-sharing, for certain COVID-19 tests and related services for those:

- With individual and group health insurance (including ERISA and grandfathered plans) (per section 6001),
- Covered by Medicare fee-for-service (section 6002) and Medicare Advantage (section 6003),
- Covered by Medicaid and the Children’s Health Insurance Program (CHIP)(section 6004),
- With coverage through the Department of Defense (i.e., TRICARE)(Section 6006), the Department of Veterans Affairs (Section 6006), and Federal civilians (i.e., FEHBP) (Section 6006),
- Covered by the Indian Health Service (IHS)(Section 6007), and
- Without insurance by providing a State option to expand Medicaid for those individuals with a 100% FMAP for the COVID-19 services or, if the State does not opt to expand Medicaid, for payment through the National Disaster Medical System (NDMS).

In addition, for many of the Federal programs, the H.R. 6201 adds additional funding for these activities including:
- $82 M for the Department of Defense,
- $60 M for the Department of Veterans Affairs,
- $64 M for the Indian Health Service, and
- $1B for the uninsured through NDMS.

What’s Included in the Coverage
H.R. 6201 uniformly provides coverage, without cost sharing, for: (1) COVID-19 testing and (2) for the professional services tied to administering the test (i.e., doctor’s visit, ED visit, or urgent care visit). Further, coverage must be made available without requiring prior authorization from a health insurance plan.

H.R. 6201 initially limited coverage to tests with an Emergency Use Authorization (EUA). On March 16, the Food and Drug Administration (FDA) released a final guidance document which would allow additional tests to be used, beyond those with an EUA. This would include tests approved by States. The guidance also allows a fourteen-day

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1 Section 3716 of HR 748 clarified the definition of uninsured by stating: “Such term shall include an individual who is described in subclause (VIII) of section 1902(a)(10)(A)(i) if such individual resides in a State that does not make medical assistance available to individuals described in such subclause. Such term shall also include individuals who are enrolled for benefits under a State program under this title or another Federal health care program (as so defined) but whose benefits under such program do not include coverage at no cost sharing of a COVID-19 vaccine (and the administration of such vaccine) or coverage at no cost sharing of an in vitro diagnostic testing product described in section 1905(a)(3)(B) (and the administration of such product).”
window for use of tests that are in the process of obtaining an EUA. However, in the field, it is unlikely that physicians and other clinicians will know details about the regulatory status of a given test; instead, they must use what is available. The CARES Act addressed this issue in sections 3201 and 3702 by covering all tests under the FDA guidance.

How Much is the Provider Paid
Under section 3202, the CARES Act further clarified the reimbursement for COVID-related testing from a group health plan (including grandfathered and ERISA plans) or a health insurance issuer would be either (1) the in-network rate or (2) “the cash price for such service as listed by the provider on a public internet website, or such plan or issuer may negotiate a rate with such provider for less than such cash price.”

What’s Not Included in the Coverage
Despite these key coverage provisions, there are still a few potential gaps in coverage, including (1) coverage of simultaneous tests or procedures, (2) coverage of professional services when the diagnostic is unavailable, (3) and subsequent treatment (except for the certain insurers and the uninsured).

Coverage of Simultaneous Tests or Procedures. COVID-19 testing may not be the only evaluation required for accurate diagnoses (e.g., blood work up or other testing). Thus far, concurrent testing has not been addressed by policymakers.

Coverage of Professional Services when Diagnostic is Not Utilized. Of course, any discussion of COVID-19 diagnostic reimbursement assumes that a diagnostic is utilized. However, there are widespread reports of insufficient diagnostics as well as policies regarding presumptive testing. As patients present, clinicians are assessing patients and recommending self-quarantine in suspected cases, even when there is no diagnosis confirmed by diagnostic testing. On March 20, several members of Congress wrote to key insurers asking them to cover “presumptive” testing, given that the tests are not always available. The letter also urged insurers to cover subsequent treatment. Subsequent to that letter, CVS, Cigna, and Humana opted to provide such coverage, with certain caveats.

Subsequent Treatment. In addition to the diagnostic, patients may incur significant out-of-pocket costs for treatment of any disease – including COVID-19. Thus far, the insurance industry has catalogued the response, which does include some coverage for subsequent care and treatment. Further, States have opted to move forward with specific insurer requirements. Additional State efforts to address potential gaps in coverage are being followed by the Commonwealth Fund, with a map here.

Coverage of the Uninsured
As outlined in HR 6201, coverage for the uninsured follows two potential routes – (1) either a State opts to temporarily expand its Medicaid program to allow for limited coverage for the uninsured under a section 1135 waiver for the COVID-19 test and professional services related to that test; or (2) for States that do not provide such expansion, reimbursement from the National Disaster Medical System (NDMS).

Section 1135 waivers. To determine whether a particular State has opted to expand Medicaid to cover the uninsured for COVID-19 testing, please visit the CMS website.

Note: This expansion is separate and distinct from the Medicaid expansion related to the Affordable Care Act (ACA).
NDMS. For States who do not opt to expand Medicaid, then those services would be reimbursed through the NDMS. According to the payment rules of the NDMS (prior to the enactment of the recent COVID-19-related legislation), to receive payment for certain patients through the NDMS, any Medicare or Medicaid participating provider can receive reimbursement, provided that they register with the NDMS and submit specific claims. Generally, reimbursement rates are set at Medicare rates. At this time, additional direction has not been provided regarding the uninsured and its application to NDMS.

Subsequent Treatment. On April 3, during the Task Force press conference, Secretary Azar noted that a portion of the $100B provided to the Public Health and Social Services Fund (PHSSEF) for health care providers in the CARES Act would be allocated to cover the cost of the treatment for the uninsured. Such funding would be through the same mechanism as COVID-19 testing. As a condition of receiving the funds, providers would have to agree not to balance bill, and the reimbursement rates would be set at Medicare rates.

On April 7, CMS Administrator Seema Verma noted that $30B of the $100B fund through the PHSSEF for health care providers, $30 billion will be available via grants, based on Medicare revenue, and such funds will NOT be on a first come, first serve basis. To receive the funds, providers will need to register with CMS. Money can be direct deposited. She acknowledged that certain providers (e.g., pediatricians, OB/Gyns, etc.) do not serve a large portion of the Medicare population. As such, CMS will address those issues in the second wave of funding from the fund. During that announcement, there was no discussion regarding the uninsured.

On April 7, the Kaiser Family Foundation (KFF) released a report that estimated that “total payments to hospitals for treating uninsured patients under the Trump administration policy would range from $13.9 billion to $41.8 billion. At the top end of the range, payments on behalf of the uninsured would consume more than 40% of the $100 billion fund Congress created to help hospitals and others respond to the COVID-19 epidemic.”

Other Federal Efforts
With regard to Medicare and Medicaid, the Centers for Medicare and Medicaid Services (CMS) has issued information related to coverage of COVID-19 testing. In addition, CMS has also stated that COVID-19 testing is an Essential Health Benefit (EHB), and the IRS has issued guidance regarding High Deductible Health Plans to allow for the elimination of cost-sharing for COVID-19 testing.