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 new law, the *Family First Coronavirus Response Act* (H.R. 6201), 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 law 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

The law uniformly provides coverage, without cost sharing, for: (1) COVID-19 testing under an Emergency Use Authorization (EUA) or otherwise cleared or approved by the Agency 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.

What's Not Included in the Coverage

Despite these key coverage provisions, there are still a few potential gaps in coverage, including: (1) tests available without an Emergency Use Authorization (EUA); (2) coverage of simultaneous tests or procedures; (3) coverage of professional services when the diagnostic is unavailable, and subsequent treatment.

Tests without an EUA. H.R. 6201 limits coverage to tests with an Emergency Use Authorization (EUA). However, 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 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 recently unveiled CARES Act (Phase III proposal) by Senate Majority Leader McConnell would address this potential coverage gap by covering all tests under the FDA guidance. It is unclear at this time if it will be included in the final Phase III package.

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 Unavailable. Of course, any discussion of COVID-19 diagnostic reimbursement assumes that a diagnostic is available. However, there are widespread reports of insufficient diagnostics. As patients present, clinicians are assessing patients and recommending self-quarantine in suspected cases, even when there is no diagnosis confirmed by diagnostic testing.

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 stated that it will cover treatment of COVID-19 the same as treatment of any other disease, meaning coverage terms would be subject to a patient's individual plan. In recognition of the potential for high costs to patients, the State of Washington submitted a waiver request to CMS in which it requested the authority to temporarily waive any patient cost-sharing for COVID-19 screening, testing, and treatment. As more cases are diagnosed and treated, more States will likely request this authority.

Federal Implementation 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.

Additional State Efforts

Additionally, thus far, according to the Commonwealth Fund, at least fourteen States have prevented insurers from charging cost-sharing for the COVID-19 diagnostic test.