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COVID-19 Testing: Who Pays?

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As COVID-19 testing continues to increase throughout the nation, providers and patients alike are faced with the issue of who is responsible for covering the cost of testing. Whether a payor will reimburse for a COVID-19 test will depend not only on the payor, but on other factors such as the type of test and whether testing is medically appropriate.

Group Health Plans

The Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security (CARES) Act, requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide benefits for certain items and services related to testing and diagnosis of COVID-19 after March 18, 2020, through the end of the public health emergency.

Specific to COVID-19 diagnostic testing, plans are required to cover fees incurred in the administration of a COVID-19 diagnostic test, including facility fees, without cost-sharing, prior authorization, or medical management requirements, if the evaluation results in an order for or administration of a COVID-19 diagnostic test. If an individual's attending provider also determines that other tests are necessary, such as influenza or blood tests, to determine the need for COVID-19 diagnostic testing, the plan must also provide coverage for the related tests.

Generally, group health plans will require COVID-19 diagnostic testing to comply with each of the following elements to qualify for reimbursement:

> *Medically Appropriate.* Specific to COVID-19 testing, plans are required to cover in vitro diagnostic testing that has been determined medically appropriate for the patient in accordance with current accepted standards of medical practice. The requirement that a test be medically appropriate will generally preclude coverage of tests that are performed for purposes of epidemiological or population health screening purposes, or for employment screening, including return-to-work determinations.
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> *Determination by Attending Provider.* The determination as to whether a test is medically appropriate must be made after an individualized clinical assessment by an “attending provider,” or the individual licensed under applicable law, acting within the scope of their license, who is responsible for providing care to the patient.
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> *Authorized Test.* COVID-19 diagnostic tests encompass several different testing types: polymerase chain reaction (PCR) tests, antigen tests, and antibody/serology tests. Each test has specific applications for which it is best suited, and selection of which test is

appropriate must be made by the attending provider. Regardless, only those in vitro diagnostic tests that have secured specific authorization are required to be covered. Generally, this means a diagnostic test that has been authorized by the Food and Drug Administration (FDA) through the Emergency Use Authorization (EUA) process, or that is in the process of obtaining such authorization. The FDA is maintaining a list of EUA-authorized tests, and those that are in the process of obtaining such authorization. Some states, listed here, have notified the FDA of their intent to authorize specific laboratories to develop and perform COVID-19 testing, and these tests would also be considered authorized for purposes of coverage requirements.

Out-of-network providers performing COVID-19 testing that do not have a negotiated rate with the payor can expect to be reimbursed the cash price that is posted on the provider's public-facing website – the posting of this price is required under Section 319 of the Public Health Service Act. Patients may not be balance billed for amounts not paid by their insurer.

For additional information about coverage requirements for group health plans, visit the FAQ published June 23, 2020, or the earlier FAQ published April 11, 2020. Excluded from these requirements are short-term limited duration insurance plans, retiree-only plans, and HIPAA excepted benefit plans.

Medicare

Medicare coverage requirements are similar to those for group health plans. Medicare will cover medically necessary COVID-19 in vitro diagnostic tests with no cost-sharing requirements when tests are ordered by a healthcare professional authorized under state law. Medicare not only reimburses labs performing the testing, but also hospitals and practitioners who assess beneficiaries and collect samples for testing. And, because COVID-19 and influenza have similar symptoms, Medicare is also covering clinical diagnostic laboratory tests for influenza virus and respiratory syncytial virus with no cost-sharing requirements when furnished in conjunction with a COVID-19 test.

Medicare also recently announced it will cover COVID-19 diagnostic testing for nursing home residents and patients, as recommended by the Centers for Disease Control and Prevention's (CDC's) testing guidelines for nursing homes. This coverage began July 6, 2020. This includes testing those with symptoms of COVID-19, testing asymptomatic individuals who have been exposed to COVID-19, initial baseline testing, and testing to determine infection resolution. More information about this coverage is available in the July 17, 2020, MLN Matters.

Uninsured Patients

The U.S. Department of Health and Human Services (HHS) has established a program administered through the Health Resources and

Services Administration (HRSA) to reimburse healthcare entities that have conducted COVID-19 testing of uninsured individuals on or after February 4, 2020. These healthcare entities can submit claims electronically through the program for reimbursement at Medicare rates, subject to available funding. The FFCRA and Paycheck Protection Program and Health Care Enhancement Act (PPPHCA) each appropriated $1 billion for the purposes of COVID-19 testing reimbursement. For more information on how to enroll in the program or requirements for reimbursement, visit the HRSA FAQs webpage.

Other Considerations

The general consensus among payors is that COVID-19 testing performed for epidemiological or public health surveillance purposes will not be covered. As far as other testing of asymptomatic individuals, each payor has unique parameters for determining whether such testing is medically appropriate (e.g., early identification in special settings, determining resolution of infection).

Providers should also consider whether they are bound by other terms and conditions that may influence their ability to seek reimbursement from private payors or patients for COVID-19 testing. For example, a provider's acceptance of payments from the Provider Relief Fund for a presumptive or actual case of COVID-19 requires the provider to certify that it will not seek to collect from the patient for any out-of-pocket expenses that are greater than what the patient would have been required to pay if the care was provided by an in-network provider. Generally, providers will be prohibited from balance billing patients for COVID-19 diagnostic testing that is reimbursed by another payment source.

Finally, state Medicaid programs have their own standards for reimbursement. For more information about testing requirements specific to Idaho's Medicaid program, see the current Information Release, or contact your state's Medicaid department.