How much do Medicare beneficiaries pay for COVID-19 testing?

Currently, Medicare beneficiaries are required to pay for the cost of at-home rapid tests for COVID-19 and are not getting reimbursed by Medicare (unlike people with private insurance). According to new actions announced by the Biden Administration in December 2021, beneficiaries can access free at-home tests through neighborhood sites such as health centers and rural clinics. In addition, beginning January 19, 2022, Medicare beneficiaries and others can request four free at-home tests through a new federal government website.

Medicare beneficiaries who get a lab test for COVID-19 are not required to pay the Part B deductible or any coinsurance for this test, because clinical diagnostic laboratory tests are covered under traditional Medicare at no cost sharing. Beneficiaries will also not face cost sharing for the COVID-19 serology test, since it is considered to be a diagnostic laboratory test. (Under traditional Medicare, beneficiaries typically face a $233 deductible for Part B services and coinsurance of 20 percent.)

A provision in the Families First Coronavirus Response Act also eliminates beneficiary cost sharing for COVID-19 testing-related services, including the associated physician visit or other outpatient visit (such as hospital observation, E-visit, or emergency department services). A testing-related service is a medical visit furnished during the emergency period that results in ordering or administering the test. The law also eliminates cost sharing for Medicare Advantage enrollees for both the COVID-19 test and testing-related services and prohibits the use of prior authorization or other utilization management requirements for these services.

Does Medicare cover treatment for COVID-19?

Patients who get seriously ill from the virus may need a variety of inpatient and outpatient

services. Medicare covers inpatient hospital stays, skilled nursing facility (SNF) stays, some home health visits, and hospice care under Part A. If an inpatient hospitalization is required for treatment of COVID-19, this treatment will be covered for Medicare beneficiaries, including beneficiaries in traditional Medicare and those in Medicare Advantage plans. This includes treatment with therapeutics, such as remdesivir, that are authorized or approved for use in patients hospitalized with COVID-19, for which hospitals are reimbursed a fixed amount that includes the cost of any medicines a patient receives during the inpatient stay, as well as costs associated with other treatments and services. Beneficiaries who need post-acute care following a hospitalization have coverage of SNF stays, but Medicare does not cover long-term services and supports, such as extended stays in a nursing home.
Medicare covers outpatient services, including physician visits, physician-administered and infusion drugs, emergency ambulance transportation, and emergency room visits, under Part B. Based on program instruction, Medicare covers monoclonal antibody infusions, including remdesivir, that are provided in outpatient settings and used to treat mild to moderate COVID-19, even if they are authorized for use by the U.S. Food and Drug Administration (FDA) under an emergency use authorization (EUA), prior to full FDA approval.

Two new oral antiviral treatments for for COVID-19 from Pfizer and Merck have recently been authorized for use by the FDA. These treatments will likely be covered under Medicare Part D once they are approved by the FDA; however, the definition of a Part D covered drug does not include drugs authorized for use by the FDA but not FDA-approved. CMS recently issued guidance to Part D plan sponsors, including both stand-alone drug plans and Medicare Advantage prescription drug plans, that provides them flexibilities to offer these oral antivirals to their enrollees and strongly encourages them to do so, though this is not a requirement. In the near term, access to these drugs may be quite limited based on limited supply, although the federal government has purchased millions of doses of these drugs and is distributing them to states.

How much do Medicare beneficiaries pay for COVID-19 treatment?

Beneficiaries who are admitted to a hospital for treatment of COVID-19 would be subject to the Medicare Part A deductible of $1,556 per benefit period in 2022. Part A also requires daily copayments for extended inpatient hospital and SNF stays. For extended hospital stays,

beneficiaries would pay a $389 copayment per day (days 61-90) and $778 per day for lifetime reserve days. If a patient is required to be quarantined in the hospital, even if they no longer meet the need for acute inpatient care and would otherwise by discharged, they would not be required to pay an additional deductible for quarantine in a hospital. Traditional Medicare beneficiaries who need post-acute care following a hospitalization would face copayments of $194.50 per day for extended days in a SNF (days 21-100).
For outpatient services covered under Part B, there is a $233 deductible in 2022 and 20 percent coinsurance that applies to most services, including physician visits and emergency ambulance transportation. However, according to a recent CMS program instruction, for COVID-19 monoclonal antibody treatment specifically, an infused treatment provided in outpatient settings, Medicare beneficiaries will pay no cost sharing and the deductible does not apply.

While most traditional Medicare beneficiaries (90% in 2018) have supplemental coverage (such as Medigap, retiree health benefits, or Medicaid) that covers some or all of their cost-sharing requirements, 5.6 million beneficiaries lacked supplemental coverage in 2018, which places them at greater risk of incurring high medical expenses or foregoing medical care due to costs. Medicare does not have an out-of-pocket limit for services covered under Medicare Parts A and B.

Cost-sharing requirements for beneficiaries in Medicare Advantage plans vary across plans. Medicare Advantage plans often charge daily copayments for inpatient hospital stays, emergency room services, and ambulance transportation. Medicare Advantage enrollees can be expected to face varying costs for a hospital stay depending on the length of stay and their plan's cost-sharing amounts. According to CMS guidance, Medicare Advantage plans may waive or reduce cost sharing for COVID-19-related treatments, and most Medicare Advantage insurers temporarily waived such costs, but many of those waivers have expired. Plans may also waive prior authorization requirements that would apply to services related to COVID-19.

Does Medicare cover vaccines and boosters for COVID-19 and how much do beneficiaries pay?

Medicare Part B covers certain preventive vaccines (influenza, pneumococcal, and Hepatitis B), and these vaccines are not subject to Part B coinsurance and the deductible. Medicare Part B

also covers vaccines related to medically necessary treatment. For traditional Medicare beneficiaries who need these medically necessary vaccines, the Part B deductible and 20 percent coinsurance would apply.

Based on a provision in the CARES Act, a vaccine that is approved by the FDA for COVID-19 is covered by Medicare under Part B with no cost sharing for Medicare beneficiaries for the vaccine or its administration; this applies to beneficiaries in both traditional Medicare and Medicare Advantage plans. Although the CARES Act specifically provided for Medicare coverage at no cost for COVID-19 vaccines licensed by the U.S. Food and Drug Administration (FDA), CMS has issued regulations requiring no-cost Medicare coverage of COVID-19 vaccines that are also authorized for use under an emergency use authorization (EUA) but not yet licensed by the FDA. This policy of providing vaccines without cost sharing to Medicare beneficiaries also applies to booster doses.

To date, the FDA has issued EUAs for three COVID-19 vaccines from Pfizer-BioNTech, Moderna, and Janssen, as well as boosters for Pfizer and Moderna after completing a primary series of the vaccine.

What telehealth benefits are covered by Medicare, and how much do beneficiaries pay?

Based on waiver authority included in the Coronavirus Preparedness and Response Supplemental Appropriations Act (and as amended by the CARES Act) the HHS Secretary has waived certain restrictions on Medicare coverage of telehealth services for traditional Medicare beneficiaries during the coronavirus public health emergency. The waiver, effective for services starting on March 6, 2020, allows beneficiaries in any geographic area to receive telehealth services; allows beneficiaries to remain in their homes for telehealth visits reimbursed by Medicare; allows telehealth visits to be delivered via smartphone with real-time audio/video interactive capabilities in lieu of other equipment; and removes the requirement that providers of telehealth services have treated the beneficiary receiving these services in the last three years. A separate provision in the CARES Act allows federally qualified health centers and rural health clinics to provide telehealth services to Medicare beneficiaries during the COVID-19 emergency period, which was most recently renewed in January 2022.

Telehealth services are not limited to COVID-19 related services, and can include regular office visits, mental health counseling, and preventive health screenings. During the emergency period, Medicare will also cover some evaluation and management, behavioral health, and patient education services provided to patients via audio-only telephone.
Separate from the time-limited expanded availability of telehealth services, traditional Medicare also covers brief, "virtual check-ins" via telephone or captured video image, and E-visits, for all beneficiaries, regardless of whether they reside in a rural area. These visits are more limited in scope than a full telehealth visit, and there is no originating site requirement.

Medicare covers all types of telehealth services under Part B, so beneficiaries in traditional Medicare who use these benefits are subject to the Part B deductible of $233 in 2022 and 20 percent coinsurance. However, the HHS Office of Inspector General is providing flexibility for providers to reduce or waive cost sharing for telehealth visits during the COVID-19 public health emergency.

Medicare Advantage plans can offer additional telehealth benefits not covered by traditional Medicare, including telehealth visits for beneficiaries provided to enrollees in their own homes, and services provided outside of rural areas. Medicare Advantage plans have flexibility to waive certain requirements regarding coverage and cost sharing in cases of disaster or emergency, such as the COVID-19 outbreak. In response to the coronavirus pandemic, CMS has advised plans that they may waive or reduce cost sharing for telehealth services, as long as plans do this uniformly for all similarly situated enrollees.

Can Medicare beneficiaries get extended supplies of medication?

The Department of Homeland Security recommends that, in advance of a pandemic, people ensure they have a continuous supply of regular prescription drugs. In light of the coronavirus pandemic, a provision in the CARES Act requires Part D plans (both stand-alone drug plans and Medicare Advantage drug plans) to provide up to a 90-day (3 month) supply of covered Part D drugs to enrollees who request it during the public health emergency. (Typically Medicare Part D plans place limits on the amount of medication people can receive at one time and the frequency with which patients can refill their medications.)

According to CMS, for drugs covered under Part B, Medicare and its contractors make decisions locally and on a case-by-case basis as to whether to provide and pay for a greater-than-30 day supply of drugs.

What happens if Medicare beneficiaries in private plans need to receive care from out-of-network providers?

Plans that provide Medicare-covered benefits to Medicare beneficiaries, including stand-alone prescription drug plans and Medicare Advantage plans, typically have provider networks and limit the ability of enrollees to receive Medicare-covered services from out-of-network providers, or charge enrollees more when they receive services from out-of-network providers or pharmacies. In light of the declaration of a public health emergency in response to the coronavirus pandemic, certain special requirements with regard to out-of-network services are in place. During the period of the declared emergency, Medicare Advantage plans are required to cover services at out-of-network facilities that participate in Medicare, and charge enrollees who are affected by the emergency and who receive care at out-of-network facilities no more than they would face if they had received care at an in-network facility.

Part D plan sponsors are also required to ensure that their enrollees have adequate access to covered Part D drugs at out-of-network pharmacies when enrollees cannot reasonably be expected to use in-network pharmacies. Part D plans may also relax restrictions they may have in place with regard to various methods of delivery, such as mail or home delivery, to ensure access to needed medications for enrollees who may be unable to get to a retail pharmacy.

Are there any special rules for Medicare coverage for skilled nursing facility or nursing home residents related to COVID-19?

In response to the national emergency declaration related to the coronavirus pandemic, CMS has waived the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) for those Medicare beneficiaries who need to be transferred as a result of the effect of a disaster or emergency. For beneficiaries who may have recently exhausted their SNF benefits, the waiver from CMS authorizes renewed SNF coverage without first having to start a new benefit period.

Nursing home residents who have Medicare coverage and who need inpatient hospital care, or other Part A, B, or D covered services related to testing and treatment of coronavirus disease, are entitled to those benefits in the same manner that community residents with Medicare are. Medicare establishes quality and safety standards for nursing facilities with Medicare beds, and has issued guidance to facilities to help curb the spread of coronavirus infections. In the early months of the COVID-19 pandemic, the guidance directed nursing homes to restrict visitation by all visitors and non-essential health care personnel (except in compassionate care situations such as end-of-life), cancel communal dining and other group activities, actively screen residents and staff for symptoms of COVID-19, and use personal protective equipment (PPE).

More recently, CMS has issued reopening recommendations and updated guidance addressing safety standards for visitation in nursing homes to accommodate both indoor and outdoor visitation. Nursing facilities are also required to report COVID-19 data to the Centers for Disease Control and Prevention (CDC), including data on infections and deaths, COVID-19 vaccine status of residents and staff and provide information to residents and their families. They are also required to conduct weekly testing of staff if they are located in states with a positivity rate of 5% or greater.

Of note, CMS guidances to nursing facilities and data reporting requirements do not apply to assisted living facilities, which are regulated by states. Analysis has shown considerable variation across states when it comes to regulations to protect against the spread of coronavirus infections in assisted living facilities, as well as COVID-19 data reporting requirements.

https://www.kff.org/coronavirus-covid-19/issue-brief/faqs-on-medicare-coverage-and-costs-related-to-covid-19-testing-and-treatment/