A Test for Long COVID Can’t Leave Anyone Behind

Long COVID has required a kind of medicine that is collaborative, curious and rooted in partnership. That spirit must not be lost the moment a test arrives.

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A blood draw. A panel of results. For the first time, biological proof of what millions of people have known in their bodies for years. A test for long COVID will be transformative, and we should start preparing for its arrival now.

That test will be a biomarker: a measurable sign of disease that a clinician can test for, track over time, and use to guide treatment. For long COVID, that could mean detecting viral persistence, immune dysregulation, microvascular damage, neurologic inflammation, or some combination of these. It would transform a diagnosis that has relied on self-reporting and clinical judgment into one grounded in objective evidence.

This will be an extraordinary step forward. A test any doctor could order would provide validation, reduce stigma, and unlock access to services and protections that have been denied to people with long COVID for years. Biomarkers could help clinicians personalize treatment, enroll the right participants in clinical trials, and give pharmaceutical companies the measurable outcomes needed to justify investment. There is a reason researchers and advocates have been working toward this milestone: a validated test will accelerate progress for everyone.

We are getting closer, but we are not there yet. And as researchers work to deliver on that promise, we also need to prepare for what that test won’t do.

Several promising candidates are under active investigation, and the science is accelerating. But turning a research finding into a test a doctor can order takes time. The eventual long COVID test will need to hold up across research teams and study populations, and be practical enough for everyday use.

This is no easy task with long COVID: It affects the whole body, and many of its defining features, like fatigue, post-exertional malaise, cognitive dysfunction, and dysautonomia, are shared across conditions like myalgic encephalomyelitis (ME), postural orthostatic tachycardia syndrome (POTS), and fibromyalgia. These conditions also lack definitive diagnostic tests, and where long COVID ends and they begin is a question we cannot answer with confidence yet. A biomarker will help

clarify those boundaries but is unlikely to resolve them entirely on its own.

The most meaningful part of being a long COVID clinician and researcher has been the inclusivity this work demands. From the beginning, people with long COVID have been the experts, teaching us what this illness feels like and how it unfolds. We have learned to listen closely, to treat symptoms as truth, and to build care around the complexity of human experience. Long COVID has required a kind of medicine that is collaborative, curious, and rooted in partnership. That spirit must not be lost the moment a test arrives.

In medicine, no test is perfect. Biology is messy. The first version of any biomarker will likely only reflect part of the truth of long COVID. A good test will identify most who are ill, but not every single person, just as COVID-19 PCR tests can miss infections. And the consequences of drawing lines between who is counted and who is excluded have the potential to reshape care in ways that leave people behind.

A biomarker will inevitably change how long COVID is defined. If we are not ready, those shifts could undermine the very community that has built this field from the ground up. The time to prepare is now, not after people are left behind.

When the test misses the disease

The first group of people who will need protection is those who have long COVID but whose biology does not test positive on the initial test. These are called “false negatives.” These people will still be disabled, still in need of care, and still waiting for answers. Their disease may involve mechanisms the test was not designed to detect, or it may manifest in ways that only become measurable as the science matures.

Celiac disease offers a useful parallel. Celiac is an autoimmune condition triggered by gluten, and for years, the standard blood test used to diagnose it missed a meaningful number of people who had the disease. When the blood test came back negative, most were never referred for the biopsy that would have confirmed their diagnosis. Over time, clinicians and researchers recognized the test’s limitations, diagnostic guidelines evolved, and the definition of the disease expanded to include those the original test had missed.

The same trajectory is likely for long COVID. The first test will not be the last, and the people it misses are not any less sick because of its limitations.

But in the early years of biomarker adoption, we face a real dilemma. Clinical trials will likely need to limit enrollment to people who test positive, because this is the best research design to identify who may benefit and measure whether a treatment is working. But it means that some of the sickest people may be temporarily excluded from the trials they need most — not because they do not have the disease, but because the test cannot yet see it.

While that trade-off may be necessary for research to accelerate finding cures, it is not acceptable as a basis for denying care. Unless we are vigilant, insurers will copy and paste from trial eligibility criteria into coverage decisions, using a negative biomarker to save money rather than inform

care. This is especially likely if the first approved treatments are expensive.

Coverage policies must explicitly state that biomarker results can inform clinical decisions but cannot override them. A negative test result cannot become an automatic barrier to treatment, and that standard must hold at every level, from the insurer reviewing a claim to the primary care physician deciding what to do next. A test is a tool. It is not a verdict.

A correct test still isn't the final answer

The second group that needs protection is people who test negative because they do not have long COVID: the "true negatives." In the early years of biomarker adoption, many true negatives will be indistinguishable from false negatives. Both groups will have significant, disabling symptoms, and sorting one from the other will require sustained evaluation with a thoughtful clinician, improved testing, and time.

Conditions like ME, POTS, and fibromyalgia are serious illnesses with their own long histories of being dismissed, underfunded, and poorly understood. These illnesses and others in the umbrella of infection-associated chronic conditions (IACCs) predate long COVID by decades; some may overlap with long COVID, while others may have entirely different causes. Some people who have found care and community within long COVID clinics will test negative, and for some of them, the right diagnosis may turn out to be one of these conditions, or something else entirely.

One of my patients was getting by for years with unexplained symptoms until a SARS-CoV-2 infection led to severe disability. Careful evaluation with other specialists eventually revealed a rare genetic disorder, and later, an autoimmune condition layered on top of it. Even now, we cannot say whether she also has long COVID or whether the infection simply accelerated those illnesses. A biomarker would help answer that question.

Saying someone does not have long COVID is not a statement about whether they are sick. It is a statement about what they are sick with, and better biological stratification will move us closer to precision treatments for everyone.

Long COVID clinics have tried to build something where the health system typically fails: care for people with complex, unexplained illness. Those lessons do not stop being relevant the moment a biomarker returns negative. Patients with these conditions have historically been orphaned, bounced between specialists with no one willing to take responsibility for their care.

A negative test will always be cheaper and easier than continued care, and health systems will be tempted to use it as a gatekeeper to entry or a reason to discharge. We must resist that reflex. Clinics and health systems need to build care pathways now so that the models developed for Long COVID can support anyone living with complex chronic illness, regardless of their test result.

A negative test does not mean a person is well. It means they need a different kind of attention, not less of it.

Preparing for a biomarker is the real test

For both groups of people who do not test positive, biomarkers must expand what is possible in care, not restrict it. Long COVID has already shown us how to do better: to see patients in full, to practice medicine that values lived experience, and to meet disability with dignity rather than doubt.

Clinics and health systems need clear policies, created in partnership with people with long COVID and other IACCs, that spell out how care continues when a test comes back negative. That includes protocols for ongoing evaluation, treatment access, and thoughtful referral so that no one is denied the care they need. Researchers should study how treatments perform in people without biomarker positivity: supervised access programs, open-label extensions, and dedicated follow-up groups that collect real-world evidence.

And we need commitments from the Centers for Medicare and Medicaid Services, state insurance regulators, and private payers. A negative biomarker cannot be used to deny coverage when clinical judgment and symptoms say otherwise. These standards need to exist before the first test is widely available, not in reaction to the harm that follows without them — and they could inform better standards for other diseases in the future.

Early tests will be imperfect. Policy must account for that from day one. The real breakthrough will not be in the lab. It will be in our collective refusal to forget anyone who is sick.

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