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Freedom Without Opportunity: Using Medicare Policy and CMS Mechanisms to Anticipate the Platform Economy's Pitfalls and Ensure Healthcare Platform Workers Are Fairly Paid

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Freedom Without Opportunity

USING MEDICARE POLICY AND CMS MECHANISMS TO ANTICIPATE THE PLATFORM ECONOMY'S PITFALLS AND ENSURE HEALTHCARE PLATFORM WORKERS ARE FAIRLY PAID

"Freedom without opportunity is a devil's gift, and the refusal to provide such opportunities is criminal."[1]

INTRODUCTION

The Golden Age is here. "Baby boomers," or people born between 1946 and 1964, are part of the fastest-growing demographic, proportional to other age groups, in the United States.[2] This "gray tsunami"[3] has revealed a lack in, and has in turn, necessitated long-term healthcare and supports.[4] The rate at which the elderly population continues to grow, however, outpaces the growth of the available amount of healthcare workers.[5] By 2026, the oldest of the baby boomers will be in their eighties, increasing the gap between the number of baby boomers

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1 Noam Chomsky, *Market Democracy in a Neoliberal Order: Doctrines and Reality*, Z MAG. (Nov. 1997), https://chomsky.info/199711 [https://perma.cc/DCY4-R2ND].

2 In 2018, the United States Census Bureau made a projection that "[b]y 2030, all baby boomers will be older than age 65" meaning that "within just a couple of decades, older people [will] outnumber children for the first time in U.S. history." Press Release, United States Census Bureau, Older People Projected to Outnumber Children for First Time in U.S. History (Mar. 13, 2018), https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html#:~:text=By%202030%2C%20all%20baby%20boomers,residents%20will%20be%20retirement%20age.&text=The%202030s%20are%20projected%20to,decade%20for%20the%20U.S.%20population [https://perma.cc/Y929-JL94].

3 The term "gray tsunami" is a term colloquially used to describe the trend of an intensifying aging population. This rapidly growing demographic has been associated with a natural calamity due to its potential to deluge healthcare systems on a global scale and pillage "social, political, and economic norms." This terminology also suggests that it is a phenomenon for which our society predicted and could have planned. Jeff Wheelwright, *The Gray Tsunami*, DISCOVER (Sept. 18, 2012, 1:00 AM), https://www.discovermagazine.com/health/the-gray-tsunami [https://perma.cc/CF5N-HTYH].

4 Mark Mather et al., *Aging Baby Boomers to Face Caregiving, Obesity, Inequality Challenges*, PBR (Jan. 13, 2016), https://www.prb.org/unitedstates-population-bulletin [https://perma.cc/6BTA-3Y8Q] ("The aging of the baby boom generation could fuel a 75 percent increase in the number of Americans ages 65 and older requiring nursing home care . . . .").

5 NAT'L ACADS. OF SCIS., ENG'G, & MED., COMM. ON FAMILY CAREGIVING FOR OLDER ADULTS, FAMILIES CARING FOR AN AGING AMERICA 58 (Richard Schulz & Jill Eden eds., 2016) [hereinafter COMM. ON FAMILY CAREGIVING].

and the availability of home healthcare workers and other types of caregivers.[6] Furthermore, the aging population's anticipated longer life expectancy, coupled with its increasing desire to receive care at home, fuels a growing shortage of home healthcare delivery.[7] The demographic shift, as such, has elicited a technological response.[8] Even Silicon Valley has ventured into the market of technology geared toward the elderly in an industry appropriately termed "senior tech."[9] Startups are rushing into the scene with hopes that their products strike gold.[10] What's more, venture capitalists are just as enthusiastic about funding the next big "disruptor"[11] in senior tech.[12] And, the use of technology in healthcare generally promises to cut costs and spending,[13] incentivizing providers to adopt a more tech-driven practice.

So far, senior tech has made strides into the long-term healthcare industry. From apps that pair with Google Home and Amazon Echo to help caregivers "[manage] help requests, performance reports, and remote controls"; to robotic voice-enabled "assistant[s]" that simplify tasks like medication reminders and scheduling doctor appointments; to interactive apps that help jog memories; the senior tech field is a rapidly

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[6] *Id.* at 34.

[7] Drew Simshaw et al., *Regulating Healthcare Robots: Maximizing Opportunities While Minimizing Risks*, 22 RICH. J. L. & TECH. 1, 4–5 (2016); Bob Woods, *America's $103 Billion Home Health-Care System Is in Crisis as Worker Shortage Worsens*, CNBC (Apr. 9, 2019, 11:06 AM), https://www.cnbc.com/2019/04/09/us-home-healthcare-system-is-in-crisis-as-worker-shortages-worsen.html [https://perma.cc/WR45-TCS8] (describing that the healthcare system's goal to deinstitutionalize seniors and keep them at home has caused a major shift in healthcare spending to cover home healthcare services).

[8] *Id.* at 1 n.1 ("To support, enhance, and mitigate the healthcare burdens, our healthcare system is witnessing robotic medical technology entering hospital surgical suites, in-patient rooms, in-home patient care, and uses with emergency services and vehicles.").

[9] Tom McNichol, *10,000 Baby Boomers Turn 65 in the US Every Day – Can Silicon Valley Help with 'Happier Ageing'?*, GUARDIAN (Sept. 3, 2019, 1:00 AM), https://www.theguardian.com/technology/2019/sep/03/senior-citizens-apps-tech-devices [https://perma.cc/Y53N-58K7].

[10] *Id.*

[11] The term "disruptor" is often used within the context of business, technology, and marketing as a way to refer to disruptive innovation. A disruptor "create[s] a product, service, or way of doing things which displaces the existing market leaders and eventually replaces them at the helm of the sector." Barney Cotton, *What is a Disruptor?*, BUS. LEADER (Sept. 27, 2018, 9:15 AM), https://www.businessleader.co.uk/what-is-a-disruptor/52464 [https://perma.cc/Y8AL-5JXL].

[12] *See* McNichol, *supra* note 9.

[13] Nicolas Terry, *Of Regulating Healthcare AI and Robots*, 18 YALE. J. HEALTH POL'Y L. & ETHICS 133, 187 (2019); *see also* Ronald S. Weinstein et al., *Telemedicine, Telehealth, and Mobile Health Applications That Work: Opportunities and Barriers*, 127 AM. J. MED. 183, 184 (2014) (stating that the passage of the Affordable Care Act propelled the implementation of health technology by providers recognizing the potential for technologies to "fundamentally change the way medical services are delivered"). *But see* Neel U. Sukhatme & M. Gregg Bloche, *Health Care Costs and the Arc of Innovation*, 104 MINN. L. REV. 955, 961 (2019) (attributing the rise of long-term healthcare spending, in part, to the advancement of technology in the industry).

saturating market.[14] For example, Paro is a therapeutic robotic baby seal created by Japanese developer Takanori Sibati, intended to be a "pet alternative" to boost the mood of elderly persons who lack or desire companionship.[15] Completely automated, Paro responds to humans and the environment thanks to its five types of sensors which perceive touch, light, sound, temperature, and posture.[16]

Mabu, another recent technological creation for seniors, is a tabletop robot created as a "personal health assistant [] working to reduce congestive heart failure" and prevent readmission to hospitals.[17] Developed by San Francisco-based Catalia Health, Mabu applies its conversational and social intelligence AI technology to foster long-term health engagement through personalized interactions with its elderly user.[18] Mabu's imbued social intelligence serves a secondary function as a companion for individuals experiencing loneliness.[19]

Like many industries embracing technological advances to automate and digitize services, the healthcare industry has begun to turn to new labor markets like the platform economy.[20] The platform economy can be described as an economy in which businesses tap into an online platform to facilitate community-based interactions between individuals.[21] Inserting a digital platform between the consumer and worker to facilitate online peer-to-peer sharing of assets, goods, or services disrupts the notion of traditional jobs and "amplifies the scale on which platform economy activity occurs."[22] The platform economy's

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[14] *See* McNichol, *supra* note 9.

[15] Naveed Saleh, *Paro Is the Therapeutic Robot Seal*, VERYWELLHEALTH (June 11, 2020), https://www.verywellhealth.com/paro-the-therapeutic-robot-seal-1123855 [https://perma.cc/SGF4-3MKM].

[16] *Id.*

[17] Khari Johnson, *Mabu, A Robot Helping Patients with Congestive Heart Failure, Is Working with the American Heart Association*, VENTUREBEAT (Oct. 2, 2018, 8:09 PM), https://venturebeat.com/2018/10/02/mabu-a-robot-helping-patients-with-congestive-heart-failure-is-working-with-the-american-heart-association [https://perma.cc/9QRV-PT5C].

[18] Conn Hastings, *The Mabu Personal Healthcare Companion: Interview with Dr. Cory Kidd, Founder & CEO of Catalia Health*, MEDGADGET (Mar. 30, 2017), https://www.medgadget.com/2017/03/mabu-personal-healthcare-companion-interview-dr-cory-kidd-founder-ceo-catalia-health.html [https://perma.cc/4CEH-R8MJ].

[19] *See* Imani Moise, *For the Elderly Who Are Lonely, Robots Offer Companionship*, WALL STREET J. (May 28, 2018, 10:01 PM), https://www.wsj.com/articles/for-the-elderly-who-are-lonely-robots-offer-companionship-1527559260 [https://perma.cc/RW35-EMZ7].

[20] *Gig Economy Thriving in Healthcare*, WHEEL (Apr. 23, 2018), https://www.enzymehealth.com/blog/gig-economy-thriving-in-healthcare [https://perma.cc/3M2L-K2WJ] [hereinafter *Gig Economy Thriving*].

[21] *See* Juho Hamari et al., *The Sharing Economy: Why People Participate in Collaborative Consumption*, 67 J. ASS'N. FOR INFO. SCI. & TECH. 2047, 2048 (2016).

[22] Nancy Leong, *The First Amendment and Fair Housing in the Platform Economy*, 78 OHIO ST. L.J. 1001, 1005 (2017).

potential to widen profit margins for healthcare platforms and shrink autonomy gaps for platform workers makes it an appealing option to healthcare organizations looking for available workers and also for workers looking for work flexibility.[23]

The precarious work popularized by the new labor markets,[24] however, has devastated the platform economy workforce, depriving workers of an opportunity to earn a livable wage, resulting in widespread financial strife for millions of Americans—evidenced by various case studies of common participants in the platform economy[25] like Uber and TaskRabbit.[26] Despite the benefits platform work may afford individuals, "[m]ost workers in the gig[/platform] economy have no minimum wage, no unemployment benefits, no paid sick days, no pensions, and even no maximum or minimum working hours."

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[23] *See Gig Economy Thriving*, *supra* note 20.

[24] New labor markets refer to the new class of on-demand platform workers that have emerged from the "proliferation of nontraditional and contingent employment relationships, fostered in part by new technological platforms." JANE DOKKO ET AL., HAMILTON PROJECT, WORKERS AND THE ONLINE GIG ECONOMY 1 (2015), https://www.hamiltonproject.org/assets/files/workers_and_the_online_gig_economy.pdf [https://perma.cc/WZ6M-CX5G]. To elaborate, online technology has allowed consumers to digitally connect and contract with on-demand workers to perform tasks (usually in-person) such as cleaning, shopping, building furniture, and driving. To demonstrate, tech companies like Uber, TaskRabbit, and Grub Hub—participants of the platform economy—tap into this new labor market as a key component of their business model.

[25] "Platform workers" is often used interchangeably with the term "gig workers." While there is considerable overlap between the two in the sense that most contemporary gig workers may also be considered platform workers, the inverse is not necessarily true. Gig work connotates shorter term work, usually a single task, e.g., providing a ride to a customer from work to home or building a piece of furniture. Platform work can be any work facilitated by technology, for any length of time or frequency. Gig work is usually also facilitated by technology, usually vis-à-vis a phone application; but this is not always the case. Therefore, for the purposes of this note, the terminology "platform workers" is used to describe any persons who engage in work facilitated by a digital platform in the platform economy and is also intended to encompass gig workers who are enlisted through a digital platform. *See* Nicole Kobie, *What is the Gig Economy and Why is It so Controversial?*, WIRED (Sept. 14, 2018), https://www.wired.co.uk/article/what-is-the-gig-economy-meaning-definition-why-is-it-called-gig-economy [https://perma.cc/27GT-PS8G]; April Rinne, *What Exactly is the Sharing Economy?*, WORLD ECON. F. (Dec. 13, 2017), https://www.weforum.org/agenda/2017/12/when-is-sharing-not-really-sharing [https://perma.cc/9LCN-F4LA].

[26] Additionally, when platforms like Uber decide to cut rates unilaterally and precipitously for consumers, workers have no recourse but to compensate by working longer hours just to make the same amount. Paris Marx, *The Gig Economy Has Grown Big, Fast—and That's a Problem for Workers*, VOX (Oct. 26, 2016, 9:00 AM), https://www.vox.com/2016/10/26/13349498/gig-economy-profits-workers-desperate-services-labor [https://perma.cc/E47B-9G95]. As a result, the exploitative labor models of the platform/gig economy have "create[ed] extreme financial hardship for millions of American workers." It has been found that workers who support themselves through platform economy work—like Uber and TaskRabbit—experience more financial struggle than the average person and over half of full-time platform workers would struggle to afford emergency bills. Alexia Fernández Campbell, *The Recession Hasn't Ended for Gig Economy Workers*, VOX (May 28, 2019, 12:30 PM), https://www.vox.com/policy-and-politics/2019/5/28/18638480/gig-economy-workers-wellbeing-survey [https://perma.cc/4JTU-C52Z].

This note maintains that because digital health platforms will continue to flourish in the healthcare industry, "low-skilled"[27] healthcare platform workers (e.g., home caregivers, health aides, and other workers who receive their work through an online platform)[28] are susceptible to a similar financial fate to that in which Uber drivers and TaskRabbit-ers have found themselves. So how can Congress heed the cautionary tale of Uber and ensure fair compensation for healthcare workers who choose to engage in work through digital health platforms and healthcare technologies to take care of patients? In short, federal legislators must ensure that the digital healthcare platform worker at least earns a livable wage.

And the novel COVID-19 pandemic sheds a new light on these issues.[29] In response to the worldwide public health crisis, the federal government not only loosened restrictions to virtual healthcare delivery, but also expanded the scope of telehealth policies, beckoning a new age of technology-driven healthcare delivery.[30] As virtual, digital, and remote healthcare delivery becomes more than just a luxury, healthcare platform workers will become more commonplace in the realm of the emerging labor economy. Hence, they will be further subjected to the nuanced vulnerabilities precipitated by the platform economy and will become more central to these broader conversations.

An additional concern that prevents easy resolution of the workforce issues presented by new labor markets in healthcare is the need to meet the demands of providing care for a rapidly aging population in a way that satisfies healthcare's "triple aim." In healthcare, the "triple aim" is the simultaneous

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[27] "Low skilled" is an industry term used to describe jobs with "low education entry requirements" (relative to occupations that require bachelor's, master's, or doctorate degrees). Bianca K. Frogner et al., U. WASH. CTR. FOR HEALTH WORKFORCE STUD., COMPARING THE SOCIOECONOMIC WELL-BEING OF WORKERS ACROSS HEALTHCARE OCCUPATIONS (2016), https://depts.washington.edu/fammed/chws/wp-content/uploads/sites/5/2016/12/Socioeconomic-Well-Being-of-Workers_FR_2016_Dec_Frogner.pdf [https://perma.cc/Z9HZ-9FAC]. This term, however, is a misnomer—most healthcare work comes with great responsibility and demands "diligence, insight, and attention to detail". Karolina Gerlich, *Care Workers Like Me Aren't Low Skilled – These Immigration Rules Will Risk Lives*, GUARDIAN (Feb. 20, 2020, 6:23 AM), https://www.theguardian.com/society/2020/feb/20/care-workers-like-me-arent-low-skilled-THESE-immigration-rules-will-risk-lives [https://perma.cc/SQ5Z-A6PM]. Instead, a more appropriate term to describe these workers is "low wage" workers, to accurately reflect the income disparity generated by careers requiring academic training and those that do not.

[28] It is salient to note that "platform work" does not refer to the nature or mode of the work, but rather the means by which individuals are connected and initiate a consumer/worker relationship. Therefore, the term "healthcare platform worker" is used to describe a worker who receives healthcare/care-giving work through an online platform and may refer to work that is either exclusively virtual, in-person, or a combination of the two.

[29] *See infra* Section II.B.

[30] *See infra* Section IV.D.

pursuit of "improving the patient experience of care . . . improving the health of populations, and reducing the per capita cost of healthcare."[31] Two competing approaches to meet the triple aim have become evident. On one hand, there is a push to make cost control a top priority through new care delivery models like episode-based, bundled payments which, by virtue of their cost-saving nature, incentivize cheaper components of care. On the other hand, there are policymakers who believe in prioritizing higher quality care and higher quality jobs in healthcare, even if that means a higher cost of care.[32]

Because current rhetoric around the triple aim suggests that mitigating cost is "*primus inter pares*,"[33] this note operates within the framework of the first approach. Over the past decade, it has been widely accepted that the United States trumps any of the other wealthiest countries when it comes to healthcare spending.[34] The nation's collective goal of cost-cutting (or at the very least, cost control) has resulted in the development of innovative healthcare delivery models, for example, bundled payment programs[35] that promote cost-effective individual elements of an entire episode of care.[36] An "episode of care," is defined by the Centers for Medicare and Medicaid Services (CMS) as "the set of services provided to treat

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[31] This multi-dimensional approach to healthcare emerged in response to the fact that "[t]he US healthcare system is the most costly in the world" and that "[a]ging populations and increased longevity . . . have become a global challenge, putting new demands on medical . . . services." *The IHI Triple Aim*, INST. FOR HEALTHCARE IMPROVEMENT, http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx [https://perma.cc/Q6K6-6BA5].

[32] *See* Frank Pasquale, *The Hidden Costs of Health Care Cost-Cutting: Toward a Postneoliberal Health-Reform Agenda*, 77 LAW & CONTEMP. PROBS. 171, 191–93 (2014).

[33] *Id.* at 172 (asserting that the formulation of policy aimed to cut healthcare costs is a goal "liberals and conservatives, libertarians and progressives are eager to rally around").

[34] Timothy Stoltzfus Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537, 546–47 (2006). Interestingly enough, even though the United States spends the most on healthcare relative to other high-income nations, the United States has also been found to "spend the most time in the hospital for preventable diseases, visit their physicians less . . . and have the highest rates of preventable deaths." Hannah Smothers, *Longer American Life Expectancy Means More Time to Enjoy This Dying Planet*, VICE (Jan. 30, 2020, 3:16 PM), https://www.vice.com/en_us/article/939kvv/cdc-life-expectancy-report-2018 [https://perma.cc/4D3E-ENKH].

[35] Bundled payment programs are one form of alternative payment models created by the Center for Medicare and Medicaid Innovation as part of the Bundled Payments for Care Improvement initiative. Bundled payments link single payments for an array of services provided by a team of healthcare professionals and workers to the outcome of an episode of care for a single patient. Organizations and providers opt into payment arrangements that "included financial and performance accountability for episodes of care." *Bundled Payments for Care Improvement (BPCI) Initiative: General Information*, CTRS. FOR MEDICARE & MEDICAID SERVS. (June 19, 2020), https://innovation.cms.gov/initiatives/bundled-payments [https://perma.cc/YFF4-HJUD].

[36] *See* Jacqueline LaPointe, *Key Strategies for Succeeding with Healthcare Bundled Payments*, REVCYCLE INTELLIGENCE (Aug. 11, 2017), https://revcycleintelligence.com/features/key-strategies-for-succeeding-with-healthcare-bundled-payments [https://perma.cc/B5Z7-C6BL].

a clinical condition or procedure."[37] The use of technology has been proven to meet the cost-saving goals of bundled payment models.[38] Accordingly, this note maintains that as long as bundled payment models and other innovative delivery models continue to cut healthcare spending, the platform economy will continue to be utilized because it has the potential to meet the goals of bundled payment by keeping costs low.

Globalizing labor markets exacerbate this emerging healthcare workforce issue and further undermine any existing protections or rights given to workers.[39] Ultimately, the U.S. healthcare industry is faced with the dilemma of reconciling the cost-cutting concerns of corporations in the industry with the potential cost-saving solution that the exploitative platform economy offers. But how can it do this—given the gig economy's precarious nature—in a way that promotes fair labor standards and without leading to a global "race to the bottom?"[40]

This note brings attention to the duality of the platform economy: its potential to create a new, narrow category of on-demand healthcare workers and its potential to exploit these very same workers. This note also acknowledges that U.S. labor and employment laws are not reacting nearly as fast as they should be to close the loopholes that allow the platform economy to perpetuate pay disparity in a modernizing workforce. These laws must be amended to afford statutory labor protections to all healthcare workers engaged in remote, technology-driven work.[41] Ultimately, this note focuses on how the healthcare industry can ensure fair compensation for a very narrow class of workers in a rapidly transforming labor economy. To that end, this note primarily argues that the U.S. government, through administrative agencies like CMS, should mitigate the wage

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[37] *Episode of Care or Bundled Payments – Health Cost Containment*, NAT'L CONF. ST. LEGISLATURES (Jan. 20, 2018), https://www.ncsl.org/research/health/episode-of-care-payments-health.aspx [https://perma.cc/PED5-DCZJ].

[38] *See* Eric Wicklund, *Telehealth Helps CMS Bundled Payment Program Show Some Savings*, MHEALTH INTELLIGENCE (Jan. 7, 2019), https://mhealthintelligence.com/news/telehealth-helps-cms-bundled-payment-program-show-some-savings [https://perma.cc/MB3Q-EVJG] (reporting that in 2018, providers saved almost $3,000 by utilizing telemedicine/telehealth services for post-discharge rehabilitation following one particular surgery).

[39] Henry H. Drummonds, *Transnational Small and Emerging Business in a World of Nikes and Microsofts*, 4 J. SMALL & EMERGING BUS. L. 249, 293 (2000).

[40] The "global race to the bottom" may be described as "the progressive movement of capital and technology from countries with relatively high wages, taxation and regulation to countries with relatively lower levels." E.E. Daschbach, *Where There's a Will, There's a Way: The Cause for a Cure and Remedial Prescriptions for Forum Non Conveniens as Applied in Latin American Plaintiffs' Actions Against U.S. Multinationals*, 13 LAW & BUS. REV. AM. 11, 24–25 (2007).

[41] Alek Felstiner, *Working the Crowd: Employment and Labor Law in the Crowdsourcing Industry*, 32 BERKELEY J. EMP. & LAB. L. 143, 199 (2011).

issues that emerge from the platform economy's penetration into healthcare by expanding existing rules governing compensation to ensure a livable wage for the digital healthcare workforce.

The note proceeds in four parts. Part I provides background on how the rapidly aging population, along with the demand for innovative Medicare delivery models such as bundled payment programs, incentivize the use of technology in healthcare because of its potential to cut costs while improving quality of care. Part II discusses how digital health platforms have disrupted healthcare delivery yet have catalyzed the adoption of new labor markets that popularize precarious work to the benefit of a corporation but at the expense of platform workers. This part also discusses how the COVID-19 pandemic, on the one hand, galvanized providers to embrace technology-driven healthcare delivery, but on the other hand, accentuated the unstable nature of platform work. Part III examines—and ultimately dismisses—two potential solutions that address the problems that the platform economy has caused, including expanding the antitrust labor exemption and redefining the definition of "employee" to include platform workers. Part IV recommends an expansion of the existing Medicare policy and CMS procedural codes as an efficient and immediate way to ensure that digital health platform workers in a new labor market are compensated fairly and at the very least earn a livable wage. This final part also makes an argument that this solution will be even more imperative in a post-COVID-19 world.

I. BACKGROUND

A. *Medicare and CPT Codes: Background*

Before discussing the details of the healthcare platform economy, it is helpful to understand how healthcare services for individuals—primarily seniors—insured by Medicare are reimbursed. Medicare, funded by the federal government, is an insurance program established by Congress under the Social Security Act in 1965.[42] The U.S. Department of Health and Human Services (HHS) operates CMS which administers the Medicare program and provides healthcare coverage for individuals over the age of sixty-five, individuals who are severely disabled, and individuals with end-stage renal disease.[43] Some of

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[42] Michael J. DeBoer, *Medicare Coverage Policy and Decision Making, Preventive Services, and Comparative Effectiveness Research Before and After the Affordable Care Act*, 7 J. HEALTH & BIOMEDICAL L. 493, 500 (2012).

[43] *Id.* at 500–01.

the services covered by Medicare include "medical care services . . . skilled nursing facility and home health care, and hospice care."[44] To date, Medicare spending accounts for about 15 percent of federal spending, covering sixty million people.[45]

When a physician provides a service for a Medicare patient, she must submit a claim which describes "the reasons for, circumstances surrounding, and exact nature of [the] services."[46] Medicare claims contain code sets, a combination of diagnosis codes and procedure codes, which then are processed by Medicare Administrative Contractors or third-party payers.[47] Diagnosis and procedure codes are generally provided by a standardized coding system called the Healthcare Common Procedure Coding System (HCPCS).[48] All medical services, procedures, supplies, and miscellaneous articles used in treatment by physicians are identified and given an individual code through HCPCS.[49] Basically, "[p]rocedure codes describe the service that the doctor has provided to the patient" and "the diagnosis code evidences the medical necessity" of the procedure.[50] The HCPCS codes are divided into two groups: Level I and Level II.[51]

Level I of the HCPCS is pertinent to this note because it identifies medical services and procedures provided by physicians and other health care professions, whereas Level II of the HCPCS is a coding system primarily used to identify products and supplies.[52] The American Medical Association maintains another system of coding, the Current Procedural Terminology (CPT) code set, to "standardize terms and allow computerized service analysis."[53] Over time, CPT codes have been expanded from covering primarily surgery to now including "medicine, radiology, laboratory, diagnostic and therapeutic services and procedures."[54] The CPT system further divides codes into categories in order to: document traditional procedures and services performed (Category I); "track provider performance" (Category II); and to temporarily account for "emerging technology, services and procedures"

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[44] *An Overview of Medicare*, KAISER FAM. FOUND. (Feb. 13, 2019), https://www.kff.org/medicare/issue-brief/an-overview-of-medicare [https://perma.cc/8YGR-Y3EU].

[45] *Id.*

[46] Timothy D. Martin, *The Impact of Healthcare Reform on Revenue-Cycle Management and Claim Coding*, 4 J. HEALTH & LIFE SCI. L. 159, 175 (2011).

[47] *Id.*

[48] *Id.* at 182.

[49] *Id.*

[50] Peter J. Carpentier, *The Risk of Getting Paid: Why ICD-10-CM May Increase Physician Liability Under the False Claims Act*, 16 QUINNIPIAC HEALTH L.J. 117, 120 (2013).

[51] *See* Martin, *supra* note 46, at 182.

[52] *Id.* at 182–83.

[53] *Id.* at 182.

[54] *Id.*

(Category III).[55] For telemedicine, CMS reviews the individual telemedicine services billed by providers via the CPT or HCPCS codes and approves each code on a case-by-case basis.[56] Despite the progress that has been made in Medicare coverage of telemedicine, however, only seventy-five out of ten thousand telemedicine service codes are ever approved for Medicare reimbursement.[57] This has negative implications for the largest population that utilizes telemedicine services, namely, the senior citizen population.

B. The Gray Tsunami

The senior citizen population, which is anticipated to double by 2050,[58] is more susceptible to both physical and cognitive impairment.[59] While researchers and healthcare providers are uncertain as to whether the rates of disability[60] in older adults will actually increase in years to come, major chronic diseases (e.g., cancer, diabetes, heart disease, high blood pressure, stroke, etc.)[61] are expected to increase in this population.[62] Additionally, improvements in medicine generally allow people to live longer.[63] As such, people are living longer, but perhaps with comorbidities and an inability to completely function independently, thus requiring ongoing care.[64]

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[55] "To make the move from Category III to Category I, a number of providers in multiple locations must perform the services and the Food and Drug Administration must approve it." *Id.* at 183.

[56] AM. HOSP. ASS'N, TREND WATCH: REALIZING THE PROMISE OF TELEHEALTH: UNDERSTANDING THE LEGAL AND REGULATORY CHALLENGES 2 (2015), https://www.aha.org/system/files/research/reports/tw/15may-tw-telehealth.pdf [https://perma.cc/NH6L-YFMC].

[57] *Id.*

[58] UNITED NATIONS, WORLD POPULATION AGEING: HIGHLIGHTS 1 (2017), https://www.un.org/en/development/desa/population/publications/pdf/ageing/WPA2017_Highlights.pdf [https://perma.cc/LH32-4MLB].

[59] *See* COMM. ON FAMILY CAREGIVING, *supra* note 5, at 44.

[60] The Centers for Disease Control and Prevention (CDC) define disability as "any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions)." *Disability and Health* Overview, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 16, 2020), https://www.cdc.gov/ncbddd/disabilityandhealth/disability.html [https://perma.cc/G6JV-C7E9].

[61] Per the CDC: "Chronic diseases are defined broadly as conditions that last [one] year or more and require ongoing medical attention or limit activities of daily living or both." Chronic diseases relate to disability in the respect that "[c]hronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States." *About Chronic Diseases*, CTRS. FOR DISEASE CONTROL & PREVENTION (Jan. 12, 2021), https://www.cdc.gov/chronicdisease/about/index.htm [https://perma.cc/2YGK-RQ9M].

[62] *See* COMM. ON FAMILY CAREGIVING, *supra* note 5, at 44.

[63] Kenneth D. Kochanek et al., *Changes in Life Expectancy at Birth, 2010-2018*, CTRS. FOR DISEASE CONTROL AND PREVENTION (Jan. 30, 2020), https://www.cdc.gov/nchs/data/hestat/life-expectancy/life-expectancy-2018.htm [https://perma.cc/UH9H-ZQYR]; *see also* Smothers, *supra* note 34 (reporting that along with a dip in cancer death rates, an overall decrease in drug overdose-related deaths is also contributing to the extension of life expectancy).

[64] *See* COMM. ON FAMILY CAREGIVING, *supra* note 5, at 44.

Furthermore, there is a growing—and often overlooked—disease unique to the elderly: loneliness.[65] Loneliness among the elderly is often rooted in the lack of close relationships, satisfying social roles, and sense of value.[66] Whether loneliness is caused by a perceived rejection by relatives and friends, or by disability (i.e., hearing loss),[67] chronic loneliness in older adults can have a deleterious effect on health, leading to "increased levels of stress hormones as well as a heightened risk for heart attack and stroke, dementia, and premature mortality."[68] A growing interest in the effects of loneliness in the elderly has prompted major insurance companies like Anthem,[69] UnitedHealthcare,[70] and Kaiser Permanente[71] to launch programs aimed to combat social isolation and loneliness in the elderly in their Medicare plans. However, uncertainty about the effectiveness of these programs leaves open the search for a solution.[72]

The problem of taking care of seniors who experience loneliness is further exacerbated as the United States faces "a national move toward letting frail elders remain in their homes without resorting to residential facilities."[73] This "home care revolution" has led to a demand for home healthcare workers

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[65] Jamie Ducharme, *One in Three Seniors Is Lonely. Here's How It's Hurting Their Health*, TIME (Mar. 4, 2019, 11:54 AM), https://time.com/5541166/loneliness-old-age [https://perma.cc/CC8S-6PTE].

[66] Judith Graham, *Understanding Loneliness in Older Adults – And Tailoring a Solution*, KAISER HEALTH NEWS (Mar. 14, 2019), https://khn.org/news/understanding-loneliness-in-older-adults-and-tailoring-a-solution [https://perma.cc/VZW8-EURL].

[67] *Id.*

[68] Cathie Gandel, *Loneliness Is Lethal*, AARP (July 17, 2018), https://www.aarp.org/health/conditions-treatments/info-2018/loneliness-risk-death.html [https://perma.cc/JED9-PRV4]. Isolated feelings of loneliness and chronic loneliness are distinguished: "We're all lonely from time to time, but the problems come when someone is chronically lonely, day in and day out." *Id.* (quoting Steve Cole, a professor of medicine and genomics researcher at the University of California in Los Angeles).

[69] CareMore Health, a subsidiary of Anthem, Inc., has launched their 'Togetherness Program' for Medicare Advantage members which is dedicated to "identify and intervene in the loneliness among its senior patients." Healthcare Team, *4 Ways Health Insurers Are Addressing Loneliness, A Social Determinant of Health*, MEDIA LOGIC (July 30, 2019), https://www.medialogic.com/blog/healthcare-marketing/4-ways-health-insurers-are-addressing-loneliness-a-social-determinant-of-health [https://perma.cc/F7KD-6YN6].

[70] UnitedHealthcare's 'Navigate4Me' program "provides individualized support to Medicare Advantage members facing complex health issues" and provides both social and emotional support for patients who experience a lack of social connection and feelings of loneliness. *Navigating Medicare: 5 Allies Who Can Help*, UNITED HEALTHCARE NEWSROOM (Feb. 12, 2018), https://newsroom.uhc.com/experience/awareness/navigating-medicare.html [https://perma.cc/E6TC-P86M].

[71] "Kaiser Permanente is starting a pilot program that will refer lonely or isolated older adults in its Northwest region to community services . . . ." *See* Graham, *supra* note 66.

[72] *Id.*

[73] Barbara Peters Smith, *Robots and More: Technology and the Future of Elder Care*, SARASOTA HERALD-TRIB. (May 27, 2013, 3:25 PM), https://www.heraldtribune.com/article/LK/20130527/News/605195720/SH [https://perma.cc/JE78-6WQQ].

that may not be easy to fill.[74] Furthermore, high turnover rates for home healthcare workers may ultimately hurt seniors with complex conditions like dementia,[75] or those who experience chronic loneliness; caring for patients afflicted by dementia or loneliness requires more than just "random human contact," and instead demands care that fosters a quality relationship.[76] This is where healthcare providers and payors have found that senior tech can be an effective tool, as the potential of automated elderly care to address loneliness is increasingly recognized.[77] Key healthcare stakeholder will continue to increasingly prioritize such discussions as the technology becomes more widespread, necessitating attention to the problems posed by this developing subindustry.

C. Bundled Payment Models Incentivize Cost-Cutting and Technology Use

The growing demographic of elderly Americans continues to exacerbate the demand for healthcare services, posing an unprecedented challenge to the nation's healthcare system.[78] Ironically, within this demographic is a population of retiring physicians or physicians who are approaching retirement, furthering concerns of a physician shortage.[79] One response to meet the demands of a rapidly aging population that satisfies healthcare's overarching "triple aim" has been a bipartisan movement in the United States to make cost control a top priority through new care delivery models. An example of such innovative delivery models is bundled payment programs.[80]

Bundled payment programs emerged amidst general efforts of the U.S. healthcare system to abandon traditional fee-for-

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[74] Barbara Peters Smith, *Finding Skilled Elder Home Care Workers Not Easy*, SARASOTA HERALD-TRIB. (May 26, 2013, 3:30 PM), https://www.heraldtribune.com/article/LK/20130526/News/605195601/SH [https://perma.cc/H2GF-XZ8J].

[75] *Id.*

[76] *See* Graham, *supra* note 66.

[77] *See* Moise, *supra* note 19 ("Robots that help people connect with and maintain their relationships with others are becoming increasingly important . . . . ").

[78] Fazal Khan, *The 'Uberization' of Healthcare: The Forthcoming Legal Storm Over Mobile Health Technology's Impact on the Medical Professional*, 26 HEALTH MATRIX 123, 130 (2016).

[79] *Id.* at 130–31 (predicting that "[e]ven if medical schools dramatically expand their class sizes, they cannot come close to closing the projected primary care shortfall of 90,000 doctors within the next five years").

[80] Professor Frank Pasquale, however, forebodes that cost-cutting in healthcare, while a seemingly valiant effort, may actually veil "unpleasant realities." Because much of health insurance is tied to employment, corporations are the actual customers of health insurers, and therefore any money saved as a result of cost-cutting initiatives may not actually go to individuals, but rather be retained as corporate profit. *See* Pasquale, *supra* note 32, at 191–93.

service models[81] with the general goal of improving health outcomes and preventing excess costs incurred from events like hospital readmissions.[82] In 2015, Congress promulgated the bipartisan Medicare Access and Chip Reauthorization Act (MACRA), creating the Quality Payment Program (QPP), which changed the way that Medicare paid providers, rewarding them for value-based care as opposed to volume-based care.[83] To that end, the QPP gave providers several options for payment, one of which is to receive bonus payments by opting to take on financial risk through Alternative Payment Models (APMs).[84] Bundled payment programs, which qualify as an "Advanced APM" [85] under the QPP,

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[81] April M. Elliott, *Medicare as Technology Regulator: Medicare Policy's Role in Shaping Technology Use and Access*, 26 BERKELEY TECH. L.J. 1489, 1518–19 (2011).

[82] Though the Bundled Payments for Care Improvement's four bundled payment models account for readmissions in their list of services, hospitals and providers are penalized for high readmission rates within the 90-day episode periods. *See* KAISER FAM. FOUND., 8 FAQS: MEDICARE BUNDLED PAYMENT MODELS 1–2 (2018), http://files.kff.org/attachment/Evidence-Link-FAQs-Bundled-Payments#:~:text=The%20CJR%20model%20effectively%20bundles,after%20the%20initial%20hospital%20discharge [https://perma.cc/R69X-QABM] [hereinafter 8 FAQS]; *see also* Cian P. McCarthy & Ambarish Pandey, *Predicting and Preventing Hospital Readmissions in Value-Based Programs*, 11 CARDIOVASCULAR QUALITY & OUTCOMES 1 (2018).

[83] Medicare Access and CHIP Authorization Act of 2015, Pub. L. No. 114-10, 129 Stat. 87 (2015); *see also MACRA*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html [https://perma.cc/4BFC-GC6A]. The difference between volume-based care and value-based care is in a volume-based system, the "provider is paid on a per service basis" which incentivizes them to provide as many services as possible regardless of type or quality whereas in a value-based system, providers "will receive a set payment for a patient regardless of how many services are furnished" and are "incentivized to keep the patient healthy by taking preventative measures . . . ."

[84] *See* sources cited *supra* note 83; *see also* Press Release, Ctrs. for Medicare and Medicaid Servs., CMS Announces New Payment Model to Improve Quality, Coordination, and Cost-Effectiveness for Both Inpatient and Outpatient Care (Jan. 9, 2018), https://www.cms.gov/newsroom/press-releases/cms-announces-new-payment-model-improve-quality-coordination-and-cost-effectiveness-both-inpatient [https://perma.cc/C3LE-MSVZ] (describing the other track created by MACRA through the QPP is payment via the Merit-Based Incentive Payment System through which "providers have to report a range of performance metrics and then have their payment amount adjusted based on their performance"). APMs are payment models that deviate from traditional "fee-for-service" models which reimburse providers for each individual service provided and offer additional payment incentives for providers to deliver high-quality and low-cost care for either specific clinical conditions, care episodes, or a population., *Advanced Alternative Payment Models (APMs)*, CTRS. FOR MEDICARE & MEDICAID SERVS.: QUALITY PAYMENT PROGRAM, https://qpp.cms.gov/apms/advanced-apms [https://perma.cc/D5NG-8Z48].

[85] Advanced APMs are a different path of the QPP that offer five percent incentive payment for meeting particular threshold levels of payments or patients. Advanced APMs differ from regular APMs in that they must meet three criteria: (1) participants are required to use certified Electronic Health Records technology; (2) payments must be provided for covered professional services based on "quality measures comparable to those used in the MIPS quality performance category"; and (3) the APM must either be a "Medical Home Model expanded under CMS Innovation Center authority" or participants must "bear a significant financial risk." *See Advanced Alternative Payment Models (APMs)*, *supra* note 84.

utilize a "lump sum, per episode payment, or global budget"[86] to shift the focus of the payment model from one that is based on volume to one that is based on value or quality and efficiency.[87]

Bundled payment models promote the use of technology in patient care.[88] Though the initial purchase of technology may be costly, providers are "incentivized to purchase new technologies" because there is a defined amount of money allotted for each episode of care under this model and they are not "subject to coverage determinations altering payment rates."[89] Before the rise of bundled payment, providers have only been incentivized to invest in new technologies when the technology is "medically sound and cost-effective."[90] Since the passage of MACRA, however, technology use in episodes of care has saved providers money under bundled care programs.[91] For example, a study conducted by Duke University found that the use of telemedicine saved providers almost $2,750 per patient when replacing in-person treatment with telemedicine for post-discharge physical therapy after comprehensive joint replacement surgery.[92] Technology and other digital health platforms enable providers and caretakers to monitor patients while they recover at home, reducing travel costs for patients while empowering them to engage in their own recovery process.[93]

The use of technology in elder care has become an increasingly viable option to supplement home healthcare work done by humans.[94] The increased sophistication of technology

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[86] *See* Elliot, *supra* note 81, at 1520.

[87] Michael L. Barnett et al., *Two-Year Evaluation of Mandatory Bundled Payments for Joint Replacement*, 380 NEW ENGL. J. MED. 252, 253 (2019). One example of a bundled payment program is the Comprehensive Care for Joint Replacement (CJR) program. Under the CJR program, CMS bundles payments for "lower extremity joint [] replacement episodes" which consists of "inpatient hospital services, physician services, post-acute care services, and any readmissions or other related services through 90 days after the initial hospital discharge." Participating providers and hospitals are financially rewarded if the expenses for an entire episode are below a "target price" set by CMS which is determined by an accumulation of historical spending data for such procedures. On the other hand, if providers and hospitals exceed the target price, they are required to pay a penalty to CMS. Therefore, providers and hospitals who opt into the CJR program or any other bundled payment program are incentivized to provide (1) cost-effective care to avoid surpassing the target price and (2) high-quality care to prevent the risk of readmissions which are also costly. *See* 8 FAQS, *supra* note 82.

[88] *See* Elliot, *supra* note 81, at 1520–21.

[89] *Id.* at 1520 (stating that "bundled payments . . . grant providers greater financial security in their decisions to invest in new and often costly technologies").

[90] *Id.* (asserting that bundled payment programs "incentiviz[e] providers to monitor new data on available technologies and base [their] decisions on the most current data").

[91] *See* Wicklund, *supra* note 38.

[92] *See id.*

[93] *See id.*

[94] *See* COMM. ON FAMILY CAREGIVING, *supra* note 5, at 193.

has mitigated complications in its use for elder care, thus allowing automation to become more realistic.[95] Technology for elder care is especially appealing because of its "potential to help preserve independence, or at least maintain it, for many, many more years than is currently possible."[96] Other advantages that technology provides for elder care include the potential to reach more individuals, increased flexibility and precision of care, and of course, convenience.[97]

The same incentives that promote the use of technology in bundled payment programs, however, are the same incentives to cut costs in the payment of healthcare providers and workers. CMS has considered "revising global payment codes for . . . surgery bundles," effectively cutting Medicare payments to surgeons in an effort to reduce unnecessary spending.[98] These considerations raise some concern because it is reasonable to assume that these types of cuts, if enacted, will not only affect physicians and other "high skill" workers, but also "low skill" workers like home healthcare aides. The need for cost-effective healthcare delivery through innovative payment models and the worker shortage presents a window of opportunity for the health tech industry and further drives an incentive for the healthcare industry to adopt new labor models.[99]

D. Challenges Encountered by Platform Workers

In response to this new pressure to cut healthcare costs, platform work has penetrated the healthcare industry, as in many other areas of modern life.[100] Broadly, the platform economy presents a new type of employer-employee relationship, disrupting the traditional employee versus independent contractor paradigm framed by the Fair Labor Standards Act (FLSA).[101] The FLSA's dichotomous classification system displaces platform workers

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[95] *See* Moise, *supra* note 19 ("While the idea of bringing automation to elder care has been discussed for years, recent technological advances in natural-language processing have moved it closer to reality . . . . Before such advances, people had to speak to digital assistants in specific formulaic commands, making technology difficult and frustrating to use, especially for seniors.").

[96] Shirley S. Wang, *For Those With Dementia, Help From Technology*, WALL STREET J. (May 28, 2018, 10:03 PM), https://www.wsj.com/articles/for-those-with-dementia-help-from-technology-1527559380 [https://perma.cc/ELP5-CAEG].

[97] *See* COMM. ON FAMILY CAREGIVING, *supra* note 5, at 193.

[98] Harris Meyer, *Medicare Proposes Range of Pay Cuts, Increases for Outpatient Services*, MOD. HEALTHCARE (Aug. 3, 2019, 1:00 AM), https://www.modernhealthcare.com/payment/medicare-proposes-range-pay-cuts-increases-outpatient-services [https://perma.cc/TJ7E-DM7G].

[99] *See Gig Economy Thriving*, *supra* note 20.

[100] *See infra* Section II.A.

[101] Benjamin Means & Joseph A. Seiner, *Navigating the Uber Economy*, 49 U. C. DAVIS L. REV. 1511, 1525–27 (2016).

outside of the traditional definition of "employee," instead categorizing them as "independent contractors" by default.[102] In reality, however, these workers fall into a category somewhere in between.[103] The effects of this legal misclassification have devastated the livelihood of platform workers.[104]

The classification system disadvantages platform workers because most of the social safety nets in the United States—minimum wage, overtime pay, Social Security, disability insurance, workers' compensation insurance, unemployment insurance, etc.—are tied to the "employee" classification under the FLSA and the National Labor Relations Act (NLRA).[105] Furthermore, under the NLRA, only employees—not independent contractors[106]—are afforded the right to collectively bargain through unions.[107] The independent contractor classification prevents platform workers from being able to bargain for protections such as higher pay, overtime pay, healthcare benefits, or working conditions.[108]

The platform economy's promise of work flexibility and schedule autonomy is not enough to prevent the ambiguous and narrow worker classification system under FLSA and NLRA from pulling the safety net right out from under platform workers looking to make ends meet. Many platform workers have a primary wage-earning job and rely on platform work as a secondary source of income.[109] However, in 2016, up to 32 percent of workers in America relied on platform work as a primary source of income.[110]

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[102] Haley Ford, Note, *Gigging' in the 21st Century*, 80 MONT. L. REV. 299, 301 (2019).

[103] *Id.* (arguing that the "current classification system for gig economy workers . . . is imperfect"); *see also* Matthew L. Timko, *The Gig Economy: An Annotated Bibliography*, 39 N. ILL. U. L. REV. 361, 365 (2019) (suggesting that "[t]he FLSA defines employer and employee narrowly, and somewhat ambiguously").

[104] Keith Cunningham-Parmeter, *From Amazon to Uber: Defining Employment in the Modern Economy*, 96 B.U. L. REV. 1673, 1686 (2016) (discussing how "workers who devote a significant amount of labor to [platform work] may earn wages that fall well below the legal limits" and also may be subjected to harsh working conditions).

[105] Marina Lao, *Workers in the "Gig" Economy: The Case for Extending the Antitrust Labor Exemption*, 51 U.C. DAVIS L. REV. 1543, 1551–52 (2018).

[106] 29 U.S.C. § 152(3) ("The term 'employee' . . . shall not include . . . any individual having the status of an independent contractor . . . . ").

[107] 29 U.S.C. § 157 ("Employees shall have the right to self-organization, to form, join, or assist labor organizations, to bargain collectively through representatives of their own choosing, and to engage in other concerted activities for the purpose of collective bargaining . . . . ").

[108] *See* Rick Bales, *Resurrecting Labor*, 77 MD. L. REV. 1, 19–20 (2017); *see also* Dmitri Iglitzin & Jennifer L. Robbins, *The City of Seattle's Ordinance Providing Collective Bargaining Rights to Independent Contractor For-Hire Drivers: An Analysis of the Major Legal Hurdles*, 38 BERKELEY J. EMP. & LAB. L. 49, 52 (2017).

[109] Kathleen DeLaney Thomas, *Taxing the Gig Economy*, 166 U. PA. L. REV. 1415, 1421 (2018).

[110] Andrew Soergel, *1 in 3 Workers Employed in Gig Economy, But Not All By Choice*, U.S. NEWS & WORLD REP.(Oct. 11, 2016, 1:00 PM),

The growing number of full-time platform workers undermines the advantages of work flexibility that the gig economy flaunts; rather, full-time platform workers are often compelled to work irregular hours over a seven-day week just to maximize their earning potential.[111] Full-time platform workers who engage in multiple platforms struggle to barely collect a livable wage once they account for external expenses required to perform the tasks (e.g., time spent, insurance costs, and other expenses like gas).[112] Adding to this troubling reality is the fact that in many metropolitan cities, most platform workers are people of color and immigrants, some of whom rely on public welfare programs—affixing another level of complexity to the adverse effects engendered by the platform economy.[113] This note reasonably predicts that as healthcare platform work becomes more commonplace, healthcare platform workers face nearly identical challenges faced by platform workers in the broader economy.

II. NEW DELIVERY AND LABOR MODELS IN HEALTHCARE: "UBERIZING" HEALTHCARE

As discussed earlier in this note, healthcare has turned to technology to streamline the connection between patients and healthcare workers.[114] Advances in healthcare tech have transformed the relationship between healthcare workers and healthcare technology, and in turn the relationship between healthcare providers and patients. This concept is coined as the "Uberization of Healthcare" by Fazal Khan.[115] In describing the circumstances contributing to the "Uberization" of healthcare, Khan warns us of an impending physician shortage, but describes the potential of advanced technology to compensate

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https://www.usnews.com/news/articles/2016-10-11/1-in-3-workers-employed-in-gig-economy-but-not-all-by-choice?context=amp [https://perma.cc/VX3K-A5MP].

[111] Natasha Singer, *In the Sharing Economy, Workers Find Both Freedom and Uncertainty*, N.Y. TIMES (Aug. 16, 2014), https://www.nytimes.com/2014/08/17/technology/in-the-sharing-economy-workers-find-both-freedom-and-uncertainty.html [https://perma.cc/6JYP-NNCB] (sharing the story of Jennifer Guidry, 35, who relies on gig work to provide for her family by driving for Uber and Lyft usually at 4 AM; assembling furniture, tending gardens, catering, and pet-sitting for clients on TaskRabbit on the weekends; and picks up shifts as a personal chef on Craigslist occasionally).

[112] *Id.*

[113] Megan Rose Dickey, *Gig Workers in San Francisco are Mostly People of Color and Many are Immigrants, According to Survey*, TECHCRUNCH (May 5, 2020, 12:45 PM), https://techcrunch.com/2020/05/05/gig-workers-survey-san-francisco [https://perma.cc/SA4M-22NP] (citing a survey conducted by Local Agency Formation Commission in San Francisco, California which reveals that of the 643 San Francisco platform workers surveyed, 78% are people of color, 56% are immigrants, and 15% rely on public assistance).

[114] *See supra* INTRODUCTION.

[115] *See* Khan, *supra* note 78, at 123.

through its ability to perform instantaneous patient evaluations and empowering "physician extenders" (i.e., physician assistants, nurse practitioners, home health aides) to respond to serious conditions "without sacrificing safety or quality."[116] Inspired by existing business theory, Khan encapsulates how technology has ushered in a new era of healthcare delivery: "[m]any of the most powerful innovations that disrupted other industries did so by enabling a larger population of less-skilled people to do in a more convenient, less expensive setting things that historically could be performed only by expensive specialists in centralized, inconvenient locations."[117]

This concept points to the trend of labor and employment already seen through the popularization of apps like Uber and TaskRabbit.[118] These companies and their technology-powered platforms have introduced a new economic model in which "traditional services . . . have been streamlined directly to the customers' specifications" in an on-demand fashion.[119] This reimagined economic paradigm has in turn altered how labor is performed and how employment is categorized.[120] Crucial to the understanding of this framework is the central notion that the Uberization of healthcare is primarily focused on the streamlined connection between patients and healthcare workers—characteristic of the new labor economy—and less focused on the shift of access to "less skilled" workers described by Khan.

A. *Platform Work in Healthcare*

The recent demographic shifts and sudden increases in nontraditional modes of healthcare delivery necessitated by COVID-19 have increased the likelihood that platform work will become more popular in healthcare. The development of technology, the threat of a healthcare worker shortage,[121] and the

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[116] *Id.* at 126–27, 130–31 (positing the question, "[w]ho needs to wait weeks or even months to see an expensive specialist when a physician extender backed up by an artificial intelligence engine like IBM's Watson can give you an 'expert' answer without the wait?").

[117] *Id.* at 127 (emphasis omitted) (quoting "business innovation scholar Clayton Christensen").

[118] *Id.* at 128.

[119] *See* Timko, *supra* note 103, at 362.

[120] *Id.*

[121] Parija Kavilanz, *The US Can't Keep Up with Demand for Health Aides, Nurses and Doctors*, CNN BUSINESS (May 4, 2018, 10:51 AM), https://money.cnn.com/2018/05/04/news/economy/health-care-workers-shortage/index.html [https://perma.cc/LBW5-YYLH] (projecting that "there will be a shortage of 446,300 home health aides by 2025," and "that there will be 400,000 new nursing assistant positions and nearly 51,000 new nurse practitioner openings," and "nearly 103,000 new openings for [physicians and surgeons] [but] a shortage of 11,000 skilled professionals for these roles").

pressure to cut healthcare costs[122] all make the platform model increasingly appealing.[123] For instance, a startup called "Boon" has recognized that platform work in healthcare could be appealing to both healthcare workers and employers.[124] Boon is designed to provide a "proprietary marketplace aimed at . . . bringing the gig economy's on-demand service to the world of healthcare staffing."[125] Operating through a centralized dashboard, an algorithm matches workers and practices "based on factors such as technology utilization, past experience, and personality traits" (think: Uber meets TaskRabbit meets a staffing agency).[126] Boon appeals to healthcare employers and organizations looking for workers who meet their qualifications and their budget.[127] Likewise, it appeals to healthcare workers looking for autonomy over their schedules, equitable and transparent pay, and an opportunity for licensed professionals who have turned to platform work for the flexibility to fulfill their career goals again.[128]

While the tech-facilitated labor engagement concept, as demonstrated by Boon, may be quite revolutionary in the healthcare realm, the platform model in healthcare is not an entirely new concept. Healthcare organizations have long used staffing agencies to hire healthcare workers for temporary work—the original "platform," if you will.[129] The employment of contingent workers through temporary staffing agencies contributed to increased efficiency and cost controls that were

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[122] The United States spends over three trillion dollars on healthcare a year and this "continues to rise about 10% [every] year," a crushing amount of spending that has proven to encumber the nation's economy. *See Gig Economy Thriving*, *supra* note 20.

[123] *See* Jess Jones, *Bringing the Gig Economy to Healthcare*, HURON, https://www.huronconsultinggroup.com/insights/gig-economy-healthcare [https://perma.cc/MZS5-9ZXG]; *Healthcare Staffing Is Newest Sector for Gig Economy Expansion*, CISION PR NEWSWIRE (Aug. 24, 2020, 9:20 AM), https://www.prnewswire.com/news-releases/healthcare-staffing-is-newest-sector-for-gig-economy-expansion-301116862.html [https://perma.cc/NBQ2-494P].

[124] *Breakthrough in Temporary Healthcare Staffing With the Launch of Boon*, CISION PR NEWSWIRE (June 3, 2019. 8:30 AM), Simran Oberoi, https://www.prnewswire.com/news-releases/breakthrough-in-temporary-healthcare-staffing-with-the-launch-of-boon-300860395.html [https://perma.cc/5Y3J-E5YS].

[125] *The Role of Digital Identity in Growing the Healthcare Services Gig Economy*, PYMNTS (June 17, 2019), https://www.pymnts.com/healthcare/2019/gig-economy-healthcare-staffing-boon [https://perma.cc/EHH7-92XG].

[126] *See Durham Startup Launces 'Gig Work' App for Healthcare Workers*, WRAL TECH PYMNTS (June 7, 2019), https://www.wraltechwire.com/2019/06/07/durham-startup-launches-gig-work-app-for-healthcare-workers [https://perma.cc/ETB7-VLTW].

[127] *Why Boon is the Solution to Temp Work*, BOON BLOG (Aug. 19, 2019), https://www.doingboon.com/blog/why-boon-is-the-solution-to-temp-work [https://perma.cc/J9YT-R64C].

[128] *Id.*

[129] *See Gig Economy Thriving*, *supra* note 20.

demanded by the rise in managed care organizations.[130] Staffing agencies, however, have proven to be costly and slow due to coordination issues between vendor management systems, such as the time it takes to communicate with hiring managers, submit candidates for open orders, and assess candidate performance.[131] As such, the streamlined process enabled by online tech-driven platforms make them more appealing for healthcare companies with staffing needs.[132]

The platform model of labor may afford digital healthcare companies and providers significant economic benefits by classifying their platform workers as independent contractors instead of employees. The shift of worker classification absolves companies from "pay[ing] taxes, overtime, minimum wage, [and] providing healthcare benefits."[133] Healthcare companies or providers are then empowered to enhance the patient experience because they have the flexibility to set prices at any given time, ultimately granting the patient less out-of-pocket expenses than a traditional office visit.[134] These benefits to the corporations include reduced transaction costs to engage workers and lower barriers of entry into the market.[135] These platforms would also incur lower fixed costs,[136] meaning platforms seeking healthcare workers would not have to worry about paying for training because they could just filter through the platform to find workers who already meet their specific qualifications.

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[130] James van Wagtendonk, *Is There an Employer in the House?: Evaluating the National Labor Relations Board's Joint-Employer Standard in the Fissured Health Care Workplace*, 98 B.U. L. REV. 1105, 1123 (2018).

[131] *See Gig Economy Thriving*, *supra* note 20; *Staffing Firms Largely Dissatisfied with VMS, Report Says*, STAFFING INDUSTRY ANALYSTS (Nov. 22, 2016), https://www2.staffingindustry.com/site/Editorial/Daily-News/Staffing-firms-largely-dissatisfied-with-VMS-report-says-40166 [https://perma.cc/9GSH-YYDR].

[132] *See* Healthcare Staffing *supra* note 123.

[133] Alex Kirven, *Whose Gig is it Anyway? Technological Change, Workplace Control and Supervision, and Workers' Rights in the Gig Economy*, 89 U. COLO. L. REV. 249, 259 (2018).

[134] FED. TRADE COMM'N, THE "SHARING" ECONOMY: ISSUES FACING PLATFORMS, PARTICIPANTS & REGULATORS 26–27 (2016), https://www.ftc.gov/system/files/documents/reports/sharing-economy-issues-facing-platforms-participants-regulators-federal-trade-commission-staff/p151200_ftc_staff_report_on_the_sharing_economy.pdf [https://perma.cc/TVN7-VHD6] (stating that platforms have the ability to engage in "dynamic pricing strategies" which allows platforms to set prices lower initially and surge the prices as the market matures).

[135] *Id.* at 23–25.

[136] Internet-driven businesses of the sharing and platform economies disrupt traditional businesses. These digital enterprises operate their business, provide the similar services, and meet consumer demands just as well as their brick and mortar counterparts, but at lower costs. ANALYTICS FOR THE SHARING ECONOMY: MATHEMATICS, ENGINEERING AND BUSINESS PERSPECTIVES 119-20 (Emanuele Crisostomi et al. eds., 2020). Cyrille Schwellnus et al., *Gig Economy Platforms: Boon or Bane?* 8, 12–13, 17 (Organisation for Economic Co-operation and Development, Working Paper No. 1550), https://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=ECO/WKP(2019)19&docLanguage=En [https://perma.cc/R7C3-R7P9].

Proponents of the platform economy argue that the benefits to platform workers are also immense. The emerging labor market model's on-demand nature boasts "greater efficiency, productivity, competitiveness" and is defined by its flexibility and autonomy.[137] Greater work autonomy and the concept of a worker "being their own boss," is paramount to the new labor economy's success.[138] This flexibility and autonomy allows people to work as much or as little as they like, enabling them to engage in other aspects of their lives, or alternatively, engage in other jobs.[139] Even traditional part-time employment does not always make this possible.[140]

An example of innovation in the senior tech market driven by platform work is CareCoach. CareCoach is a digital platform that displays an avatar on a tablet—usually taking the form of an animated cat or dog—which engages with, and coaches, the patient-user.[141] Behind the avatar is a person, usually in a different state or country, monitoring the elderly person.[142] The platform worker uses CareCoach's dashboard to communicate with the elderly patient, either reminding the patient to take their medication, to get up and walk around, or just to chat and share photos.[143] CareCoach exemplifies the dual trend emerging from the Uberization of healthcare described by Khan: digital health platforms can enable a population of less-skilled people to do work usually performed by a trained worker but in a more streamlined, convenient, and less expensive manner.[144] CareCoach enables a person working on the other side of the country or the world to engage with an elderly person the way a home health aide or even a nurse would.[145] Notably, the extent of a CareCoach worker's function may not be comparable to that of a medically trained worker.[146] When a patient does not require extensive care or in-person supervision, however, having someone observing and engaging remotely may be less costly than having a full-time

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[137] *See*. Ford, *supra* note 102, at 299.

[138] *See* Kirven, *supra* note 133, at 261.

[139] SETH D. HARRIS & ALAN B. KRUEGER, HAMILTON PROJECT, A PROPOSAL FOR MODERNIZING LABOR LAWS FOR TWENTY-FIRST-CENTURY WORK: THE "INDEPENDENT WORKER" 9–10 (2015).

[140] *Id.*

[141] Scott Mace, *IT Spending Guide: Place Your Bets*, HEALTHLEADERS (Feb. 1, 2018), https://www.healthleadersmedia.com/innovation/it-spending-guide-place-your-bets [https://perma.cc/A85P-3EHP].

[142] Lauren Smiley, *What Happens When We Let Tech Care For Our Aging Parents*, WIRED (Dec. 19, 2017, 6:00 AM), https://www.wired.com/story/digital-puppy-seniors-nursing-homes [https://perma.cc/L5XN-HSND].

[143] *Id.*

[144] *See* Khan, *supra* note 78, at 127.

[145] *See* Smiley, *supra* note 142.

[146] *Id.*

home caretaker. And while Khan discusses the Uberization of healthcare in the context of high-skill work performed by physicians, it is likely that the future of digital platform work will also affect low-skilled healthcare workers.

B. COVID-19 Highlights the Importance of Digital Healthcare Delivery

The COVID-19 pandemic, which necessitated social distancing, spurred a rapid shift towards digital healthcare services. This marked the beginning of the new decade as the novel pandemic brought the world to its knees.[147] When the virus finally—and inevitably—made its way to the United States, the effects were calamitous.[148] Local and state stay-at-home orders, plus a general fear of contracting the virus from public gatherings, kept people at home.[149] The need for patients to see their doctors did not dwindle, however, and key healthcare stakeholders turned to telehealth and other virtual technologies to continue delivering care to patients in the safety of their own homes.[150] Additionally, federal changes to telehealth policy, such as the HHS's loosening of privacy laws for virtual doctor visits,[151]

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[147] The virus was first discovered in Wuhan, China late 2019. It then made its way around the world by way of international travelers, eventually landing in the United States early 2020. Mike Baker, *When Did the Coronavirus Arrive in the U.S.? Here's a Review of the Evidence*, N.Y. TIMES (June 1, 2020), https://www.nytimes.com/2020/05/15/us/coronavirus-first-case-snohomish-antibodies.html [https://perma.cc/XL7P-N6A6].

[148] To say that the U.S. healthcare system was unprepared to face this type of public health crisis is a grave understatement. The novel coronavirus met a United States with approximately 30 million uninsured individuals, steadily declining public health funding, and uncertainty about whether testing would become readily available to those who sought it. Adam Gaffney, *America's Extreme Neoliberal Healthcare System is Putting the Country at Risk*, GUARDIAN (Mar. 21, 2020, 6:32 AM), https://www.theguardian.com/commentisfree/2020/mar/21/medicare-for-all-coronavirus-covid-19-single-payer [https://perma.cc/Q92K-ER4Y]; *see also* Dylan Scott, *Coronavirus is Exposing All of the Weaknesses in the US Health System*, VOX (Mar. 16, 2020, 7:30 AM), https://www.vox.com/policy-and-politics/2020/3/16/21173766/coronavirus-covid-19-us-cases-health-care-system [https://perma.cc/T9XD-GTKK] (claiming that the United States "was less prepared for a pandemic than countries with universal health systems" and that "patchy" dispatch of COVID-19 testing contributed to the abysmal death rate in the United States compared to these other countries).

[149] *See* Jennifer Kates et al., *Stay-At-Home Orders to Fight COVID-19 in the United States: The Risk of a Scattershot Approach*, KAISER FAM. FOUND. (Apr. 5, 2020), https://www.kff.org/policy-watch/stay-at-home-orders-to-fight-covid19/ [https://perma.cc/82SM-M3MC] (summarizing the list of state-mandated stay-at-home orders and also showing that nine states did not initially pass orders requiring their citizens to stay home).

[150] Rishi Iyengar, *The Coronavirus Pandemic Could Push Telemedicine Into the Mainstream*, CNN BUS. (Apr. 27, 2020, 11:04 AM), https://amp-cnn-com.cdn.ampproject.org/c/s/amp.cnn.com/cnn/2020/04/27/tech/telemedicine-coronavirus-wellness/index.html [https://perma.cc/CQZ8-3K8V]; *see also* SAGE GROWTH & BLACKBOOK RESEARCH, AS THE COUNTRY REOPENS SAFELY 2 (2020).

[151] The HHS Office of Civil Rights (OCR) announced that for the duration of the COVID-19 emergency, "that it will exercise its enforcement discretion" by waiving certain

heralded the increasing importance of telehealth and other virtual healthcare delivery modes during the crisis.[152] And although the spread of COVID-19 will eventually taper, the need for technology-enabled healthcare will only continue to grow.[153] Thus, the popularization of digital healthcare delivery during the COVID-19 pandemic could leave healthcare platform workers further vulnerable to the exploitation platform workers at-large already regularly face.[154]

The decline in platform workers,[155] though consistent with the lamentable trend of unemployment provoked by COVID-19,[156] largely left healthcare workers unscathed. In fact, as the number of COVID-19 cases and hospitalizations rises, the demand for healthcare workers is at an all-time high.[157] In addition to the demand for physicians and nurses, the home healthcare subindustry witnessed a massive shortage and

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penalties against providers who violate Health Insurance Portability and Accountability Act (HIPAA) when using common digital communication platforms "such as FaceTime or Skype" so long as the acts are found to be done "in good faith for any telehealth treatment or diagnostic purpose." Press Release, Dep't of Health & Human Servs., OCR Announces Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency (Mar. 17, 2020), https://www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth-remote-communications-during-the-covid-19.html [https://perma.cc/4XFH-LR9G].

[152] Gabriela Weigel et al., *Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 Emergency and Beyond*, KAISER FAM. FOUND. (May 11, 2020), https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond [https://perma.cc/34C8-QXRM].

[153] *See* Joe Harpaz, *5 Reasons Why Telehealth Is Here to Stay (COVID-19 and Beyond)*, FORBES (May 4, 2020), https://www.forbes.com/sites/joeharpaz/2020/05/04/5-reasons-why-telehealth-here-to-stay-covid19/#225d358153fb [https://perma.cc/M9XQ-RN48] (citing a report by Global Market Insights which predicted the value of the telehealth market to be at $175.5 billion by the year 2026 indicating the extent of a growing need for such services).

[154] *See* INT'L LABOUR ORG., ILO MONITOR: COVID-19 AND THE WORLD OF WORK 1, 7 (3d ed. 2020) (reporting that "informal economy workers" are "among the most vulnerable in the [labor] market" worldwide amidst the COVID-19 pandemic because "[t]hey often have poor access to health-care services and have no income replacement in case of sickness or lockdown"); *see also supra* discussion Section I.D.

[155] Josephine Moulds, *Gig Workers Among the Hardest Hit by Coronavirus Pandemic*, WORLD ECON. F. (Apr. 21, 2020), https://www.weforum.org/agenda/2020/04/gig-workers-hardest-hit-coronavirus-pandemic [https://perma.cc/LF7N-C69G].

[156] Heather Long & Andrew Van Dam, *U.S. Unemployment Rate Soars to 14.7 Percent, the Worst Since the Depression Era*, WASH. POST (May 8, 2020, 5:05 PM), https://www.washingtonpost.com/business/2020/05/08/april-2020-jobs-report [https://perma.cc/RUA7-WNV7] (enumerating the Labor Department finding of the approximately twenty million people who suddenly became unemployed following business shut-downs, demonstrating the unemployment acceleration rate to twice that of the financial crisis between 2007 and 2009).

[157] Alex Kacik & Harris Meyer, *Demand for Clinicians, Support Staff Grows as COVID-19 Spreads*, MOD. HEALTHCARE (Mar. 16, 2020, 7:02 PM), https://www.modernhealthcare.com/providers/demand-clinicians-support-staff-grows-covid-19-spreads [https://perma.cc/X2CB-NCFK].

demand for workers.[158] There is no reason to believe this demand for in-person healthcare labor did not also reflect the trend in digital platform healthcare labor. In fact, the risks associated with a shortage of personal protective equipment that home healthcare workers faced[159] inspired some home healthcare givers to provide virtual services to patients "[d]espite a lack of direct reimbursement from Medicare."[160] This supports the inference that the demand for healthcare platform workers rose with the escalation of COVID-19. This is all to say that with platform workers—classified as essential workers—now "more visible than ever," the fight for long-term protections is at a critical point.[161] The need for the federal government to respond to shifts in flexible care—that can both weather future public health crises like the COVID-19 pandemic and thrive in "normal" times—is paramount. Crucial to those efforts are the advancement of laws, policies, and general labor infrastructures that account for the vital role of platform workers, healthcare workers, and healthcare platform workers alike.

III. Review of Two Existing Proposals to Address Challenges Facing Platform Workers

The precarious work conditions popularized by the platform economy has (rightfully) garnered serious concern, inspiring legal scholars to propose various approaches to address the situation. This part of the note discusses two potential approaches.[162] One

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158 Bob Woods, *Home Health-Care Workers in U.S. at Tipping Point Amid Coronavirus Outbreak*, CNBC (Apr. 14, 2020), https://www.cnbc.com/2020/04/14/home-health-care-workers-at-tipping-point-amid-coronavirus-outbreak.html [https://perma.cc/JTU3-GMT9].

159 *Id.*

160 Joyce Famakinwa, *Home Health Provider Excelin Leverages Virtual Care Tool to Conserve PPE, Keep Caregivers Safe*, HOME HEALTH CARE NEWS (Apr. 9, 2020), https://homehealthcarenews.com/2020/04/home-health-provider-excelin-leverages-virtual-care-tool-to-conserve-ppe-keep-caregivers-safe [https://perma.cc/NQ48-NDE4].

161 Arielle Pardes, *This Pandemic Is a 'Fork in the Road' for Gig Worker Benefits*, WIRED (Apr. 9, 2020, 3:36 PM), https://www.wired.com/story/gig-worker-benefits-covid-19-pandemic [https://perma.cc/AD92-ZBWT].

162 Another solution that has been proposed by Seth Harris and Alan Krueger of Cornell University and Princeton University, respectively, is the creation of a new legal "independent worker" classification. According to Harris and Krueger, workers under this classification would "qualify for many, although not all, of the benefits and protections that employees receive, including the freedom to organize and collectively bargain, civil rights protections, tax withholding, and employer contributions for payroll taxes." Independent workers, however, would not be entitled to protections tied to work hours such as minimum wage, overtime pay and unemployment benefits because the classification operates under the assumption that most independent workers would have relationships to multiple employers. And because it would be "impossible or deeply problematic" to determine who an independent worker actually works for, guaranteeing these benefits would thus be incompatible with the platform work model. Given that this last proposed solution has considerable overlap with the former approaches, this note

approach involves expanding the antitrust labor exemption to allow workers who are classified as independent contractors, yet are not actually individual business owners, to unionize and collectively bargain for better wages, overtime pay, and benefits without the fear of antitrust liability.[163] Another proposal is to "redefine employment" more broadly in order to clarify the scope of employment under laws like the FLSA and NLRA to ensure platform workers receive the protections and social safety nets these laws are meant to provide.[164] For the reasons that follow, neither of these solutions effectively protects platform workers.

A. Expanding the Antitrust Labor Exemption

Through the NLRA, Congress granted workers the right to unionize and collectively bargain with the understanding that individual workers face a disparity in bargaining power against their employer.[165] This right allows employee-classified workers to negotiate as a collective group for higher wages and better conditions of labor and employment.[166] The NLRA, however, explicitly prohibits independent contractor-classified workers from unionizing and collectively bargaining.[167] Similarly, contemporary antitrust laws prohibit independent contractors from engaging in this fundamental labor activity.[168] These laws operate under the outdated assumption that employees, as compared to independent contractors, have less autonomy and are more dependent on their employer for economic security; therefore the laws provide more protection to employees than independent contractors.[169]

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will only discuss the first two solutions to in depth. *See* HARRIS & KRUEGER, *supra* note 139, at 2, 9–10, 13.

163 *See* Lao, *supra* note 105, at 1543.

164 BRISHEN ROGERS, AM CONSTITUTION SOC'Y FOR LAW & POLICY, REDEFINING EMPLOYMENT FOR THE MODERN ECONOMY 2, 6–9 (2016), https://www.acslaw.org/wp-content/uploads/2018/04/Redefining_Employment_for_the_Modern_Economy.pdf [https://perma.cc/RE85-W98P].

165 *See* National Labor Relations Act, 29 U.S.C. § 151 ("The inequality of bargaining power between employees who do not possess full freedom of association or actual liberty of contract, and employers who are organized in the corporate or other forms of ownership association substantially burdens and affects the flow of commerce, and tends to aggravate recurrent business depressions, by depressing wage rates and the purchasing power of wage earners in industry and by preventing the stabilization of competitive wage rates and working conditions within and between industries.").

166 *The Benefits of Collective Bargaining: An Antidote to Wage Decline and Inequality*, ECON. POL'Y INST. (Apr. 14, 2015), https://www.epi.org/publication/benefits-of-collective-bargaining/#epi-toc-3 [https://perma.cc/4Y32-FRMG].

167 *See* 29 U.S.C. §§ 152(2)–(3), 157.

168 *See* Lao, *supra* note 105, at 1551–53.

169 *See* HARRIS & KRUEGER, *supra* note 139, at 7.

In 1890, Congress passed what today remains the keystone antitrust law: the Sherman Act.[170] This act works to protect the competitive marketplace by prohibiting unreasonable restraints of trade or commerce and prohibiting concentrations of economic power by monopolists.[171] Over a decade later, through section six of the Clayton Act,[172] Congress amended the antitrust laws, carving out an exemption dealing with concerted activities of labor organizations.[173] The collective actions of independent contracts were deemed inapplicable to this labor exemption following two major Supreme Court cases: *Los Angeles Meat & Provision Drivers Union, Local 626 v. United States* and *Columbia River Packers Ass'n v. Hinton*.[174] In *L.A. Meat* and *Hinton*, the Supreme Court determined that collective actions by independent contractors may essentially be considered collusion to restrain competition.[175]

Essentially, expanding the antitrust labor exemption to encompass platform workers will eliminate restraints placed on independent contractors, enabling them to collectively bargain for increased wages and other benefits and rights without the fear of antitrust liability. So even with their current independent contractor classification, platform workers would be afforded the protections of modern day labor laws.[176] Scholars argue, however, that expanding the antitrust labor exemption may not go far enough or may effectively ensure a livable wage for digital health platform workers.[177] Ultimately, this solution only removes a barrier to collective bargaining and fails to accomplish

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[170] Sherman Antitrust Act of 1890, 15 U.S.C §§ 1–7.

[171] 15 U.S.C. § 1 ("Every contract, combination . . . or conspiracy, in restraint of trade or commerce among the several States . . . is declared to be illegal."); 15 U.S.C. § 2 ("Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States . . . shall be deemed guilty of a felony . . . . ").

[172] Clayton Antitrust Act of 1914, 15 U.S.C. §§ 12–27.

[173] 15 U.S.C. § 17 ("The labor of a human being is not a commodity . . . . Nothing contained in the antitrust laws shall be construed to forbid the existence and operation of labor . . . instituted for the purposes of mutual help . . . or to forbid or restrain individual members of such organizations from lawfully carrying out the legitimate objects thereof . . . . ").

[174] *See* L.A. Meat & Provision Drivers Union v. United States, 371 U.S. 94, 103 (1962) (holding that union membership of grease peddlers was not justified because they were classified as independent workers who shared "no job or wage competition or economic interrelationship of any kind . . . [with] members of the [] union"); Columbia River Packers Ass'n v. Hinton, 315 U.S. 143, 144–45(1942) (holding that the union's fishermen were independent fishermen who "carr[ied] on their business as independent entrepreneurs, uncontrolled by the . . . processors").

[175] *L.A. Meat*, 371 U.S. at 102–03; *Hinton*, 315 U.S. at 144–45.

[176] *See* Bales, *supra* note 108, at 42–43.

[177] *See* Lao, *supra* note 105, at 1583–84.

an affirmative grant of the protections guaranteed to employees, as mandated by the FLSA and NLRA.[178]

Even with a chance to collectively bargain, logistical and practical barriers may still hinder platform workers from participating in unions. Because digital health platforms enable workers to perform their tasks from remote locations, their disparate locations would likely render it difficult to physically assemble workers. And even willing and able workers may struggle to organize around time zone differences. Difficulties in disparate unionization have exemplified the attempt to organize home healthcare workers, largely because individual workers typically work apart from one another.[179]

Ultimately, expanding the antitrust labor exemption may be a weak solution for platform workers, even with its promises for collective bargaining power. Union membership in the United States has generally been on the decline.[180] While this drop has been a gradual one, taking place over the course of the past several decades,[181] it has been particularly prominent since 2019, following the 2018 Supreme Court ruling in *Janus v. American Federation of State*.[182] The Supreme Court in *Janus* held that fair share fees typically required of unionized public employees—which cover a variety of costs, including those associated with collective bargaining—violated workers' First Amendment rights.[183] This ruling has been considered a "huge blow to public-sector unions and the labor movement in general" because it deprives unions of revenue that affords them representation in collective bargaining arbitration proceedings.[184] The *Janus* decision, though a resounding death knell rung only for public-

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[178] *Id.*

[179] Kristin Jenkins Gerrick, *An Inquiry into Unionizing Home Healthcare Workers: Benefits for Workers and Patients*, 29 AM. J. L. AND MED. 117, 130 (2003).

[180] *See* Eli Rosenberg, *Workers are Fired Up. But Union Participation is Still on the Decline, New Statistics Show*, WASH. POST (Jan. 23, 2020, 12:01 PM), https://www.washingtonpost.com/business/2020/01/22/workers-are-fired-up-union-participation-is-still-decline-new-statistics-show/ [https://perma.cc/6W2T-HGPV] (reporting a 0.2 percent decline in U.S. union membership from 2018 to 2019). *See generally* Bales, *supra* note 108 (discussing that participation in American labor unions has incrementally decreased over the last fifty years).

[181] *See* Rosenberg, *supra* note 180.

[182] Janus v. Am. Fed'n of State, 138 S. Ct. 2448 (2018).

[183] *Janus*, 138 S. Ct. at 2464 (reasoning that there are circumstances in which public-sector union members are required to pay fees to unions that engage in activities to which the member objects; in such situations, the mandatory membership fee essentially "compels them to voice ideas with which they disagree," which runs counter to First Amendment principles of free speech because "commanding 'involuntary affirmation' of objected-to beliefs" is equally reprehensible to "demanding silence" (quoting W. Va. State Bd. of Educ. v. Barnette 319 U.S. 624, 633 (1943))).

[184] Alana Semuels, *Is This the End of Public-Sector Unions in America?*, ATLANTIC (June 27, 2018), https://www.theatlantic.com/politics/archive/2018/06/janus-afscme-public-sector-unions/563879 [https://perma.cc/VH4D-U4PE].

sector unions, is a harbinger for a similar fate for private-sector unions.[185] The general movement to undermine the benefits of unionization and collective bargaining therefore make this a futile recourse for healthcare platform workers.

B. Expanding the Definition of "Employee" to Include Platform Workers

The most obvious benefit of expanding the definition of "employee" to encompass platform workers is that it would prompt platforms to provide their workers the assurance of benefits and protections mandated by laws like FLSA and NLRA.[186] As a solution, redefining "employee" would actually be more beneficial than expanding the antitrust labor exemption. The expansion of the "employee" definition would result in two major outcomes: (1) platform workers would be swept under the NLRA framework which would trigger the antitrust labor exemption, enabling healthcare platform workers to unionize and collectively bargain without fear of antitrust enforcement,[187] and (2) platforms would be required to comply with FLSA's provisions on paying workers minimum wage[188] and overtime pay.[189] As a protection, this solution would provide platform workers with the same safety net as workers who have the traditional employee classification through their employer

Right now you may be thinking, "problem solved!" But not so fast. As compelling as it sounds, expanding the "employee" definition may actually disrupt the platform-enabled business model(s), in turn subverting the value of the platform economy for both workers and patients (or healthcare companies). The platform work model boasts "greater efficiency, productivity, [] competitiveness" and is defined by its flexibility and autonomy which allows workers to work multiple platform jobs and maximize income based on their schedule.[190] Additionally, the ability of digital health to instantaneously connect a patient to a healthcare provider and get results just as immediately is the

[185] *See id.* (noting that twenty-eight states—colloquially termed "right-to-work" states—have passed legislation "preventing unions from collecting fair-share fees from private-sector employees who chose not to join the union" and predicting that this will increase as part of a post-*Janus* "drop-off" and broader anti-labor and anti-union movements).

[186] *See* Jennifer Pinsof, Note, *A New Take on an Old Problem: Employee Misclassification in the Modern Gig-Economy*, 22 MICH. TELECOMM. & TECH. L. REV. 34, 345–47 (2016).

[187] *See supra* Section II.A.

[188] *See* Fair Labor Standards Act, 29 U.S.C § 206(a)(1).

[189] *See* Fair Labor Standards Act, 29 U.S.C § 207(a)(1).

[190] *See* Ford, *supra* note 102, at 299.

hallmark of the Uberization of healthcare.[191] That said, encompassing platform workers under the employee classification would ultimately force platforms to make fundamental changes to their business models in a way that would uproot the very premise of worker autonomy.[192] Platforms that are forced to comply with the employee classification would be required to ensure a minimum wage and overtime pay for anyone who engages in work for them. It is likely that platforms would then want to cap the hours anyone could work in order to prevent having to pay overtime.[193] Furthermore, platforms that incur increased administrative costs rationally may want to make up for those costs by limiting the number of actual workers that can perform services through the platform.[194] Increasing barriers to work or reducing work opportunities completely undermines the concept of the new labor market and the role healthcare Uberization plays in alleviating the worker shortage in the industry in addition to hindering general job growth.

The effect of a mandated employee classification will be particularly harmful to healthcare platform workers who have established patient relationships. For healthcare workers who perform services through multiple platforms, having to abandon one or more platforms for the purposes of meeting hour requirements linked to benefits would force them to uproot any existing patient relationships they might have formed in the course of their work. This could have negative health effects for the patients who will lose the established relationship with a trusted healthcare worker.[195]

Moreover, patients may end up paying more for care provided through digital health platforms. From a purely economic standpoint, platforms will likely incur increased administrative, transactional, and fixed costs that accompany the

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[191] *See* Khan, *supra* note 78, at 126 (describing how "physician extenders" like physician assistants, nurse practitioners, etc. could be empowered in their diagnostic and treatment abilities with the help of "powerful artificial intelligence engines" which does not require "weeks or even months" to see a patient).

[192] *See* Taylor Soper, *Uber and Lyft Drivers Protest Union Ordinance in Seattle, Say Law Would 'Threaten Our Livelihood*,' GEEKWIRE (Jan. 17, 2017, 3:01 PM), https://www.geekwire.com/2017/uber-lyft-drivers-protest-union-ordinance-seattle-say-law-threaten-livelihood [https://perma.cc/8E7B-LHTX] (reporting about Seattle Uber and Lyft drivers' pushback against a Seattle law that would allow these gig workers to unionize and collectively bargain saying that the law would result in the loss of freedom).

[193] *See* Lao, *supra* note 105, at 1576 (predicting that should Uber or Lyft be subject to the requirements of FLSA, these companies "would rationally wish to limit their drivers to no more than forty hours per week of work in any given week" in order "to avoid paying overtime pay").

[194] *See id.* at 1577.

[195] *See* Susan Door Goold & Mack Lipkin, *The Doctor-Patient Relationship: Challenges, Opportunities, and Strategies*, 14 J. GEN. INTERNAL MED. 26, 29 (1999) (discussing the importance continuity of healthcare has on patients including improved outcomes of health).

employee classification.[196] Therefore, any increased input costs absorbed by insurance plans will most likely fall on the patient in the form of higher deductibles.[197] It is clear that classifying platform workers as employees would cripple the very concept of healthcare platform work, detracting from the employee benefits platform workers would receive from the FLSA and NLRA.

IV. USING EXISTING CMS INFRASTRUCTURE TO ENSURE HEALTHCARE PLATFORM WORKERS ARE PAID FAIRLY

Ensuring that platform healthcare workers earn a livable and sufficient wage would be best accomplished through CMS. As discussed above, CMS has been the conduit to reimburse services rendered by physicians and other licensed healthcare professionals administered though digital health platforms and technology.[198] Telehealth—often interchangeable with telemedicine—is defined as the delivery of healthcare services as well as the diagnosis and treatment of patients by licensed clinicians via telecommunications technologies.[199] Telehealth is a prime example of how Medicare can be expanded to accomplish this type of reimbursement for low wage and unlicensed healthcare platform worker, which is currently not covered by Medicare.[200] Paying platform workers through Medicare reimbursement is a way to use existing infrastructure built over time through federal legislation and through CMS. When looking at the history of telehealth, it is clear that policies governing telehealth primarily relate to how services are reimbursed and how healthcare providers are to be paid.[201] As discussed below, over the course of twenty-two years, Congress passed at least three laws that govern the reimbursement of telehealth through public health programs like Medicare. Congress should authorize Medicare coverage of digital health

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[196] Orly Lobel, *The Law of the Platform*, 101 MINN. L. REV. 87, 106 (2016).

[197] Robert Pitofsky, Chairman, Fed. Trade Comm'n, Before the Comm. on the Judiciary United States House of Representatives Concerning H.R. 1304 the "Quality Health-Care Coalition Act of 1999" 6 (June 22, 1999), https://www.ftc.gov/sites/default/files/documents/public_statements/prepared-statement-federal-trade-commission-quality-health-care-coalition-act/healthcaretestimony.pdf [https://perma.cc/3QPW-ECQL] (testifying that economic theory allows for a reasonable assumption that "industry-wide increase in input costs will ordinarily raise the price of the final product").

[198] *See supra* Section I.A.

[199] *What Is Telehealth?*, NEJM CATALYST (Feb. 8, 2018), https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0268 [https://perma.cc/TP9N-ZKWK].

[200] *See infra* Section IV.A (discussion about the limited CMS Medicare Physician Fee Schedules which limit reimbursable services to those provided by physicians or "qualified healthcare professionals").

[201] Mei Wa Kwong, *Telehealth and Public Programs – Evolution of Telehealth Policy in Medicare and Medicaid*, 15 J. HEALTH & BIOMEDICAL L. 7, 7 (2019).

services by amending and expanding these laws as a first step to ensuring platform workers are paid fairly.

The promulgation of the telehealth laws aligns with the general trend of increased interest in the use of technology "as federal and state policymakers face a myriad of concerns such as rising costs, limited resources and public health crises."[202] This interest and desire to find innovative alternative healthcare delivery models that cut costs while maintaining or improving quality of care has led the government to explore new models of incentivizing the use of technology in healthcare. For example, Congress included several sections in the Affordable Care Act (ACA) that "provide for the testing and evaluation of new healthcare delivery models"[203] and "include telehealth technology as a means for reform . . . to improve the quality of care while reducing costs."[204] These mechanisms would collect evidence that digital health platforms cut costs and improve quality care, which could be a way to overcome the barriers of needing to garner widespread support and spurring legislative and policy reform to expand Medicare coverage.

A. *"Communication Technology-Based Services"[205]: CMS's Open Door to Reimburse Remote Services*

In July 2018, CMS promulgated its annual proposal for changes to the Medicare Physician Fee Schedule[206] (fee schedule).[207] CMS included in the proposed 2019 fee schedule a series of new reimbursable services furnished via "communication technology-based service[s]."[208] The proposal noted it will begin reimbursing the following services: "Virtual

[202] *Id.*

[203] Amy E. Zilis, Note, *The Doctor Will Skype You Now: How Changing Physician Licensure Requirements Would Clear the Way for Telemedicine to Achieve the Goals of the Affordable Care Act*, 2012 U. ILL. J. L. TECH. & POL'Y 193, 198 (2012).

[204] Avery Schumacher, Note, *Telehealth: Current Barriers, Potential Progress*, 76 OHIO ST. L J. 409, 430 (2015).

[205] 83 Fed. Reg. at 35,724.

[206] Fee schedules list the fees for particular services offered by healthcare providers and is used by CMS to reimburse providers for their services. *Fee Schedules – General Information*, CTRS. FOR MEDICARE & MEDICAID SERVS. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo [https://perma.cc/538W-D864].

[207] Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, 83 Fed. Reg. 35,704 (July 27, 2018) (to be codified at 42 C.F.R. pts. 405, 410, 411, 414, 415, 495), https://www.govinfo.gov/content/pkg/FR-2018-07-27/pdf/2018-14985.pdf [https://perma.cc/UM6M-YKFU].

[208] 83 Fed. Reg. at 35,724.

Check-In,"[209] "Remote Evaluation of Pre-Recorded Patient Information,"[210] and "Interprofessional Internet Consultation."[211]

In November 2018, CMS issued the proposed 2019 fee schedule,[212] which healthcare watchdogs heralded to have "opened the door to reimbursement for services that enable providers to manage and coordinate care at home."[213] Significantly, it is the first time that CMS explicitly included payment codes that will pay healthcare providers for remote patient monitoring which, until recently, has been a "gray area" for providers.[214] The 2019 fee schedule expanded the range of services that can be reimbursed through CMS into the realm of remote and virtual monitoring.[215] And notably, the release of the 2021 fee schedule demonstrates that CMS intends to continue the trend of expanding remote services.[216]

The fee schedule in its current state, however, is still limited because reimbursable services are restricted to those provided by physicians, other "qualified healthcare

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[209] "Brief communication technology-based service[s] . . . by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous [seven] days nor leading to an E/M service or procedure within the next [twenty-four] hours or soonest available appointment; [five-ten] minutes of medical discussion." 83 Fed. Reg. at 35,723–24.

[210] "Remote evaluation of recorded video and/or images submitted by the patient (e.g., store and forward), including interpretation with verbal follow-up with the patient within [twenty-four] business hours, not originating from a related E/M service provided within the previous [seven] days nor leading to an E/M service or procedure within the next [twenty-four] hours or soonest available appointment." 83 Fed. Reg. at 35,724–25.

[211] "Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional." 83 Fed. Reg. at 35,725.

[212] Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, 83. Fed. Reg. 59,452 (Nov. 23, 2018) (to be codified at 42 C.F.R. pts. 405, 410, 411, 414, 415, 415, 495), https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf [https://perma.cc/V3SK-AC6U].

[213] Jeff Lagasse, *Getting Paid for Remote and Virtual Care Services: CPT Codes to Know and Understand*, HEALTHCARE FIN. (Mar. 19, 2019), https://www.healthcarefinancenews.com/news/getting-paid-remote-and-virtual-care-services-cpt-codes-know-and-understand [https://perma.cc/5TW8-UNJB].

[214] *Id.*

[215] *See* Sheila Madhani & Mara McDermott, *Top 10 Takeaways: 2019 Medicare Physician Fee Schedule*, NAT'L L. REV. (Nov. 6, 2018), https://www.natlawreview.com/article/top-10-takeaways-2019-medicare-physician-fee-schedule [https://perma.cc/B3ZY-UH56] (describing the 2019 fee schedule's expansion of remote and technology-driven services as a "historic change" for CMS).

[216] *See* Eric Wicklund, *CMS Finalizes Telehealth, RPM Coverage in 2021 Physician Fee Schedule*, MHEALTH INTELLIGENCE (Dec. 2, 2020), https://mhealthintelligence.com/news/cms-finalizes-telehealth-rpm-coverage-in-2021-physician-fee-schedule [https://perma.cc/X64X-5XTP].

professionals," and by clinical staff[217] which traditionally only includes "registered nurses and medical assistants."[218] Additionally, the new remote patient monitoring codes in the 2021 fee schedule primarily account for—and still only reimburse—services such as documentation and management of physiologic metrics like weight, blood pressure, pulse oximetry, and respiratory rate.[219] Accordingly, the 2021 fee schedule continues to not reimburse for services provided by unregistered platform workers. CMS should expand the fee schedule definitions for "healthcare provider," or alternatively, create a new term which encompasses healthcare platform workers to include services that could be provided by healthcare platform workers who get virtual or in-person work through digital health platforms and technology. Furthermore, CMS should create more CPT codes for these services beyond just physiological monitoring. Alternatively, CMS could define a new category of codes for remote patient care and include codes for services provided by workers beyond its current definition of qualified healthcare professionals.

B. *Using Center for Medicare and Medicaid Innovation to Test Delivery Models*

Finding and gathering evaluative information regarding the use of digital health and technology will likely be the greatest barrier to establishing Medicare reimbursement for digital health platform workers. For any concerns regarding the efficacy of digital health and whether these platforms could actually cut costs and improve patient care and health outcomes, CMS should utilize the Center for Medicare and Medicaid Innovation (CMMI) to encourage the testing and use of digital health innovations through which platform workers provide services to patients. Section 3021 of the ACA established the CMMI, which is designed to "research, develop, test, and expand innovative payment and delivery arrangements."[220] The goal of

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[217] Elena Muller, *2021 Medicare Physician Fee Schedule: 101*, HEALTH RECOVERY SOLUTIONS, https://www.healthrecoverysolutions.com/blog/2021-medicare-physician-fee-schedule-101 [https://perma.cc/99VX-9CM8].

[218] *See* Lagasse, *supra* note 213.

[219] Nathaniel M. Lacktman et al., *2021 Medicare Remote Patient Monitoring FAQs: CMS Issues Final Rule*, FOLEY & LARDNER (Dec. 7, 2020), https://www.foley.com/en/insights/publications/2020/12/2021-remote-patient-monitoring-cms-final-rule [https://perma.cc/ELT9-CNXK].

[220] *See* DEMOCRATIC POLICY & COMM., THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: SECTION-BY-SECTION ANALYSIS 22 (2009), https://www.dpc.senate.gov/healthreformbill/healthbill05.pdf [https://perma.cc/6UFT-LSH5]; *see also*

CMMI is to promote new ways to reduce the cost of care provided to Medicare, Medicaid, and CHIP patients, while also improving quality of care provided to these patients.[221]

In Phase I (of the two phases enumerated in Section 3021), CMMI provides grants to individual states to test new payment and delivery models and considers "[w]hether the model utilizes technology, such as . . . patient-based remote monitoring systems, to coordinate care over time and across settings."[222] Once testing of a delivery model has been initiated, the quality and cost of the care is evaluated.[223] Then in Phase II of Section 3021, if a model has been found to improve the quality of patient care and maintain or lower costs, the Secretary of CMS may choose to expand the model.[224]

History tells us that Congress will be reluctant to expand Medicare policy for emerging technologies—or at least that is what history reveals about the adoption of telehealth policy and the reimbursement of telehealth services.[225] It is not unreasonable for stakeholders and decisionmakers to seek proof of the potential values of new services. Some findings, however, indicate the financial value digital health platforms could potentially offer. For example, just last year, CareCoach reported that assigning avatars to patients who have been known to visit the emergency room most frequently has "saved $150,000 in emergency room costs."[226] Additional support demonstrating the savings made possible with digital health and the improved quality of patient care could be used to push states to develop digital health-driven delivery care models to be tested and evaluated by CMMI.

C. Telehealth Policy in Medicare as a Model to Promote Reimbursement for Digital Health Platform Work

Three major federal laws are responsible for getting Medicare coverage for telehealth services. The passage of the

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Patient Protection and Affordable Care Act, Pub. L. No. 111–148, § 3021, 124 Stat. 119, 389–95 (2010) (codified as 42 U.S.C. § 1315a).

221 *See* Patient Protection and Affordable Care Act § 3021(a)(1), 124 Stat. at 389 (codified as 42 U.S.C. § 1315(a)(a)(1)).

222 *See* Patient Protection and Affordable Care Act § 3021(b)(2)(C)(iv), 124 Stat. at 392 (codified as 42 U.S.C. § 1315(a)(b)(2)(C)(iv)).

223 *See* Patient Protection and Affordable Care Act § 3021(b)(4)(A), 124 Stat. at 393 (codified as 42 U.S.C. § 1315(a)(b)(4)).

224 *See* Patient Protection and Affordable Care Act § 3021(c), 124 Stat. at 393 (codified as 42 U.S.C. § 1315(a)(c)) (indicating that once evaluation has been completed, "the Secretary may . . . expand . . . the duration and the scope of a model that is being tested").

225 *See* Kwong, *supra* note 201, at 10.

226 *See* Moise, *supra* note 19.

Balanced Budget Act (BBA) in 1997 marked the first instance in which Congress authorized Medicare coverage of telehealth services.[227] The BBA mandated the Secretary of HHS to make Medicare Part B[228] payments to healthcare providers for telehealth services delivered to patients living in rural areas that are classified as health professional shortage areas.[229] The bill subjected payments to Medicare coinsurance and deductible requirements to determine the amount of payments for the telehealth services.[230]

Several years later in 2000, Congress passed the Benefits Improvement and Protection Act which had the goal of encouraging telehealth by expanding telehealth coverage to geographic areas other than Metropolitan Statistical Areas and any entity approved for a federal telehealth demonstration project.[231] However, telehealth services were still restricted to reimbursement of only the live video modality, which is a small scope of services that could be provided.[232] And even though the act expanded geographic coverage, coverage was still limited to rural health professional shortage areas or "non-Metropolitan Statistical Areas."[233]

Lastly, the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 further expanded Medicare coverage of telehealth services to included "hospital-based or [critical access hospital]-based renal dialysis facilities, [skilled nursing home facilities], and community mental health centers."[234] Following MIPPA, telehealth coverage has not been further expanded with the exception of the 2018 Bipartisan Budget Act and the SUPPORT for Patients and Communities Act which provided expansions to cover conditions such as end

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[227] WINIFRED V. QUINN, AARP PUB. POLICY INST., TELEHEALTH & MEDICARE: WHAT IS COVERED 1 (2019), https://www.aarp.org/content/dam/aarp/ppi/2019/08/telehealth-medicare-what-is-covered.doi.10.26419-2Fppi.00080.001.pdf [https://perma.cc/P445-PD2N].

[228] Medicare Part B helps pay for services from doctors and other healthcare providers, outpatient care, home healthcare, durable medical equipment, and some preventive services. *See* 42 U.S.C. §§ 1395k(a).

[229] CTR. FOR TELEMEDICINE LAW, TELEMEDICINE REIMBURSEMENT REPORT 3 (Oct. 2003), https://www.hrsa.gov/sites/default/files/healthitBACKUPJan6-17/telehealth/reimburse.pdf [https://perma.cc/764C-QQWJ].

[230] *See* Kwong, *supra* note 201, at 11.

[231] Matlin Gilman & Jeff Stensland, *Telehealth and Medicare: Payment Policy, Current Use, and Prospects for Growth*, 3 MEDICARE & MEDICAID RES. REV. 5 (2013); DEPT. HEALTH & HUMAN SERVS.: HEALTH CARE FIN. ADMIN., REVISION OF MEDICARE REIMBURSEMENT FOR TELEHEALTH SERVICES 1 (2001), https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/AB0169.pdf [https://perma.cc/F46W-47WE].

[232] *See* CTRS. FOR MEDICARE AND MEDICAID SERVS., INFORMATION ON MEDICARE TELEHEALTH 6 (2018), https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Information-on-Medicare-Telehealth-Report.pdf [https://perma.cc/T35M-A4PY].

[233] *See* Kwong, *supra* note 201, at 11.

[234] Debra A. McCurday & Catherine A. Hurley, *The Medicare Improvements for Patients and Providers Act of 2008*, REED SMITH (Aug. 11, 2008), https://www.lifescienceslegalupdate.com/2008/08/articles/legislative-developments/the-medicare-improvements-for-patients-and-providers-act-of-2008 https://perma.cc/N2DA-2V4J].

stage renal disease, acute stroke, and substance abuse disorder.[235] While the fear that telehealth will only lead to unnecessary care and costs has deterred lawmakers from expanding telehealth policy to cover more services,[236] innovative programs promoted by CMMI have allowed provider networks to quell these types of concerns by testing delivery models to ensure telehealth services are both cost-efficient and targeted.[237]

Using telehealth as a guide, it is reasonable to assume that the barriers hindering telehealth expansion are likely the same barriers expanding Medicare coverage for other technology-enabled healthcare services. There has been a push, however, to promote innovative healthcare delivery methods and place telehealth and other digital health platforms at the forefront of conversations for their potential to address the opioid epidemic and other public health crises.[238] For example, Congress has already "expanded access to telehealth for Medicare treatment of substance use disorders,"[239] showing that a variety of technology-driven services can—and should—be covered by Medicare. And, as of late, the push for expanded and deregulated telehealth has been at the forefront of healthcare—and economic—discourse sparked by the recent COVID-19 pandemic.[240]

D. COVID-19 Revealed CMS Medicare Policy Possibilities, Beckoning a New Age of Digital Healthcare Delivery

The COVID-19 pandemic has pushed the boundaries of the U.S. healthcare system. Perhaps most prominently, the pandemic

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[235] *See* Bipartisan Budget Act of 2018, Pub. L. No. 115–123, §§ 50323–25, 132 Stat. 64, 202–05 (2018); SUPPORT for Patients and Communities Act of 2018, Pub. L. No 115–271, §§ 2001, 7162, 132 Stat. 3924–25, 4062–67 (2018).

[236] *Reimbursement Labs, Legal Hurdles Slow Telemedicine Adoption*, MANAGED HEALTHCARE EXECUTIVE (Oct. 1, 2015), https://www.managedhealthcareexecutive.com/view/reimbursement-lags-legal-hurdles-slow-telemedicine-adoption [https://perma.cc/Q837-KCKJ].

[237] Billy Wynne & Josh LaRosa, *A Tell-All on Telehealth: Where is Congress Heading Next?*, COMMONWEALTH FUND. (May 16, 2019), https://www.commonwealthfund.org/blog/2019/telehealth-where-congress-heading-next [https://perma.cc/58WB-DWSS].

[238] U.S. DEP'T. OF HEALTH AND HUMAN SERVS., STRATEGY TO COMBAT OPIOID ABUSE, MISUSE, AND OVERDOSE: A FRAMEWORK BASED ON THE FIVE POINT STRATEGY 4 (2018), https://www.hhs.gov/opioids/sites/default/files/2018-09/opioid-fivepoint-strategy-20180917-508compliant.pdf [https://perma.cc/N3G4-Y56B] (describing HHS' strategy to address the opioid epidemic which includes the use of telehealth to provide "direct care and consultation approaches to [Medication Assisted Treatment]").

[239] *See* Wynne & LaRosa, *supra* note 237.

[240] *See* Council of Econ. Advisers, *Deregulation Sparks Dramatic Telehealth Increase During the COVID-19 Response*, WHITE HOUSE (Apr. 28, 2020), https://www.whitehouse.gov/articles/deregulation-sparks-dramatic-telehealth-increase-covid-19-response [https://perma.cc/CF3Y-LXW8] (stating that "targeted [telehealth] deregulation . . . allow[s] the private sector to complement the Federal Government's COVID-19 responses" which "can help the American healthcare system meet patients' needs during a national emergency").

revealed just how flexible the CMS reimbursement system can be when it comes to digital and remote healthcare delivery. As state and local governments passed stay-at-home orders, CMS identified several goals and action plans in the hopes of adapting to the new, syncopated American life of social distancing and self-quarantining.[241] As stated in its goals, CMS made it a priority to "remov[e] barriers for physicians, nurses, and other clinicians" and "increase access to telehealth in Medicare to ensure patients have access to . . . clinicians while keeping patients safe at home."[242] Concurrently, CMS laid out ways it intends to meet these goals in its promulgated action plans.[243]

To effectuate its objective of increasing access to healthcare in the safety of a patient's home, CMS expanded the types of practices that can be delivered vis-à-vis telehealth or digital health services.[244] In doing so, CMS waived limitations restricting the delivery of certain ancillary healthcare services such as physical, occupational, and speech therapies.[245] The most salient of the announced expansions, however, was the opportunity for hospitals to bill for remote, non-clinical outpatient services, including counseling services and educational services.[246] These types of services can be likened to services that are typically provided by platform workers on elder tech platforms such as CareCoach. As discussed in an earlier section, these types of platform workers primarily perform monitoring services.[247] But at the outermost boundaries of their scope of practice, platform workers for elder tech platforms may engage in educational and behavioral services for patients.[248]

The various COVID-19 initiatives and waivers announced by CMS, in part, demonstrate the fruits of lobbying efforts by several professional health organizations that "called on CMS to ease the restrictions around [remote] services."[249] In their advocacy

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[241] CTRS. FOR MEDICARE & MEDICAID SERVS., HOSPITALS: CMS FLEXIBILITIES TO FIGHT COVID-19 1 (2020), https://www.cms.gov/files/document/covid-hospitals.pdf [https://perma.cc/GT3K-XSH7].

[242] *Id.*

[243] *See generally id.*

[244] Press Release, Ctrs. for Medicare & Medicaid Servs., Trump Administration Issues Second Round of Sweeping Changes to Support U.S. Healthcare System During COVID-19 Pandemic (Apr. 30, 2020), https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid [https://perma.cc/3N5H-5CNK].

[245] *Id.*

[246] In its announcement, CMS also indicated that it would increase reimbursements for certain "audio-only . . . behavioral health and patient educational services." *Id.*

[247] *See* discussion *supra* Section II.A.

[248] *See* discussion *supra* Section II.A.

[249] Eric Wicklund, *CMS Expands COVID-19 Telehealth Reimbursement to Therapists, Phone Services*, MHEALTH INTELLIGENCE (May 1, 2020), https://mhealthi

to CMS, these organizations highlighted the particular benefits of remote services for seniors and low-income individuals.[250] Though CMS prescribed these changes only for "the duration of the public health emergency,"[251] Medicare patients would benefit greatly should CMS make these changes permanent. Even with the advancement of telehealth and the proliferation of other digital healthcare platforms, low-income individuals and populations are still burdened by the repercussions of healthcare access disparities. Moreover, the COVID-19 pandemic and its disastrous impact on the United States has put our healthcare system on notice for future pandemics and public health crises. There is no doubt that tech companies will continue to develop technologies and digital healthcare platforms in response to these circumstances.[252] And if they have not already, healthcare providers and payors will start to invest in these technologies.[253] This will no doubt come with an increasing need for healthcare platform workers. Reversion of Medicare policy back to its pre-COVID-19 state, however, will generate an increase of platform workers, but no additional measures to guarantee they receive at least a minimum wage. With the federal government's response discussed above, this does not have to be the outcome. If there is something to be learned by this pandemic, it is the possibility for Medicare policy to be expanded to cover a wider array of digital healthcare services.

CONCLUSION

The United States now finds itself at the vanguard of a burgeoning healthcare era. The Uberization of healthcare is well on its way; the progression of technology has manifested the potential for delivering all sorts of healthcare services to almost

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ntelligence.com/news/cms-expands-covid-19-telehealth-reimbursement-to-therapists-phone-services [https://perma.cc/N3ZN-WRP6].

[250] *Id.*

[251] On March 13, 2020, President Trump declared the COVID-19 outbreak in the United States a national public health emergency that "threaten[ed] to strain our Nation's healthcare system." The President's declaration granted the Secretary of the HHS to "temporarily waive or modify certain requirements of . . . Medicare . . . " with "advance written notice to the Congress." *Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak*, WHITE HOUSE (Mar. 13, 2020), https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak [https://perma.cc/2M3L-BM3L].

[252] *See* Iyengar, *supra* note 150.

[253] *See* SAGE GROWTH & BLACKBOOK RESEARCH, *supra* note 150, at 5 (reporting that "[t]elehealth services have moved to the forefront as people delay or avoid seeking care at brick and mortar healthcare facilities for fear of contracting the virus," and that 45% of those 517 surveyed felt 'extremely satisfied' with telehealth visits signaling a "growing acceptance and use of telehealth" and an "opportunity for [] providers to develop new, expanded models of care delivery" which allows patients to choose between in-person or virtual doctor visits).

anyone, from almost anywhere. As such, it is paramount for policymakers to recognize the threats of emerging labor models and address the precarity birthed by the platform economy. Reconciling the cost-cutting concerns of major players in the healthcare industry with the value offered by the platform economy does not need to be a race to the bottom. And with the current Medicare policies and mechanisms in place, protecting healthcare platform workers does not require the U.S. healthcare system to reinvent the wheel. Medicare policy should be expanded to reimburse a wider array of virtual and remote healthcare services. In doing so, healthcare platform workers can be guaranteed fair pay. Withal, COVID-19—the global pandemic that blighted the United States and its healthcare system—has proven that this type of solution is more necessary than ever. If COVID-19 has taught us anything, it is that healthcare workers are essential. Without the opportunity to earn a livable wage, the freedom promised to healthcare workers by the platform economy is but a devil's gift.

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