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Joan Claybrook, President

MEMORANDUM

TO: **State legislators, public health officials, and other interested parties**
FR: **Public Citizen's Global Trade Watch**
DT: **November 4, 2004**
RE: **Actions Needed to Prevent Preemption of Healthcare Reform Initiatives by Trade Agreements: Absent Action the General Agreement on Trade in Services (GATS) Could Limit States' Ability to Regulate the Healthcare Sector and Implement Measures to Expand Access and Reduce Healthcare Costs.**

Today's international "trade" agreements, such as the North American Free Trade Agreement (NAFTA) and various World Trade Organization (WTO) pacts, contain many policy obligations and constraints to which U.S. federal, State and local governments are bound to conform their domestic policies. State laws that conflict with these rules can and have been challenged as illegal "barriers to trade" in binding dispute resolution systems established by these agreements.

Currently, the United States Trade Representative (USTR) is re-negotiating the WTO's General Agreement on Trade in Services (GATS)[1], a multilateral trade pact that could affect domestic laws and policies governing a number of health-related services[2], including:

- health insurance;
- health services provided by physicians, nurses and other health professionals;
- health services provided by hospitals, nursing homes, HMOs and other healthcare facilities;
- medical education;
- medical research and development; and
- data processing services, including medical records and insurance claim processing.

During the Uruguay Round, the initial 1986-1994 GATT negotiations that led to the establishment of the WTO and the GATS, the United States made "specific commitments" to subject some health services to the jurisdiction of the GATS' powerful market access and national treatment rules. Countries that join the WTO agree to "ensure conformity of all laws, regulations, and administrative procedures"[3] to the agreements, including the GATS, enforced by the WTO. Thus, when a country "binds" a specific service sector to be covered by GATS rules, that country is required to conform its domestic policy to the requirements of GATS, including policy regarding non-trade matters such as how a covered service is regulated when operating within the country. Health-related services that are already partially bound under GATS' rules include: health insurance, hospital and other healthcare facilities, medical records, and health insurance claim processing.[4] Since 2000, additional GATS talks have been underway. Countries are to "progressively liberalize" their service sectors in these talks. In these current and/or future rounds of GATS negotiations, the United States could expand "specific commitments" in these sectors and bind other health sectors to the GATS' market access and national treatment rules. In addition, new GATS rules on domestic regulation, government procurement and subsidies are being contemplated that could impact U.S. healthcare services.[5]

Unless healthcare services are taken off of the GATS negotiating table now, State and federal governments' ability to effectively regulate the delivery of healthcare services and implement healthcare reform measures designed to expand access and reduce the cost of healthcare in the future could be jeopardized in the following ways:

- **Universal Health Insurance.** The GATS (Article VIII:4) requires that if a WTO signatory nation grants monopoly rights to supply a service to a single government or non-profit provider in any sector covered by its "specific commitments," it must compensate trading partners for the change. Since the health insurance sector is already covered by U.S. "specific commitments," the United States could be obligated to compensate trading partners (e.g. other WTO member nations) if either the federal government or any U.S. State enacted single-payer universal health insurance legislation. Unless U.S. "specific commitments" in the health insurance sector are withdrawn, the prospect of having to negotiate compensation with an array of trading partners for the right to enact a universal health care program could have a chilling effect on future health reform legislation.

- **Privatization of Medicare.** The existing federal Medicare program appears to be exempt from GATS rules under Article I(3)b, which exempts certain "services provided in the exercise of government authority" from GATS coverage. However, proposed Medicare reforms that would allow private health insurers to compete against the government program could disqualify the Medicare program from the GATS exemption,[6] which only covers services provided neither on a commercial basis nor in competition with one or more service suppliers.[7] Moreover, unless U.S. "specific commitments" covering health insurance are withdrawn, experiments in the privatization of Medicare could prove difficult to reverse. Once a sector is open to competition, the GATS anti-monopoly rules could jeopardize the re-establishment of an exclusively public Medicare program.[8]

- **Expansion of Medicare**. Any new legislation to expand the existing federal Medicare program to cover children, nursing home care, or prescription drugs could come into conflict with GATS "market access" rules if such legislation limits private, for-profit commercial access to domestic markets for health insurance, health services, or distribution of pharmaceutical products.[9] Domestic policies that violate GATS rules are subject to challenge in WTO tribunals and countries are subject to imposition of trade sanctions if WTO-illegal policies are not eliminated. GATS market access rules (Article XVI) also could limit policy options for reforming Medicare to market-friendly types of "reforms" – such as the recent Medicare prescription drug law – that may not be the most effective means to expand access to healthcare services or control spiraling healthcare costs. To maintain the policy space necessary to effectively expand or reform Medicare, U.S. "specific commitments" covering health insurance, HMO's, hospitals, nursing homes, and distribution services would need to be withdrawn.

- **State Health Reform Initiatives**. Short of universal health insurance, a number of States are experimenting with different legislative initiatives designed to expand access to healthcare services and decrease healthcare costs. For example, the proposed Wisconsin Health Care Plan (WHCP) promises to provide health insurance to all workers and their dependents in the State of Wisconsin at a cost affordable to employers.[10] Other States, such as California, are experimenting with so-called "pay or play" insurance mandates that require employers either to provide health insurance to employees, or to pay into a State fund that will provide insurance.[11] Unless U.S. "specific commitments" in the health insurance sector are withdrawn, reform proposals like these could run afoul of the GATS rules because they limit "access" to insurance markets by commercial entities, or grant "discriminatory" subsidies to public insurance plans

that compete with private insurers. If a WTO tribunal determines that State health insurance laws designed to expand access or to reduce healthcare costs are inconsistent with the GATS, the U.S. could face trade sanctions unless the laws are modified or repealed.

- **Regulation of the Health Sector.** Professional and institutional licensing, qualification requirements, and technical standards governing hospitals, nursing homes, HMOs, health insurers, physicians, nurses and other health professionals are essential to ensuring the quality of healthcare delivery in the United States. GATS Article VI:4 required launch of additional WTO talks to establish so-called "disciplines" (rules) to ensure that domestic laws governing licensing, qualification and technical standards are not "more burdensome" or "more trade restrictive" than necessary. The prospect of "necessity testing" – the prospect that WTO tribunals will be given authority to determine whether U.S. domestic laws are unnecessarily burdensome to trade – constitutes a significant threat to democratic, accountable governance and sovereignty. Yet, the Office of the United States Trade Representative (USTR) has indicated its willingness to adopt disciplines (rules) that would subject U.S. laws governing the accounting, engineering and architecture professions to "necessity tests" in the current round of GATS negotiations. Unless "necessity testing" is opposed and defeated in these sectors, a dangerous precedent will be set for "necessity testing" in other sectors, including healthcare.

- **Telemedicine.** Advances in telemedicine are making it technologically feasible to provide health services such as medical consultations, pathology, radiology and other diagnostic and testing services from offshore locations.[12] Telemedicine raises a myriad of health policy issues related to quality assurance, malpractice liability, privacy, control over licensing and standards, and reimbursement eligibility, as well as labor issues related to the offshoring of healthcare jobs. At present, many telemedicine services appear to be outside the reach of GATS rules, because the United States has not made any "specific commitments" governing telemedicine services. In current and future rounds of GATS negotiations, however, the United States could extend "specific commitments" to cover professional medical services delivered by physicians, other health practitioners, and hospital outpatient clinics. Unless extension of "specific commitments" in these areas is opposed, the United States could lose flexibility in determining how best to govern the new and burgeoning field of telemedicine in the public interest.

Taking Healthcare Off the GATS Negotiating Table

The implications of the GATS for U.S. healthcare are long term and structural. Urgent action is needed to eliminate the present threat to health care reforms posed by current U.S. "specific commitments" on health care-related services as well as current services negotiations now underway at WTO and in regional and bilateral fora. The full impact and consequences of the threats described above may not be realized for several years. However, we cannot wait to act, because absent action now, "trade" policies may make it possible for foreign private, for-profit insurers, hospitals, and HMOs (perhaps subsidiaries of U.S. mega-corporations reorganized overseas to obtain the preferential treatment of the trade pacts) to gain a substantial foothold in the U.S. market. We will then find that we have made binding legal commitments under international trade law that constrain our ability to maintain or implement meaningful healthcare reforms. Unless healthcare is taken off the negotiating tables in the WTO and other "trade" deals now, our ability to act on the local, State and national levels in the future will be limited. "Taking healthcare off the negotiating table" means that the USTR must take immediate action to:

- **Withdraw existing U.S. "specific commitments" in health-related services, including commitments in the following sectors: 1) health insurance, and 2) hospitals and other**

healthcare facilities. The GATS rules allow us to withdraw specific commitments provided that we negotiate a "compensatory adjustment" with trading partners who are affected by the withdrawal. While we cannot withdraw existing commitments with impunity, the costs of "compensatory adjustment" will be less today than it will be in the future when foreign providers have gained a larger share of the U.S. domestic insurance, HMO, and hospital markets. Unless these commitments are withdrawn now, the possibility of achieving healthcare reform, expanding access to care to the millions of uninsured, and effectively controlling spiraling healthcare costs is seriously jeopardized.

- **Do not undertake new "specific commitments" in health-related services – including professional services provided by physicians, nurses, and other health professionals**. In current and future rounds of GATS negotiations, the USTR should not make new market access and national treatment commitments in any health-related sector.

- **Do not expand existing "specific commitments" in the health-related sectors.** In the current GATS negotiating round, other WTO signatory nations are asking the United States to expand our existing market access commitments in the insurance sector to cover cross-border trade (Mode 1).[13] Any expansion of existing U.S. "specific commitments" in the health insurance sector, and other health-related sectors, should be opposed.

- **Oppose new constraints on "domestic regulations" in the service sector, including "necessity testing" under GATS rules.** WTO "disciplines on domestic regulations" should be opposed in principle as an inappropriate invasion of one-size-fits-all rules into an area of decision-making that should be controlled by those living with the results. Unless current proposals to establish "disciplines" for accounting, architecture and engineering are defeated, a dangerous precedent will be set for "necessity testing" in other service sectors, including health services.

For more information, contact Public Citizen's Global Trade Watch: Mary Bottari at (608) 255-4566 or mbottari@citizen.org, or Sara Johnson at (202) 454-5193 or sjohnson@citizen.org.

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[1] *General Agreement on Trade in Services (GATS)*, Annex 1B of the Uruguay Round Final Act. The full legal text is available at www.wto.org

[2] See Arnold, P.J. & Reeves, T.C., 2004, International Trade Law and US Healthcare: Why GATS Threatens US Health Policy, Working Paper, University of Wisconsin-Milwaukee, for an analysis of the implications of the GATS for healthcare delivery in the U.S.

[3] Agreement Establishing the WTO, Article XVI-4

[4] *United States of America, Schedule of Specific Commitments*, GATS/SC/90 (April 1994) and GATS/SC/90/Suppl.3 (26 February 1998).

[5] GATS Article VI:4 empowers the WTO to develop disciplines (rules) on domestic regulation; GATS Article XIII mandates further multinational negotiations on government procurement; GATS Article XV mandates multilateral negotiations to develop disciplines (rules) to avoid the "trade-distortive" affects of subsidies.

[6] Belsky, L., Lie, R. Mattoo, A. Emanuel, E.J. and Sreenivasan, G., 2004. The General Agreement on Trade in Services: Implications for Health Policymakers; To what extend does the GATS allow governments to regulate health service providers? *Health Affairs,* 23(3):137-145.

[7] GATS Article I-3-b and c. "...(b) "services" includes any service in any sector except services supplied in the exercise of government authority; (c) "a service supplied in the exercise of governmental authority" means any service which is supplied neither on a commercial basis, nor in competition with one or more service suppliers."

[8] Although proposals to privatize Medicare are controversial, The *Medicare Prescription Drug, Improvement and Modernization Act of 2003* creates a mandate for a demonstration project to test competition between private insurance plans and traditional Medicare beginning in 2010.

[9] Market access obligations are set out in GATS Article XVI. In sectors where market access commitments are undertaken, the United States may not maintain or adopt: "1) limitations on the number of services suppliers via quotas, monopolies, exclusive service suppliers, or the requirements of economic needs tests; 2) limitations on the total value of services transactions or assets in the form of numerical quotas or the requirement of an economic need test; 3) limitations on the total number of services

operations or the total quantity of service output expressed in terms of designated numerical units or in the form of quotas or the requirements on an economic needs test; 4) limitations on the total number of natural persons that may be employed in a particular service sector or that a service supplier may employ in the form of numerical quotas or requirements of an economic needs test; 5) measures which restrict or require specific types of legal entity or joint venture through which a service supplier may supply a service; or 6) limitations on the participation of foreign capital in term of maximum percentage limit on foreign shareholding or the total value of individual or aggregate foreign investment."

[10] The Wisconsin Health Care Plan is a proposal of the Wisconsin State AFL-CIO. A description is available at www.wisaflcio.org.

[11] California's "Pay or Play" health law, the *Health Insurance Act of 2003 (SB 2),* will require any employer with 50 or more employees in California either to pay a fee into a fund for financing health coverage for its employees or to provide them with a prescribed level of coverage beginning in 2006.

[12] Chanda, R., 2002. Trade in health services. *Bulletin of the World Health Organization*, 80(2):158-163.

[13] The GATS defines several methods or "modes" of delivering services. Currently, US "specific commitments" in the insurance sector apply to Mode 3, i.e. the situation where non-US insurers establish a commercial presence in the US and do business on US soil. During the current Round of GATS negotiations the US could extend this commitment to apply to Mode 1, i.e. the situation where non-US insurance companies located offshore provide health insurance coverage to US consumers.