Public Citizen
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Joan Claybrook, President

MEMORANDUM

TO: **State Legislators, Public Health Officials and Other Interested Parties**
FR: **Mary Bottari, Public Citizen's Global Trade Watch**
DT: **July 24, 2007**
RE: **Implication of the WTO's General Agreement on Trade in Services for Universal Health Care, Nonprofit Hospitals and State Health Care Reform Initiatives**

Traditionally trade agreements were limited to issues relating to movement of goods between countries and eliminating barriers to trade, such as tariffs and quotas applied by the federal government at the border. However, many of today's international trade agreements establish binding obligations constraining federal, state and local government policy and actions in numerous service sectors, including health services. These rules are not limited to trade in services across borders, but also constrain government regulation of foreign service sector firms operating within the United States. As a result, today's "trade" pacts are delving deeply into domestic regulatory issues that have little or nothing to do with the traditional concept of trade between nations.

The North American Free Trade Agreement (NAFTA) and various World Trade Organization (WTO) agreements contain many obligations and constraints to which U.S. federal, state and local governments are bound to conform their domestic policies. Federal and state laws that conflict with these NAFTA and WTO rules can and have been challenged as illegal "barriers to trade" in binding dispute resolution systems established by these agreements. Yet neither the citizens most directly affected by these trade pacts nor their elected representatives in state or local government are being consulted about the agreements' terms. This memo is an effort to alert state legislators, public health officials and those in the medical profession about an international trade agreement that may act as an impediment to the innovative efforts of states to create low-cost public health care systems, reduce the cost of prescription drugs and ensure high standards of quality and safety in the provision of health care.

During the Uruguay Round of General Agreement on Tariffs and Trade (GATT) negotiations, which resulted in the formation of the WTO in 1995, the United States was a key proponent of the service-sector pact, called the General Agreement on Trade in Services (GATS).[1] Because the U.S. demand to include the service sectors in a trade agreement was so controversial, GATS is structured as a "bottom-up" agreement, which means that it applies only to the service sectors each nation volunteers to bind (or "commit" in trade parlance) to the obligations and constraints set forth in the GATS text.

Few in Congress ever reviewed the content of the thousands of pages comprising the Uruguay Round agreements package. Thus, in passing the Uruguay Agreements Act, Congress approved the binding of nearly 100 sectors of the U.S. service economy to GATS requirements with little discussion, debate or understanding. The Uruguay Round agreements, including GATS, were approved by Congress in 1994. The Uruguay Round Agreements Act adopted the agreement's text as federal law, binding states and localities. Health care services bound to comply with the terms of the GATS include:

- financial services, including health insurance;
- health services provided by hospitals, HMOs and other health care facilities;
- distribution services, including wholesale and retail distribution of prescription drugs and tobacco;
- telemedicine for certain nursing services;
- travel abroad for health services; and
- data processing services, including medical records and insurance claim processing. [2]

The service sectors the United States committed to the GATS are contained in a document called the "U.S. schedule of commitments." [3] The text of the U.S. schedule of commitments, along with a glossary of terms and other materials to help you decipher often inaccessible trade jargon, can be found in Public Citizen's GATS directory available at: www.citizen.org/GATSdirectory.

U.S. negotiators were not able to push other countries into agreeing with all of the U.S. demands on services during the Uruguay Round negotiations. As a compromise, language was included in the original GATS agreement that automatically launched a new round of GATS-expansion talks in 2000 aimed at increasing the number of service sectors to be covered by the agreement. These GATS-expansion talks were later incorporated into the WTO's "Doha Round" of broader WTO expansion negotiations launched in 2001. The text also calls for future, additional rounds of GATS-expansion talks.

In the current and future rounds of GATS negotiations, the United States could expand its health care service commitments by binding other health-related sectors. For instance, currently the United States is proposing making commitments in "higher education services," including public and private medical schools and nursing programs, a proposal with significant and wide-ranging implications for health care degree granting institutions. The United States is also being pressed to make commitments in the area of professional services delivered by doctors, nurses, dentists and other health care professionals, including telemedicine and the increased importation of medical workers on a temporary basis.

When a service sector is bound to the agreement, GATS requires all policies "affecting trade in services" "taken by central, regional or local governments and authorities" and nongovernmental bodies in the exercise of powers delegated by governments, conform to GATS constraints.[4] Thus, for example, the GATS "nondiscrimination" (Article XVII) rule requires that public subsidies and grants be shared with foreign service suppliers on the same footing as U.S. service suppliers, unless those funds are specifically exempted from the terms of the agreement within the U.S. schedule of commitments.

The broadly written GATS "market access" rules (Article XVI) forbid any policy that limits the number or size of service suppliers, including limits "in the form of numerical quotas, monopolies, exclusive service suppliers or the requirements of an economic needs test" or policies that limit the "value of a service transaction or asset."[5] GATS Article VI-4 promoted the launch of additional WTO talks to establish "disciplines on domestic regulation" for the service sector to ensure that domestic laws governing licensing, qualification and technical standards are not "more burdensome" or more trade restrictive than necessary.[6] Various drafts that have leaked from these ongoing talks reveal that the new disciplines being proposed threaten to undermine state sovereignty over the licensing requirements for insurance providers and hospitals.

The GATS also covers every way in which a service can be delivered, with the different means called "modes of delivery." GATS Mode 1 entails the delivery of services across borders via the Internet, phone, mail or satellite (such as telemedicine). Mode 2 entails the travel of the consumer abroad to receive a service (such as heart surgery) from a foreign service provider. Mode 3 covers the acquisition, establishment and operation of service sector operations on U.S. soil by a foreign investor or foreign firm (such as foreign insurance providers entering the U.S. market or the purchase of a U.S. hospital by a foreign firm). Mode 4 entails the importation of the service worker (such as a doctor, nurse or dental technician) into the United States to provide the service here on a temporary basis.

The federal McCarran-Ferguson Act grants states the right to regulate insurance in the public interest. U.S. GATS commitments undermine this regulatory authority and state sovereignty by subjecting state laws and regulatory policies perceived as violating GATS rules to be challenged as "barriers to trade" through the WTO's powerful and binding dispute resolution mechanism. If a state law is found to violate the terms of the GATS, the federal government is obliged to use all constitutionally-available powers – for instance, pre-emptive legislation, lawsuits and cutting off funding – to force state governments to comply with WTO tribunal rulings. After a period allowed for implementing the WTO-ordered changes, the United States faces indefinite trade sanctions until the U.S. policy is brought into conformity with the WTO ruling.

During the Uruguay Round of trade talks, the Office of the U.S. Trade Representative (USTR), which negotiates trade deals on behalf of the White House, failed to consult directly with elected state leaders before signing up the insurance sector and hospital services to the constraints of the GATS. This lack of consultation continues with regard to U.S. commitments being proposed currently in the context of the ongoing Doha Round of WTO negotiations. Most recently, USTR has failed to respond to a series of letters from various state governors sent throughout 2006 asking for a withdrawal of GATS commitments regarding their states in the context of the current round of negotiations.[7]

Health Care Policies Jeopardized by U.S. GATS Commitments

Unless U.S. health care services are withdrawn from the GATS in the current round of negotiations when horse-trading on major issues is still a possibility, state and federal governments' ability to effectively regulate the delivery of health care services and implement health care reform measures designed to expand access and reduce the cost of health care in the future could be jeopardized in the following ways:

- **State Initiatives Toward Universal Health Insurance:** GATS Article VIII-4 requires that if a WTO signatory nation grants monopoly rights to supply a service to the government or a single nonprofit provider in any sector covered by its "specific commitments," the country must compensate other WTO signatory countries for lost business opportunities. Since the health insurance sector is already covered by U.S. "specific commitments," the United States could be obligated to compensate other WTO member nations if either the federal government or any U.S. state enacted a single-payer universal health insurance system. While no state has yet developed a universal health insurance plan, a number of states are experimenting with different legislative initiatives designed to expand access to health care services and decrease health care costs. Certain health care plans and proposals could run afoul of GATS rules. For example, the proposed Wisconsin Health Care Plan (WHCP) promises to provide a low-cost, state insured health care plan to all workers and their dependents in the State of Wisconsin at a cost affordable to employers.[8] Unless U.S. "specific commitments" in the health insurance sector are withdrawn, reform proposals like these could come into conflict with U.S. GATS obligations because they limit "market access" (GATS Article XVI) for commercial entities to insurance markets, or grant "discriminatory" subsidies (GATS Article XVII) 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 health care costs are inconsistent with the GATS, the United States could face trade sanctions unless the laws are modified or repealed.[9]

- **Preferential Tax Treatment for Nonprofit Hospitals:** The United States committed "hospitals and other health care facilities" to the GATS.[10] This commitment is limited to the "direct ownership and management and operation by contract of such facilities on a 'for fee' basis." However, the GATS covers any measure that "affects trade in services" in a committed service sector. In the United States, most hospital services are provided by nonprofit institutions that enjoy tax-exempt status from federal, state and local taxes. Many of these nonprofits are managed by private for-profit firms and thus are institutions covered by the U.S. GATS commitment. In return for their preferential tax treatment, nonprofit hospitals traditionally provide charitable community services, such as uncompensated care for uninsured and underinsured patients. GATS rules on nondiscrimination (GATS Article XVII) require that all tax benefits or subsidies provided by governments to domestically-owned or operated health care facilities must be provided equally to health care facilities owned and operated by foreign firms. If a foreign firm bought a chain of U.S. hospitals and decided to run them on a for-profit basis, it could argue that it is still owed the preferential tax treatment that domestic nonprofits are given as it provides identical or nearly identical services. While the U.S. government exempted certain federal and state tax policies from the GATS, this language does not appear to safeguard the benefits granted to nonprofit hospitals.[11]

- **Prescription Drug Reform:** The United States has made GATS commitments in the categories of wholesale and retail "distribution services." Included in these categories is the distribution of pharmaceuticals. GATS market access rules prohibit governments from setting certain limits on distributors. The majority of U.S. states have Medicaid programs which utilize Preferred Drug Lists (PDLs) that allow states to buy bulk orders of prescription

drugs at significant cost savings. PDLs encourage the use of medicines that are both clinically effective and have the lowest price. Under Medicaid, nonpreferred drugs may also be ordered by doctors, but a doctor must first seek a prior authorization. PhRMA, the powerful lobbying arm of drug manufacturers, is on the record stating that "market access barriers of concern include pricing and reimbursement practices that fail to recognize the value of patented innovative medicines."[12] PhRMA has also characterized PDLs as overly burdensome. While PhRMA has sued many states in an effort to overturn their PDLs, they have largely failed in U.S. domestic courts. GATS and other "trade" agreements may give PhRMA and their governmental allies a new venue and new grounds (GATS Article XVI and GATS Article VI-4) for attacking these important state policies which have generated billions of dollars in taxpayer and consumer savings.

- **Tobacco Controls:** The extensive U.S. commitments in the area of wholesale and retail "distribution services" cover tobacco. While the U.S. GATS schedule includes an exemption for domestic laws that limit alcohol distribution, the United States did not exempt tobacco distribution and sale. Thus, standards applied to the licensing of distributors of tobacco products could be challenged under the proposed domestic regulation disciplines discussed above (GATS Article VI-4). For instance, states that enforce prohibitions on tobacco sales to minors with random inspections could have these rules challenged as "more burdensome than necessary." Because U.S. "advertising services" have also been committed to the WTO, bans on tobacco advertising on television, billboards and other venues may violate U.S. GATS commitments. Regulatory bans in a committed sector have already been interpreted as market access barriers by WTO tribunals.[13]

- **State Licensing and Insurance Mandates:** All U.S. states have state-specific requirements for the licensing of insurance providers. These include laws to ensure the financial viability of insurance companies and laws requiring insurance firms to offer certain types of coverage. For instance, most states now require coverage for mammograms, alcohol and drug addiction, but only a handful of states currently require coverage for autism or Alzheimer's. The new "disciplines on domestic regulation" being negotiated under GATS Article VI-4 would apply to state licensing requirements for insurers and would give U.S. trading partners grounds for bringing a trade complaint over the diversity of state requirements, which could be considered "more burdensome than necessary to ensure the quality of a service." If the United States loses such a case in a WTO trade tribunal, it may consider pre-empting states in this area, a plan that is already backed by many U.S. insurance companies that would also like to see uniform national standards that limit consumer protections. Licensing of health care facilities and hospitals is also implicated, threatening to undermine requirements to provide or maintain emergency wards, emergency care to the uninsured, obstetrical care or certain nursing/patient ratios.

- **Telemedicine:** Mode 1, or cross-border provision of services over the Internet, phone or mail, is a primary mode of delivering services under the GATS. 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.[14] 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 health care jobs. So far, the United States has not made any overt commitments to telemedicine under any professional service category or under hospital services. However, under the category of "placement and supply services of personnel," the United States has completely committed services that it otherwise appears to have tried to exclude in the rest of its GATS schedule. For instance, the United States has not made Mode 4 commitments under "professional services" for services provided by nurses, yet its "placement and supply services of personnel" commitment clearly covers **nursing services** on a fee or contract basis.[15] GATS market access and non-discrimination rules would require that the supply of nursing services on a cross-border basis (such as through nurse line services where medical advice is provided by nurses by phone) be permitted and opened up to foreign providers. Moreover, further commitments in this area may yet occur in the ongoing negotiations as this is a primary demand of key trading partners, including China and Mexico.

- **Health Tourism:** Mode 2, covering the situation of a consumer traveling abroad to receive a service, also is a primary mode of service delivery under the GATS. Increasingly, U.S. consumers are traveling abroad to receive health care in developing countries. For instance, India has become a center for inexpensive heart surgeries. A coronary bypass that would cost $75,000 or more in the United States costs $11,000 in India,[16] a price that often includes airfare and a brief vacation package. Increasing this type of "health tourism" is the goal of many developing countries in the current GATS negotiations. Foreign service providers want health tourists to be able to use their private insurance or government insurance to pay for their services. [17] While the United States government has placed a significant caveat on its Mode 2 GATS commitments, limiting federal and state reimbursements to domestic service operations, the government will come under tremendous pressure domestically and from trading partners to lift these restrictions as reliance on this mode of service provision increases. Dramatic increases in medical tourism are forecast as the health of the estimated 200 million baby boomers in the developed world begins to decline. While health tourism may be an attractive option to many Americans, especially those without insurance, the hazards entailed in "outsourcing your heart" and shuffling extremely ill patients long distances on commercial airlines is likely to generate concern and controversy. Future regulatory efforts by states or the federal government to address these dangers or regulate issues such as quality assurance, liability and consumer redress could all be subject to challenge as "trade barriers."

- **Health Data and Consumer Privacy:** Under "hospital services," the United States did not make cross-border (Mode 1) commitments. However, this appears to conflict with the cross-border service commitments it has made under "computer services" which include "data processing services" as a subcategory. Covered by this commitment is a vast array of data processing, including sensitive data such as medical records, insurance claims, tax records and banking records. These categories are included because they are not specifically *excluded* from the scope of U.S. commitments. Over the past decade, the rate of offshoring of this work via the Internet has greatly accelerated, raising tremendous concerns about privacy, liability and consumer redress. Bills pending in several states that ban the offshoring of health records, insurance claims and other sensitive data could be challenged as being inconsistent with the GATS. This is the case because regulatory bans in a committed service

sector have been interpreted by WTO tribunals as a GATS-forbidden "zero quota" that denies "market access." It is unclear if the GATS general exception for measures "necessary" to protect privacy (GATS Article XIV) would be sufficient to safeguard the diversity of domestic law and regulation that may arise to protect consumer privacy in this area. Most laws challenged in the WTO on the basis of necessity have failed to meet the WTO's strict requirement that a policy can only be found to be necessary if it can be proved to be the "least trade restrictive" policy option available without consideration of financial, political or technological factors.

- **Medical Education and Training:** In the context of the GATS expansion negotiations that began in 2000, the U.S. government is proposing signing up the "higher education service sector" − including public and private medical, dental and nursing schools − to comply with GATS rules. If enacted, this proposal would have an array of consequences for medical training and the credentialing of health care professionals. State licensing of medical schools and nursing school programs is based on a large number of factors, including standards to ensure financial stability and quality of educational providers; appropriate curricula and faculty qualifications; appropriate library resources and physical plant; needs tests to weed out duplicative programming and other factors. Under the proposed Article VI-4 "disciplines on domestic regulation," individual policies pursued by states, as well as state-by-state variation in policies, could be challenged in WTO tribunals as "more burdensome than necessary to ensure the quality of a service." If the final disciplines include requirements that standards be harmonized to a uniform standard, global mechanisms for accreditation and quality assurance outside the control of federal or state regulators may follow. If the final disciplines include mutual recognition or equivalency requirements as planned, a global mechanism for the recognition of medical degrees and student credits may follow. Such developments could severely undermine the authority of medical training institutions and states to set enforceable standards of quality.[18]

- **Further Implications for Health Care Workers:** Each GATS mode of supply carries implications for U.S. workers in the health care arena. For instance, full commitments in cross-border telemedicine (Mode 1) will create significant downward pressure on the wages of diagnostic service providers. While the United States has not yet committed to this, it has made significant "health tourism" (Mode 2) services commitments. While some economists may favor health tourism as a means for providing competition and lowering health care costs, it also "has the potential of doing to the U.S. health care system what the Japanese auto industry did to American carmakers," according to Princeton University health care economist Uwe Reinhardt.[19] Mode 4, the movement of natural persons across borders, is another one of the key modes of delivery of services under the GATS. Currently the number of nurses and temporary professional workers allowed into the country is limited. However, many of the largest U.S. trade partners, including China, India and Mexico, are demanding that the United States greatly increase the number of workers allowed into the country on a temporary basis to provide a wide range of services, including work in medical and dental services. The 2006 proposal coming out of the GATS Mode 4 negotiating group, which is chaired by India, states that "wage parity will not be a precondition of entry."[20] If agreed to, this proposal threatens to undercut the wage base for U.S. workers and create a second tier of easily exploitable workers who could be deported on a moment's notice. This type of "trade"

also contributes to the severe problem of "brain drain" suffered by many developing countries.

Getting Health Care Out of the GATS

The implications of the WTO's General Agreement on Trade in Services for U.S. health care are long term and structural. Urgent action is needed to eliminate the present threat to health care reforms posed by current U.S. GATS commitments on health care-related services, as well as safeguard health services from further constraints being imposed by the ongoing GATS expansion negotiations underway now or via various bilateral negotiations relating to pending NAFTA expansion pacts, formally called "Free Trade Agreements."

The full effect and consequence of the threats described above may not be realized for several years. However, absent action ***now,*** service sector rules in trade agreements may make it possible for foreign private, for-profit insurers, hospitals and HMOs to gain a substantial foothold in the U.S. market and undermine current federal and state law. U.S. health care regulators and consumers would then be confronted by binding commitments under international trade law that not only constrain our ability to maintain or implement meaningful health care reforms, but are extremely difficult to reverse due to market integration and to GATS compensation requirements.[21] Unless health care is taken off the trade negotiating table, our ability to address some of our most pressing national health priorities at the local, state and national levels will be limited.

"Getting Health Care Out of the GATS" requires that the U.S. Trade Representative be persuaded to take immediate action to:

- **Withdraw or modify existing U.S. GATS commitments in health-related services, including commitments in the following sectors: 1) health insurance, 2) hospitals and other health care facilities, 3) placement and supply services of personnel, 4) computer services and data processing regarding health information.** The GATS rules allow any WTO signatory country to withdraw specific commitments provided that we negotiate a "compensatory adjustment" with trade 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 health care reform, expanding access to care to the millions of uninsured and effectively controlling spiraling health care costs could be seriously jeopardized.

- **Exempt pharmaceutical and tobacco products from U.S. commitments in wholesale and retail distribution.** The USTR took the necessary steps to exempt alcohol and firearms from U.S. commitments in the wholesale and retail distribution sector. Unless pharmaceutical and tobacco products are also exempted, the GATS could jeopardize state and federal initiatives to control the spiraling cost of pharmaceuticals and limit the devastating health impacts of

cigarette addiction. These commitments can be withdrawn using the same compensation negotiating process noted above.

- **Not make new "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 U.S. Trade Representative should not make new market access and national treatment commitments in any health-related sector.

- **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).[22] Any expansion of existing commitments in the health insurance sector, and other health-related sectors, should be opposed.

- **Oppose new disciplines on "domestic regulations" in the service sector, including "necessity testing" under GATS rules.** Draft texts from these negotiations that have leaked show that the proposed draft rules would apply tests of "transparency," "objectivity" and "necessity" (or a "least trade restrictive" test) to licensing requirements, qualifications and technical standards for covered for insurers and hospitals. These rules should be opposed in principle as an inappropriate invasion of one-size-fits-all rules into an area of decision-making that has traditionally been left to the states.

For more information about U.S. commitments under the GATS please see Public Citizen's GATS Directory available at: http://www.citizen.org/trade/forms/gats_search.cfm or contact Saerom Park at (202) 454-5127 or spark@citizen.org.

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[1] WTO, 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] Arnold and Reeves, "International Trade and Health Policy: Implications of the GATS for US Healthcare Reform," Journal of Business Ethics, Vol. 63, 2006, at 313-332.

[3] United States of America, Schedule of Specific Commitments, GATS/SC/90 (April 1994) and GATS/SC/90/Suppl.3 (26 February 1998). U.S. insurance commitments are also covered by the Financial Services section of the GATS, by the WTO's Understanding on Commitments in Financial Services and the WTO's Annex on Financial Services. It is also important to note that the United States made changes to its financial services schedule *after* Congress approved the original schedule of commitments as part of the Uruguay Round Implementation Act of 1994.

[4] WTO, General Agreement on Trade in Services, Article I-3 (a).

[5] WTO, General Agreement on Trade in Services, Article XVI-2 on market access reads: "In sectors where market-access commitments are undertaken, the measures which a Member shall not maintain or adopt either on the basis of a regional subdivision or on the basis of its entire territory, unless otherwise specified in its Schedule, are defined as: (a) limitations on the number of service suppliers whether in the form of numerical quotas, monopolies, exclusive service suppliers or the requirements of an economic needs test; (b) limitations on the total value of service transactions or assets in the form of numerical quotas or the requirement of an economic needs test; (c) limitations on the total number of service operations or on the total quantity of service output expressed in terms of designated numerical units in the form of quotas or the requirement of an economic needs test; (d) limitations on the total number of natural persons that may be employed in a particular service sector or that a service supplier may employ and who are necessary for, and directly related to, the supply of a specific service in the form of numerical quotas or the requirement of an economic needs test; (e) measures which restrict or require specific types of legal entity or joint venture through which a service supplier may supply a service; and (f) limitations on the participation of

foreign capital in terms of maximum percentage limit on foreign shareholding or the total value of individual or aggregate foreign investment."

[6] GATS Article VI-4 empowers the WTO to develop disciplines (rules) on domestic regulation. In addition, GATS Article XIII mandates further multinational negotiations on government procurement and GATS Article XV mandates multilateral negotiations to develop disciplines (rules) to avoid the "trade-distortive" effects of subsidies. These negotiations may also impact health services.

[7] In 2006, four state governors took action to try to safeguard from GATS their states' sovereignty to regulate service suppliers in the public interest. On April 5, 2006, Governor Baldacci of Maine wrote to the USTR, stating: "There are several areas where previous GATS commitments threaten to limit the State's ability to innovate. Maine is a leader in expanding health care coverage for the uninsured. We must retain the flexibility to make significant progress in this area unrestricted by GATS rules or trade tribunals. Please carve Maine out of all sectors relating to health care…" Governor Kulongoski of Oregon, Governor Vilsack of Iowa and Governor Granholm of Michigan wrote similar letters to the USTR, as did members of the Maine and California state legislatures. The four governors' letters can be accessed at: www.citizen.org/statesGATSletters.

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

[9] GATS proponents regularly state that government services are exempt from the agreement's terms. However, in reality, very few government services qualify for the poorly written GATS exemption to which these proponents refer. Only governmental services not supplied "on a commercial basis" or "in competition with one or more service suppliers" are protected. Since there is plenty of competition in the health insurance arena, health care plans offered by governments are generally not exempt from GATS rules unless specifically provided for in the U.S. GATS schedule of commitments.

[10] The United Nations Central Product Classification (UN CPC) code is a database of goods and services definitions relied upon by most WTO members in making their GATS commitments. "Hospital services" is UN CPC 93110 which includes: Services delivered under the direction of medical doctors chiefly to in-patients, aimed at curing, reactivating and/or maintaining the health status of a patient. Hospital services comprise medical and paramedical services, nursing services, laboratory and technical services including radiological and anaesthesiological services, etc.

[11] Three different GATS documents have further implications for U.S. tax policy beyond the specific commitments under hospitals and financial services: GATS Article XIV (d) and footnote 6; the horizontal section of the 2005 U.S. GATS services offer, available at: www.ustr.gov/Trade_Sectors/Services/2005_Revised_US_Services_Offer/Section_Index.html; and the U.S. schedule of MFN exemptions available at: http://www.wto.org/english/tratop_e/serv_e/serv_commitments_e.htm.

[12] National Trade Estimate Report on Foreign Trade Barriers (NTE) submitted by the Pharmaceutical Research and Manufacturers of America (PhRMA), Dec. 12, 2003 at 5.

[13] The GATS Market Access article (Article XVI) lists specific measures governments cannot maintain when they make full commitments in a covered service sector (see footnote 5). In a case where U.S. laws prohibiting Internet gambling were challenged as GATS cross-border (Mode 1) market access barriers by the nation of Antigua, the United States contended that a ban in a particular service sector does not violate Article XVI because regulatory bans do not appear on this list. However, the WTO panel in this case ruled that a ban on behavior was in effect a numerical ban or a "quota of zero." The United States strenuously objected to this interpretation, saying it "greatly constrains the right of Members to regulate services – one of the objects and purposes of the GATS," to no avail. The final 2005 WTO Appellate Body decision in this case upheld this key aspect of the lower panel ruling, throwing the doors open to GATS challenges to a wide range of government regulation, including bans on other forms of prohibited behaviors in every service sector covered by GATS commitments.

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

[15] The United Nations Central Product Classification (UN CPC) code for nursing services under this category is 87206.

[16] Jennifer Alsever, "Basking on the Beach, or Maybe on the Operating Table," *New York Times*, Oct. 15, 2006.

[17] Recently U.S. self-insured firms have started to cover certain out-of-country procedures. Unmesh Kher, "Outsourcing Your Heart," *Time Magazine*, May 29, 2006.

[18] For more information about GATS and higher education, please see a Public Citizen memo available at http://www.citizen.org/trade/subfederal/services/education/.

[19] Unmesh Kher, "Outsourcing Your Heart," *Time Magazine*, May 29, 2006.

[20] Collective Request, Mode 4 Movement of Natural Persons, Sumanta Chaudhuri, Counsellor, Permanent Mission of India to the WTO, undated, available at: http://commerce.nic.in/wto_sub/services/Plurilateral%20Requests%20in%20Mode%204.pdf.

[21] GATS Article XXI requires that the United States cannot withdraw a sector from GATS coverage without first negotiating with and compensating its WTO trading partners for current and future lost business opportunities. After inadvertently committing the gambling sector to the GATS in 1995 and losing a WTO GATS case on Internet gambling in 2005, the United States finally announced it would clarify its commitments to remove the gambling sector from WTO jurisdiction. Antigua alone is already claiming $3.4 billion in compensation.

[22] The GATS defines several methods or "modes" of delivering services. Currently, U.S. commitments in the insurance sector apply to Mode 3, which refers to the situation where non-U.S. insurers establish a commercial presence in the United States and do business on U.S. soil. During the current round of GATS negotiations, the United States could extend this commitment to apply to Mode 1, the situation where non-U.S. insurance companies located offshore provide health insurance coverage to U.S. consumers.