The World Trade Organization and Health Care

THE POTENTIAL IMPACT OF THE WORLD TRADE ORGANIZATION'S GENERAL AGREEMENT ON TRADE IN SERVICES ON HEALTH SYSTEM REFORM AND REGULATION IN THE UNITED STATES

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The collapse of the World Trade Organization's (WTO) Doha Round of talks without achieving new health services liberalization presents an important opportunity to evaluate the wisdom of granting further concessions to international investors in the health sector. The continuing deterioration of the U.S. health system and the primacy of reform as an issue in the 2008 presidential campaign make clear the need for a full range of policy options for addressing the national health crisis. Yet few commentators or policymakers realize that existing WTO health care commitments may already significantly constrain domestic policy options. This article illustrates these constraints through an evaluation of the potential effects of current WTO law and jurisprudence on the implementation of a single-payer national health insurance system in the United States, proposed incremental national and state health system reforms, the privatization of Medicare, and other prominent health system issues. The author concludes with some recommendations to the U.S. Trade Representative to suspend existing liberalization commitments in the health sector and to interpret current and future international trade treaties in a manner consistent with civilized notions of health care as a universal human right.

The collapse of the World Trade Organization's July 2008 Doha Ministerial in Geneva was a significant setback for advocates of increased economic liberalization of service sectors. Although developed nations' agricultural subsidies and market access to emerging economies played the key roles in the breakdown,

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service sector business interest groups from wealthy nations adamantly pushed for further services deregulations throughout the talks, including in the health care and health insurance sectors.

Academics, policymakers, and civil society groups are now presented with an important opportunity to evaluate the implications and the wisdom of current and future commitments of health services to liberalizing international trade rules. The need to rethink the ramifications of exposing sensitive areas of national policy to the World Trade Organization (WTO) system was underscored by a 2005 ruling by the WTO Appellate Body, discussed below, in which that tribunal held WTO rules to be far more broad and invasive of member nation's domestic regulation than even the United States—the leading proponent of services liberalization—had anticipated.

The hastening deterioration of the U.S. health system, the continuing public dissatisfaction with domestic health services, and the primacy of reform as an issue in the 2008 presidential elections (at least, prior to the meltdown of the world financial system) all highlight the need for maximal sovereignty in the ability to make policy in an area that affects all members of society in the most deeply personal ways. Yet few commentators or policymakers realize that existing WTO health care commitments may already significantly constrain domestic policy options for reform and regulation of the U.S. health system. This article reviews potential implications of the WTO's General Agreement on Trade in Services (GATS) for the U.S. health sector. It then applies the text of the GATS and the interpretations given to it by WTO tribunals to (*a*) the implementation of a single-payer national health insurance system in the United States; (*b*) currently proposed national and state-level health system reforms; (*c*) the privatization of Medicare; and (*d*) other areas of important national interest. In each of these areas, the GATS potentially has the effect of shackling policymakers to a set of neoliberal profit-oriented options that have largely already proven to be failures. The article concludes with recommendations for the U.S. Trade Representative to remove health care from the jurisdiction of the GATS and the WTO.

This article is intended to highlight *potential* constraints placed on domestic policymakers by the GATS treaty. The potential constraints identified herein are included because, in my judgment, they are plausibly based on the (often ambiguous) text of the treaty and the interpretations given to it by WTO adjudicatory bodies. In no way are they presented as the only possible—or even most possible—interpretations of the GATS text. Critics would doubtless protest that what follows is a maximally invasive reading of the treaty's provisions. However, given the WTO tribunals' demonstrated willingness to interpret GATS rules as more expansive than even the most ardent supporters of services liberalization understood them to be, a sense of just how far the GATS rules could *potentially* reach is critical to an informed discourse on the wisdom of future health system liberalization.

HOW THE GENERAL AGREEMENT ON TRADE IN SERVICES APPLIES TO HEALTH CARE

The WTO is an international institution created by multilateral treaty in 1995, ostensibly for the purpose of liberalizing trade. WTO agreements create rules governing trade sectors such as tariffs, patent rights, and the dumping of goods on foreign markets. The agreement establishing the WTO also created a Dispute Resolution Body—a kind of "court" for the WTO—and a set of procedures for resolving conflicts between states over their rights and obligations under the treaty. Member countries agree to implement WTO rules and to submit to the jurisdiction of its dispute resolution system by ratifying and signing on to the treaty. The 21 international agreements the WTO administers were the product of more than a decade of negotiation and comprise thousands of pages. When the U.S. Congress voted in 1994 to pass the legislation (the Uruguay Agreements Act) agreeing to submit to WTO rules, few legislators had read the contents of the agreements. Hence, many sectors of the economy were bound to WTO agreement requirements with little discussion, debate, or understanding (1).

One of the most controversial WTO agreements was the docile-sounding General Agreement on Trade in Services. U.S. negotiators were insistent on including services in the WTO treaty, but other nations perceived how far-reaching such an agreement could be. Allowing service sectors to be bound in the same way as goods would dramatically extend the reach of commercial trade rules favoring markets and privatization into areas traditionally seen as essential to the public welfare: education, social security, libraries, mail service, police and fire protection, prison systems, water, energy, telecommunications, transportation, and health care. Illustrating the WTO leadership's recognition of the expansive nature of the GATS, former WTO Director General Renato Ruggiero said in 1998 that "GATS provides guarantees over a much wider field of regulation and law than [other WTO treaties]; the right of establishment and the obligation to treat foreign services suppliers fairly and objectively in all relevant areas of domestic regulation extend the reach of the Agreement into areas never before recognized as trade policy" (2).

The GATS was so controversial that it had to be structured as a "bottom-up" treaty. In other words, its most controversial provisions (called "Market Access" and "National Treatment"; see below) apply *only to service sectors that each nation volunteers* to bind to them. Each WTO member country has a document (its "schedule") that lists the service sectors it is binding to GATS rules (its "commitments"). Once a sector is committed in a nation's GATS schedule, that nation is obligated to conform nearly all its domestic policies governing that sector (and sometimes even those merely *affecting* it) to GATS rules. If it does not, the WTO agreements require it to negotiate compensation with international investors adversely affected by its domestic policies or face international trade sanctions (3).

What the GATS Rules Require

Broadly speaking, there are three "tiers" of GATS rules affecting health care. The first tier of rules, General Obligations and Disciplines, apply equally to all service sectors of all WTO member countries, regardless of whether those sectors are committed in a country's schedule or not. The second tier, Specific Commitments, apply only to those sectors that a country commits to its schedule. These rules are more far-reaching, and members were given the opportunity to write any exceptions or limitations to them into their schedules. Finally, under GATS Part III, Article XVII, WTO member countries are allowed to negotiate a third "tier" of rules to govern their commitments above and beyond the underlying Specific Commitments rules that normally apply. Citing this provision, the United States has inscribed its Financial Commitments schedule with the "supplemental" rules of the Understanding on Commitments in Financial Services. These rules apply *in addition* to the underlying GATS Specific Commitments rules on Market Access and National Treatment (described below).

Table 1

Selected rules included in the General Agreement on Trade in Services

Rule tier	Binding upon	Rule content
General Obligations (Tier 1)	All member states of the World Trade Organization	1. Most-favored nation treatment. 2. Prohibition on "new monopolies" 3. Disciplines on domestic regulation
Specific Commitments (Tier 2)	Only those service sectors that members *choose* to bind in their schedules of commitments	1. Open market access obligations 2. National treatment of all foreign service provider
Supplementary Voluntary Commitments (Tier 3)	Service sectors *already scheduled* that members *choose* to make additional liberalization commitments in (financial services in the U.S.)	1. Subjection of public entities to GATS rules 2. "Standstill" of existing exceptions to liberalization 3. Requirement to allow any new financial service 4. Requirement to "endeavor to remove or limit any significant adverse effects" of domestic regulation

General Obligations and Disciplines. These rules apply to all service sectors of all WTO member countries, regardless of whether or not the sectors have been committed to a nation's schedule. While these are generally the least controversial provisions, several may have serious implications for reform or regulation of the health sector (4).

Most-Favored-Nation Treatment: This provision requires a member to give service suppliers of any other WTO member no less favorable treatment than it gives service suppliers of "any other country" (4, Art. II).

Prohibition on New "Monopolies": This provision requires that if a country grants new "monopoly rights" regarding the supply of a service covered in its schedule, the country granting the "monopoly" must enter into negotiations to provide compensation to any other member adversely affected by it. If an agreement is not reached, the affected member may refer the matter to arbitration, and the "monopoly" may not go into force until the compensation required by the arbitration has been made. The term "monopoly rights" is not defined anywhere in the agreement (4, Art. VIII).

"Disciplines" on Domestic Regulation: In sectors where no commitments have been undertaken, the GATS states that a special Council for Trade in Services shall develop "disciplines" that assure that qualification requirements and procedures, technical standards, and licensing requirements for the provision of services are "not more burdensome than necessary to ensure the quality of the service." Regarding sectors in which commitments have been undertaken, however, it is unclear whether such a "necessity test" is *already in force* (4, Art. VI).

Specific Commitments. These rules apply only to service sectors that members have volunteered to submit to the rules by inscribing them in their schedules. Members were also given an opportunity to reserve specific exceptions to the rules during the negotiations of their schedules. Rules in this section fall into two broad categories, Market Access and National Treatment.

Market Access: The rules in this section are aimed at preventing governments from limiting the number, type, form, or size of foreign service suppliers in their markets or intervening to affect or regulate the way the firms provide the service. Examples of prohibited measures include (4, Art. XVI):

- Limitations on the number of service suppliers
- Limitations on the total quantity of service output
- Requiring a specific type of legal entity (e.g., nonprofit)
- Limitations on the "total value of service transactions or assets"

National Treatment: This set of rules requires that foreign service suppliers receive, "in respect of all measures affecting the supply of services," the same treatment that a nation gives to its own service suppliers. It is easy to think of situations in which a country may want to shape policy to favor domestic industry

over foreign operations, but the GATS rules go even *farther* than these requirements. Under the National Treatment rules, any measure that *modifies the conditions of competition* in favor of a domestic supplier is a GATS violation. In other words, even if a policy has no intent to discriminate against foreign service suppliers—indeed, it can be totally unrelated to service provision at all—if it has the *effect* of disadvantaging them, it is potentially a violation of the GATS (4, Art. XVII).

Special Rules for Health Insurance. The United States committed health insurance to its schedule under the Financial Services section. Two special sets of rules apply to commitments made under this section. The first is the Annex on Financial Services, a unique set of constraints that apply to all commitments in financial services, no matter what nation makes them. The second is an even more expansive Understanding on Commitments in Financial Services, a set of extreme liberalization rules that are an optional "attachment" to commitments in financial services that the United States has chosen to take. These rules go so far in constraining governments that only developed countries have signed on to them.

The Annex on Financial Services: Most financial services are related to banking and investment, hence the Annex provisions pertain mostly to them. One provision in particular is significant in assessing the impact of the GATS on health care:

- *Subjection of "Public Entities" to GATS Rules:* Normal GATS rules make an exception for government services and procurement (with significant limitations). The Annex specifically states that if a nation allows domestic service suppliers to compete with "public entities," those entities are subject to GATS rules. This will have significant implications for Medicare, as we will see (4, Annex on Financial Services, §1(b)(iii)).

The Understanding on Commitments in Financial Services: The most far-reaching document in the GATS, the Understanding binds signatory nations to an extreme level of financial services liberalization. The commitments undertaken by signatories to the Understanding include (interpretation of the Understanding [5] aided by Kevin C. Kennedy, Professor of Law, Michigan State University College of Law):

- *The "Standstill" Provision:* The signatories pledge that any exceptions to the commitments they have made are limited *to existing measures*. The implications of this vaguely worded provision are not entirely clear. Some commentators believe that the signatories bind themselves to *never enact a limitation on their commitments in the future that was not in effect when the Understanding was inscribed in their schedule.* In effect, the level of privatization at the time of the implementation of the Understanding is "locked in" (5).

- *New Financial Service:* Signatories pledge to allow foreign firms to offer any new financial product in their territory, as long as another WTO member offers it (5, Art. B(7)).
- *Domestic Regulation:* Signatories pledge to "endeavor to remove or limit any significant adverse effects" on foreign investors of any laws that "affect adversely" the ability of foreign firms "to operate, compete, or enter" the domestic market (5, Art. B(10)).

INTERPRETING THE GATS RULES: THE *U.S.-GAMBLIN*G CASE

Critics of the WTO recognized early on that GATS rules held the potential to infringe on the ability of governments to regulate committed services in the public interest, but trade officials assured them that such fears were unfounded. A May 2005 letter from the U.S. Trade Representative to state officials reiterated the top trade official's promises that the GATS did not pose a threat to their regulatory prerogatives, repeating eight times the Representative's view that "nothing in the GATS impedes the ability of a state to maintain or develop regulatory requirements as appropriate to each jurisdiction" (6). This view has been severely undermined, however, by a pair of WTO tribunal rulings that demonstrate that the entities charged with interpreting GATS rules may hold them to extend to greater reaches than even the nations most supportive of services liberalization had intended.

On March 13, 2003, the Caribbean island nation of Antigua alleged that U.S. law violated the GATS by operating to prohibit the cross-border supply of Internet gambling and betting services to the U.S. territory (7). Lacking many kinds of traditional resources, Antigua had made the establishment of Internet-based gambling operations a central part of its economic development strategy; indeed, Antiguan lawyers submitted evidence to the WTO that, in 1999, Internet gambling revenue accounted for 10 percent of the nation's gross domestic product (8). By 2003, however, stricter enforcement of U.S. anti-racketeering laws had cut the number of licensed Antiguan gambling service operators from 119 to 28. Antigua claimed that a combination of more than 100 federal and state statutes, judicial opinions, and administrative actions together constituted a "total prohibition" on cross-border gambling and betting services, in violation of GATS market access rules prohibiting limitations on the number of service suppliers or service operations in sectors in which commitments have been undertaken.

A surprised United States argued in response that it had not intended to commit gambling and betting services to GATS jurisdiction when it placed "Other Recreational Services (except sporting)" on its schedule of commitments and that Antigua was misinterpreting the United States' schedule (8). Alternatively, the United States argued, its anti-gambling laws were valid under GATS clauses exempting laws from the treaty's normal rules if they are "necessary to

protect the public morals or to maintain public order" or "necessary to . . . the prevention of deceptive and fraudulent practices" (8).

The WTO Dispute Settlement Body panel ruled against the United States on both its defenses (8, p. 271). The Panel held that, regardless of whether the United States had intended to or not, it had committed gambling services to its schedule under normal rules of treaty interpretation. It further held that the United States had failed to demonstrate that the anti-gambling laws were "necessary" to protect public morals or to prevent deception and fraud, because it had not "exhausted" all opportunities to explore measures that were more amenable to international trade, and that the United States could not defend its laws from GATS rules, because they discriminated against international trade by allowing for the provision of domestic online betting on horse races. After dismissing the U.S. defenses, the Panel ruled that three U.S. federal laws (the Wire Act, the Travel Act, and the Illegal Gambling Business Act) and similar state laws in South Dakota, Louisiana, Massachusetts, and Utah violated the GATS market access rules, and held that they should be "brought into conformity" with the GATS (i.e., substantially modified or repealed). Significantly, the Panel held that because it had already found that the U.S. laws violated the GATS market access provisions, it would not rule on *other* claims made by Antigua, including alleged violations of GATS national treatment and payments and transfer restriction provisions. A third claim of a U.S. violation of GATS domestic regulation provisions was dismissed only because Antigua had not submitted a sufficient claim.

On appeal, the United States argued (somewhat ironically, considering that it was perhaps the most adamant proponent of services liberalization) that the Panel's ruling "unreasonably and absurdly deprives [nations] of a significant component of their right to regulate services by depriving them of the power to prohibit selected activities" (9). These protests notwithstanding, the WTO Appellate Body (the highest "court" of the WTO) upheld the Panel's ruling (albeit on modified reasoning) that the United States had committed gambling services to GATS and that the federal laws violated its GATS commitments, holding that a prohibition on gambling constitutes an impermissible "zero quota" on the number of allowed service providers or operations. It overturned the Panel's finding, however, that the U.S. laws were not "necessary" to protect morals or against fraud, but upheld its conclusion that the U.S. gambling laws were discriminatory and held that, as a result, the "necessity" defense could not be invoked. The Panel's ultimate conclusion that the U.S. law violated the GATS was affirmed (9, p. 123). Negotiations on compensation by the United States are ongoing.

Several unsettling conclusions can be drawn from the *U.S.-Gambling* case. First, domestic statutes and regulations, even criminal ones, can be found to be violations of the GATS in sectors in which specific commitments have been undertaken, and probably also in those in which no commitments have been

undertaken (as in the general prohibition on new monopolies). Second, in sectors in which commitments are undertaken, foreign service suppliers must be granted market access *even if domestic suppliers are prohibited from doing so*, unless the prohibition can be shown to be "necessary" to protect public order or against fraud. Third, the GATS treaty and schedules are written with such ambiguity that *trade experts are not even aware of what they have committed to GATS jurisdiction.* The *U.S.-Gambling* case raises concerns that other broadly worded commitments may be subject to undesired interpretations. Finally, the Dispute Settlement and Appellate Bodies have demonstrated that they are willing to give extreme and unanticipated interpretations to the GATS rules. Few would consider a criminal anti-gambling law a "limitation on the total number of service operations," indistinguishable from a trade quota. But the WTO adjudicatory system has demonstrated a willingness to view public protections in exactly this way and to rule against them where they inhibit commerce.

What are the potential implications of the relevant WTO rules and jurisprudence for the U.S. health sector? I turn to this in the next section (see Table 2)).

SHUTTING THE DOOR ON SOLUTIONS: THE GATS AND SINGLE-PAYER NATIONAL HEALTH INSURANCE

The United States has the highest per capita health spending of any nation in the world. Yet, while other industrialized countries manage to provide universal health insurance for their citizens and achieve superior health outcomes at a far lower price, 47 million Americans lack insurance, more than one-third of *insured* Americans go without needed care due to cost, and medical bankruptcy leaves even the insured in financial ruin (10–13).

Many academics and legislators, most physicians, and the majority of Americans support the adoption of a publicly financed, privately delivered, single-payer system of national health insurance (14, 15). Such a system would eliminate private insurance companies and streamline health care financing through a single public payer, potentially producing administrative savings of more than $300 billion per year—enough to cover every American without additional spending (projections based on 16). The sustainability of benefits would be ensured through effective cost-control mechanisms, such as global budgeting of hospitals, negotiated bulk purchasing of drugs and durable medical supplies, and rational planning of health capital allocation. Investor ownership of health delivery facilities such as hospitals, dialysis centers, and nursing homes—which has been shown to raise costs and worsen care—would be prohibited. The U.S. Government Accountability Office, Congressional Budget Office, and independent financial consulting firms such as the Lewin Group and Mathematica have confirmed the viability of a single-payer system for the United States.

Table 2

Health system reforms and potential GATS violations

Health system reform/regulation	GATS provisions potentially violated
Implementation of a single-payer national health insurance system	Art/ VIII:4 (establishment of "new monopolies") Art. XVI:2(a) (numerical limits) Art. XVI:2(e) (legal form of supplier)
Market-based coverage expansions through subsidies and insurance firm regulation	Art. VI:5(a)(i) (more burdensome than necessary) Art. XVI:2(a) (numerical limits) Art. XVI:2(b) (total value of transaction) Art. XVII:1 (national treatment of foreign firms) Art. XVII:3 (modifies conditions of competition)
Reforming the privatization of Medicare	Art. VIII:4 (establishment of "new monopolies") Art. XVI:2(a) (numerical limits)
Specialty hospital regulation	Art. XVI:2(a) (numerical limits) Art. XVI:2(b) (total value of transaction) Art. XVI:2(e) (legal form of supplier) Art. XVII:1 (national treatment of foreign firms)
Catastrophic reinsurance	Art. XVII:1 (national treatment of foreign firms)
Disease management regulation	Art. XVI:2(e) (legal form of supplier)
Medical-loss ratios	Art. XVI:2(b) (total value of transaction)
Nonprofit hospital taxes	Art. XVII:1 (national treatment of foreign firms)

Single-payer is both proven and popular, but constitutes exactly the kind of threat to transnational investor interests that GATS rules are designed to neutralize. The GATS treaty is structured to award the home nations of multi-national investors compensation for domestic policies that adversely affect their investments, such that the implementation of far-reaching social service programs would become extremely difficult. If single-payer legislation such as Representative John Conyers's United States National Health Insurance Act (HR 676) were to be implemented, foreign-owned hospitals, drug companies, disease management programs, and other service companies could (through their home states) claim a violation of GATS rules in a WTO tribunal. A WTO dispute resolution panel would first determine whether the single-payer program was in conflict with the United States' existing GATS commitments. First, the statutory

establishment of a single-payer system of health insurance that barred the provision of private health insurance that duplicated the benefits of the single-payer may be claimed to be a new "monopoly right" and hence a violation of the GATS prohibition on new monopolies. In addition, under the interpretations advanced in *U.S.-Gambling*, any outright ban on the provision of a service (i.e., private health insurance, for-profit hospitals, or disease management programs) may constitute an impermissible "zero quota" on the provision of the service and may hence be claimed to be a GATS violation. Finally, regulations prohibiting investor ownership of health delivery facilities are potentially banned by GATS market access rules, which forbid limitations on the type of legal entity a service supplier may assume.

Should the WTO tribunal find a single-payer system to violate any of these rules, it would first ask the United States to bring the system "into conformity with the covered agreements" (3, Art. 22(1)). This would be the same as asking the United States to dismantle the system. If the United States refused, it would be obligated to negotiate compensation equivalent to the level of expected harm to international investors, and if it failed to do so, equivalent trade sanctions could be authorized. Medical Facilities Corporation, a Canadian firm that owns a controlling interest in a multistate U.S. specialty hospital chain, reported $169 million in revenue in 2007 alone (17). The cost of claims against the United States for implementation of a single-payer national health insurance system could be in the billions of dollars under current GATS commitments, and if further liberalization is undertaken, as is currently planned, the costs could be astronomical. The ability of the United States to implement a popular and effective single-payer national health program hence faces potentially severe constraints under existing GATS rules and commitments.

THE GATS AND HEALTH INSURANCE EXPANSION

Over the past decade, American policymakers have run low on ideas for expanding health insurance coverage to the rising numbers of uninsured. Escalating costs have swelled the ranks of the uninsured and rendered private insurance subsidies and public coverage expansions unsustainable. Unwilling to challenge insurance and pharmaceutical companies by proposing a single-payer national health insurance system, legislators of both parties have congregated around a narrow set of reforms that share a near-identical set of features: (*a*) private health insurance offered through a public "exchange" or "connector," an entity that serves simultaneously as a public regulator of and broker for commercial insurers; (*b*) a mandated minimum benefit package and other criteria for participating insurers; and (*c*) subsidies provided for the uninsured to purchase coverage through the "exchange." In some versions, a public program competes with commercial insurers in the "exchange." Variants of this model were

enacted in Massachusetts and proposed in California and Illinois. The three leading Democratic presidential candidates all offered variations on this theme during the 2008 primaries. Hence, it is likely that these features will figure prominently in the coming health reform debate. But even these more market-oriented reforms may run afoul of GATS rules.

Any new public health insurance program created at the state or federal level will be fully subject to all GATS rules. The United States committed health insurance services to the GATS without a reservation in its schedule to protect public insurance programs from GATS rules. Because the GATS defines health insurance to be a "financial service," the special rules of the Annex on Financial Services and the Understanding on Commitments in Financial Services apply to public health insurance programs. And because, under these proposals, a public program would compete with commercial insurers, it cannot be protected as a government entity.

Any such program is likely to attract those individuals that the private insurance industry currently finds it unprofitable to enroll (i.e., the sick). As state and national reformers promise generous benefits packages and low premiums, the program is likely to lose financial stability rapidly as health costs increase and the program suffers adverse selection. Massachusetts's Commonwealth Care, a state-subsidized "connector" arrangement similar to that proposed by presidential candidate Barack Obama, is being forced to consider raising co-payments or premiums, decreasing subsidy levels, or increasing taxes after the program came in $147 million over budget in 2007 due to high enrollment (18). Maintaining coverage for the sick and low-income while simultaneously keeping premiums low is certain to require significant public subsidies. The subsidization required to sustain such a plan may run afoul of GATS National Treatment rules, which require nations to give identical "national treatment" to foreign and domestic insurers. Hence, if a foreign financial services provider were to enter the U.S. health insurance market (e.g., by purchasing or merging with a large U.S. insurance company), it could potentially lodge a WTO complaint claiming that GATS rules entitle it to the same subsidies the public insurance plan receives. The government would then be faced with two unattractive choices: repeal the subsidy and consign the public program to collapse, or accept trade sanctions from the foreign insurer's home country.

It is conceivable that legislators could seek to have new limitations on market access and national treatment provisions inscribed in future negotiations of its schedule that would allow for the new public program. But modification of scheduled commitments requires the modifying member to negotiate compensation with members whose investors are adversely affected. In addition, such an attempt may violate the Understanding's "Standstill" provision, which specifically requires that any "conditions, limitations, and qualifications" to commitments in the Understanding be limited to those on the date the nation committed to the Understanding, February 26, 1998 (5).

Even without a participating public program, an "exchange" or "connector" itself potentially violates existing GATS law.

Public insurance programs inherently have lower administrative expenses than for-profit insurers and, in theory, should be able to offer lower premiums if they enroll a comparably healthy population. When placed in a competitive environment with a public health insurer, the traditional behavior of commercial insurance companies has been to attempt to "cherry-pick" the healthy and profitable patients, either by offering skimpier—and hence cheaper—plans that are disproportionately attractive to the healthy, or by more creative means such as selective advertising.

Reformers presumably aim to reduce cherry-picking behavior by limiting subsidies to those plans that are approved by the "exchange" and conditioning approval on various factors designed to favor an even risk pool among insurers (Obama specifically mentioned setting minimum benefits, requiring guarantee-issue coverage, and regulating premiums). This arrangement potentially violates the GATS in a number of ways. If a numerical limit is placed on the number of insurers that may participate in the exchange, this may violate market access rules as a "limitation on the number of service suppliers." But even if the exchange were open to all insurers who met the qualifications, a foreign insurer might argue that under GATS rules the exchange's prohibition on offering a skimpier (and hence cheaper) benefit package than the public program constitutes a "limitation on the total value of service transactions," or unfairly alters the conditions of competition in favor of the public program. Alternatively, a firm might argue that participation standards imposed by the exchange are "licensing standards" that violate GATS Article VI rules by imposing requirements "more burdensome [i.e., 'trade restrictive'] than necessary to ensure the quality of the service."

The more expansive rules of the Understanding on Commitments in Financial Services might be invoked as well. Specifically, regulations that set a floor on benefit packages that may be offered through the exchange potentially violate the Understanding's market access provision, which requires nations to allow foreign insurers to offer "any new financial service" in their territory.[1] A foreign insurance firm may argue that different, skimpier, benefit packages are "new financial services," or that the benefit regulations prohibit the introduction of exotic health-financial hybrid products such as health savings accounts. Given the WTO Appellate Body's demonstrated willingness to take a surprisingly expansive view of GATS rules, the wide variety of possible implications should be cause for concern.

THE GATS AND REFORMING THE PRIVATIZATION OF MEDICARE

Originally purported to bring businesslike efficiency and competitive market cost-saving techniques to Medicare, for-profit Medicare HMOs (health maintenance organizations) were first established in 1972 and given financial boosts in

1982 and in the 1997 Balanced Budget Act, which opened the door for other kinds of for-profit Medicare plans. For-profit Medicare plans were greatly expanded in the 2003 Medicare Modernization Act, which extended privatization by requiring that Medicare drug benefits be obtained from private insurers. But by cream-skimming healthy and profitable seniors, for-profit Medicare Advantage plans now receive, on average, 112 percent of the cost of treating their enrollees in the traditional public Medicare program (19). Obama, in vague wording, proposed to "eliminate the excessive subsidies to Medicare Advantage plans and pay them the same amount it would cost to treat the same patients under regular Medicare." The easiest and most logical way to do this is by enacting legislation forcing the Centers for Medicare and Medicaid Services to engage in an accurate risk-adjusted payment scheme (i.e., payment according to the health of the enrolled population, not a set fee, no matter how healthy or sick the enrollee is). The entire point of instituting a risk-adjusted payment scheme would be to "modify the conditions of competition in favor of" Medicare, tilting the scales back to undo the harm that private insurers have done by gaming the system. However, this is arguably prohibited in the GATS rules on national treatment. In addition, the Understanding requires the United States to endeavor to remove or limit the "adverse effects" of any *nondiscriminatory* measures that simply "affect adversely" the ability of foreign insurers to operate or compete. Purposefully reducing the reimbursement levels for the beneficiaries of for-profit plans, as risk-adjusted payment would, by definition, adversely affect the plans' profits. Modification of the Medicare payment scheme to reduce payments to private insurers enrolling healthier populations hence may conflict with the United States' GATS obligations.

Even more significantly, a strong argument can be made that the 1998 level of privatization of Medicare is locked in by current commitments under the GATS (1998 being the year of the United States' most recent inscription of its schedule). First, the United States had the opportunity to specifically protect Medicare in its schedule of limitations on market access and national treatment, and failed to do so; indeed the United States made far-reaching commitments in Life, Accident and Health Insurance. Significantly, the U.S. schedule specifically exempts workers' compensation insurance from commitments, but makes no analogous exemption for Medicare, nor does it at any point attempt to make a distinction between public and private health insurance. Second, it can no longer plausibly be claimed that Medicare falls under the exception exempting services supplied in the exercise of government authority. Under GATS rules, a government program is only exempted if it is not supplied in competition with one or more service suppliers. Yet the 1997 Balanced Budget Act (which established for-profit Medicare+Choice plans) and the 2003 Medicare Modernization Act (which established for-profit Medicare Advantage plans and required that Medicare drug benefits come through private insurers or HMOs) were enacted with the intention of placing Medicare in direct competition with private

insurance companies. The Annex on Financial Services restates and strengthens this language.[2] Third, negotiators specifically created an exemption for statutory systems of social security and public retirement, but did not take the opportunity to expand this exemption to statutory public health insurance systems. Considering the tremendous influence of U.S. negotiators on the texts of the financial services agreements, it is hard to believe that this was an oversight. Fourth, the Understanding on Commitments in Financial Services supports the notion that U.S. negotiators considered Medicare a semi-privatized program (as opposed to a coherent single-payer system with private HMOs administering some of its functions) and that Medicare's privatization level was being locked in.[3] The Understanding's Market Access section specifically instructs the United States to list all financial services monopoly rights in its schedule; Medicare is not listed. Since the last wholesale reimplementation of financial services commitments took place on February 26, 1998—*after* the 1997 privatization had taken place—the full GATS underlying rules and supplementary Understanding rules may now apply to Medicare. In other words, any attempts to restore Medicare to a true single-payer system could conflict with GATS obligations. Finally, anecdotal evidence exists that such an interpretation was intended by adherents of neoliberal economic ideology, who dominated negotiations over the GATS and financial services texts. House Speaker Newt Gingrich told insurance executives in 1995 that he couldn't get rid of Medicare immediately "because we don't think it's politically smart." But, he said, he could cause Medicare to "wither on the vine" by having for-profit plans compete against it and cripple it (20). In sum, it appears that a WTO tribunal could find ample reason for concluding that the United States intended to commit Medicare to the GATS, and its commitments under current agreements obligate it to maintain Medicare's 1998 level of privatization.

If an Obama or subsequent administration were to try to restore Medicare to a full single-payer form by prohibiting competition by private insurance, affected foreign insurance firms may be able to invoke GATS provisions in an attempt at rescission or compensation. If the restoration of Medicare to single-payer form were to be interpreted by a WTO tribunal as a new "monopoly right," schedule modification rules requiring the negotiation of compensation would be triggered. An alternative claim could be made that the restoration of a single-payer system constitutes prohibited "limitation on the number of service suppliers."

Given the saturation of the U.S. health insurance market, insurers' desire to expand into foreign markets, and the proliferation of new hybrid health-financial instruments such as health savings accounts, it is only a matter of time before foreign financial firms and domestic insurance and financial companies meet. If the freedom of domestic policymakers to regulate and reform the health system unobstructed by international trade rules is not assured soon, the price of removing the health sector from GATS jurisdiction will continue to increase exponentially.

OTHER HEALTH SECTORS WHERE THE GATS IS IMPLICATED

Specialty Hospital Regulation

Much recent media and congressional attention has focused on the large and growing number of physician-owned "specialty" hospitals. These highly specialized clinics, which focus on a few, very profitable procedures such as cardiac or orthopedic surgery, attracted notice after a series of incidents in which patients died from complications that the specialty hospital facility and staff seemed ill-equipped to handle—eventually having to call 911 to have patients taken to a traditional hospital. Critics have argued that these investor-owned hospitals are focused on profits at the expense of patient care, prompting congressional investigation (21). In addition, critics charge that investor-owned specialty hospitals are often established for the purpose of "cream-skimming" profitable patients away from community hospitals. Nonprofit or public hospitals that provide a full menu of services to a community sustain themselves by supplying some procedures they profit from (e.g., orthopedic surgery) and using those profits to subsidize the provision of unprofitable services (e.g., uncompensated care to the indigent or uninsured). Investor-owned specialty hospitals have been criticized for diverting profitable patients from full-service community hospitals. Often those doing the diverting are the physician-owners of the specialty hospitals, who are on staff at the community hospital and self-refer to the specialty hospitals they own. For instance, the surgical staff of Lincoln General Hospital in Ruston, Louisiana, established their own competing surgery center (Greene Clinic Surgical) directly adjacent to Lincoln General and began referring their patients there, causing Lincoln General to lose $8 million in operating margins. When a physician-owned diagnostic and surgical center opened in West Bend, Kansas, Great Bend Community Hospital lost 60 percent of its outpatient surgeries, had to lay off more than 100 staff, and is operating at a negative margin. Similar scenarios have played out in South Dakota and elsewhere (22).

Foreign firms have begun to enter this profitable segment of the U.S. market. Medical Facilities Corporation, a Canadian firm, bought up a 51 percent interest in three South Dakota specialty hospitals when their physician-owners decided to go public; the company now owns a controlling interest in four specialty surgical hospitals and two ambulatory surgery centers in four states (10). It is only a matter of time before this market accommodates more foreign investors.

Nine states have pending or have attempted legislation banning investor-owned specialty hospitals. In addition, 16 states have legislation that would implement a single-payer public health insurance system and ban investor ownership of hospitals.

The United States has committed hospital services to the GATS under the Health Related and Social Services section of its schedule of commitments, with

the only restriction on market access being that the establishment of hospitals may be subject to a needs-based test. In practice, this means that any existing hospital that comes under foreign ownership, or that is established by a foreign firm, is subject to GATS rules. Were any of the states to pass their bans, the laws could potentially violate GATS rules against requiring specific types of legal entity (i.e., nonprofit), against limitations on the number of service providers, or against limitations on the total value of service transactions.

But even less far-reaching regulations might be subject to GATS attack. For instance, a regulation placing a numerical quota on the maximum number of procedures physicians could refer from a community hospital to a specialty hospital in a month could run afoul of GATS market access provisions that ban limitations on "quantity of service output expressed in terms of designated numerical units." Other reasonable regulations, such as a requirement that if physicians engage in self-referrals to a specialty hospital they own they must pay some percentage of profits to the community hospital, could violate GATS provisions that forbid "limitations on the total value of service transactions or assets." Finally, the institution of tax preferences to promote community hospitals would likely violate GATS national treatment rules, because even though it does not discriminate between foreign and domestic community hospitals, almost certainly no community hospitals are foreign owned and the benefits would accrue only to U.S.-based hospitals.

Catastrophic Reinsurance for Employer Plans

Presidential candidate Barack Obama, in a proposal similar to others suggested by advocates and policymakers, suggested reimbursing employer health plans for a portion of the catastrophic costs they incur above a certain threshold, provided the insurer guarantees the savings are used to reduce the cost of workers' premiums. This reform will have its primary effect on small businesses, whose small risk pools mean that a serious illness befalling a single employee can mean dramatically higher premiums for the whole company. Small risk pools also have the effect of diminishing small business owners' ability to compete for employees with large firms, which can offer more comprehensive benefits for a lower cost because of their larger purchasing power. Small service businesses committed to the U.S. GATS schedule, such as retail, construction, communications/media, engineering, maintenance/repair, cleaning, and so on, are more likely to be locally owned than their large multinational counterparts. The majority of the advantage of catastrophic reinsurance policy will hence accrue to small, locally owned firms by cutting their health insurance premium costs and allowing them to offer and maintain more attractive benefits. Under GATS "national treatment" rules, domestic policies can be challenged by foreign companies if they even *have the effect of modifying the conditions of competition* in a way that favors domestic firms. The threat of a WTO challenge to this policy is particularly stark because, in

contrast to foreign insurers, large foreign multinationals already operate in the United States in several service sectors

Chronic "Disease Management" Programs

Some states, including California, Illinois, Massachusetts, and Vermont, have made or proposed chronic "disease management" programs as a tool to enhance care quality and reduce costs. "Disease management" centers around the idea that primary care physicians are preoccupied with more acute conditions, and their practices do not have organized systems tailored to the less-urgent needs of those with chronic disease, such as diabetes, hypertension, asthma, congestive heart failure, or depression. "Disease management" programs purport to enhance care quality and cut costs by identifying persons at risk of or already having chronic disease, and intervening with specific care programs. For example, a diabetes disease management program might include classes and Internet resources on proper blood sugar monitoring, letters or phone calls reminding patients of the need for check-ups, and a hotline with a nurse available to answer questions.

Disease management programs can generally be classified into two forms. The first is based on primary care and integrated into a managed care setting, and is generally not for profit (such as the Chronic Care Model pioneered by Group Health Cooperative and Kaiser Permanente). The other form is the for-profit corporate disease management program.[4] In contrast to the nonprofit programs' primary care basis and integration with managed care, corporate disease management has traditionally focused on a single chronic disease, usually the one the drug company manufactures a product for. As these programs "carve out" certain diseases for treatment and are detached from the patient's primary care setting, they have been criticized for disorganizing care and prioritizing profit (23, 24). A literature review undertaken by Dr. John Geyman (25) found that nonprofit disease management programs did improve care quality in some cases, but did not save money, while there was no reliable evidence that for-profit programs either improved care or produced savings.

In contrast to the private health insurance market, a substantial number of corporate disease management programs currently operating in the United States are owned by foreign drug companies. Of the 10 drug firms most active in the disease management market, 6 are foreign (26). Florida's Medicaid program has already implemented a corporate disease management program run jointly by four drug firms, two of which are foreign (27).

The rapidly growing corporate disease management industry represents a threat to consumers' dollars through wasteful profit-driven operations and a threat to patient health through the disorganization of care. States have various options for assuring that their residents have access to proven, integrated models. Possibilities include providing tax incentives for insurers to adopt nonprofit integrated models or requiring disease management programs to be not for profit.

By the very nature of disease management services, it is difficult to know exactly which GATS service sector would cover them. The only commitment the United States has made under Health Related and Social Services is "Hospitals and Other Health Care Facilities." Certainly, a dialysis center would qualify as a "health care facility," and arguably, a center that provides diabetes self-management training and houses a nurse call-center could also be classified as one. Alternatively, the bulk of what disease management programs do—teaching patients about self-management, answering questions at call centers, developing online support resources, and providing practice guidelines and resources to physicians—is educational. The United States has bound "adult education" services and "other education services" to the GATS.

If a WTO tribunal found the United States to have committed disease management programs under either of these sectors, either of the above options may constitute GATS violations. According to Geyman (25), the only real solution to the problem of corporate disease management programs is to require that all such programs be nonprofit and integrated into a primary care setting. But such a regulation may violate GATS market access provisions by requiring a specific type of legal entity (i.e., not-for-profit) through which the service must be supplied. If such a regulation were instituted, the host country of every foreign disease management firm currently doing business in the United States might be able to challenge it in a WTO tribunal, potentially costing taxpayers billions of dollars. Similarly, if a state were to put in place a system of tax incentives for the adoption of integrated nonprofit "medical home models," such a system may violate GATS rules because, even though the system does not discriminate against foreign suppliers on its face, it would almost certainly *have the effect* of advantaging U.S.-based disease management service providers, given that, presumably, few foreign firms enter the U.S. market to provide nonprofit disease management services to Americans.

Medical-Loss Ratio Requirements

As health insurance markets became saturated, insurance companies found that the only way to continue increasing their profits was to merge with and absorb smaller companies (and to break into public programs). As a result, many insurance markets are not competitive. Obama made a vague proposal during the presidential campaign to require insurers in noncompetitive markets to "pay out a reasonable share of premiums for patient care." Almost certainly this will take the form of a medical-loss ratio requirement (a technical term for the proportion of premium dollars that are used for care versus those that are used for administration). A regulation may say, for example, that 85 percent of premiums collected must be used for care. Such a law might conflict with what an insurer believes is in its financial interest—for example, an insurance company would probably find it more profitable to spend a larger share of premiums on utilization

review or screening of enrollee records to find reasons to retroactively deny payment of claims.

Although this provision of the GATS is ambiguous and without definition, disallowing a foreign insurer to engage in the most profitable course of service business could arguably constitute a market access violation, by placing a limitation on the value of the insurer's service transaction or asset in the form of a numerical quota. Once again, the Appellate Body has already proven willing to take a surprisingly expansive interpretation of what constitutes a "numerical quota," so caution should be urged in any area where GATS rules might be implicated.

Because it pertains to health insurance, regulation of this sector is subject to the more far-reaching Annex on Financial Services and Understanding on Commitments in Financial Services, where investors may have additional avenues to claim violations. In order for a foreign insurer to establish that the Understanding has been violated, it need only prove that the medical-loss law will "affect adversely [its] ability . . . to operate, compete, or enter [the market]." If the firm's home country were able to convince a WTO tribunal that a violation had occurred, the United States would be obligated to "endeavor" to remove the law or to "limit any significant adverse effects." The fact that few foreign-owned insurers currently operate in the U.S. market means that there is time to rescind or revise our GATS commitments, before U.S. patients and taxpayers find themselves in the position of having to pay foreign governments to enact consumer protections.

Preferential Tax Treatment for Nonprofit Hospitals (1)

The United States committed hospitals to the GATS with the limitation that the commitment extends only to "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. Some of these nonprofits are managed by private, for-profit firms and hence are institutions covered by the United States' GATS commitment. In return for their preferential tax treatment, nonprofit hospitals are obligated to provide charitable community services, such as uncompensated care for uninsured and indigent patients. GATS national treatment rules require that all tax benefits or subsidies provided by governments to service providers committed under a nation's schedule (i.e., hospitals managed or operated "for fee") must be provided equally to service providers owned and operated by foreign firms. If a foreign for-profit hospital company decided to buy a full-service hospital, it could argue that it is owed the preferential tax treatment that domestic nonprofits are given, as it provides identical or nearly identical services. Perhaps even more disturbing, because the

GATS commits member nations to successive rounds of negotiation aimed at "achieving a progressively higher level of liberalization," it is possible that *all* nonprofit and public hospitals will be committed to GATS rules. The recent entry of foreign firms into the hospital market makes this problem especially clear. Indeed, the idea that community and public hospitals should be exposed to "competition" is an argument often voiced by supporters of market-oriented reforms (28).

CONCLUSION

The United States' current commitments under the General Agreement on Trade in Services have tremendous and far-reaching implications for the ability to regulate the health sector in the public interest. The examples discussed are not an exhaustive list; indeed, they are meant only to illustrate the breadth of the health system's exposure to trade rules. These implications have largely been hidden from those who will be affected by them—doctors, nurses, and patients—by esoteric trade language and assurances that have proven inaccurate. The potential implications of the GATS for U.S. health care are clear; informed debate is urgently needed to evaluate the wisdom of current and possible future commitments to health services liberalization.

A GATS-based roadblock to health system reform or regulation may not be encountered, if it ever is encountered, for years. Without action *now*, however, the expanding presence of foreign health services providers in the U.S. market will make any eventual decision to modify U.S. obligations to international investors exponentially more expensive and hence difficult to implement. Unless health care is taken off the trade negotiating table, our ability to address our health system's most pressing ailments may be severely compromised.

Recommendations for the U.S. Trade Representative

1. *Immediately withdraw or substantially limit existing U.S. GATS commitments in all health-related services, including the following sectors.*

1. Health insurance
2. Hospitals and other health care facilities
3. Medical education of all forms (doctor, nurse, etc.)
4. Placement and supply services of personnel
5. Computer services and data processing in the area of health information

The GATS rules allow the United States, or any WTO signatory country, to withdraw specific commitments, provided that the United States negotiates "compensatory adjustment" with trade partners affected by the withdrawal. While we cannot withdraw existing commitments with impunity, the costs of

compensation will be less today than they would be in the future when foreign providers have gained a larger share of the U.S. market. Unless these commitments are withdrawn now, promising avenues of achieving health care reform, expanding access to care to the millions of uninsured, and effectively controlling spiraling health care costs could be effectively closed off.

2. *Halt the scheduling of new "commitments" in health-related services—including professional services provided by physicians, nurses, and other health professionals*. GATS negotiators have ambitions to commit professional services in future rounds of negotiation. The U.S. Trade Representative should not make new market access and national treatment commitments in any health-related sector until the obligations arising from and consequence of doing so are clearly defined and the public has been allowed input.

3. *Oppose new disciplines on "domestic regulations" in the service sector, including "necessity testing" under GATS rules.* Leaked draft text from negotiations show that the proposed draft rules would apply tests of "transparency," "objectivity," and "necessity" (i.e., a "least trade restrictive" test) to licensing requirements, qualifications, and technical standards for covered insurers and hospitals. These rules should be opposed on principle as an inappropriate invasion of sovereign decision-making.

4. *Insist that WTO agreements be interpreted and implemented with respect to existing international human rights obligations in the area of medical care.* The WTO creates extraordinary new rights and obligations for multinational investors by limiting the ability of domestic laws to affect their commercial interests. WTO rules and jurisprudence privilege deregulated commerce above nearly all other values, holding that domestic measures must be the least trade restrictive possible, even if fashioning laws in this way diminishes their effectiveness in achieving social goals. WTO agreements make no mention of binding international treaties and customary international law aimed at protecting those who will potentially feel the negative effects of trade liberalization. The United States should begin the process of amending the Marrakesh Agreement establishing the WTO to require that its agreements be interpreted and implemented with respect to the International Covenant on Economic, Social, and Cultural Rights, the Universal Declaration of Human Rights, and other international instruments that recognize and protect the human and social value of health care (29, 30).[5]

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NOTES

1. Article B(7) of the Understanding on Commitments in Financial Services reads: "A Member shall permit financial service suppliers of any other Member established in its territory to offer in its territory any new financial service." A "new financial service" is defined as "a service of a financial nature, including services related to existing and new products or the manner in which a product is delivered, that is not supplied by any financial service supplier in the territory of a particular Member but which is supplied in the territory of another Member." This curious language leaves much unclear. How "different" does a financial service need to be in order to be "new," if the service may be "related to existing or new products" or the "manner in which [it is] delivered"? May country A demand country B allow it to offer a financial service in country B's territory because country C supplies it domestically?

2. Annex on Financial Services Article 1(c) reads: "For the purposes of subparagraph 3(b) of Article 1 of the Agreement [i.e. the section defining exempted governmental activities], if a Member allows any of the activities referred to in subparagraphs (b)(ii) or (b)(iii) of this paragraph [i.e., the exemptions for social security and activities of a public entity] to be conducted by its financial service suppliers in competition with a public entity or a financial service supplier, 'services' shall include such activities [i.e., the activities will be subject to full GATS rules and commitments]."

3. Even if Medicare were considered a statutory system of social security, within the (undefined) meaning of Article 1(b)(ii) of the Annex, its placement into competition with for-profit insurers precludes 1(b)(ii) protection under Article 1(c).

4. The first corporate disease management programs were devised by drug companies in the mid-1990s in response to their fears that HMOs would begin cutting drug prices, as they had done for physician and hospital payments. Drug companies used databases of prescribed drugs to identify patients with chronic diseases, and then offered "educational" services to them. The drug companies believed they could sell these services as a cost-cutting mechanism to HMOs, businesses, and hospitals. The drug companies could then sell their own products as part of the bargain, and use insurance company health status data to identify potential new customers.

5. Any WTO member may initiate the amendment process pursuant to Article X, Marrakesh Agreement Establishing the World Trade Organization. The International Covenant on Economic, Social, and Cultural Rights provisions include: "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness" (Article 12; December 10, 1948). The Universal Declaration of Human Rights provisions include: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" (Article 25).

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