

Comparative Study of Obamacare and Trumpcare: From the Perspective of Liberal International Order

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Abstract. Different from most studies that focus on the external shocks to the Liberal International Order, this research discusses the domestic identity of the order. Drawing on the experience of the U.S. healthcare system from Obamacare to Trumpcare, this study critically analyses urgent priorities, key provisions, policy effects, and social responses, and further discusses the structural dilemmas of the U.S. social welfare reflected. By expanding health insurance coverage through administrative means, prohibiting price discrimination and background checks of insurers, and establishing a “value-based” healthcare payment system, Obamacare has increased the U.S. health insurance to unprecedented coverage, especially for low-income groups, but at the expense of increasingly heavy federal burden and expensive per capita spending, resulting in a counter-productive effect of “health care tax” as well as triggering criticism for undermining the free market and resentment from the middle class and beyond. In contrast, Trumpcare may be able to curb rising federal healthcare spending in the short term, protect the interests of specific interest groups, and demonstrate a return to the free market. Essentially, however, its abandonment of low-income groups, the elderly, and other disadvantaged groups, alongside its institutionalization of inequality, embodies precisely the endogenous self-collapse gene of the Liberal International Order. In the long run, Trump’s system tends to create more damaged people and further exacerbate the tear in American society, thus weakening the domestic identity of the Liberal International Order and shaking its political foundations.

Keywords: Obamacare; Trumpcare; the Liberal International Order.

1. Introduction

Among the debates engulfing the U.S. foreign policy area in recent years, fears about the fate of the liberal international order (LIO) have become a topic in focus, with the dominant consensus suggesting that the Trump administration poses a major threat to the order and is largely responsible for its failure [1]. As a domestic counterpart, in the context of continuously rising healthcare spending, the resulting wave of localized unemployment, and the growing discontent of the middle class and beyond, Trump’s repeal and replacement of Obama’s healthcare policy has made his first as well a major political goal, which profoundly radiates into all social aspects from the national economy to individual behavior [2]. Back to the Obama administration who set sail amidst the scars of the Great Recession, the U.S. healthcare system held high spending while leading to a severely under-covered population and unsatisfactory delivery performance [3]. In the face of rising demand for reform across numerous fields and the urgent challenge of reducing the huge fiscal deficit, the Obama administration launched a comprehensive reform into the U.S. healthcare system, making it a policy priority to expand public healthcare coverage, reduce healthcare costs and improve the quality of care [4].

From the Affordable Care Act to the proposal of Healthcare Reform to Make America Great Again, this paper aims to address how the U.S. healthcare reform reflects the dilemmas of the welfare system behind and serves a domestic response to the decline of the LIO. Structurally, this study begins with a review of the relevant literature on LIO, the basic scheme of the U.S. healthcare system, and the main orientations of the two parties’ healthcare reform, thus proposing a marginal contribution. Then, in the main body, the paper elaborates and compares in depth the context, policy priorities and the

policy effects of Obamacare and Trumpcare. Finally, this study concludes by expanding into research limitations and future perspectives.

2. Liberal International Order and the Process of the U.S. Healthcare Reform

2.1. Liberal International Order

The Liberal International Order (LIO) describes a global system of governance and institutional international relations based on political and economic liberty as well as liberal internationalism, operated through international collaboration facilitated by multilateral international organizations, dominated by the U.S. since the post-World War II era [5]. While the existence, nature, scope, and characteristics of the order have shown diverse and controversial derivations over time, there is a consensus that the LIO has been severely damaged and even faces collapse, with the Trump administration's ambivalent attitude towards global security alliances, abrogation of free trade treaties and questioning of globalization as a symbol [1]. While the Western elites who created and benefited from the LIO have tried to blame the Trump administration for its failures, the fact is that the gene of "self-undermining feedback effects" buried deep at the core has long determined the self-collapse of the order [6]. The LIO applies double standards and institutionalizes inequality, which has led to a situation where those who lose from globalization -the lower and middle classes -are much more than those who gain from it -mainly the thin elites within Western countries [7, 8]. All these structural problems in turn have weakened both the domestic and international identity of the LIO and further exacerbated populism, protectionism, and xenophobia within the West, thus severely shaking the political foundations of the order [9]. Therefore, rather than Trump's views and policies being the cause of the failure of the LIO, it is Trump who has harnessed the wave of discontent spawned by the order's endogenous seeds of self-destruction, thereby causing irreparable damage to the LIO and the wider Western world [10].

2.2. The U.S. Healthcare System

The U.S. is considered to have the most expensive healthcare system in the world, which affects every social aspect from financial soundness to family well-being to individual health security. In schema terms, the U.S. healthcare cost includes three components: public insurance, private insurance, and out-of-pocket payments. According to the Centers for Medicare & Medicaid Services (CMS), since the 1960s, the rising healthcare spending has been a central challenge for the long-term federal budget, reaching 18.3% of GDP by 2021. On the one hand, the U.S. healthcare system has long faced the challenges of leading public spending, expensive per capita costs, narrow public health insurance coverage, and a high overall uninsured rate compared to other OECD countries. On the other hand, however, high healthcare costs lead to relatively poor outcomes -the U.S. has been performing worse than most OECD countries on life expectancy as well as most measures of healthcare use and healthcare quality [3, 11].

2.3. Bipartisan Healthcare Reform in the U.S.

Given the U.S. making one of the few developed capitalist countries that has not achieved universal coverage and where the existing healthcare system has failed to perform to its potential, there have been several major waves of healthcare reform by both parties based on their respective value propositions, which mainly differ in terms of the boundaries of citizen rights to health care and the role of the government in the health insurance market [12]. From Roosevelt to Clinton to Obama, the Democratic Party has considered healthcare as part of basic human rights and believed that the U.S. government takes the responsibility to provide basic healthcare to its citizens, thus demonstrating a predominant orientation of "big government, small market" in policy. In contrast, from Reagan to George W. Bush to Trump, the Republican Party has advocated a free market on healthcare issues, limited the government's responsibility to specific areas such as assistance to the elderly and the poor, and demonstrated a basic view of "small government and big market" in policy [13].

The long-running game between the two parties on the U.S. healthcare reform proves that rather than merely an economic issue, healthcare reform makes a political process of interest integration. Furthermore, the alternating administration of the two parties also serves the reason for the repeated changes, gradual processes, and incompleteness of U.S. healthcare policy. In a broader sense, the impact of such a political game on the U.S. healthcare system can be considered a microcosm of the LIO's efforts to undermine social consensus and widen class divisions through institutionalized inequality, which has not been adequately connected in the studies so far. Therefore, this study seeks to discuss the welfare dilemma, the failure of LIO, and its causes as embodied in the experience of the U.S. healthcare system from Obamacare to Trumpcare.

3. Analytical Framework and Discussion

3.1. Obamacare: The Affordable Care Act

The Obama administration set sail in severe economic and social crises left behind by the Great Recession, with surging demands for "reform" across all social sectors and reducing heavy fiscal deficit becoming major priorities [14]. In the field of healthcare, on the one hand, on the eve of Obama's presidency, the U.S. healthcare system faced a total healthcare expenditure of 16% of GDP and a per capita healthcare cost twice the average of OECD countries [3]. On the other hand, however, the high cost had not resulted in adequate healthcare for those in need. Prior to the Obama administration, only 26.2% of the U.S. population was covered by public health insurance and more than one in seven did not have any health insurance--the figure was more than 50% among poor adults [2, 3]. Worse still, the U.S. recorded worse performance than most OECD countries in quality of care, patient waiting time, and use of most health services [15].

In such context, the Obama administration proposed that healthcare is a right for all rather than a privilege for a few, and further pushed for a comprehensive, sweeping healthcare reform--the Affordable Care Act (ACA)--in 2010. Specifically, with the core priorities of expanding coverage, reducing the level and growth of healthcare costs, and improving the quality of healthcare, the ACA highlighted the following three main aspects [14].

First, Obamacare aspired to expand healthcare coverage through a series of mandates. The individual mandate required that all citizens and families choose to be insured or pay a penalty before the age of 26, except for those who already spent more than 8% of their income on minimum premiums. Meanwhile, nationwide health exchanges were established, on the basis of which income-based cost-sharing subsidies for insurance were provided. People at or below 138% of the poverty income level received Medicaid from federal financial, and existing health insurance coverage in most states was also expanded to provide healthcare to more low-income groups. In addition, employers were required to purchase health insurance for a specific proportion of their employees depending on business size.

Second, by setting guarantee issues, Obamacare prohibited insurers from denying coverage or charging high premiums on the grounds of customers' health status. Premiums could only be decided according to family structure, geography, actuarial value, health habits, health promotion program history, and age, with the extent of differential pricing based on age and health habits limited. Meanwhile, insurers were required to offer lifetime reimbursement terms, except in cases of policyholder fraud.

Third, Obamacare aimed to improve the quality of healthcare by reforming the payment system. Unlike the dominant "service-based" payment system, which had failed to reward organizations and practitioners for providing efficient and high-quality healthcare, the ACA deployed the Hospital Value-Based Purchasing Program to establish a "value-based" payment system, linking healthcare costs with the quality and efficiency of healthcare services, encouraging professional organizations and practitioners to focus on service quality while reducing healthcare costs and waste.

3.2. Trumpcare: Make America Great Again

Representing the Republican political will and maintenance of middle-class interests, Trump made “full repeal of the ACA” a key campaign slogan from the start of his candidacy. Although legislation to fully repeal the ACA was defeated by Congress, a series of administrative orders restricting the operation of Obamacare were signed, followed by a bill that was narrowly passed in Congress to replace specific provisions of the ACA. By deftly harnessing the discontent with Obamacare from all sides within the U.S.--primarily the high healthcare costs, the restrictions on the free market, and the discontent of the middle class and beyond, the Trump administration has officially brought the U.S. healthcare system into the Trumpcare era since 2017 [16]. Given that Trumpcare is a targeted repeal and replacement of Obamacare, its policy priorities can also be categorized into three dimensions of coverage, healthcare costs, and healthcare quality [17, 18].

Firstly, the Trump administration repealed mandatory health insurance by replacing administrative means with price leverage. Instead of paying additional punitive taxes, uninsured individuals and business employers who went beyond a specified period would be subject to excess insurance costs. Meanwhile, the income-based cost-sharing subsidies were replaced by an age-based mechanism, and the rules relating to the ratio of premiums to income were also removed. In addition, the additional taxes on high-income earners, insurers, and medical equipment providers were eliminated.

Secondly, the Trump administration reversed Obamacare’s policy on insurers. Price discrimination against the elderly was liberalized to incentivize people to purchase health insurance as early as possible. Restriction of background checks on policyholders was also lifted, and states were given the discretion to authorize insurers to levy excess premiums on customers with specific interruptions of enrolment. In addition, insurers were also allowed to re-impose caps on annual and lifetime reimbursement terms.

Thirdly, the Trump administration made sweeping changes to the Medicaid mechanism established by Obamacare. Under strict fiscal year caps, Medicaid coverage was tightened and its payroll disbursement was changed to an appropriation system. The states were allowed to set their limits, with the amount of per capita federal aid reduced. Meanwhile, states were required to levy additional taxes on Medicaid recipients to subsidize federal spending. In addition, the Trump administration passed the American Patients First program in 2018, which increased competition among drugs, gave sponsors greater negotiating power against drug companies, provided incentives to lower the list price of drugs, and removed the gag order on pharmacists to ensure consumers access to information about lower-cost alternatives, to reduce costs by market means, so as to effectively curb the rise of healthcare expenditures.

3.3. Comparative Evaluation of Effects and Responses

Given the common priorities in policy, this paper conducts a comparative analysis of policy effects and social responses of Obamacare and Trumpcare along three dimensions: coverage, healthcare spending, and free market, and further discusses the implicit “endogenous self-collapse gene” of the LIO.

3.3.1. Coverage

From the perspective of health insurance coverage, Obamacare has increased the U.S. health insurance coverage to an unprecedented level, with the uninsured rate among the non-elderly decreasing from 18.2% in 2010 to 10.3% in 2016 (see Figure 1). More importantly, the ACA provides a safety net for the unemployed and low-income groups [19]. By repealing mandatory health insurance and a series of price discrimination provisions, however, Trumpcare predictably witnessed a 12.15% climb in the uninsured rate among the non-elderly between 2017 and 2019 (see Figure 1). As Trumpcare limits the availability of public health insurance, the majority of uninsured non-elderly groups come from low-income households [19]. In addition, Trumpcare has also posed a substantial impact on access to health insurance and healthcare services for the elderly [20]. What calls for special attention is that the U.S. government has protected access to and retention of health insurance for

those at risk of losing jobs or income during the pandemic through federal policies and thus witnessed a decline in the uninsured rate, therefore, the period since 2020 is not included in the discussion, which also holds for the subsequent analysis.

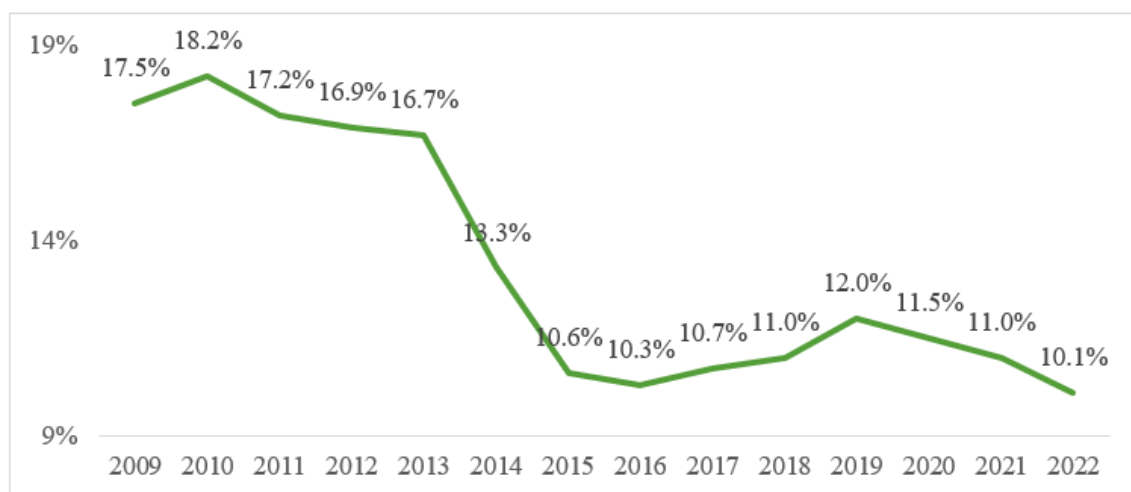


Fig 1. Uninsured rate among the nonelderly population (2009-2022) (Photo Credit: Original).

Source: CDC, Health insurance coverage: Early release of estimates from the National Health Interview Survey; CDC, No health insurance coverage among people under age 65.

3.3.2. Healthcare expenditure

In terms of healthcare expenditure, generally, the National Health Expenditures climbed from 17.2% of GDP in 2010 to 17.7% in 2016 during Obamacare (see Figure 2), which is predictable as federal healthcare spending serves as the underpinning of health insurance coverage and healthcare quality. Trump's targeted healthcare provisions, on the other hand, did effectively curb the climb in the National Health Expenditures as a share of GDP--at the cost of a rising uninsured rate (see Figure 2). However, despite Obamacare's efforts to improve the affordability of health insurance, the healthcare expenditures per capita in the U.S. continued to increase at a high rate as a result of high costs of insurance pushed up by the restrictions on insurers and business employers (see Figure 3), which is particularly evident during Obamacare---the healthcare expenditures per capita increased by 22.3% in 2016 compared to 2010, and by 8% in 2019 compared to 2017 [19]. This is a major aspect of that Obamacare has been criticized and questioned.

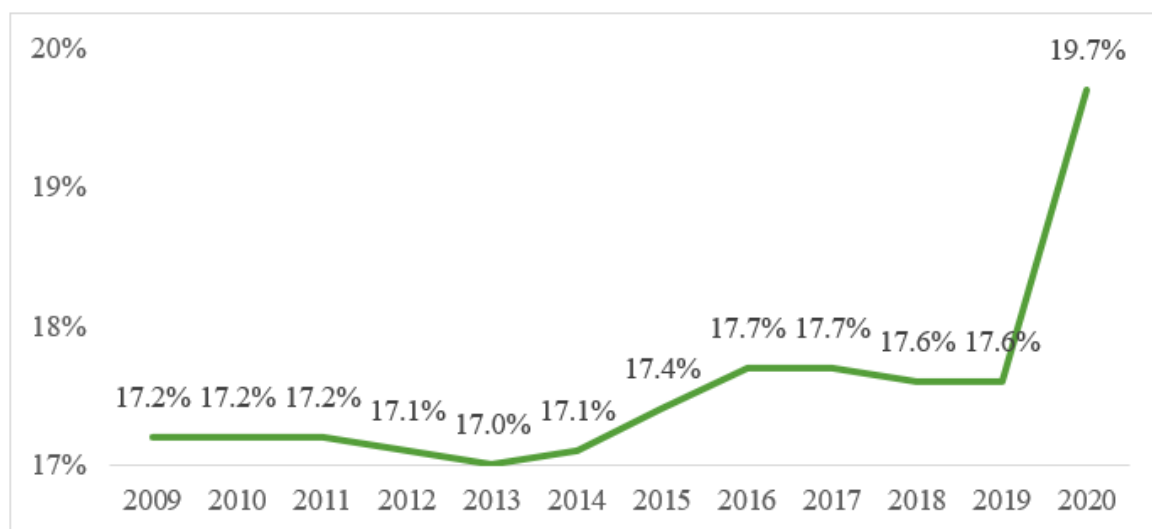


Fig 2. National health expenditures as a percent of GDP (Picture Credit: Original).

Source: CMS, National Health Expenditure Data-NHE Summary

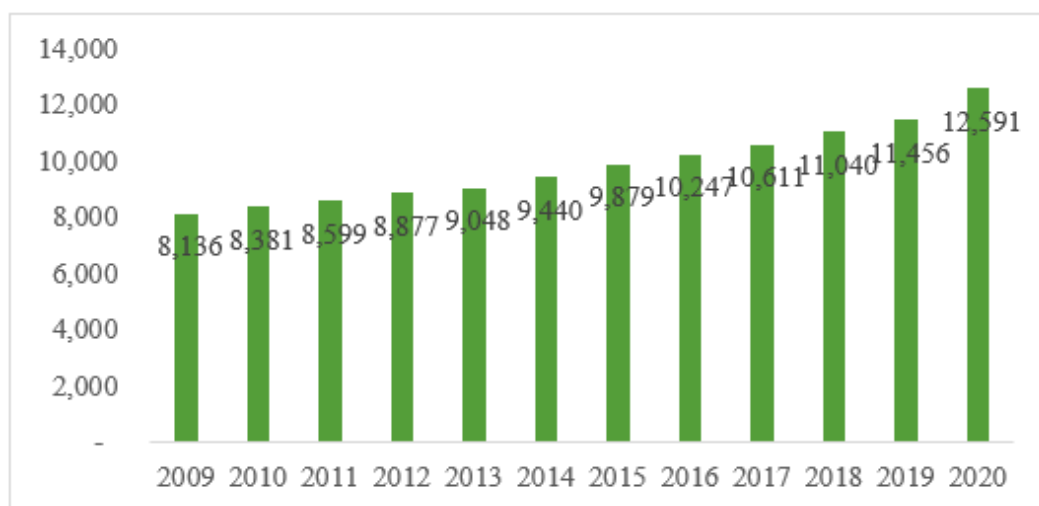


Fig 3. National health expenditures (Per Capita Amount) (Photo Credit: Original).

Source: CMS, National Health Expenditure Data-NHE Summary

Furthermore, in terms of expenditure type, although the proportion of personal healthcare in total health consumption expenditures has not changed much between 2010 and 2019, with the climb of per capita healthcare expenditures, the U.S. citizens inevitably bear increasingly high healthcare consumption expenditures (see Figure 4). The high cost makes a major contributor to the lack of health insurance among the uninsured, and its impact is particularly pronounced among low-income populations, thus exacerbating the structural distress of the U.S. healthcare system [19].

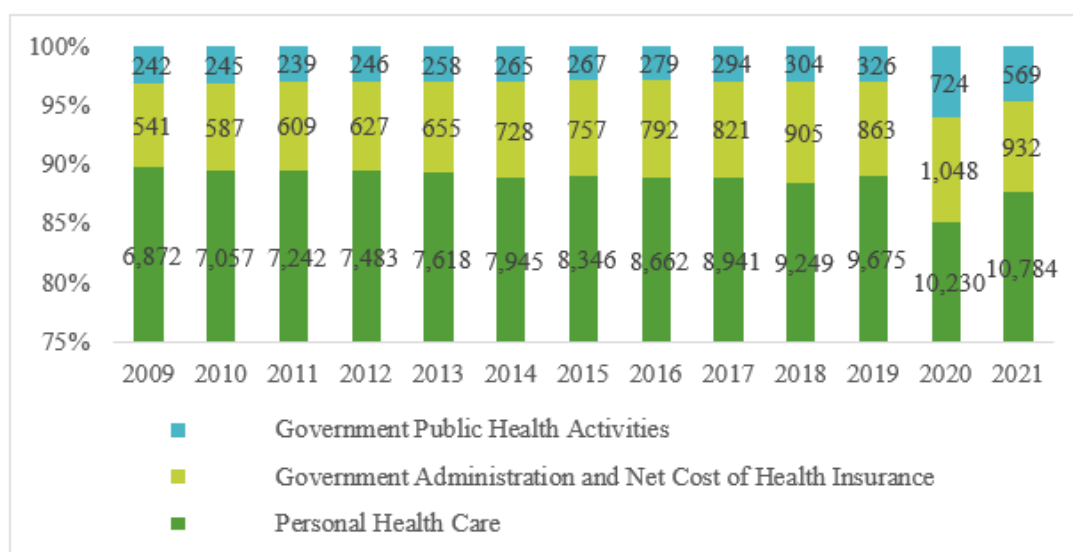


Fig 4. Health Consumption Expenditures Per Capita by Type Contribution (Photo Credit: Original).

Source: CMS, National Health Expenditure Data-NHE Summary

3.3.3. Free market

When it comes to the free market perspective, it is the perception of the property of healthcare that best reflects the differences between the two parties' philosophies and the essential differences between Obamacare and Trumpcare. The Obama administration emphasizes the public goods nature of healthcare, thus expanding federal and state intervention in the healthcare market in order to achieve universal coverage, and imposes a series of restrictions on insurers and employers in order to improve low-income families' access to healthcare, leading to another major criticism--the undermining of the free market of which the U.S. has been long proud of. In contrast, the Trump administration places more emphasis on the commodity nature of healthcare, shifting costs and risks

back to the market and thus to ordinary citizens so as to curb federal healthcare expenditures, and lifting restrictions on insurers and employers to maintain the interests of specific interest groups [16].

Furthermore, the main mechanism of Obamacare is to leverage the excess taxes from the middle and wealthy classes for the healthcare of low-income populations, including illegal immigrants. In this process, the middle and wealthy have gotten no substantial benefits and thus have accumulated resentment against the ACA. It was by harnessing the wave of discontent from interest groups and the middle class and beyond that Trump was able to run a successful campaign and implement the Make America Great Again Healthcare Reform [17]. However, Trumpcare's "return" to the free market came at the cost of social equality and by the underlying logic of institutionalizing inequality, which not only exacerbated the tears in American society and the structural dilemmas of the welfare system but also embodied the "endogenous self-collapse" gene of the LIO.

4. Limitations and Future Outlooks

In the research findings, this paper fails to focus on and discuss more aspects and specific provisions of Obamacare and Trumpcare, especially structural terms targeting different demographics and income groups, such as coverage of drugs and diseases, regulations of drug prices, specific terms of cost-sharing subsidies, healthcare sales across state lines, specific measures for children and the elderly. Meanwhile, in the analysis of policy effects, this research pays the most attention to the structural impacts of Obamacare and Trumpcare on coverage and healthcare costs, while ignoring the quality of healthcare. In the research framework, in contrast to most existing studies that focus on the external challenges facing the LIO--mainly the new multipolar pattern with the rise of emerging powers such as China--or the attribution of the U.S. as an affected or even victimized position when taking insight into the endogenous self-undermining feedback effect of the order, this paper provides a rather new and essential perspective on the nature and decline of the LIO, which is embedded in the mechanisms of social functioning and domestic identity within the U.S.. In addition, the critical review and analysis of the U.S. healthcare reform can also provide experience for welfare systems in other countries, both developed and developing, capitalist and socialist.

5. Conclusion

By expanding health insurance coverage through administrative means, prohibiting price discrimination and background checks of insurers, and establishing a "value-based" healthcare payment system, Obamacare has increased the U.S. health insurance to unprecedented coverage, especially for low-income groups, but at the expense of increasingly heavy federal burden and expensive per capita spending, resulting in a counter-productive effect of "health care tax" as well as triggering criticism for undermining the free market and resentment from the middle class and beyond. In contrast, Trumpcare may be able to curb rising federal healthcare spending in the short term, protect the interests of specific interest groups, and demonstrate a return to the free market. Essentially, however, its abandonment of low-income groups, the elderly, and other disadvantaged groups, alongside its institutionalization of inequality, embodies precisely the endogenous self-collapse gene of the LIO. In the long run, Trump's system tends to create more damaged people and further exacerbate the tear in American society, thus weakening the domestic identity of the Liberal International Order and shaking its political foundations, and even witnessing the eventual decline and collapse of the order.

References

- [1] Allison G. The myth of the liberal order: From historical accident to conventional wisdom. *Foreign Affairs*, 2018, 97: 124.
- [2] Rice T, Unruh L.Y, Van G.E, et al. Universal coverage reforms in the USA: from Obamacare through Trump. *Health Policy*, 2018, 122(7): 698-702.

- [3] Anderson G.F, Frogner B.K. Health spending in OECD countries: obtaining value per dollar. *Health Affairs*, 2008, 27(6): 1718-1727.
- [4] Cutler D.M. The simple economics of health reform. *The Economists' Voice*, 2010, 7(5): 10.
- [5] Lake D.A, Martin L.L, Risse T. Challenges to the liberal order: Reflections on international organization. *International Organization*, 2021, 75(2): 225-257.
- [6] Farrell H, Newman A.L. The Janus face of the liberal international information order: When global institutions are self-undermining. *International Organization*, 2021, 75(2): 333-358.
- [7] Börzel T.A, Zürn M. Contestations of the liberal international order: From liberal multilateralism to post national liberalism. *International Organization*, 2021, 75(2): 282-305.
- [8] Flaherty T.M, Rogowski R. Rising inequality as a threat to the liberal international order. *International Organization*, 2021, 75(2): 495-523.
- [9] Mearsheimer J.J. Bound to fail: The rise and fall of the liberal international order. *International Security*, 2019, 43(4): 7-50.
- [10] Stokes D. Trump, American hegemony and the future of the liberal international order. *International Affairs*, 2018, 94(1): 133-150.
- [11] Cutler D.M. The world's costliest health Care. *Harvard Magazine*. 2020, (5): 5.
- [12] Oliver T.R. The politics of public health policy. *Annu. Rev. Public Health*, 2006, 27: 195-233.
- [13] Liu L.H. Value orientation and political game: Health care reform in the United States. *Chinese Journal of Health Policy*, 2010, 3(08): 41-48.
- [14] Obama B. United States health care reform: progress to date and next steps. *Jama*, 2016, 316(5): 525-532.
- [15] Schoen C, Davis K, How S.K. & Scheinbaum S. C. US health system performance: A national scorecard: The United States would have to improve its performance on key indicators by 50 percent or more to reach benchmark rates. *Health Affairs*, 2006, 25(Suppl1): W457-W475.
- [16] Zou W.J. Analysis of American healthcare reform: A case study of Obamacare and Trumpcare. *China Insurance*, 2020, 387(03):61-64.
- [17] Chen Y, Wang M.Y, Tang M. Review of Trump's healthcare reform. *Sub National Fiscal Research*, 2017, 157(11):105-112.
- [18] Li Y.Z. A study on the predicament of social welfare system under the reform of American medical insurance: 2009-2018. Hangzhou: Zhe Jiang University, 2019.
- [19] Tolbert J, Drake P, Damico A. Key facts about the uninsured population. Kaiser Family Foundation, 2022.
- [20] Jones D.K, Gusmano M.K, Nadash P, et al. Undermining the ACA through the executive branch and federalism: What the Trump administration's approach to health reform means for older Americans in aging policy and politics in the Trump era, Routledge, 2020, 90-107.