

Individuation and Stratification

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There's no such thing as society. There are individual men and women and there are families.
And no government can do anything except through people.

Margaret Thatcher

Introduction

Recent institutional transformations in capitalist societies have heightened the role of individual choices, individual risks, and individual data across numerous domains of socio-economic life. In this note, I focus on individuation as a main current of neo-liberalism and discuss its implications for contemporary social stratification regimes. I illustrate the argument by presenting empirical results on the relationship between devolved choice and medical expenditure burdens in US employer-sponsored health insurance.

By “individuation,” I mean the restructuring of institutions to create more personalized, individual-specific mechanisms for allocating resources and risks. This includes the devolution of choice to individuals in public and private social provision, such as school-choice programs, defined-contribution pension systems, and consumer-based health insurance (Le Grand 2007; Langley 2008; O’Rand 2011; Hacker and O’Leary 2012). It also includes efforts to rationalize bureaucratic decisions by using personal data to make ever more granular distinctions between individuals (Fourcade and Healy 2013; 2017). Examples include the widening use of individual credit records as an evaluative signal in market transactions (Kiviat 2016), as well as the diffusion of “personalized” criminal justice penalties based on predictive algorithms about offenders (for example, Kleinberg et al. 2015). Whether driven by profits, efficiency, or fairness concerns, in all of these cases, outcomes that were primarily a function of one’s inclusion in broad categorical criteria (for example, citizenship, place of residence, employment status, age) are now also increasingly mediated through individuals’ own choices and/or person-specific data profiles.

I want to suggest that such forms of institutionalized devolution help explain the pervasive growth of both within- and between-group inequalities. My approach contrasts with existing formulations (Beck and Beck-Gersheim 2002; Pakulski and Waters 1996), which treat individuation as ushering in a post-class stratification regime as idiosyncratic risks displace inter-group bases of inequality. As I shall illustrate, individuation at the proximate level in fact heightens between-group disparities in outcomes because it renders more consequential all of the preexisting resource disparities between social

groups. Similarly, nominally person-specific evaluative criteria, such as credit scores, amplify inter-group differences while obscuring their underlying social structural bases (Fourcade and Healy 2017).

Empirical example: Devolved choice in US employer-sponsored health insurance, 2002–2013

To assess the effects of individuation on between-group stratification, I consider how the introduction of consumer choice architecture in US employer-sponsored health insurance alters the distribution of medical expenditure burdens across the social class spectrum. The majority of the US non-elderly population receives medical insurance through an employer. Increasingly, provision of these benefits is accompanied by high-stakes demands to “choose the plan that’s right for you.” In the case of insurance, this means learning to be one’s own actuary by selecting from among plans with varying risk and cost profiles. Each year from 2002 to 2012 approximately 2–4 percent of firms that had offered traditional low-deductible (lower risk) plans transitioned to offering employees a choice between at least one high-deductible plan (higher risk, lower cost) and one low-deductible plan.¹ The share of ESI-enrolled employees who faced a choice grew from virtually zero in the early 2000s to over 42 percent by 2013.

Offering employees a choice of plans with varying risk profiles is touted as a means of reducing costs while matching consumers to plans that best meet their needs. However, the prospect of lower monthly costs can lure individuals into plans that carry greater risks, with potentially severe financial consequences. Moreover, actors in different social positions have disparate resources to draw on when navigating complex decisions such as selecting insurance contracts. Prior empirical research highlights clear socio-economic disparities in insurance comprehension, selection processes, and choices. Loewenstein et al. (2013) find that more highly educated and higher income respondents accurately answer more questions about basic insurance and cost-sharing concepts, irrespective of their prior experience with healthcare providers. Norton et al. (2014) report similar disparities in comprehension across educational attainment categories. This implies that individuation may exacerbate social stratification.

OOP burdens are an important site of social stratification. Throughout most of the late twentieth century, employer-sponsored insurance (hereafter ESI) coverage afforded those covered by it relatively privileged protection from the financial risks of medical care. Since the 1990s, however, OOP burdens have come to represent an increasingly acute financial strain on households (for example, Pollitz et al. 2014). Among those

1 I define high-deductible plans as > 1,000 dollars for individual coverage and > 2,000 dollars for family coverage. This matches the IRS’s eligibility threshold for tax-advantaged health savings accounts at the outset of our study period in 2001.

continuously covered under ESI, the share with *realized* OOP in excess of 10 percent of income increased from approximately 9 percent in 2002 to 16 percent in 2013 (Collins et al. 2014). As of 2014, 43 million Americans have unpaid medical debt on their credit report, and medical debt accounts for 52 percent of all delinquent credit accounts (CFPB 2014). Medical bills are the primary cause of at least 17 percent of personal bankruptcies (Dranove and Millenson 2006) and play a contributing role in as many as 62 percent (Himmelstein et al. 2009).

To what extent does the individuation of choice (between plans with varying financial risks) alter the social stratification of cost burdens among employees? Does placing responsibility on individual employees result in increased social class inequality in OOP? To answer these questions I draw on unique data from a matched employer–employee insurance claims database (OptumInsight), which includes information on plan offerings and realized out-of-pocket expenditure burdens for over 37 million persons from 2002 to 2013. Longitudinal matched employee–employer claims data allow us to leverage variation within employees and employers over time. It is possible to compare how the same individuals fare across institutional contexts with varying levels of choice. Moreover, one can reasonably treat employers’ decisions to transition to devolved choice arrangements as exogenous with respect to individual employees. I captured social class differences using a gradational index of socio-economic status (SES) based on enrollees’ estimated education and income levels.

The results of triple difference-in-difference type regression models with individual fixed effects show that when firms devolve choice, lower SES employees end up experiencing greater absolute increases in costs relative to higher SES colleagues, and consequently end up bearing a greater relative share of the total OOP burden than before the shift. This is shown in Figure 1. Out-of-pocket differences at the conditional mean are modest (\$22 annually). The results of conditional quantile regressions at the 95th percentile of the OOP distribution, however, reveal a more pronounced disparity (\$170) (Figure 2). These estimates are conservative insofar as they do not account for class-differentiated adjustments in total healthcare utilization. The estimated effect of devolution on inter-group disparities appears approximately twice as great when individuals’ total healthcare utilization is held constant at the pre-devolution level (not shown). The between-group disparities are also virtually identical when adjustments are made to account for differing monthly premium contributions in low- and high-deductible plans. Additional unreported analyses show that these patterns are not driven by differences in prior health status, suggesting that the devolution of choice itself contributes to widening inter-group differences.

Figure 1 Estimated within-person change in mean OOP, by SES tercile

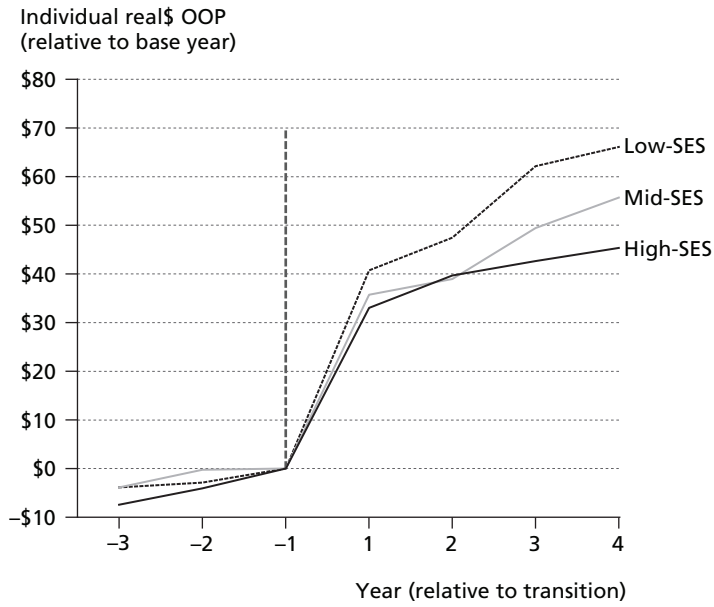
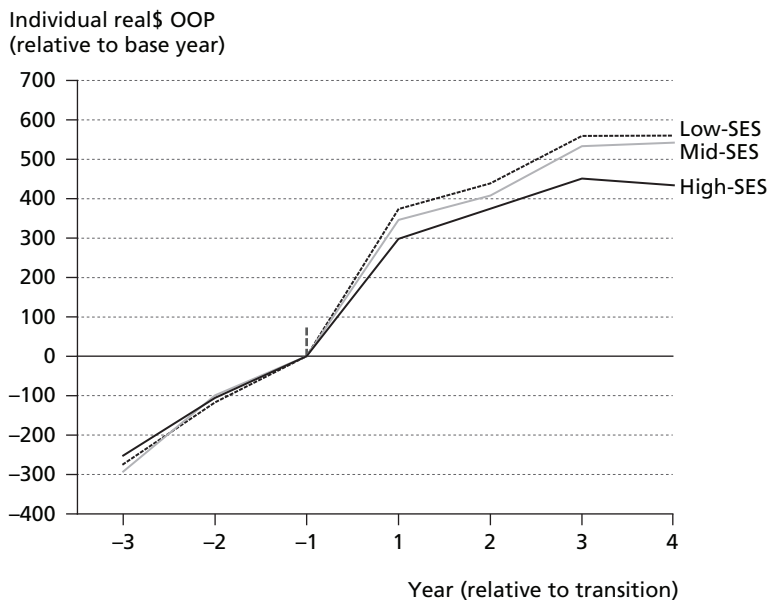


Figure 2 Estimated within-person change in 95th percentile OOP, by SES tercile



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