

The immediate needs annuity and long-term care insurance

Executive summary

The market for traditional long-term care insurance is quite small in high-income countries, even in those that lack universal insurance. The market for income annuities (annuities that pay an income stream for life) is also small, and in the United States, annuities aren't medically underwritten. That means there's no market for individuals seeking to insure consumption or bequests very late in life. In the United Kingdom, an immediate needs annuity (INA) has emerged. Individuals purchase an INA when the need for care arises. INAs are medically underwritten, like long-term care insurance, but annuity payments aren't dependent on care usage. Compared to purchasers of income annuities, the expected remaining lifespan of an INA purchaser is diminished, yet the variance—relative to expected longevity—might be considerably increased, potentially making an INA a riskier product to offer and perhaps lowering its value relative to income annuities.

In this paper, we describe the functioning of INAs in the U.K. market and evaluate the potential demand for them in a theoretical model, with implications for the U.S. market. We find that purchasing an INA upon first needing care makes individuals better off if they have moderate to high wealth levels. INA purchasers are able to sustain higher levels of consumption in their remaining lifetimes; and while their assets initially drop at purchase, asset levels (and hence potential bequests) decline more slowly afterwards than they would otherwise.

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We also find that for individuals at the lower end of the wealth levels at which an INA purchase is optimal, the likelihood of taking government-financed care drops by a moderate amount, while higher-wealth purchasers are unlikely to use government care, whether or not they purchase an INA.

The market for traditional long-term care insurance (LTCI) is quite small in high-income countries, even in those that lack universal insurance. For example, in the United States, only about 10% of individuals aged 61 or over held policies between 1992 and 2012, even though care costs can be extremely burdensome for individuals to bear. Moreover, some individuals are denied coverage at any price (Hendren, 2013; Braun et al., 2019), and some policyholders lapse their policies and forego all benefits (Friedberg et al., 2023). Theoretical calculations show—over a large part of the wealth distribution—that much of the gain from holding LTCI in the United States accrues not for policyholders but for the government in the form of lower Medicaid outlays (Brown & Finkelstein 2008). In short, LTCI policies don't significantly reduce financial risk and might even increase it, while low take-up leaves the government bearing high costs. In their absence, income annuities might fill a similar insurance function for individuals facing high long-term care costs late in life, and thus facing the risk of spending all their wealth before they die. However, in the United States, income annuities (annuities that pay an income stream for life) aren't medically underwritten, which makes them a poor deal for individuals needing care; nor are they sold to individuals at very advanced ages. This leaves a market missing for individuals seeking to insure consumption or bequests late in life.

The U.K. market is similar to the U.S. market in many dimensions, including in morbidity, mortality and the availability of public long-term care services on a heavily means-tested basis. One difference is that traditional income annuities in the United Kingdom are often priced based on health and geographic location (an indicator of socioeconomic status), affording the possibility of enhanced income protection for those in poor health.

On the other hand, long-term care insurers have withdrawn completely (Lloyd, 2011), while a different product has emerged: an immediate needs annuity (INA). An individual purchases an INA when the need for care arises. INAs are medically underwritten, like long-term care insurance but unlike U.S. income annuities. Annuity payments aren't dependent on care usage but may be paid directly to care providers, in which case they aren't taxable. INAs insure against the risk of surviving longer than expected, as do income annuities. Compared with purchasers of income annuities, the expected remaining lifespan of an INA purchaser is likely to be considerably diminished. The variance, relative to expected longevity, might be

considerably increased though, and a high variance raises willingness to pay for insurance by risk-averse individuals. The variance of expenses for individuals needing expensive care for an uncertain duration may also be correspondingly high. Thus, individuals needing care may be concerned about outliving their capacity to pay either for private care or for non-care consumption, at extreme realizations of “right-tail” risk, or about a substantially eroded bequest at lesser extremes.

Our research describes the functioning of INAs in the U.K. market and evaluates the potential demand for them in a theoretical model, with implications for the U.S. market. Our analysis has three objectives. The first objective is to acquaint U.S. readers with developments in the U.K. market, one that closely resembles the United States in terms of the wealth and health status of retired households, the limited role of the government (which only provides heavily means-tested long-term care), and the role of insurers facing difficulties in pricing and sustaining sales volumes for long-term care policies. INAs offer some advantages relative to conventional insurance products. With payments reflecting the purchaser's poor remaining life expectancy, an INA avoids many pitfalls of a traditional LTCI, including long time horizons that require forward-thinking individuals to plan far ahead and that increase vulnerability of policies to adverse selection, inflation, interest rate fluctuations, and unexpected LTC cost growth (Braun et al., 2019). Though denials of coverage are frequent for LTCI (Hendren, 2013; Braun et al., 2019), they appear to be nonexistent for INAs—because anyone purchasing an INA needs care and, from the insurance company perspective, the worse their health, the better the risk. Since the premium for an INA is paid in a lump sum, policies can't lapse, avoiding the individually costly and advantageously selected lapses pointed out in Friedberg et al. (2023). And, as payments are made over a relatively short period of time immediately following purchase, the insurer faces little interest-rate risk. Administrative costs may be lower, and the value may more closely resemble the comparatively high money's worth offered by other annuity products, rather than the much lower money's worth offered by LTCI products (Brown & Finkelstein, 2009). LTCI policies often cap the duration or dollar amount of benefits, so that purchasers retain the risk of living exceptionally long. In contrast, INA benefits are paid for life. Offsetting these practical advantages is a key theoretical drawback: In principle, traditional LTCI can offer greater insurance protection per dollar of premium than an INA, because the premiums of those who die without ever needing care can be reallocated to those needing care. It's an empirical question—which product is more effective at transferring risk?

Our second objective is to gauge the potential money's worth of INAs, relative to calculated values from the academic literature of the money's worth of traditional long-term care

policies and income annuities. *Money's worth* is defined as the expected present value of lifetime benefits as a percentage of the premium paid. Importantly, that definition doesn't capture the full value of the product to insured individuals. It can, however, offer a yardstick for evaluating whether an insurance market may be competitive, offering low costs of distributing its products, and insuring its policyholders. Given that individuals are required to consult financial advisors before purchase, policies are relatively homogeneous (like immediate annuities but unlike LTCI); and because several competitors exist in the market, it appears unlikely that insurers earn excess profits.

Money's worth of INAs may be expected to be somewhat lower than money's worth of income annuities, potentially reflecting greater risk and higher underwriting costs. For example, INAs may involve greater longevity risk than do income annuities. An insurer selling an immediate income annuity that starts at age 65 can be relatively certain that the purchaser will survive to age 66. The insurer faces greater uncertainty about survival to older ages, but old-age payments are subject to substantial time discounting. In contrast, INA providers not only face the cost of medical underwriting but also the risk that purchasers may live substantially longer than the insurer expects, whether due to underwriting errors, unexpected improvements in medical technology or information asymmetries. These factors can lead to an expensive risk pool, though the use of detailed medical questionnaires reduces the information asymmetry between insurer and insured that gives rise to adverse selection (in which individuals use private information about their risk when deciding whether to purchase insurance, as suggested by evidence in Finkelstein and Poterba, 2000). However, the insurer may suffer from an additional source of passive adverse selection, in that better-quality care may result in greater longevity. INA providers will be required to hold greater capital or make greater use of reinsurance than providers of traditional immediate annuities relative to their premium income, and this risk capital must be compensated. These factors give us reason to expect that money's worth may be lower (but not dramatically lower) for INAs than for immediate annuities, reflecting the greater risk that INA providers face and the resulting need to hold regulatory capital, along with the costs of medical underwriting.

Our third research objective is to explore potential demand for INAs, with implications for the U.S. market. To do this, we calculate willingness to pay (WTP) for INAs of risk-averse

households, based on an optimizing model of individuals facing the need for long-term care. For traditional LTCI, theoretical models point to low WTP over much of the wealth distribution, as a result of several factors, including government provision (Brown & Finkelstein, 2008), value of bequests (Lockwood 2018), and illiquidity of housing wealth (Friedberg et al., 2024). Yet even those explanations generally leave a shortfall between predicted and actual take-up, especially toward the upper end of the wealth distribution, and it's possible that INAs might help fill that gap.

Analysis of our optimization model shows that WTP for INAs is generally quite high among those with at least moderate wealth levels, for whom the implicit tax imposed by means-tested state benefits is relatively low. We focus on retired individuals who are unmarried (since they're much more likely to use paid formal care) and consider their optimal decision upon first needing care. At the lowest wealth level we consider, someone who has £200,000 upon first needing care is willing to pay £24,151 for the ability to purchase an INA that initially covers 50% of their care cost, if their risk aversion is moderate (when they have a coefficient of relative risk aversion of two). In comparison, someone in the same circumstances but with £300,000 is willing to pay £75,716, and someone with £1,000,000 is willing to pay £194,452. The reason for these high values is that, with a short time horizon, the degree of uncertainty of remaining lifetime care expenses (and thus the ability to maintain consumption and preserve a bequest) is quite high (unlike the case for someone who's healthy and whose potential care costs may arise far in the future). Individuals who purchase INAs can sustain higher levels of consumption in their remaining lifetime; and while their assets initially drop at purchase, asset levels (and hence potential bequests) decline more slowly afterward than they would otherwise.

In further results, we demonstrate that the tax benefits of purchasing an INA and directing payments to care providers have small effects on WTP. Lastly, we find that for individuals at the lower end of the wealth levels we consider, the optimal choice of purchasing an INA results in a moderate reduction (from 15.9% to 9.6%) in the likelihood of ending up in government-financed care. Higher-wealth individuals are extremely unlikely to use government care, whether or not they purchase INAs; and for them, the INA purchase affects their level of spending and bequests.

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