Reply to Mr. Redfoot's Comments on my Paper

I want to thank Mr. Redfoot for his thoughtful and creative comments, and comment a bit further for clarity and to hopefully create even higher levels of potential solutions for people facing the burdens of paying and dealing with long-term care.

To begin, Mr. Redfoot writes about the at-need annuity as a possibility for the future and that it "might be useful." In fact, my story was/is real, and many others have been similarly helped for several years now with such a product in the United States, and for even longer and more robustly in the United Kingdom.

He then suggests that the concept might be set up as long-term care insurance — I assume he means a reimbursement approach because the at-need annuity is indeed long-term care for a person already disabled. As to a reimbursement format, that was considered but it is subject to a lot of anti-selection. Moreover, the significant leverage comes into play fairly late in the game, so a reimbursement form can pretty much anticipate cost, and add-on purchases are always possible.

I agree that a reverse mortgage that considers a person's health would have appeal to the mortgager as well as the mortgagee, similar to allowing higher reverse mortgage limits for older home owners, but underwriting would be a major new element to be reckoned with by mortgagers. They might, though, just as in the case of at-need annuities, rely on outside underwriters and/or formulaic approaches. And I also agree that this might allow lower FHA insurance rates in such cases.

As to Medicaid, I agree the impoverishment route needs recasting, regardless of whether a person's holdings are home equity or more direct forms of savings and investments. It would seem that it is time to recognize that long-term care is a universal risk that few can afford (it can even impact the affluent) and that it is time for an expansion of Medicare to cover part of the cost from day one of being impaired. This would permit most people to pay their co-share of the costs for the duration of their lives, either from private funds or lower premium insurance analogous to MediGap, and only those that then run short of monies for co-pays would need to revert to a Medicaid type impoverished program.

Once again, I want to thank Mr. Redfoot for advancing forward-going discussion, though I hope the essence of the paper will open the door to greater consideration and use of at-need annuities already available.

In the latter regard, it should be noted that consideration of purchasing an at-need annuity has many subtleties, including focus, benefit levels, at-risk variations, and leverage with long-term care providers. Presenting them must be done artfully as well as in a financially astute manner.

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