Informal Discussion Transcript
Concurrent Session 4A: Longevity in the Public Eye

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ANDREW PETERSON: All right. Thanks to all our presenters and Sam as discussant. We have about 20 minutes left for questions from the audience, so I'd welcome any questions from you all. If not, I'll have a few myself, but love to have the audience interact. Sue?

SUE SAMES: Hi. Sue Sames, and I had a question about the research. Other surveys that I've seen, when people talk about what they think they're able to withstand and what they think their budgets are and when they think they're going to retire, they are way off. I think it's just human nature to underestimate things. What's your sense from the study and from the focus groups? Are retirees really that precise about it, or should we be even more concerned because we should reality-check some of these results?

ANNA RAPPAPORT: With respect to the risk surveys, the focus groups and other research that we do with Greenwald, we recognize that there are a lot of questions which will not be answered accurately. We don't ask them certain kinds of questions, because of the limits of self-reporting. We try to use Greenwald's experience to identify what not to ask. We know that there are errors in responses on many issues. When we discuss doing new surveys, there are things that people requested that we do not do because of these errors.

The SOA survey results seem to be compatible with a number of other surveys. Other work uses the Health and Retirement Study, a very extensive longitudinal survey of retirement. That gives us a source which offers more extensive data. We also look at the Survey of Consumer Finances. So we can put together our work with other sources that have related. Data quality is a potential problem in all of the surveys.

SUE SAMES: Thank you.

ANNA RAPPAPORT: I don't know if I answered it well.

SUE SAMES: Yeah, I think that that does cover it, and there was a comment—I can't remember if it was an official comment from one of the other sessions—but a comment that someone made that for older people, their confidence in their decisions and the soundness of their decisions are not necessarily in line. So if we're asking questions about how confident they are in things, that's not necessarily an indication that they should be that confident about it.

ANNA RAPPAPORT: Correct. We know that people tend to be overconfident about a lot of

things, and they tend to view themselves as above average. That has not surfaced in these surveys. However, in other surveys where, for example, if you ask people how many people on average are going to need long-term care and whether they're going to need long-term care, the respondents would seldom need long-term care. People see much more need in general but rarely a need for themselves. Or you ask people about their job performance, nearly everyone is above average. So yes, there are definitely challenges. But asking people and having these surveys and combining them with other sources is very valuable. Focus groups are very valuable, but there are limitations on them.

SUE SAMES: Thank you.

JOHN ROBINSON: John Robinson, Minnesota Department of Commerce. I've got nuggets from hearing from all of you, so I really want to thank you. This is my first time to this symposium, and I appreciate all that I've heard. Just a couple points, Anna, from your section, your presentation. We've had a pretty strong theme at this conference about planning and planning ahead for retirement, and yet one of the things that, one of the points you make is that shocks can derail any retirement plans that you had, and it's like, well, if you spend all this time planning, that's not necessarily good news. One of the things you said was that—there was a slide that had the number of shocks that people had experienced, and it looked like it went from 0 to 4-plus. And I wasn't sure, is that for—is this over the duration of retirement, or was this per year—what exact time frame?

ANNA RAPPAPORT: If I remember correctly, the question we asked them was over the last three years was about shocks.

ANDREW PETERSON: That was during retirement. The question's on the bottom.

ANNA RAPPAPORT: Oh, okay, it says during retirement.

JOHN ROBINSON: Okay, and so was the number of shocks correlated with the length of retirement? Would anyone happen to know?

ANNA RAPPAPORT: I'm pretty sure we didn't do that. That's a good question. I will check on that.

JOHN ROBINSON: Okay. The other thing I wanted to just comment briefly on: There was a

reference about people disappearing from surveys and focus groups, and if you can find that reference for me, Anna.

ANNA RAPPAPORT: Okay. When I say people disappearing from the survey pool, I mean that they are not accessible by whatever means the survey is conducted.

JOHN ROBINSON: Yes.

ANNA RAPPAPORT: Okay. Maybe a better way to say it is that they're not in the pool that you sample from.

JOHN ROBINSON: Right.

ANNA RAPPAPORT: Let's talk a little about the limitations of survey panels, because it's usually not like they're there and go away. If, say, we're using an Internet panel, if someone is not interacting with the computer and the panel, they're not going to be included. If they can't get to the focus group facility, even if they're called, they're not going to participate. So you need to recognize the limitations of your sampling method.

We did the first six risk surveys by phone. I believe you call the sampling technique random-digit dialing. Historically, that was a better way to get a random sample than using an Internet panel. But the environment changed, and telephone surveys got very expensive, and in addition, because of many people that are no longer using land lines, and other people hang up the phone. So the quality of random-digit dialing sampling surveys went down while the cost was going up and the quality of the internet panels also went up. So we decided it was a better decision for us to go to Internet panels. But we know that people who don't have computers are not part of Internet panels.

JOHN ROBINSON: Okay. I was going to suggest, and I don't know whether it's worth it to you—because, you know, whether the information is worth going the extra mile, as it were—but for every such person that has disappeared, as long as they are still alive, I was thinking there's probably someone who is a family member, a power of attorney that is taking care of that person, who could provide information.

ANNA RAPPAPORT: That's why we did the interviews of the caregivers and patched them back in. That was exactly the point of the interviews.

JOHN ROBINSON: Okay, thanks.

TOM GETZEN: Hi. Tom Getzen from Temple University, and first I want to thank you for this great topic and, I think, really good presentations. I have two questions, one for Anna and one for Sam, even though you're a discussant.

Anna, when you talked here about resilience, that struck me as important—particularly how it differed from some of the preconceptions that people had before you did your surveys. I wonder if, in the reports or in subsequent write-ups, it isn't as important to point out that much of this resilience, at least in part financially, can be attributed to the Medicare and Medicaid programs. Without those two programs, it would be much more difficult for people to meet these two risks. It may be our responsibility as researchers not just to point out the problems, but to point out a major policy success.

That brings me to my second question, for Sam, and I know it's unfair to question a discussant, but you made this comment that the ACA [Affordable Care Act]—"Obamacare"—addressed access but didn't address the cost of medical care, which Dan Bailey talked about. Yet there were a number of cost containment components within Obamacare. What we noted was that there was some strain on Medicare increases to be implemented by a sequester process and by the IPAD, the Independent Payment Advisory Board, which was later essentially rendered useless. As I look at that and I look at another major Medicare cost control mechanism, the SGR sustainable growth rate formula, which limited increases in physician payments to a relationship with GDP, I see real cost control policies being neutered by Congress. The incoming nominee for secretary of HHS [the U.S. Department of Health and Human Services] has a major health care legislative accomplishment: getting rid of that SGR constraint on physician payment. Given that history, doesn't it seem that those of us who are technicians may need to help the politicians before they ever really address these cost control issues?

ANNA RAPPAPORT: I'm going to answer the first question and let Sam go to the second question. We try to put context and perspective at the beginning of our reports. We recognize the value and importance of Social Security and the value of public programs. We understand that they make a huge difference. However, the project oversight group was pretty surprised in both

2013 and in 2015. Retirees who had much less than called for by the traditional norms for planning were pretty satisfied. This included some who weren't anywhere close to the traditional norms. One of the implications of the study is a question as to whether the traditional norms and methodology that are used for planning really make sense, and whether there need to be some adjustments to them.

SAM GUTTERMAN: I hope I'm not getting too much into the politics of this, but I was involved in the—if you want to call it—the Hillarycare discussions in the middle 1990s, and there [were] a lot of discussions in terms of gatekeepers, the R-word, rationing. And I didn't hear any of that very much in the discussions of the ACA. So that's—you're right, there is a lot of really good pilot projects in the ACA. You don't hear about that, and I know I've had many discussions in terms of the relationship between access, cost, quality, and I think more recently choice was added, but those three items. I mean, how can you get at all three of those at the same time if you push on two of them? If you increase access, you have to increase costs, because—. And then if you increase access, you increase the power of the providers, and therefore you have pressure on costs. It's just a spiral, and that might have been what Daniel was referring to, at least in part, in terms of this spiral. Health care costs spiral. I just don't see enough discussion in the U.S. regarding either how to deal with health care costs. I don't have an answer, but there's insufficient amount, and I think that's the reason why Obamacare is really as unpopular as it is, because people's costs are higher, their premiums are higher, or deductibles are higher. Therefore, all they see is the cost implications to them, and it's really a really hard nut to crack.

ANNA RAPPAPORT: Sam, you and I have both had some experience in the last year with physical therapy. My experience is that it seems like physical therapy professionals know the maximum amount of service that's covered. Regardless of where you are when you start off with a prescription, they want to get you up to the maximum covered by insurance. Then they don't want to continue.

ANDREW PETERSON: Dan, anything you want to add on this topic?

DANIEL BAILEY: Just one very brief comment is the first question: Was it really difficult to identify income for the retirees and elderly? I think it's kind of a squishy item.

ANNA RAPPAPORT: There's a recognized major income identification problem. Money that's withdrawn from defined-contribution plans—whether they be IRAs, i.e., individual retirement accounts, which are tax-protected individual plans, or 401(k)s, i.e., the employer plans—individual account withdrawals are not counted in income in any of the income statistics. This problem is well identified.

DANIEL BAILEY: Just to the issue of cost, there were some ACO [accountable care organization] programs under the ACA, Medicare shared-savings programs, for example, that try to control costs, but clearly access was the problem. If you think of it this way, there are roughly 300 million people in the United States, and 50 million people got—310 [million], say, 50 million got the coverage through Medicare, 60 million through Medicaid. That left 200 [million] people who were getting coverage in the commercial sector. Of them, 50 million people were without health coverage—roughly 25 percent of that sector. So there was an access issue.

I worked for the companies that struggled with increasing health costs, and their solution was to spend money on data and better systems to find ways to enroll the members who had the greatest likelihood of being profitable members, and finding the groups that—and again, most of its group coverage—the groups that would be the most expensive. Some states reacted. As a chief actuary in New York, and the state had community rating for large group HMOs, and over a period of time, a lot of the better employer plans ended up going to self-funding, and about half of the health care in the United States is funded through self-funding. So clearly, cost is an enormous problem. It was an enormous problem 25 years ago, back when it cost $100 per member per month and pharmacy was 5 percent of that overall cost. I think the government's tried to work on it, but clearly access was the bigger issue.

The ACA followed suit with what was done in Massachusetts, and in Massachusetts, clearly, they couldn't solve the cost problem initially, but they wanted to get people covered. It doesn't happen overnight. It may take a number of years, but I do think the repeal of SGR, as we mentioned, was a good thing insofar as previously the unit cost of Medicare services was locked down, but doctors could perform more and more and more services, and that was never tracked, and that is the intensity of service that we talk about, and that's why we saw such large increases

in the overall cost of Medicare and Medicare Advantage, which I do. For like five years, we had this "doc fix" that you've heard about. First it was 5 percent; then it went to 10 percent. I don't recall now; it was somewhere around 25%. So when we priced the bids, we had to factor in the probability of whether the doc fix would actually occur. So health cost is a big issue. We haven't tackled it yet, and I hope that I've made you think about it a little bit more in the sense that it's really only going to get worse.

STEVE GOSS: Because all the discussion is about health care costs, I just want to suggest first of all to disentangle the ACA, the private-sector side, the exchanges from what was done from Medicare—leaving the exchanges aside for the moment, on the Medicare side. One of the biggest factors was the multifactor productivity restriction on the growth in hospital payments, and that was really the biggest driver in bringing down back in 2010 the projected rate of growth in Medicare costs at that time. SGR was a big deal, too, but SGR reductions, which were supposed to happen every year, were always delayed another year, another year, until they got to be so large that they made no sense, and so they were completely eliminated, so it never really had any direct impact. Now, the question is on the multifactor productivity, will that really be in as a constraint going forward, or is that going to go away with the Affordable Care Act?

But here's really my basic question. My basic question is going back to Sam's point. I was actually at that initial Medicare technical panel where there was discussion about GDP plus 1—that is, to have the rate of growth in health care costs grow at the rate of growth of overall GDP plus 1 percent. It was observed at that very meeting—and I don't know if you recall this, Sam—that that was a completely unsustainable assumption, because that would be a concave-up curve for health costs. After about a hundred years, you'd hit 100 percent of GDP, and it's hard to sustain it, especially after that. So it was suggested at the time to Mike Chernew and discussed with him, and I think with the whole panel in the session, why not have it be a non-health GDP growth plus 1? That would be an S curve; that could actually happen. So I'm wondering—I mean, I've heard other stories, but Sam, what your recollection is of why the panel didn't come up with that recommendation, because unfortunately the trustees were then stuck with this GDP-plus-1 thing for several years, which we all knew made absolutely no sense. But the real part of

the question is for all of you, especially the gentleman on your right side of the panel, what do you think is going to be the growth rate of GDP, and where are we going to top out as a percentage of GDP for health expenditures in the advanced economies? We're at 18 now; are we going to stop at 20, 25, 30, or are we going to go to 100?

DANIEL BAILEY: One of the things I talk about in the paper, Steve, is just—I heard a discussion at an SOA meeting recently, and someone from I think it was CMS [the Centers for Medicare and Medicaid Services] or Office of the Actuary said they were certain that it couldn't go above 100. I'll try to be polite, but I suppose it could theoretically go above 100 in the distant future if we just push that cost off on our kids. And that's where the intergenerational-equity issue comes in, but there are certainly economic constraints. If you remember that SOA meeting where the head of the British magazine *The Economist* spoke and talked about the U.S. economy. The one question I wanted to ask was, To what extent do the higher health care costs in the United States and the fact that the employers finance it slow down, act as a drag on the U.S. economy? Because those are some of the issues that will prevent the NHE [national health expenditures] as a percent of GDP from going too much higher.

I don't know for certain if it's necessarily as bad. I think 20 years ago, I thought it was a bad thing that the NHE was such a high percent of GDP in the United States, but it has to do with people's wants, and I have the sense, talking to people around the world, that people feel they get excellent care here for very serious illness. I remember having this conversation with a health actuary in Germany 20 years ago, who explained that one of his employees had a heart condition and went to the state hospital where everything would be paid for in Germany and was told there that his probability of surviving would be 20 percent, but if he went to this hospital in Houston, his probability of surviving would be 80 percent. And so, long story short, he made a deal with them, they gave him *x* dollars. He ended up having to pay $40,000 out of pocket back in, like, 1990, and that was the cost of his life. And those are the differences that I think go into this health care system that aren't necessarily recognized when we look at NHE as a percent of GDP.

ANDREW PETERSON: All right, we're a little over time. So, Sam, you want to make a final comment?

SAM GUTTERMAN: Just a very brief response to Steve. I'm not sure which technical panel you're referring to, but the 1990–91 panel had a lot of modeling done in terms of what that trajectory would be for excess health care costs, and the CMS actuaries did a lot of modeling based on input, and the results ranged from, I think it was, 29 to 59 percent of GDP that would be devoted to health care costs. And I think we just threw up our hands and said, "Well yeah, but okay, how much is going to be for education?" Right. We've really got to drive the fertility rates down, and we've really got to sacrifice our national security, and you ask the question of—. Well, first of all, you can't model that in isolation. Anyway, I think the GDP plus 1 was maybe thought in many cases as to be a low estimate. That's just food for thought.