

Discussant Comments

Concurrent Session 4A: Longevity in the Public Eye

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SAM GUTTERMAN: My task is to discuss the papers by Daniel and by Anna, but before I begin, I'd like to make one comment on the first presentation, which I found very interesting. I don't like the use of a single adequacy measure that is supposed to relate to an average person, such as the 70 percent adequacy noted. To provide useful information, adequacy values relating to a range, such as at quartile intervals, are needed, because you want to look at replacement ratios for the well-off, for something like the average, and the not-so-well-off.

The first paper that I reviewed is the one by Daniel Bailey. My first observation after reading it was that the indicated scope of the paper was daunting. To attempt to cover domestic and international health care and retirement security in less than 30 pages is a herculean task. I would approach it with a lot of trepidation. In the U.S., health care costs now constitute more than a sixth of national GDP, [it] should be a fifth within a decade, and the author projected it to be more than a fourth in the time horizon studied. This is serious and a concern.

The current political discussion, as an aside, is debating the future of ACA [Affordable Care Act], better known as Obamacare, in the United States. Unfortunately, Obamacare primarily addressed access and is basically health insurance reform, rather than constituting comprehensive health care reform. The current discussion doesn't address the fundamental issue, which is health care costs. I don't take sides, but I would really appreciate politicians to address the underlying issue, which is health care costs, which is the primary scope or the direction of the paper. In fact, the statement made in the paper is appropriate. Increased longevity is interconnected with increased health care costs in several ways, going even beyond what the author has presented.

One related area that wasn't discussed is one that is commonly raised: A large percent of health care costs are spent in the last year of life. I've read in many papers that the very high cost just prior to death is an important reason for high overall health care costs. Because of increased longevity, the average age at death has been delayed in many cases, which has several implications. One is that timing of intense health care is deferred. That means health care inflation is somewhat dampened, but when you die at an older age, typically the length of the final health condition is reduced. That is, in many cases if you die in your nineties, rather than in your seventies, the time from the onset of the final adverse health condition that results in death is shorter, and therefore, health costs may be reduced. This—over the long term, this may have a favorable effect on health

care costs; on the other hand, it could increase long-term care services and support costs, both informal and formal caregiving. This latter issue is, as Anna mentioned, an area for which insufficient societal attention has been given.

Daniel's paper has several lists regarding components of health care cost inflation; on the slide, I listed the major components. I'm not going to go through them now; most of them are common sense. Usually, health care cost inflation is described as consisting of the general increase in cost of living and excess health inflation. Sometimes the latter is grouped under the topic of the effect of technology. However, it also covers such factors as an increase in utilization and intensity, the changes in mix of types of health care costs and its delivery.

There are also offsetting factors, as not everything contributes to increased health care costs. For example, the use of a primary physician as a gatekeeper, who can place increased emphasis on prevention and less expensive and more quality-of-life-driven end-of-life-care. The author wisely notes that many of these factors are double-sided and complex. Many of these factors both can increase costs and have at least the possibility of decreasing costs in other ways. For example, health care productivity and technology have a positive and negative aspect, enhancing quality while decreasing costs in some cases.

The net result is that an increasing percentage of GDP devoted to health care is almost a universal trend in the world, not only in the U.S. I typically think about health care costs in terms of the traditional categories of utilization, intensity, and price, the latter of which is a factor of general inflation, the effect of demographic factors, which the author alluded to as increases in population and in aging.

Demand factors include an increase in mandates, but I would add that human behavior is a significant factor. The sheer existence of a health insurance scheme will drive up utilization. That was first shown by Kenneth Arrow 50 years ago; it is still true. The existence of a comprehensive health care system will increase utilization. For example, when I collected my Medicare and Medicare supplement benefits, I found out my prescribed physical therapy didn't cost me anything. Would I make use of the two physical-therapy sessions that I felt I needed, or was I going to go to take advantage of the 18 sessions that I was allowed under Medicare and my Medicare supplement? An actuary has to recognize that some of those influences on human behavior are

significant.

Access and demand-driven factors: If more people utilize services, the total cost of those services will tend to increase. Then there are supply-driven factors, such as the relative amount of investment in pharmaceutical development. Having only a few oligopolistic providers typically drives up prices. Market control by providers and their lack of productivity improvement are also key supply-related factors. Then there are also a series of what may be quality-enhancing factors. Requiring approval of a gatekeeper can help ensure true need for health care delivery, but it can also be a costly step. The increased use of expensive specialists, which although their involvement can increase quality of care, can also increase costs. Then there are unnecessary defensive practice to avoid malpractice suits and personalized medicine, both of which can enhance both quality and cost.

The other day, I was talking with a physician who told me that in the U.S., digitized information can theoretically provide significant research information. But unfortunately, it can also be accompanied by significant additional cost. In many situations, someone follows him to take notes, enters the data into a computer or tablet; that note taker adds cost. That person has to have sufficient medical knowledge to enter the data correctly and can introduce errors, but at the same time may increase the doctor's efficiency. In many cases, the doctor may have to review the material entered to ensure quality data anyway. Ten years ago, the doctor might have had to enter the data at home in the evening. In sum, each doctor may have to add one or two staff members who aren't particularly knowledgeable about medical care—a more costly bureaucratic system with relatively limited professional time saved.

Regarding the projection of excess health care costs, one formulation is to project these based on a function of the increase in GDP. This was discussed in the 2000 technical panel for Medicare. We came up with the formulation of future annual excess health care cost increase—over and above general inflation, after the next 20 years—would be at a rate of the expected increase in GDP plus 1 percent, which the Medicare trustees accepted and used. This rate was at the time a lot lower than what had recently been experienced. In 2006, the trustees modified this assumption somewhat to use an average of GDP plus 1 percent over the projection period, 75 years, graded from where we are at now to 0 percent in 75 years. The 2010 technical panel modified

the 2006 approach somewhat in their projection of Part A—hospital coverage—to reflect Obamacare-driven productivity improvements. So the trustees subsequently decreased their assumption. In 2012, the trustees developed a more economically sophisticated approach, referred to as the factors contributing to growth approach. In it, the trustees are now projecting GDP minus 0.2 percent, rather than their previous GDP plus 1 percent. This means that the trustees' Medicare projections in the trustees' report—287 pages—are somewhat more optimistic than those made earlier.

Overall, I thought this paper needed to be enhanced in certain areas, because its objective was so broad that it would be difficult to say otherwise.

Now, to Anna's paper. Overall, I found it an excellent presentation of the significant financial issues and risks that pre-retirees and retirees face. In particular, its back section includes focus group comments. Having managed a marketing research area for a decade, I have found that this source of information is an underutilized source of useful information. Actuaries should become more knowledgeable about how to run focus groups and how to obtain optimal value from them.

Household income data suggests to me that replacement rates and needs analysis should be conducted for several income or wealth categories. Anna's paper properly points out that the use of averages can be misleading. As I commented earlier about replacement or adequacy rates, you have to assess the results based on a range of circumstances/situations, whether it be based on socioeconomic demographics, income levels or financial developments, to gain useful insight into this type of information. It addresses the risks that would face individuals. In addition, the observations and insights regarding unexpected costs provide excellent insights. Having looked back at my own personal experience in the last month and a half, I can find significant examples of home repairs and dental costs that can be significant budget-busting costs and demands on a person's or couple's budget.

I have several additional observations on several of the interesting points made, of which there were many the paper said, and which the first presentation also alluded to. Fifty-two percent of American retirees own no investments. Typically, actuarial discussions relate to the market for insurance companies or pension plans—often those in the upper income or wealth levels—and we

forget about those 52 percent. What options will these people have? I'll provide further comments on them shortly.

As indicated in Anna's slides, in Exhibit 4 of the paper, about half of those age 70 and older indicated they could easily afford to pay a thousand dollars of unexpected expenses. However, in the paper's Exhibit 3, which she didn't show, only 30 percent of adults of all ages responded in that way. This provides a really important message, at least in the United States, that Social Security income represents the primary source of income for many retirees and those who are disabled. In fact, even despite this, many of the elderly are now in better financial shape than many younger-aged individuals. This suggests to me financially resilient. In general, they can withstand most financial shocks that will face them, although certainly not all of them. No matter what, if most people are faced with multiple financial shocks, they will likely experience significant problems. Maybe we should spend more time studying the effect of these shocks on the "younger" population, because this is as significant and in many cases represents an even more significant issue than for the average retiree.

The paper indicated that there was only a 29 percent chance that a median household will have a positive amount of wealth at death. This is another frightening statistic, because as the baby boomers age, this probability may decline still further. In other words, there will be fewer households with net assets at death. This is a concern, even though as mentioned, retirees tend to be quite resilient. It's sort of running on a pay-as-you-go system. As a result, the provision of long-term care will be even a more significant issue in the future.

When I served on a Social Security/Medicare technical panel in 1990, I first looked at the statistics relating to the demographic and financial life cycle implications of the baby boom population in the U.S. It was clear even then that our society will be subject to severe stress when this large population group begins to hit age 85 just prior to 2035. We concluded that this period will begin a financially frightening period. Now it's 27 years later, the demographic projections were right on, and the situation remains frightening. Same date, same year, easily predicted, but we have done little to prepare for it.

My last observation relates to something that Anna briefly mentioned: the importance of management of housing assets. If you remember, I noted that 52 percent, or about half of the

people, don't have any investments. Well, I believe that's nonhousing investments. According to the U.S. Census, overall home ownership (including partially owned) is 63.5 percent in the third quarter of 2016. This is down from a peak of more than 69 percent in 2005. Now, this decrease may in part be a result of the financial crisis of 2007-plus. This should be followed for its implications regarding personal wealth and quality of life in the future.

Looking at this statistic by age group, 79 percent of those at least age 65, down to 58 percent at ages in the 30s and 40s. Although this percent looks good for retirees, it doesn't look as great in looking to the future. So this represents another area of caution, especially for future retirees who may be financing their retirement on a pay-as-you-go basis without as much to fall back on as the prior generation. What happens when those people who don't have a home as an asset to fall back on when needed?

If you look at the statistics by racial/ethnic group, you can see that 77.8 percent of households with greater than median income own their home. Less than or about half with less than median income. If you look at not just the averages that are the top numbers on the slide, but if you look it focusing on income distribution, there will be a further challenge for those with little or no assets. This suggests we need further research addressing the lower or middle classes at all ages. Homes of these individuals may have lower market values, need more house repairs, because the elderly may have been in their homes for a long time, therefore needing more repairs, especially since those with lower income may have more debt in the first place.

In conclusion, I would have liked to see more information regarding statistics between those who are single versus those who are married. In addition, I noted that there is a significant spread between actual and expected incidence of working at older ages. Actuaries have projected that, due to increased longevity, more of those who expected to become early retirees are going to have to work. But I expected that a large driver of that difference in retirement is due to health deterioration, but it will be worthwhile to confirm the reasons for this difference. I'd also like to see in a future study separate categories for those who work full-time, part-time, or volunteer.