Continuous
Mortality Investigation
Institute and Faculty of Actuaries

CMI update on longevity modelling and high age mortality

Presentation to the Life Conference 2016

Tim Gordon
Chair of the CMI Mortality Projections Committee

Andrew Gaches
CMI High Age Mortality Working Party

4 November 2016

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The CMI

Tim Gordon
Chair of the CMI

CMI

CMI

- Wholly owned by Institute and Faculty of Actuaries
- Independent executive and management

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Mission

> *To produce high-quality impartial analysis, standard tables and models of mortality and morbidity for long-term insurance products and pension scheme liabilities on behalf of subscribers and, in doing so, to further actuarial understanding.*

Our vision is to be regarded across the world as setting the benchmark for the quality, depth and breadth of analysis of industry-wide insurance company and pension scheme experience studies

Recent and ongoing work

- Graduation and Modelling Working Party report March 2015 (WP77)
  - Update graduation toolset – no more GM(r,s) / include co-graduation
  - *Software freely available – 'CMI Graduation Software v0.2 (beta)'*
- Investigations
  - Annuities – 08 tables finalised June 2015 (WP81)
  - Assurances – proposed 08 tables: accelerated critical illness released in May 2016 (WP89) and term assurance due September 2016
  - SAPS – S3 targeted for release in 2019
- Projections
  - Proposed model released June/August 2016 (WP90/WP91)
  - *Model and calibration software are freely available*
- High Age Mortality Working Party initial report October 2015 (WP85)

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Recent mortality and the proposed CMI Projection Model

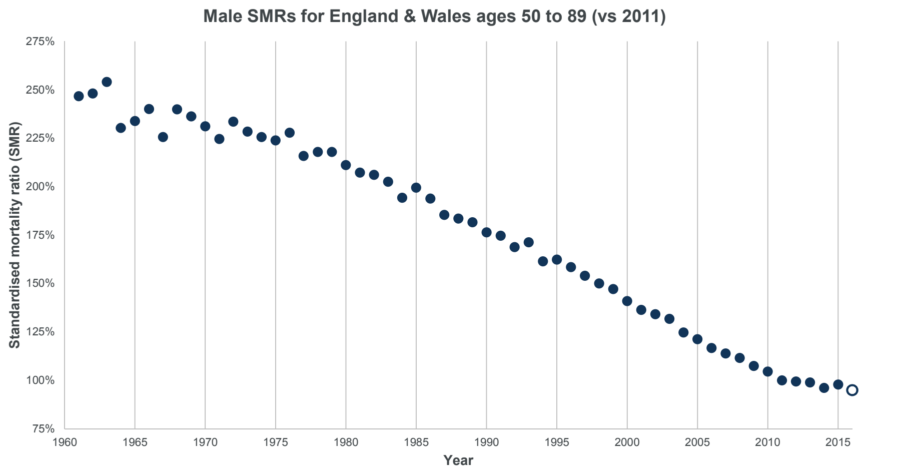
Tim Gordon
Chair of the CMI Mortality Projections Committee

1. Recent mortality in England & Wales

Analysing past mortality using SMRs

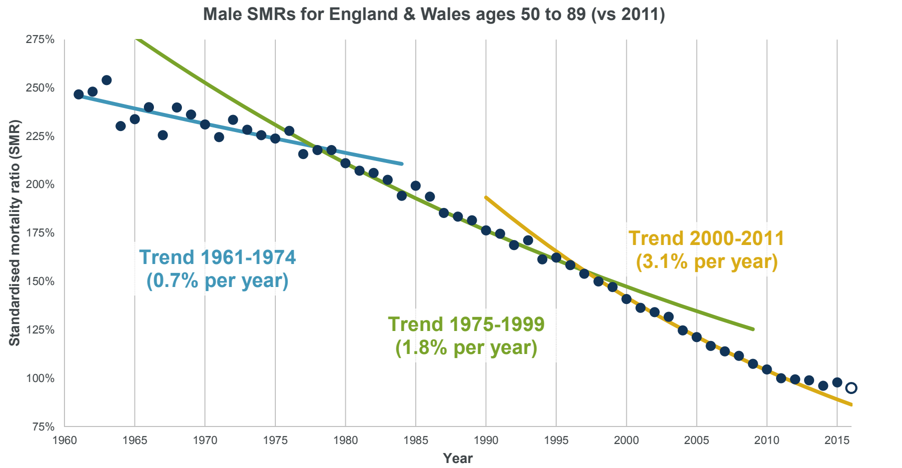
- Standardised mortality ratio (SMR): $$\frac{\sum_{x=50}^{89}\left\{(\text{deaths})_{xt} \times \frac{(\text{exposure})_{x,2011}}{(\text{exposure})_{xt}}\right\}}{\sum_{x=50}^{89}(\text{deaths})_{x,2011}}$$
- Measure of 'average mortality' – useful to understand broad trend
- Use ages 50 to 89 – ONS data over age 90 is less reliable
- Comparable year to year – removes population change effects
- Not comparable males vs females – female population is older
- Trend lines chosen by reference to males – deliberately suggestive
- (2016 point is calculated by Aon Hewitt as 'neutral' – don't rely on this)

Male SMR



Calculations by Aon Hewitt using ONS data

Male SMR



Calculations by Aon Hewitt using ONS data

Observation

Apart from very recently – 2012 onwards – relying solely on predictive power would likely select a model that *always* predicted higher future mortality improvements than the past

Renormalised SMR

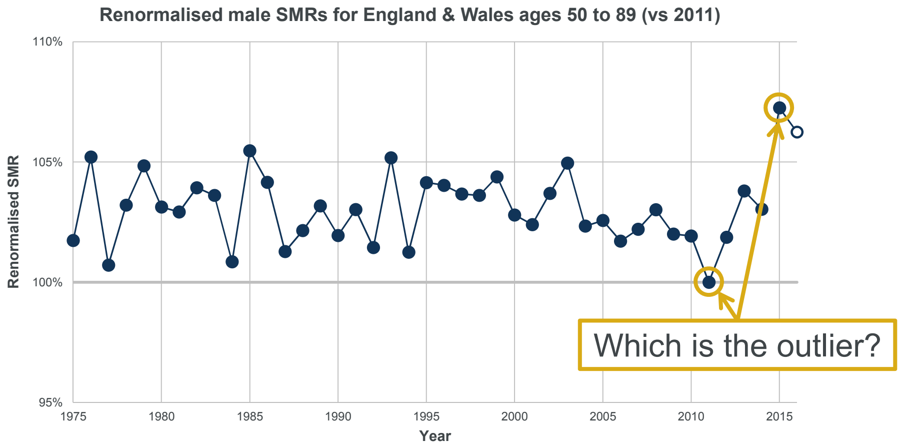
- What about the cohort effect?
- Renormalised SMR:

$$\frac{\sum_{x=50}^{89}\left\{(\text{deaths})_{xt} \times \frac{(\text{exposure})_{x,2011} \times m_{x,2011}}{(\text{exposure})_{xt} \times m_{xt}}\right\}}{\sum_{x=50}^{89}(\text{deaths})_{x,2011}}$$

where m_{xt} is the mortality rate in the proposed CMI model calibrated to end 2015 (or any other slowly varying reasonable model)

- Residual is change in 'average annual mortality' vs 'average' expected deaths on chosen mortality – useful to understand deviation from trend
- (2016 point is calculated by Aon Hewitt as 'neutral' – don't rely on this)

Male SMR – renormalised



Calculations by Aon Hewitt using ONS data and the proposed CMI projection model calibrated to data to end 2015

2. Proposed CMI Projection Model

Consultation process

Date	Item
22 June 2016	Working Paper 90 published
29 June 2016	Edinburgh consultation meeting
11 July 2016	London consultation meeting
31 August 2016	Working Paper 91 published and model software released
30 September 2016	Responses to consultation due
November 2016	**Working paper summarising responses and revisions**
March 2017	Publish CMI_2016 (based on data to 31 December 2016)

Approach

This is an *evolution* of the model

This is *not the answer* – it's a flexible tool that's been made reasonable by

- building on the existing model, and
- exposure to actuarial review

This is *not a predictive model*

- Wide age range mitigates against a *simple* predictive model
- We're short on test data (by the nature of mortality improvement)

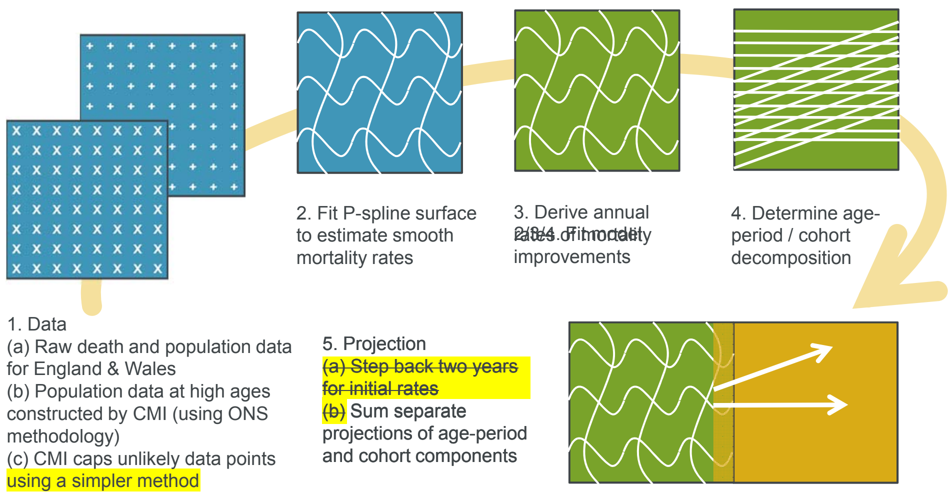
We have simplified where possible

- One step calibration vs smooth *plus* APC improvement split
- One software environment vs Excel/VBA *plus* R
- One smoothing step vs smooth *plus* step back

We have focussed on ease of use

- Allow users to incorporate views e.g. short term responsiveness
- Real time calibration

What's changed – big picture



3. Proposed CMI Projection Model – initial improvements

Model log m_{xt}

- We model (logarithm of central) mortality rate directly:

$$\log m_{xt} = \alpha_x + \beta_x(t - \bar{t}) + \kappa_t + \gamma_{t-x}$$

  where:
  - x and t are age and calendar year
  - α_x and β_x are vectors of parameters indexed by age
  - κ_t is a vector of parameters indexed by calendar year (period)
  - γ_{t-x} is a vector of parameters indexed by birth year (cohort)
  - $\bar{t}$ is the midpoint of the period used to calibrate the model
- The natural measure of mortality improvement is $\log m_{xt}$-based, *not* q_{xt}:

$$MI_{xt} = -\left(\log m_{xt} - \log m_{x,t-1}\right)$$

Model log m_{xt}

- Definition of the model:

$$\log m_{xt} = \alpha_x + \beta_x(t - \bar{t}) + \kappa_t + \gamma_{t-x}$$

- Mortality improvement (reduction in $\log m_{xt}$) is:

$$MI_{xt} = \underbrace{-\beta_x}_{\text{Age}} + \underbrace{(\kappa_{t-1} - \kappa_t)}_{\text{Period}} + \underbrace{(\gamma_{t-x-1} - \gamma_{t-x})}_{\text{Cohort}}$$

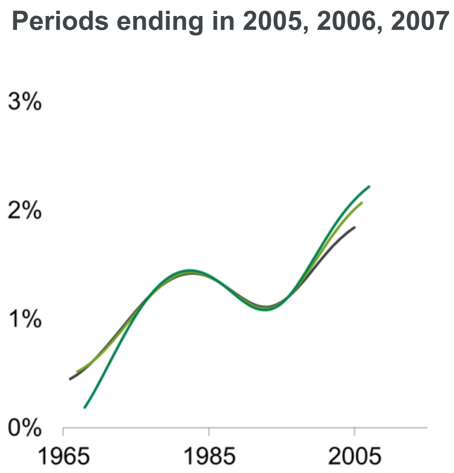
- Gives us mortality rates / improvements and APC split *in one step*
- Fit by minimising
  - deviance (aka $-2 \times \log \text{likehood}$) for goodness-of-fit, plus
  - multiples of squared 3rd differences of α_x, β_x and γ_{t-x}, plus
  - multiple of squared 2nd differences of κ_t – tends to flatten MI_{xt},

  and applying identifiability – sounds innocuous but this step matters

4. Proposed CMI Projection Model – projection

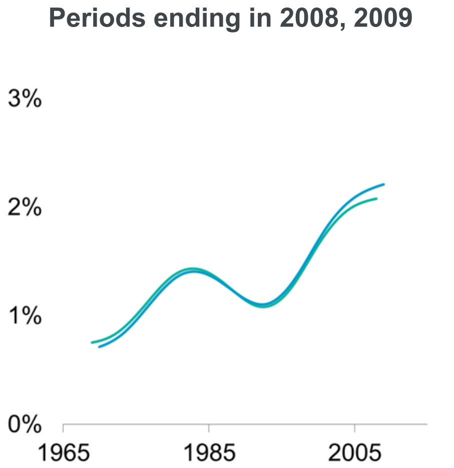
Apparent direction of travel

Chart shows period components of mortality improvements from the (old) p-spline model fitted to male data for various 41-year periods



Apparent direction of travel

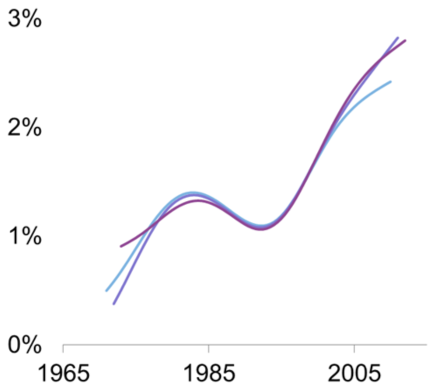
Chart shows period components of mortality improvements from the (old) p-spline model fitted to male data for various 41-year periods



Apparent direction of travel

Chart shows period components of mortality improvements from the (old) p-spline model fitted to male data for various 41-year periods

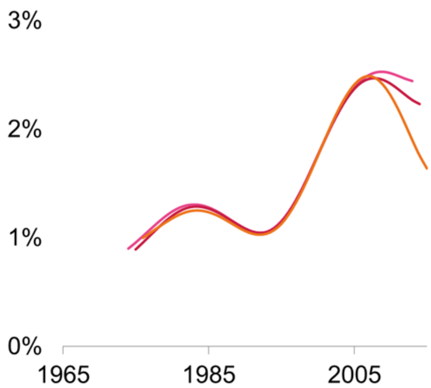
Periods ending in 2010, 2011, 2012



Apparent direction of travel

Chart shows period components of mortality improvements from the (old) p-spline model fitted to male data for various 41-year periods

Periods ending in 2013, 2014, 2015



Apparent direction of travel

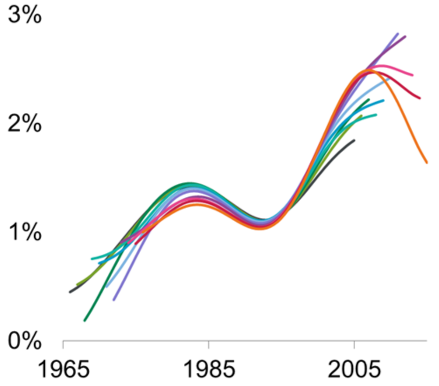
Lesson:

Apparent direction of travel from period component is uncertain

CMI proposed approach

- Core assumption to remain as nil allowance for direction of travel
- Give users option to specify direction of travel
- Model to output direction of travel

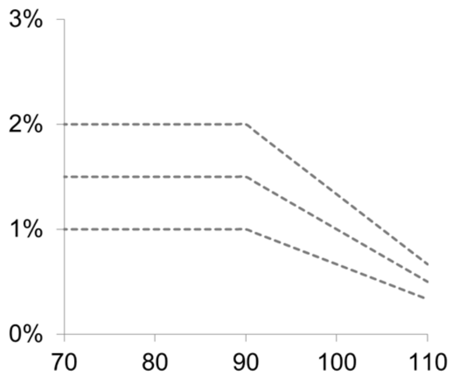
Periods ending in 2005 to 2015



Current shape of long-term rate (LTR)

- Under the current Core assumption, the LTR applies up to age 90, and tapers to zero at 120

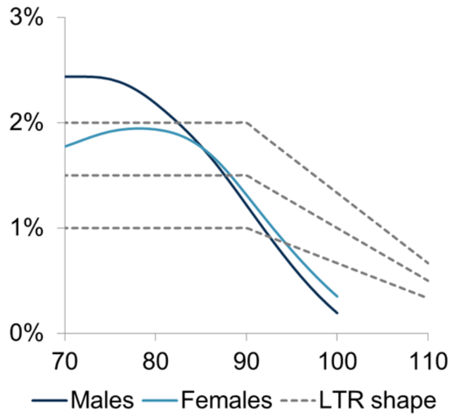
Shape of LTR by age



Current shape of long-term rate (LTR)

- Under the current Core assumption, the LTR applies up to age 90, and tapers to zero at 120
- This implies a sharp rise in improvements for centenarians in future, which is out of line with past experience

Mortality improvements by age
APCI age component and LTR shapes



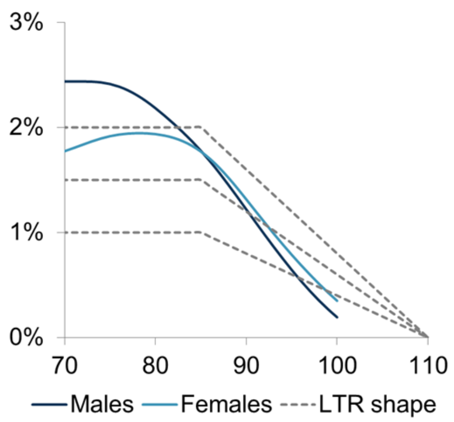
Proposed shape of long-term rate (LTR)

- We propose that the LTR applies up to age **85**, and tapers to zero at age **110**
- This implies a more modest rise in improvements for centenarians

Note

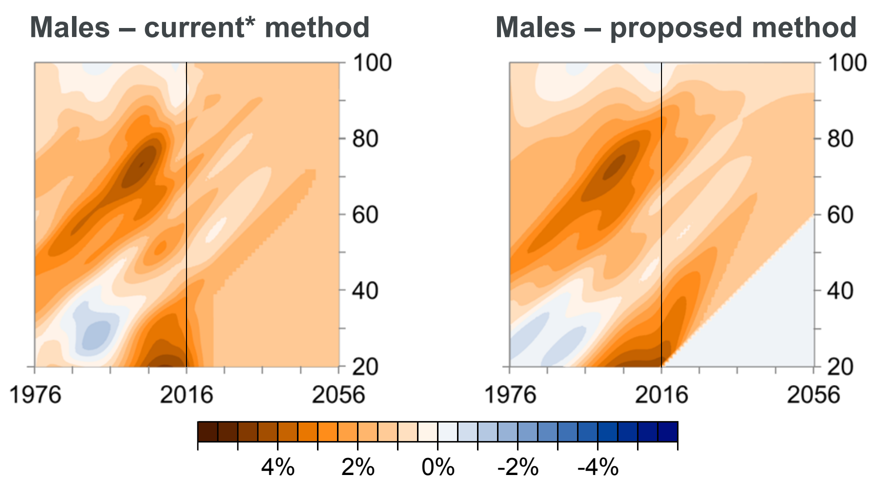
- **The objective is best estimate**
- **This still allows for higher improvements at later ages**

Mortality improvements by age
APCI age component and LTR shapes



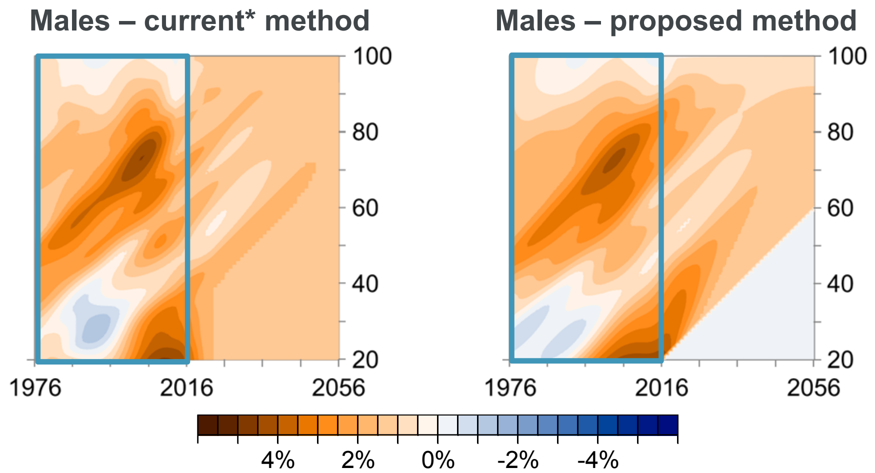
5. Proposed CMI Projection Model – impact

Comparison of male mortality improvements



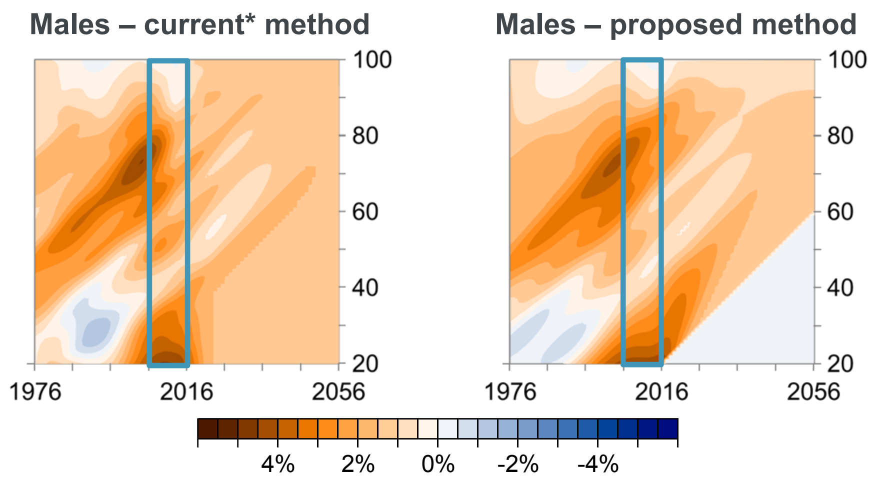
*Note that "current" is not the same as CMI_2015

1. Historical fit is broadly similar



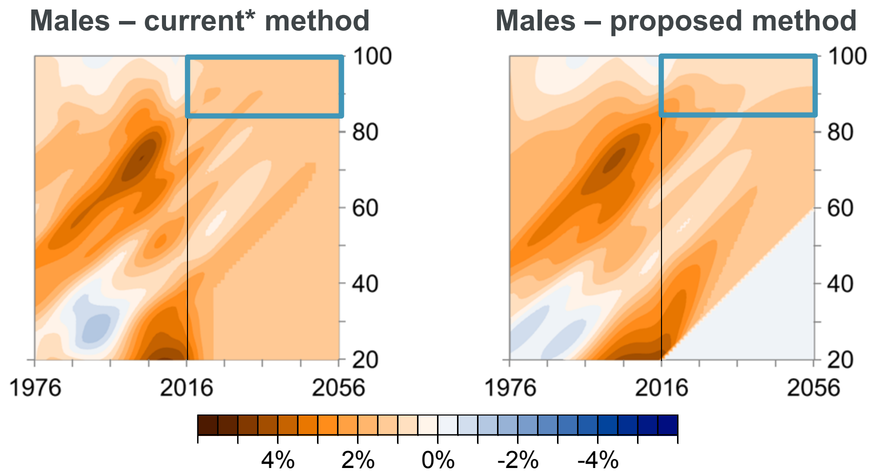
*Note that “current” is not the same as CMI_2015

2. Recent improvements are higher



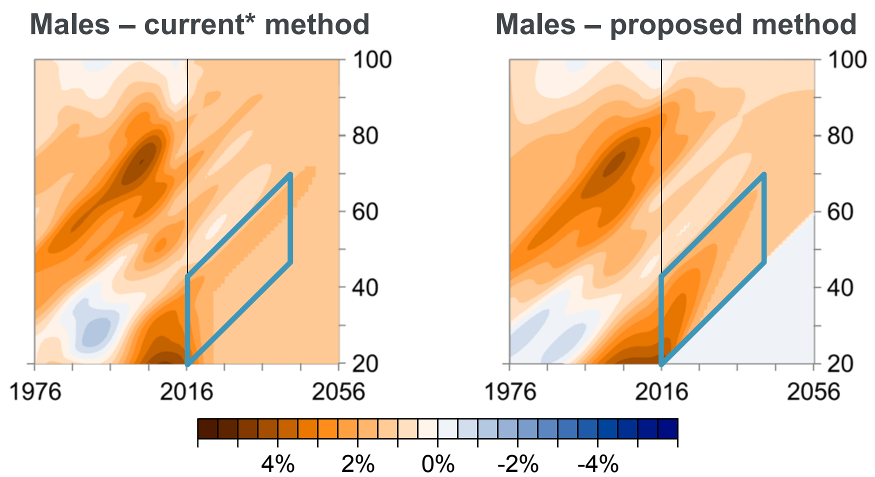
*Note that “current” is not the same as CMI_2015

3. Lower long-term old-age improvements



*Note that “current” is not the same as CMI_2015

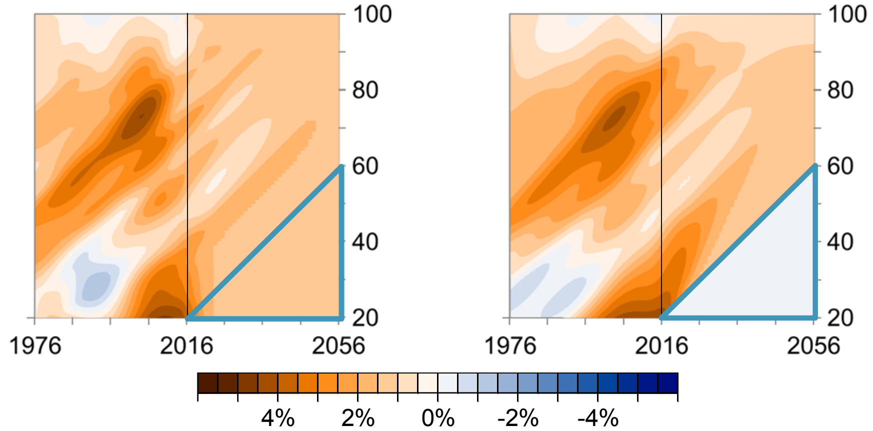
4. Young-age cohort improvements



*Note that “current” is not the same as CMI_2015

5. ‘New’ cohorts not projected

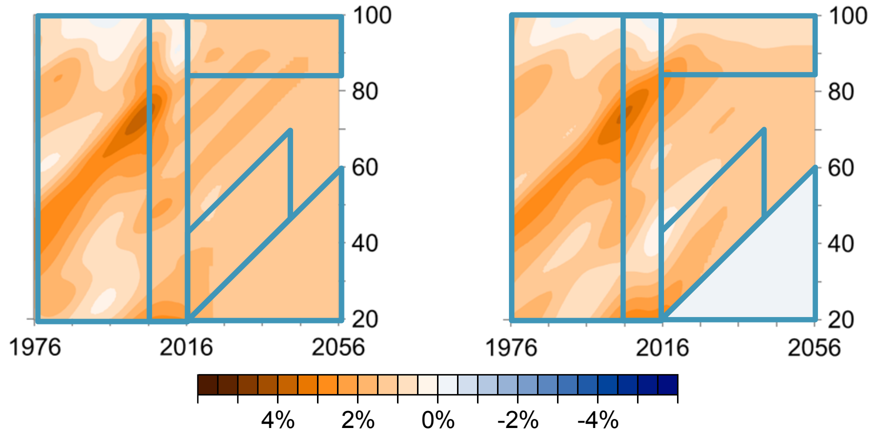
Males – current* method **Males – proposed method**



*Note that “current” is not the same as CMI_2015

Comparison of female improvements

Females – current* method **Females – proposed method**



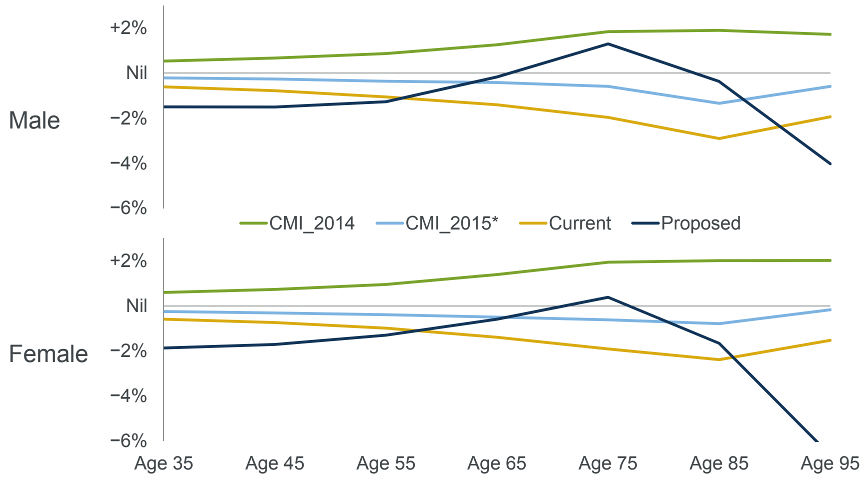
*Note that “current” is not the same as CMI_2015

Life expectancy at end 2015 vs CMI_2015

Sex	Method	Age 35	Age 45	Age 55	Age 65	Age 75	Age 85	Age 95
Male	CMI_2014	+0.53%	+0.67%	+0.87%	+1.26%	+1.84%	+1.90%	+1.72%
	CMI_2015*	−0.21%	−0.26%	−0.36%	−0.42%	−0.59%	−1.34%	−0.59%
	Current	−0.61%	−0.78%	−1.06%	−1.41%	−1.97%	−2.91%	−1.94%
	Proposed	−1.50%	−1.51%	−1.27%	−0.17%	+1.29%	−0.38%	−4.03%
Female	CMI_2014	+0.60%	+0.73%	+0.95%	+1.39%	+1.94%	+2.01%	+2.02%
	CMI_2015*	−0.25%	−0.31%	−0.39%	−0.50%	−0.62%	−0.79%	−0.17%
	Current	−0.59%	−0.74%	−0.99%	−1.39%	−1.91%	−2.39%	−1.53%
	Proposed	−1.87%	−1.71%	−1.30%	−0.59%	+0.38%	−1.66%	−6.63%

- CMI_2014 = actual data to 30 September 2014 + initial year 2011
- CMI_2015 = actual data to 31 July 2015 + initial year 2012
- CMI_2015* = CMI_2015 + data to end 2015 (but still initial year 2012)
- 'Current' = CMI_2015* + initial year 2013
- 'Proposed' = data to end 2015 (no step-back applicable)

Life expectancy at end 2015 vs CMI_2015



6. Proposed CMI Projection Model – consultation

Consultation and current MPC inclination

Issue	Consultation responses	MPC inclination
Overall	• Positive	
E&W or UK data?	• Some support for UK, but v strong concern over consistency and timeliness	• Use E&W data
LTR metric	• Concern re consistency vs previous model	• Use $\Delta \log m_{xt}$ per model
LTR tapering 85 to 110	• Concern about change and evidence	• As proposed, but provide more analysis
Responsiveness	• S_κ is unintuitive (and requires recalibration) • Analysis for selecting Core value simplistic • Approximately equal numbers disagreed re over vs under responsive	• This was black box beforehand • We share the concern, but note the lack of consensus • Use scenarios to aid intuition (one of which is CMI_2016) • No inclination to change from S_κ=7.5 (yet)
Identifiability constraints	• Concern about edge effects	• This is being reviewed
Name	• Numbering vs year of release	• Use CMI_2016

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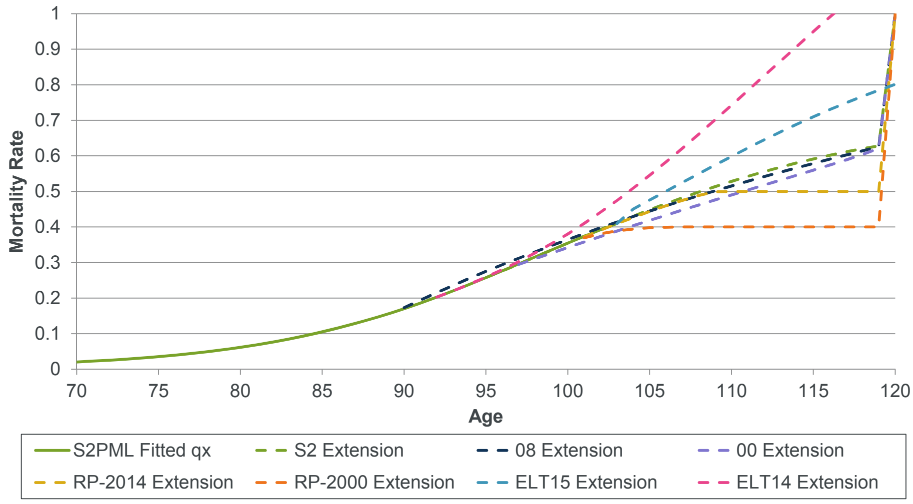
High age mortality

Andrew Gaches
CMI High Age Mortality Working Party

Phase 1: Initial findings

- Working Paper 85 released October 2015
- Key areas of analysis:
  - Summary of recent research
  - Functional forms for closing mortality rate tables
  - Modelled impacts of late reporting and age mis-statement
  - Closed cohort mortality
- https://www.actuaries.org.uk/learn-and-develop/continuous-mortality-investigation/cmi-working-papers/mortality-projections/cmi-wp-85

Phase 1: Comparison of Published Graduations



Phase 2: Continued analysis

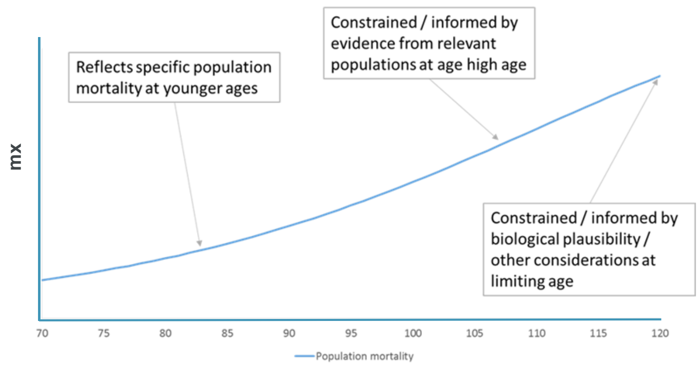
- Three strands of work

- Strand 1: Principles for closing off mortality tables
- Strand 2: Seek high quality portfolio data for analysis
- Strand 3: How might high age population variants impact the CMI Model?

- Focus today is on Strand 1
- Work in progress, provisional findings presented

Strand 1: Closing mortality rate tables

Strand 1: Desirable features



- Plausibility
- Data compatibility
- Cohort features
- Robustness of fit
- Uncertainty assessment
- Trend allowance
- Smooth progression

Strand 1: Areas explored

- The very highest ages
  - What is the evidence?
  - What is our thinking on a proposed approach?
- Extending graduations
  - Do different groups converge?
  - If so, what is typical shape of convergence?
- What is our current thinking on a proposed approach?

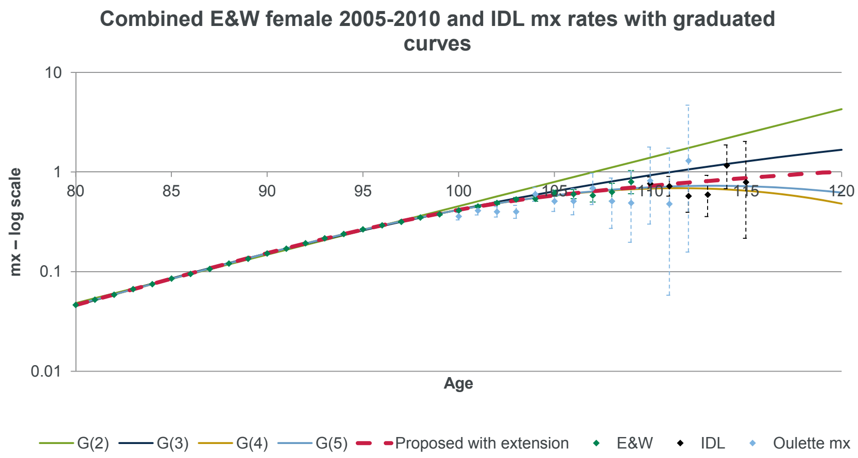
Mortality deceleration: Two camps

Gavrilov & Gavrilova (2015)

- Little evidence of mortality deceleration at high age in IDL supercentenarian dataset
- Factors explaining observed deceleration include:
  - Aggregation of birth cohorts resulting in homogeneous groups
  - Inaccurate age reporting resulting in downward bias
  - Common assumptions on high age mortality breaking down

- Ouellette and Bourbeau Study (2014)
  - Canadian death rates using church parish registers
  - Greater certainty on DOB information from baptismal certificates

Mortality dataset comparison



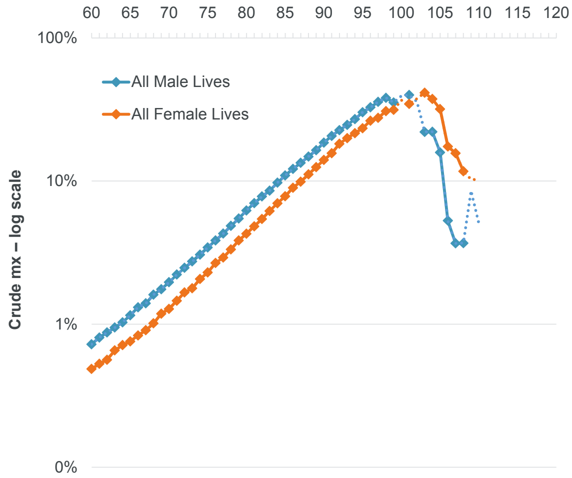
Findings

- Wider considerations
  - Need to consider whole age curve, not just 110+
  - IDL dataset may not be complete
- IDL mortality and E&W graduated rates lie within Ouellette CI
- View on mortality deceleration remains inconclusive

Do we see convergence?: CMI data (i)

SAPS: Gender

- Evidence of convergence
- Not fully converged by 101
- Data unreliable at 100+ (S2 graduated to age 95)



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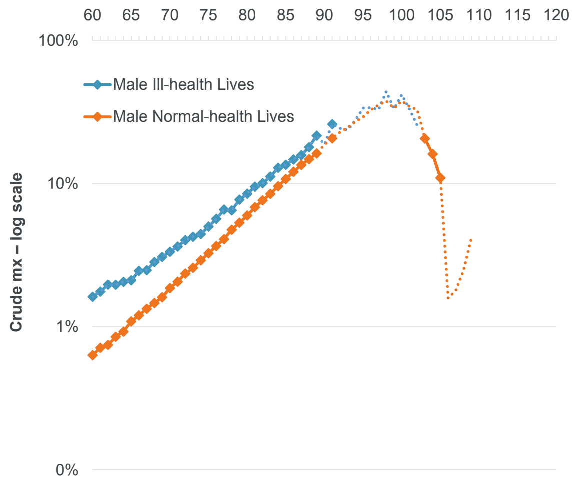
Do we see convergence?: CMI data (ii)

SAPS: Retirement Health

- Evidence of convergence
- Not fully converged by 91
- Possibly converged by high 90s?



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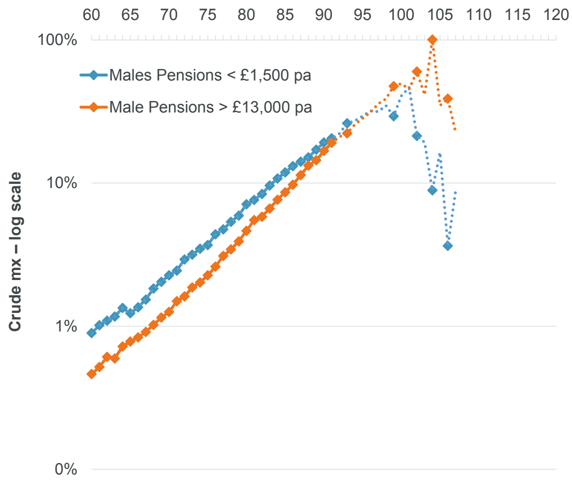
Do we see convergence?: CMI data (iii)

SAPS: Pension Amount

- Evidence of convergence
- Not fully converged by 93
- S2_L/H extended from 90



Do we see convergence?: CMI data (iv)

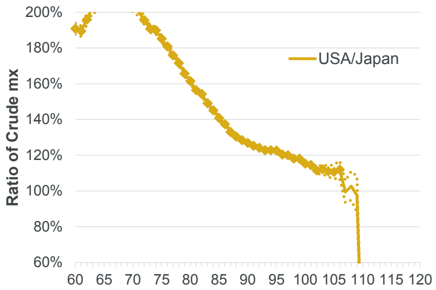
- Typically see convergence between groups
- Typically not fully converged by age from which apply extensions
- Similar observations for CMI Annuities data

- Suggests extensions should allow for continued convergence

- But should look to other datasets to test if always see convergence

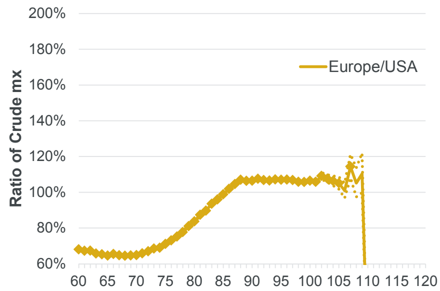
Do we see convergence?: HMD data

USA vs Japan (females)



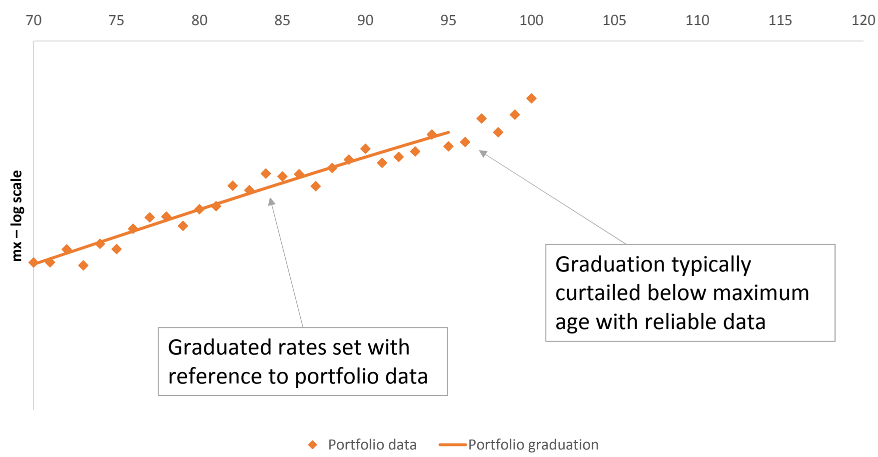
- Evidence of convergence through to highest ages
- Not fully converged by 106

Europe vs USA (females)

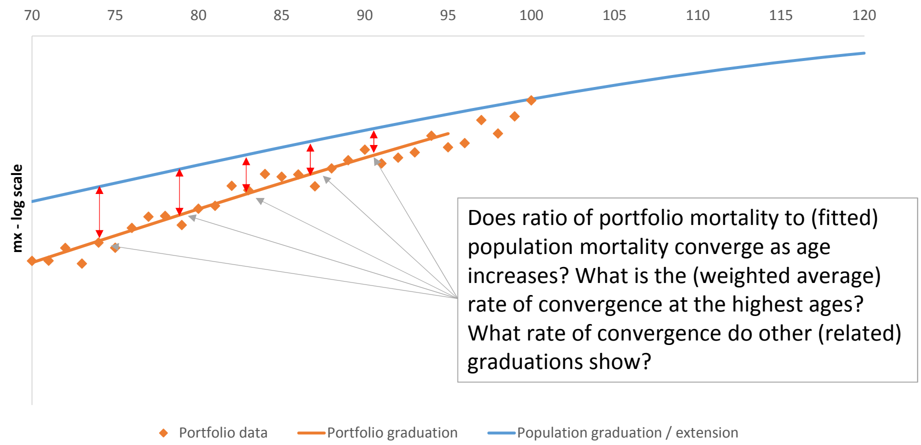


- No evidence of convergence at 90+
- Not converged by 107
- **So may not always see converge**

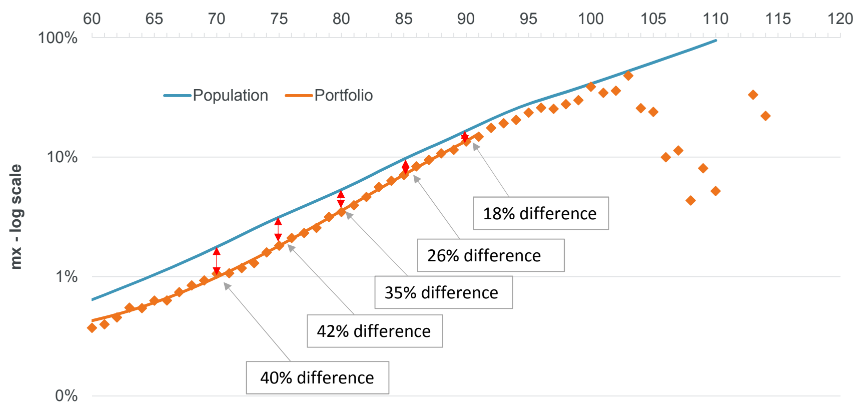
Proposed framework: 1- Graduate portfolio data



Proposed framework: 2- Analyse convergence

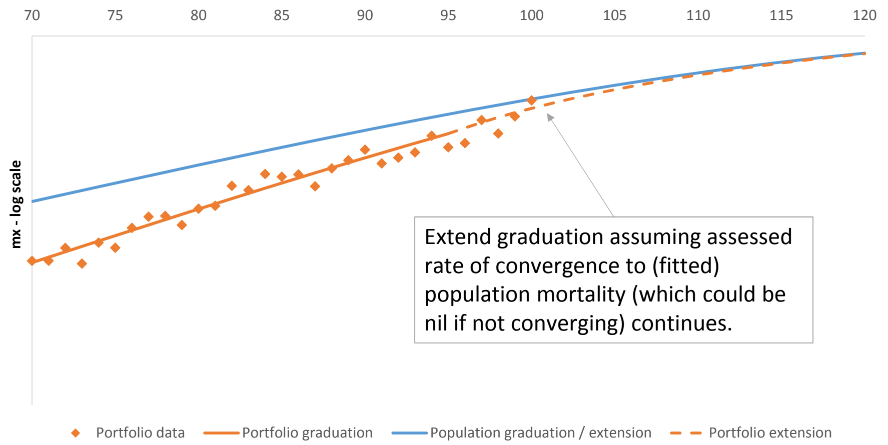


Example

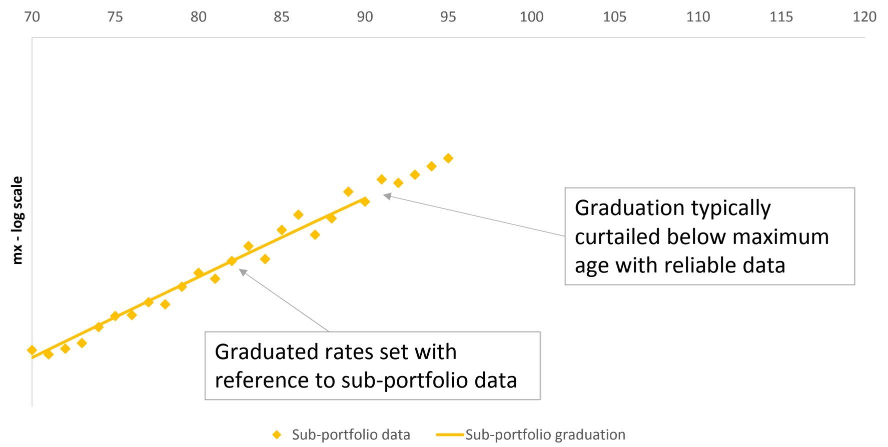


- Clear convergence
- % difference reducing by around x0.75 each 5 years

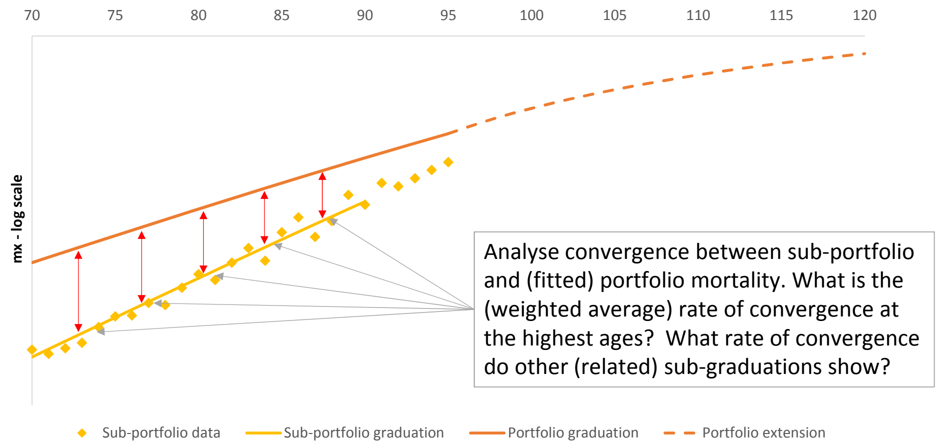
Proposed framework: 3- Extend graduation



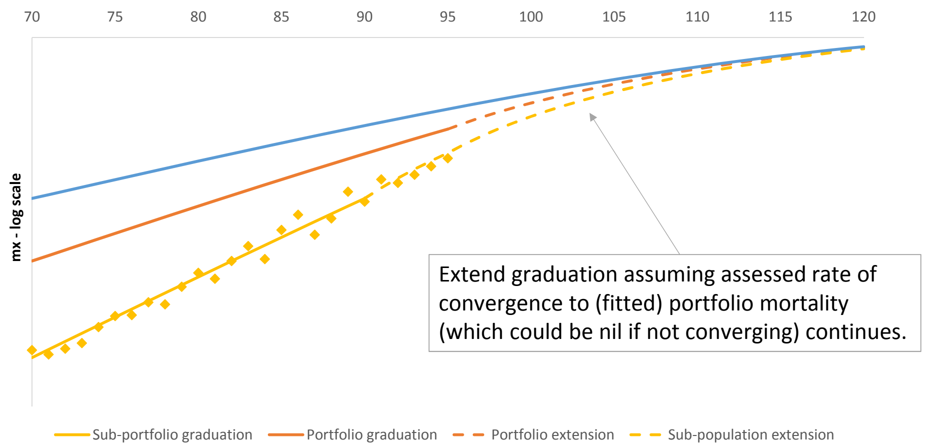
Sub-portfolios: 1- Graduate sub-portfolio data



Sub-portfolios: 2- Analyse convergence



Sub-portfolios: 3- Extend graduation



Strand 1 next steps

- Applying approaches discussed to:
  - UK population data (for tables to converge to)
  - More recent CMI tables
- Analysing impact
- Paper to inform CMI Committees

Strand 3: Population data modelling

Candidates considered as variants of England & Wales exposure data:

- Current Kannisto-Thatcher (KT) with population constraint
- KT with allowance for simple survival ratio trend
- Other KT variants in progress:
  - Allocation of calendar year deaths into relevant cohorts via Lexis triangles
  - Assessment of adjustments proposed under “Phantoms Never Die”
  - Assessment of different join age
  - Assessment of modelled populations
- Allowance with and without exposure smoothing

Questions Comments

The views expressed in this presentation are those of the presenter.

Continuous Mortality Investigation
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