LCP response to CMI_2026 Mortality Projections Model consultation

CMI Working Paper 216

Issued on 5 November 2026

I am writing on behalf of Lane Clark & Peacock LLP in response to the consultation questions included in the Mortality Projections Committee's Working Paper 216 regarding the proposed CMI_2026 version of the Model.

Lane Clark & Peacock LLP ("LCP") is a firm of financial, actuarial and business consultants, specialising in pensions, investment, insurance, energy, health and business analytics, with over 1,200 people in the UK.

LCP welcomes the opportunity to provide input into the consultation on the CMI_2026.

We continue to have alternative views about how mortality improvements could be projected at old ages in the Core model. This view is reflected in our response to Question 4.

We would like to thank the committee for their work on preparing the working paper and the analysis in it; we recognise that a significant amount of time has been involved in producing the paper.

Ben Rees FIA CAct
Partner

+44 (0)20 7432 0699
ben.rees@lcp.com



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Answers to specific questions in Working Paper 216

1. Do you have any comments on the new model parameters paper, released alongside this consultation?

We welcome the new model parameters paper. However, in our view, the document may benefit from some additional structure. For example, a table or consistent headings throughout to highlight:

- Date the parameter was set
- Date of last review
- Purpose of parameter
- Current parameter value
- Rationale for choice of current parameter value
- Confirmation of the Committee's view that the parameter value remains fit for purpose.

2. What is your preferred value for the half-life, and why?

Whilst we believe that a range of views is acceptable, we generally agree with the Committee that a half-life of 1 remains a suitable value for the core half-life.

We note that the impact of the half-life, and hence the overlay, on future projected mortality rates will continue to diminish over time as the model is calibrated to post-pandemic data. As such, modifications to the parameter value may be unnecessary.

We also note that some of the longer values of half-lives presented appear to be a better fit to the observed mortality rates than the core half-life of 1. However, we do not propose changing the core value given:

- Different 12-month periods showing different run-off patterns;
- Uncertainty on the potential impacts of mortality selection; and
- A preference for stability in the parameter value.

3. What is your preferred approach for the age-period and cohort convergence periods, and why?

We understand the Committee's view that a guiding principle of how to set convergence periods should be to consider the relative reliance that can be placed on the derivation of initial improvements versus the long-term. This view naturally leads to the conclusion of short convergence periods at old ages, given the uncertainty in observed mortality trends at the highest ages (a point illustrated in Section 7 of the Working Paper).

That said, our view remains that, first and foremost, the model should be parameterised to align with the user's view of the future. In our view, short-term mortality improvements at the oldest ages appear too high in the Core version of the CMI model (albeit recent data has led to this difference being less stark than it was in earlier versions of the model).

Our preference would be for the Core CMI model to produce lower mortality improvements at the oldest ages. There are a number of ways that this could be achieved, including changes to convergence periods at the oldest ages, more period smoothing at older ages, or changes to the taper of the long-term rate of improvement (see Question 4).

We continue to appreciate the CMI model's flexibility and the strong steer from the Committee that users of the model should calibrate the model in line with their own views.

4. What is your preferred approach for the taper of the long-term rate for the age-period component, and why?

The core parameterisation of the CMI model produces mortality improvements at the oldest ages which are stronger than our own view, and experience over a number of years.

It may be that changes to the taper of the long-term rate for the age-period component could better align the Core model with our view, noting that the flexibility in the CMI model allows us to adopt a different parameterisation as we see fit.

In our view, the analysis provided in the Working Paper could support a taper that starts and ends at younger ages.

For example, there is arguably a strong rationale to lower the top age for the taper from 110 to 100. This would be more in line with historical data and will produce lower mortality improvements at the oldest ages.

There may also be rationale to lower the bottom age of the taper from 85 to 80. The data at this age range is noisier and so the picture is less clear. However, reducing the taper to a lower age range does appear to better reflect the observed shape in historical mortality improvements.

5. Do you have any comments on other aspects of projections?

Not at this stage.

6. We have described our initial review and further areas to investigate. Do you have any comments on the review so far and our plans? Are there any important areas that we have missed?

We are happy that you have focussed on the most important areas.

In particular, we agree with the Committee that high-age population estimates should be given a high level of attention, given their materiality and changes made in the 2021 census.

7. Are you comfortable with our proposal to continue to use calendar year data? If not, what is your preferred approach?

We welcome the analysis of non-calendar year mortality rates and would encourage the CMI to include this analysis periodically going forward.

At this stage, we see no reason to not continue using calendar year periods.

That said, the non-calendar year data raises questions about the appropriateness of the concept of excess deaths running off exponentially.

8. Do you agree with our view that the impact of mortality selection is small and not worth further investigation? If not, what is your assessment of the impact of mortality selection?

We are open-minded to the possibility that the impact of mortality selection may be greater than is being suggested by the range of analysis currently available.

In our view, there remains uncertainty as to why mortality rates have been low over the previous 2 years. The analysis provided by the Committee is useful, but we do not view it as conclusive evidence that displacement can entirely be ruled out.

9. Setting aside any opinion on the methods used, how does the male life expectancy at age 65 shown in bold in Table 3.1 compare to your best-estimate view based on mortality improvements for the general population of England & Wales?

The life expectancies shown are dependent on the choice of base table, the long-term rate, as well as the core parameterisation of the model. As such, we don't think answering this question sheds particular light on the aspects of the model that are being consulted on.

10. Setting aside any opinion on the methods used, how does the female life expectancy at age 65 shown in bold in Table 3.1 compare to your best-estimate view based on mortality improvements for the general population of England & Wales?

See 9.

11. Do you have any further comments on this? For example, how your response would vary by age?

See 9.

12. Do you have any further comments on any aspect of the Model that you would like to bring to our attention?

No.

13. We intend to change the format of the summary mortality monitor from a static PDF file to an interactive web page. Would you see this change as positive, neutral, or negative?

In our view, the mortality monitor is an excellent source of the latest summary statistics. It is easily digested and can be simply referenced in our advice.

We are supportive of the move to an interactive webpage if it continues to deliver the existing strengths of the monitor, with the additional flexibility that can be achieved via interaction.

14. Do you have any other comments on the mortality monitors?

In our view, the mortality monitors have become central CMI outputs and would encourage you to keep producing them in the future.

We find that the shorter monthly output with more detailed quarterly outputs strikes a good balance.

15. We published the results of our 2026 benchmarking survey in Working Paper 213 in June 2026. We are conscious that the results working paper is long so we sought feedback on ways to shorten and improve it. We would welcome further views on this.

As a consultancy we are not asked to fill in the benchmarking survey. Our response is limited to the ease with which the survey can be interpreted.

We often find that many of the responses to questions are difficult to interpret as they relate to questions on a parameter and not combinations of parameters that are linked together, and because the questions can be binary. For example, we learn little finding out that insurers commonly use a non-core taper without knowing whether these are longer or shorter and what long-term rate is being used in conjunction with it.

16. We are starting to consider our plans for the 2027-2028 CMI year. Do you have any suggestions for areas of research or other work?

We believe that you have already highlighted the most important areas for consideration.