Comment #1 – 12/27/20 – 6:31 p.m.

These are the comments of a stakeholder, a qualified actuary, and a professional and represent the call of conscience and integrity. No corporate interest, per se, is involved. I'll go through:

1. some overall comments,
2. then make a suggestion for your consideration,
3. add specific remarks on the draft as written
4. consider possible actions that the ASB might take, and
5. close with consideration of how this ASOP fits into traditional actuarial standards.

Overall Comments.

1. Our hope is that our profession be the principled respected authority for matters involving the contingencies of risk and finance. That requires that we rise above mere recipes for practice. We serve the public first and the values, standards, and particularistic interests of the actuarial profession secondarily.
2. The Exposure Draft uses the term "At Home Program" to refer to what the Elder Services industry generally refers to Continuing Care at Home for which the acronym, CCaH, is typically used. My comments use the more generally accepted terminology. An "At Home Program" might be confused with the Home Based Services industry which provide caregivers on an as needed basis to infirm older people in their own homes apart from residential care facilities. An example of such a firm is Home Instead®, which operates a "network of caregivers to provide essential care services to seniors." It would be best to avoid such confusion even if, or especially if, the author's intent is to deflect attention away from the insurance nature of CCaH.
3. It's evident that much thought, work, and extended discussion, has gone into the preparation of the Exposure Draft. It's written from the perspective of a consultant advisor. The implication is that the responsibility for whether the advice is followed or not is beyond the scope of the actuary's burden.
   That detachment from implementation responsibility might not apply to an actuary employed by a provider organization. However, that may be moot for the moment since I know of no one who works for a CCRC/CCaH provider. This contrasts with the frequent employment by insurance companies of actuaries. Since Elder Services involves contingencies in very much the same way as

insurance companies, it might be desirable to encourage larger Elder Services providers to employ actuaries.

4. The ASOP appears to be intended to guide actuaries in their practice, though it's in depositions that actuaries are most likely to be held to account for detailed mastery of ASOP contents. As one who has experienced this, I can affirm that counsel are very gifted at jumping about among the growing body of ASOPs and drilling in with Yes or No questions that in truth require elaboration. Very few litigating attorneys or presiding judges are tolerant of the nuances of actuarial practice. It seems fair to suggest that, as a generality, litigating lawyers are more likely than most actuaries to be versed in how to probe word usages in the language of documents like ASOPs. No actuary should have to have legal advice or representation to be able to follow the directives of actuarial practice.
5. The American Academy of Actuaries' mission is to serve the public and the United States actuarial profession. No public representatives, no consumers impacted by the subject CCRC and CCaH services, and no direct providers of these services were included on the Task Force. There are a number of actuaries who are resident in CCRCs and who are fully qualified to participate in these discussions if the Academy is open to consumer and public voices.

ASOP No. 3 Task Force

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Four of the seven Task Force members also participated in guiding the drafting in 2007 of the predecessor ASOP which omitted CCaH. My comment then on that earlier draft noted that "None of these people appears to be a resident of a CCRC or to represent residents' issues." That remains true with this revision.

6. For actuarial practitioners who may be thinking of entering this often-neglected corner of actuarial practice, the Academy's requirements and this ASOP, can put a chill on their impetus to open a new branch of their firm. I had conversation some time ago with principals of a pension consulting firm, which I will leave unnamed here, who were thinking of advising CCRC managers.

It was evident that the firm's pension and retirement healthcare modeling software and capabilities were also applicable to CCRC and CCaH modeling. The firm decided against this expansion of its practice because it lacked a practitioner with the specific CCRC experience and expertise which the firm interpreted Academy qualification standards to have placed on the profession. This is unfortunate for the growth of the profession and for the refinement of its practice standards through fresh eyes.

7. Although Academy requirements make it difficult for actuarial firms not yet advising Elder Services enterprises to enter CCRC consultancy, the proposed ASOP unilaterally condones an extension of practice to CCaH. For these firms, this extension opens not only a new area for consulting practices but also a new business area for Elder Services providers, i.e. a managed care approach to long term care insurance, called "At Home Program" by the author of the ASOP, but for which the more generalized Continuing Care at Home parlance is more common.
8. By establishing CCaH practice directives, the American Academy of Actuaries is endorsing this new risk bearing, non-licensed insurance activity and may have legal liability for any adverse developments. Has the Academy considered it's legal exposure in the absence of a regulatory requirement for capital adequacy?
9. For CCRC residents or CCaH members the core concern is peace of mind and that requires assurance that any enterprise they depend on will survive financially to be there for them when, as, and if they grow frail and need the promised care services. This ASOP does not address the central need for capital adequacy to assure sound financial operations. As noted above, this oversight might expose the Academy to legal liability. The ASOP focuses on consulting practices as advisory and, therefore, there may be a belief that actuaries have plausible deniability to duck the liability that attaches directly to a provider organization which follows the actuary's advice.
10. As suggested by Item 6 above, there are congruences among the practice areas that deal with contingencies of aging, which is the core area of practice which this ASOP seeks to address. The ASOP is reactive in that it simply codifies the practices developed by the handful of actuarial consultants who advise CCRCs, a subindustry of the larger Elder Services industry. Many facets of the larger Elder Services industry similarly involve mortality and morbidity contingencies. The practice is now to be extended by the addition of an unlicensed long term care insurance program, in the form of CCaH. It ignores, however, other related

areas of actuarial practice, e.g. pension firms, that might also advise such entities since their expertise involves similar contingencies and modeling challenges. Retiree health benefits is one such area. For the lifetime annuity commitments implicit in entry fees (aberrantly called "Advance Fees" in this draft ASOP) straightforward pension analysis applies.

PACE (Program of All-Inclusive Care for the Elderly), like CCaH, is an emerging business which has actuarial aspects but which has yet to employee actuaries. So far, PACE has been limited to a small, select, group of indigent people, who would otherwise require confinement in a skilled nursing facility. That limitation, however, is not germane to the concept and, if PACE concepts were extended to the entire population, the socioeconomic impact would be great. By limiting the ASOP to a narrow practice corridor, instead of taking a more principled approach to the societal value that actuaries can provide to the Elder Services industry generally, the ASOP limits the prospects for future actuarial practice areas to evolve in the natural course of business.

11. In commenting in February 2007 (nearly 14 years ago) on the Exposure Draft of what then became the currently authoritative ASOP #3, I wrote: "The risk is that ASOPs can be shaped to benefit special interests without regard to the larger public interest and that the authority of the Academy behind the pronouncements masks any such suborning of the process whether by intent or by myopia in service to an employer or client." That risk remains and I can only hope that the Academy and ASB will act to restore the unbiased public interest focus that has distinguished the actuarial profession throughout its history.

Suggestion.

These overall considerations lead me to suggest that the ASOP 3 Exposure Draft be withdrawn so that the Actuarial Standards Board can consider how best to address the emerging practice area of Elder Services with Contingency Features. I believe that a more comprehensive approach can better serve the United States actuarial profession as a whole, as opposed to a small set of highly specialized practitioners, and can better serve the public in the process.

Detailed Comments.

With those introductory thoughts, I turn to the specifics of the draft as presented.

1. The requirement that comments indicate whether they "are being submitted on your own behalf or on behalf of a company or organization" raises the question whether the Academy is a trade association representing the special interests of corporate members or, alternatively, a professional organization guided by the

ethical and competency standards of individual members who are led in the practice by high standards of personal integrity. This distinction should be clarified at a high level within the Academy and the Actuarial Standards Board.

2. Committee Member Darryl G. Wagner's first name is misspelled in the draft as promulgated.
3. Itemized paragraph 1 on page vi, announcing the applicability of the ASOP to "At Home Programs that are not regulated as an insurance entity" raises numerous questions among them: (1) why aren't CCaH long term care insurance programs regulated as insurance? and (2) is it wise for the Academy to participate in encouraging long term care insurance programs by unlicensed entities?
4. §1.1 and §1.2: The limitation to "At Home Programs that are not regulated as insurance entities" is repeated. Presumably, one would infer that CCaH programs offered by licensed insurers are subject to different standards though it's hard to understand why the actuarial characteristics would be differentiated.
5. §2.4: The "Advance Fee" terminology departs from the terms that are commonly used for these single-premium-life-annuity-type prepayments of fees that would otherwise be paid on a recurrent basis over the insured's ("resident" or "member" in the terminology of the ASOP) lifetime. The more usual terms are "entry fee" or "entrance fee" or, less frequently, "Founder's fee." The American Seniors Housing Association's Model Residence & Services Agreement uses the terminology "Entrance Fee." The Model contract does not include a specific Definitions section, so the term is only defined implicitly by its usage in context.
6. §2.11: The definition includes an odd turn of phrase which could benefit from clarification. The phrase is "Non-residents may also live in the facility." Generally, a person who lives in a facility or other living quarters would be considered a "resident." The "Non-resident" terminology is confusing, and I have no idea what it refers to other than to speculate that it may refer to transient rehabilitation customers in the skilled nursing facility, or to respite customers who temporarily place a person in their care in a facility to gain relief from their caregiving responsibilities, or perhaps even transient guests, often marketing prospects or family and friends of residents, who may temporarily occupy guest quarters on campus. It would be better if readers didn't have to speculate about the intended meaning.
7. §2.18: This paragraph defines a "Non-Resident" in terms that usually would define a "resident." This is particularly confusing especially since there a growing number of "Type C" CCRC communities which charge "Advance Fees" without health care

guarantees and without a refund guarantee. The qualifier "normally" is highly debatable and subject to interpretation.

8. §2.24: The sentence reading, "The contract is usually of long duration and may be for the life of each resident," is at odds with the AICPA Guidance that CCRC contracts are month-to-month because the resident may cease paying. Moreover, I know of no CCRC contract that is not for the life of the resident unless the resident voluntarily elects to leave, is advised by the provider to leave, or is evicted by the provider either for behavior or because the resident's care needs become more than what the provider is willing or able to provide within its licenses.
9. Page 5, The second to the last paragraph reads: "In the event the CCRC or At Home Program fails to meet any of three conditions as specified above, the actuary should consult with the organization to address possible corrective actions to achieve satisfactory actuarial balance." The use of the term "organization" here presumably refers to the provider organization for whom a consulting actuary consults or by whom an actuary might be employed and not, say, to the ASB. This statement also raises the question of what the responsibility of the actuary is if the "organization" refuses to follow the advice, or just ignores it, or hypothecates its revenues, etc., so as to render the applicability of the three conditions meaningless.
10. §3.3: The concept of an "Actuarial Balance Sheet" is one borrowed from accountancy where it refers to a retrospective summary of the cumulative operations of an enterprise over its history. It rarely includes prospective projections, which can be considered speculative, and its introduction into actuarial discussions has only arisen very recently as the accounting profession with its GAAP codifications has become increasingly dominant in business circles. Reasonable people might well disagree as to whether this usage is a desirable addition to actuarial determinations.
11. §3.3.2: The inclusion of "the actuarial present value" of (1) "the future periodic fees" and (2) "the future additional fees" has the effect of treating items dependent on future managerial actions, e.g. what level of increase to apply to "future periodic fees" or what items to include among those subject to "future additional fees," as though they had the solidity of the hard assets generally included on accounting balance sheets.

    This treatment of projections as though they had a certainty they lack has the effect of blurring the connection between these associated projected future revenue elements and the projection of the contingent obligations which they are intended to fund. This reduces the information value for concerned stakeholders of the resulting actuarial presentation since stakeholders would have to extract matching

asset and liability elements to get a clear picture, and those details may be obscured when the elements of the presentation are not broken out in detail.

12. §3.4: The sentence, "The actuary should project surviving resident or member movements through various levels of care until contract termination," is a bit glib about what is a complex determination. One might infer that the actuary can project that transfers to a higher level of care are irreversible though that is the not the case in practice.

    An example may make this clear. My sister lives in a CCRC. She and her husband started in the "independent living" section of the CCRC. "Independent living" is in quotes here because under California law, the state in which she lives, all parts of a CCRC are licensed as a Residential Care Facility for the Elderly, which is the California term for assisted living. Therefore, all parts of a California CCRC can be considered assisted living though many managements do have a distinct area which they term as "assisted living."

    Back to my sister. As my sister's husband deteriorated into dementia, he and she were moved as a couple to the assisted living section. Eventually, he moved into the health center (skilled nursing) where he lived for some time until his death. My sister continued to live in the assisted living unit they had shared. After his death, the management decided to have her remain in assisted living since she had eye problems. The management did move her to a smaller assisted living unit as soon as such a unit became available. Then, when marketing created more demand for assisted living units, my sister was again moved back to the independent living section. Although her monthly payments were not impacted by the moves, she did have to pay the costs for the movers for each move.

    Thus, in her case, there were five moves in both directions, i.e. to a higher level of care and then back to a lower level of care: (1) move in, (2) transfer to assisted living, (3) transfer of husband to skilled nursing, (4) transfer to smaller assisted living unit, and (5) transfer back to independent living. The moves reflect a combination of resident need and management financial interests although management has the sole authority to direct transfers. My sister's case is more typical than it is atypical.

    From this, it's clear how complex the projection modeling task is for the advising actuary (or for the managing actuary if actuaries come to find employment within the industry other than as consulting actuaries).

13. §3.4: Also in paragraph 3.4, the last sentence, "The actuary may consider, subject to disclosure, the use of expense levels consistent with the targeted number of

residents or members when a material change in the population, such as growth resulting from new construction or expansion, is expected," implies that enterprise interests are the paramount consideration of the actuary rather than the individual interests of the residents or members as the stakeholders most impacted and most at risk in the undertaking. This may follow the money from a consulting actuarial perspective as in the adage that "he who pays the piper calls the tune," but it is not consistent with the professional obligation to hold the public interest paramount. This is an aspect of this ASOP that needs ethical and moral reflection and elaboration.

14. §3.5: The opening sentence here shows the highly speculative nature of the quantitative exercise that it is proposed that actuaries undertake when consulting with CCRC and CCaH enterprises. The sentence reads, "The actuary should perform cash flow projections using an open group population projection that includes existing residents or members on the valuation date together with expected future residents or members consistent with assumed occupancy and membership levels."

    The mathematics of such projections has long been an object of interest for math-centric actuarial theorists. There were several papers on the topic as it applies to pension plans in the era in which actuarial papers were published and discussed in academically respected journals, e.g. the Transactions of the Actuarial Society of America, the Transactions of the Society of Actuaries, the Record of the Society of Actuaries, Proceedings of the Conference of Actuaries in Public Practice, and similar journals of other bodies. If run long enough, the projected enterprise population comes to be comprised solely of the assumed future population (a theoretical construct which may be informative about patterns though it just reflects the actuary's judgments). Here that future population would be comprised of the assumed characteristics of the theoretical future "occupancy and membership" cohorts. Thus, as the projection period extends, such a projection becomes increasingly speculative, and in the extreme simply reflects the actuary's assumptions as though they would automatically be self-fulfilling.

    That display of future quantifications can give a false impression to management as any historian knows full well. Events occur, markets change, fashions shift, and culture evolves rendering any such long-term projection no more than partially informative. This is where the professional judgment of an accomplished and experienced actuary can come into play to explain the limitations of the projection and to advise lay stakeholders on how they should and should not be used for

decision purposes. Any one who has worked with startups and their business plan projections knows how the inclinations, wishes, and hopes of those crafting the projections can color the result and undermine their value as an analytical tool for management.

The impact of the changing environment within which actuaries' practice, i.e. the flow of history, is evident in the frequent revisions called for from time to time in the various ASOPs. They tend to be more prescriptive than principled. The use of the modal verb "should" throughout the ASOP implies a degree of certainty that is not warranted by the limits of any technically theoretical methodology. It is that higher level of judgment that differentiates a profession from the craft work of technicians. The cross-reference to ASOP 7, as reasonable as it may seem, suggest how Byzantine a legalistic structure can become and in that complexity lies weakness and vulnerability to misuse and misinterpretation.

15. §3.6.6: In turning here to the "refund" provisions included in many, though far from all, Residency Agreements, the ASOP returns from its perspective regarding the enterprise as a collective, to consider aspects relating to individual residents or members. A common refund provision predicates payment of the refund on the resale of the residential unit. The ASOP here refers to refund "guarantees." It is hard to reconcile the use of the term, "guarantees" given the uncertain marketing contingency requiring that successor residents agree to pay Advance Fees to be used to "refund" the claim of the predecessor. Such a contingent promise is not a "guarantee."

    The ASOP suggests that these marketing and successor-willingness contingencies (beyond those, for instance, with which life insurers are familiar with respect to death benefits or cash value claims) can be modeled according to "the organization's actual practice." Presumably here, "organization" refers to the behavior of the provider organization that has contracted to pay the contingent refund. The ASOP ignores the very real possibility that future practice may depart from historical practice if management or ownership changes and adopts new standards for making such payments.

    These contracts, in which future residents are expected to pay to fund payments made to earlier investing residents, constitute one of the more confounding aspects of how CCRC contracts, in particular, have evolved. The forward cascading refunds benefit only the early generational cohorts. Ignoring the runoff liability at enterprise termination depends on the questionable premise of the perpetual operation of the enterprise.

Those are matters of financial manipulation that actuaries, historically, have avoided becoming associated with. Their presence here has led regulators to be skeptical of the integrity of actuarial determinations as can be seen in the cursory dismissal of actuarial credibility found at https://youtu.be/clMCO-cYaOI.

16. §3.7.1: In this paragraph, the word "reasonable" appears for the first time in the ASOP. Whenever an actuary makes a "reasonable" judgment, respect for the readers and stakeholders who may be impacted suggests that the analysis and logic leading to the chosen conclusion should be documented at the time the judgment is finalized. It is suggested that this requirement for documentation be added to the ASOP.
17. §3.7.2: This gives the actuary enormous power to alter projection outcomes based on a critical assumption. Moreover, the sentence, "The actuary may use different trend assumptions, as appropriate, for various categories of revenues and expenses," cries out for a companion requirement that the actuary document the analysis and logic for making the choice.
18. §3.7.5: This paragraph blithely adopts the accounting concept of a going concern as a perpetual entity with the sole caution (after a discussion of what is implied) that "The actuary should assess the ability of the organization to attract new residents or members or any other known, significant circumstances that, in the actuary's professional judgment, may affect the organization's ability to remain a going concern." No reference is here made to standards of capital adequacy nor is there any cross reference to ASOP #55 which deals with capital adequacy. The absence of mention of this key standard, together with all omission of any requirement that the insuring CCRC or CCaH entity hold any actuarial reserves, renders questionable the entire ASOP. A modicum of risk analysis is, however, contained implicitly in the reference to "significant circumstances."
19. §3.7.6: The same principle applies here that when actuaries make judgments based on an assessment of what is "reasonable" the actuary should be required to document at the time the judgment is made the analysis and logic that renders the judgment other than simply arbitrary, or worse, responsive to a desired outcome for the analysis as asserted by regulator Thompson in the YouTube video cited earlier.
20. §3.7.6 (f): The actuary shouldn't merely "take into account" questions of the size of the population modeled, as presumably a stochastic and credibility consideration (though this is not stated), but should also consider whether there is a need for reinsurance or special contingency reserves to respond to the stochastic challenges of modeling small populations.

21. §3.8: In addition to considering any positive financial impacts that associated benevolence funds may have on revenues the actuary modeling a tax exempt business entity should take into account the stipulation in IRS Revenue Ruling 72-124 that "First, the organization must be committed to the established policy, whether written or in actual practice, of maintaining in residence any persons who become unable to pay their regular charges." That Revenue Ruling makes this requirement a primary condition for tax exemption with the allowance that the business entity can offset its liability for this contingency "by utilizing the organization's own reserves, seeking funds from local and Federal welfare units, soliciting funds from its sponsoring organization, its members, or the general public, or by some combination thereof."

    Moreover, unless the benevolence funds are specifically restricted to "financial assistance subsidies … for residents or members who do not pay the contractual funds," there is no assurance that the benevolence fund might not later divert those funds to some other worthy cause, leaving the primary tax exempt business organization liable for the required assistance. It seems contrary to established actuarial professional principles and practices for speculative future charitable funds to be used to offset contractual obligations.
22. §3.10: Frankly, this paragraph is rather confounding. I don't understand why it matters whether the community is owned by the residents or by outsiders or by a combination of residents and outsiders or how that conflates with CCaH programs. I suppose that the same might be said of §3.9 as well since ownership is involved with all such undertakings. A mutual corporation, for instance, is simply one in which the customers form the ownership interest, while nonprofit organizations may nominally have public ownership, but in practice the ownership prerogatives for nonprofits are exercised by the management and the board subject only to loose oversight from the state.

    Hence, I have trouble following the distinction that the ASOP is recording here. In addition, if enumeration implies exclusion of what is not enumerated, these paragraphs would seem to exclude other arrangements like a mutual benefit corporation, just alluded to, or an interinsurance exchange. This section of the ASOP would seem to need more thought before it is codified as binding on the profession.
23. §3.11: The sentence, "The actuary should determine the scope of the organization's commitments to current and prospective residents or members and the nature of its fee structure," requires interpretation. It seems to focus on management's current practices with respect to contract obligations and other business decision making,

e.g. the risk classification process involved in admissions, etc. The reference to "refund guarantees" is incomplete, for instance, in light of Comment 15 on §3.6.6 above.

The reference to "any other matter that, in the actuary's professional judgment, is expected to have a material effect on the organization's current or future financial statements" puts a high burden on the actuary to delve deeply into the organization. Moreover, there is no requirement here for the actuary to document how this assessment is to be carried out or what documentation of the actuary's investigation or professional judgment is required. The broad latitude conveyed here lends a subjective element to the process and that may be the author's intention, though a more principled approach would be better.

24. §3.14: The documentation verbiage leaves considerable discretion to the standards of the individual actuary. As commented earlier, documentation of judgmental items as "reasonable" or "appropriate" should be spelled out and fully explained to reduce the temptation to brush over complex matters, to render superficial judgments, or to respond to pressure from clients or paying stakeholders to slant the outcomes of the analysis. There should also be a requirement that all documentation be retained for as long as there is any possibility of a question arising in which the actuary's work is a material factor.
25. Page 16, second paragraph under "Background": "Care Management" is included as a key to the successful operation of a CCaH program but not for a CCRC. This seems absurd unless managerial interests take all precedence over the interests of the resident stakeholders. Moreover, risk management and capital adequacy are omitted altogether as "keys to the successful operation" of both CCRCs and CCaH. Is this the concerted position of the Academy concerning organizations with actuarial obligations that serve the public?

Takeaways and Closing Thoughts.

The extensive elaboration evoked above by a close reading of the proposed ASOP reveals that it deserves much deeper consideration from a variety of perspectives that are unrepresented on the Task Force. Let's say, for instance, that AARP were to adopt a self-funded association form of CCaH for its members nationwide providing them benefits wherever they live. Would this ASOP represent the best approach for the actuarial profession to take toward such a venture?

It seems evident that, despite the evidently considerable effort that has gone into the committee drafting effort, there are many unintended consequences that may eventuate from the ASOP and that ought to be given full consideration before such a sweepingly

authoritative standard is promulgated as binding. This leads to the suggestion that the entire draft ASOP be withdrawn for reconsideration, so that the larger context of Elder Services with Contingency Features can be considered consistent with the professional aspirations and mission of the Academy.

Relevant Actuarial Precedents.

Elizur Wright, the mathematically inclined abolitionist, is arguably the founder of the American Actuarial Profession (https://www.soa.org/about/historical-background/). He dedicated his life to opposing injustice, and he considered the loose use of funds collected by early life insurance companies to constitute an injustice.

Elizur Wright's most lasting contribution to society was his insistence that life insurance companies hold scientifically calculated reserves, what we now call actuarial reserves. Those companies that were put on a sound basis by his actions were called "old line legal reserve companies," a mark of financial soundness, and they soon supplanted the earlier assessment companies. In the broadest sense, we might speak of the Elder Services industry as including not only the evolving CCRC and CCaH components but also the full plethora of possibilities, e.g. home and community based services, programs of all-inclusive care, and mere potentialities such as interinsurance exchanges or the fantasized AARP program alluded to above.

The Elder Services industry (with its risk and actuarial profile) today is in the position that life insurance companies were in before the arrival of Elizur Wright and the beginnings of the actuarial profession in America. The total silence of the ASOP concerning actuarial reserves demonstrates the parallels of today's Elder Services practices with those of the life insurance industry before Wright and actuaries came on the scene. The role of the Academy ought not, in my opinion, be to protect the limited interests of today's actuarial consultants but to develop principles that can govern the larger perspective of how Elder Services may evolve into the future.

History of ASOP "Codifications".

The idea that "codifications" should supplant statements of principle, as a form of quasi-legal prescription of technical processes as opposed to the more common law covenantal responsibility of professionals, began with the formation of the Accounting Principles Board in 1959, i.e. within the lifetimes of many who are still living today. Before that, professionals were expected to conform to high ethical and moral principles and to accept personal responsibility. Professionals were characterized by specialized knowledge, training, and experience that equipped them to exercise judgment in advising people and organizations that serve a public function. They were

expected to demonstrate integrity in their lives and, particularly, in the exercise of their profession. Professionals put the public interest before their own personal interests. By that professional standard, for instance, an accountant attesting to financial statements would affirm that the statements, in the overall judgment of the auditor, fairly present the financial condition of the enterprise. The auditor took personal professional responsibility for the applicability of the opinion. Later, as codification became common, opinions were modified to merely assert that the financial statements accord with generally accepted accounting principles. The term "principle" in this context is stretched to cover "codifications" adopted by the codifying authorities or their interpretation by authorities in the form of "guidelines." Thus, audit practitioners deflect personal professional responsibility onto the codifications that govern accountancy.

Subsequently in 1988, the Academy created the Actuarial Standards Board which began to issue Actuarial Standards of Practice. While they do not purport to define principle, they have the effect of containing the approved methods of practice within limits prescribed by documents formatted along the lines of legal prescriptions. They are crafted by committees and lack the personal attribution that inhered in the authored papers and named discussants that defined actuarial standards before 1988.

Moreover, the wording used in the language crafted for ASOPs takes on high significance for practicing actuaries though it has been more than fifty years since a verbal literacy requirement was applied to actuarial qualification. After 1960, the verbal literacy requirement, the first Society of Actuaries' actuarial exam before then, was eliminated. Following ASOPs in practice and defending them in disputes requires actuaries to have a high degree of verbal literacy beyond that of the average college graduate.

The ASB may want to give these effects consideration to ensure that the very process of ASOP drafting, which is intended to advance actuarial practice standards, does not have the unintended consequence of inhibiting that advance.

Many actuaries, and some trial attorneys, share a common malaise. That is what we might call the-smartest-one-in-the-room syndrome. If a person believes that they are the smartest in the room, they may feel called to prescribe what's best for others in a sincere attempt to use their intellectual gifts to better the human condition. That belief can lead to a kind of fiat governance in which what's best is prescribed to become universal. Plato called this the philosopher-king form of governance and Kant wrote of a categorical imperative. Time and history have shown this to be a false idealism.

Our profession can be at its best when it rises to a give and take among learned discussants together with entrepreneurial visionaries to apply our special knowledge for the improvement of enterprises. Let's not inadvertently put a freeze on what has distinguished our profession historically.

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