



State of New Mexico: Office of the Superintendent of Insurance

Benchmark Plan Benefit Valuation Report

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Introduction and Background

New Mexico retained Wakely to analyze the estimated cost impact of proposed changes to its state benchmark plan in the individual and small group Affordable Care Act (ACA) markets. Wakely was tasked to analyze the cost impact of a new benchmark and to determine if the new benchmark met the actuarial requirements as stated in 45 CFR 156.111.

Starting in 2020, the federal government allowed the following additional options for defining a state EHB benchmark plan, beyond what the states had previously been allowed:

1. Selecting an EHB benchmark plan used by another state in 2017
2. Replacing one or more EHB categories in the current benchmark plan with those categories as defined by another state in 2017
3. Selecting a set of benefits to become the state benchmark plan

New Mexico wants to utilize the greater flexibility granted by CMS to update their EHB benchmark plans to provide greater stability and clarity to New Mexico's market and enrollees.

This is the actuarial report which is part of the State of New Mexico's application for a change in the Federal CMS Plan Year 2022 Essential Health Benefit Benchmark Plan under Selection Option 3. There are two actuarial requirements in order for a change in the benchmark to be accepted. The first is that the new EHB benchmark plan must be equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at 45 CFR 156.110(a) than the scope of benefits provided under a typical employer plan. The second is that the new EHB benchmark plan does not exceed the generosity of the most generous among the plans listed at 45 CFR 156.111(b)(2)(ii).

This document has been prepared for the sole use of New Mexico. This report documents the results, data, assumptions, and methods used in our analyses and satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements. Using the information in this report for other purposes may not be appropriate.

Executive Summary

The State of New Mexico’s Office of the Superintendent of Insurance (“OSI” or “New Mexico”) retained Wakely Consulting Group, LLC (“Wakely”), to analyze the estimated cost impact of proposed changes to its state benchmark plan in the individual and small group ACA markets. Pursuant to 45 CFR 156.111, New Mexico has elected to select a set of benefits to comprise the new EHB benchmark plan. Per OSI’s request, we specifically priced the following changes in benefits offered relative to the current (2017) New Mexico Benchmark Plan:

- Adding Artery Calcification Testing
- Removing the benefit limit on Prosthetics (currently 1 device per year) and instead requiring medical necessity
- Extending coverage for Weight Loss to cover Obese members (currently covers Morbidly Obese only)

Additionally, while we believe that the following drugs were included as supplements to the current benchmark and therefore not additions, we still priced the inclusion of the following drugs:

- Adding Opioid Reversal Agents and Anti-Hepatitis C Agents to the EHB Benchmark Formulary

The above EHB benefits were targeted based on discussions with OSI, participating New Mexico carriers, and Wakely’s and OSI’s interpretation of the current regulations regarding selection of a new state EHB benchmark plan.

We tested this new benchmark to ensure it met both the generosity test and the typical employer test as defined under 45 CFR 156.111, both of which are discussed in greater detail in a subsequent section of this report. Wakely found the new benchmark to meet both regulatory requirements.

The remainder of this document presents the pricing results and analysis of each of the benefit changes, as well as the associated methodology underlying that analysis.

Proposed Benchmark

The current New Mexico benchmark plan is Presbyterian Health Plan’s Individual Silver C HMO, supplemented with Pediatric dental, Pediatric vision, and habilitation services. This plan was set in 2017 in accordance with the EHB rules and approved by CMS. Under the current regulations, using Option 3, the State is allowed to develop a new benchmark plan by selecting a set of benefits rather than an existing plan offered in the market. As part of its process of reviewing and

potentially updating the benchmark, Wakely was tasked on reviewing what alterations should be made to the existing benchmark. As part of its review process, Wakely discussed potential changes with New Mexico's individual and small group issuers to get their feedback. Wakely also conducted analysis on the potential actuarial impact of the changes. Several of the benefits considered for change were not ultimately recommended as a change. Listed below are the recommended changes and their potential impacts.

Note that no proposed changes to the New Mexico EHB benchmark plan relate to Pediatric dental or vision benefits.

Recommendation: Artery Calcification Test

Description

Artery calcification testing measures calcification in the heart for purposes of diagnosing certain heart disease such as ischemic heart disease. It would be performed, at most, every five years and is suggested for anyone between the ages of 45 to 75 who exhibits hypertension, hyperlipidemia, diabetes, smoking or family history of heart disease.

Methodology and Results

We pulled claim experience for the West region from the Wakely ACA (WACA) database for unit cost information on procedures covered under this benefit's definition per AMA Current Procedural Terminology (CPT) code assignments. Annual utilization was derived from the percentage of members in the same experience data who are both 45+ and have a diabetes Hierarchical Condition Code (HCC). While we expect not just diabetics to use the service we believe this is an appropriate proxy. We assumed 20% utilization annually as the test will only be given once per 5 years at most (i.e., no more often than this). Finally, we assumed a 25% take-up rate among those eligible for the test based on the current perceived level of awareness and education regarding this procedure.

The resulting PMPM allowed cost, from the WACA unit cost information and utilization level derived above, was equal to 0.03% of the total allowed claims from the same experience dataset. This result is higher than the baseline WACA data by an approximate factor of 4.8, which suggests a substantial degree of conservatism in this approach. This impact was assessed in isolation; i.e. we did not assume any explicit offsetting reduction in any other treatment areas that may arise due to the adoption of this test as a covered benefit.

Recommendation: Prosthetics

Description

The current New Mexico benchmark plan includes coverage for one prosthetic device per year. We propose removing this limit from the current benefit and instead basing on medical necessity.

Methodology and Results

We pulled member-level claim experience for the West region from the WACA database and used this to create a Claims Probability Distribution (CPD) based on the annual number of prosthetic claims per person reported in a calendar year. Prosthetic claims were identified using the most recent Wakely ACA Claims Grouper code set to identify CPT codes assigned to the prosthetics category. Using this CPD, we determined the total PMPM allowed claim cost for insureds with more than one prosthetic claim. It was found that such claimants accounted for approximately 23% of the total prosthetics claim cost in the experience data.

The WACA data is not available at a state level. The West region data was pulled since New Mexico is included in the region. However, not all states in the West region cover prosthetics. As a result, we reviewed the EHBs for all states in the West region. We then grossed up calculated PMPM amount for the percentage of members insured in states where prosthetics are currently covered in the EHB Benchmark, per publicly available CMS EHB Benchmark Plan information. This gross up was done to ensure our projected claim cost was not understated due to lack of coverage.

The resulting PMPM allowed cost was equal to 0.02% of the total allowed claims from the same experience dataset.

Recommendation: Weight Loss Drugs / Programs

Description

We propose expanding member eligibility for weight loss drugs and programs to obesity, rather than morbid obesity alone.

Methodology and Results

We pulled claim experience for the West region from the WACA database for drugs covered under the United States Pharmacopeia (USP) Weight Loss drug class, per National Drug Code (NDC) code assignments. Weight Loss Drugs is not currently covered as a USP class according to the Benchmark documents, but the expectation is that at least one anti-obesity drug is covered to account for this benefit.

We then pulled member-level data from the same dataset and identified the percentage of obese and morbidly obese members present in that population. We assumed that member behavior would be uniform within these two groups if coverage and availability were also uniform. Therefore, the additional projected allowed PMPM amount was calculated based on the difference in the size of the eligible population with obese members included as eligible.

The resulting PMPM allowed cost, after a coverage utilization adjustment similar to the one described under the above section relating to prosthetics, was equal to 0.03% of the total allowed claims from the same experience dataset.

Recommendation: Opioid Reversal Agents

Description

We propose adding Opioid Reversal Agents to the Benchmark Formulary as a covered USP Drug Class, with three submissions.

Methodology and Results

We pulled claim experience for the West region from the WACA database for all opioid reversal drugs covered under the USP Opioid Reversal Agents drug class. The recommendation is to add the following three drugs to the benchmark formulary. Note that the issuers are not required to cover the specific drugs used in the analysis. Regulations only require that the issuers cover at least three drugs in this drug class.

- Naltrexone HCl (including Anhydrous)
- Naloxone HCl
- NARCAN

The specific drugs analyzed were those currently covered on at least one formulary among those filed by New Mexico carriers in the ACA market.

The resulting PMPM allowed cost for the three drugs listed above, after adjusting utilization for current benchmark coverage, was equal to 0.00% of the total allowed claims from the same experience dataset. Our recommendation, based on current issuer coverage, is to cover three submissions. We estimate the impact to allowed claims based on this recommendation to be 0.00%.

Recommendation: Anti-Hepatitis C Drugs

Description

We propose adding Anti-Hepatitis C Drugs to the Benchmark Formulary as a covered USP Drug Class, with two submissions.

Methodology and Results

Using the claim experience for the West region from the WACA database, we identified the Average Wholesale Price (AWP) unit cost for each NDC in the USP Anti-Hepatitis C Agents drug class and used this to determine the specific drug(s) for New Mexico to add to its EHB Benchmark formulary. The drugs selected are currently covered by at least one issuer in the ACA market. Note that the issuers are not required to cover the specific drugs used in the analysis. Regulations only require that the issuers cover at least two drugs in this drug class.

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We further assumed for pricing purposes that all utilization would shift to these drugs, i.e. the total utilization for the class combined with the unit cost derived in the previous step would result in the appropriate PMPM.

The resulting PMPM allowed cost was equal to 0.33% of the total allowed claims from the same experience dataset. No adjustment for potential drug rebates, or other cost offsets, was assumed in the impact. It should be noted that we do not expect any actual realized impact to claim costs or premiums arising from this benefit change as issuers are already covering multiple drugs in the class. However, per CMS's instruction, we have included the impact as derived above for generosity testing purposes.

Additional Clarifications on Certain Benefits

Recommendations

In addition to the benefit changes listed above, New Mexico recommends making additional changes to the language present around its current benchmark plan with the goal of clarifying the coverage of select existing benefits or to comply with federal requirements. While these recommendations do constitute changes to the current benchmark in the strictest sense, based on conversations with New Mexico and CMS they do not represent actual changes in any EHB benefit coverages. Therefore, no pricing exercise was performed for any such changes. The specific recommendations pertinent to these EHB benefits are:

- Infusion Therapy – The recommendation is to clarify that this benefit is in fact covered by the EHB benchmark plan, as there are currently conflicting sources regarding coverage. Infusion Therapy was covered in the Presbyterian Health Plan’s Individual Silver C HMO.

The current benchmark plan states the following with respect to medical drugs (page 56 of the plan document, NM BMP.pdf, on the CMS website): “Outpatient Medical benefits include, but are not limited to, the following services: ...Medical Drugs (Medications obtained through the medical benefit). Medical Drugs are defined as medications administered in the office or facility that require a Health Care Professional to administer. These medications include, but are not limited to oral, injectable, infused, or inhaled drugs.” Based on this we believe that infusion therapy is covered and that the current Summary of EHB inadvertently stated that it was not covered. Please note that all New Mexico issuers have correctly understood infusion therapy is included in the current EHB benchmark based on the above language..

- Infertility Diagnosis and Treatment – Similar to infusion therapy, the recommendation is that New Mexico clarify that this benefit is an EHB as it was part of Presbyterian Health Plan’s Individual Silver C HMO plan offering. Coverage is only for the diagnosis and treatment of underlying physical conditions causing infertility.

Prior to 2012, New Mexico implemented a state-mandated benefit for HMOs related to fertility treatment.¹ Specifically it states under their health promotion program “other preventative health services shall include, under a covered person’s primary care practitioner’s supervision... diagnosis and medically indicated treatments for physical conditions causing infertility except as required to reverse prior voluntary sterilization surgery.” While the Presbyterian Health Plan’s Individual Silver C HMO plan does not specifically call out this benefit as being covered, the excluded services under infertility treatment (page 80 of the plan document, NM BMP.pdf, on the CMS website) do not explicitly list these services and given the state mandate to include, we assume that they are covered. Please note this mandate is currently not documented on CMS’ website and should be updated.

- Habilitative Treatments – The recommendation is to clarify the intention behind what services are covered, i.e. Physical, Occupational and Speech Therapy and Autism Spectrum disorder diagnosis and treatment.

The current summary of New Mexico’s benchmark states that habilitative services is covered using the federal definition. We only seek to codify and clarify what this includes

¹ The mandate was implemented in 2009.

by listing the specific habilitative services that are being covered by New Mexico's issuers in order to meet the EHB requirements as currently stated. In addition, the current benchmark plan (page 52 of the plan document, NM BMP.pdf, on the CMS website) lists the autism coverage as part of the habilitative benefit. Consequently, issuers would not need to change any benefits offered under habilitative services.

- Hearing Aids – The recommendation is to remove any language specifying an age limit on this benefit. This would not result in an effective coverage change due to ACA discrimination restrictions. Issuers already must comply with anti-discrimination provisions as listed at 45 CFR 156.125 so this change clarifies existing requirements.
- Prior Authorization – The recommendation is to remove any prior authorization language in the benchmark. Prior authorization is not a benefit in and of itself, but rather a way to ensure the appropriateness of the services provided under covered benefits. As such, this is not an actual benefit change and issuers would have the ability to include prior authorization in their benefit and plan designs, subject to state and federal law.
- Additional Prescription Drugs – The issuers should note that there are additional drug categories/classes that still do not have any drugs covered under the benchmark plan. Under 45 CFR 156.122 the issuers will be required to provide at least one drug for each drug category/class for the following:
 - Category; Class
 - Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers); Progesterone Agonists/ Antagonists
 - Respiratory Tract/ Pulmonary Agents Pulmonary Fibrosis Agents; Pulmonary Fibrosis Agents

Summary

After performing the above pricing exercises for the listed benefit changes, the projected total increase is 0.4% as a percent of total allowed claims.

Typical Employer and Generosity Tests

There are two separate tests that a new benchmark must meet in order for it to be approved. The first test that needs to be met is the typical employer test. In particular, a new benchmark must provide a scope of benefits that is equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category within each EHB category at 45 CFR 156.110(a), the scope of benefits provided under a typical employer plan. A typical employer plan

can be any one of the state's 10 base-benchmark plan options from 2017 or one of the five largest group health insurance products (provided the group health plan meets certain criteria).

The second requirement for a new benchmark is the generosity test. In particular a state's EHB-benchmark plan must not exceed the generosity of the most generous among plans listed at 45 CRR 156.111(b)(2)(ii)(A) and (B).

CMS notes that "...the actuary may want to consider using the same plan, for both the typicality and the generosity tests, provided that the plan meets the standards at both §156.111(b)(2)(i) and (ii)."² Wakely selected the United Healthcare Choice Plus plan for both the typicality and generosity tests. The United Healthcare Choice Plan is a comparison plan under 45 CFR 156.111(b)(2)(i) and 45 CFR 156.111(b)(2)(ii).³

The primary differences between the proposed benchmark and the United Healthcare Choice Plan (the comparison plan for both the typicality and generosity tests) are as follows: The proposed benchmark plan includes the new benefits (as analyzed above), which are not in the United Healthcare Choice Plan; and the United Healthcare Choice Plan includes a Private Duty Nursing benefit⁴, which is not in the proposed benchmark. In order for the proposed benchmark plan to pass both tests, the value of the new benefits needs to be equal to the Private Duty Nursing benefit.

Wakely analyzed the expected relative cost difference of the benefit of Private Duty Nursing relative to the new benefits in the proposed benchmark. We used claim experience for the West region from the WACA database for unit cost information on procedures covered under Private Duty Nursing, per AMA Current Procedural Terminology (CPT) code assignments. As there is no clear delineation between CPTs for Private Duty Nursing and Home Health, we then looked at each CPT code and applied judgment to use codes that were specific to Private Duty Nursing. Similar to other benefits, the PMPM was grossed up to account for states in the West region where the benefit is not covered. The resulting PMPM allowed cost for Private Duty Nursing was equal to 0.4% of the total allowed claims from the same experience dataset.

² <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Example-Acceptable-Methodology-for-Comparing-Benefits.pdf>

³ The United Healthcare Choice plan was one of the base-benchmark plans options for the 2017 plan year, specifically a small group plan as defined under 45 CFR 156.100(a)(1) .

⁴ The benefit differences between the United and current benchmark are based on the *State of New Mexico Essential Health Benefits, Analysis of 2017 Benchmark Plan Options, June 2015, Leif Associates, Inc.* It should be noted that the report indicated a second difference under infertility treatment, which Wakely does not believe is actually a difference since it is a state-mandated benefit as noted in the Additional Clarifications on Certain Benefits section of this report.

As demonstrated in the previous analysis, the difference in the new benefits in the proposed benchmark plan, relative to the United Plan is 0.4% (see Table 1).

Table 1: Impact of Differences – Proposed Benchmark to the United Plan

Benefit Difference	Allowed Cost Impact⁵
Artery Calcification	0.0%
Prosthetics	0.0%
Weight Loss Drugs	0.0%
Opioid Reversal Agents	0.0%
Anti-Hepatitis C Drugs	0.3%
Total	0.4%

As seen in Table 2, this results in the proposed benchmark having the same level of generosity as a typical employer plan (as defined by the United Healthcare Choice Plan). Given that the proposed benchmark is equal to a typical employer plan, the new benchmark meets the typical employer test. Since the proposed benchmark does not exceed the generosity of the plan by 0.0%, it also meets the generosity test. As a result, the proposed benchmark meets both the typicality and generosity tests. Note that the needed supplementation for both the proposed benchmark and the United Healthcare Choice Plan are identical.

Table 2: Comparison of Proposed Benchmark to Typical Employer Plan

Benefits	Proposed Benchmark	United Healthcare Choice Plan
New Benefits in Proposed Benchmark	0.4%	n/a
United’s Private Duty Nursing Benefit	n/a	0.4%
All other benefits (including supplementation)	0.0%	0.0%
Differences from Typical Employer Plan	0.0%	n/a

⁵ Figures rounded to the first decimal to align with CMS de minimis rule of 0.0% and consequently may not equal total.

Appendix A: Data and Methodology

Wakely pulled 2017 allowed information by service line from its 2017 Wakely ACA (WACA) experience database and used this data to assess utilization and unit cost data for select benefit. The WACA data repository is comprised of issuer EDGE server data and includes over 7 million member lives in 2017. The data itself is available at the Regional level; for this analysis we used West US individual and small group market data as the starting point.

We used information in the data including (but not limited to) CPT / HCPCS codes, Revenue Codes, Inpatient DRGs, and NDCs to assign claims to Wakely-defined service lines and USP classes as applicable. For benefits that did not coincide with a specific service line (e.g. Artery Calcification Test), we looked at specific CPT codes⁶ linked to that procedure.

Once CPT-level (in some cases member-level was also used) data was acquired, we made any appropriate adjustments to the base information in order to isolate the projected costs pursuant to the specific benefit recommendations outlined in prior sections of this document. Specific adjustments by EHB benefit may have included:

- Unit cost adjustments to reflect coverage for only a portion of NDCs within a class
- Adjustments to the utilization in instances where the covered population would vary compared to what is covered in the data
- Coverage utilization adjustments to account for specific benefits not being included in all state benchmarks within the region being analyzed

⁶ <http://www.medicarepaymentandreimbursement.com>

Appendix B: Reliances and Caveats

The following is a list of the data Wakely relied on for the analysis:

- The 2017 Wakely ACA Database
- Analysis by Leif Associates, Inc. “Essential Health Benefits: Analysis of 2017 Benchmark Plan Options for the State of New Mexico”
- Presbyterian Health Plan Subscriber Agreement and Guide to Your Managed Care Plan, Individual HMO Plans
- The benefits and formulary for current individual and small group plans with the largest enrollment were also reviewed, vis-à-vis the following documents:
 - 2020 Molina Healthcare of New Mexico, Inc. Agreement and Individual Evidence of Coverage
 - 2020 New Mexico Health Connections Evidence of Coverage (Member Handbook), Individual HMO Plan
 - 2020 True Health New Mexico Health Plan Coverage Evidence of Coverage (Member Handbook), Small Group HMO Plan
 - 2020 Presbyterian Health Plan, Inc. Group Subscriber Agreement and Guide to Your Managed Care Plan, Group Metal Benefit Plan HMO

The following caveats in the analysis should be considered when relying on the results.

- **Data Limitations.** As discussed in the body of this report, the WACA database is comprised of EDGE server data. There are some variances in the EDGE data compared to other data sources that may be used to check the reasonability of the EDGE data; however, the variances were reasonable and not expected to impact the results. Additionally, it is possible that some portion of the data used may have been truncated due to state-specific EHB limits that are stricter than New Mexico’s current limits. Our analysis indicated any potential impact of such truncation to be low, if not negligible.
- **Enrollment Uncertainty.** This report was produced based on 2017 experience data. To the extent that the risk profile, mix of services utilized, size, or any other significant characteristic or combination of characteristics of the insured population changes significantly between 2017 and any year for which these projections are being used, the data on which this report is based may no longer be applicable.

- **Mental Health Parity.** Any testing for compliance with the requirements of the Mental Health Parity Act of 1996 was outside the scope of this project, and therefore was not performed. Changes in benefit coverage may affect such compliance; as such, OSI should be aware of any potential effects and take appropriate measures and / or precautions in order to ensure no issues arise.
- **Issuer Conformity.** The estimated impacts of removing coverage for specific benefits assumes that any changes to the New Benchmark plan will be adopted by all issuers present in the state, with respect to their covered benefits offered to members. All estimates are Wakely's of the change in allowed costs. Actual paid cost and premium impacts may vary by issuers, based on their internal data, models and drugs that they choose to include in their formulary, etc.

Appendix C: Disclosures and Limitations

Responsible Actuaries. Julie Peper and Andy Large are the actuaries responsible for this communication. They are Members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report. Abby Wolpern and Michael Cohen contributed to this report.

Intended Users. This information has been prepared for the sole use of New Mexico. Distribution to parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their own actuarial experts in interpreting results.

Risks and Uncertainties. The assumptions and resulting estimates included in this report and produced by the modeling are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that New Mexico will attain the estimated values included in the report. It is the responsibility of those receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. The responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent of New Mexico.

Data and Reliance. We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly. The information included in the 'Data and Methodology' and 'Reliances and Caveats' sections identifies the key data and reliances.

Subsequent Events. These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this report. Material changes as a result of Federal or state regulations may also have a material impact on the results. There are no specifically known relevant events subsequent to the date of engagement that would impact the results of this report.

Contents of Actuarial Report. This document (the report, including appendices) constitutes the entirety of actuarial report and supersede any previous communications on the project.

Deviations from ASOPs. Wakely completed the analyses using sound actuarial practice. To the best of our knowledge, the report and methods used in the analyses are in compliance with the appropriate ASOPs with no known deviations. A summary of ASOP compliance is listed below:

ASOP No. 23, Data Quality

ASOP No. 25, Credibility Procedures

ASOP No. 41, Actuarial Communication