

Proposed Revision of Actuarial Standard of Practice No. 45, “The Use of Health Status-Based Risk Adjustment Methodologies

Comment Deadline: September 1, 2026

Identification: Cori E. Uccello (comments submitted on my own behalf)

Thank you for the opportunity to review the exposure draft of the proposed revision to ASOP 45, “The Use of Health Status-Based Risk Adjustment Methodologies.” Risk adjustment is a critical component of the health system. It helps ensure insurers are appropriately paid for the risks they bear, providers are compensated in a manner that reflects their patients' health status and expected resource needs, and quality metrics accurately reflect outcomes rather than patient conditions, among other uses. Risk adjustment can facilitate payment approaches that more appropriately reflect differences in expected healthcare needs across individuals and populations.

Policymakers are paying increasing attention to risk-adjustment methodologies. At the same time, new approaches are being developed to address concerns such as coding intensity, gaming, and predictive performance, including models that incorporate electronic health record data, patient-reported information, or more parsimonious variable sets. These developments underscore the importance of actuaries understanding the strengths, limitations, intended uses, and potential consequences of the models they select and use.

The exposure draft highlights many of the issues inherent in choosing and using a risk adjustment methodology. My comments below highlight areas that could benefit from additional detail.

Section Number	Recommendation	Rationale
1.2	Provide additional discussion regarding the boundary between model design activities governed by ASOP Nos. 12 and 56 and model selection and use activities governed by ASOP No. 45.	The revised scope explicitly excludes actuaries involved in designing, reviewing, or modifying risk adjustment models. It is unclear why, especially since many actuaries are involved in evaluating model specifications, variable selection, and model updates as part of the model selection process.
3.2.1	Add quality measurement and provider performance assessment as an example of an intended use of risk adjustment.	Risk adjustment is commonly used to facilitate comparisons of outcomes across providers and organizations by accounting for differences in patient health status.
3.2.2	Add additional examples of behavioral responses, including enrollee selection incentives and more aggressive coding practices.	These are common and important consequences of risk-adjusted payment systems.
3.2.5	Consider adding examples of changes in healthcare patterns, such as the introduction of new treatments.	Provides additional clarity regarding the types of changes the actuary should consider.
3.2.7	Clarify that predictive accuracy is only one consideration when selecting among models.	A model with greater predictive power may be less appropriate if it creates undesirable incentives, lacks transparency, or is more susceptible to gaming.

3.3.2	Clarify what actions may result from identifying differences in coding accuracy and completeness.	The draft directs actuaries to take coding differences into account but does not indicate whether this should affect model selection, adjustments, interpretation of results, or some combination thereof.
3.3.4	Clarify what actions may result from identifying material provider contract differences.	Similar to Section 3.3.2, additional guidance regarding the expected response would improve consistency in application.
3.3.5	Consider expanding discussion of diagnostic test results and emerging models that rely on electronic health record data.	Newer risk adjustment methodologies increasingly rely on EHR information rather than claims data alone.
Appendix-Background	Add discussion of quality measurement and provider performance assessment.	Risk adjustment is widely used not only for payment but also for comparing outcomes across providers, plans, and other entities.
Appendix-Current Practices	Expand discussion of factors influencing selection of concurrent versus prospective models.	Model selection depends on intended use as well as the availability and completeness of prior-period information. In some circumstances, concurrent models may be necessary because prior-period diagnostic information is unavailable or incomplete.