Health Insurance Exchange Quality Rating System (QRS) 101

Overview: Quality Ratings of Qualified Health Plans on the Exchanges

Consistent with section 1311(c)(3) of the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) established a rating system for qualified health plans (QHPs) offered through an Exchange on the basis of relative quality and price. The purpose of the QRS (or star ratings) is to: (1) help consumers make informed decisions about health insurance coverage, (2) facilitate oversight of QHPs, and (3) provide actionable information to health plans to improve the quality of services they provide.

Star ratings for QHPs give consumers a snapshot of how the quality of each QHP compares to that of other Exchange plans across the country. Under the QRS, QHPs offered through Exchanges are given an Overall rating on a 5-star scale, with 5 stars representing highest quality. This rating is based on three categories: Member Experience, Medical Care, and Plan Administration. Each of these categories also has its own rating that is based on a 5-star rating scale. This provides consumers with an objective way to quickly compare plans, based on quality, as they shop for a plan that best meets their needs.

QRS Requirements

Eligible issuers that offer QHPs through Exchanges are required to submit quality data to CMS. This data submission requirement applies to all issuers that offered coverage in the prior year and the current year, and have more than 500 members. These issuers are required to collect and submit data for each unique product type offered in a state, called a reporting unit (Issuer ID-State-Product Type). Product types subject to the QRS requirements include Exclusive Provider Organization (EPO), Health Maintenance Organization (HMO), Point of Service (POS), and Preferred Provider Organization (PPO). At this time, the QRS requirements do not apply to indemnity plans (i.e., fee for service plans), stand-alone dental plans, child-only plans or basic health program plans. The data submitted to CMS is used to calculate each QHP's rating. In some cases — like when plans are new or have low enrollment — star ratings may not be available.

QRS Measures

The star ratings displayed beginning with the Plan Year 2024 Open Enrollment Period were calculated using a total of 38 quality measures including 28 clinical quality measures that assess general performance of the quality of health care services provided and 10 survey measures that assess member experience with their health plan. The measures are organized into three categories: Medical Care, Member Experience, and Plan Administration.

These three categories are combined to create the Overall ratings, with the Medical Care category given the greatest weight:

- **Medical Care** is based on how well the plans' network providers manage member healthcare, including providing regular screenings, vaccines, and other basic health services and monitoring some conditions.

- **Member Experience** is based on surveys of member satisfaction with their healthcare and doctors and ease of getting appointments and services.

- **Plan Administration** is based on how well the plan is run, including customer service, access to needed information, and network providers ordering appropriate tests and treatment.

The full list of the measures is included in the *QRS and QHP Enrollee Survey: Technical Guidance for 2023* which is available on the CMS website.

QRS Methodology

The QRS uses a methodology developed with input from key stakeholders and a technical expert panel. CMS calculates QRS star ratings based on validated clinical quality and survey measure data submitted by eligible issuers for each of their products in the Exchange.

The measures are organized into a hierarchy that serves as a foundation of the methodology. The levels of the hierarchy are designed to make the QHP quality rating information more understandable and allow consumers to review specific aspects of quality performance (i.e., Medical Care, Member Experience, and Plan Administration).

CMS calculates measure scores using performance targets or benchmarks. The measure benchmarks are defined by the top performing reporting units in the current year. Scores are calculated at each level of the hierarchy, resulting in three summary indicator scores and an overall score. CMS converts the summary indicator and overall scores into star ratings using a 1–5-star scale (5 stars is the highest). Each reporting unit will get an overall global star rating and its three underlying summary indicator star ratings, where eligible.

CMS continuously refines the QRS program and QHP Enrollee Survey based on a variety of factors, including interested party feedback, clinical guideline changes, Agency priorities, and advances in quality measurement and survey administration.

To learn more about the methodology applicable to the 2023 ratings year (Plan Year 2024), please see the *QRS and QHP Enrollee Survey: Technical Guidance for 2023*. Additionally, the *Final 2023 Call Letter for the QRS and QHP Enrollee Experience Survey*, that communicates changes for future years, is available on the CMS website.

Star Ratings Display on HealthCare.gov

During the Plan Year 2024 Open Enrollment Period, quality ratings will be displayed on HealthCare.gov when consumers view the list of QHPs available in their area. Each plan will show the Overall Rating within the list, or let the consumer know if the individual plan hasn't been rated. Consumers can see three additional ratings for Member Experience,

Medical Care, and Plan Administration with the Overall Rating when selecting an individual plan's detailed information along with other coverage and benefits. The Overall Rating and the three additional quality rating categories are displayed as well when consumers choose to compare up to three plans side-by-side.

Star Ratings Display on State-based Exchanges (SBEs)

Similar to the Exchanges that use HealthCare.gov, SBEs that do not use the federal platform are generally required to display the Overall Rating and the star ratings for the three categories which comprise the Overall Rating for each QHP offered through the Exchange. However, SBEs will continue to have flexibility to display additional state or local quality information for their health plans. SBEs will also have some flexibility to customize the display of their health plan quality information and to adjust the display names of the star ratings. CMS will work with SBEs in preparation of the display of star ratings for the Plan Year 2024 Open Enrollment Period.

Quality Public Use File (PUF) and Nationwide Quality Rating System PUF

The Quality PUF provides the star ratings assigned to QHPs available on HealthCare.gov, including those offered in Federally-facilitated Exchanges (FFEs) and State-based Exchanges using the Federal platform. The Nationwide Quality Rating System PUF provides star ratings and additional QRS measure data for QHPs offered in FFEs, State-based Exchanges on the federal platform (SBE-FPs), and in SBEs.

The *Quality Rating Information Bulletin* with display guidance for Exchanges and Direct Enrollment Partners for Plan Year 2024 is available on the CMS website.

The *Health Insurance Exchange QRS for Plan Year 2024: Results At A Glance* summary document is available on the CMS website.