Health Insurance Exchanges 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 based on relative quality and price for qualified health plans (QHPs) offered through an Exchange. 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 with other Exchange plans across the country. QHPs offered through Exchanges are given an Overall QRS rating on a 5-star scale, with 5 stars representing the highest quality. This rating is based on three categories: Medical Care, Member Experience, and Plan Administration, with each of these categories also receiving a rating on the 5-star scale. This provides consumers with an objective way to compare plans, based on quality, as they shop for a plan that best meets their needs.

QRS Requirements

Eligible issuers offering QHPs through Exchanges are required to submit quality data, including clinical and QHP Enrollee survey data, to CMS, which is used to calculate each QHP's rating. 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). Currently, 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. 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 2026 Open Enrollment Period were calculated using a total of 35 quality measures, including 26 clinical quality measures assessing the quality of health care services provided, and 9 survey measures assessing member experience with their health plan.

The measures are organized into three categories: Medical Care, Member Experience, and Plan Administration, which are combined to create the Overall star 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 of some conditions.
- **Member Experience** is based on survey responses regarding 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.

For a full list of the measures used to calculate the 2025 QRS star ratings for the 2026 Plan Year, refer to Exhibit 8 (pages 18-19) of the *QRS and QHP Enrollee Survey: Technical Guidance for 2025*.

QRS Methodology

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, using a methodology developed with input from key stakeholders and a technical expert panel.

The QRS measures are organized into a hierarchy that serves as the 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 one Overall global score. CMS converts those scores into one Overall star rating and three underlying category ratings using a 1–5-star scale (5 stars is the highest).

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 2025 ratings year (Plan Year 2026), please see the *QRS and QHP Enrollee Survey: Technical Guidance for 2025*. Additionally, the *Final 2025 Call Letter for the QRS and QHP Enrollee Experience Survey* communicates changes for future years.

Star Ratings Display on HealthCare.gov

During the Plan Year 2026 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 either show the Overall Rating with the number of stars from 1 to 5, or will note

if the individual plan has not been rated. The three additional ratings for Medical Care, Member Experience, and Plan Administration, along with the Overall Rating are available, along with other coverage and benefits, when selecting an individual plan's detailed information. These four ratings are also displayed when consumers choose the "Compare Plans" function, 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 have flexibility to display additional state or local quality information for their health plans. SBEs 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 for the display of star ratings for the Plan Year 2026 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 QRS display guidance for Exchanges and Direct Enrollment Partners for Plan Year 2026 is available in the Quality Rating Information Bulletin.

The Health Insurance Exchange QRS for Plan Year 2026: Results-at-a-Glance summary document is available on the CMS Marketplace Quality Initiative website.