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 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 qualified health plans, and (3) provide actionable information to health plans to improve the quality of services they provide.

Star ratings in the Exchange give consumers a snapshot of how each qualified health plan's quality compares to that of other Exchange plans in each state and across the country. Under the QRS, qualified health plans offered through Exchanges are given an overall rating on a 5-star scale, with 5 stars representing highest quality. This rating is based on 3 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

Issuers that offer qualified health plans through Exchanges are required to submit quality data to CMS. This data submission requirement applies to all issuers that offered coverage during the previous consecutive plan years and the current year, and have more than 500 enrollees. 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 Quality Rating System requirements include Exclusive Provider Organization (EPO), Health Maintenance Organization (HMO), Point of Service (POS), and Preferred Provider Organization (PPO). The star ratings measure data submitted to CMS is used to calculate each qualified health plan'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 that will be displayed beginning with the Plan Year 2023 Open Enrollment Period, were calculated using a total of 34 quality measures including 24 clinical quality measures that assess general performance of the quality of health care services provided and 10 survey measures that assess enrollees' experience with their health plan. The overall rating is based on Medical Care, Member Experience and Plan Administration. The Medical Care category is given the greatest weight, but these three categories are combined to create an overall rating.

- **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 available in the Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2022.

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. CMS calculates scores at each level of the hierarchy, resulting in one overall global score. The levels of the hierarchy are designed to make the qualified health plan quality rating information more understandable to consumers, and allow consumers to review specific aspects of quality performance (e.g., Medical Care, Member Experience). CMS converts those scores into an overall global star rating 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 stakeholder feedback, clinical guideline changes, Agency priorities, and advances in quality measurement and survey administration. For the 2022 ratings year (Plan Year 2023), CMS anticipated that QRS measure data and results may be impacted by the ongoing COVID-19 public health emergency (PHE) and therefore retained a temporary refinement to mitigate the impact of the COVID-19 PHE on the QRS star ratings.

To learn more about the methodology applicable to the 2022 ratings year, please see the Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2022. Additionally, the *2022 QRS Proof Sheet User Guide,* which reflects updates to the QRS rating methodology finalized via the Final Call Letter for the 2022 QRS and QHP Enrollee Experience Survey, is available on the Marketplace Quality Initiatives website.

Star Ratings Display on HealthCare.gov

During the Plan Year 2023 Open Enrollment Period, quality ratings will be displayed on HealthCare.gov when consumers view the list of qualified health plans available in their area. Each plan will show the Overall Rating with the number of stars from 1 to 5 filled in towards the top of each plan 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 qualified health plan 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 beginning with the Plan Year 2023 Open Enrollment Period.

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

The Quality PUF provides the star ratings assigned to qualified health plans 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 qualified health plans offered in FFEs, SBE-FPs, and in SBEs.

The QRS display guidance for Exchanges and Direct Enrollment Partners for Plan Year 2023 is available on the Marketplace Quality Initiatives website

The Health Insurance Exchange QRS for Plan Year 2023: Results At A Glance summary document is available on the Marketplace Quality Initiatives website.