



EMPLOYER AND HEALTH PLAN ANALYTICS

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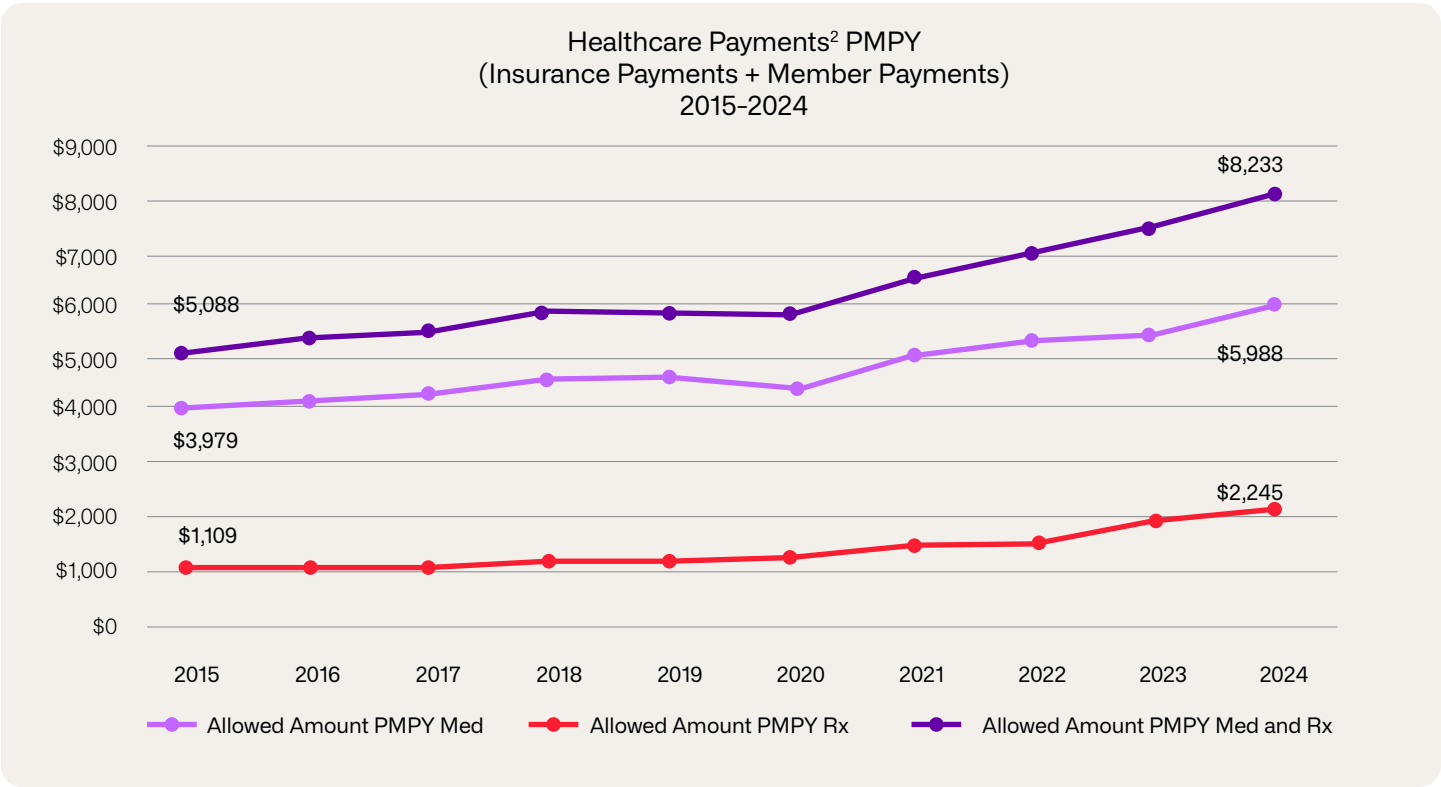
Notable trends in healthcare spend from 2015 to 2024

By: Leah Kamin

Source: Truven Semi Annual Norms Report¹

Truven’s employer client’s healthcare spend per member per year (PMPY) trend from 2023 – 2024 was 9.6%, with high growth in both medical and drug (9.1% and 10.9%, respectively). [PWC predicted group trends to be around 7.5%.](#)

Since 2015, the compound annual growth rate (CAGR) in prescription drug costs has outpaced CAGR in medical costs (8.2% versus 4.6%). The medical and prescription drug healthcare growth rate post-COVID (2021-2024) is stronger than the growth rate pre-COVID (2015-2019) (7.9% versus 3.8%, respectively). While this is true for both medical and prescription drug spend, prescription drug growth post-COVID is almost 3.5 times higher compared to pre-COVID (13.1% versus 3.6%, respectively).



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	% Change from 2023-2024	CAGR since 2015	CAGR from 2015-2019	CAGR from 2021-2024
Payments PMPY Med	\$3,979	\$4,239	\$4,233	\$4,580	\$4,632	\$4,454	\$4,996	\$5,230	\$5,488	\$5,988	9.1%	4.6%	3.9%	6.2%
Payments PMPY Rx	\$1,109	\$1,160	\$1,200	\$1,271	\$1,278	\$1,355	\$1,552	\$1,756	\$2,024	\$2,245	10.9%	8.2%	3.6%	13.1%
Payments PMPY Med and Rx	\$5,088	\$5,399	\$5,523	\$5,851	\$5,910	\$5,809	\$6,548	\$6,986	\$7,512	\$8,233	9.6%	5.5%	3.8%	7.9%

Note: PMPY is per member per year

From 2023 to 2024, payers experienced the largest growth rates for facility outpatient services (10% per contract per year), other professional services (9.6% per contract per year), mental health and substance use services (MHSA) (15.5% per contact per year), and prescription drugs (10.2% per contact per year). Members experienced a 5.8% increase in out-of-pocket costs per family per year, which is less than what payers experienced (8.7% increase per contract per year). Members had the largest growth for laboratory services (11.7% increase) and prescription drugs (9.4% increase).

Activities	Insurance Payments per Contract per Year (PEPY)			Patient Payments per Contract per Year (PEPY)		
	2023	2024	% Change	2023	2024	% Change
Facility Inpatient	\$2,230	\$2,307	3.5%	\$117	\$118	0.9%
Facility Outpatient	\$3,082	\$3,391	10.0%	\$527	\$522	7.4%
Physician Inpatient	\$250	\$268	7.2%	\$37	\$38	2.7%
Physician Outpatient	\$1,246	\$1,345	7.9%	\$347	\$365	5.2%
Other Professional Services ⁽²⁾	\$1,406	\$1,541	9.6%	\$392	\$396	1.0%
MHSA	\$685	\$791	15.5%	\$173	\$185	6.9%
Laboratory Outpatient	\$392	\$409	4.3%	\$128	\$143	11.7%
Radiology Outpatient	\$653	\$706	8.1%	\$174	\$181	4.0%
Prescription Drugs	\$3,857	\$4,249	10.2%	\$446	\$488	9.4%
Total	\$13,801	\$15,007	8.7%	\$2,343	\$2,480	5.8%

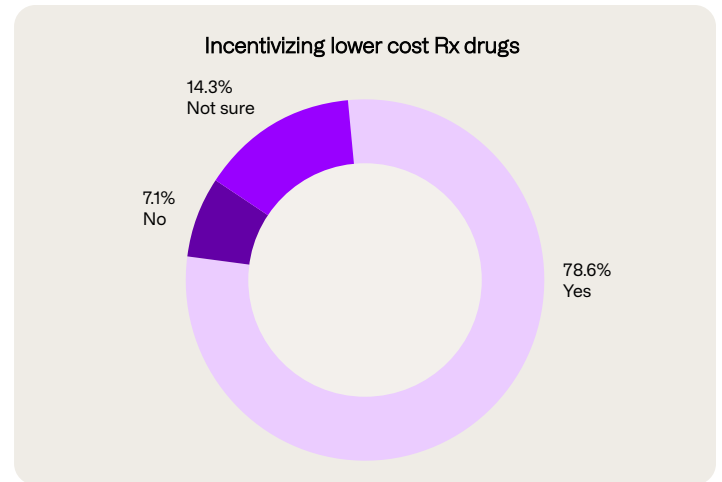
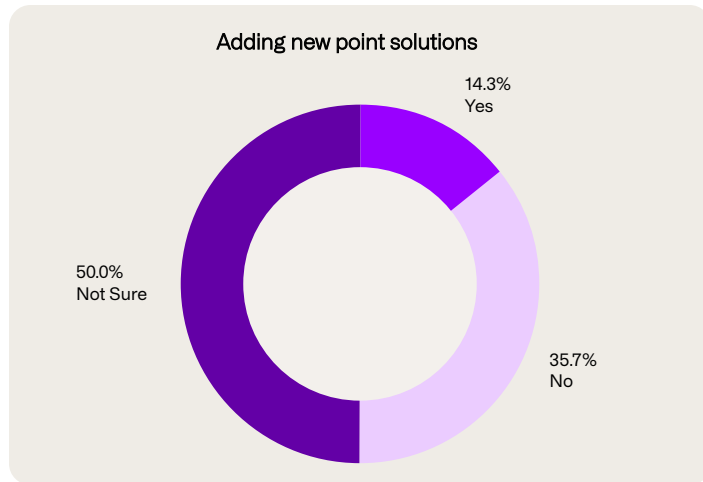


Q1 survey recap: Healthcare policy shifts

In our last Spotlight, Truven asked you how you are planning are preparing to meet regulatory changes. Our Q1 client survey showed there is great uncertainty regarding recent healthcare policy shifts. Half of respondents said they were not sure if they were planning any cost-saving measures in their plan benefits or coverage in the next 12 months. This includes reducing certain benefits, switching to lower-cost health plans, or steering individuals to low-cost care settings.

Half of those surveyed were also not sure whether they would implement any new point solutions to help manage high-cost or high-risk conditions or populations, either in 2025 or in the next 12 months. Just over half (57%) said they were not planning to phase out any existing solutions along those lines, either this year or in the next 12 months.

However, respondents say they are incentivizing members to choose lower cost prescription drugs (78%), choose lower cost sites of care (64%), and choose lower cost providers (50%).



Your Truven account team can help you as you navigate strategies to address policy uncertainty – reach out to your team to learn more.



Reforming the prior authorization process

U.S. Health and Human Services Secretary Robert F. Kennedy, Jr. and CMS Administrator Dr. Mehmet Oz met with industry leaders to discuss pledges aimed at streamlining prior authorization processes for Medicare Advantage, Medicaid Managed Care, and commercial plans. Federal health officials announced that health insurance companies have committed to reforming the prior authorization process, which affects most insured Americans.

Among the efforts is establishing a common standard for submitting electronic [prior authorization](#) requests by the start of 2027. By then, at least 80% of electronic prior authorization approvals with all necessary clinical documents will be answered in real time, the release said. Additionally, individual plans will reduce the types of claims subject to prior authorization requests by 2026.

To understand if your plans are making meaningful changes to the prior authorization process, consider loading prior authorization data into your integrated data warehouse.

SURVEY

Prior authorization

Please take a few minutes to tell us about your organization's experience with prior authorization.

[Complete our quick survey now!](#)



Results will be confidential, de-identified, and aggregated in our next Spotlight.

Start survey





GLP-1 outcomes: What we've learned and where payers need to focus next

By: Katherine Shanahan

Over the past few years, everyone from employers and health plans to pharmaceutical manufacturers, providers, legislators, and researchers are focused on GLP-1s – investigating the impact these medications are having on clinical and financial outcomes as a result of treatment.

Recently, several outcome studies have been published (or are in progress). This includes research from the Institute for Clinical and Economic Review (ICER), which gave Diabetes GLP-1s (such as [Rybelsus](#) and [Mounjaro](#)), fairly good “value ratings,” noting that their use provides a net health benefit, but their prices are high. ICER “value prices” these medications up to \$5,700 annually for Mounjaro and \$6,400 for Rybelsus, which is significantly lower than real-world pricing in MarketScan (\$12,533 and \$10,592, respectively). ICER is currently working on an Obesity-specific GLP-1 study, which is expected to be published in November 2025, but has released a whitepaper in the meantime, advising the healthcare industry on strategies to manage GLP-1 Obesity mediations. This includes [exploring various market strategies](#) for commercial payers such as carving out Obesity management services, innovative payment arrangements, provider network management, enhanced prior authorization and formulary management, and temporary coverage denial.

Similarly in April 2025, [Aon published a study](#) identifying a 7-percentage point improvement in medical spend growth for GLP-1 users who were adherent to treatment, driven by a 44% reduction in cardiovascular hospitalizations. These results mirror what Truven is seeing in client-specific analyses, but miss the three major issues that payers are encountering with total population management:

1. There remains significant improper use of GLP-1 medications.

This includes both true off-label utilization, as well as improper engagement with physicians and care coordination. Analysis in MarketScan still shows 11% of patients taking a Diabetes GLP-1 are missing a diagnosis for Diabetes in 2024. While this has decreased from 15% in 2023, this misuse leads to an additional \$34 in PMPY spend. Even for patients who fit the appropriate FDA criteria, a rise in online prescribing and doctor shopping is leading to patients missing the care coordination necessary for successful outcomes. Critically, this includes coaching lifestyle changes and side effect management; without which patient persistence on GLP-1s is severely impacted.

2. GLP-1 persistence is low, especially for Obesity medications.

MarketScan data shows that only 63% of continuously enrolled new GLP-1 patients were persistent on Obesity medications for at least 40 weeks (10 months) in 2022 – 2024, compared to 75% of patients taking Diabetes products. Most clinical trials for GLP-1s study outcomes at a minimum of 40 weeks (with many going far beyond this initial measurement period). Patients who do not reach at least the 40-week threshold are unlikely to see the same outcomes (clinical and financial) that are the goal of treatment. [A study published by the Cleveland Clinic](#) in June 2025 showed that real world outcomes did not match clinical trials largely because of early discontinuation and non-persistence. MarketScan shows medication spend for these non-persistent patients makes up 12% of total GLP-1 spend for Obesity patients and 7% for Diabetes patients.

3. GLP-1 costs are unsustainable.

GLP-1s are driving healthcare trends for nearly all payers and many report budgetary issues due to their uptake and cost. GLP-1 pricing per days' supply has a compound annual growth rate (CAGR) of 6% since 2020, outpacing inflation. This growth is mostly due to newer, more effective products coming to market – when adjusted, same-product growth ranges from only -11% to 5% during the same period. Still, [when compared to other countries](#), U.S. payers are paying 2x – 5x times higher for GLP-1 medications⁶ (although U.S. payers also reporting receiving high rebates, narrowing this gap).



Truven is working with entities across the healthcare landscape to investigate whether GLP-1s are moving the needle and providing value. In addition to working with payers to analyze GLP-1 utilization and identify opportunities to improve outcomes, we continue to advocate for payers to share their perspectives on what is working and what isn't. To continue the discussion from Merative's GLP-1 roundtable and client survey results from 2024, we asked payers to speak about how they are managing GLP-1 utilization and setting their members up for success at our Truven Health Summit back in May 2025.

Here are some of the key takeaways from the feedback and advice we've heard:

- GLP-1s are working, but only for a small subset of total patients. Patients who are treated appropriately, who are adherent/persistent, and are making lifestyle changes.
- Rebates may make up the difference between actual and value pricing, but payers need better transparency.
- For some payers, enhanced prior authorizations and wrap-around requirements may outweigh rebate savings because a higher percentage of patients will see better outcomes.
- Many payers are having to drop Obesity GLP-1 coverage due to high cost and inflexibility of PBMs and drug manufacturers.
- Wrap-around care is critical, but payers are generally not in a place to align across benefits (and struggling with leadership to invest even more money, when GLP-1s are already heavily impacting budgets).
- There is a severe lack of transparency into appropriate prescribing and data recording.

Based on this feedback, below are the key recommendations for payers looking to manage GLP-1s into 2026 and beyond:

1. Require a recorded diagnosis code GLP-1 prior authorizations. This includes either a Diabetes diagnosis code for Diabetes products or a BMI diagnosis (Z-code) for Obesity products.
2. Require wrap-around care coordination to improve side effect management, persistence, and lifestyle changes. This could include carving out Obesity management services, a narrow network of prescribers, or engagement with care managers.
3. Require product-level rebate transparency to aid in financial outcome analysis and more informed formulary management.
4. Negotiate vendor performance guarantees specific to engagement and utilization measures that are known to produce the best outcomes. This includes risk-matching patients with the right product or keeping patients adherent to treatment.
5. Expand utilization and spend reporting to track key outcome measurements, including improper use and non-adherence. Consider how to track clinical outcomes such as HbA1c or BMI improvement.

For more information on GLP-1s, including how we can help support your business initiatives, please reach out to your Truven account team.

MarketScan data for this article represents commercial claims incurred January 2020 – October 2024.





Control costs and improve outcomes through site of care optimization

By: Jeff Cowan

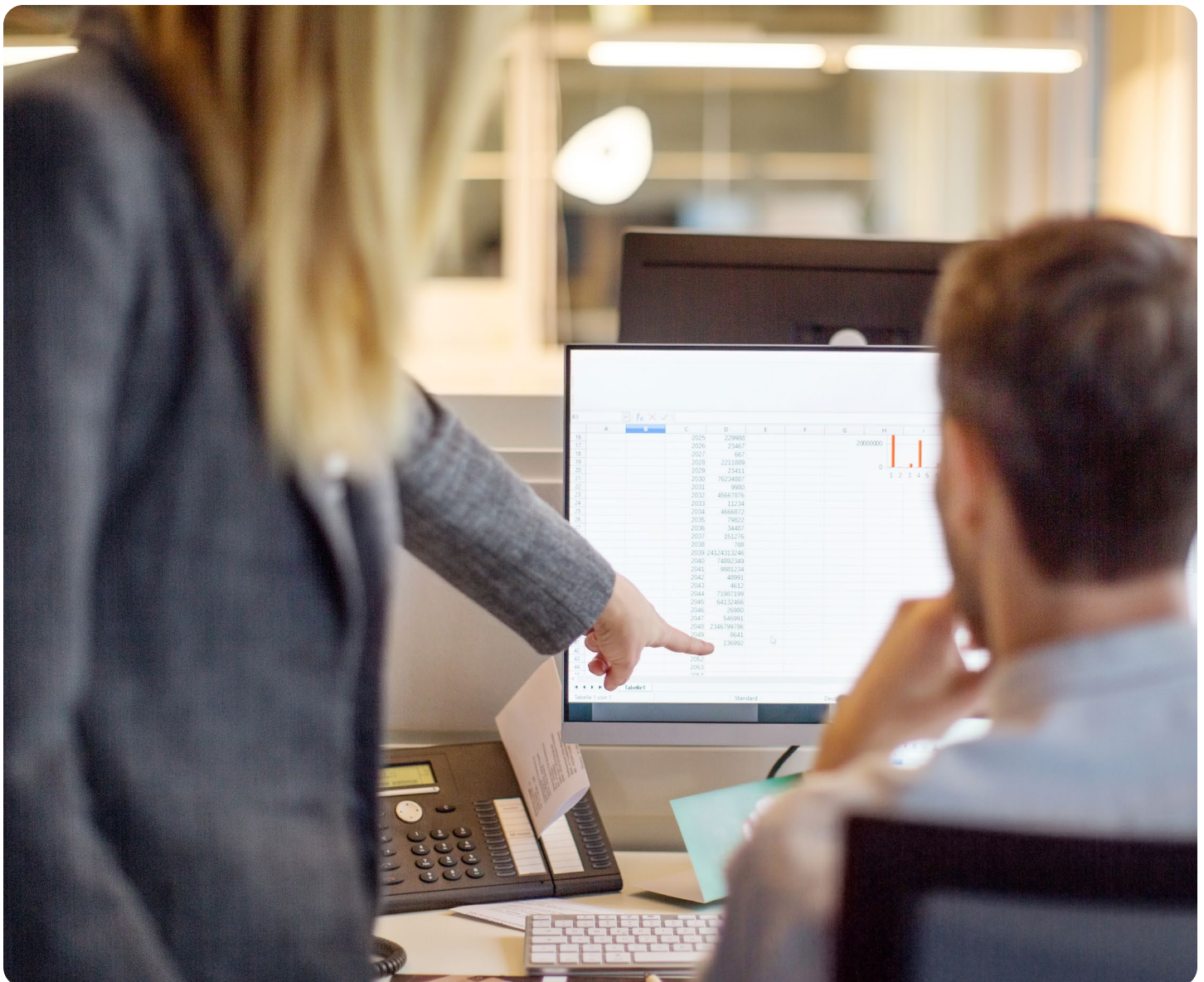
Healthcare costs are on the rise, and are expected to increase 8% this year, according to a 2025 survey from the Business Group on Health. This is the highest annual rate in the last decade and caps off a cumulative 50% increase since 2017.

Everything from rising prescription drug costs to medical technology to pharmacological advancements and innovations to provider consolidations and even increased chronic condition prevalence are impacting that increase. However, numerous strategies can be utilized to mitigate costs, such as focusing on [population health](#), new benefit designs, [value-based care](#), payment integrity, [price transparency tools](#), and many others.

Site of care optimization is a broad-based strategy that gained popularity during the COVID-19 pandemic. It's designed to improve efficiency in healthcare delivery by identifying the most cost-effective and clinically appropriate location for delivering healthcare services to patients.

Health plans and employers interested in pursuing site of care optimization as a means of controlling costs and improving outcomes need strong and reliable data to shape strategy, steer members, and successfully negotiate contracts. By identifying services that yield meaningful opportunity, understanding the nuances of reimbursement amounts, and having reasonable price and quality goals, the odds improve for successfully implementing a site of care optimization strategy or engaging suitable provider partners.

Read the full blog [here](#).





CT scans and the hidden risk of future cancer

By: Leah Kamin

Computed tomography (CT) scans have revolutionized modern medicine, offering rapid, detailed imaging that helps diagnose everything from internal injuries to cancer. But a growing body of research is raising concerns about the long-term risks associated with the radiation exposure from these scans—particularly the potential link to future cancer.

[A recent study](#) led by Dr. Rebecca Smith-Bindman at the University of California, San Francisco, and published in *JAMA Internal Medicine*, has updated national estimates on how CT scan radiation may contribute to cancer risk. Using data from over 140 healthcare facilities across 20 states, researchers analyzed nearly 93 million CT scans performed in 2023. Their findings are sobering: if current practices continue, CT scans could be responsible for up to 5% of all new cancer diagnoses in the U.S. each year.

CT scans use X-rays to create detailed images of the body. While incredibly useful, they expose patients to significantly more radiation than standard X-rays. This radiation can damage DNA, potentially leading to mutations that cause cancer over time.

The study used the NIH's Radiation Risk Assessment Tool (RadRAT) to estimate lifetime cancer risks. It found that abdominal and pelvic scans were the largest contributors to projected future cancers, followed by chest and head scans. Lung and colon cancers were the most common types linked to CT radiation exposure.

Children at higher risk

Although only 4% of CT scans were performed on children, the risk per scan is significantly higher for younger patients—especially infants under one year old. Their developing tissues are more sensitive to radiation and they have more years ahead during which cancer could develop.

Balancing risk and benefit

CT scans can save lives. The key takeaway from the research is not to avoid CT scans altogether, but to use them judiciously. Medical professionals are encouraged to:

- Avoid unnecessary scans
- Use the lowest effective radiation dose. Radiation doses for the same type of scan (e.g., abdominal CT) could vary up to 50-fold between facilities. This variation was [attributed more to operator practices](#) than to differences in equipment or patient needs
- Consider alternative imaging methods, like MRI or ultrasound, when appropriate

What you can do

As a patient, you can take an active role in your healthcare:

- **Ask questions:** Why is this scan necessary? Are there alternatives?
- **Keep records:** Track your imaging history to avoid redundant scans.
- **Discuss risks:** Especially if you or your child are undergoing multiple scans.

Some regions performed far more scans per capita than others, even after adjusting for population age and health status. In 2023, there were 1.3M CT scans in the U.S., with MarketScan data showing the following variation by region:

Region	% Population with CT scan
U.S. Total	7%
New England	5%
Mid Atlantic	6%
East North Central	7%
West North Central	7%
South	7%
East South Central	8%
West South Central	6%
Mountain	7%
Pacific	6%

Some of the factors leading to geographic variation include

- **Local medical culture:** Some areas have a higher tendency to order imaging as a precaution or due to defensive medicine.
- **Access to imaging facilities:** Urban centers with more hospitals and imaging centers tend to have higher scan rates.
- **Insurance and reimbursement policies:** Regions with more generous coverage may see more frequent use of advanced imaging.
- **Patient expectations:** In some communities, patients may request or expect imaging even when not strictly necessary.

Other risk factors associated with future cancers include:

Tobacco use

- Still the leading preventable cause of cancer.
- Strongly linked to lung, throat, mouth, esophageal, bladder, and pancreatic cancers.
- Responsible for about 30% of all cancer deaths in the U.S.

Alcohol consumption

- Even moderate drinking increases the risk of breast, liver, colorectal, and esophageal cancers.
- Alcohol acts as a carcinogen and can also enhance the effects of other carcinogens like tobacco.

Obesity and excess body weight

- Associated with 13 types of cancer, including breast (postmenopausal), colorectal, endometrial, kidney, and pancreatic cancers.
- Excess fat can lead to chronic inflammation and hormonal imbalances that promote cancer development.

Poor diet

- Diets high in processed meats, red meat, and low in fruits and vegetables, are linked to colorectal and stomach cancers.
- High sugar intake and ultra-processed foods may also contribute indirectly through obesity.

Physical inactivity

- Sedentary lifestyles are associated with increased risk of colon, breast, and endometrial cancers.
- Regular physical activity helps regulate hormones and immune function.

UV radiation (sun exposure and tanning beds)

- Major cause of skin cancers, including melanoma.
- Risk is cumulative and higher with early-life exposure.

Infections

- Certain viruses and bacteria are linked to cancer:
 - HPV → cervical, anal, and oropharyngeal cancers.
 - Hepatitis B and C → liver cancer.
 - Helicobacter pylori → stomach cancer.

Environmental and occupational exposures

- Includes asbestos, benzene, formaldehyde, and air pollution.
- Long-term exposure in certain jobs or urban environments increases cancer risk.

Genetic predisposition

- Inherited mutations (e.g., BRCA1/2) significantly increase the risk of breast, ovarian, and other cancers.
- Family history is a key factor in screening decisions.





How price transparency impacts cost savings

By: Mark McKenzie

Controlling healthcare costs remains a hot topic for both healthcare payers and consumers. Like many other industries, healthcare is looking out for potential rising costs due to recently imposed tariffs, which may affect things like medical supplies and prescription drugs. On the other hand, the “Most Favored Nation” policy is expected to have more of a cost-mitigating effect as it continues the federal government’s efforts to negotiate lower drug pricing. With the heightened interest in the area of lowering healthcare costs, the value of leveraging price transparency tools similarly increases as they provide valuable insight for both members and payers into the cost of services and variation among providers, which can aid efforts to reduce the amount we are spending on healthcare.

For example, the cost for a vaginal delivery as reported on Hospital and Health Plan MRFs ranged between \$9,847 and \$11,372 for individuals with insurance coverage, which is similar to the client rate of \$10,610. Comparing the client rate instead to the median rate of \$9,737 from [Reimbursement Benchmarks](#) uncovers a potential savings opportunity of over \$1.4 million.

Reimbursement codes		Client Data	Hospital MRF	Hospital MRF						Health plan MRF	MarketScan	Medicare	Saving opportunity	
Code	Code description	Client rate	Admits Claims	Gross charge	Cash price	Plan 1	Plan 2	Plan 3			Reimbursement benchmarks median	Fee schedule rate	Renegotiate rate to RB median	Potential Savings
MS-DRG 807	Vaginal delivery without sterilization/D&C without CC/MCC	\$10,610	1,620	\$16,199	\$12,149	\$11,372	\$10,245	\$9,847	\$10,847		\$9,737	\$7,402	\$873	\$1,414,260
CPT 99285	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making	\$1,850	3,320	\$2,670	\$2,003	\$2,003	\$1,823	\$1,744	\$1,804		\$1,633	\$1,151	\$217	\$720,440

In another example, we take a group of cardiologists and compare each of their costs to the average amongst their peers. A simple comparison shows that Dr. Smith has the lowest cost. However, taking the additional step to adjust the benchmark to control for differences in each physician’s patient population reveals that Dr. Reid is less costly than expected for their patient population risk, and is one of the better performing physicians. Dr. Smith was actually expected to be less costly after accounting for patient risk and was the least efficient physician in the group, despite having the lowest cost.

Managing physician	Actual average cost per episode	Expected average cost per episode	Performance ratio
Dr. Smith	\$772	\$594	1.3
Dr. Reid	\$1,039	\$1,915	0.8
Dr. Mitchell	\$1,287	\$1,299	1.1
Dr. Taylor	\$1,724	\$1,170	0.9
Cardiology specialty	\$1,100	\$1,100	1

Read the full blog [here](#).



Commercial insurance considerations during economic downturns

By: Leah Kamin

Many economists and financial pundits are [predicting a financial downturn](#) that will be driven by President Trump's threat of tariffs and other policies. In times of economic uncertainty, payers can prepare by making appropriate adjustments to their commercial insurance offerings.

A Truven survey of large payer respondents during March 2025 demonstrated that only 2 payers (of 14) were planning on employing cost savings measures during the next 12 months, while 5 of those payers are considering additional investments in their benefits and wellbeing programs. Firm cost containment needs may shift quickly in our current environment, but today, we do not see evidence that benefits offerings will be among the first of employers' cost containment strategies.

What are the impacts of an economic downturn on insured populations?

An economic downturn may result in loss of employment for an increased portion of the population. Layoffs will increase rates of COBRA use and cause the rate of uninsured individuals to increase. Those who remain employed, financial and price pressures may result in [delaying or forgoing elective care](#) and possibly necessary care. Mental health may be impaired by financial and social pressures and as a result, physical health may suffer.

What can payers do to prepare?

Employers may respond to the price pressures by going out to bid for new health insurance plan administrators. Recessions may be an optimal time to consider new insurance products because [the insurance market will likely become much more competitive](#), not only in terms of price, but also in attracting and retaining customers through better customer service or offering innovative solutions. Payers will also likely push lower costing alternative health plans and high-deductible health plans that have a lower premium and cost shift to employees. Given the lower premiums of these plans, employees may decide to switch to high-deductible health plans.

If a recession is imminent, payers should educate members on low- or no-cost options available to help them to maintain their health if they are reluctant to use care because of its perceived cost.

An "easy button" option to help firms and members save money and improve efficiency in the system is to ensure efficient plan choice during open enrollment. [A research study by economist Ben Handel](#) has shown that people do not translate readily available information into knowledge that would help them make better decisions. This results in families losing at least \$1,000, by choosing one option versus the other. The families most likely to choose less efficient plan options were often poorer people, earning less than \$40,000 a year. Payers should reconsider the tools they are providing to their employees during plan selection to ensure payers are [employing high quality tools](#) that will help families make efficient choices.

[An American Economic Association paper](#) also showed that these choices are, in part, driven by offering at least one plan, called a dominated option, that is not optimal for the firm or for the member. This lower efficiency plan is the result of updating their premiums according to an algorithm. Payers should continue to work with their actuarial vendors to ensure safeguards are in place to not offer these plan choices.



Save the Date for the 2026 Truven Health Insights Summit

By: Marcy Tatsch

It's been six years since we were together in person for the Truven Health Insights Summit. We were delighted that nearly 80 employers, health plans, public plan sponsors, and benefits advisors all joined us in Chicago this past May.

The two-day event had three key takeaways:

- Healthcare faces rising costs but applying data and analytics can help better manage population health and financial outcomes
- Employers need a benefits program with a clear mission to help secure buy-in across the organization
- AI holds promise, but there is still an opportunity to unify data more seamlessly

Prescription drugs were also a hot topic. There was a fascinating panel discussion where presenters shared varied experiences and strategies for dealing with the rising costs of GLP-1 drugs – and everyone's in a different place. Attendees also discussed the importance of benchmarking your data to drive relevant industry or geographical comparisons. Clients recommended leveraging MarketScan® Data and pulling in other industry benchmarks, such as Reimbursement Benchmarks for medical procedures or NADAC and Cost Plus for drugs.

Truven's own research shows that 37% of employers, health plans, and brokers lack high-quality, reliable data on health outcomes, and 33% fall short on analytics or data science talent within their organizations. Our goal is to help plug those gaps for our clients.

We can't wait to see what the 2026 Truven Health Insights Summit – scheduled for May in Nashville – will bring! Save the date and keep up with the event details [here](#).

Read the complete blog [here](#).

About Truven

Truven by Merative is a portfolio of healthcare data and analytics solutions, backed by 40 years of deep healthcare expertise. We provide trusted insights and proven expertise to help employers, health plans, life sciences organizations, and government agencies drive better health and financial outcomes. With market-leading solutions like Health Insights and MarketScan, Truven serves 7 of the top U.S. health plans, over 40% of the Fortune 500, and the top 20 global pharmaceutical companies.

Learn more at merative.com/truven

About Merative

Merative provides data, analytics, and software for healthcare and government social services. With focused innovation and deep expertise, Merative works with providers, employers, health plans, governments, and life sciences companies to drive real progress. Merative helps clients orient information and insights around the people they serve to improve decision-making and performance.

Learn more at merative.com

References

1. Source: Truven MarketScan's Employer Semi-Annual Norms report (SANR). This report of benchmark data are released twice a year and contain some of our most common requests for benchmarks. For more information, please contact a Truven team member for what is included in this benchmark data.
2. Payments represent claims payments, and they do not include premiums, rebates or fees.
3. Other professional services include services from providers like physician assistants, nurse practitioners, transportation, DME, etc.

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