KEY FINDINGS

U.S. EMPLOYER BENCHMARKS AND TRENDS

EMPLOYER PRACTICE LEADERSHIP
TRUVEN HEALTH ANALYTICS
JULY 2012

TRUVEN
HEALTH ANALYTICS

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EXECUTIVE SUMMARY

Employers who take a data-driven approach to managing population health and productivity can minimize financial and delivery risk. They can also maximize their opportunities to reduce cost trends and ultimately make their benefit programs sustainable in the context of healthcare reform.

Timely and appropriate benchmark comparisons are essential to identify areas for program intervention, measure progress, and provide decision-makers with appropriate context for program performance. Our Truven Health MarketScan® Research Databases comprise the industry-leading standard for comprehensive employer-focused benchmarks for all aspects of health and productivity programs.

RECENT MARKETSCAN TRENDS

From 2007–2011, U.S. employers experienced average trends of 5.4 percent annually in active per member per year (PMPY) allowed medical and pharmacy costs. We expect allowed amounts for actives to grow by 4 to 5 percent in 2012 and 2013. Employee out-of-pocket costs (deductibles, copayments, and coinsurance) increased at roughly a 6.6 percent annual rate over the same period.

Total allowed active medical and pharmacy costs increased by 4.6 percent from $9,430 per employee per year (PEPY) for the rolling year from Nov. 1, 2009, to Oct. 31, 2010, to $9,867 PEPY for the following 12-month period. The service categories of Mental Health and Substance Abuse (MHSA, 13.8 percent), Facility Outpatient (8.6 percent), and Outpatient Laboratory (4.6 percent) had the highest cost trend rates.

Employer pharmacy costs have moderated in recent years because of the increasing availability and use of generic medication, changes in overall drug prescriptions heavily influenced by generic use, and proactive plan design management. Recent MarketScan data show that PEPY allowed pharmacy costs increased by 3.7 percent from $1,835 to $1,903 for the period Nov. 1, 2009, to Oct. 31, 2010.

Medical and pharmacy costs and cost trends vary significantly by industry segment. Chemical and Refining ($12,170) and Auto Manufacturing ($11,614) had the highest annual per active employee allowed costs in 2011. Retail ($8,057) and Transportation/Logistics ($8,089) had the lowest industry group costs.

This report contains additional details on medical and pharmacy cost trends, as well as sections on dental trends and Consumer Directed Health Plan (CDHP) norms.

DATA AND METHODOLOGY

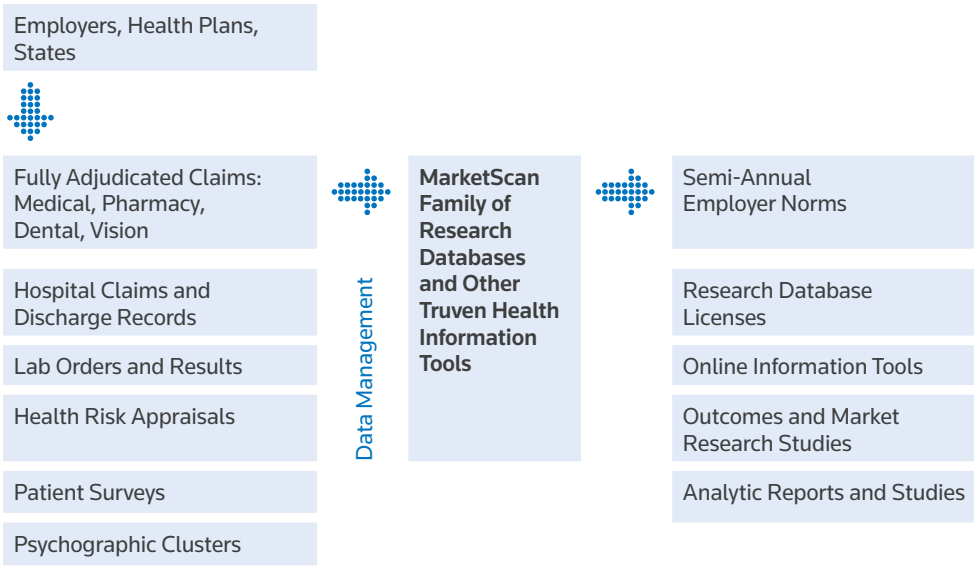
MARKETSCAN RESEARCH DATABASES

The gold standard in proprietary U.S. research databases, the MarketScan data warehouse, gives healthcare researchers access to fully integrated, anonymous, individual-level healthcare claims data to help them understand health economics and outcomes. Patient-level data (inpatient, outpatient, drug, lab, health risk assessment, and benefit design) from commercial, Medicare supplemental, and Medicaid populations reflect real-world treatment patterns and costs (Figure 1).

The MarketScan Research Databases offer:

- **Longitudinal Strength.** MarketScan provides the longest data history available, extending data back to 1995. This enables us to track patients over multiple years in detail.
- **Unique Data Sources.** Unlike competitors, MarketScan is comprised of data from both employers and health plans. This allows us to track patients even when they switch health plans.
- **Multi-faceted Patient-Level Detail**. We link MarketScan data at the patient level using a unique identifier that is consistent across services, health plans, and time. This includes patient copayments, mail-order prescriptions, specialty pharmacy, carve-out services, manually and electronically submitted claims, and plan summaries.
- **Complete Continuum of Care Views**. MarketScan data fully integrate all treatments and plan designs to provide insights into the impact of cost, treatment, and behavioral drivers.
- **Reliability and Validity**. Researchers have published more than 100 studies using MarketScan data over the past 5 years.

FIGURE 1: MarketScan Research Databases



MARKETSCAN SEMI-ANNUAL EMPLOYER NORMS

We create the MarketScan Semi-Annual Employer Norms Report from the claims experience of more than 340 employers representing 18.3 million covered lives and crossing the full spectrum of industry types, health plans, and pharmacy benefit managers (PBMs). We design these semi-annual norms to supplement the data available from the MarketScan Research Databases and focus on measures and segments of particular value to employers in managing their population's health and productivity. We aggregate the semi-annual norms at the employer level, rather than the claim or member level. This means that the results for each employer included in a norm receive equal weight, so that a single employer does not skew the results.

A key difference between the MarketScan Semi-Annual Employer Norms and other available employer healthcare cost trend data is that the MarketScan norms reflect *actual client experience* data from health plans, PBMs, disability, workers' compensation, eligibility, and other vendors. MarketScan data are not self-reported survey data.

MarketScan norms are also not limited to a single vendor's book of business or narrow industry segments, but reflect data from hundreds of data suppliers and clients. The norms reflect our independent status in the marketplace across health plans and healthcare providers.

We build the MarketScan norms using data gathered from our clients' data warehouses. The data are aggregated and scrubbed through standardized processes so that they can be used to report health and productivity. Our processes are compliant with the Statement on Standards for Attestation Engagements (SSAE) No. 16 (formerly SAS-70). This means that we define and calculate values for a given measure consistently across all clients.

All year-over-year or multi-year trend results in the MarketScan Semi-Annual Employer Norms reflect a convenience sample drawn from a consistent group of 344 employer clients with 14.5 million active members (6.3 million active employees) across the most recent 2 years. By including only clients with complete data for the 2 years of this study, we minimize the impact of variance over time in our MarketScan book of business data. Unless otherwise indicated, *data* reflect paid — as opposed to incurred — claims data. This feature allows us to produce trends for the most current data available without application of completion methodologies necessary for trend analysis on incurred basis data.

We also included in this report a multi-year trend study that reflects a consistent group of 139 clients with more than 10 million covered lives, whose data are available for all years in the period from 2007 through 2011. We exclude results for clients with severe outlier experience or who show significant variance in covered membership during the study period.

Results, unless otherwise indicated, reflect averages of values calculated at the employer level with each employer receiving equal weight. PEPY rates included in the study reflect the experience for the employee and their covered dependents at the "contract" level. PMPY rates also reflect the experience for the employee and his or her covered dependents on a per capita basis.

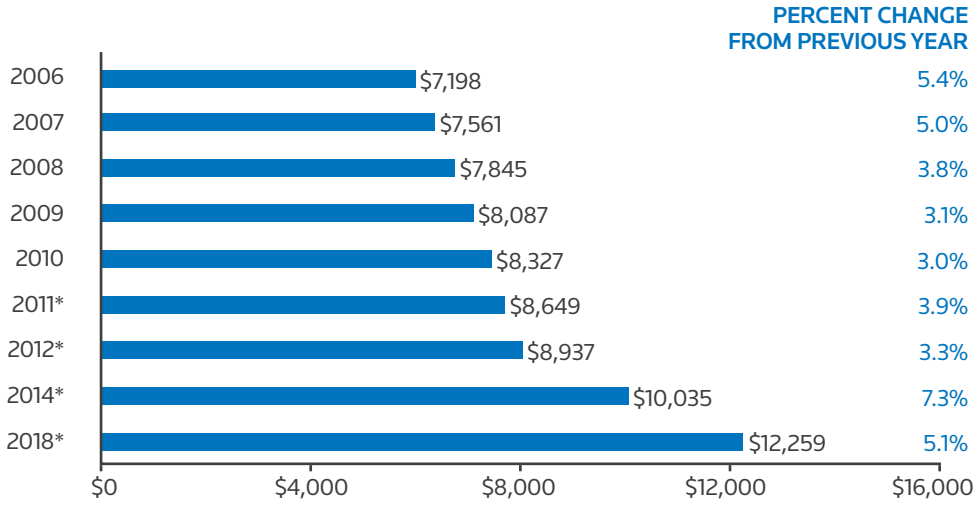
MEDICAL AND PHARMACY DATA: THE FOUNDATION FOR EFFECTIVE RISK MEASUREMENT AND MANAGEMENT

THE HEALTHCARE LANDSCAPE

U.S. Healthcare Expenditures

In 2010, U.S. healthcare costs reached $2.9 trillion, or $8,327 per capita. We anticipate that costs will continue to increase by 3.9 percent annually in the following years (Figure 2). In 2014, National Health Expenditures (NHE) are expected to increase by 7.3 percent as a result of the impact of key provisions of the Patient Protection and Affordable Care Act (PPACA). Healthcare costs are predicted to reach $4.6 trillion, or 19.8 percent of the Gross Domestic Product (GDP), by 2020.

FIGURE 2: Per Capita National Healthcare Expenditures 2006–2018 (Actual and Projected*)

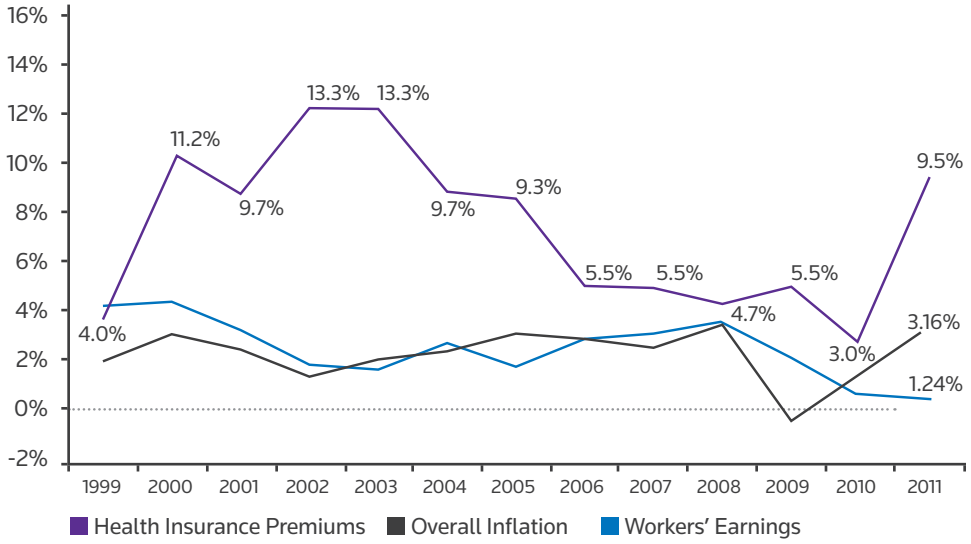


Source: CMS Office of the Actuary, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads//proj2010.pdf

Healthcare Inflation

Overall healthcare inflation will continue to exceed overall inflation rates and wage increases. Health insurance premiums, in particular, continue to trend 2 to 4 percent higher than general inflation, even in an environment of historically low inflation rates (Figure 3).

FIGURE 3: Comparison of Health Insurance Premiums to Workers' Earnings and Overall Inflation



Sources: Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation 1913–2011
Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1988–2011
Health Insurance Association of America (HIAA), 1988, 1989, 1990
Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2011
KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996

Country Comparisons

Currently, U.S. per capita healthcare spending is more than twice the average for Organisation for Economic Co-operation and Development (OECD) countries. It comprises 17.4 percent of the GDP compared to an average of 9.7 percent for the OECD overall (Figure 4). Despite this level of healthcare spending, in 2009, the United States had a lower average life expectancy than the OECD as a whole.

U.S. employers also pay a disproportionate share of national healthcare costs compared to OECD countries. This provides a significant disadvantage in a highly competitive global economy.

FIGURE 4: Healthcare Comparisons Across the OECD

COUNTRY	2009 NHE PER CAPITA (IN US $)	2009 NHE PER CAPITA GROWTH	HEALTHCARE SPEND AS A % OF GDP	HEALTHCARE PUBLICLY FINANCED (%)	LIFE EXPECTANCY
United States	$7,960	2.2%	17.4%	48%	78.2
Switzerland	$5,144	2.8%	11.4%	60%	82.3
Ireland	$3,781	-1.0%	9.5%	75%	80.0
New Zealand	$2,983	7.4%	10.3%	81%	80.8
Germany	$4,218	4.0%	11.6%	77%	80.3
France	$3,978	2.7%	11.8%	78%	81.0
Sweden	$3,722	1.8%	10.0%	82%	81.4
United Kingdom	$3,487	5.2%	9.8%	84%	80.4
Italy	$3,137	-0.8%	9.5%	78%	78.9
Spain	$3,067	1.5%	9.5%	74%	81.8
Group Average	**$4,148**	**2.6%**	**11.1%**	**73%**	**80.5**
OECD Average	**$3,361**	**4.1%**	**9.7%**	**72%**	**79.4**

Source: OECD – Organisation for Economic Co-operation and Development Health Data 2010 (Selected Data)

RECENT EMPLOYER COST TRENDS

Recent Employer Medical and Pharmacy Cost Trends

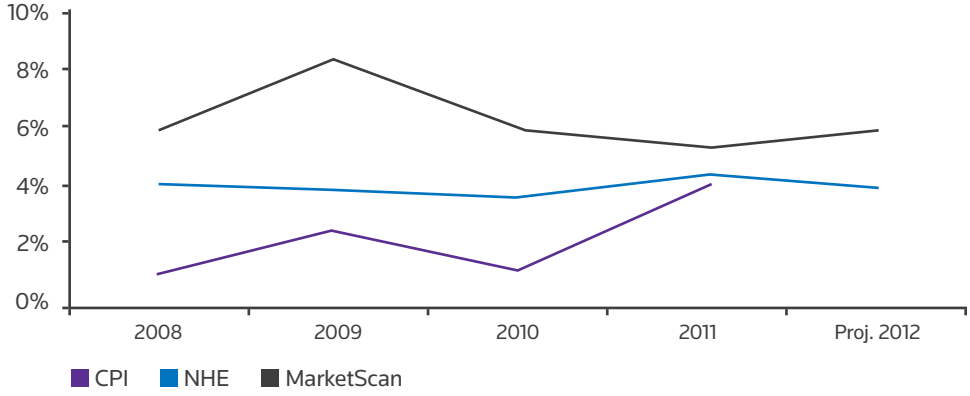
Healthcare trend management has been a high-priority issue for corporate executives over the past decade. To develop and implement an effective healthcare cost management strategy, it is essential to put program performance in a meaningful context. MarketScan Semi-Annual Employer Norms — reflecting data paid through the third quarter of 2011 — are summarized in the following overview of employer healthcare norms.

Employer Group Health Trend Rates Are the Lowest in Five Years

Average active 2011 total healthcare costs increased by 4.6 percent based on results from the MarketScan Semi-Annual Employer Norms Report for the third quarter of 2011. The modest total cost trend rate was less than predicted by many sources as this was the first full year that key provisions of the Healthcare Reform law affected employer benefit plans.

Employer-allowed healthcare costs still exceeded both the 3.4 percent annual U.S. inflation rate as measured by the Consumer Price Index (CPI) and the 3.7 percent annual inflation rate for per capita National Health Expenditures (NHE) (Figure 5). Allowed healthcare costs reflect medical and pharmacy claims payments after reduction for provider pricing adjustments.

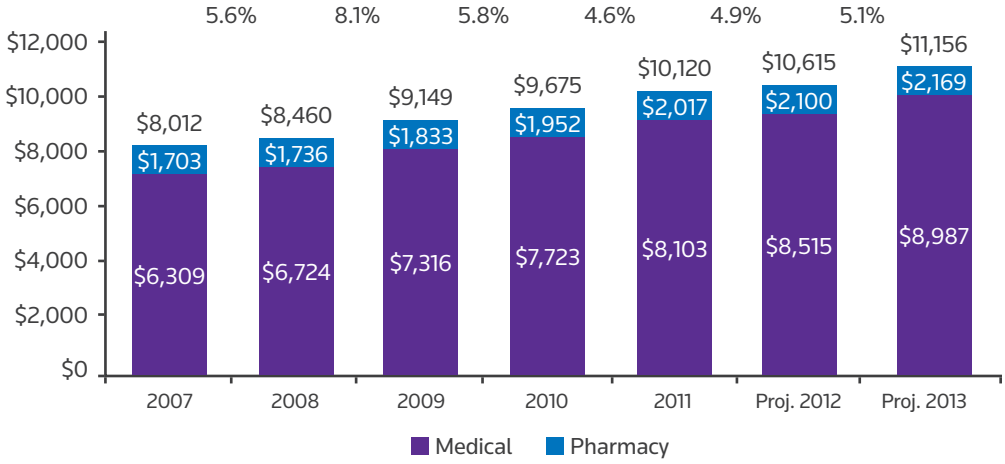
FIGURE 5: MarketScan, CPI, and NHE Trends, 2008–2011



Historic and Projected Employer Net Cost Trends

Based on a study of MarketScan data for 139 large employers, U.S. employers experienced average trends of 6 percent annually in PEPY allowed medical and pharmacy costs from 2007–2011 (Figure 6). We expect these costs to continue to increase by 5 percent annually in 2012 and 2013.

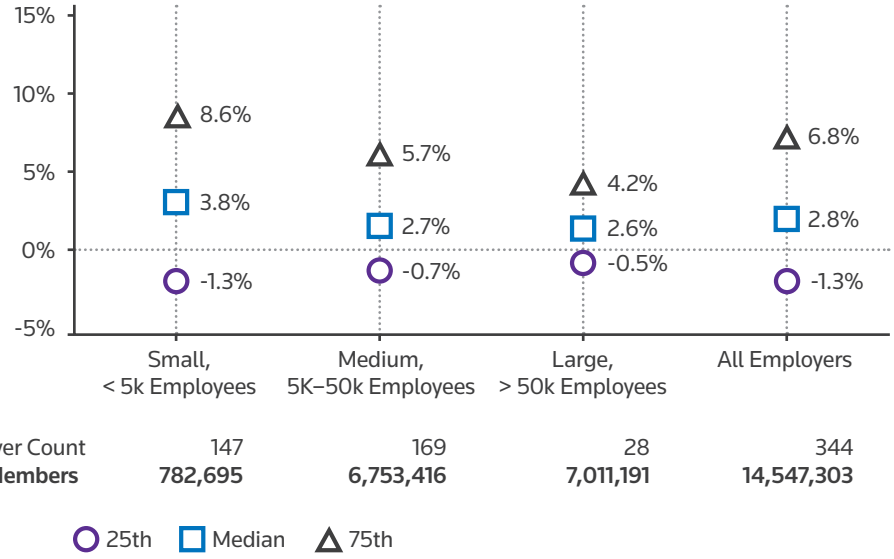
FIGURE 6: 2007–2011 MarketScan PEPY Allowed Medical and Pharmacy Payments*



* These normative results reflect a consistent group of 139 companies with 10 million active members for the past 5 years (2007–2011). We calculated overall average costs by assigning an equal weight to each company in the average. The consistent study group helps minimize distortions in rates caused by fluctuations in the client mix over time. Results are medical and pharmacy claims costs only and do not include dental claims.

Because of the diversity of clients included in the third quarter of 2011 MarketScan Semi-Annual Norms, it is revealing to look beyond the average trend increase and examine the range of trend increases segmented by employer size (Figure 7).

FIGURE 7: 2011 Annual Net Pay PMPY Trend Rates by Employer Size



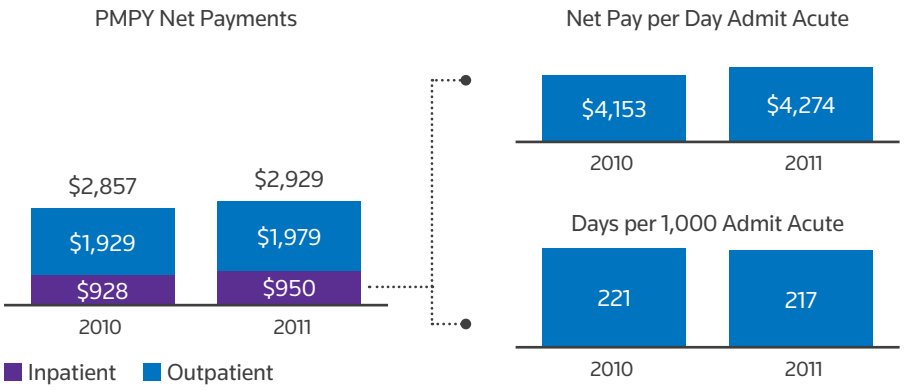
	Small, < 5k Employees	Medium, 5K–50k Employees	Large, > 50k Employees	All Employers
Employer Count	147	169	28	344
Total Members	**782,695**	**6,753,416**	**7,011,191**	**14,547,303**

25th Median 75th

The median overall 2011 MarketScan trend rate was 2.8 percent for PMPY medical and pharmacy net costs. For large employers (more than 50,000 employees), the median 2011 trend rate was 2.6 percent compared to 3.8 percent for small employers (less than 5,000 employees) and 2.7 percent for midsized organizations. The spread between the 25th and 75th percentiles was roughly twice as wide for small clients as for midsized or large clients.

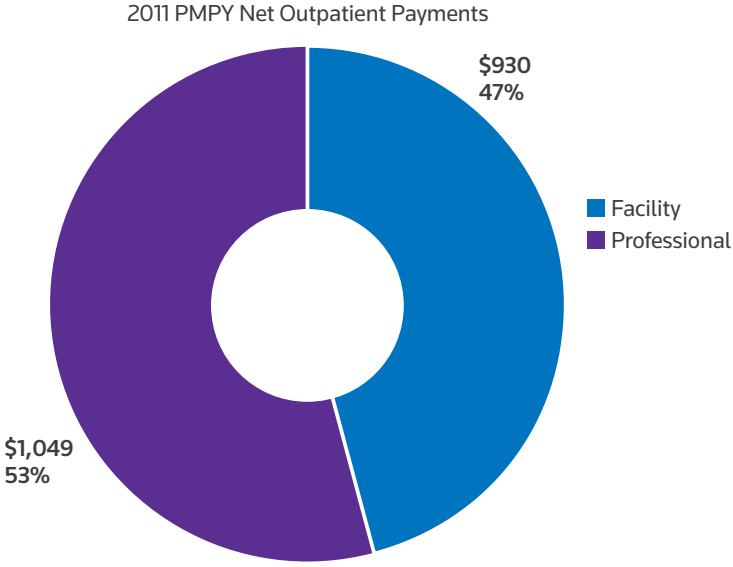
Figure 8 shows that net PMPY medical payments increased by 2.5 percent to $2,929 in 2011. PMPY net medical cost inflation reflects an annual inpatient cost trend of 2.3 percent. Changes in inpatient cost reflect a 2.9 percent increase in cost per inpatient day and a 1.7 percent decrease in inpatient days per 1,000 members.

FIGURE 8: Components of PMPY Net Medical Payments — Inpatient



Outpatient net costs increased by 2.6 percent to $1,979 PMPY in 2011. Outpatient services per 1,000 members increased by 1.2 percent and net pay per outpatient service increased by 1.8 percent to $85. Figure 9 shows that outpatient facility costs increased by 5.1 percent to $930 PMPY and outpatient professional costs were nearly flat at 0.5 percent, increasing to $1,049 PMPY.

FIGURE 9: Components of PMPY Net Medical Payments — Outpatient

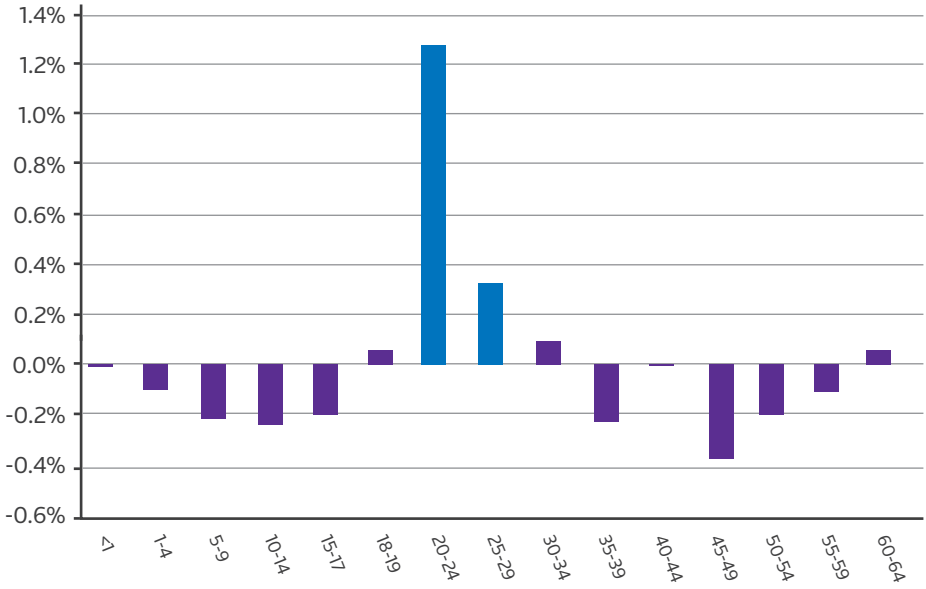


Emergency room costs continue to be an important component of medical trends. In 2011, emergency room allowed costs increased by 6.9 percent to $279 PMPY. This reflected no change in ER visits per 1,000 members and a 6.8 percent increase to $1,313 in allowed costs per ER visit.

Impact of Key Provisions of the Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA) extended health benefits through age 26 for unmarried children, regardless of student status, for plan years beginning after Sept. 30, 2010. In 2011, the average contract size for active employees increased by 1.6 percent, primarily driven by the addition of lives in the 20–24 and 25–29 year age ranges. Figure 10 illustrates the change in the portion of lives by age cohort in 2011 commercial data.

FIGURE 10: Change in Portion of Total Commercial Population by Age Cohort, 2011 Compared to 2010

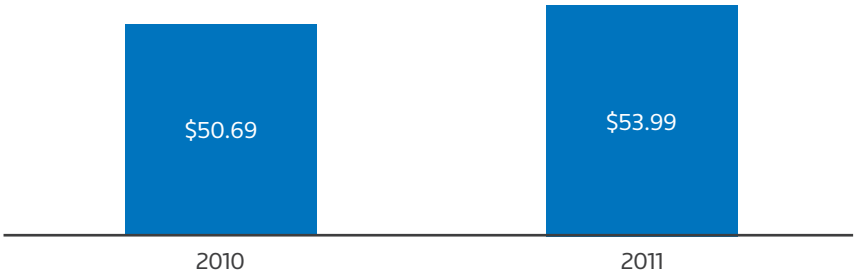


The increase in the covered population between the ages of 20–26 had the net impact of reducing the average active PMPY allowed medical and pharmacy costs by 0.2 percent, reflective of the lower than average costs of individuals in this age group. The extension of dependent coverage in 2011 contributed to 1.4 percent of the overall 4.6 percent increase in average active PEPY allowed medical and pharmacy costs to $9,867 in 2011.

PPACA also requires that a broad range of preventive services be covered with no patient cost-sharing for plan years beginning on or after Sept. 23, 2010. Figure 11 shows that preventive office visits increased by 3.8 percent to 445 visits per 1,000 commercial members in 2011. The allowed amount PMPY for preventive office visits increased by 6.5 percent to $54 in 2011 (Figure 12). These relatively modest increases may be reflective of the generous preventive coverage offered by many large employers prior to PPACA.

FIGURE 11: Commercial Preventive Office Visits per 1,000 Members

FIGURE 12: Commercial Allowed Amount PMPY for Preventive Office Visits



Impact of the Mental Health Parity Regulations

The Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was enacted on Oct. 3, 2008. Interim final regulations for the MHPAEA were released on Feb. 2, 2010, and are generally effective for plan years beginning on or after July 1, 2010.

Figure 13 shows that the underlying use of Mental Health and Substance Abuse (MHSA) services increased by 11.2 percent to 1,039 services per 1,000 members. Active employee MHSA benefits increased by 13.7 percent from $239 PEPY in 2010 to $272 in 2011 (Figure 14).

FIGURE 13: MHSA Services per 1,000 Members

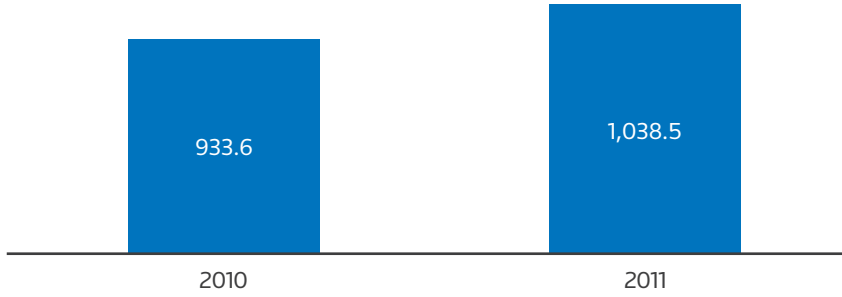
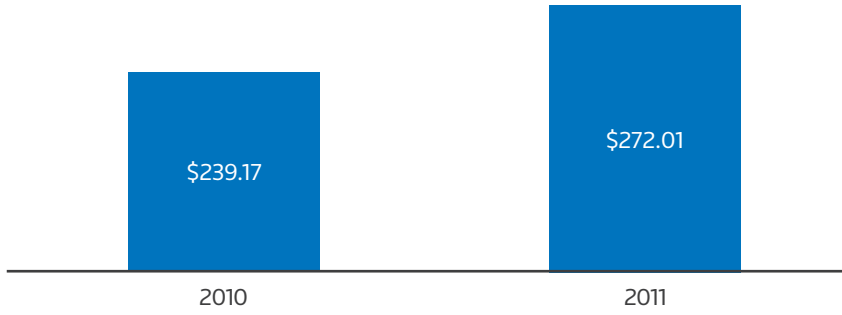


FIGURE 14: Allowed Amount PEPY for MHSA Services



Impact of "Pay" or "Play" Strategies on Employer Health Costs

For the past 2 years, PPACA has been at the center of one of the fiercest political debates in this country's history. Signed into law in March 2010, everyone from physicians to business owners to individual healthcare consumers has been trying to gauge the financial impact of the new law. For U.S. employers, part of that process has been trying to navigate how to best address their employees' group health plans when further reform takes effect in 2014.

Background

A central concern among employers is what the "pay or play" provisions will mean for the long-term prospects of their healthcare programs. The PPACA will require employers to make a choice: either pay a penalty tax for dropping group health benefits or play by continuing to offer such benefits. The mandate will affect employers with 50 or more full-time employees beginning on or after Jan. 1, 2014.

Under the law, employers are not required to provide group health insurance. However, employers providing coverage must meet minimum coverage levels or face penalties. These penalties, intended to help finance the cost of coverage expansion, are as follows:

- If an employer chooses not to provide group health coverage in 2014, and at least one full-time employee obtains federally subsidized coverage through a Health Insurance Exchange (HIX or Exchange) — a platform allowing those ineligible for Medicaid coverage to price-shop and find a plan that best suits them — the employer pays a $2,000 free rider penalty for each full-time employee. An employer can exclude its first 30 employees from this calculation. The penalty is assessed on a monthly basis. This is the so-called "pay" scenario.
- If an employer chooses to "play" and continues to provide group health coverage in 2014, and at least one full-time employee obtains federally subsidized coverage through an HIX an employer will be assessed a monthly penalty. The federal subsidy (tax credit) is available to an employee if at least one of the following conditions is met:
  - An employer offers employees the opportunity to enroll in a group health plan providing minimum essential coverage, and health plan premium costs for single coverage are greater than 9.5 percent of an employee's household income

  OR
  - An employer contributes less than 60 percent of actuarial plan value
- The employer penalty is equal to the lesser of:
  - $3,000 multiplied by the number of full-time employees receiving subsidized coverage in an exchange

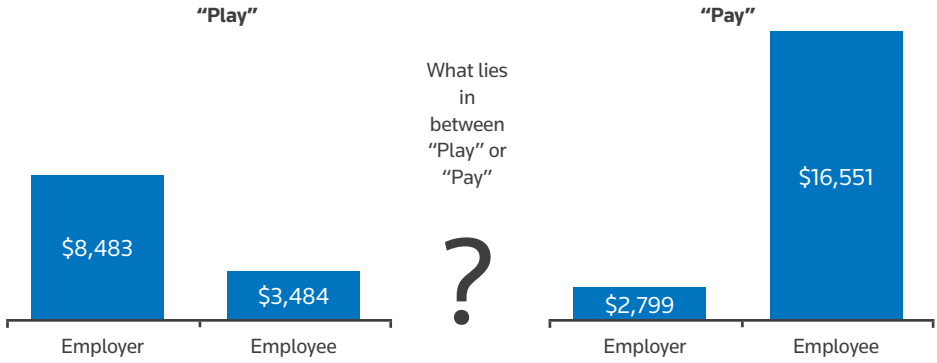
  OR
  - $2,000 multiplied by the number of full-time employees (excluding the first 30 full-time employees).

Methods and Results

In light of these federal requirements, employers are faced with a burning question: Should they continue to offer group health benefits despite the current trend of 6 percent annual insurance premium increases or eliminate benefits altogether and take the penalty at $2,000 for each employee?

To help answer this question, we analyzed a dataset consisting of 33 large employers with 933,000 employees in the university, pharmaceutical, retail, financial, and manufacturing industries. Our model used granular, employee-level wage, demographic, and healthcare data. We examined the direct benefit and tax cost of eliminating group health benefits, and we projected costs for 2014–2020 under a variety of scenarios (Figure 15).

FIGURE 15: The Impact of Pay or Play



2014 MarketScan PEPY Net Costs*

* Net employer costs to "play" reflect net medical and pharmacy payments less employee contributions and payroll tax deductions plus any penalties for individuals failing the income test and assumed to enroll in exchange-based benefits. Net employer costs to "pay" reflect the $2,000 per employee penalty plus the additional assumed cost impact to "pay" on disability, workers' compensation, absence, and productivity. In this scenario, an employer is not assumed to "make employees whole." Net employee costs to "play" include out-of-pocket, employee premium contributions less payroll and income tax savings. Net employee costs to "pay" reflect the cost of exchange-based care, including out-of-pocket costs less any federal subsidies.

Results show that employers who choose to cut plans as a perceived cost-saving measure will not benefit as much as they might assume. Our analysis revealed three key findings:

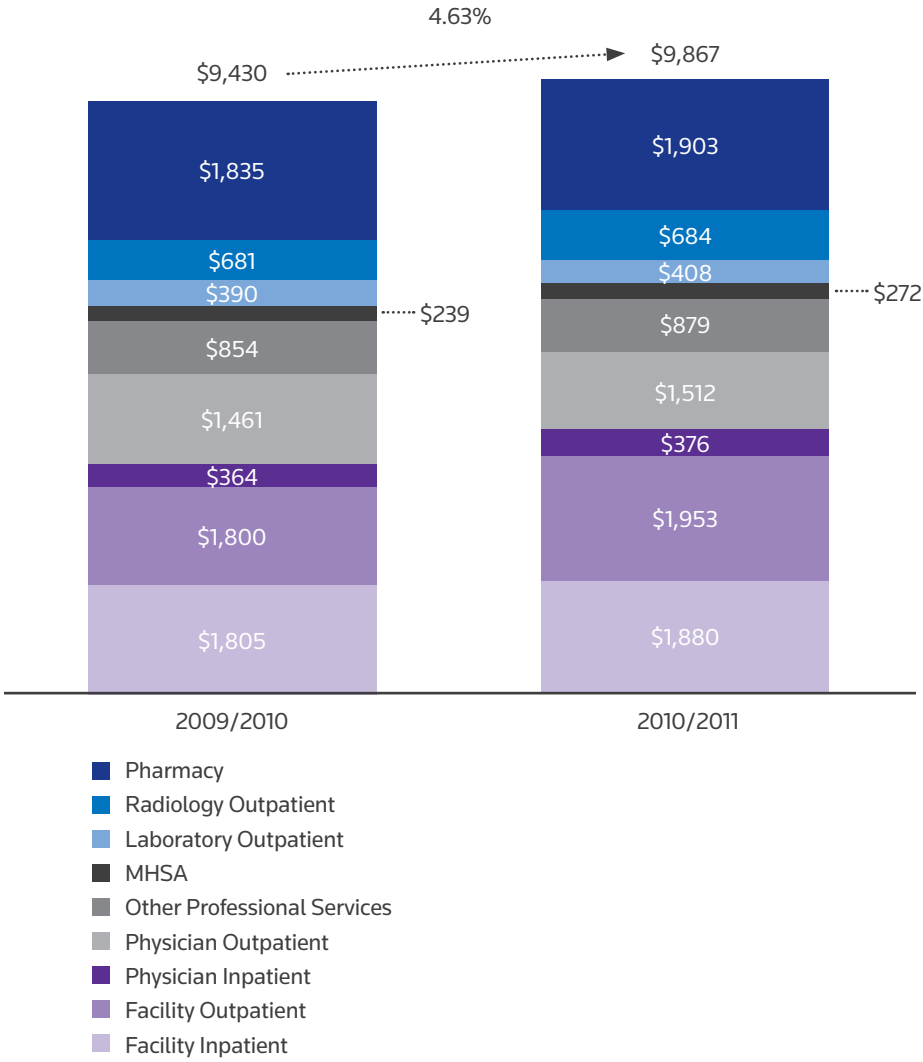
- Employers have no immediate or long-term cost advantage to eliminate group health benefits.
- Employers will pay more to make employees "whole" when shifting their benefits to an exchange than if they continue existing group health plans.
- Should employers choose to eliminate group health, employees will experience a significant reduction in overall compensation when they assume the incremental costs of benefits.

EMPLOYER MEDICAL AND PHARMACY COST TRENDS

Cost Trends by Service Category

Total PEPY allowed costs increased by 4.6 percent for the rolling year from Nov. 1, 2009, to Oct. 31, 2010, to the following 12-month period ending Oct. 31, 2011. This rate was driven by increases in Facility Outpatient ($153 or 8.5 percent), Facility Inpatient ($75 or 4.1 percent), and Pharmacy ($68 or 3.7 percent) costs (Figure 16).

FIGURE 16: PEPY Allowed Amount by Service Category



Facility Inpatient Cost Trends

PEPY Facility Inpatient allowed costs increased by $75 (4.1 percent) to $1,880, primarily because of increases in Facility Inpatient Surgical ($33, 3.6 percent), Facility Inpatient Medical ($24, 4.5 percent), and Facility Inpatient Maternity ($17, 5.1 percent). Overall days per thousand decreased by 1.7 percent to 217 per 1,000 actives, so the increase in PEPY costs reflects price increases that may be related to the continued shifting of lower-intensity encounters to an outpatient setting (Figure 17).

FIGURE 17: Comparing the Change in PEPY Allowed Costs for Actives: Facility Inpatient

ACTIVES	2010	2011	$ CHANGE	% CHANGE
Facility Inpatient Surgical	$918.61	$951.54	$32.93	3.6%
Facility Inpatient Medical	$545.42	$569.71	$24.29	4.5%
Facility Inpatient Maternity	$326.94	$343.76	$16.82	5.1%
Facility Inpatient Long-Term Care	$9.98	$9.83	($0.15)	-1.5%
Facility Inpatient Non-Acute	$4.42	$5.43	$1.01	22.9%
Subtotal	**$1,805.37**	**$1,880.27**	**$74.90**	**4.1%**

Facility Outpatient Cost Trends

Facility Outpatient costs increased by $153 (8.5 percent) to $1,953 PEPY (Figure 18). This trend reflects an underlying:

- $54 (6.5 percent) increase in Surgery costs from $835 to $889
- $28 (13.5 percent) increase in Pharmacy costs from $205 to $233
- $39 (9.2 percent) increase in Emergency Room (ER) costs from $427 to $466

FIGURE 18: Comparing the Change in PEPY Allowed Costs for Actives: Facility Outpatient

ACTIVES	2010	2011	$ CHANGE	% CHANGE
Facility Outpatient Surgery	$834.57	$889.02	$54.45	6.5%
Facility Outpatient Pharmacy	$204.89	$232.63	$27.74	13.5%
Facility Outpatient Supplies and Devices	$24.04	$27.68	$3.64	15.1%
Facility Outpatient Diagnostic Services	$80.14	$87.82	$7.68	9.6%
Facility Outpatient Specialty Drugs	$32.93	$36.05	$3.12	9.5%
Facility Outpatient Dialysis	$46.87	$55.92	$9.05	19.3%
Facility Outpatient Emergency Room	$426.70	$466.01	$39.31	9.2%
Facility Outpatient Physical Therapy, Occupational Therapy, Speech Therapy	$54.77	$59.40	$4.63	8.5%
Facility Outpatient Other	$84.98	$87.50	$2.52	3.0%
Facility Outpatient Home Health	$4.82	$4.89	$0.07	1.5%
Facility Outpatient Transportation	$5.03	$5.97	$0.94	18.7%
Facility Outpatient Durable Medical Equipment	$0.48	$0.36	($0.12)	-25.0%
Subtotal			**$153.03**	**8.5%**

Physician Inpatient Cost Trends

Physician Inpatient costs increased by $12 to $376 PEPY in 2011, largely reflecting a 5.1 percent increase in Specialty Inpatient costs (Figure 19).

FIGURE 19: Comparing the Change in PEPY Allowed Costs for Actives: Physician Inpatient

ACTIVES	2010	2011	$ CHANGE	% CHANGE
Physician Specialty Inpatient	$228.93	$240.56	$11.63	5.1%
Physician Non-Specialty Inpatient	$135.15	$135.72	$0.57	0.4%
Subtotal	**$364.08**	**$376.28**	**$12.20**	**3.4%**

Physician Outpatient Cost Trends

Physician Outpatient service costs increased by $51 PEPY to $1,512 in 2011 (Figure 20). This trend reflects an underlying $21 (3.6 percent) increase in Non-Specialty Office Visits, an $8 (2.6 percent) increase in Specialty Outpatient Surgery, and an $8 (3.4 percent) increase in Specialty Office Visits.

FIGURE 20: Comparing the Change in PEPY Allowed Costs for Actives: Physician Outpatient

ACTIVES	2010	2011	$ CHANGE	% CHANGE
Physician Non-Specialty Office Visits	$571.34	$591.89	$20.55	3.6%
Physician Specialty Outpatient Surgery	$314.15	$322.44	$8.29	2.6%
Physician Specialty Office Visits	$244.14	$252.33	$8.19	3.4%
Physician Specialty Outpatient Other	$113.84	$118.30	$4.46	3.9%
Physician Specialty Emergency Room	$68.53	$74.93	$6.40	9.3%
Physician Non-Specialty Outpatient Other	$57.54	$58.77	$1.23	2.1%
Physician Non-Specialty Outpatient Surgery	$67.76	$68.45	$0.69	1.0%
Physician Non-Specialty Emergency Room	$23.80	$24.68	$0.88	3.7%
Subtotal	**$1,461.10**	**$1,511.79**	**$50.69**	**3.5%**

Cost Trends for Other Professional Services

Other Professional Services costs increased by $26 in 2011 to $879 PEPY (Figure 21). The largest Professional PEPY dollar increases occurred in:

- Professional Office Visits ($8, 17.3 percent)
- Professional Supplies and Devices ($5, 7.3 percent)
- Professional Transportation ($4, 10.3 percent)

FIGURE 21: Comparing the Change in PEPY Allowed Costs for Actives: Other Professional Services

ACTIVES	2010	2011	$ CHANGE	% CHANGE
Professional Physical Therapy, Occupational Therapy, Speech Therapy	$134.61	$138.10	$3.49	2.6%
Professional Office Visits	$46.94	$55.04	$8.10	17.3%
Professional Injections	$126.63	$127.89	$1.26	1.0%
Professional Supplies and Devices	$62.25	$66.80	$4.55	7.3%
Professional Durable Medical Equipment	$50.68	$53.14	$2.46	4.9%
Professional Transportation	$38.79	$42.80	$4.01	10.3%
Professional Chiropractic Services	$44.45	$44.02	($0.43)	-1.0%
Professional Home Health	$19.26	$21.35	$2.09	10.9%
Professional Diagnostic Services	$137.03	$135.98	($1.05)	-0.8%
Professional Dialysis	$2.07	$2.16	$0.09	4.3%
Professional Specialty Drugs	$95.30	$92.91	($2.39)	-2.5%
Professional Services Other	$95.57	$99.13	$3.56	3.7%
Subtotal	**$853.58**	**$879.32**	**$25.74**	**3.0%**

Mental Health and Substance Abuse (MHSA) Cost Trends

MHSA costs increased by $33 ($13.7 percent) to $272 PEPY in 2011, reflecting the impact of the adoption of the Mental Health Parity requirements. This double-digit trend increase reflects a $15 (10.9 percent) increase for Mental Health Other Outpatient, a $5 (10.4 percent) increase for Mental Health Inpatient, and a $6 (40.3 percent) increase for Substance Abuse Other Outpatient (Figure 22).

FIGURE 22: Comparing the Change in PEPY Allowed Costs for Actives: MHSA

ACTIVES	2010	2011	$ CHANGE	% CHANGE
Mental Health Other Outpatient	$139.93	$155.12	$15.19	10.9%
Mental Health Inpatient	$50.74	$56.01	$5.27	10.4%
Substance Abuse Other Outpatient	$15.27	$21.42	$6.15	40.3%
Mental Health Office Visits	$16.81	$18.80	$1.99	11.8%
Substance Abuse Inpatient	$15.84	$19.88	$4.04	25.5%
Substance Abuse Office Visits	$0.58	$0.79	$0.21	36.2%
Subtotal	**$239.17**	**$272.02**	**$32.85**	**13.7%**

Laboratory Outpatient Cost Trends

Laboratory Outpatient costs increased by 4.5 percent to $408 PEPY in 2011 (Figure 23). This cost trend was driven by Laboratory Outpatient Chemistry Tests, which increased by $10 (6.1 percent) to $170. This reflects roughly equal increases in unit price and services.

FIGURE 23: Comparing the Change in PEPY Allowed Costs for Actives: Laboratory Outpatient

ACTIVES	2010	2011	$ CHANGE	% CHANGE
Laboratory Outpatient Chemistry Tests	$160.34	$170.06	$9.72	6.1%
Laboratory Outpatient Other	$139.11	$144.18	$5.07	3.6%
Laboratory Outpatient Pathology	$90.73	$93.69	$2.96	3.3%
Subtotal	**$390.18**	**$407.93**	**$17.75**	**4.5%**

Radiology Outpatient Cost Trends

Radiology Outpatient costs increased modestly by $2 (0.3 percent) to $684 PEPY in 2011 (Figure 24). Outpatient Mammograms, Therapeutic Radiology, and Ultrasounds had the largest PEPY cost increases with $4 (6.4 percent), $4 (5.8 percent), and $3 (3.3 percent), respectively. These increases were offset by a $9 (7.6 percent) drop in costs for CAT Scans.

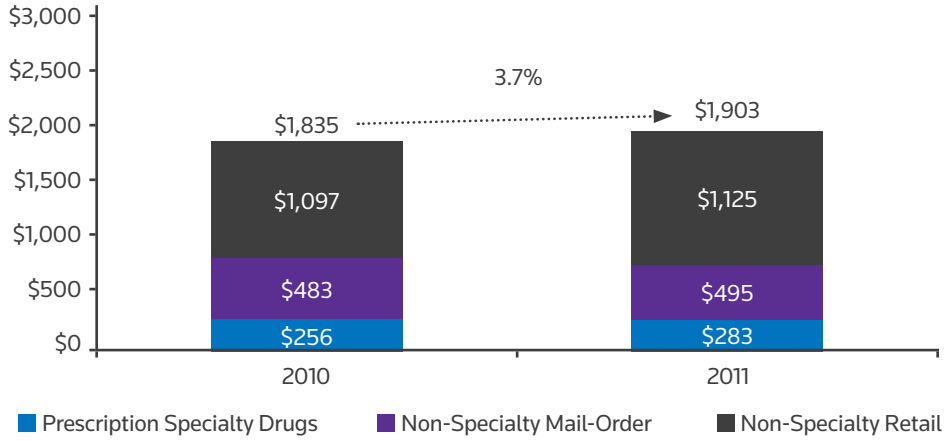
FIGURE 24: Comparing the Change in PEPY Allowed Costs for Actives: Radiology Outpatient

ACTIVES	2010	2011	$ CHANGE	% CHANGE
Radiology Outpatient CAT Scans	$122.25	$113.02	($9.23)	-7.6%
Radiology Outpatient MRIs	$166.45	$168.49	$2.04	1.2%
Radiology Outpatient Ultrasounds	$100.80	$104.09	$3.29	3.3%
Radiology Outpatient Mammograms	$61.14	$65.03	$3.89	6.4%
Radiology Outpatient X-Rays	$79.53	$79.88	$0.35	0.4%
Radiology Outpatient Therapeutic	$76.74	$81.17	$4.43	5.8%
Radiology Outpatient Other	$29.71	$29.92	$0.21	0.7%
Radiology Outpatient Nuclear Medicine	$44.79	$41.96	($2.83)	-6.3%
Subtotal	**$681.41**	**$683.56**	**$2.15**	**0.3%**

Pharmacy Cost Trends

MarketScan data show that PEPY pharmacy costs increased by $68 (3.7 percent) from $1,835 for the period Nov. 1, 2009, to Oct. 31, 2010, to $1,903 for the next 12-month period (Figure 25). Retail drugs made up the largest share of the pharmacy benefit and had a $28 (2.6 percent) increase from $1,097 to $1,125. Mail-order drugs increased by $12 (2.5 percent) from $483 to $495. Costs for specialty drugs dispensed through a pharmacy increased by $27 (10.5 percent) from $256 to $283 PEPY.

FIGURE 25: PEPY Pharmacy Costs Comparison



Most Common Drugs Prescribed in 2011

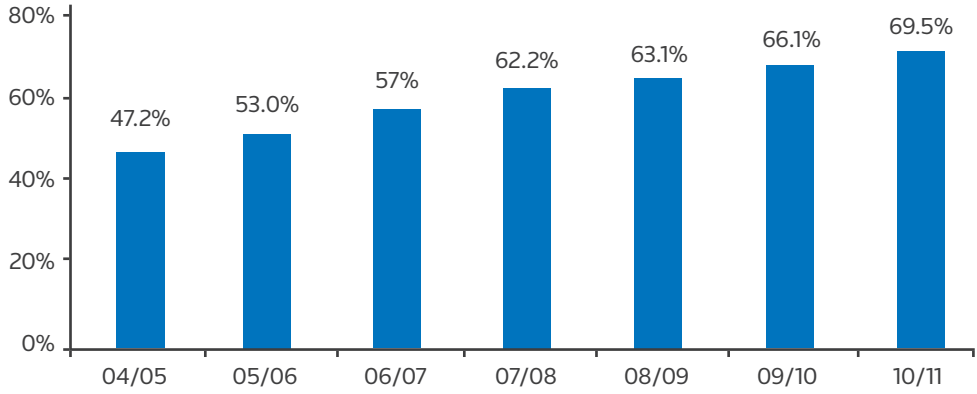
In 2011, Lipitor® was still the top brand name drug prescribed based on dollar volume, making up 2.9 percent of overall drug spending with a median allowed cost-per-day supply of $4.33. Simvastatin was the top generic drug prescribed, accounting for 0.5 percent of total drug costs at $0.39 cost-per-day supply. Enbrel® was the top specialty pharmacy drug prescribed, costing $425 per metric quantity dispensed and making up 1.9 percent of total drug spending (Figure 26).

Figure 26: Top Drugs Prescribed in 2011 Based on Dollar Volume			
	RANK BY TOTAL ALLOWED $	PERCENTAGE OF TOTAL PHARMACY	MEDIAN RETAIL ALLOWED AMOUNT PER DAY SUPPLY (METRIC QUANTITY DISPENSED FOR SPECIALTY)
Top 10 Brand Drugs			
1	Lipitor®	2.9%	$4.33
2	Plavix®	2.2%	$5.93
3	Nexium®	2.2%	$6.41
4	Crestor®	1.6%	$4.27
5	Singulair®	1.6%	$4.50
6	Actos®	1.4%	$7.15
7	Abilify®	0.9%	$18.23
8	Lexapro®	0.9%	$3.56
9	Diovan® or Diovan Hct®	0.8%	$3.25
10	Januvia®	0.8%	$6.74
Top 10 Generic Drugs			
1	Simvastatin	0.5%	$0.39
2	Hydrocodone bitartrate	0.4%	$1.48
3	Azithromycin	0.3%	$11.42
4	Fluticasone propionate	0.2%	$1.22
5	Omeprazole	0.2%	$0.76
6	Lisinopril	0.2%	$0.24
7	Amlodipine besylate or amlodipine besylate and benazepril Hcl	0.2%	$0.36
8	Amoxicillin clavulanate potassium	0.2%	$3.08
9	Bupropion Hcl or bupropion Hcl Xl	0.2%	$1.44
10	Metformin	0.2%	$0.31
Top 10 Specialty Drugs			
1	Enbrel®	1.9%	$424.88
2	Humira®	1.7%	$878.93
3	Avonex®	0.7%	$748.49
4	Revlimid®	0.5%	$361.78
5	Rebif®	0.5%	$484.14
6	Gleevec®	0.4%	$163.79
7	Tracleer®	0.2%	$98.99
8	Tarceva®	0.2%	$140.77
9	Xolair®	0.2%	$647.39
10	Advate®	0.2%	$1.31

Generic Prescription Trends

Generic drugs made up 69.5 percent of all prescriptions in the period from Nov. 1, 2010, to Oct. 31, 2011 (Figure 27). This represented a 3.4 percent increase over the prior year.

FIGURE 27: Percentage of Prescriptions Filled as Generics



Specialty Pharmacy Trends

Specialty Pharmacy, including drugs dispensed through pharmacies, outpatient facilities, or office settings, increased by 7.3 percent from $384 in 2010 to $412 in 2011. This is double the rate of the overall pharmacy cost trend increase (Figure 28).

Specialty drug cost drivers include therapies for autoimmune disorders (rheumatoid arthritis, psoriasis, and Crohn's disease), multiple sclerosis, cancer, and pulmonary hypertension.

FIGURE 28: Comparing the Change in PEPY Allowed Costs for Actives: Specialty Drugs

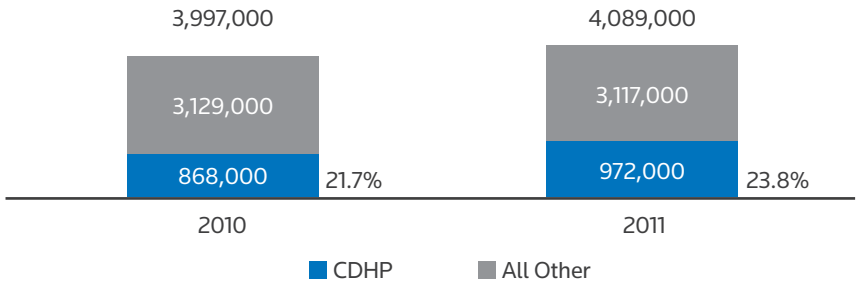
ACTIVES	2010	2011	$ CHANGE	% CHANGE
Prescription Specialty Drugs	$255.51	$282.64	$27.13	10.6%
Facility Outpatient Specialty Drugs	$32.93	$36.05	$3.12	9.5%
Professional Specialty Drugs	$95.30	$92.91	($2.39)	-2.5%
Total Specialty	**$383.74**	**$411.60**	**$27.86**	**7.3%**

MARKETSCAN SEMI-ANNUAL NORMS — PAID DATA UPDATED THROUGH THIRD QUARTER 2011

Consumer-Driven Health Plan Norms

Our comprehensive Consumer-Driven Health Plan (CDHP) norms reflect the experience of employers' CDHP and competing health plan options (Figure 29). The current CDHP norms reflect claims and enrollment data for 70 companies offering CDHP options in both 2010 and 2011. CDHP enrollment increased by 2 percent in 2011 to 23.8 percent of the 4 million total members included in this study.

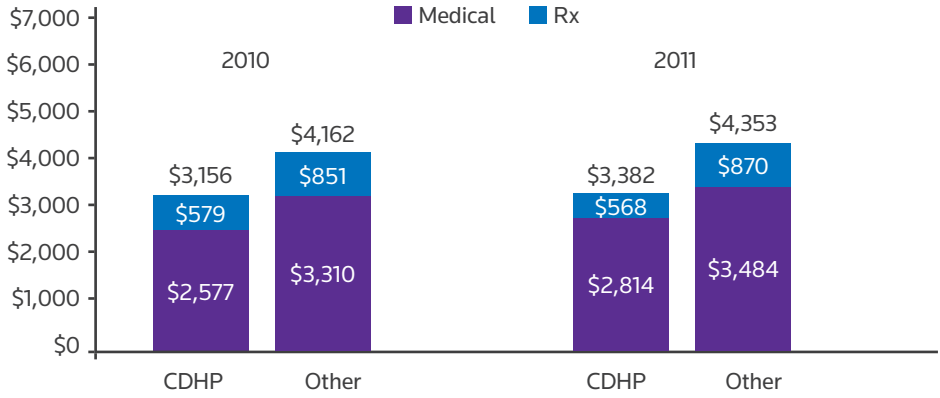
FIGURE 29: Consumer-Driven Health Plan (CDHP) Norms



CDHP Cost Trends

Our most recent norms show that CDHP options have significantly lower costs than competing options, but CDHP allowed cost trend rates of 7.2 percent (combined medical and drug) are almost double the non-CDHP trend rates of 4.6 percent (Figure 30).

FIGURE 30: CDHP vs. Other Plans: PMPY Allowed Medical and Pharmacy Costs



ANNUAL TREND RATES	CDHP	ALL OTHER
Medical	9.2%	5.2%
Pharmacy (Rx)	-1.8%	2.1%
Total	**7.2%**	**4.6%**

CDHP Use and Price Measures

The CDHP trends are driven by modest increases in both inpatient and outpatient use, coupled with more significant increases in unit price (Figure 31).

FIGURE 31: CDHP Use and Price Measures

CDHP: USE AND PRICE MEASURES	2010	2011	CHANGE (%)
Admits per 1,000 Acute	43.1	44.5	3.24%
Allow Amount PMPY IP Acute	$700	$806	15.12%
Services per 1,000 OP Medical	18,230	18,436	1.13%
Allow Amount per Service OP Medical	$103	$107	3.99%
Visits per 1,000 Office Medical	5,239	5,154	-1.62%
Allow Amount per Visit Office Medical	$137	$140	2.27%
Services per 1,000 OP Laboratory	5,318	5,454	2.55%
Allow Amount per Services OP Laboratory	$32	$32	0.19%
Services per 1,000 OP Radiology	1,467	1,420	-3.24%
Allow Amount per Services OP Radiology	$195	$204	4.45%
Visits per 1,000 Emergency Room	163	172	5.43%
Allow Amount per Visit Emergency Room	$1,260	$1,328	5.43%

Consumer-Driven Health Plans Continue to Experience Higher Trend Rates than Competing Plans

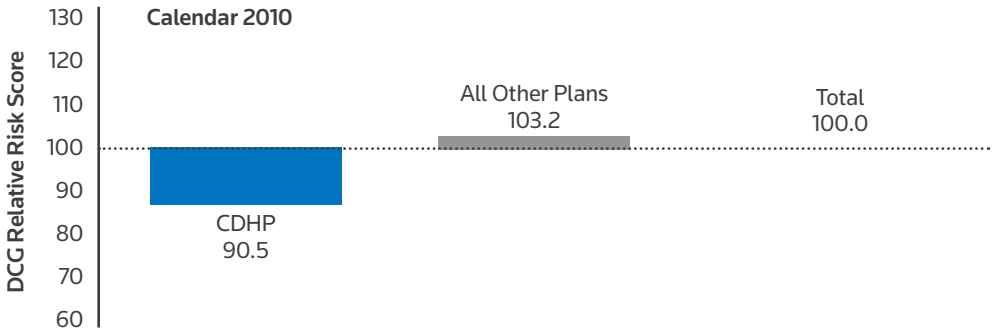
We have tracked CDHP performance in the MarketScan Semi-Annual Norms Report for the past 6 years. Over this period, we have consistently found that CDHP plans, as a group, are less efficient on a risk-adjusted basis than competing plan options.

MarketScan 2010 CDHP Results

CDHP plans have historically experienced lower population health risk and lower PMPY costs according to the MarketScan data. However, when we adjust PMPY allowed costs for the difference in health risk between CDHP and competing plans, the CDHP plans, as a group, are 3.4 percent less efficient than expected. We used the Verisk Health DxCG relative risk scores to quantify the risk adjustment (see Figure 32). In reviewing the data, we find that individual companies do experience relatively cost-efficient benefit delivery through CDHP, but on average, we have consistently seen the pattern illustrated below in our MarketScan data going back to 2005.

Figure 32 illustrates the difference in illness burden or health risk as measured by Verisk's DxCG medical and pharmacy All-Encounter Risk Model for a group of 65 clients with 3.6 million active members covered in CDHP and competing plan options — mainly Preferred Provider Organizations (PPOs).

FIGURE 32: Risk-Adjusted CDHP and All Other Plan Costs



	MEMBERS	AGE	FAMILY SIZE	DCG RISK SCORE*	2010 ALLOW AMT PMPY MEDICAL AND RX		EFFICIENCY**
					Actual	Expected	
CDHP	926,912	32.4	2.37	90.5	$3,808	$3,683	1.034
All Other	2,710,249	32.7	2.35	103.2	$4,159	$4,202	0.990
Total	**3,637,161**	**32.6**	**2.35**	**100.00**	**$4,069**	**$4,069**	

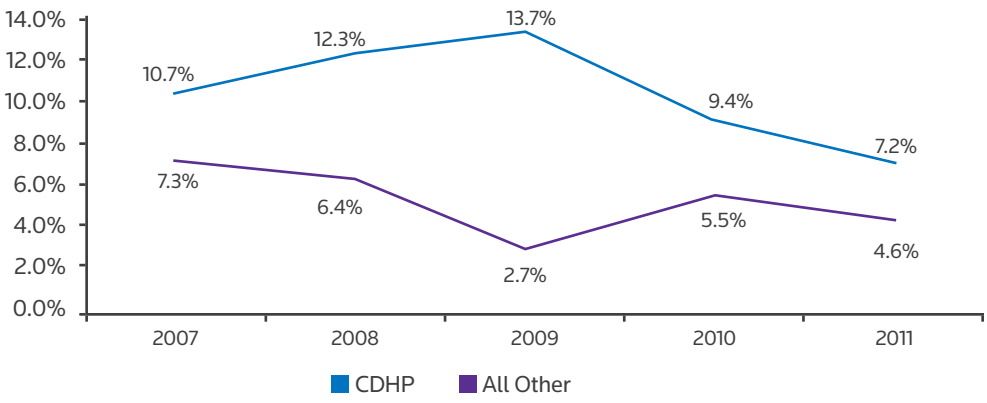
Data were collected from 65 clients with active employee CDHP membership; plans reflect Health Reimbursement Accounts (HRAs) only.

* Each Relative Risk Score describes the individual's expected medical cost relative to a mean score of 100. The mean score is based on the average of the active population whose diagnosis and demographic data were used by the DCG model. DCG is licensed by Verisk Health.

** Efficiency scores are calculated based on the underlying health risk of the population. An efficiency score of >1.0 indicates that the plan's actual cost exceeds its expected cost and is relatively more inefficient than expected. An efficiency score of <1.0 indicates that the plan's actual cost is less than its expected risk-adjusted cost and is, therefore, relatively more efficient than expected.

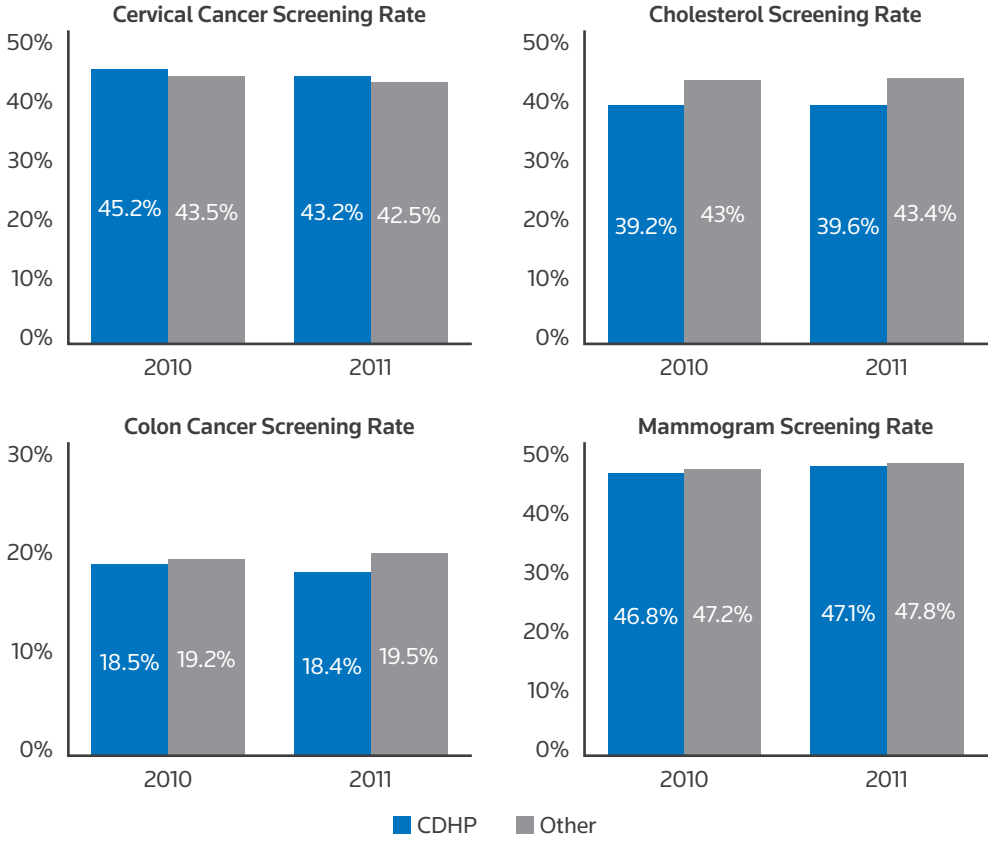
CDHP plans in MarketScan historically have trended at a higher rate than competing plans — typically PPO and Point of Service (POS) plans. We expect that some of these trends reflect the movement to a mean level of cost and risk over time as CDHP plans absorb an increased portion of total membership (Figure 33).

FIGURE 33: MarketScan CDHP PMPY Allowed Medical and Pharmacy Cost Trends



In 2010 and 2011, active CDHP enrollees had comparable performance to participants in competing PPO and POS options for key preventive service measures, including colon cancer, mammogram, and cervical cancer screenings, and slightly lower compliance with cholesterol screenings (Figure 34).

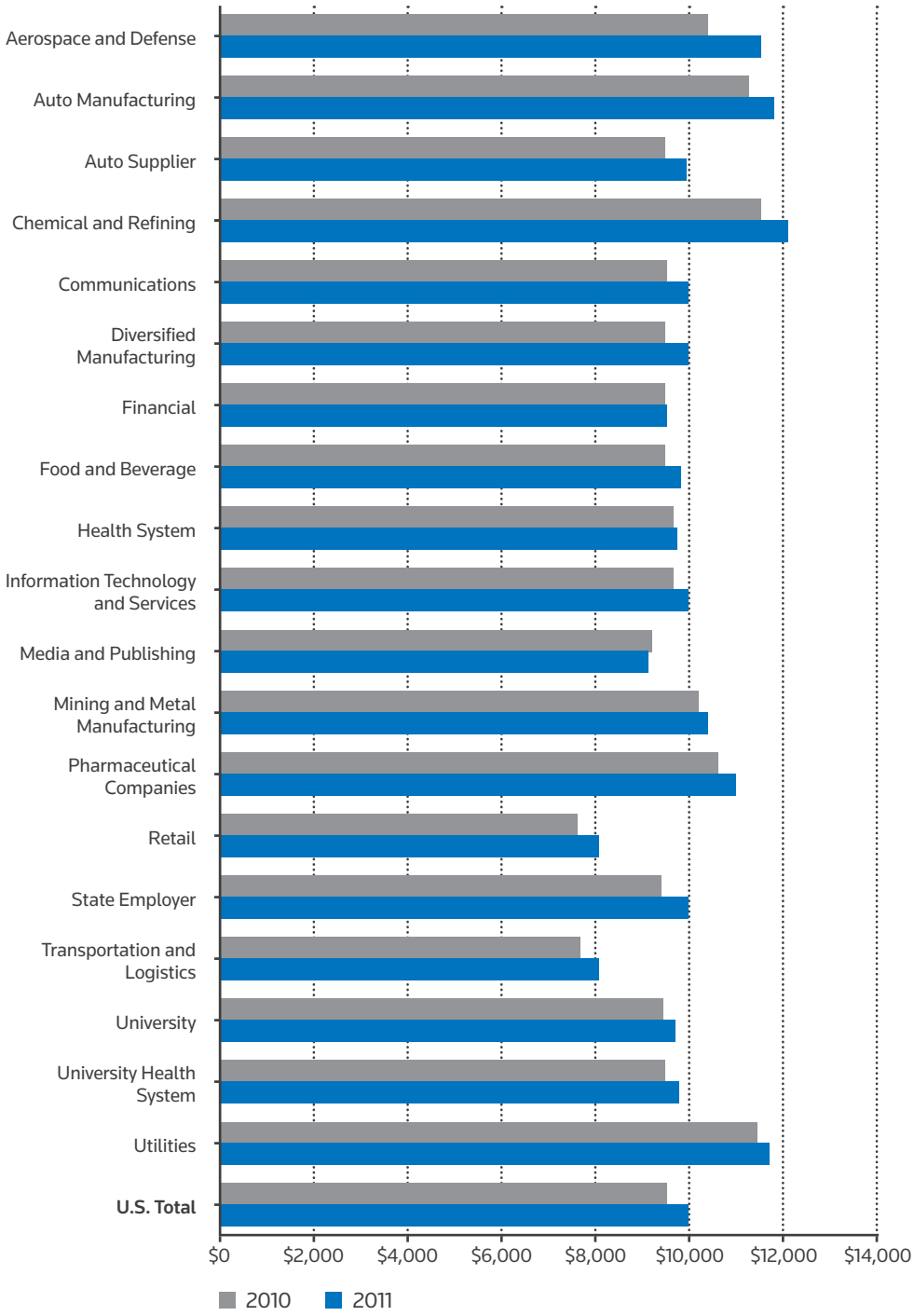
FIGURE 34: CDHP and All Other Plan Preventive Services



Cost Trends by Industry Segment

Medical and pharmacy costs and cost trends vary significantly by industry segment, particularly with respect to employer net payments and employee out-of-pocket costs. Figure 35 shows that Chemical and Refining ($12,170) and Auto Manufacturing ($11,614) had the highest annual per employee allowed or gross costs in 2011 for active employees and their dependents. Retail ($8,057) and Transportation/Logistics ($8,089) had the lowest costs.

FIGURE 35: PEPY Allowed Medical and Pharmacy Costs by Industry Segment

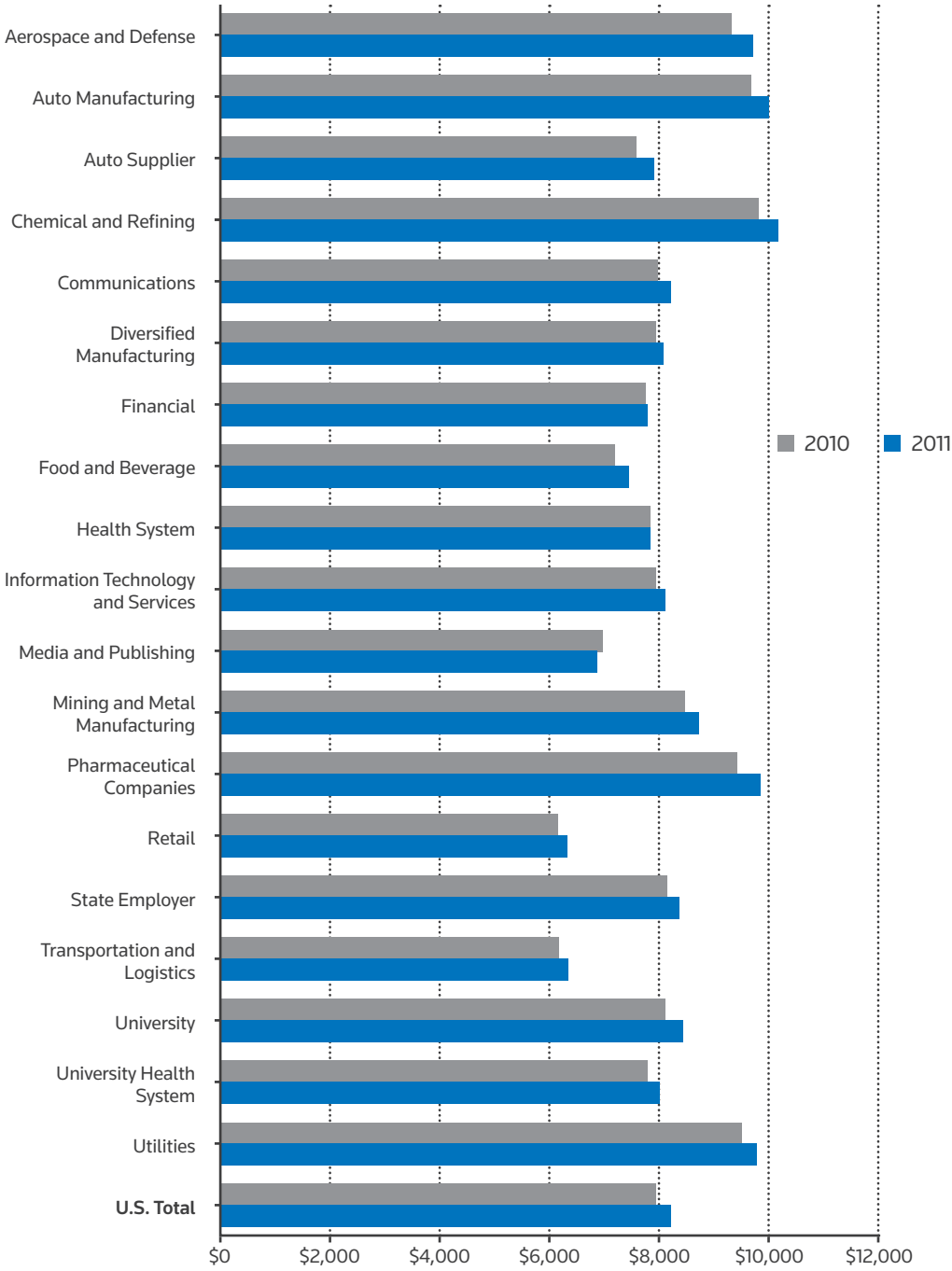


The comparison above does not adjust for factors like the age and sex profile of an industry segment or average family size.

Net Costs by Industry Segment

On a net PEPY basis, the Chemical and Refining segment had the highest annual medical and pharmacy cost ($10,167 PEPY), but other sectors, such as Aerospace and Defense, Auto Manufacturing, and Utilities, had costs in excess of $9,000 PEPY. The Retail ($6,595) and Transportation and Logistics ($6,780) segments had the lowest PEPY net costs (Figure 36).

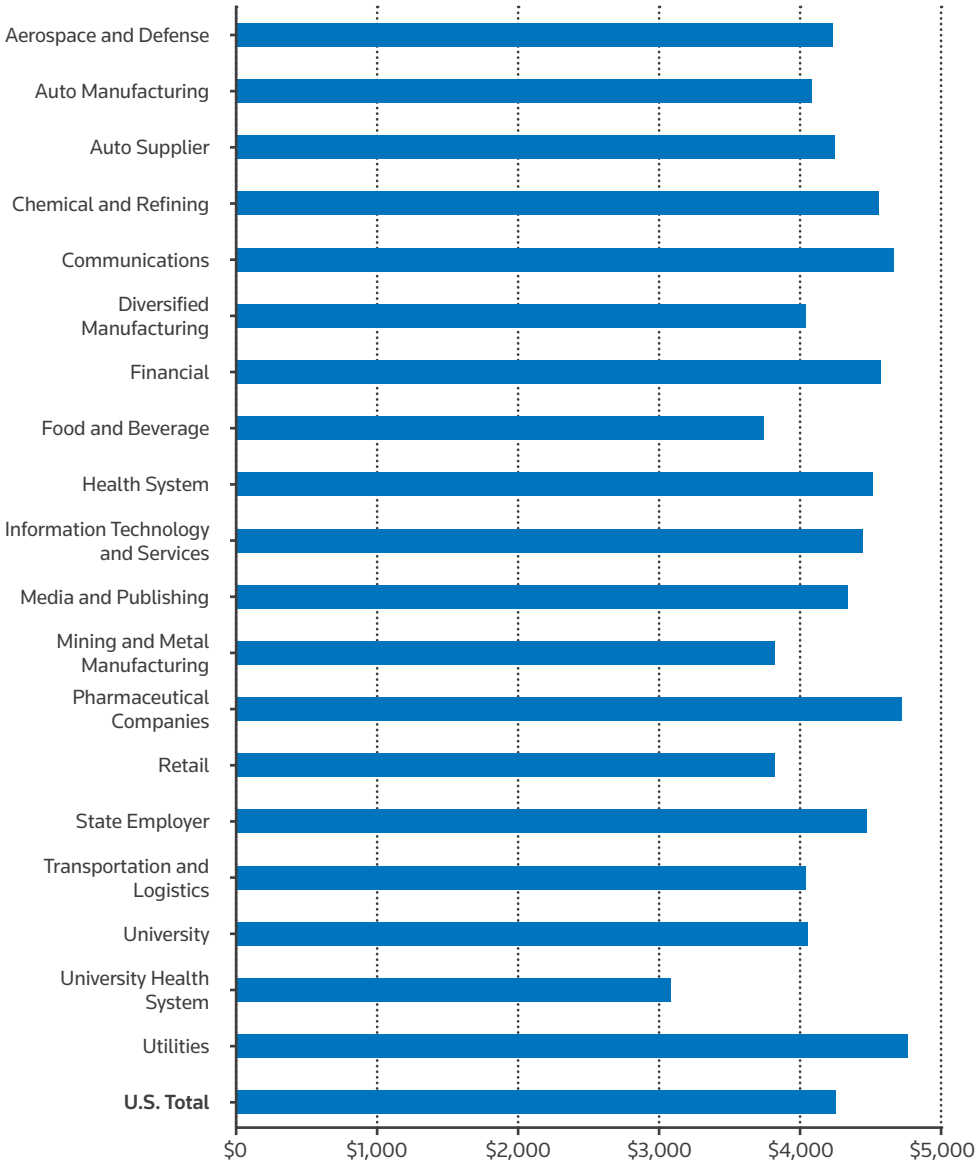
FIGURE 36: PEPY Net Medical and Pharmacy Payments by Industry Segment



Allowed Medical and Pharmacy Costs by Industry Segment

If we adjust for age and sex differences between industry segments and compare costs on a consistent basis, we get a different picture. Auto Manufacturing had costs above the U.S. average on an unadjusted basis, but had lower than average costs after adjustment to a normalized age and sex profile. Financial employers had lower than average unadjusted costs, but on an age- and sex-adjusted basis, this group had higher than average costs for the U.S. as a whole (Figure 37).

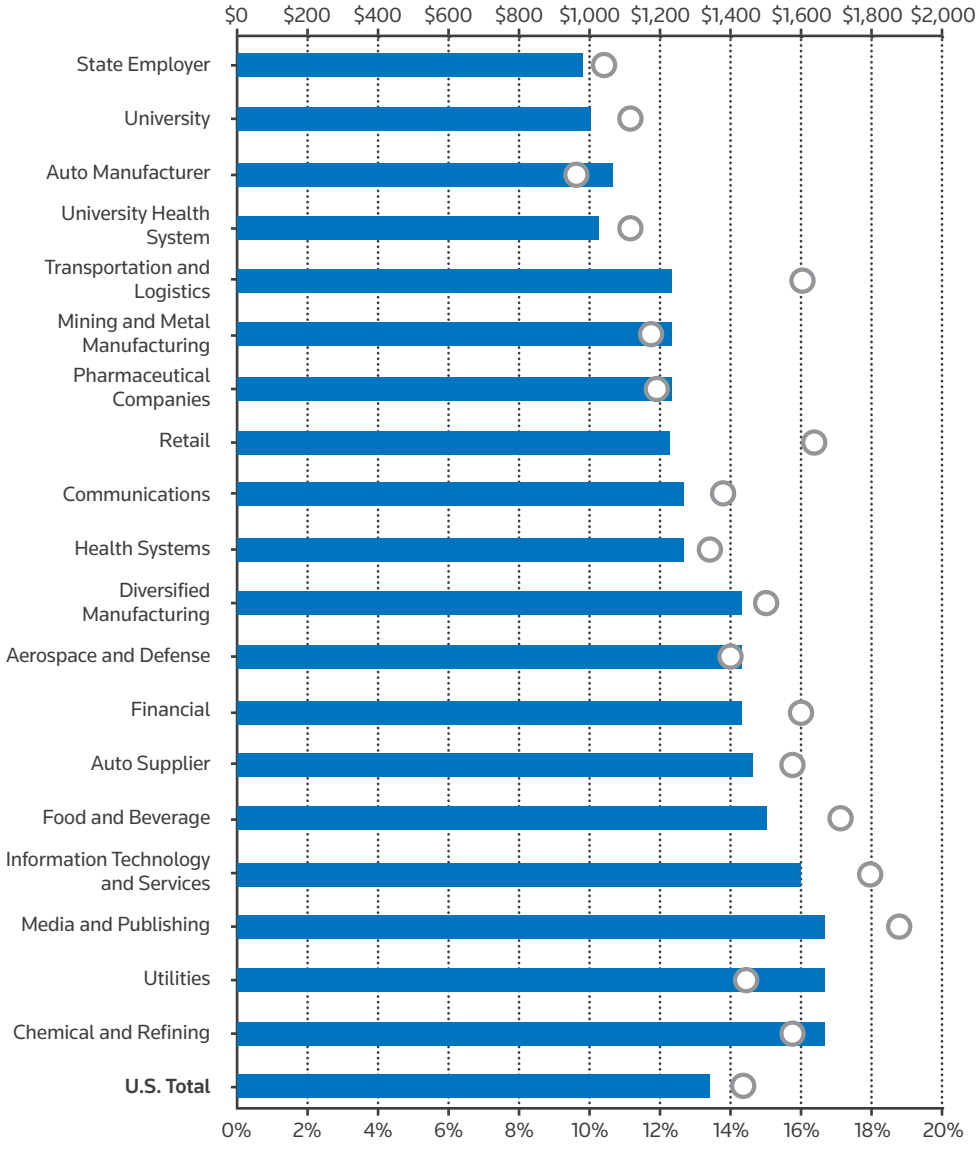
FIGURE 37: Age- and Sex-Adjusted PMPY Medical and Pharmacy Allowed Payments by Industry



Out-of-Pocket Costs

As a percentage of allowed medical and pharmacy costs, Auto Manufacturers had the lowest cost share* (10 percent of allowed costs), followed by State Employers and Universities at 11 percent. Media and Publishing (19 percent of allowed costs), Information Technology (18 percent of allowed costs), and Food and Beverage (17 percent of allowed costs) had the highest proportion of out-of-pocket costs. The average out-of-pocket percentage for all U.S. employers was 15 percent (Figure 38).

FIGURE 38: PMPY Out-of-Pocket and Out-of-Pocket Percentage of Allowed Costs

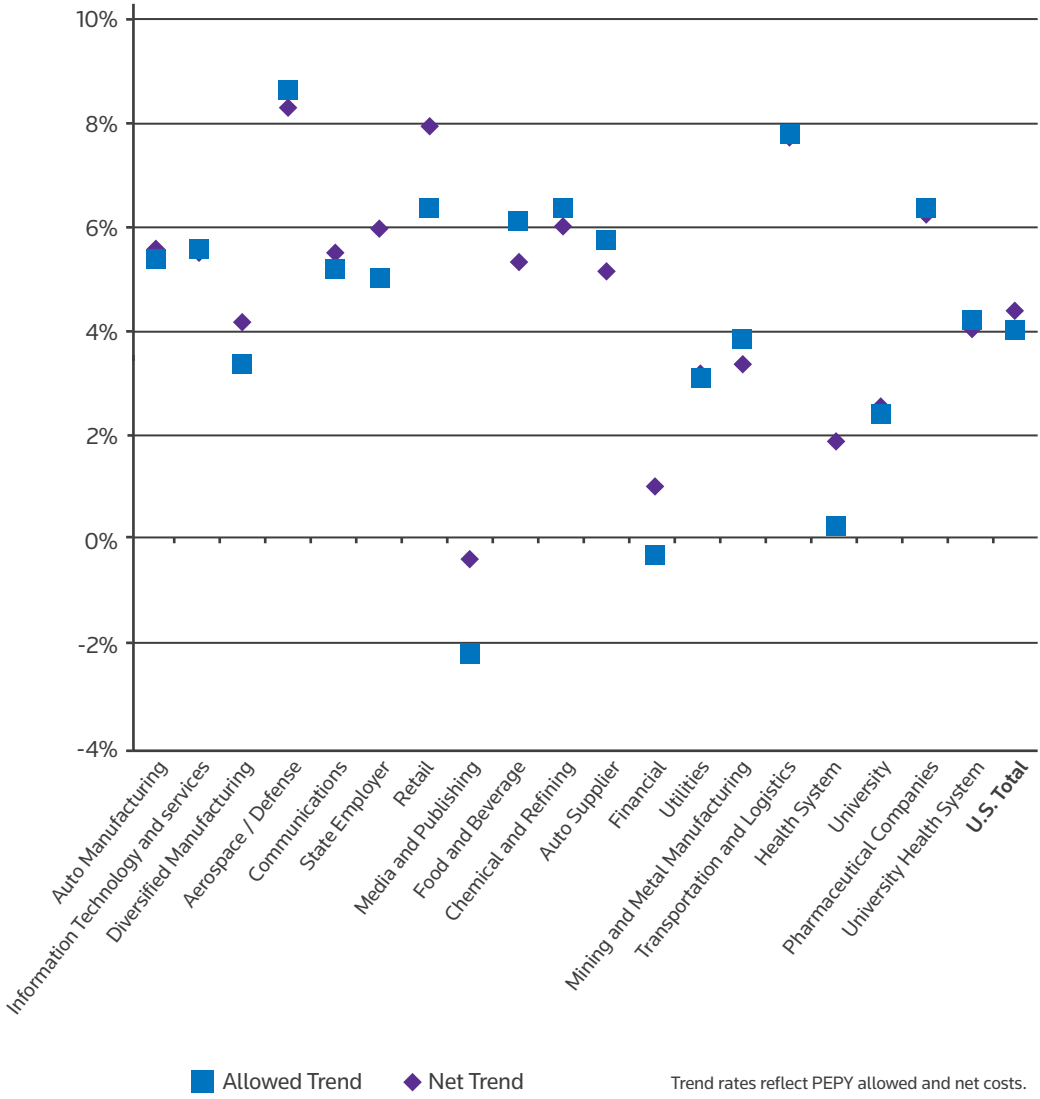


Note: costs above are not age- or sex-adjusted.
* Out-of-pocket costs are deductibles, copayments, and coinsurance and do not include employee premium contributions.

Recent Medical and Pharmacy Cost Increases

Aerospace and Defense, Retail, Chemical and Refining, Transportation and Logistics, and Pharmaceutical companies all had 2011/2010 annual net and allowed medical and pharmacy trend rates in excess of 6 percent. Food and Beverage companies also had net payment trends in excess of 6 percent. Media and Publishing, Financial, and Health System employers all had net and allowed trends of less than 2 percent (Figure 39).

FIGURE 39: 2011/2010 Medical and Pharmacy Trend Rates (Cost Change)

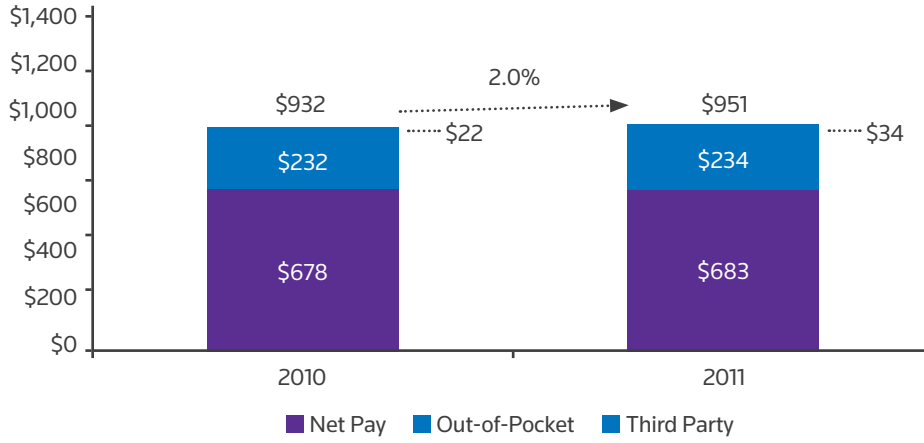


Trend rates reflect PEPY allowed and net costs.

Dental Cost Trends

In 2011, allowed dental costs increased by 2.0 percent from $932 per employee to $951. Net payments increased by 0.7 percent from $678 to $683, and out-of-pocket costs increased at a slightly lower rate of 0.9 percent from $232 PEPY to $234 (Figure 40).

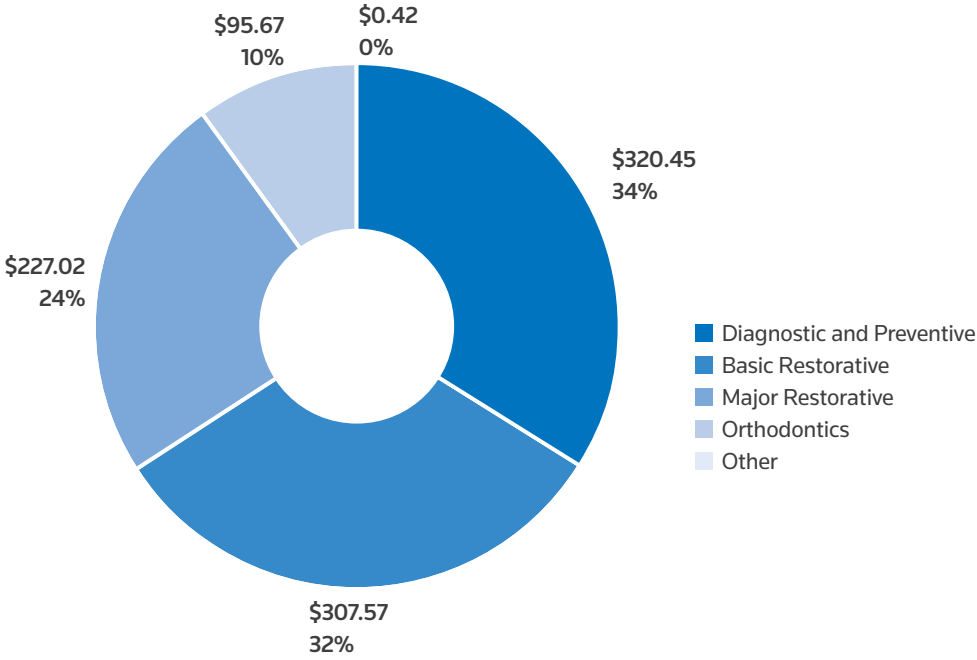
FIGURE 40: PEPY Allowed Dental Costs — Dollar and Percent Change



Dental Services

Diagnostic and Preventive Services contributed to 34 percent of total dental costs followed by Basic Restorative (32 percent), Major Restorative (24 percent), and Orthodontics (10 percent), as shown in Figure 41.

FIGURE 41: Dental Service Percentages



CONCLUSION

Organizations have always sought to maximize the value of their investment in the health of their workforce. Making the most of every health investment is even more critical during the current economic downturn and the move toward a more global marketplace. Employers face the enormous challenge of balancing cost control with the wellness and productivity of their employees.

MarketScan norms are a valuable tool for allowing an employer to identify performance gaps that drive healthcare financial risk and areas of their programs that are functioning effectively. These benchmarks play an important role in monitoring the ongoing performance of programs and provide a source of independent data in evaluating vendor and plan administrator performance. We hope that you will be able to incorporate these MarketScan norms into your plan management and evaluation activities.

FOR MORE INFORMATION

For more information or to review additional figures presented with these findings, please contact:

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ABOUT TRUVEN HEALTH ANALYTICS

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