

**Michael J. Critelli**  
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Good morning. I am pleased to have the opportunity to discuss the ways business can lead transformation of health care in America in a state that is actively focused on its role in this process as well. My perspectives on health care are drawn from my experience of leading a company, Pitney Bowes, which is both a payer and a provider of health care. In my remarks, I will draw some broad lessons from our experience that might provide useful guidance as we think about one of the most important domestic issues facing not only the United States, but the entire developed world.

The health care problem is large and growing: the United States spends far more in absolute dollars (over \$2 trillion), percentage of GDP (15.2% and rising) per capita costs (\$5,711), on health care than any other country in the world. However, in terms of overall health system performance, the World Health Organization would rate the United States only 37<sup>th</sup> out of 191 countries. For example, with life expectancy at 77.85 years at birth, we rank 29<sup>th</sup>, just below Bosnia-Herzegovina. In infant mortality, we rank 20<sup>th</sup> in the 2007 statistics, behind countries such as Spain, Portugal, Greece, and the Czech Republic.

So why the divergence between what we spend and what we get? Though there are several reasons, I believe that one of the major root causes is that we have defined the primary objective incompletely and, therefore, incorrectly and, as a result, we have a flawed strategy for achieving it.

Relative to physical and mental well being, I believe that as a society our objective should be to make all of our citizens as healthy and productive as possible. Also, to provide affordable, effective health care when our citizens need it due to illness, injury or other conditions requiring medical attention. Contrast this with the major focus of our health care reform debate today, which is to achieve universal coverage. While universal coverage is a necessary component of a well-functioning health care system, as Michael Porter and Elizabeth Teisberg said in their recent book, Redefining Health Care: “Universal coverage provides a payment mechanism that covers everyone, but does not guarantee good quality care.”

Thus, if we define health and the greater ability to engage in productive lives that comes from health as the objectives, then we must focus on, and invest in, improving and maintaining health. American health costs are skyrocketing because American health is deteriorating. Here are a few examples:

- There is an epidemic of preventable chronic diseases like diabetes, cardio-vascular diseases, and hypertension. They comprise the highest percentage of our health care costs, and according to the Centers for Disease Control and Prevention, they account for 7 of every 10 deaths in the United States and affect the quality of life for over 100 million Americans. According to the World Health Organization, we have a higher incidence of obese adults over 15 years of age at 19.7% for males and 21.2% for females than most other developed countries. Cardiovascular diseases, the leading killer in the U.S., are clearly preventable, and all of these preventable chronic diseases interact with one another in very harmful ways.

- There is also a crisis with respect to infectious diseases. Besides the obvious broad problem of HIV/AIDS, we are also seeing a resurgence of tuberculosis and other infectious diseases once believed to be under control. The Global Health Council also points out that we are also seeing an increased incidence of deaths in hospitals from antibiotic resistant bacteria. The New England Journal of Medicine pointed out in 2000 that we are also seeing more infectious diseases from more uncommon sources than ever before. Public health officials also tell us that we are at more risk than ever of a major flu pandemic.
- Other environmentally-induced conditions like emphysema and other chronic obstructive pulmonary diseases continue to grow.

In fact, many of our societal decisions make our citizens less healthy, such as the junk food and beverages we serve daily in our schools and the cutbacks in school physical education programs. The lack of parks and bicycling walking spaces and the insufficient attention we pay to the link between environmentally-induced diseases and children's health is particularly a problem.

What my experience has shown me is that there has to be a unifying objective in transformation. That objective then becomes the framework for strategy, prioritization of investments, and the measure of success. In order to transform the state of health in this country, we must agree that our objective is health. Then find out why Americans are less healthy than they should be and attack that issue in parallel with the other important issues of access, cost, and structure.

I know that was true for us at Pitney Bowes. In 1990, when I became chief human resources officer, our health care costs had been skyrocketing for five years. We started by defining our goal as taking actions that maximize the health of employees and those covered under our plans. This was really a defining moment, because it marked our departure from viewing health in the traditional way. Even today, many companies regard health care as a line item charge against earnings, and thus their focus is on managing the costs. By taking the perspective that the focus should be on health, it guides our priorities and investments.

What has this focus on health versus health care yielded for us? From 1992 through the end of last year, we have had a virtuous combination of high employee satisfaction and well-below-normal health care cost increases. In fact, for many years during the 1990's and in recent years, our health costs -- among our populations in our facilities -- were flat from year to year, and significantly below other companies that we benchmark with.

Before I tell you how we turned our focus on health into a transformative objective, let me first tell you a little about our demographics. From a health benefits standpoint, our 26,000-employee U.S. population is really two different populations of roughly equal size. Population 1 resembles the demographics of a large employer, that is, all employees either work on, or report to, sites we control, and many of those sites have sufficient scale that we can support free on-site clinics, cafeterias, and fitness centers. Population 2 resembles the demographics of a collection of small businesses, that is, employees work in small concentrations on hundreds of customer sites as part of our Pitney Bowes Management Services facilities

management business. For this population, we do not have sufficient scale to support clinics, cafeterias, or fitness facilities. Moreover, the second population is primarily lower-wage workers with a higher concentration of employees who come to us less healthy, less educated about their health and how to use the system efficiently, and with less convenient access to health care. Finally, we have recently acquired a variety of companies whose approach to health care is more traditional and whom we are just beginning to incorporate with our approach.

Why have we been successful?

We have invested heavily in improving health through illness and injury prevention.

- In our large facility cafeterias, we not only serve appropriate portions of nutritious food and beverages, but our pricing, marketing and merchandising practices drive employees to eat the healthy food.
- We have fitness centers in several of our facilities and subsidize exercise programs and outside fitness center memberships. We also give benefit premium discounts for employees that participate in fitness programs like the 10,000 steps-a-day walking program.
- We designed a program called Health Care University (HCU) to incent healthy lifestyles through reduced benefit costs.
  - HCU features a curriculum of health education initiatives and healthy lifestyle programs in everything from stress reduction to disease management, each with a designated number of credits for successful completion that reduce out-of-pocket costs for benefit coverage.

- For example -- non-smokers receive credits for maintaining a healthy lifestyle,
  - Those completing a wellness assessment and completing several recommended behavioral changes – such as reducing their BMI, exercising several times a week and drinking more water receive credits as well.
- We expanded Health Care U to dependents through eHealth portals.

We are in good and growing company when it comes to focusing on health and prevention. In 2003, the City of New York launched a program called Take Care New York, of 10 preventive health steps that every person could take to significantly improve his or her health. In a speech on health care Mayor Bloomberg said, “In health care, as with everything else, you get what you pay for. And right now, it’s not stretching the truth very much to say that in America we’re paying for a disease care system, not a health care system. That means that if we want a healthier, greater-life expectancy nation, we’ve got to change, and start paying for prevention, as well as for treatment. Take Care New York is just one part of a true sea change in health care in our city – one where we’re re-directing our resources to bring about a shift -- from simply responding to and treating illnesses to actually preventing them. We must begin to “pay for prevention” to fundamentally re-order our priorities, and reward primary and preventive care that keeps people out of hospitals in the first place.”

We have enhanced access to and marketing and educational outreach for, affordable care

In addition to making health-promoting plans available to employees, we have made access to health care far easier.

- We have a network of seven on-site medical centers in our major population facilities across the country
  - In-house medical function with two physicians and an array of professional providers including physician assistants, nurse practitioners, and nurses.
- These clinics are free of charge for employees and are open every workday to accommodate the demand within a particular facility.
- We can generally give them a full course of therapy for medications at no charge to treat their acute illness
- We make valuable preventive screenings free or as low-cost as possible and do as much marketing outreach as possible. Aggressive outreach is particularly important because many adults are simply not aware of many disease risk factors.
- We make immunizations free or as low-cost as possible
- These clinics have benefited us as well as the employees for a variety of reasons:
  - Employees have access to clinical care for minor illnesses and injuries without having to leave the office, without having to schedule an appointment, and without the long waiting times they experience at private care physician offices.

- In fact, employees who have non-contagious conditions will come to work to use the clinic, rather than making a discretionary decision to stay home for the day to access their private care physician. Our savings are enough to cover the cost of the on-site medical care facilities and staff.
- If their condition is more serious, we refer them to a competent outside physician or health care facility and communicate in advance what might be needed. This facilitates easier access to higher quality care in the outside health care system as well.

Our experience with the clinics reinforced our belief in the benefit of continuity of care, and the management of health information to optimize health and disease management. This led us to our involvement of Dossia, which Craig just spoke about, and my current position as Chairman of the initiative. Health providers need to have a more unified understanding of the patient's health and history. This is especially critical in effectively managing chronic conditions. Issues such as diabetes often require multiple specialists, medications, and care regimens, without the benefit of a consolidated account of key health indicators, recommended treatments or reactions to treatment. We are excited about the possibilities to enhance health that Dossia can bring.

Our health plans and initiatives are designed with certain objectives in mind:

- To make sure healthy people stay healthy;
- To get those who are at risk of chronic diseases to undertake programs that will prevent the chronic diseases from taking hold;

- To get early and appropriate diagnoses and treatment of illnesses and injuries;
- To maximize adherence to treatment requirements, especially for chronic diseases to prevent those conditions from getting more serious;
- To drive employees toward highest quality providers based on results achieved following clinical best practices and to reward those providers; and
- To use rigorous data-driven Six Sigma analyses in the design and implementation of our plans, particularly in recognizing that plan designs can drive healthy and cost-effective behaviors.
- We make informed, data-driven choices about what we will or will not pay for, and how much we will pay. For example, we do not cover fertility treatments, high-risk procedures like gastric bypass, or experimental treatments that are unlikely to be recognized as effective and mainstream over the long term. We do cover certain kinds of alternative medicine treatments based on our judgment as to their efficacy. We also increase co-pays and deductibles for overused procedures like MRI's, to make sure our employees are making informed decisions about when to authorize the procedure.
- We look at multiple factors when we invest in health improvement, and try to create a culture of health among our employees, not just the return in terms of lower medical costs. We consider the benefits of reduced absenteeism and “presenteeism” and reduced disability and workers compensation costs.

On this last point, I want to weigh in on the value of employer-provided or paid health plans. Many health care policy advocates advocate one of three alternative options: single-payer plans that make the government the purchaser and regulator of health care, insurance-centric plans that make insurance companies or cooperatives the purchasers and managers of health plans, or consumer-driven plans that make consumers the purchasers and self-managers of their health.

The first two of these approaches, the government and insurance-centric models are not as good as an employer-paid plan because neither the government nor the insurance companies have the same incentive to drive employee health as employers do. At best, they are focused primarily on either universal access, lower cost or better health care in the form of improved disease and injury treatment. None can marry these worthwhile outcomes with the fundamental goals of improved health and the productivity and quality of life that a state of optimal health drives the way an employer can.

At worst, single-payer plans make decisions on mandated treatments based political or media pressures that are unrelated to optimal health outcomes. We also have to recognize that government priorities are often based on static budget scoring and pay-as-you-go models that over-emphasize annual cost analyses at the expense of investing in health care strategies that produce huge, but deferred, multi-year paybacks. Governments are more likely than not to skew care priorities in favor of voting blocs that are more powerful, such as the healthy and wealthy elderly, than have higher returns in terms of health and productivity, such as investments in children's health.

The best recent example of this has been the reduced focus on medically-necessary early periodic screenings, treatments, and diagnoses for children to accommodate federal and state budget deficits in the funding of the SCHIP and Medicaid programs. As an employer divorced from these short-term, politically-charged considerations, we can make sensible decisions about health and productivity because we have a direct financial stake in them, and are free when we are acting as a self-insured employer from costly and dysfunctional state government mandates.

An insurance-centric model avoids the problems of a single-payer system, but insurance companies are focused on medical cost reduction only, not on the enhancement of citizen productivity. They also have the difficulty of investing in long-term health because of the annual enrollment processes and turnover that results from those processes. As an employer, we have far more stability in our covered populations and can justify multi-year investments in their health. That stability even applies to the higher-turnover parts of our employment base, since, even with these populations, there is a critical mass of long-term employees in whom we can invest.

The consumer-driven approach would, at first glance, appear to be the best system of all because it appears to incent consumers to manage their health as cost-effectively as possible. While consumer-driven health needs to be a component of a viable health care system, there are four fundamental flaws with relying totally on a pure consumer-driven health system. First, consumers often engage in highly-destructive health behaviors like smoking, abusing alcohol or drugs, or not taking appropriate safety precautions. A system that does not involve a third-party incentive or penalty to drive

healthy behaviors is inherently flawed. Second, consumers often trade off long-term health for short-term benefit. At any given stage of a person's life, there is spending that is necessary for optimal long-term health. A plan that rewards behavior that avoids this optimal spending will cost us more, rather than less, over the long term. For example, consumers do not get preventive screenings, immunizations, and treatments for minor illnesses or injuries that they should get because they want to save money or they believe they do not need the treatment. They pocket the financial benefits from deferring care, but, in the long run, they and we pay dearly for their short-term decision in the form of higher chronic disease and catastrophic care costs which the rest of us share in community-rated health plans.

Third, buying health services is not the same as buying cars or consumer electronics items. The benefit of buying a car is obvious and the problem of not buying it is immediately painful. Health problems are different. Many conditions have no symptoms and the benefit of detecting them early is not obvious. Moreover, many of the procedures used in preventing screenings, immunizations or treatments are unpleasant or even painful, so people who should use them do not. A very small fraction of those who should get preventive screenings like colonoscopies do so. Therefore, there is a very real risk that a pure consumer-driven system will not drive the appropriate kinds of health care interventions that are needed to reduce costs. Fourth, for many medical conditions, the data with which a consumer could compare quality among potential providers is simply non-existent or not readily available.

With respect to health plan designs, we have been quite successful in increasing adherence to chronic disease treatment plans by reducing the cost of maintenance drugs to virtually zero and by assigning care advocates to patients to help them manage complex treatment programs. It costs us money in the short run, but it saves significantly on emergency room and hospital visits, particularly for chronic diseases that have no symptoms like hypertension, where adherence is more challenging. Government and private insurance health plans need to be designed to incent the most sensible behaviors by chronic disease patients to reduce long-term cost, not simply to reduce the plan cost for a specific patient interaction like a maintenance prescription. Since we redesigned our plan to reduce our maintenance drug costs over the last several years, our total diabetes treatment costs have declined 6% and our costs for asthma treatments have declined 15%.

For behavioral health conditions, we provide eight free consultations through our employee assistance program to give employees incentives to work with us to find the appropriate provider rather than having them automatically look for the most expensive and fastest treatment plan. This is particularly important for substance abuse treatment, where the most expensive program is not always the most effective. We believe that using “gatekeeping” programs like this is most effective when it is made financially more attractive, not when plan providers eliminate choices for patients. We have also reduced behavioral health costs over the last several years as well.

## LESSONS TO BE DRAWN FROM OUR EXPERIENCE

Regardless of the specific role employer health plans play in any future health care system, I would draw the following lessons from our experience:

- The end goals of a world-class health care system should be the maximization of the health, quality of life and productivity of its citizens. We should not be looking as much at what we spend for health care, but what we get relative to that spending.
- Investing the most resources in wellness, prevention, and early diagnosis and treatment of illnesses and injuries is the best way to achieve these twin goals.
- Plan designs and health care system structures should allow for investments that pay back over a multi-year period and that recognize the behavioral responses to health care plan designs. For example, multi-year adherence to treatment plans is a far more productive goal than reduce the current year's cost of prescription drugs for the plan sponsors.
- It is not enough to have health care designs that reimburse the right behaviors, such as prevention and wellness. The plans must have providers that enable convenient access, aggressive and tailored education and marketing outreach, and strong financial incentives for healthy behaviors. Community rating systems that do not allow for differential premiums based on healthy behaviors are a bad idea.
- Best-in-class treatments and providers should be rewarded based on the results they achieved, with far greater availability of comparative performance data.

- A comprehensive personal, portable, private, patient-controlled electronic health record is an essential tool for a world-class health care system, and we should invest in quality management processes and tools across the entire system.
- Employer-based health plans have a unique and valuable role to play in any system because they combine more payback opportunities than any other system.

## CONCLUSION

If we tame this beast of rising health care costs and improve quality, we will make its consequences less daunting. There will be fewer uninsured Americans because premiums will be lower due to lower cost. The burden of retiree health will be lower because the projected actuarial cost increases will be lower. Americans will be more productive if they are healthier and have a higher quality of life, and we will have more competitive American businesses.

I do not believe that this is solely the responsibility of government, nor solely the responsibility of business. The most effective way for us to transform health in America will come from the combined efforts of governments, businesses, communities and individuals.

I have appreciated the opportunity to share my views on health care policy with you today. I would now be happy to take your questions.

