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THE CASE FOR EMPLOYER-BASED HEALTH PROGRAMS

Thank you for giving me the opportunity to speak about a subject of great passion for me, the value of employer-based health programs. I want to thank our sponsors for hosting this event. I come to this venue recognizing that the U.S. has a very different health care system from Canada’s, but I also recognize that the challenges we face are similar.

In both the US and Canada, as well as the developed countries outside North America, there is a crisis caused by the huge gap between public demand for low-cost, high quality universal health care and the ability of our governments and societies to deliver against this demand.

The gap is being fueled by employer financial limitations, but is also a result of the reality that mortality continues to drop, patient medical partnerships via e-communication are increasing and direct-to-consumer pharma advertising has become standard for many countries.

Why? One of the reasons is the inconvenience caused by where health care is primarily delivered. The other is the fact that health is a result of a service structure primarily composed of health care professionals.

In both our countries, health care is primarily delivered in highly-regulated health care facilities, while the vast majority of residents spend most of their waking hours at either workplaces or, in the case of children, schools.

In the U.S., 146 million Americans spend the majority of their waking hours at work, as do a similar percentage of adult Canadians. In essence, people who need to interact with the health care system and who do not have available worksite clinic care, often have to leave where they most frequent to spend significant time interacting with an unfamiliar environment of which they have a sporadic relationship.

In both countries, the implicit signal sent by government policies, insurance plan designs, and payment systems is that health management primarily resides in health care professionals, as opposed to being a partnership among health care providers, employers and other organizations to which individuals belong, and the individuals themselves. Our key premise is that health care should be delivered close to where individuals spend their waking hours, and that investments in health by employers can improve health and reduce the burden on the health care system.

Health is heavily influenced by the environment in which individuals spend the majority of their time, which means that the employer has a huge impact on health. However, in many

cases, the employer has no economic involvement in the health care process, other than as a possible payer of benefits.

We, at Pitney Bowes, began our journey toward creating a culture of health for our employees 18 years ago when I became head of our human resources function.

For five years, our health care costs had been increasing 14% per year, our employee satisfaction with their health care benefits was declining, and our employees were paying very little of the expense for health care. My boss, the Company's CEO, told me that I had to decrease the rate of health care cost increase, improve employee satisfaction, and increase the level of employees' contribution to their own health care benefits. We clearly could not solve all three of these problems using conventional strategies.

Fortunately, I received an audiotape of a series of lectures given by Dr. John Wennberg of Dartmouth College, the founder of the Center for Clinical Evaluative Studies, which provided the key insight that enabled me to find a way of accomplishing these goals.

Dr. Wennberg's rigorous analysis of two decades of Medicare and Medicaid health care and outcome data from communities around the United States, demonstrated that health care spending to address the same medical problem varied widely by community, with no differences in results.

In effect, he was saying that spending more did not produce better outcomes, but that spending based on good data and evidence-based medicine could improve outcomes. Everything we did from that point forward was based on the principle of getting better value for what we spent, and making our employees and their families partners in improving their health.

Before I describe what we [at Pitney Bowes] did, I want to provide some context by giving you a little background on our U.S. demographics, then sharing my understanding of those within Canada – specifically the Atlantic Canada region.

In the United State, like in Canada, we have many different population segments, such as ethicnicity, culture and socioeconomics, but, for the purposes of devising employer health promotion programs; there are four relevant segments that supersede the others:

- The first segment consists of a large business population that reports to, and works in, company owned facilities. For Pitney Bowes, this population includes headquarters staff and line populations; including corporate, business unit engineering, supply chain, and marketing, call centers, software developers and support personnel, and self-contained high-end service delivery managers and professionals. For Pitney Bowes, this constitutes approximately 25% of our 26,000 U.S.- based employees. We have a similar large business population in our Mississauga, Ontario, headquarters.
- The second segment is the mobile worker population, which includes sales and service professionals who report to regional offices owned by Pitney Bowes, but largely work in their automobiles, or, if they are in big cities, use public transportation or walk between customer sites. An example in this area would be our Halifax sales and service office in Nova Scotia, Canada. Approximately 15% of our U.S. population fits into this segment.

- The third segment is the production population. These workers which account for over 15% of our U.S. workforce, work in company-occupied mail production and consolidation centers which house 100 to 150 employees per site. Unlike the first two work populations I mentioned, this third Pitney Bowes employee group consists of immigrants from over 20 countries, who tend to only speak their native language. We have no comparable population in Canada. However, like Pitney Bowes, I understand this is a segment of interest for Canada.
- The fourth and last segment consists of our Pitney Bowes Management Service and onsite product repair employee populations. This employee segment resembles small, independent businesses in that they average about 20 Pitney Bowes employee per location, across a total of over 600 different customer sites. This remote population constitutes the remaining 45% of our U.S. population. We have a small Management Services business in Canada that would fit this profile.

So, you can see that within Pitney Bowes, we have a work population which is composed of the various types typically found within today's work environment. For each, Pitney Bowes has had to create and implement a different strategy to yield improved health care for our employees in each of these segments.

In respect of time, I will spend most of my time discussing what we have done with our first work population – large business. I will then discuss the strategies that apply to the other populations; then, finally, the strategies applicable across all four populations. Before I do that, I want to note that these strategies were not adopted all at once. They were part of a multi-year trial-and-error process.

As we moved from a traditional benefits design in 1990 which was nothing more than an insurance plan that managed claims and adjusted rates based on prior year experience to one in which we actively sought to improve employee health and to increase employee participation in managing their own health, we followed certain change management principles:

- Every time we increased employee contribution levels, we sought to offer something new and valuable to employees. In 1991, we expanded our range of preventive services for which we would reimburse the employees. In 1992 and other years, we opened free onsite clinics. In 1993, we launched a flexible benefits program to give our employees more choices on how to spend their benefit dollars. Later in the 1990's, we launched Health Care University, which provided a range of wellness programs that contained financial incentives and rewards for employees.
- We never justified increasing employee contributions based on our inability to afford the benefits we had in place. Describing benefits as being "too rich" or "too costly" is a recipe for class warfare. We were careful to point out that we felt that increasing employee financial participation made it more likely that they would receive appropriate care, rather than being a target for unnecessary care by providers who were trying more aggressive treatments.
- Our message was consistent over time. Our focus was, and is, improved health and well-being, not universal, affordable health care. We recognized that improved health would enable universal, affordable health care, but we focused on the root cause of health care cost increases, rather than the symptoms of the problem.

- Our leadership took major steps consistent with a culture of health. We banned smoking in our buildings in 1990. We significantly reduced alcohol consumption in all of our company events over time. We redesigned facilities to encourage more exercise. We also made behavioral health, which is a root cause of many health care costs associated with other chronic diseases, a high priority by making behavioral health counseling a much more visible part of our benefit program. We eliminated the stigma associated with asking for help on situations that caused stress or triggered behavioral health problems.
- Finally, everything we did was driven by data collection and analysis and by adherence to the best available evidence-based medicine practices. We retained Medstat to collect all of our health-related data to give us the best ability to make informed decisions about health care plan designs and health promotion programs.

With these principles in mind, let's describe what we have in place today.

Our first population benefits from working in facilities large enough to support clinics, Company dining facilities, and, in a few cases, Company fitness centers. In our World Headquarters, we also now have an onsite pharmacy.

Across our entire four populations, we have employed health care plan design strategies to drive healthy behaviors. About 80% of our employees are in a self-insured Company plan administered by one or two third-party administrative services operations providers. The other 20% are in insured plans with a handful of large national providers, such as CIGNA, Aetna, Kaiser, and United Health Care. We have some common principles in these plans:

- We encourage secondary prevention usage of the health care system by making screenings and well-child visits very low cost or even free of charge.
- We encourage tertiary prevention behaviors by reducing the cost of, or even giving away, maintenance medications for chronic diseases. This is particularly important because once an individual has asthma, or a metabolic chronic disease like diabetes, cardio-vascular disease, or hypertension, that individual's health condition can range from being fully able to function every day with medication to having health deterioration that results in a variety of pathologies, including neuropathic conditions that lead to lower limb amputations. Clearly, to the degree that we can keep individuals at the state of health at which they are managing their condition through maintenance medication, we have significantly improved their productivity.
- To the degree that U.S. law allows, we provide incentives in the form of lower cost premiums, or incentive gifts, for participation in wellness programs. Our award-winning Health Care University program has been providing benefits credits for health-promoting behaviors for over a decade. We also have had a pre-natal program called Great Expectations to encourage expectant mothers to engage in healthy behaviors, and we reward their participation with a gift, a portable baby carrier.

We call our health care plan design "value-based health care," which means that we pay more for high-value, necessary, and cost-efficient health interventions, especially upstream preventive care interventions than we do for downstream treatment services. Just as world-class manufacturers and other businesses discovered that the best investments in product and process quality were made at the earliest possible point in a process, we focus on interventions that keep people healthy, or keep those with chronic diseases at a maintenance

level. While we reimburse people for necessary treatments for diseases, illnesses, and injuries, we clearly skew our most financially attractive plan provisions toward necessary, cost-effective preventive interventions.

With respect to our first population segment, we focus more resources on primary prevention strategies, such as improved nutrition, exercise and fitness, lifestyle changes, and immunizations and other infectious disease prevention and containment strategies. Our food service strategy is designed not only to insure the availability and abundance of healthy foods at work, but to un-level the playing field in favor of healthy foods. We use a number of strategies to make it more likely that our employees will select healthier foods when they make their dining choices:

- We attempt to price healthy foods more favorably than less healthy foods.
- We provide abundant information about the nutritional value of different foods at the point at which employees are making food selections.
- We have used proven merchandising techniques to insure that the healthy foods are more visible and easier to access than the less healthy foods. For example, we have healthy fruits and vegetables at the checkout counters, because we know that, just as supermarkets and pharmacies put their most profitable offerings at the checkout counter, where they are the subject of many impulse purchases, we want the impulse purchase to be a piece of fruit or a vegetable.
- We make our healthy foods attractive to eat. For example, we invite ethnic chefs to our facilities every week to prepare foods on site that the employees do not get every day.

Relative to exercise, we make walking and exercising more convenient in our large facilities. We have inviting stairwells that are easier to access than the elevators, and, as we have remodeled our facilities or built new ones, we have built the workspaces with an open office design and with shared multi-functional imaging devices, conference and huddle spaces, and mini-dining areas to induce employees to get up and walk around all day, and to interact more frequently with their fellow employees.

We have also placed smoking cessation counselors at many of our facilities, and have provided subsidized smoking cessation programs for many years. Our best smoking cessation counselors have had a phenomenal record in getting employees to stop smoking and keeping from relapsing. And, starting in January 2009, with our move to include our external grounds in our work-site smoking ban, we expect a continuation of our success.

We have had an active program to refocus our employees on basic tools for reducing the likelihood that they or their colleagues will contract infectious diseases. We actively communicate the importance of hand-washing, and have signage in all of our restrooms and kitchen areas. We also have hand-sanitizer dispensers in many of our buildings in places where employees and visitors are likely to be carrying infectious agents, such as the lobby areas where people enter our buildings from the outside.

As we have redesigned work spaces, we have focused on getting our work spaces LEED-certified. For those of you not familiar with LEED certifications, this is a certification that the workspace meets an array of energy and water usage reduction and environmental

standards for buildings, HVAC systems, furniture and furnishings, the air quality in the work spaces, temperature and humidity control, and the exposure to light and sun, which we know is important to health. We also have a strong focus on educating our employees on ergonomics as it relates to work spaces and work activities. We do not have specific data on our LEED-certified facilities because our work is too recent. However, older studies show some startling statistics:

- A 1974 study by the New York State Commission on Ventilation showed that workers using keyboards are between 18% and 49% more productive when temperature and humidity are optimal than when they are 4 degrees Celsius higher. There are similar statistical comparisons for factory worker and driver productivity.
- A California Energy Commission study reported in 2003 on Sacramento Municipal Utility District telephone service workers showed that they processed calls 7-12% faster with proper sunlight and views.
- Another study done for the Pacific Gas and Electric Company and reported in a March, 2007, article in Thespaceplace.net reported that computer programmers spent 15% more time on task when they had proper sunlight and views.

We deliver free clinical care onsite for employees. Our clinics deliver five kinds of services:

- Treatment for minor illness or injuries;
- Screenings;
- Immunizations;
- Behavioral health counseling by third parties through our employee assistance program; and
- Smoking cessation counseling.

We also consult with employees with more serious medical conditions and refer them to community-based physicians. In fact, for physicians who have sizable populations of Company employees as patients, we make our headquarters clinic available to them for office visits one day a week. One of our core goals, beyond treatment and encouragement of primary, secondary, and tertiary prevention strategies is to get employees to have primary care physicians with whom they can develop a long-term relationship.

For all our populations we run an internal disabilities management department, staffed by nurses and physician to insure that those receiving disability payments, are receiving proper therapy and appropriately receiving benefits for which they are entitled.

In short, we have a very robust program, developed over many years, and committed efforts, addressing employee health. However, we can not make onsite clinic care model work for all workforce populations segments. For our smaller, remote workforces, we have begun to apply some unique, straight-forward strategies:

- We communicate by multiple channels to encourage employees and their families to get seasonal immunizations, and provide financial incentives that make these essentially free.
- We visit facilities and areas from time to time to do preventive screenings.

- We use our Health Care University website to communicate with our remote populations to get them to use health risk assessments, to get screenings and immunizations, and to take charge of their health.

Two of our most successful web-based Health Care University programs are our “Maintain, Don’t Gain” and our “Count Your Way to Health” offerings.

“Maintain, Don’t Gain” is based on the simple principle that, if we can help employees reduce their weight gain during holiday seasons when most people gain a considerable amount of weight, we can help them manage obesity issues better. As the slide shows, we had excellent success with this program.

“Count Your Way to Health” is designed to get employees to focus on six health-related metrics by remembering six numbers: 0, 1, 5, 25, 30, and 100. Zero reminds them to do no smoking. “1” reminds them to floss their teeth once a day; “5” reminds them to eat five fruits and vegetables a day; “25” is their target body mass index; “30” reminds them to get 30 minutes of exercise every day; and “100” reminds to use seat belts and safety helmets all the time. The slide shows that this simple program has significantly improved our employees’ focus on some important health drivers.

Why do we do all this? In the United States, we have a compelling financial incentive because we provide health care as a core benefit, which makes us responsible for most of our employees’ health care costs. By having a strategy focused on prevention and on convenient delivery of basic clinical care, we have been able to keep our rate of cost increase well below national benchmarks and averages.

Obviously, there is no comparable financial incentive here in Canada because of your very different health care delivery model.

However, we have learned that what we do with our first population has delivered other benefits over time:

- Clearly, to the degree that individuals are healthier, they have fewer lost work days from hospitalizations, outpatient medical procedures, and visits to physicians’ offices.

- By having clinics on site, we reduce absences caused by the need for individuals to visit offsite physician offices for the tasks we can provide on site. Not only do employees save on the travel time to the outside physician, but their waiting time in our clinic averages between 5 and 10 minutes, far less than what they would experience in an outside physician’s office. At the same time, our health care professionals, who are unburdened from operating a profit-making medical practice and from dealing with the complexity of making claims on outside payers, are able to spend much more time with patients than outside physicians would be.

- We see reduced disability costs, and, because we have generous health care benefits, we tend to see fewer cases in which individuals claim that a medical condition is work-related solely to collect a richer benefit from our workers compensation system.

- We see specific benefits from offering behavioral health counseling to all our employees, and offering onsite counseling to employees in larger facilities. Employees disclose issues that are preventing them from working as effectively as possible, and they get more immediate help. This is especially important for treatable problems such as clinical depression, since depression not only affects work productivity, but a person's ability to manage other medical conditions that require intensive self-management.

- We also see benefits from getting employees to participate in smoking cessation programs. We see many smokers leave the buildings to smoke during the work day. To the degree that we get them to stop smoking, we recover that time that they spent leaving the building, taking smoking breaks, and returning to their [offices and]work stations. In 2009, we will make our smoking ban apply to areas outside the buildings, and to entire campuses on which our facilities are located.

- We also have focused on reducing the incidence of allergies and migraine headaches that do not necessarily result in absences or periods of disability, but significantly reduce work productivity while individuals are suffering from the condition.

What has our combination of health promotion initiatives accomplished, aside from reducing health care costs?

- Our clinics have produced a measurable investment return of $2.30 for every dollar spent. This measurement includes not only medical cost avoidance, but reduced lost workdays. It does not include the more difficult-to-measure subject of presenteeism.
- Over the last several years, we have seen a 66% drop in the length of disability, and a 19% drop in sick days.
- Our chronic disease treatment and pharmacy costs have dropped. For example, we have experienced a 6% reduction in diabetes treatment costs and a 15% decrease in asthma treatment costs. Furthermore, we have realized 7% and 19% reductions in pharmacy costs for our diabetic and asthmatic employees, respectively.
- Continuing, our focus on helping our employees adhere to health and medical treatment plans reduced emergency department use for asthma by 30%, hospitalizations by 38% and disability costs by 50%.
- Finally, our overall health expenditures have produced a cumulative $39.5 million in savings on a baseline expense of $111 million over a 12-year period.

Our experience is not unique. In a 2005 issue of the American Journal of Health Promotion, Professor Steven Aldana of Brigham Young, reported that those who have comprehensive health promotion programs realize a 28% lower incidence of employee sick leave than those organization which do not.

Dr. Aldana found that the aggregate results of 73 studies, some of which are studies external to US confirmed that employers realized a $3.50 return on every dollar invested in workforce health, much of it in workforce productivity.

In an article in Health Promotion International, co-authors Angela Downey and David Sharp report that BC Hydro in British Columbia claims to have saved $3 for every $1 spent in workplace health promotion.

We have not yet been able to quantify the presenteeism improvement benefits of improved health. However, there are many studies that illustrate the costs of presenteeism from untreated medical conditions.

These studies, which were summarized in a 2004 article in the Journal of Occupational Environmental Medicine by Doctor Ron Goetzel and his colleagues, are either surveys taken by organizations using standardized productivity audit tools, like the American Productivity Audit, the McArthur Foundation Midlife Development Survey, or the Work Productivity Short Inventory, or actual real-time measurements, such as The Bank One Worker Productivity Index or the study reported in the January, 2001, Journal of Occupational and Environmental Medicine, by Doctors Wayne Burton and Dee Edington and their colleagues. Those costs result from people leaving their workplaces, performing tasks more slowly, or making errors because of reduced concentration. Some of the findings:

- Productivity losses from "presenteeism" for the top ten medical conditions range from a low of 5.7% to a high of 17.9%;
- The average number of days absent from work for the ten top medical conditions in these multiple surveys and studies are about 10 per year.
- Even something as simple as untreated allergies, according to the Burton-Edington study, results in a 10% drop in productivity for telephone customer service workers.

We also have not been able to quantify the morale and relative employee satisfaction impacts of our health improvement programs. We know from our employee satisfaction surveys that our medical benefits are very popular and that we deliver a high degree of satisfaction with them. We specifically know from surveys that, of the employees in buildings that have onsite clinics, about 75% of our employees will use the clinic in any given year, and we will have over a 95% satisfaction rating from those employees.

Thus far, I have discussed the large business population that works in large Company-owned or Company-leased facilities every day. I want to touch on the challenges of our other populations. Clearly, we can deliver health programs on line or through mobile delivery systems, but we are challenged in delivering health care the way we do so in our large facilities. We cannot influence what these employees eat, how conducive their environment is for exercise, and what kinds of lifestyle challenges might be more daunting for them in the multiple environments in which they work.

However, we are beginning to look at strategies for reaching these other populations:

- We are talking with several major clinical providers to identify the best alternatives for reaching our remote employees for screenings and immunizations.
- We want to make primary care as affordable and convenient as it can be. For example, we know that our employees often defer doctor's visits until after work, only to find that most doctors' offices close by the time they get back to their communities from work. For example, in Connecticut, the most popular time for people to visit emergency rooms is 7 pm, and the majority of people who visit the emergency room have affordable health insurance coverage. They are going to the emergency room because they do not have access to a primary care provider, not

because they do not have insurance. We are looking at a variety of options for after-hours care for our employees.
- For employees who do not speak or understand English well enough to go to an English-speaking health care professional, we are looking at translation services that can be accessed and that have medically-certified translators to help our employees and their families receive correct and culturally appropriate care. We are at the early stages of talking with an outside firm to help us reach this population.

Delivering health and realizing productivity benefits are complicated because of the diverse populations and the diverse environments in which they work, but we believe that a commitment to their health and well-being is a great investment in building the vital human capital of our organization.

Two points should be obvious:

- Employers can gain great benefit from investing in delivering health to employees, in terms of reduced absenteeism, reduced disability, reduced work-related injuries and illnesses, reduced turnover, and improved employee satisfaction and productivity.
- A health system that disconnects the employer from the delivery of health programs is missing a huge opportunity in improving the health and well-being of its population, and in reducing the cost of health care.

I will not deny that many employers have not seen the light in terms of the benefits of intervening to improve the health of their employees. When they fail to do so, we hear three typical rationales:

- They are too small to afford health-related programs in the workplace;
- They have such high employee turnover that they cannot recover their investment in the employee's health before the employee leaves their employ; or
- The payback periods are too long and the returns on investment are too speculative to justify investment in workplace health and productivity.

To these arguments, I would make the following responses:

- Smaller businesses are even more dependent on the health and well-being of every employee than we are as a large employer. They typically have one employee performing multiple by valuable functions, and are far more vulnerable to serious work disruption if a single employee is ill or injured. This reminds me of a conversation I had once with a former woman small business owner who complained that, although she believed strongly in equal rights for woman, she was at serious risk in hiring women of child-bearing age for critical jobs because she could not afford to have them leave the workplace for maternity leave for several weeks or months.

- Generally, when workplaces have high turnover, there are still many employees who have longevity, and for whom health-related investments make sense. For the high-turnover employees, it still makes sense to have programs that reduce absenteeism and disability, and that have quick paybacks relative to health, such as seasonal immunizations. I would also question whether excessive turnover is good in any organization. While workers get costlier the longer they are on the job, they also have

the potential to add more value and to move up the ladder into management over time. Health-related investments reduce turnover.

- Relative to return on investment, Doctors Troy Brennan and Kyra Bobinet of Aetna completed a paper on workforce health promotion earlier this year. They made the following observations about return on investment:

    - Presenteeism, absenteeism, and decreased disability savings can be realized immediately, and the paybacks on these items are measurable and compelling for many types of work.
    - Decreased population risk and health costs take longer to realize, but are no less compelling.
    - In any event, the savings over a three-year period are generally huge, and, on a present-value basis, are 2x-3x the money spent.
    - Investing in workplace health promotion requires rigorous data analysis of the nature of your workforces, the types of health and productivity issues you have, and the kinds of solutions that would produce the highest-leverage returns. Anyone wanting to achieve world-class results from a workplace health promotion program must start with the data, and go where the data takes them, rather than trying to borrow a program off the shelf.

One of the reasons we are gathered here today is to initiate a process that will result in meaningful contributions toward public policy change in both the U.S. and Canada. From my work in health care, postal, and transportation reform, I make the following observations:

- Government decision makers and their staffs welcome business engagement, but they want CEO and senior line executive involvement. They interact frequently with government affairs and, in the case, HR professionals, as well as lobbyists and trade association representatives, but they want to hear from senior executives who have the ability to take a broader and less partisan position.

- They value, knowledge and insight from those who are solving real-life workplace problems, not just those who can think conceptually.

- They value CEO perspective from companies who are not in the health care business, but who care deeply about their employees' health and well-being.

- They value long term engagement, because public policy decisions typically take more than one year to put together.

So, just as we started a Leading by Example initiative several years ago in the United States to promote health improvements policies, this is the time to get a CEO-level initiative underway in Canada.

I have covered quite a bit of ground today, and look forward to your questions.

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