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Good afternoon. Thank you Laurent for that introduction, and thank you Randy for giving me an opportunity to join you in this important dialogue about health and innovation. I would like to talk about our journey to develop a culture of health at Pitney Bowes and what we would like to see from innovative life science and biotech enterprises like you.

Innovations in health care are creating, touching and sustaining life in ways never before possible. From fertility treatments to multiple organ transplants, diagnostic advances to widespread use of vaccines, medical science has impacted the quality and length of human life in a variety of wondrous new ways.

Yet, the irony is that much of the global population remains in varying states of ill health, despite now having the ability to treat more and more conditions that were previously deemed untreatable. Why? While we can discuss the relative causal impacts of shifts to more sedentary lifestyles, environmental issues, and nutrition, I think we would all agree that rising costs are one of the biggest deterrents to accessing health care today.

Increasingly the costs associated with illnesses are forming a devastating divide between the haves and have-nots. This is particularly true here in the U.S. where the costs for health care are the highest, and regrettably the health conditions of our poorest are equal to third world countries at best. Even the middle class cannot “afford” to become seriously ill today, because

the high debt loads and minimal savings, which characterize the fiscal condition of many, leave no cushion for an emergency.

Am I suggesting that there is no value to the current steady stream of innovation in health care today? Of course not. What I am suggesting however is that our country could reap higher value from our health system, if more of our innovation efforts were focused on the quality of life for chronic conditions, particularly during earlier, less debilitating stages.

Let me explain. Historically, much of research and development has been focused on “saving” lives through enhanced pharmaceutical intervention and medical treatment for acute conditions such as heart attack or strokes, or treatment of diseases such as cancer. Those advances are important and must continue. However, increasingly our aging, diverse, population is “living” with chronic conditions, like diabetes or asthma, which worsen and can lead to multiple complicating conditions over time. The advances relative to cancer and HIV/AIDs are effectively transforming them into chronic conditions. Thus, what I am advocating, based on our experiences at Pitney Bowes, is that we could impact more of the population with breakthroughs in “enhancing” lives affected by chronic conditions.

Pitney Bowes is in the middle of this discussion on innovation and health, along with the rest of corporate America, because it impacts shareholder value in several ways. First, the key to global competitiveness is in our ability to optimize the productivity of our human capital. Our strategies, technologies and quality processes are all for naught without healthy, engaged employees to execute, innovate and lead.

Second, uncontrollable and unpredictable increases in health care costs are a major factor in reducing the number of employees hired, in causing employers to discontinue both retiree and active medical coverage, and driving employers to move operations from high labor cost areas to lower labor cost areas onshore and offshore.

Third, in extreme cases escalating health costs are neutralizing to wiping out earnings. In several highly publicized cases of late, health and benefit costs were identified as leading sources of pressure on earnings and shareholder value creation. I believe if we don't see some fundamental changes, this will unfortunately become more of the norm, rather than the exception. A story in the Wall St. Journal last fall noted that U.S. employers' health care costs rose an average of 6.1%. We estimate, for example, that if we had not made changes in our health program our out of pocket costs would have increased in excess of \$20 million in 2005. It is important to note that we obtained these savings through changing our infrastructure cost and not through cost-shifting to employees. No public company that I know can afford ever increasing, uncontrollable expense on a year-over-year basis.

### Summary of our story

Let me begin with a summary of our story, in order to provide you with a context for our approach, and underscore my belief on how we can all benefit from innovation in management of chronic conditions. We began our journey to create a culture of health in the early 1990s. As a result of our initiatives our total annual out-of-pocket costs for health were virtually flat during the entire 1990s, and our spend was an average of approximately

20% lower than the companies with which we benchmark. In 2000, despite the ongoing success of our initiatives we saw a double-digit increase in our year-over-year health costs for the first time in over a decade. The innovations that we have implemented since have reduced our annual increase in cost of care into the single digits. Keep in mind that our total costs are still 20% below our benchmark companies. We have shared the savings with our employees in the form of lowered contributions.

### Fundamentals of our Approach

The concepts that underlie our approach are simple. But as you have just heard, for us, they have had some profound effects. We started in the 1990s by defining our goal as taking actions that maximize the health of employees and those covered under our plans. Starting with health maximization and not health care as the goal was important, because it guided our priorities and subsequent investments. Our working hypotheses remains simple: if the people we cover in our plans are healthy, they will be more engaged and productive, and have less need for the more expensive elements of the health system.

Our core strategy is to promote behaviors that maximize health. We believe that proper nutrition, appropriate levels of exercise and fitness, healthy lifestyles and early detection, intervention and appropriate treatment of conditions, all promote health. We knew that to embed a focus on health in the culture, and engage as many employees as possible, we would need to create an environment that reinforced these behaviors in multiple ways. The program we designed focused primarily on education and convenient access

to professional support to foster prevention, early intervention and active management of chronic disease.

### Education

Our goal in education is to equip employees to manage their lifestyles and health care purchasing decisions. We knew it was important to engage employees as active partners in this change management process. They needed to be informed health consumers, not passive recipients of treatments provided by the health care system. Our individual, group and web-based programs teach them how to enhance health, identify treatments needs early, and manage disease or injury recovery situations together with their providers.

One of the umbrella programs that we created to educate and reward employees for continuous learning is Health Care University. Health Care U offers a range of courses in everything from stress reduction to disease management, each with a designated number of credits for successful completion. The credits can be applied to reduce annual health care costs. We have on-site fitness centers in several facilities with our highest concentration of employees. In addition to personal training, these centers also provide a variety of programs on the benefits and how tos of physical activity, including strength and resistance training, walking clubs, hip hop dance, and yoga.

As we have become more granular about the key health levers for any condition, we've put in more programming to support our employee's efforts in those areas. Take weight control for example. Obesity is linked to any

number of chronic diseases. Levers for managing weight include nutrition, portion control, exercise and stress reduction. In addition to nutritional counseling, in recent years we've run programs on the body mass index and its importance, increasing the use of pedometers as a way of incorporating exercise into your lifestyle, and portion control with pictures of the right portion equivalents in the cafeteria. Our cafeterias also feature healthy menus with nutritional information, and subsidies that make unhealthy food more expensive.

#### Access to professional support

We have a network of seven on-site clinics to provide employees in major population centers with convenient access to health care for routine illnesses. The clinics also help employees monitor chronic conditions and provide immunizations and screenings such as mammography. We handle an average of 35,000 patient visits annually in our clinic network and services and prescriptions are free. We've found that with on-site medical care employees come in more frequently, and get checked for potential problems earlier. The savings from treating illnesses before they develop into more serious conditions, combined with productivity gained from eliminating time away from work to travel to the doctor, more than pays for our total investment in the clinics, medical personnel and prescriptions.

These clinics provide us with two other big benefits in maximizing health. First, we are able to build up a significant and comprehensive record of each employee seen in the clinic over time. This not only helps in monitoring chronic conditions more closely, it also provides a thorough background that enhances the quality of care our employees can receive if they need to seek

additional medical care. Second, and related to this last point, is the fact that our group of medical professionals acts as consultative resources for helping employees interface with the broader health care system.

We can also help facilitate their interface with the system, which is particularly important in the treatment of serious chronic diseases. We believe the multi-disciplinary approach to chronic disease management helps maximize the quality of life. It serves as a comprehensive early warning system for the onset of more debilitating, related complications. For example, in managing diabetes, a patient not only needs to interact with a primary care doctor, but with nutritionists, nurses, pharmacists, podiatrists, dentists, eye doctors and counselors. Our medical professionals become a focal point for helping the patient identify and work with these various professionals.

#### Data driven approach

These initiatives helped move our employee population toward better health and keep our costs flat for a decade. When we saw the unanticipated big jumps in health costs in 2000, however, we knew we needed a more robust understanding of what was driving the change in cost structure. Were these cost increases all out of our control? Or, was there something going on within our population that contributed to the increase, and therefore could be managed in a more disciplined way to impact both the state of health and cost outcomes?

I mentioned how our ongoing contact with our employee population has given us a comprehensive health record of each individual as needed for

them to seek additional medical care. It also provides us with an abundance of information about the health of our population. Our next phase of innovation in the delivery of health, was data-driven and linked to trends within our population.

With costs accelerating we needed an assessment of the most prevalent conditions and their cost implications. We then examined the behaviors that supported prevention or management of these conditions. It led us to ask, what was the tipping point, between having the condition, and having it escalate in terms of seriousness and treatment costs?

### Predictive modeling

This last question was particularly intriguing because as we analyzed the data, we saw a pattern where employees incurred minimal to no costs for health, and then within 12 months were incurring costs in excess of \$10,000. We also realized, that beyond the cost impact, these rapid progressions in spending patterns signaled diminished productivity. The productivity implications were critical during this period because we were at the beginning of a major business transformation for growth.

I believe there is a spectrum of health and productivity that ranges from productive engaged employees, to “presentism” – during which employees are physically present, but in the early stages when a condition, or its precursor, impacts stamina, concentration and focus. The shift from presentism to absenteeism is marked by more rapid progression in the severity of the condition and increasing periods of limited attendance. We knew the cost and productivity implications of employee absence. What we

needed to be able to predict were the conditions under which an employee was most likely to move rapidly from productive to merely present. Our plan was to use this information to design programs that would prevent or delay this negative spiral.

We turned to predictive modeling, but not in the traditional sense. The common modeling application is great for using past experience and projecting this forward. It is not necessarily an accurate indicator of the future since it can't accommodate multiple variables. Its value is also compromised by the fact that most predictive modeling is rules based, which is complex to apply to a relatively small employee population. We took a different approach. Based on our preliminary data analysis we understood the outcomes that we needed to be on the lookout for – chronic diseases such as asthma, diabetes and cardiovascular related. We used a sophisticated software program that started with the outcomes, and then predicted the behaviors that moved individuals from normal to high cost within a 12-month period.

We found a strong association between chronic condition progression and low possession rates of medication and lack of preventive screening and use of care management programs. For example, if an individual diagnosed with diabetes has filled less than 9 prescriptions for diabetes drugs in the preceding year, then in the following year, their cost of care will probably significantly increase. Another marker was the absence of health care spending in the previous year, indicating that no routine checkups or screenings were performed. Traditionally an employee with a chronic disease is deemed a risk. Our findings revealed that the risk is not in the

disease, but in not actively managing its treatment and progression. Or, it is the person who has several risk factors for a condition, and is not screening for any early warning signs.

### The cost factor

This analysis also really helped us understand the relationship between compliance and costs, and in particular the impact on pharmaceutical regimens. The recurring theme that our programs are built around is that it is more effective to maintain health, than to attempt to restore it. This plays itself out rather graphically in what I call the “bell curve” or 80-20 rule of health costs in the workplace. The thought is that at the bottom of the curve are healthy people, as you move up the curve there are minor ailments, and in many instances chronic conditions in the earliest stages. Further still, the severity of the ailment, or the number of ailments increases. While only 20% of any employee population is distributed at the height of the curve at any given time, those employees generate 80% of the costs.

The Wall St. Journal story that I referenced earlier agreed that the traditional way of responding to this cost distribution is cost shifting. Most employers will shift cost management resources to the top of the curve. This minimizes the company outlay while increasing the costs for employees. We believe that this approach is shortsighted for several reasons.

First, cost-shifting does not address the fundamental condition that causes the employee at the top of the curve to need more services in the first place. What makes the employee delay treatment and forego compliance thereby worsening their condition? We found that the biggest driver was cost. Thus,

if you increase the costs for this employee, you only serve to exacerbate their non-compliance, accelerate their deterioration, and ultimately drive up their total cost of care, which includes inpatient/outpatient services, pharmacy, disability and absenteeism.

Second, it perpetuates this same cycle of declining health and productivity for more employees at the bottom of the curve by erecting potential cost barriers in the early stages of disease management. In other words, cost-shifting increases the probability that more employees will progress towards the top of the curve as escalating costs influence their decisions to get the screening, regular check-ups and pharmaceutical therapies that would prevent their condition from worsening.

It brings us full circle to our goal of taking actions to maximize health. Our approach has been to manage the top of the cost curve and invest in the lower part of the curve. That's why in 2002 our modeling led us to remove the barriers to screening and managing chronic diseases by taking on more of the cost, so that the employee would pay less. That included expanding Tier 1 coverage for generic prescriptions and all brand name prescriptions for targeted conditions such as asthma, diabetes and hypertension. The average cost for a 30 day supply of any of the designated pharmaceuticals is 50-80% lower than it was prior to initiation of this program. We also lowered or eliminated costs for preventive services, and we provided first dollar coverage for routine services. (no deductibles)

We are excited about the results. For diabetes treatment, for example, Amylin (Ginger Graham – CEO will have just participated in panel which

precedes Mike) developed a medication that helps the pancreas create insulin. This medicine, that was introduced last year, helps forestall some of the long-term effects of injectable insulin, by enabling the body to do more on its own for longer. While many employers would have put this medicine in a higher cost category, we added it to Tier 1 as soon as it was available so that our people could take advantage of it as quickly as possible. For those who are using longer acting insulins, previously they were all more expensive because they are all brand names. By adding all brand names to Tier 1 we immediately brought cost relief to those who needed it most. Regular monitoring of blood sugar levels is also critical in effective diabetes management. The least expensive methods involve prick tools, which can be uncomfortable over long-term usage. There is a machine that sits on top of the skin, which is a higher cost and its test strips are significantly more expensive (about \$50 per 30 day supply). Thus, we also dropped the price of supplies.

Since dropping the cost on all diabetes medications and supplies, we have seen purchase/use of meds double; use of emergency rooms dramatically decrease; and our disability costs cut by 50%. Relative to asthma treatment hospital admissions are down by 20%, and our overall costs down by 20%.

Overall, we have seen improved adherence to pharmaceutical therapies, and better management of the conditions as reflected in the types of medications that employees are purchasing which are more in the “controller” category rather than the “rescue” category associated with emergencies.

### Innovation and Investment at the Bottom of the Curve

We have approximately 34,000 employees worldwide, and about 26,000 employees in the U.S. The demographics of our population are not dissimilar to the general population in the U.S. We invest almost exclusively at the bottom of the bell curve rather than the top as I discussed earlier. It is much more expensive for everyone to deal with the issues at the top of the curve. So we invest that money in education, access to experts and active management of chronic conditions. And, in particular, we invest in making regular screenings and compliance with prescribed regimens a way of life. This has yielded a big payoff for us in terms of productivity and cost management, in addition a five to one return on investment.

So why can't it work for the rest of America? We believe that it can. But, it will take innovation and investment at the bottom of the curve. That's where you come in. Everyone recognizes the U.S. as leaders in treatment of the deadliest conditions at the top of the curve. We would love to see the talented companies in this room, and in the industry, apply your considerable, collective skills in working on conditions that are long, lingering, and debilitating. There is a particular need at the early stages, where there is potential to restore functionality or keep individuals closer to optimal health longer. Focus on the things that keep people healthy and active. The ability to impact the quality of life here is profound.

This is where I would like to end my remarks so that we can engage in a dialogue on these issues. There is a link between health, productivity and global competitiveness. We will continue to invest to maximize the health

and productivity of our talented workforce. We think elements of our approach could have a broader applicability to enhance the efficacy and efficiency of the U.S. workforce. We also think investing and innovating to monitor and manage chronic conditions could make health affordable for more of our population. Thank you. Now I am anxious to hear your thoughts and answer your questions.