

DRIVING ENTERPRISE VALUE THROUGH HEALTH CARE  
INVESTMENTS FOR EMPLOYEES  
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APRIL 19, 2006

(TITLE SLIDE 1) Good morning. I am pleased to be here to discuss our journey to develop a culture of health and would like to focus my remarks on the investments that we've made to drive enterprise value, and what we see ahead.

## INTRODUCTION

Our talented workforce, or human capital, is our most significant competitive advantage and as a result our most valuable asset. Our goal at Pitney Bowes for the last 16 years has been to maximize the health of our employees and those covered under our plans affordably. We believe that maximizing health maximizes our return on our human capital. Strategies, technologies and quality processes would all be for naught without healthy, engaged employees to execute, innovate and lead. Our working hypotheses remain simple: if the people we cover in our plans are healthy, they will be more engaged and productive, and drive more enterprise value for all our stakeholders.

Starting with health maximization and not health care as our goal was really a defining moment for us, because it guided our priorities and subsequent investments. Some companies regard health care as a line item charge against earnings, and thus their focus is on managing the costs. However we believe, managing costs instead of managing health results in poorer health

and higher costs. By contrast, our focus has ultimately enabled us to deliver health and value less expensively.

(SLIDE 2) Some experts have identified five barriers to accessing health: knowledge, location, cost, bureaucracy and cultural/attitudinal factors. Up until now, we have been primarily focused on investing to remove the first four barriers by giving employees access to information, tools and services to assess and manage their health. As we look toward the future, we will increase our investments in outreach programs that empower employees to take even more control of their health management. We believe that effective outreach also involves addressing the fifth barrier of cultural/attitudinal factors.

## SUMMARY OF OUR STORY

Let me begin with a summary of our results, in order to provide you with a context for our approach to investing in health. We began our journey to create a culture of health in the early 1990s. We invested in information, tools and services that encouraged healthy lifestyles, prevention, and active disease management. As a result of these initiatives our total annual out-of-pocket costs for health were virtually flat during the ensuing decade, and our spend was an average of approximately 20% lower than the companies with which we benchmark.

In 2000, despite our ongoing success we experienced a double-digit increase in our year-over-year health costs for the first time in over a decade. We created a data-driven approach to enhancing compliance with pharmaceutical regimens by reducing the cost of prescriptions and supplies

for the most prevalent conditions within our population. This innovation has since reduced our annual cost increases into the single digits, while continuing to hold our total costs 20% below our benchmark companies. We have shared the savings with our employees in the form of lowered contributions.

But our focus is still on maximizing health. As we now look across our aging, diverse, geographically dispersed population, we see some unexpected variability in the risk of developing chronic conditions. That is why we are now focusing our efforts and investments in more proactive outreach to support employee self-management of health risks and chronic conditions.

## INVESTING TO REMOVE BARRIERS

### (SLIDE 3) Access to Information

We felt it was important to equip our employees with the information 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 provided self-paced online modules on long-term strategies for weight management, and 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 Treatments and Services

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 catching the conditions earlier, 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.

We applied the concept of easier, earlier intervention to psychiatric and substance abuse cases as well. We set up an eight-session EAP program to make sure that those covered by our health plans were seen early and often by qualified health care professionals before we released them for the next stage of treatment. Although this model has higher up-front costs, it ultimately saves money by getting better results from dealing with less advanced issues.

### Removing Cost As a Barrier

We have found that there is a strong correlation between the cost of pharmaceuticals and the employee's compliance with treatment plans. Non-compliance, in turn, generally leads to a worsening of the condition, and increased costs, as patients experience the need for even stronger medication, and see a rise in complicating conditions, emergency room visits, and hospitalizations. This negative spiral is especially common with patients with chronic conditions like diabetes and asthma. The likelihood of non-compliance during the initial phases of the disease is increased because patients can find themselves incurring heavy medication costs, while they are either not experiencing symptoms at all or are only intermittently symptomatic.

(SLIDE 4) In order to remove cost as a barrier to compliance, we invested in taking on more of the costs so that our employees would pay less for medications associated with chronic diseases prevalent in our population. 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.

We are very pleased with our results thus far. (SLIDE 5) We are seeing higher rates of compliance, significant reductions in emergency room visits for diabetics, and significant declines in hospital admissions for asthmatics. In fact, we actually lowered the annual cost of treating people with asthma by 19% and decreased their pharmaceutical cost by the same amount. We decreased the annual cost of treating a person with diabetes by 8% and their pharmaceutical cost by 7%.

## OUTREACH TO EMPOWER

### Changing Nature of Illness in America

Like every other large, self-insured employer, we are facing a different set of challenges as the health profile of America changes. Much like that classic line from Charles Dickens it is “the best of times and the worst of times” for health in America. Our country is the acknowledged leader in medical innovation, featuring breakthrough treatments and pharmaceuticals. Yet, the number of uninsured individuals grows daily, and many of the current large insurers are straining under the burden of unmanaged, escalating costs.

At the beginning of the 1990s, most of our focus at Pitney Bowes was on managing large-ticket acute illnesses, such as those involving heart attack, cancer, organ transplants, and premature births. Though these situations often cost us several hundred thousand dollars a case, they tended to have a very definitive treatment plan, beginning and end. (SLIDE 6) Thus far today I am sure you have noticed that I mentioned chronic diseases and the complexities associated with their management in several different contexts. That is because, along with the American population in general, our employees are older, more sedentary, and more diverse. And, as a result, “living” with a much larger number of chronic diseases which can worsen and lead to multiple related conditions over time. The advances in treating some types of cancer and HIV/AIDs are also effectively transforming them into chronic conditions. All told, there are more people than ever before trying to manage illness over extended periods of time.

In fact, as I referenced last year, the Robert Wood Johnson Foundation reported that health care expenses for chronic illnesses now constitute about 78% of the country’s health care spending, and the costs are increasing by well over 10% a year. Currently at Pitney Bowes approximately 1/3 of our pharmaceutical spend is for chronic disease, with almost all of the increase driven by increased consumption.

### Why Outreach

How then is the changing nature of illness in America, changing how we maximize health and how we invest our resources? From the beginning we knew it was important to engage employees as active partners in managing

their health. However, we've recently come to the conclusion that an even higher level of employee ownership is necessary to successfully accomplish the complex self-management required for long-term if not lifetime illness. Employees must feel empowered to take control of their health and the health of those family members covered under our health plans. Our planning is now driven by the questions "How do we support/motivate employees to take the steps to avoid preventable illness and to proactively treat manageable conditions after they have been identified? We want to continue to look for ways to eliminate barriers, and are focusing on the cultural and attitudinal factors that are critical in the behavior modification necessary to manage long-term illness.

### Consumer Driven Health

Before I discuss the ways we are trying to help employees take more responsibility and control of managing their health, let me distinguish this from one of the hottest topics in health care today (SLIDE 7) --- consumer driven health. While the term consumer driven health is very quickly becoming part of the social and political language of America, it is actually a broad concept that encompasses three main ideas:

- The flow thru of tax benefits to individuals for managing their health
- Increased accessibility to information about the performance of health care providers and insurers
- The ability to reap financial rewards from limiting use of the health care system

There are some proponents of consumer driven health who believe that health care deductions for corporations should be eliminated and passed

directly to individual consumers. Their rationale is that the consumer would then use these tax benefits to make better spending decisions about their health, and in the process would create a more competitive health care market.

There are other advocates who correctly point out, that the benefits of the first scenario will be limited, unless individuals are given access to enough data about health care providers and insurers to make informed spending decisions. So for example, how do you choose Dr. A over Dr. B if you don't have easy access to information such as their track record in treating certain conditions, their treatment arrangements with certain hospitals and outpatient clinics, and the insurers who do and don't cover their services. All information, which is generally inaccessible to the average person today.

There are yet others involved in this important discussion that say that if consumers are healthy enough to not use the system for a designated period of time – such as 1 year – they should be rewarded by being able to bank the savings in a special account. This is a discussion that we all should pay very close attention to as it progresses.

### Outreach to the Medical Community

When I talk about employee responsibility for managing their health and treatments, I am talking about the person with the most to gain from optimal health, being the person most involved in making that optimal health a reality. Chronic illnesses require a partnership between the health care provider and the patient, because the patient has to be much more actively involved in managing the treatment plan. We are exploring two dimensions

of outreach to help our employees maximize their health and manage any necessary treatment. (SLIDE 8) The first is supporting our employee's ability to interact with the diverse, fragmented medical community. We believe the multi-disciplinary approach to chronic disease management helps maximize the quality of life. Most chronic illnesses require multiple health care providers to treat the entire spectrum of conditions that may be associated with the disease over time. This need for interface with multiple health providers simultaneously means that employees have to manage through the inevitable bureaucracy and scheduling involved in receiving treatment and verifying insurance eligibility and payment for multiple doctors, outpatient clinics and labs to prevent, monitor and treat a chronic disease.

Our network of in-house clinics provided our first platform for helping our employees reach out and navigate the medical system to get holistic treatment for chronic disease. 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 serve as consultative resources and they become a focal point for helping the patient identify and work with these various professionals.

### Outreach to the Individuals to prompt Behavior

The second dimension of outreach is having the health system reach out to the individual to prompt them to follow through with preventative measures, or engage in necessary treatment. There is a particular challenge in managing chronic conditions like hypertension because patients can go for

significant periods of time without acute, obvious symptoms. As a result, if patients are not focusing on optimizing health, reducing risk factors, and actively getting screened they could develop a chronic condition and seemingly “overnight” go from being healthy to needing to treat a variety of issues related to an unmanaged chronic condition. The other risk of managing these “silent killers” is that even after diagnosis the patient may discontinue vital treatments, because they don’t feel sick and the treatment regime involves multiple elements, such as medication, diet, exercise, periodic self-testing and diagnosis.

(SLIDE 9) That’s what our data-driven approach to health assessment and risk analysis confirmed in our own population. We have relied upon rigorous analysis of data about the health and treatments of our employee population to prioritize the best opportunities to deliver better health at lower costs. Our analyses examined the segments of the employee population incurring the highest medical costs, the types of medical conditions that are increasing cost fastest, and the geographic concentrations of higher-cost medical events. In 2000 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. 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. (SLIDE 10) 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.

### Pilot

We're piloting a program with one of our plan administrators, (SLIDE 11) where they reach out to employees on our behalf, when they need to undergo any medical intervention beyond a routine office visit. The concept is that if we can in essence get the medical system to "reach out" to our employees in a accessible, non-threatening way, they will be more likely to follow-up with the scheduling and participation in the identified screening or treatment.

Here's how it works. During a routine appointment a physician suggests that an employee have an MRI. The Care Advocate has a phone conversation with the employee to explain the procedure; help schedule the appointment; and think through next steps. They show employees how to navigate the health care system and gain a better understanding on what is going to happen. We still require that employees reach out to the Care

Advocate, but if they don't call they experience an increased co-pay when they show up for the visit. Early results are encouraging and we are expanding the pilot, both in terms of the geographies where it is available, and we're adding a proactive outreach by the Care Advocate to follow-up after certain procedures.

### Cultural/Attitudinal Factors in Outreach

(SLIDE 12) We are also exploring the extent to which cultural and attitudinal factors impact our employee's self-management of health and long-term illness. An African American cardiologist for example has done some research that indicates he could motivate older African Americans to take better care of their own health risk factors by helping them see how maintaining optimal health as long as possible would enable them to positively impact the lives of their children and grandchildren. The University of Southern California has done some outreach to African American and Hispanic boys and girls about the risks associated with obesity and a sedentary lifestyle. They found that the boys were much more responsive to a fitness trainer who also gave them nutritional advice. I noticed the same with my own teenage sons who respond much more favorably to fitness experts than to nutritional advice coming from other sources. We are just beginning to explore the implications of taking a more segmented approach to our health communications outreach based on the cultural and attitudinal factors within our employee population.

### Continuity of Care

We believe that another critical component of effective self-management of chronic conditions is continuity of care. The concept of continuity of care is

based on the desire to optimize the patient's health by making sure that each health care provider that they encounter has the same comprehensive understanding of all of the factors that contribute to their current status. The theory is that each doctor's interaction with the patient would be captured, and be an integral part of the next doctor's understanding of how to treat the patient for whatever condition that they are currently presenting. This is especially important in treating life-long conditions such as diabetes, for example, where today patients often are treated by multiple physicians who all keep separate records, and have distinct perspectives on the health and inherent risks for an individual under their care. Often there is not an integrated picture of the individual's health status until they are hospitalized and multiple specialists are reviewing one medical record.

Continuity of care was a much simpler concept in earlier times. When families were less mobile and doctors established more long-term relationships with patients, it wasn't unusual for an individual to be treated by the same physician or group practice for almost their entire life. The treating physician also tended to have access or first-hand knowledge of critical family medical history. We believe that technology will play an important role in providing continuity of care in today's marketplace. Portable electronic health records that the individual owned, could follow them throughout their life, and provide a detailed repository of things such as treatment history, illnesses, test results, surgical procedures, prescriptions and allergies to name a few.

The combination of our in-house network of clinics and the average long-term tenure of our employees has enabled us 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.

There are currently many drivers that are working against continuity of care that are the unintended consequences of consumer options and plan design structures. State Medicaid and HUSKY (need right acronym) programs allow individuals switch back and forth between these options and corporate or private plans. The result is that uninsured, low-income children, for example are in plans an average of 21 months before being switched.

Another factor working against continuity of care is when provider networks get consolidated within corporate plans, and individuals are often forced to switch physicians, because the plan is no longer available through the network.

### Total Cost Analysis

(SLIDE 13) It is important as you think about your own investments in health, that you look at the total cost picture. Health costs go beyond the costs of medical treatments and pharmaceuticals, to other elements of well-being as well. For example, when we saw the shifts from low/no health care spending to high costs in a 12 month period, we also realized, that beyond the cost impact, these rapid progressions in spending patterns signaled diminished productivity. 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. There are cost and productivity implications from employee absence. There are also costs associated with presentism when employees are physically there but not necessarily producing the quality or quantity of work product that is needed. Disability and behavioral health all contribute to the total cost of health.

## **CONCLUSION**

(SLIDE 14) There is a link between health, productivity and global competitiveness. We have been driving enterprise value by investing in maximizing employee health for over 16 years. While we will continue to invest to remove the barriers to health, we will focus on outreach to take employee empowerment in the health care arena to the next level. Thank you for your attention and now I will be happy to take your questions.