

Speech: Leaders-to-Leaders
Conference Centers for Disease Control and Prevention
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I want to begin by thanking Doctor Gerberding and her team for convening and hosting this extremely important conference. I come to you as a leader of a company, Pitney Bowes that defined employee health and well-being as a core value even before I became CEO in 1996.

Our mail stream businesses have always required a high degree of subject matter expertise and relationship-building with postal services and customers that take many years to learn and master. Therefore, for several decades, we had been a generous company in delivering benefits that rewarded and encouraged employee loyalty and commitment.

In 1990, this commitment to employee health and well-being was being challenged by our inability to continue offering health plans that essentially provided medical benefits without meaningful employee contributions in terms of premiums, co-pays and deductibles. Our costs were increasing at an alarmingly high 14% per year, and we were not delivering a high degree of employee satisfaction. When I became head of human resources in 1990, I had the unenviable task of committing us to a long-term course of action that required higher employee premiums, co-pays and deductibles, but I also recognized that we had to maintain and/or increase employee satisfaction with our benefit offerings, or we were going to lose one of our key talent retention tools.

From 1990 on, we changed our philosophy in subtle, but important, ways. First, we engaged our employees in the dialog. We gave them the information which helped them understand and embrace the reality that the existing health plan, while it appeared to be highly-beneficial, provided virtually free care, resulting in the siphoning off of money to outside providers, thus reducing reinvestment into our business, shareholder value through dividends, or even yearly compensation increases. In effect, totally free health care meant massive wealth transfer was taking place from Pitney Bowes shareholders, which includes our employees, to outside health care providers and administrators without obvious benefits or results. Accountability was missing from providers, administrators, employees, and insurance plans.

Second, we helped our employees understand that more care, even if it were free, was not necessarily better care. Based on data, we demonstrated that there were good, bad, avoidable, and marginal uses of the health care system, and that we would modify our plans to provide our employees with more effective and results based care and to discourage bad, avoidable or marginally-beneficial uses of the health care system.

Resulting from our employee engagement efforts, in 1991, we did increase premiums, co-pays, and deductibles, but we also introduced coverage for many valuable preventive screenings in our self-insured plan, including mammograms, colonoscopies, and blood

tests to detect and effectively manage diabetes and cardio-vascular conditions. We also introduced free coverage for well-baby and well-child care, including immunizations.

In 1992, as planned, we again increased premiums, co-pays and deductibles, but we also opened our first free clinic in our World Headquarters, and we introduced premium incentives for non-smokers and those who regularly used seat belts and safety helmets.

In 1993, we launched our flexible benefits program, which gave employees far more flexibility to use their benefit dollars in ways that mattered to them, but we again increased premiums, deductibles, and co-pays.

We balanced the reality of increasing cost-sharing employee requirements with the provision of 'value add' free services, which the employees desired and appreciated.

Later in the 1990's, based on our earlier challenges, successes and a commitment to trying to reduce the financial impact of burgeoning healthcare costs, we became even more convinced that we needed to develop a strategy which would influence our employees to adopt healthy behaviors. After much research we implemented a strategy of linking voluntary, healthy behavior adoption to financial incentives. We built a platform called "Health Care University," which enabled participants to gain benefit credits for completing a health risk assessment or for participating in various kinds of wellness programs. This initiative exceeded our expectations in terms of employee satisfaction and improved the overall health of our employee base.

Leaping forward into this decade, we have made two further innovations. First, in our health plan designs, we began to understand that we could predict future costs by looking at population-level data for prior years. For example, we discovered that if we had employees who had been diagnosed with diabetes, but had not spent any money on maintenance drugs or were not taking them, these participants were highly likely to cause us to spend more than \$10,000 in hospitalizations or emergency department care in a current or future year. The solution was clear. We knew that we needed to modify our plans to reduce the likelihood that this would happen in the future.

In fact, very much like the way Edward Deming and disciplines like Philip Crosby talked about upstream investment in quality that would pay for itself over time, we recognized that upstream investment in engaging plan participants to take maintenance medications would pay off over time in terms of employee health and productivity and improved shareholder investment return.

Thus, rather than increasing the cost of maintenance drugs for chronic illnesses, which was the more common approach across most health plans, we reduced the cost. For chronic disease medications conditions such as asthma, diabetes, cardiovascular disease, and behavior health, we reduced employee co-pays for brand name drugs by between 50% and 85%. We received a significantly positive payback, which I will share with you in a few moments.

More recently, we became acutely aware of the multiple benefits from creating a positive work environment for our employees. As we renovated our World Headquarters, we reduced the number of walled offices and shrunk average office sizes. We also virtually

eliminated desktop printers, copiers, and fax machines, and replaced them with core area multi-functional devices.

By doing this, we created more exposure to natural sunlight for everyone; encourage our employees to walk around more during the work day, which was good for their health; and we created more meeting rooms for people to converse with one another, which improved morale and a sense of well-being.

We also significantly altered their experience in our cafeterias. The healthy food was more plentiful, lower cost and more easily accessible. The less-healthy food was made more expensive, less plentiful, and less accessible – we increased the distances people had to walk to find it. We also slowly, reduced portion sizes for all meals to reflect the recommended healthy portions of anything an employee choose to eat. For those who have chosen to participate fully in our benefit offerings, the wellness results have been tremendous.

Hence, I have come to realize that, while we must continue to emphasize personal responsibility for health among our employees, we, the employers, have an obligation to do what we can to create healthy work environments. Employees, like anyone else, will respond to the environment in which they find themselves. We, at Pitney Bowes have made doing the healthy thing an easy course of action to take and maintain.

At the risk of making our Pitney Bowes healthcare story sound easy, like any other large employer, we have challenges. We particularly are challenged by those employees who work remotely at customer sites in small numbers. Our Management Services Division has over 600 sites, with an average population of 20 employees per site, which makes that part of our business resemble a collection of small businesses. We also have several thousand sales and customer service professionals for whom their automobile is their workplace, as they travel from call to call during the day. We have come to realize that, for these populations, we need to communicate our health and wellness strategy more regularly at their remote sites and homes, and to engage their spouses or partners for added support.

We also recognized that, for populations in which we experience higher average turnover, like Sales, we needed to emphasize investment in health with shorter paybacks, such as our Flu Fighters program, which we launched in fall 2007. This program was very successful in getting employees from all over the country to get their seasonal flu shots, which significantly decreased our incidence of both influenza and other upper respiratory ailments last winter.

In spite of the challenging and highly financially competitive business environment in which many of our businesses operate, we have not experienced higher-than-anticipated employee turnover among longer-service employees, or among our executive population. Our only turnover challenge has been younger and relatively low-tenured professionals, who do not always tend to value health care benefits as highly.

I mention this last population because I believe that the longer-term solution is to educate them that managing their health is as important in their 20's as they will perceive it to be when they are in their 40's, 50's and 60's. We know that Type 2 diabetes is hitting our

younger people earlier and earlier, and, sadly, the population that seems most resistant to the longer-term declining trend in smoking is younger, single women. At Pitney Bowes, we have begun an active, but empathetic outreach to these populations to get them more engaged in managing their health, and, although we have experienced some early successes, we are still at the beginning stages of understanding how to be effective in changing health behaviors in young people and how to use our commitment to their health and well-being as a retention tool.

In short, we at Pitney Bowes have achieved a lot, but humbly, there is still a lot of work to do and it is not necessarily easy. It will take creativity and innovation.

One innovation initiative that PB is vested in is the growing arena of tools for self-management of health. We are one of the founders of an initiative called Dossia, a non-profit, third-party organization with members such as Intel, BP, AT&T and Wal-Mart. Dossia's goal is to fund the development of a web-based framework through which U.S. employees, dependents and retirees, and, eventually, others, can maintain private, personal and portable health records, as a way of empowering individuals to pursue health and to reduce provider medical costs. Dossia's premise is that we can not overcome the health crisis in this country until most Americans manage their health metrics as closely as they manage their daily and weekly budgets.

At Pitney Bowes, we believe that employees should be as conscious of their exact state of health as they are of everything else that matters to them. Health management is a collaborative opportunity to work with others to share knowledge and to reinforce best practices. To the degree that we create an environment where people eat healthy foods together, participate in healthy exercise programs together, and support each other in refraining from smoking and excess alcohol consumption, we have created an environment in which they will also team to create shareholder and customer value opportunities. Good health requires vigilance and personal responsibility.

What are the tangible results of Pitney Bowes decades of efforts?

For many years during this decade and before, we were able to keep per-employee health care costs for employees at our sites growing at low single-digit rates. For our total population, which included the half of our population which worked at our remote customer sites, we have experienced, per employee, consistently increasing cost savings vs. regional benchmarks. Where by 2007, Pitney Bowes realized an estimated annual total cost offset or avoidance of \$39.8 million on a cost base of around \$150 million!

It has been hard work, but great reward!

Next, for the specific chronic conditions on which we concentrated this decade's revised health plan, diabetes, cardio-vascular conditions, behavioral health, and asthma, our rates of increase in cost have been a fraction of those realized by benchmark companies.

We moved medication and services required for these chronic diseases from the more expensive 30-50% coinsurance tier, to the lower or 10% coinsurance tier.

The results were:

- A 50-80% reduction in employee cost on 30 day supply of medications without utilization of generic asthma controller medications and limited utilization of generic diabetes medications.
- Employee copays were kept to less than \$20 for diabetes and asthma medications.
- Medication adherence increased.
- Compliance with disease management programs increased.

We were able to reduce the cost of treatment of employees with diabetes by 6% and treatment for asthma by 15%. We reduced annual pharmacy costs associated with diabetes by 7% and for asthma by 19% as well as we were able to keep behavioral health costs essentially flat. Also, because of our greater focus on adherence to treatment plans, we reduced emergency department use by asthma patients by 30%, hospitalizations by 38% and disability costs by 50%.

In short, we found that our on-site clinics produced a return of \$2.30 for every dollar we spent, and those employees in the buildings which housed our clinics and who used clinical services had lower absenteeism, substantially higher adherence to chronic disease treatment plans, and significantly lower incidence of acute conditions.

We proved that the right design and delivery of health care can reduce the rate of increase in health care costs, can improve employee health, can improve workforce productivity, and can be a major factor in improving the quality of life for our employees.

However, our experience is not simply a case study to support the need for the continued involvement of the employer in the delivery of employee health, although it certainly is persuasive in that regard. It provides a scalable example of how we can tackle the broader issues of health care in our country. We must:

- Invest in health first, and lower health care costs will follow.
- To invest in health, we must create a healthy environment that supports the consumption of healthy foods, fitness and exercise, and healthy lifestyles.
- Deliver high-quality health care at locations and times convenient to the people intended to be served.
- Design health plans to drive the right behaviors by both participants and providers, and to discourage the wrong behaviors.
- Make health insurance affordable and universal by reducing the overall cost burden of health care.
- Enable providers to invest in tools and technologies to improve the quality of health care delivery.
- Make sure that providers are both empathetic and competent.

These are the fundamentals which drive the Pitney Bowes healthcare story!

Finally, one question which I was also asked by our hosts today to answer was, “How can we can engage corporate leadership in this healthcare dialog?”

The most obvious answer is to highlight the financial results of healthcare optimization and behavior adoption, like those I shared today. However, the other two leadership

engaging aspects are the human factor and leader's strong desire to want to solve seemingly impossible problems – to be cutting edge.

First, yes, C-suite executives are human. They understand the basic challenges and concerns about healthcare. And, like every individual, we experience the positive and less desirable impacts of current healthcare in the United States. If we want their involvement in this dialog, we have to engage them on a personal level. At Pitney Bowes, while managing human resources, I was personally able to see first hand the impact of healthcare on all aspects of our employee's lives. This is why I personally committed to improving the health of our employees. And, now as Executive Chairman, I continue this commitment with involvement in initiatives such as Health First Connecticut, a diverse, regional initiative to improve healthcare services for all Connecticut residents.

Second, if we want to engage executives in the healthcare dialogue, we have to capture their passion for mastering new frontiers. This means highlighting the perspective that healthcare is the next place of innovation, creativity and expansion. We have to get leaders to see that solving the nation's health and healthcare crises as equivalent to man's first trip to the moon. Organizations such as Partnership for Prevention, of which my panel partner, John Clymer is CEO, provides a forum for this cutting edge and collaborative dialogue. As a leader, it is one of the critical places I go to keep my own interest engaged, energized and informed about healthcare. Please consider my comments as an invitation to the conversation.

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