

MAXIMIZING RETURN ON HUMAN CAPITAL INVESTMENT JANUARY 31, 2005

(Title Slide #1) I am honored to be here. This topic is dear to me because having a culture of health at Pitney Bowes has been my passion in all of my 16 ½ years as a senior leader at the Company. I believe that, as an employer, we can have a major impact on the health and well-being of our employees, and we have systematically acted to achieve that goal since 1990. Today, I want to focus on the challenges self-insured employers and health plans face today, and a comprehensive blueprint for success.

From 1990 to 2000, we improved employee satisfaction with our health care benefits, while keeping costs flat. Since 2000, we have achieved good employee satisfaction, with below-average cost increases. While some of our strategies, like our focus on preventive care and our network of free on-site clinics, are still relevant, we need to strike out in bold new directions to meet today's challenges, which are very different from those we faced even 10 years ago.

(Slide #2) Over that period, our workforce has aged significantly, with 41 being the average age of the active benefit eligible employee. We have also become more racially and ethnically diverse and more geographically dispersed. Over 45% of our U.S. workforce works solely on customer sites, and more than 26% are mobile workers who work in sales and customer service jobs that effectively make their car the primary workplace. As a result of these demographic changes:

- We see more complex, expensive chronic illnesses, and a greater variety of conditions than we had 12 years ago.
- Because of geographic dispersion, free on-site medical clinics are not practical for large segments of our employee population.
- The geographic dispersion and the lack of availability of technology tools for many of our workers complicates our efforts to communicate our benefits programs and strategies to them.

However, our workplace remains an excellent setting to increase awareness and try to create a culture of health among a significant number of people.

(Slide #3) So how do **you** maximize the delivery of health and the return on human capital investment? I believe there are three drivers of success:

- Take the Long-Term View
- Invest Now, Savings Accrue Later
- Engage Employees in Their Own Care

TAKE THE LONG-TERM VIEW

Good or bad health doesn't happen over night. Health is gained, sustained and, if left unmanaged, compromised over time. Similarly, as organizations think about the delivery of health, we must take a longer-term perspective on what factors impact health, and what can be done to support health over time.

Health Factors Outside the Workplace

(Slide #4) By and large the health issues that organizations are dealing with in their covered population start, are caused or are accentuated by a range of external factors. Three major influences are environmental hazards, societal nutritional practices, and the huge burden placed on all of us by the costs of non-reimbursed care.

Environmental Hazards

We all need to understand the linkages between air pollution from traffic congestion and the explosive increase in pulmonary disease cases, especially in children. In our population, asthma cases in the New York metropolitan area, where air quality fails to meet EPA standards, have increased by 50% between 2001 and 2004. We have successfully caused several hundred of our employees not to commute to work in single-occupant vehicles, and have been active in transportation and environmental regional and state initiatives. However, environmental conditions will only improve when most large organizations in a region work together aggressively to achieve this goal. We also need to recognize the linkages between environmental hazards that enter our foods, such as mercury contaminants in seafood or hazardous pesticides and fertilizers that put contaminants on fruits and vegetables, and to use our leverage to encourage food production methods that eliminate these hazards.

Nutritional Practices

Societal nutritional norms and practices are another source of external influence on health. Obesity is a national problem here in the U.S., and its impact is amplified because it also increases the risk of many kinds of disease. At our company we estimate that roughly 8% of total health care

costs are attributable to obesity. There are many theories on why this is a growing problem including the number of meals eaten outside of the home (as opposed to home cooking), trend toward more sedentary entertainment (hours in front of the computer gaming, videos, etc. as opposed to active entertainment), and the role of stress.

The rising incidence of childhood obesity does not bode well for our future, either. Look no further than the school your child attends. The combination of vending machines, lunchroom food alternatives, cutbacks in school sports and fitness activities, and the reduction of walking or biking to school, do not support the overall health and fitness of the next generation. The 2001 National Household Travel Survey reported that walking or biking to school dropped from 48% to 16% between 1969 and 2001. Corporate food vendors have put unhealthy foods into the schools; they must work with schools to achieve better diets and to stimulate more health and fitness activities.

Non-reimbursed Care

Finally, the growing prevalence of non- or under- reimbursed medical treatment is a big external factor, that all employers will need to pay more attention to in the long-term. In my opinion, reduced Medicare and Medicaid are effectively a tax increase on any organization or employee that has a health plan. The absence of any medical coverage for 44 million Americans adds further to this problem. The costs do not go away; in fact, by focusing non-covered individuals to emergency medical centers, it maximizes the costs of medical events, even for minor illnesses or injuries. We need to work cooperatively to reduce all health costs, not just those we pay directly, because, ultimately, we are paying for them indirectly anyway.

Large employers particularly need to monitor whether the major health care providers in their communities are operating as cost-efficiently as possible.

Factors within the Workplace

There are also factors which influence health within the workplace. Many organizations look at a safe workplace as a compliance exercise, not as an opportunity to invest in a healthier population. There are exceptions, such as DuPont and Dow, companies that have made workplace safety a core corporate value. Evaluating and designing work spaces based on ergonomics helps reduce accidents and repetitive injuries. All large organizations need to integrate their safety programs with their health management activities to give their employees the safest work experience possible. Failure to do so can yield significant, unnecessary increases in workers compensation costs, as well as incalculable increases in regular medical costs.

INVEST NOW, SAVINGS ACCRUE LATER

(Slide #5) Investment in health delivery is consistent with a long-term view of maximizing return on human capital. The thought is that there are definitely some investments that can and should be made, that will yield improvements in health and savings over time. Given the fact that none of us can invest in every opportunity to enhance health, the questions arises...how do you prioritize?

Prioritize investments by data-driven decision making.

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. We are using and refining computer-assisted algorithms to predict which of our covered lives are at most risk of acute or chronic conditions, in order to effectively allocate our resources and design programs that will have the most impact.

Ongoing Investment

Most of the tools that allow for more effective health management at lower cost require upfront investments that are recouped over a 1-3 year time frame. Some, like onsite clinics and wellness programs, require investments in people, capital equipment, facilities, and information technology. Others are less capital and labor intensive, but they require an organization to manage the medical plan as if it were a business, not another commodity that is purchased through a strategic sourcing function, or an item that just requires more costs to be passed on to employees. If, for example, an organization negotiates 10% lower rates for each health care event or raises employee premiums by 10%, but the number of events increases by 40%, the organization's health care costs will increase. Ultimately, the goal is to reduce health care costs while increasing employee health, satisfaction, and productivity. With investments, the multiple goals are achievable.

Early diagnosis and treatment

Investing in early diagnosis and treatment programs is a good use of shareholder funds. Our network of free on-site medical clinics gave some

expected and unanticipated benefits. We treated minor illnesses and injuries far less expensively than if employees went to outside physicians.

(Slide #6) We reduced absenteeism, since the employees would get treated on-site, rather than traveling off-site. The chart shows both a significantly lower cost for each medical condition and a significantly lower number of hours of work lost. What we did not appreciate was the extent to which employees delayed treatment for minor illnesses and injuries when it was inconvenient for them to get a doctor's appointment. By having on-site clinics, they got treated earlier when the conditions were less serious, and were cured earlier as well.

(Slide #7) We applied our thinking to the way we looked at 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. We wanted to get as good a reading as possible on what treatment program would work, and we believe that the eight-session model, although it would be more expensive in the short run, saves money by getting better results from more data.

Investing in Compliance

We also invested to enhance employee compliance with medication-based treatment programs for chronic diseases.

(Slide #8) We have found that the cost of drugs can affect the willingness of patients to stay on a long-term treatment plan. Failure to stay on the plan, in

turn, usually means that the patient encounters a much more serious, complex condition that leads to emergency room visits and hospitalizations. Where we particularly see this pattern is with patients with diabetes, lung diseases like asthma, and hypertension. These are serious chronic conditions, but they share a common characteristic: those who start a treatment program can find themselves incurring heavy medication costs, while they are either not experiencing symptoms of a serious illness or have an intermittent symptomatic experience. In fact, hypertension has often been called a “silent killer” for this reason.

By significantly reducing the cost of medications we have found that fewer patients discontinue their treatments and incur the related more serious conditions from non-compliance. For example, 85% of our covered population on lower cost prescriptions for diabetes and asthma have remained on the treatments. We also saw a significant reduction in emergency room visits for diabetics, and significant decline in hospital admissions for asthmatics. In fact, we actually lowered the annual cost of treating people with asthma by 19% and also decreased their pharmaceutical cost by the same amount. We decreased the annual cost of a person with diabetes by 8% and their pharmaceutical cost by 7%.

Strong case management.

(Slide #9) We have also invested in case management because we have found it to be a valuable tool in delivering higher-quality care at a lower cost. I want to focus on chronic diseases and injuries which have chronic impacts on the body, for which case management is particularly critical.

Chronic Diseases

As I revisited the details of our health care costs last year, in more depth than at any time since I was the Chief HR Officer in 1993, I was surprised at the extent to which the profile of our costs has changed. In 1993, we were most concerned about acute care cases, such as those involving heart attack, cancer, and liver transplant patients, and premature babies, which often cost us several hundred thousand dollars a case. These constituted the largest share of our big-ticket cases and the largest share of our case management focus.

Today, we are dealing with a much larger number of chronic disease cases involving conditions like diabetes, asthma, hypertension, and behavioral health. These cost us between \$50,000 and \$100,000 per year per case, but there are many more of them than the much higher ticket cases I focused on in 1993. In fact, the Robert Wood Johnson Foundation has reported that health care expenses for chronic illnesses now constitute about 78% of our health care spending, and the costs are increasing by well over 10% a year. Many of these conditions are more prevalent in an aging population, as well as a population that contains a higher percentage of African-Americans and Latinos, who are particularly susceptible to some of these diseases. In fact, the RAND Corporation predicts that 70 million Americans will have multiple chronic disease conditions by 2010, which means significant increases in all kinds of health care spending. To give you just one example, the 2000 Medical Panel Expenditure Survey reported that, when a patient progresses from one to five or more chronic conditions, the annual number of prescriptions issued to that patient increases from 7 to 50.

To manage chronic illnesses, we need different strategies. In acute care cases, the health care providers are administering intensive treatments to a patient, and are tightly controlling that treatment process. The illness is typically a discrete event with a beginning and ending point, and the patient either dies or returns to a more normal condition.

Chronic illnesses require a partnership between the health care provider and the patient, because the patient is much more actively involved in self-management of the treatment plan. The illness is a long-term, if not lifelong condition, and the patient has to learn to live with it. Over time, the patient is more susceptible to additional disease conditions with multiple causes.

There is a particular challenge with conditions like diabetes and hypertension because patients can go for significant periods of time without acute, obvious symptoms. As a result, the risk of a patient discontinuing vital treatments is very high, especially since the patient self-treatment regime involves multiple elements, such as medication, diet, exercise regimes, periodic self-testing and diagnosis.

In chronic disease management, our strategy requires three elements not as needed in acute care cases: first, we and the health care providers need a more proactive outreach program to help the patient accomplish the complex self-management required for the illness; second, as the chronic diseases get more complex, multi-disciplinary and coordinated case management is required, with a key worker, usually a nurse, required to be a coordinator for all the health care professionals involved, and third, we need to price medications and other necessary treatments attractively enough to prevent

the patient from discontinuing the treatment when symptoms disappear for a period of time.

(Slide #10) We apply similar principles in our behavioral health case management program. Through the combination of our free 8-session EAP visit model and our managed behavioral health program, we stay engaged with the patient far longer than organizations with health plans that release the patient into an outside provider's care after only three to five visits. Given our approach to care management, I can report that we have reduced the disability costs associated with behavioral health care problems by 25%.

We also have built a strong in-house Disability Management Department, consisting of a Registered Nurse Manager, analysts, claims examiners, and physician consultants, as well as a network of independent medical examiners and outside consultants. Through hands-on, integrated case management, we have seen a 32% reduction in the duration of disability cases and an 11% reduction in their cost.

Quality and Cost

As part of our investment in case management, we are also looking at the quality of providers and services, because providers with superior quality help lower costs. For several years, we have incented our employees to go to centers of excellence for both cancer and transplants. We have been able to direct them to best-in-class quality, while also getting significant discounts because of the number of patients we send there.

However, we have gone beyond simply identifying centers of excellence for the relatively small number of high-ticket acute care cases that fit the profile that makes these centers of excellence attractive. Through a program called Evaluate8, our health plans are reviewed and scored on quality parameters. This is done collaboratively with other employers, and we actually make selections and assign price tags based on quality scores on this instrument.

ENGAGE EMPLOYEES IN THEIR OWN CARE

My last point on case management is a good segway to a fundamental component in maximizing health – **(Slide #11)** employee engagement. The individual has the most to gain or lose relative to his or her health, and as a result should be the person most engaged in its delivery. I use the word engagement, rather than involvement, because the employee needs to be actively engaged in understanding what supports health, awareness of potential health risks, knowledgeable about any conditions he or she has, and an informed consumer of health care services. The first step in patient self-management is an aggressive preventive health program. There are at least five different dimensions to preventing illnesses or injuries:

Patient Education and Awareness

We have focused heavily on patient education and awareness of a variety of medical subject areas. As a result of our Great Expectations program for pregnant women, we believe we have caused enough of them to manage their pregnancies in a healthier fashion that we have reduced the incidence of premature, low birth-weight, or unhealthy babies. Being able to recognize symptoms and react appropriately is another educational and awareness

goal, as is knowing how to manage minor medical problems or to assist health care providers in managing more serious problems is another. Being able to self-manage the multiple facets of a chronic disease situation is another. Finally, being able to manage the process of selecting and administering medications is a great opportunity. Through our Health Care University Program, and through a partnership with WebMD, we provide a comprehensive set of information, education, and awareness services.

Healthy Lifestyles

We focus on many dimensions of healthy lifestyles: nutrition, exercise and fitness, rest, and stress management. We also focus on eliminating unhealthy behaviors, such as smoking, excessive alcohol consumption, and substance abuse. In 1990, we prohibited smoking in all of our facilities, and we helped those who wanted to quit through smoking cessation programs. We not only make healthy food available in our cafeterias, but we subsidize our healthy food to a greater degree than our less-healthy offerings, and we have a nutritionist who works with food service for regular healthy food menu choices. We have on-site fitness centers in our two largest facilities, discounts for outside fitness center memberships, and a number of fitness programs such as our promotion of walking clubs. Aggressive programs to get workers to use public transportation instead of single-occupant vehicles, where public transportation is a viable option, usually increase the amount of walking done by an employee, and subsequently improves long-term health.

I mentioned the societal impact and obesity earlier. Because of its prevalence and its role as a catalyst or enabler of other disease, employers need to look at all of the levers we have available to reduce obesity in the

population covered by our medical plans. Recently, our company launched a “Know Your Body Mass Index” campaign to raise awareness of obesity. We are considering a corporate challenge to reach our goal of decreasing the average BMI by one point a year.

Health Risk Factor Assessment

Health risk appraisals are a critical tool in helping individuals plan and execute preventive strategies, as well as identifying the highest-leverage opportunity for targeted program development to improve population health. We segment our employee population and look for risk factors over our entire population to determine what conditions to address in what geographies.

Effective Use of Screenings, Diagnostic Tools and Immunizations

Screenings and diagnostic tools are critical components of prevention strategies. We have used our clinics not only to treat minor illnesses and injuries, but have also used them to provide free recommended screenings, such as mammograms, blood tests, and blood pressure and vision examinations. In fact, we try to make screenings available at no charge to retirees as well, because we believe they are good investments in preventive health care. We have also been aggressive in getting employees to take flu shots, and to reimburse them for getting immunizations for their children and their spouses.

At the same time, through rigorous data analysis, we have found overuse of certain diagnostic tools, such as MRI's and CTScans. As a result, we have

significantly increased the cost sharing for these tests to cause patients to make more intelligent and discriminating decisions on their usage.

Holistic Health and Workplace Productivity Management

(Slide #12) We approach the management of our health plans from two perspectives: the first is the management of health and health care costs, while improving the quality of care our employees receive and patient satisfaction; the second is the perspective of having every employee be as productive as possible, whether he or she is healthy or is getting treated for an illness or injury.

As I noted earlier, our on-site medical clinics save money and improve health. They also cause employees to come to work, rather than leaving work or staying home, to get treatment for minor illnesses or injuries. Ideally, employees are getting early, highly effective, quick care for a medical condition and returning back to work on the way back to recovery.

Our focus on maximizing productivity has gone far beyond the clinics. One insight we have had is that many employees experience various kinds of pain, which is unpleasant, distracting, and frightening if they do not understand its source. Some live with the pain, while others spend our money and theirs trying to identify the source of the pain and eliminate it. We have developed a whole set of pain management protocols, but we start with the proposition that the source of many kinds of pain is unidentifiable and non-threatening. In every case, we want to get the source of the pain diagnosed and treated if the source can be diagnosed. If not, we want to help the patient manage the pain and continue to have a happy, productive life.

Another insight in productivity management is that getting people with disabilities back to work earlier is good for them and us. Traditionally, employers did not want to appear to be intrusive to an employee who had an illness or injury that took them out of the workplace. For example, I can remember a case in the 1980's in which a previously high-performing sales professional was diagnosed with cancer. He left work for treatment, and we did nothing more over the next two years than verify the continuation of his disabling condition.

I have learned since from seeing heroic employees that coming to work while receiving treatments for acute care conditions is sometimes therapeutic, both because the work gives them incentive to fight harder against the disease and because they develop a strong support system within the workplace. We work diligently to find employment re-entry opportunities for those with conditions that have disabled them from doing their prior job, and we are flexible in identifying part-time work opportunities for them without penalizing their continued receipt of disability benefits.

Concluding Thoughts

(Slide #13) Managing health care plans for employees is far more challenging than ever before. The “low-hanging fruit” that we found in the 1990's is gone. The conditions we address with an aging, diverse, geographically dispersed population require a high focus on prevention, early intervention, hands-on case management, employee engagement and a linkage between managing health and managing productivity. We must

work with high-quality data that we closely and rigorously analyze, and we must do so in an increasingly challenging legal and regulatory environment that makes data gathering and analysis more complex.

Despite all of these challenges, I fully expect that we will have as much success as we did in the 1990's, relative to benchmarks, in terms employee satisfaction, the quality of care received by patients, and cost management.

(Title Slide #14) In conclusion, I want to thank you for being an informed, attentive audience, and I look forward to your questions!