

3,741 words (approx. 25 minutes)

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Premera UW CEO Summit  
March 27, 2008

## **Title Slide #1**

Good morning. I am pleased to participate in this important discussion on different kinds of health and wellness/prevention strategies.

I am here to share the story of Pitney Bowes' 17-year journey to develop a culture of health. This Summit is unique in also encouraging CEOs to think about the ways that they can influence health personally, in the workplace, and in the public policy arena. **Slide #2** One of the ways that I stay actively engaged on all three of these fronts is through my blog "Open Mike" which can be found at [www.mikecritelli.com](http://www.mikecritelli.com). Though I write on a variety of issues, health is the most frequent. I invite you to join the dialogue.

Health is both personal and social, in that it is influenced by every person's physical and social environment, and it influences so much else that goes on in every person's life.

Prior to becoming CEO of Pitney Bowes in 1997, I was in a number of positions that required me to become familiar with the health issues facing the company, and, from the time I was a child, my family had impressed in me the linkage among health, well-being, and success.

When I took over as CEO I knew that staying focused on my own health was essential to having the energy and stamina needed to lead a multi-billion dollar international company. I had always exercised, but I also started

focusing on nutrition and made changes in my eating habits that I have maintained since.

I have also refined my approach to exercise, both in terms of increasing the level and frequency of exercise, but making sure that I did not over-stress myself in so doing. That is why I began several years ago and continue to practice a 10,000-steps-a-day walking program. My own focus on health has also kept me aware of the role that everything in one's environment plays in reinforcing healthy behaviors and supporting an ability to maintain positive changes. In a blog posting titled "Healthy Environment" I discuss the relationship between the environment and behavior change.

### **Slide #3**

This learning has caused me to stay very personally involved in creating this kind of environment for our employees at Pitney Bowes over the last 17 years – a culture of health designed to surround the employee with the information, tools, and access to services needed to enhance health and manage chronic conditions. We provide incentives for employees to engage in healthy behaviors. Yet, we also emphasize their personal accountability for utilizing the array of information and services that we make accessible.

### **Slide #4**

I would summarize our journey as follows: By actively investing in health, we have been successful in improving the health and the productive capacity of our employees, and keeping health cost increases well below market averages.

## **Slide #5**

In fact, for many years during the 1990's and in recent years, our health costs --among our populations in our facilities -- were flat from year to year, and significantly below other companies with which we benchmark. We have shared the savings with our employees in the form of investments in our culture of health.

You will note that I have yet to mention health care. That is because I believe that our focus as a company, and as a country, must be on health even before we focus on health care, and on health care before we focus on health insurance coverage. Deteriorating health is driving increased health care costs, which are making health insurance policies unaffordable for an increasingly large part of the American population. Unfortunately, when the state of health care is examined, discussions go no further than affordability of health insurance, and leave out important dimensions such as prevention and wellness, access, and quality, and efficacy of treatment. Even the discussion of insurance is incomplete because it is excessively focused on universality of coverage, without regard to whether health insurance plan design drives healthy behaviors, convenient access to health care, and health care quality.

## **Slide #6**

The majority of health care costs are being incurred for preventable and controllable metabolic chronic and infectious diseases, and preventable injuries. The implicit assumption in our health care policies and laws, and the current focus on solving the universal coverage problem, is that most health care arises from unpreventable, uncontrollable medical conditions.

Fortunately, the reality is different:

- Preventable metabolic diseases like diabetes and cardio-vascular diseases comprise the highest percentage of our health care costs. They often result from, or are exacerbated by, lifestyle-related behaviors such as smoking and obesity.
- There is a significant increase in a wide range of treatable behavioral health conditions, such as substance abuse and clinical depression. Not only does the direct treatment of these conditions cost a great deal, but they inhibit the individual's adherence to treatment for other chronic diseases.
- There is a crisis with respect to preventable infectious diseases such as HIV/AIDS and a resurgence of tuberculosis and other infectious diseases once believed to be under control. The MRSA strain of antibiotic resistant bacteria has occurred more frequently outside of hospitals in places such as schools. This highlights the fact that we cannot solve our health problems by expecting the next antibiotic "cure all."
- In an average year, 36,000 Americans die from seasonal influenza and this year we are experiencing one of the worst flu seasons in recent years. We have the ability to reduce both the incidence and the seriousness of influenza, but the majority of Americans do not get annual immunizations.
- Conditions like emphysema, which are either induced or made worse by man-made environmental conditions, continue to grow. These

environmental conditions are reversible, particularly if we take the same actions that will address carbon footprint issues.

- Medical authorities are also increasingly linking environmental conditions to the increased incidence of many auto-immune conditions, such as lupus, rheumatoid arthritis, and Type 1 diabetes.
- As a country with an increasingly older population, we also use less prudence in how we exercise, and have an excessive number of preventable and sports and exercise-related injuries.

Even acute care conditions like cancer are more manageable and far less expensive to treat if they are caught early through diagnostic screenings. But, according to the Partnership for Prevention, many Americans fail to take advantage of opportunities to get those screenings. For example, less than one in four Americans get colon cancer screenings to detect a disease that is easily treatable if caught early.

Since our health care crisis is a result of declining health, which manifests itself in more chronic, infectious and auto-immune diseases and preventable injuries, what do we do about it?

### **Slide #7**

At Pitney Bowes, we have created the equivalent of a controlled test since the early 90s to answer that question. The first critical insight was that if we aggressively created a culture of health, as opposed to focusing primarily on managing our own health insurance costs, we would improve health and reduce health care and insurance costs. That, in turn changed our health care investment priorities, our plan design, and our overall approach to health.

## **Slide #8**

Before I discuss the specifics of what we did, let me tell you a little about our demographics. Our U.S. population of 26,000 employees is really two different populations of roughly equal size. Population 1 resembles the demographics of a large employer in that all employees either work on, or report to, sites we control. The critical mass of these sites allows us to provide health supporting services such as free on-site clinics, cafeterias, and fitness centers.

Population 2 resembles the demographics of a collection of small businesses. Employees work in small concentrations on hundreds of customer sites or in mail processing centers. They are primarily lower-wage workers and a higher percentage come to us less healthy, less educated about their health, and with less convenient access to health care.

Thus, we have a total population that is remarkably representative of the American public, and I believe our experience is scalable to the larger national health care policy debate.

While this discussion will focus on Population 1, we are exploring ways to adapt and deliver the best of our successful practices to Population 2, and to our growing group of mobile and remote workers within Population 1. Use of Internet technologies, partnerships with local health care facilities, and utilization of mobile health services, are just some of the ways that we are looking to deliver health information and services to our entire workforce. We are also exploring how we can partner with other organizations to

deliver on-site or near-site clinical services to Population 2 employees, for whom our single-employer on-site clinical model does not work.

### **Slide # 9**

We have four levers to improve health, some of which are available to both of our populations:

- We deliver several health enhancement, preventive, and employee assistance programs to our entire population.
- For our large business population, we provide a total work environment focused on nutrition, fitness, and lifestyle improvement.
- We drive both populations toward healthy behaviors by designing and negotiating for health plans that create incentives for healthy and prudent health care behaviors, and attempt to discourage wasteful health care spending.
- We insure that all of our employees have affordable, high-quality health plan choices from high-quality providers, wherever they live in America.

### **Slide #10**

We designed a program called Health Care University (HCU) to incent healthy lifestyles through reduced benefit costs. HCU features a curriculum of education and healthy lifestyle programs in everything from stress reduction to disease management, each with a designated number of credits for successful completion that reduce out-of-pocket costs for benefit coverage. In a program known as “Count Your Way to Health,” for example, those completing a wellness assessment and completing several recommended behavioral changes – such as flossing once a day, keeping

BMI 25 or less and wearing seatbelts 100% of the time can receive credits. We expanded Health Care U to dependents through eHealth portals.

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Our seasonal emphasis on fighting flu is a great example of our culture of health and the ways that we are serving our entire covered U.S. workforce. In the fall every employee received a “Flu Fighter” newsletter at home. We believe this is an effective way to reach employees and raise awareness within the entire household. By equipping the employee to support the health of those that they care about, we are tapping into an important group of health influencers and also supporting their ability to stay fully engaged, while they are at work.

The newsletter featured a variety of information including tips to stay healthy during flu season and risk guidelines. Because we believe that immunizations and screenings are an important part of prevention, it also included information about our arrangements at 35,000 off-site locations for employees to get free flu shots, and 30 of our on-site locations hosting free flu shot clinics. We also provided phone and Internet registration to find the nearest flu shot location and to receive the flu shot coupon for the off-site locations.

This example illustrates that, in addition to making targeted health and prevention programs available and affordable, we need to use marketing outreach and education programs that will effectively reach target populations. It also demonstrates the need to provide flexibility both in how

we communicate, and in the options that we give plan participants for responding to calls to action and for accessing services.

The broader lesson for national health care policy is that, beyond universal, affordable coverage, there are two other prerequisites for achieving a culture of health throughout society:

- Convenient access to providers; and
- Aggressive and customized marketing outreach to target populations to persuade them to take control of their health.

### **Slide #12**

That is why one of our newest areas of focus is health care communications. We are in the process of identifying studies that demonstrate how health care communications geared toward different consumer segments should be tailored according to demographic-related information, specifically ethnic and cultural characteristics. While there is widespread agreement that communication programs and materials will be more effective when they are “culturally appropriate” for the populations they serve, little is known about how best to achieve this cultural appropriateness. Thus, our objectives are to develop a model for segmenting populations in order to target health care communications; understand the correlation between demographic attributes and response to health care communications; and identify the multi-channel communications methods that have been most effective.

The Johns Hopkins University model features an 8-step approach to segmentation which includes: identifying, prioritizing and scoring audience segments by size, likelihood of response and importance; identifying and

analyzing influencing audiences or where segments seek health advice; and identifying communications messages and vehicles. The University of Michigan also has done cutting-edge research on how to tailor messages and communications channels to increase target population responses to health-related messages.

### **Slide #13**

The **second lever** for achieving a culture of health is creating a total environment that promotes and reinforces healthy behaviors. For employees working at our larger sites we have:

- Cafeterias that serve appropriate portions of nutritious food, and pricing and merchandising practices that make healthier choices easiest.
- Fitness centers in several of our facilities and discounts for outside fitness center memberships. We also give benefit premium discounts for employees that participate in fitness programs like the 10,000 steps-a-day walking program. The fitness centers are very disciplined in insuring that employees participate in a supervised, balanced and appropriate exercise program.
- We have had smoke-free workplaces since 1990, and offer on-site smoking cessation programs, with free related medication.

Nutrition, fitness, and addressing unhealthy lifestyle issues all promote a culture of health in the environment in which most adults spend the majority of their waking hours.

The lesson for the national health care debate is that any meaningful health care reform proposal has to give employers an incentive to help employees and their families take better care of their health. Government, insurance, or consumer-centric proposals, while meritorious in many respects, all need to include components that make the employer a partner in health promotion if they are going to solve the underlying health cost problem.

#### **Slide #14**

We also provide clinical services wherever and whenever we can assemble a critical mass of those we cover in our plans.

- We have a network of seven on-site medical centers open every workday in our major population facilities across the country.
- They are free of charge for employees and we can generally give them free medications to treat their minor acute illnesses and injuries. We also make valuable preventive screenings and immunizations free or as low-cost as possible.
- The clinics are staffed by an array of medical personnel including physicians. We handle an average of 35,000 patient visits annually and 73% of employees with access to a clinic utilized it during the year. 96% of people who utilize the facility rank their experience as good to excellent.
- We also have a pharmacy managed by Caremark, our pharmacy benefit manager, adjacent to our World Headquarters and available to anyone we cover under our health plans. Employees at other nearby locations can order prescriptions that are delivered to their location on a daily basis. By having a pharmacy that only addresses medical and dental needs, we reduce the risk of individuals filling a prescription at

a commercial pharmacy and being tempted to buy the cigarettes and junk foods past which they walk on their way to the pharmacy counter. We do outreach to our employees and retirees to provide screenings and immunizations outside our clinics, either at their facilities or at other sites where they have gathered for special events.

Do not underestimate the value of immunizations and diagnostic screenings in the culture of health. Whether on-site, or in partnership with local health providers, screenings and immunizations are a great opportunity for employers to make a difference.

### **Slide #15**

These clinics have benefited us as well as the employees for a variety of reasons:

- Employees have access to clinical care without having to leave the office, and without long waiting times – average wait 6 minutes.
- In fact, employees who have non-contagious conditions will come to work to use the clinic, rather than staying home for the day to access their private care physician. Our savings are enough to cover the cost of the on-site medical care facilities and staff.
- Our physicians are not receiving free pharmaceutical samples that are later prescribed for patients. We save significantly in terms of frequency of prescriptions, as well as frequency of use of third-line drugs, compared with outside medical practices for comparable medical conditions.

- Because our health care professionals see their patients more frequently, they monitor adherence to treatment plans more easily, and achieve better adherence.
- By referring patients to primary care physicians or specialists for more serious illness we help them develop a relationship with a physician, and make them better-informed users of the health care system.

### **Slide #16**

We have also seen the benefit of the on-site clinic's role in health care communications about behavior change. The health communications research that I discussed earlier is looking at segmenting populations on a larger scale. In our clinics we have been very successful with 1-on-1 communication about smoking cessation, for example. The therapists have a highly-personalized face-to-face dialogue with the individuals and understand the specific drivers for their smoking habit. They devise customized strategies for removing smokers from high-risk situations, give them targeted strategies for coping with their particular barriers, and deliver key messages in highly individualized ways to maximize the chance that these individuals will change their behaviors. In our research on health care communications, we did find HealthMedia Inc. which has developed a methodology and technology that effectively emulates a health coaching session via the web.

On my blog, I discussed our on-site therapists' technique as one aspect of my opposition to the single-payer health care model – which tends to provide rigid regulation of processes and approaches instead of personalized care.

Two broad lessons from our clinical care experience:

- Convenient access to medical care is as important as universal affordable coverage. There are two different access challenges. The first is providing primary care at or near the workplace, to minimize time lost for treatment, and to make treatment more convenient. The second challenge is after-hours care. Too many communities have no after-hours care except for emergency rooms. Absent convenient access, patients will see physicians only when they are very sick, not when they are more easily treatable, and we will continue to see an underutilization of screenings and immunizations that would prevent or detect diseases at earlier stages.

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- Our experience with the clinics also reinforced our belief in the benefit of continuity of care, and the need for portable, patient-controlled medical information to optimize health and disease management. This led us to our involvement of Dossia, of which I am Chairman. Dossia is a consortium of large employers including Pitney Bowes and Intel, funding the development of a personal, portable electronic health record. Health providers need to have a more unified understanding of the patient's health and history. We believe that a comprehensive understanding of an individual's health treatments and trends enhances the quality of care, enhances the operating efficiency of health care providers, and, most importantly, empowers individuals to assume greater control over their health. We are excited about Dossia's possibilities.

The initiatives that I have described to you thus far 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, we knew we needed a more robust understanding of what was driving the change.

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Our next phase of innovation in the delivery of health was data-driven and linked to trends within our population, and it led us to use **the third lever**: crafting health plan designs that drove the right kinds of patient behaviors.

We did an assessment of the most prevalent conditions within our workforce, the behaviors that supported prevention or management of these conditions, and their cost implications. 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 found a strong association between chronic condition progression and low possession rates of medication, 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.

This analysis also really helped us understand the relationship between compliance and costs, and in particular the impact on pharmaceutical

regimens. We found that cost was the biggest driver in a vicious cycle of non-compliance, which accelerates deterioration, and ultimately drives up total cost of care -- which includes inpatient/outpatient services, pharmacy, disability and absenteeism.

Lack of adherence to treatment plans costs America more than \$100 billion annually in unnecessary acute care, adding over 5% to our health care cost burden.

### **Slide #19**

In 2002 our modeling led us to remove the barriers to screening and adherence to treatment of chronic diseases by taking on more of the cost, so that the employee would pay less. We found that the chronic conditions of asthma, diabetes and cardiovascular disease were the most prevalent in our population. Thus we expanded Tier 1 coverage for generic prescriptions and all brand name prescriptions for these conditions. The average employee cost for a 30 day supply of any of the designated pharmaceuticals dropped 50 - 80%. We also dropped the price of supplies, lowered or eliminated costs for preventive services, and we provided first dollar coverage for routine services.

### **Slide #20**

We are excited about the results. We saw decreased emergency department and hospitalization rates across the board for these conditions. And the average patient co-pay for these conditions decreased 50%. Average annual cost of care decreased for both diabetes (6%) and asthma (15%). The average annual pharmacy costs also decreased for diabetes (7%) and asthma

(19%). Within two years diabetes-related disability costs decreased 75% and duration of disability decreased by 29%.

The overriding lesson from our dialogue today is that value-based health care plan designs drive behavioral changes. We get the behaviors our plans incent and we see fewer of the behaviors our plans penalize. We want to ensure that our plan design drives decisions consistent with our objectives of keeping healthy people healthy, getting those at risk to become actively engaged in prevention, and getting those with chronic diseases involved in its aggressive management.

The other broad implication of the importance of a plan design that is continually modified based on behavioral responses to it is that the two worst venues for specific health plan design are state and federal legislative bodies and government regulators. Legislative mandates are exceptionally difficult to reverse if behavioral responses produce dysfunctional results later.

### **Slide #21**

The **fourth lever** for delivering better health is our ability to select the best available health plan alternatives for our employees, and provide meaningful choices for their health insurance coverage. By using tools like “eValu8” and Bridges to Excellence, and joining associations like the Leapfrog Coalition, we have given our employees better leverage than they could have got on their own. We also identify the right centers of excellence for high-cost acute care conditions.

## **Slide #22**

Based on what we have seen succeed at Pitney Bowes, I think the end goal of a national health policy has to be based on the maximization of the health, quality of life, and productivity for all Americans. We must prioritize investment in wellness, prevention, as well as early diagnosis, treatment and aggressive management of chronic conditions.

The essential elements of my national policy vision revolve around:

- Enabling and incenting healthy behaviors,
- Convenient, 24x7 access to appropriate quality care,
- Universal coverage at affordable rates, and
- A high quality health system focused on continuous improvement.
- Plan designs that drive patients to engage in healthy behaviors, adhere to appropriate treatment plans, and select best-in-class providers.

## **Slide #23**

We believe in the value and the power of a culture of health. The journey to develop and maintain a culture of health is a marathon, not a sprint. It starts with a focus on optimizing health, and the willingness to make investments, that will have returns over time. I have appreciated the opportunity to share our experience with you today. I would now be happy to engage in a discussion and take your questions.