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Pitney Bowes: Employer Health Strategy

When our employees become ill, it directly affects our bottom line. We seek a complete alignment of incentives between the company, the employee, and the providers and plans."[1]

—Michael Critelli, Pitney Bowes Executive Chairman

Michael Critelli, Executive Chairman of Pitney Bowes, had taken a strong interest in health care dating back to his service as Chief Personnel Officer of the Fortune 500 mail and document management company between 1990 and 1993. Critelli had championed a transformation in Pitney Bowes, pioneering the firm's focus on improving employee health while controlling spending. By 2008, annual health care cost increases had dropped into "the low single digits," below increases at many other large firms.

Critelli was proud of the recognition that Pitney Bowes' health care programs had received, and saw them as works in process. For example, employees based at client sites, rather than corporate locations, could not always access health and wellness programs. Pitney Bowes also faced challenges influencing the policies of contracted health plans. Critelli had to chart a course to take employee health to the next level.

Company Overview

Founded in 1920, Pitney Bowes (NYSE: PBI) was a $6 billion mail and document management firm headquartered in Stamford, Connecticut. (see **Exhibit 1**) In 2008, Pitney Bowes served more than two million corporate and government customers through operations in 130 countries. The firm's clients constituted around 80% of the U.S. mail-metering customer base and nearly 65% of the global customer base.[2] The firm had completed more than 80 domestic and international acquisitions since 2000.[3] In 2007, Pitney Bowes recorded 7% revenue growth largely due to acquisitions.

In its early years, Pitney Bowes had pioneered postage meters, which replaced stamps by printing postage directly onto envelopes at high speeds. By 2000, meter volume had stabilized with the advent of email and electronic payments. The firm shifted its strategy to products and services that were a part of the "mailstream," or the flow of physical and digital mail, packages, and information to and from organizations and homes.

In 2008, the firm operated in two business segments: mailstream solutions and mailstream services. The solutions segment included the sale and rental of mail and shipping equipment,

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software, and supplies; payment methodologies for postage sales, services, and supplies; and limited professional services such as mailing support. The services segment provided mail and document management functions ranging from operating corporate mailrooms to cataloguing, indexing, and digitizing legal documents for law firms.

Pitney Bowes had offices in every U.S. state, with major sites including three Connecticut locations, Maryland, New York, and call centers in Wisconsin and Washington. Major international sites included the firm's European headquarters in the U.K., Pitney Bowes Canada, and Pitney Bowes France. Most other international sites focused on sales and distribution.

Workforce

Pitney Bowes employed more than 36,000 people worldwide, up from 28,500 in 2000. The 26,000 U.S.-based employees could be divided into four distinct populations. The first group worked at company sites, including the firm's Stamford headquarters. These 6,000 employees averaged 42 years of age with 10.6 years of service in managerial, professional, and administrative duties, as well as call center workers.

The second group included about 4,000 mobile workers, such as sales representatives and on-call service technicians, and their managers. On average, service technicians were older, longer-service employees than sales professionals. Turnover was high among young sales professionals.

The third group consisted of about 12,000 "dispersed" employees were based at over 600 client sites, primarily operating mailrooms and U.S. Postal Service warehouses, each with around 20 Pitney Bowes workers. These employees averaged 39 years of age with four years of service to the firm. They tended to earn lower incomes than employees at corporate facilities, were more racially and ethnically diverse, and were more likely to have histories of unemployment or public assistance.

Dispersed employees often had less access to primary care than corporate staff, resulting in higher emergency room costs. In New York State, for example, primary care physicians rarely offered after-hours appointments and there were few walk-in clinics outside of Manhattan. Pitney Bowes employees based at client sites in New York incurred approximately $4 million in emergency room costs in 2006. In 2007, dispersed workers accounted for more than 20% fewer physician office visits than a national Medstat benchmark, while the average Pitney Bowes employee had 7.3% more visits than average. While dispersed employees visited the emergency room nearly 3% less often than the benchmark, corporate employee ER visits were 13% below the benchmark.

The final group included about 4,000 mail service employees working in 38 dedicated mail consolidation sites, with 100-150 Pitney Bowes workers per site. Over 20 languages were spoken by these lower-income employees, many of whom spoke little English. Pitney Bowes had acquired the mail service businesses recently, and planned to add these employees to its benefit plans for the first time in 2009.

By prevalence, the most common chronic condition among Pitney Bowes employees was hypertension, followed by diabetes, depression, asthma, osteoarthritis, and anxiety disorder. In terms of absolute costs, coronary artery disease was the most expensive, followed by osteoarthritis, depression, diabetes, hypertension, and congestive heart failure.

Pitney Bowes believed that up to two-thirds of its health-related costs were indirect. In addition to absenteeism, "presenteeism," or reduced productivity at work, frequently accompanied illnesses affecting employees or their dependents. External estimates suggested that the costs of presenteeism

linked to chronic disease were two to four times greater than the direct health care costs for those conditions.[4,5]

Employee Health Benefits in the U.S.

Employee health benefits were non-wage compensation provided to workers in addition to their normal salaries. In general, employer benefits were tax-deductible to the employer and non-taxable to the employee. Historically, health benefits were largely synonymous with health insurance, with premiums split in varying proportions between employer and employee. Sick leave, long-term care insurance, and disability coverage often supplemented employer-sponsored health insurance. Other types of health benefits included on-site health centers, workout facilities, disease management programs, and various other health and wellness programs.

While health benefits were normally voluntary, states required employers to provide workers compensation coverage to employees for workplace injuries. Employers paid premiums based on the type of work performed, associated health risks, and claims history. Injured employees were directed to providers designated by the workers compensation plan. The providers diagnosed and treated the injuries, and completed necessary documentation for the employer and state. Employers usually assigned a case manager to each patient, who worked with the clinicians to develop a treatment plan that would allow the patient to return to work quickly.

History of Employee Health Benefits

Employee health benefits, and health insurance itself, were virtually unheard of before World War II. At that time, the major financial loss related to sickness was lost wages, not the cost of care. Medical expenses were low due to the relatively limited state of medical technology; patients were provided largely hospitality services at hospitals. Expectations for medical care were limited, and patients were typically treated at home.[6]

In the late 1920s and 1930s, amid Depression-era fear of economic crisis and rising health care costs, Americans began to demand alternatives to out-of-pocket payment. The nonprofit Blue Cross and Blue Shield plans emerged as the first modern health insurers covering hospital and physician care. The Blue Cross and Blue Shield plans charged the same amount for all members, known as "community rating." For-profit insurers soon followed, appealing to employers by offering "experience rated" policies with premiums based on the expected health care costs for each member, which often resulted in lower costs for a healthy employee population.

During World War II, health benefits were excluded from national limits on wage increases, prompting employers to expand health insurance coverage to attract workers. During the 1940s and 1950s, employer contributions to employee health plans were exempted from taxation, which reinforced an employer-based insurance system.

In the 1950s, many firms began introducing health screening, personal assistance (e.g. for alcoholism or personal problems), and health education programs.[7] In the 1960s and 1970s, employers also began to offer some fitness and wellness programs as research demonstrated that exercise and healthy lifestyle practices could lower cardiac risk factors.

Until the 1970s, most employer-based insurance consisted of fee-for-service "indemnity" health plans that allowed free provider choice and fee-for-service reimbursement. In

1973, Congress passed the Health Maintenance Organization Act, spurring the growth of HMOs,[i] preferred provider organizations (PPOs),[ii] and other managed care plans. By 1987, about 60% of Americans with employer-sponsored insurance were enrolled in managed care plans, versus 5% to 10% in 1980.[8] Member cost sharing became more common among managed care plans, many of which included three principal types of cost sharing arrangements in addition to premium payments: deductibles, coinsurance, and co-payments. Plans with deductibles required beneficiaries to pay a certain dollar amount out-of-pocket before insurance coverage began. Coinsurance involved requiring beneficiaries to pay a percentage of the cost of their care, typically 20% of health care charges. Finally, many plans introduced co-payments, or fixed charges paid by members for each provider visit.

The Employee Retirement Income Security Act (ERISA) was enacted shortly after the HMO Act. ERISA exempted "self-insured" employers, or employers that directly assumed employee health care costs, effectively using their employee base as an insurance pool, from many state regulations. These included mandatory benefit levels, minimum reserve requirements, and certain state taxes. Self-insured plans were subject to federal Department of Labor oversight, while states regulated "fully-insured" health plans purchased from commercial carriers.[9] ERISA required insurers to provide information about plan features and funding, established fiduciary responsibility for managers of plan assets, and instituted member rights to sue for benefits and breaches of fiduciary duty.[10]

Throughout the 1980s, the prevalence of employee health and wellness programs grew rapidly. Over 32% of large employers offered formal fitness programs in 1985, up from 2.5% in 1979.[11] By the mid-1980s, offerings ranged from basic educational programs including newsletters, health fairs, screenings, and classes, to more comprehensive programs focused on achieving and maintaining healthy lifestyles.

After the failed Clinton Health Plan, legislation sought to address abuses by insurers.[12] The Health Insurance Portability and Accountability Act of 1996 (HIPAA) aimed to improve continuity of coverage by prohibiting discrimination in enrollment and premiums charged to employees based on health status or preexisting conditions.[13] The restrictions applied to both self- and fully-insured health plans. The Act also promoted the privacy of personal health information, and mandated national security standards for electronic health care transactions.[14]

In spite of the managed care boom's cost containment efforts, health care costs rose throughout the 1990s. Initially popular among beneficiaries, HMOs became the target of consumer backlash amid concerns about onerous approval requirements and other cost-control mechanisms on access to and quality of care. Enrollment shifted to "lighter" managed care, with PPOs growing from 28% of covered employees in 1996 to 46% in 2001.[15]

Annual employer-based premium increases reached double digits in the early 2000s, with a 59% total increase between 2001 and late 2004. The percentage of workers covered by employer plans fell from 65% to 61%, while employee cost sharing for family coverage rose 10% between 2003 and 2004. (see **Exhibit 2**) The proportion of insured workers whose employers paid their premiums in full fell from 34% in 2001 to 21% in 2004 for single coverage, and from 14% to 7% for family coverage.

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[i] HMOs were generally the most restrictive managed care plans, requiring members to use providers within a contracted network. Patients needed primary care physician referrals for specialty care, and non-network care was not reimbursed.

[ii] PPOs were managed care plans that negotiated with independent provider groups for services at discounted rates. Members were offered lower co-pays for care from network providers, facing higher charges and/or additional deductibles for non-network care.

Most employers that continued to offer coverage did not reduce the scope of benefits beyond cost sharing, and preventive care coverage remained high and rising. More than 95% of insured workers had coverage for physicals, prenatal and well-baby care, and gynecological exams.

Facing rapidly rising costs, more than half of employers shopped for new health plans in 2003, with 31% of employers changing carriers and 34% changing the types of health plans offered. "Consumer-driven" plans, typically pairing a high-deductible health plan with a health savings account, began to capture employers' attention. About 10% of firms reported offering a high-deductible plan in 2004, compared with 5% the previous year.

By 2007, the percentage of firms offering insurance had stabilized, falling just 1% from the previous year. Employees' proportion of premium payments had also changed little over the previous eight years. Average premium growth in 2007 was 6.1%, the lowest rate of increase since 1999.[16] Total premium increases since 2001 amounted to 78%, compared to total inflation of 17% and wage increases of 19%.

Employer-Based Health Insurance in 2008

In 2008, employers remained the leading source of health insurance in the United States, covering nearly 160 million non-elderly people, or around 54% of the population.[17] Medicare covered 14% of individuals in the U.S., Medicaid and other public programs covered 12%, private individual (non-group) insurance covered 5%, and 16% were uninsured.[18] Sixty percent of U.S. employers offered health benefits. Nearly all firms with more than 200 workers and around 45% of firms with fewer than 10 employees offered coverage. One-third of large firms also covered health insurance for retirees. Of firms with retiree coverage, 92% offered benefits to retirees under 65, and 71% covered Medicare-eligible retirees.

Nearly 80% of active employees at firms offering health insurance were eligible to enroll. Of eligible workers, 82% took up coverage. Reasons for employee ineligibility included minimum work-hour requirements and wait times for new employees. Eligible workers choosing not to enroll often did so for financial reasons, or because they could get coverage elsewhere (e.g. through a spouse's employer or public program). Access to employer-based insurance was correlated to income. Three in 10 workers with family incomes below the federal poverty level ($21,200 for a family of four in 2008) were covered by their or a spouse's employer, versus 92% of employees earning over 400% of the federal poverty level.[19]

Employers and employees typically shared responsibility for the cost of health coverage for both self- and fully-insured plans. Average total annual premium costs were $4,479 for single coverage and $12,106 for families, though amounts varied significantly across employers and plans. (see **Exhibit 3**) Employers usually paid the bulk of premiums, with the average worker contributing 16% for single coverage and 28% for families.

In addition to employee premium contributions, most beneficiaries faced additional cost sharing requirements. Annual deductibles were common forms of cost sharing, and some plans included both overall deductibles and separate deductibles for certain types of care (e.g. hospital care, pharmacy benefits). Average deductibles for single coverage in 2007 ranged from $401 for HMOs to $1,729 for high-deductible plans. Many health plans also included modest co-payments for actual services received. Average copays for in-network office visits in 2007 were $15 to $20 per appointment, and out of network visits were $20 to $25. Some health plans also involved coinsurance for a percentage of the cost of care, particularly for out-of-network services. Average 2007 out-of-

network coinsurance levels were 33% of the cost of care, while in-network rates were 17%. Most employer-based plans set annual caps on beneficiaries' total out-of-pocket spending.

Employers offered a number of different types of health plans; large firms were more likely to allow employees to choose among multiple options, and almost half of covered workers had access to more than one plan type. Preferred provider organizations (PPOs) were the most common plans, and high-deductible health plans were the least common. Very few employees remained in traditional fee-for-service plans.

Preferred Provider Organizations (PPO) PPOs were offered by 79% of firms providing coverage, and enrolled 57% of covered workers. PPOs were groups of providers that contracted with health plans or employers to provide services at discounted rates. Plan members paid lower copayments or coinsurance for care from in-network providers than for non-network care. Unlike HMOs, PPOs did not normally require members to designate primary care physicians and permitted patients to access specialty care without referrals. Average annual premiums were $4,638 for single coverage and $12,443 for families.

Health Maintenance Organizations (HMO) HMOs enrolled 21% of covered workers, and 42% of firms offering coverage provided HMO options. HMOs were the most restrictive plans in terms of access to services, requiring members to designate primary care physicians and obtain referrals for non-emergency specialty care. Care from non-network providers was typically not reimbursed. Average HMO premiums were $4,299 for single coverage and $11,879 for families.

Point of Service (POS) POS plans enrolled 13% of covered workers and were offered by 21% of firms providing coverage. These plans contained similarities to both PPOs and HMOs, with higher reimbursement for in-network care along with the option to obtain non-network care. Members were required to designate primary care physicians and generally needed referrals for non-emergency specialty care. Average premiums were $4,337 for single coverage and $11,588 for families.

High-Deductible Plans Also known as consumer-driven plans, high-deductible plans enrolled 5% of covered workers and were offered by 10% of employers providing coverage. These plans were often paired with savings options like health savings accounts (HSAs), to which employers and employees could contribute up to an annual cap. Employer contributions were non-taxable and not counted towards employee income, while employee payments were tax deductible and in some cases could be made on a pre-tax basis. Average deductibles for plans with HSAs were $1,923 for single coverage, although amounts varied. Average single premiums were $3,869 and family premiums were $10,693.

Most small and medium-sized employers and some large firms offered fully-insured health care coverage purchased from commercial insurance carriers. The carriers reimbursed providers for covered services, assuming the financial risk for beneficiaries' actual health care costs in exchange for fixed premium payments.

Over half of large firms offered self-insured coverage instead of, or in addition to, fully-insured plans. More than two-thirds of large firm employees were in self-funded plans, compared to 12% of small business workers. Unlike fully-insured plans, self-funded plans required employers to assume the financial risk of employee medical claims. Instead of making fixed premium payments to commercial carriers, self-insured employers paid for the care its employees received. Self-insured employers effectively functioned as insurers, using their employees as risk pools. Employers could purchase stop-loss coverage to minimize the impact of large claims, but did not shift their claims obligations to other insurers or third parties. An employer could offer one or many self-insured plan types, and PPOs were the most common.

Self-insured employers typically contracted with third-party administrators or commercial insurers to manage their plans. Some employers contracted with health plans for Administrative Service Only contracts (ASO) for claims processing capabilities, paid for either by a percentage of claims paid, a flat fee per claim processed, or a flat fee per covered employee.

Many fully- and self-insured employers selected health plans through competitive bidding. Often with the assistance of benefits consultants, firms solicited bids from competing plans that specified the type of coverage sought and particular services to be purchased.[20] Employers could request provider access and quality data[21] from each plan, and could require accepted carriers to meet specific quality standards. Many firms set specific customer service standards, while fewer included clinical quality measures in health plan contracts.[22]

Employers were increasingly pursuing "value-based benefit design," in which insurance benefits sought to align employee incentives with improving personal health and lowering costs. Pharmacy benefits were a frequent target. In 2007, 84% of large firms offered tiered prescription drug programs, 45% had implemented or planned mandatory generic substitution policies, and 19% offered or planned over-the-counter drug coverage.[23]

Some firms offered health and wellness programs tied to insurance premium reductions. In 2007, more than 25% of large employers offered premium discounts for wellness program participation, with 24% providing discounts based on smoking status, 12% based on management of health risk levels, and 9% for participation in weight management programs.[24]

In addition to traditional health insurance, many employers offered supplementary plans for other types of care. Nearly 20% of firms offering health benefits offered long-term care insurance. In 2006, half of employers offering health benefits offered dental plans, and 21% offered vision plans.[25] Around 75% of eligible employees participated in dental and vision plans, which normally involved cost sharing of premiums, co-payments, or coinsurance.[26]

Many firms offering benefits in 2007 reported they were likely to increase employee cost sharing in the coming year, though few were likely to drop coverage completely. Over 20% considered offering a high-deductible plan with a health savings account, and 37% considered raising deductibles for existing plans. (see **Exhibit 4**)

Employee Health and Wellness Benefits

Over 25% of firms with health benefits also offered at least one wellness program, and a similar percentage included at least one disease management programs in their most popular health plan.[27] Large employers were more than twice as likely as smaller firms to offer both types of programs. (see **Exhibit 5**)

Most large firms outsourced the management of health and wellness programs to health plans or other third party contractors. A 2007 survey found that 65% of large firms offering wellness programs used standard programs operated by their contracted health plans.[28] Another 17% primarily used their plans' programs, but contracted with other vendors for some services.

Exercise and Fitness Many employers, including nearly half of very large firms, offered on-site fitness facilities. Facilities were often available free of charge or for a nominal fee, and some firms encouraged staff to exercise during lunch breaks or business hours. Some smaller employers, or those facing space constraints, subsidized local gym memberships for employees.

On-Site Clinics In 2007, around 25% of large employers offered on-site clinics, with an additional 5% to 10% planning to do so within a year. Clinics ranged from a single part-time clinician offering preventive services (e.g. screenings and immunizations), to facilities with full-time clinical staff that delivered regular primary care, case management of chronic conditions, health counseling, and treatment of minor acute medical conditions. Nearly 15% of large employers offered on-site pharmacies, and 4% had on-site dental services.[29]

Health Risk Assessments and Risk Reduction Health risk assessments (HRAs) were surveys designed to identify and measure employee health risks. Offered by up to two-thirds of very large employers, HRAs ranged from simple tools measuring risks like smoking prevalence and blood pressure to more comprehensive assessments including quality of life issues and chronic conditions.[30] Many HRA programs were combined with health screenings, personalized wellness scores, and action steps for risk reduction.[31] High-risk employees were often called by health coaches to discuss their scores and were frequently referred to programs like weight loss and smoking cessation courses.[32] Over 33% of large firms also offered injury prevention programs, most common in industries like agriculture and manufacturing with higher potential for work-related injuries.[33]

Disease Management Once aimed primarily at common chronic conditions like cardiovascular disease and diabetes, disease management programs had expanded to include a wider range of ailments. In many programs, nurse educators offered personalized telephone or in-person health coaching, and periodically asked patients about their health status.[34] Efforts also included condition-specific or general educational programs on self-management of chronic disease and interaction with the health care system.

History of Health Benefits at Pitney Bowes

Pitney Bowes offered its first health plans in the years following World War II, which were fully-insured plans of large insurers like MetLife and Prudential. The firm paid employee premiums in full, and did not require employee coinsurance or co-payments for care.

Pitney Bowes introduced its first HMO in the late 1970s, and its first self-insured plans in the 1980s, a decade after ERISA. Most employees continued to choose fully-insured plans until the mid-1990s, when Pitney Bowes decided to promote enrollment in its self-insured offerings to expand the risk pool for those products. The proportion of employees in self-insured plans grew from 30% in the early 1980s to over 90% by 1986.[35] Pitney Bowes continued to offer fully-insured options in all locations due to employee demand. In some locations, workers sought access to a particular fully-insured carrier or plan. For example, the Kaiser plans were very popular in California and Health Alliance was well-liked in Detroit.

Serving as Chief Personnel Officer from 1990 to 1993, Michael Critelli faced pressure to stem the firm's annual double-digit growth in health care costs. Pitney Bowes had introduced its first employee cost-sharing policies in 1989, and cost sharing was increased from 10% to 20% between 1990 and 1993. The proportion of health care costs paid by employees rose from 20% in the mid-1990s to nearly 30% in 2007. Flexible benefit programs were introduced in 1993, giving participating employees greater control over how to spend their benefit dollars.

In 1993, Pitney Bowes decided to enroll employees at its headquarters in managed care plans with efficient physician networks, but could not find any that met its needs. The firm decided to create its own network, and asked all potential health plan contactors to submit two years of

ambulatory, outpatient, inpatient, and prescription drug claims data for analysis of treatment patterns for specific medical conditions. The data showed that a local managed care organization contracting with solo physicians and small group practices had average episode of care charges that were 34% below a major competitor plan. Specialist charges per episode were 25% lower.[36]

Pitney Bowes contracted with the local managed care organization to administer two health plans: a Point of Service network of 1,000 physicians, and an Exclusive Provider Plan that excluded 100 of the least efficient physicians and did not reimburse out of network care.[37] In the first year, per employee costs dropped over 9%, while average Connecticut premiums rose 10%. The next year, Pitney Bowes costs rose 5% less than the state average.

New Programs

In 1993, Pitney-Bowes introduced its first wellness programs as pilot initiatives for Connecticut employees. Offerings included themed brown bag lunches, on-site screenings, and programs aimed at lowering blood pressure and smoking cessation.

Pitney Bowes also transformed its occupational health centers into four on-site primary care clinics to promote access and adherence to basic care and prevention. When clinic staff discovered risk factors for chronic illness during routine visits, they encouraged employees to participate in the firm's preventive health and wellness programs. Critelli noted:

> We [had] moved rather rapidly from zero cost sharing to 20%, and we wanted to give people something in return. That's when we started [on-site] health clinics, preventive screenings, and active case management, and tried to present a more caring face to employees as [we] were asking them to spend more on health.[38]

To determine which wellness programs were most appropriate for its workforce, Pitney Bowes introduced a voluntary health risk assessment in 1995, with a follow-up in 1997.[39] HRA results were also used to help individual employees identify and prioritize their health risks.

A 1997 analysis of Pitney Bowes employee health care claims found that 20% percent of workers had not made any claims in the previous year. Concerned that employees were forgoing primary and preventative care, the firm expanded its wellness initiatives to all U.S. employees. Pitney Bowes also introduced on-site fitness centers, healthy food choices in the cafeteria, and preventative health education programs designed to fit employee work schedules.

To better understand its prescription drug costs, and to gain more control over employee drug benefits, Pitney Bowes decided to "carve out" pharmaceutical benefits from its self-funded health plans, offering drug reimbursement through a separate plan.

Also in the mid-1990s, Pitney Bowes carved out mental health services for self-insured members to offer more comprehensive benefits. In particular, Pitney Bowes wanted employees to have coverage for an Employee Assistance Program (EAP) promoting access to early-stage, outpatient treatment for mental health conditions before they required acute or institutional care. In 1997, a new benefit design created incentives for Connecticut employees and their dependents to access eight behavioral health counseling sessions free of charge before they were referred to the appropriate mental health service provider. In 1998, the program was made available to all U.S. employees.

Information and Purchasing Initiatives

Pitney Bowes health care costs soared 13% in 1999, exceeding the Hewitt Health Index benchmark.[iii] The firm set out to identify and analyze employee health trends and their causes.

In 2002, Pitney Bowes hired a software company to create an algorithm that used claims data to predict future health care costs by geography. The algorithm predicted an imminent cost increase in the New York area due to high chronic disease prevalence and poor medication adherence.[40] Pitney Bowes introduced additional health education initiatives in the region, as well as free or low-cost on-site immunizations and screening. The firm also encouraged staff to seek regular care at nearby health clinics instead of relying on the ER. It held regular on-site meetings led by Pitney Bowes managers and communicated with employees via direct mailings sent to employee homes.

Pitney Bowes chose not to renew its contract with a major New York health plan and, according to then Corporate Medical Director Dr. Jack Mahoney, sought a more proactive carrier that would "reach out to people, to help engage them before they became high-cost claimants." Mahoney, whose extensive prior experience ranged from working with Aetna on employee health benefits programs to serving as White House physician for President Gerald Ford, explained:

> Most employers focus on lowering medical expenses for the 5% of high-cost claimants. We also look at the 75% or so of employees incurring 25% of costs but who may be at risk for becoming high-cost, and work to prevent that from happening.

After an initial cost increase, 2003 costs in the New York area fell to just 1% above 2002 levels.

Pitney Bowes engaged a second contractor to help management understand why some employees had moved from having low health costs to high costs. Evaluation of medical, pharmacy, behavioral health, and disability claims, along with absenteeism and workers compensation, suggested that three groups of employees were most likely to become high-cost claimants: those with annual health care costs over $780, current non-users of health services, and chronically ill employees who did not adhere to their medications.

To promote treatment adherence, co-payments were reduced or eliminated for drugs treating the firm's three most expensive conditions: diabetes, cardiovascular disease, and asthma. Associate Medical Director Dr. Brent Pawlecki described the decision as "a little scary, because everyone said our pharmacy costs were going to go through the roof."[41]

Also around 2002, a productivity analysis by a third-party contractor estimated that Pitney Bowes had lost $51.7 million over the past year due to "presenteeism."[42] Productivity losses caused by colds and flu accounted for nearly $10 million, with other contributors including headaches, back pain, fatigue, and gastrointestinal illness. The firm began offering flu vaccines at on-site clinics and required its health plans to cover them. A cold and flu prevention campaign stressed the importance of hand washing and other ways to avoid infecting co-workers.

Another spurt in costs occurred in 2003, when health claims for self-insured beneficiaries rose 11.5%.[43] Over 33% of the increase came from inpatient costs, which rose 9% per visit, though the number and duration of admissions remained constant. The firm traced much of the change to its California sites, where powerful hospital groups had increased average per admission charges to

[iii] The Hewitt Health Index compiled health costs, health status, and utilization data from a cohort of large US employers, and provided each firm with its own data compared with an aggregate Index benchmark. The Pitney Bowes benchmark included data from 18 comparable firms.

$20,500, double the average in other states. The California Public Employees' Retirement System, which provided insurance for 415,000 members, began to drop certain hospitals from its provider network, but Pitney Bowes did not feel the firm was large enough to influence pricing.

Another 35% of the increase was for outpatient hospital charges, driven by expensive lab tests and radiology services like MRIs and CT scans. The number of employee CT scans rose 7% between 2002 and 2003, while the cost per scan rose 15% to $560. In 2004, the firm introduced 20% coinsurance and $250 service-specific deductibles for non-preventive (i.e. related to diagnosis or treatment of a suspected condition) scans and other tests, up from a fixed $75 copay.

Pitney Bowes had joined several regional business coalitions aimed at boosting employers' negotiating power with health plans. By 2004, many of the groups had begun to use the "eValue8" tool to assess health plan quality.[44] Developed by the National Business Coalition on Health (NCBH), an umbrella organization of employer health groups, NBCH member employer coalitions jointly conducted the annual eValue8 survey submitted electronically to health plans. Survey questions were revised annually based upon employer feedback. The NCBH verified and scored plan responses, and reported results to members.[45]

In 2004, Pitney Bowes participated in its first eValue8 survey through the New York Business Group on Health employer coalition, an NBCH member. Pitney Bowes subsequently added and dropped health plans based largely on eValue8 results, and estimated that it had saved $12 million in annual health care costs since joining the quality purchasing initiative.

Health Benefits at Pitney Bowes in 2008

Pitney Bowes spent over $150 million on health care in 2008, more than $140 million of which was for employee and retiree claims, payments to ASOs and carve-out vendors, and fully-funded plan premiums. The remaining $10 million was dedicated to on-site clinics, health and wellness programs, Hewitt Associates services, and benefits staff. Per capita health care costs had increased more than 70% in absolute terms between 1996 and 2007, a growth rate of around 6%. The rate of increase for Pitney Bowes' dispersed population consistently exceeded that of employees at company sites. Over the same period, Medstat benchmark costs per capita for other large employers more than doubled, with a CAGR of nearly 8%. (see **Exhibit 6** and **Exhibit 7**)

Health benefits reported to the Executive Vice President and Chief Human Resources Officer, Johnna Torsone, a senior executive position reporting directly to the CEO. The human resources department's health benefit responsibilities included budgeting for new programs, developing training programs for new and existing employees, and monitoring employee satisfaction.

Day-to-day administration of health benefits was managed jointly by Dr. Brent Pawlecki, who had succeeded Mahoney as Corporate Medical Director, and Andrew Gold, Executive Director of Global Benefits Planning. Pawlecki was responsible for designing, implementing, and monitoring employee health and wellness programs; the disability management program; workers compensation; and the on-site company clinics. Gold was in charge of contracting for all Pitney Bowes benefits, including health plans, retirement plans, and other non-health benefits.

Overall, a team of eight employees worked directly on health plan design and wellness programs. Although consultants often advised Pitney Bowes to "cut overhead" by reducing its benefits staff or filling positions with less senior employees, the company viewed its team as an investment, noting that firms with less overhead often had higher total health care costs.

Health Plans

Pitney Bowes' self-insured health plans covered 90% of employees receiving health benefits from the firm. Fully-insured plans enrolled the remaining 10%. All employees working at least 30 hours per week were eligible for coverage in 2008. Approximately 80% of eligible employees enrolled in health plans through Pitney Bowes. Many of the 20% who declined coverage obtained insurance elsewhere, for example through a spouse's employer or public program.

Pitney Bowes offered a range of PPO plans through five national carriers, and HMOs through 20 local and national carriers. Almost all PPOs were self-funded, while HMOs could be self- or fully-insured. Offerings varied by region, but most employees could choose among a comprehensive PPO, a more restrictive PPO, a high-deductible "saver" plan, and sometimes an HMO.

Self-Insured Plans Pitney Bowes offered self-insured PPO plans, as well as high-deductible plans and a small number of HMOs. All self-insured plans offered the same scope of covered services and included certain cost sharing principles. Beyond those common elements, employees could choose from plans with a range of deductible and coinsurance levels.

Self-funded plans were administered by national insurers under Administrative Services Only (ASO) contracts that adjudicated and paid employee claims from an account funded by Pitney Bowes. Pitney Bowes made monthly, fixed payments to each ASO contractor based on the number of employees covered. In return, the ASO adjudicated all claims, determining how much of the service to cover according to the beneficiary's health plan, and paid the approved portion. While ASOs were responsible for administrative functions, Pitney Bowes controlled scope of coverage, cost sharing levels, and employee benefit appeals.

Pitney Bowes allowed the ASOs to form provider networks, and did not interfere with individual provider contracting because the number of employees in each area was insufficient to identify and contract with providers based on firm-specific criteria. Instead, the firm used health plan responses to the eValue8 survey to select plans that considered quality metrics and quality improvement programs when contracting with and managing providers. Health plans were increasingly creating "high-efficiency" or "high-value" specialist networks that offered incentives for members to seek care at subsets of physicians within existing provider networks identified as low-cost and high-quality providers. Mahoney noted:

> We're still waiting for plans to demonstrate the real value of those networks. It used to be that only the highest-cost outliers were excluded, or those with serious quality concerns. Now the networks can be restricted to one or two quartiles of providers.

Fully-Insured Plans Pitney Bowes also offered fully-insured coverage in all regions. The firm purchased pre-packaged, primarily HMO plans from 20 commercial insurers, including Harvard Pilgrim, Kaiser, Aetna, and Humana. Pitney Bowes had reduced the number of HMO carriers from 46 to 20 in 2008, with additional cuts planned for 2009.

Pitney Bowes had little influence on fully-insured plan design and cost sharing. Fully-insured cost-sharing levels were similar to self-insured plans, as Pitney Bowes selected plans in part based on cost sharing requirements. Fully-insured beneficiaries were not enrolled in the pharmacy or mental health carve out plans, lowering overall premiums, however other cost sharing requirements were typically higher in commercial plans.

Each month, Pitney Bowes paid fixed premiums to fully-insured carriers based on the number of covered employees. The plans did not share utilization, claims, or health status information with the Pitney Bowes, considering the information proprietary.

Eligibility Pitney Bowes employees eligible for health insurance had to opt out of coverage; otherwise, workers who did not select plans were automatically enrolled in the high-deductible saver plan, the lowest-premium option. The saver plan offered first-dollar coverage for prevention and chronic care drugs, with primary care subject to a deductible. Once the deductible was met, all services included in the plan were covered in full.

All retirees who had worked at Pitney Bowes for at least 10 or 15 years, depending on the business unit, were offered health benefits, including those who were Medicare-eligible. Plan designs carried over between active employees and retirees so that retirees did not have to switch plans. Around 1,500 workers who had retired before 1993 received the same benefits they had as active employees, even if those benefits did not include any employee cost sharing. Employees retiring after 1993 were eligible for health benefits similar to those offered to active staff in 2008.

Plan Selection and Design Pitney Bowes began the health plan selection and benefit design process by surveying fully- and self-insured plans through eValue8. The 2008 survey covered health plan management of providers, provision of physician quality information to members, and ability to help members navigate the health care system. A new section on "total population health management" asked about programs encompassing "the full range of at risk chronic and acute conditions with a focus on prevention, risk-reduction, and self-care."[46] Additional topics included IT support, disease management, medical homes, patient safety, member communication, and financial stability. Of particular interest to the firm were a health plan's scope of benefits for chronic conditions and the cost of care for certain diseases. (see **Exhibit 8**) Pitney Bowes also shared modified eValue8 results with employees to facilitate their health plan choices.

All plans offered by Pitney Bowes covered three core components: preventive care and screening, mental health benefits, and catastrophic coverage for serious and expensive illnesses. Most preventive services were offered at low or no cost to the employee, and most routine services were eligible for first-dollar coverage. Deductibles and out-of-pocket maximums for non-routine services varied substantially across plans.

The benefits management team examined the prevalence of illness, service utilization patterns, and cost information for its workforce. Health plans were evaluated with these areas in mind. For example, as diabetes was both common and costly among its workforce, Pitney Bowes paid particular attention to the type of care delivered to diabetics. (see **Exhibit 9**)

Pitney Bowes believed a cultural fit was important, and met with new and existing health plans individually before contracting with them. Mahoney explained:

> You can look at great statistics for a member call center, but when you walk through it, you know if beneficiaries can pick up the phone and reach someone who can relate to them, who understands their situation.

Once plans were chosen, employee premiums were set such that the lowest-premium plan would be affordable to staff earning $20,000 to $25,000. Employees were given cash equivalent flex credits for use towards their premiums, with lower-income workers receiving the most credits.

Pharmacy and Mental Health

Pharmacy and mental health benefits for Pitney Bowes employees enrolled in self-insured plans were managed by specialist vendors rather than their regular health plans. Employees made a single payment for pharmacy and mental health benefits together with their health plan premiums. Beneficiaries could choose between a standard drug benefit and an upgraded plan involving higher premiums. Employees with fully-insured plans received pharmacy and behavioral health benefits through their health plans.

The pharmacy plan managed by Caremark had a three-tier formulary with tier-specific levels of coinsurance up to annual out-of-pocket limits. There were no mandatory generic substitution programs. Each medication was placed in one of the tiers, with coinsurance levels of 10%, 30%, or 50%. Pitney Bowes used predictive modeling software to identify drugs for which non-compliance was likely to raise costs, placing those in the least expensive tier. All diabetes drugs and devices, for example, were placed in the 10% tier, along with osteoporosis treatment, antiseizure medications, and prenatal supplements. Claims data had also shown that 60% of the firm's beneficiaries with diabetes and 52% of those with previous cardiac events were on cholesterol-lowering statins in 2006. By 2008, diabetics and beneficiaries with histories of heart attack, angioplasty, or stents could receive statins for free.[47]

Mental health benefits were managed by ValueOptions, a national behavioral health managed care company that received capitated payments from Pitney Bowes for each covered employee. Benefits included the Employee Assistance Program (EAP), which covered six to eight counseling sessions for non-diagnosable and less severe issues (e.g. bereavement, child behavior problems), as well as services for more serious conditions.

On-Site Medical Services

In 2008, around 20% of Pitney Bowes employees had access to one of the firm's seven on-site clinics in Connecticut, Maryland, Wisconsin, Washington, and New York. An eighth clinic was planned for Washington, D.C. The clinics had evolved from "bare bones" programs treating minor illnesses and injuries to comprehensive units offering a full suite of health care treatments, including primary care, screening and diagnostics, disability management, health counseling, patient advocacy, and referral services to community medical services.

The clinics offered limited and varying levels of specialty services relative to the size of the clinic, including allergy and asthma care, sports medicine, gynecology, gastroenterology, travel medicine, counseling, physical therapy, chiropractic care, and massage. Centers also monitored compliance with pre-employment physicals and required fitness-for-duty testing following disability claims for certain positions. Clinics also supported Pitney Bowes health and wellness initiatives, for example by distributing pedometers to promote a program challenging employees to take at least 10,000 steps per day.

The clinics could distribute an entire course of medication for common conditions through a limited formulary of mostly generic medications. Clinic prescriptions were integrated with the Caremark database, and drugs prescribed by on-site clinicians were not subject to co-pays. Stamford employees could collect their medications at an on-site pharmacy, launched in 2006, or have the prescription delivered to their offices.

While their scope of services had expanded, the clinics were treated as an extension of primary and specialty services for employees rather than the principal or sole care provider.

Clinics were staffed by full- and part-time primary care physicians, nurse practitioners, physician assistants, certified occupational health nurses, health educators, and counselors. The Stamford clinic employed five physicians with rotating hours as well as nurses and nurse practitioners. Some facilities also provided space to local physicians and specialists with large numbers of Pitney Bowes patients to hold weekly on-site office hours.

Services were free to employees and offered during work hours. Clinic licenses from the Department of Labor covered only the care of employees, not dependents. Dependents and retirees, however, were eligible to use the Stamford pharmacy.

Some smaller sites provided varying levels of on-site health services primarily due to space constraints. For example, the 200-employee Bridgeport, Connecticut facility offered on-site flu shots and screenings. Pitney Bowes operated call centers for health questions in Wisconsin and Washington, with a third planned in Maryland.

Health and Wellness

In 2008, Pitney Bowes offered health risk assessments, disease management, disability management, and Health Care University (HCU) programs. These programs were offered to all corporate employees, with some adaptations for dispersed workers. Most programs were offered only in the U.S. at corporate locations, although some major international sites had adopted certain health and wellness initiatives, such as disease management and disability management in Canada and the U.K.

Health Risk Assessment Pitney Bowes offered voluntary online HRA questionnaires to all employees. Surveys assessed individual health risks and flagged areas for improvement. Pitney Bowes required each health plan to post the HRA survey on its own website, where it could be completed electronically. Low employee participation in the HRA in 2007 was attributed to difficulty navigating the various health plan websites. Pitney Bowes decided to create a single, user-friendly HRA website, and its development was in process in 2008.

Disease Management Pitney Bowes offered a number of disease management programs for common chronic conditions to employees, dependents, and retirees. Most disease management programs were managed by health plans or ASOs, who had access to employee claims data and could target high-risk workers. The firm required all plans to have programs for asthma, cardiovascular disease, and diabetes, and many plans also offered additional options. Two programs, cancer care and prenatal care, were managed by separate, national vendors, both of which involved access to a 24-hour hotline staffed by nurses. Pitney Bowes believed that beneficiaries did not want their employer to have information about their chronic disease status.

Eligible employee participation in disease management programs ranged from a high of 47% for diabetes to a low of 16% for back pain management. Participation varied by medical condition and the enrollment criteria used by the health plans. For example, diabetes program eligibility was based on prescription and medical claims information. The firm did not seek to enroll all employees with a target condition, as some were already under good management.

Participants with access to on-site clinics often received some disease management services at the workplace. For example, the diabetes program included regular monitoring of Hemoglobin A1c levelsto assess blood sugar control, cholesterol testing, lifestyle coaching and education about

diabetes control, and access to a diabetes nurse educator. These services were provided at on-site clinics when possible. Other employees received these services from outside providers.

Disability Management Pitney Bowes offered disability management programs to help employees return to work safely and efficiently following absences due to a range of conditions, including injuries, cardiovascular disease, maternity, and behavioral health issues. Employees and their treating physicians had access to a 24-hour phone line staffed by representatives who triaged disability claims according to diagnosis, and made referrals to nurse case managers when appropriate. Case managers followed each employee until he or she could safely resume work.

Learning from disability programs was integrated into workplace safety and health program design, with input from the Corporate Medical Director, on-site physicians, safety engineers, and ergonomists. For example, after realizing that maternity-related disability was a significant contributor to lost work time and health care costs, Pitney Bowes began to include maternity management in its disability management program. The program fit better within the disability management program rather than disease management because it was not run by health plans or ASOs, and because many women took disability leave for normal delivery or complications.

The maternity program was designed to prevent or reduce poor birth outcomes such as low birth weight, neonatal intensive care hospitalization, and maternal disabilities. The program also managed postpartum return to work, and included health risk assessments during pregnancy, a 24-hour information line continuing six weeks postpartum, and educational materials.

Until 2007, short- and long-term disability management was managed internally and separately from the workers compensation program which was run by a third-party administrator. Employees contacted the workers compensation vendor for on-site injuries and disease management staff for conditions unrelated to work. In 2007, the two programs were joined under the management of the Disability Assistance Department, led by Corporate Medical Director Pawlecki. Under the new structure, employees injured on-site were simultaneously offered entry into both programs.

Health Care University Health Care University (HCU) was the Pitney Bowes umbrella program to encourage health and wellness through education. Health education programs emphasized personal responsibility and self-care through ongoing sessions and printed materials promoting healthy diet, exercise, and behaviors associated with improved health outcomes. For example, the "Count Your Way to Health" program used brochures, signs, and emails to inspire employees to comply with health guidelines. Program targets included zero tobacco use, flossing once daily, eating five fruits and vegetables daily, maintaining a body mass index below 25, exercising 30 minutes per day, and 100% seatbelt and bicycle helmet use.

Offerings were adapted in response to HRA data and employee feedback. For example, after HRA results revealed the prevalence of actual and potential cardiovascular disease, Pitney Bowes launched the Healthy Heart School program at its headquarters. The program included four teaching sessions, follow-up visits from a Health Coach, and an educational guidebook. The firm also expanded its diet and exercise efforts. A nutritionist managed cafeteria menus and oversaw portion control. Healthy items were placed at the checkout counter, and unhealthy snacks were farther away. Nutrition data on the food being served was clearly visible. Food service was eliminated for meetings other than lunch, and vending machines offered healthier snacks.

Although HCU programs were primarily held at Pitney Bowes facilities, some were available to dispersed employees. For example, the smoking cessation program adapted from the "Mayo Clinic Quit Line" was available at all work sites. In lieu of in-person consultations, dispersed employees

could call a dedicated phone line staffed by smoking cessation counselors. Wellness messages were communicated through brochures and postcards sent to employee homes.

Pitney Bowes offered financial incentives for completion of HCU programs. Employees earned credits and received financial awards applicable toward health benefit payments. Nearly 25% of employees completed HCU educational, screening, or behavior change programs in 2005.

Health Results

Pitney Bowes monitored and evaluated the collective impact of its health benefits. While program evaluations were conducted, the firm did not try to calculate return on investment for individual initiatives. Dr. Mahoney, in a new part-time role as Director of Strategic Health Initiatives, said that while the firm had invested "millions" in its clinics and to promote drug adherence, it had saved "tens of millions" from lower medical costs and increased productivity.

The firm estimated that in aggregate, its health benefits programs had saved $39.8 million in 2007.[48] Estimates suggested that one-third of the savings was due to plan design efforts such as tiered drug benefits and reduced cost sharing requirements for primary and preventive care. The remaining savings was attributed to health and wellness programs, disease management, on-site clinics, and employee "consumerism" by factoring cost into their drug choices.

Health Plan Performance

Pitney Bowes used two databases to measure health plan cost and quality. One, managed by Hewitt Associates, tracked health plan enrollment and total claims for both self-funded and fully-funded plans. The database also included administrative costs for self-funded plans. Utilization of services was recorded and the firm could access blinded employee data. Pitney Bowes could not access individual health information (e.g. test results, diagnoses) for privacy reasons.

Claims information was then combined with a second database managed by Medstat, a subsidiary of the Thomson information management corporation. The database tracked common chronic disease prevalence and corresponding hospital admissions, average length of inpatient stay, outpatient visits, and ER visits for each condition. Data could be sorted by factors including time period, health plan, Pitney Bowes business unit, state, metro area, and employment status. Pitney Bowes' data was benchmarked to Medstat's U.S. client base, mainly other large employers.

Medstat submitted annual summaries to Pitney Bowes, and the firm could request inclusion of particular metrics or trends, as well as mid-cycle reports. The core benefits team also had real-time access to the database, and frequently reviewed the information on its own. Pitney Bowes preferred the Medstat database to information provided directly by health plans because it could customize the data fields, access information at any time, and retain data upon switching plans.

In 2007, Pitney Bowes total active employee medical claims and administrative costs, including employer and employee contributions, surpassed $100 million, of which the firm paid nearly $85 million. Total annual per employee costs averaged over $7,000.

Pharmacy Performance

Reducing employee cost sharing for chronic care drugs and supplies had improved compliance with treatment. (see **Exhibit 10**) In 2007, one year after eliminating cost sharing for statins prescribed

to high-risk beneficiaries, Pitney Bowes observed a 7% increase in adherence among targeted members.

Between 2001 and 2006, asthma treatment adherence rose from 33% to 62%. The percentage of asthmatic beneficiaries on albuterol only treatment, used for acute airway spasms, dropped from 51% to 33% over the same time period, with a corresponding 28% rise in non-acute, long-acting asthma controllers. In 2003, average service utilization and cost of care decreased 15% for asthma and 6% for diabetes. Between 2001 and 2003, drug costs fell 19% for asthma and 7% for diabetes due to a drop in complications. Improved adherence was also partly responsible for a 26% decline in ER use for diabetes and a 19% decline in hospital admissions between 2001 and 2003.[49]

Annual per capita drug costs for all Pitney Bowes employees rose slightly between 2001 and 2003. The drug benefit plan incurred average annual charges of $675 per employee, 10% to 15% above comparable firms. Pitney Bowes received regular inquiries from benefits consultants offering to help manage drug costs, but chose to maintain the revised structure. Per employee costs for the Pitney Bowes mental health benefit carve out were also above average.

Health and Wellness Performance

On-Site Medical Services In 2007, Pitney Bowes recorded 35,000 employee encounters in its on-site clinics. Nearly 75% of employees with access to clinics utilized their services during the year, and 96% of people who had visited the clinics rated their experiences as good or excellent.

In Connecticut, many employees reported that the clinics were their only source of primary care. These employees registered 33% lower health care costs than workers using only outside health services. Claims data showed that clinics used fewer and less costly tests and prescription drugs, which drove much of the savings. Employees using only on-site clinics had fewer absences and disability episodes, controlling for demographics (the on-site clinic only workers were mostly young males). The firm estimated that for every dollar spent on the clinics, it saved $1 in health costs plus an additional $1 in productivity costs.[50]

Health Care University On average, Pitney Bowes estimated that health care costs for HCU program participants were 10% lower than non-participants.[51] Based on a 2005 evaluation, the Stamford-based Healthy Heart School cardiovascular screening and education program led to average participant cost decreases of 24.1% and risk score declines of 25.6% (excluding three outliers) between 2002 and 2004. Average participant cholesterol and body mass levels also fell slightly.[52] In comparison, nonparticipant health costs rose 56.7%, and risk scores increased 28.1%.

Over a decade earlier, Pitney Bowes had conducted a four-year longitudinal study comparing HCU program participants and non-participants. In 1995, non-participants' average per capita health care costs were 7% higher than participants. Participant costs decreased 5% from 1993 to 1996, while non-participant costs increased by 2%.[53]

Future Challenges

In 2008, Critelli was concerned about the firm's ability to improve the health of its 12,000 dispersed employees who could not access many Pitney Bowes on-site programs. He explained:

> This is a very diverse group of people, many of whom, such as repair people, work out of their homes and cars. They represent some of the people who need our help the most. They can't be

left out of this. It is critical to our bottom line that we find a way to bring them into our culture of wellness.[54]

Federal regulations introduced in late 2006 limited health plans' use of member incentives based on "health status-related factors" like medical conditions, claims history, genetic information, and disability, restricting the amount by which Pitney Bowes could differentiate employee premiums through, for example, limiting the magnitude of non-smoker discounts and credits for participation in some HCU programs.[55] Pitney Bowes had already reached the per employee limit for allowable credits, and Critelli considered these incentives to be a key part of the firm's value-based insurance design.

Critelli was also considering how employers could exert more influence on care delivery. For example, health plans had been unwilling to strengthen and improve access to primary care. In spite of the attention generated by new primary care models like medical homes, health plans resisted these types of arrangements because they believed reimbursement levels would not cover the costs of additional services and staff. While employer coalitions had negotiated for expanded behavioral health benefits, they had been unable to do so for primary care.

Exhibit 1 Selected Financial Results, 1998 - 2007

	Years Ended December 31									
	1998*	1999*	2000*	2001*	2002	2003	2004	2005	2006	2007
Revenue	$ 3,499,483	$ 3,811,576	$ 3,880,868	$ 4,122,474	$ 4,244,124	$ 4,440,312	$ 4,832,304	$ 5,366,936	$ 5,730,018	$ 6,129,795
Income from continuing operations	$ 443,149	$ 562,990	$ 562,125	$ 514,320	$ 464,870	$ 404,068	$ 405,439	$ 473,243	$ 565,659	$ 361,247
Return on Sales	13%	15%	14%	12%	11%	9%	8%	9%	10%	6%
Total assets	$ 7,661,039	$ 8,222,672	$ 7,901,266	$ 8,318,471	$ 8,732,314	$ 8,891,388	$ 10,211,626	$ 10,621,382	$ 8,608,944	$ 9,549,943
Return on assets	6%	7%	7%	6%	5%	5%	4%	4%	7%	4%
Stock-holders' equity	$ 1,648,002	$ 1,625,610	$ 1,284,975	$ 891,355	$ 904,392	$ 1,145,416	$ 1,349,152	$ 1,364,249	$ 699,189	$ 643,303
Return on Equity	27%	35%	44%	58%	51%	35%	30%	35%	81%	56%
Total employees	27,700	27,267	28,542	32,724	33,130	32,474	35,183	34,165	34,454	36,165

Dollars in $000s

* The figures for 1998 to 2001 are not restated for discontinued operations

Source: Company documents.

Exhibit 2 Employee Cost Sharing in Premiums and Deductibles

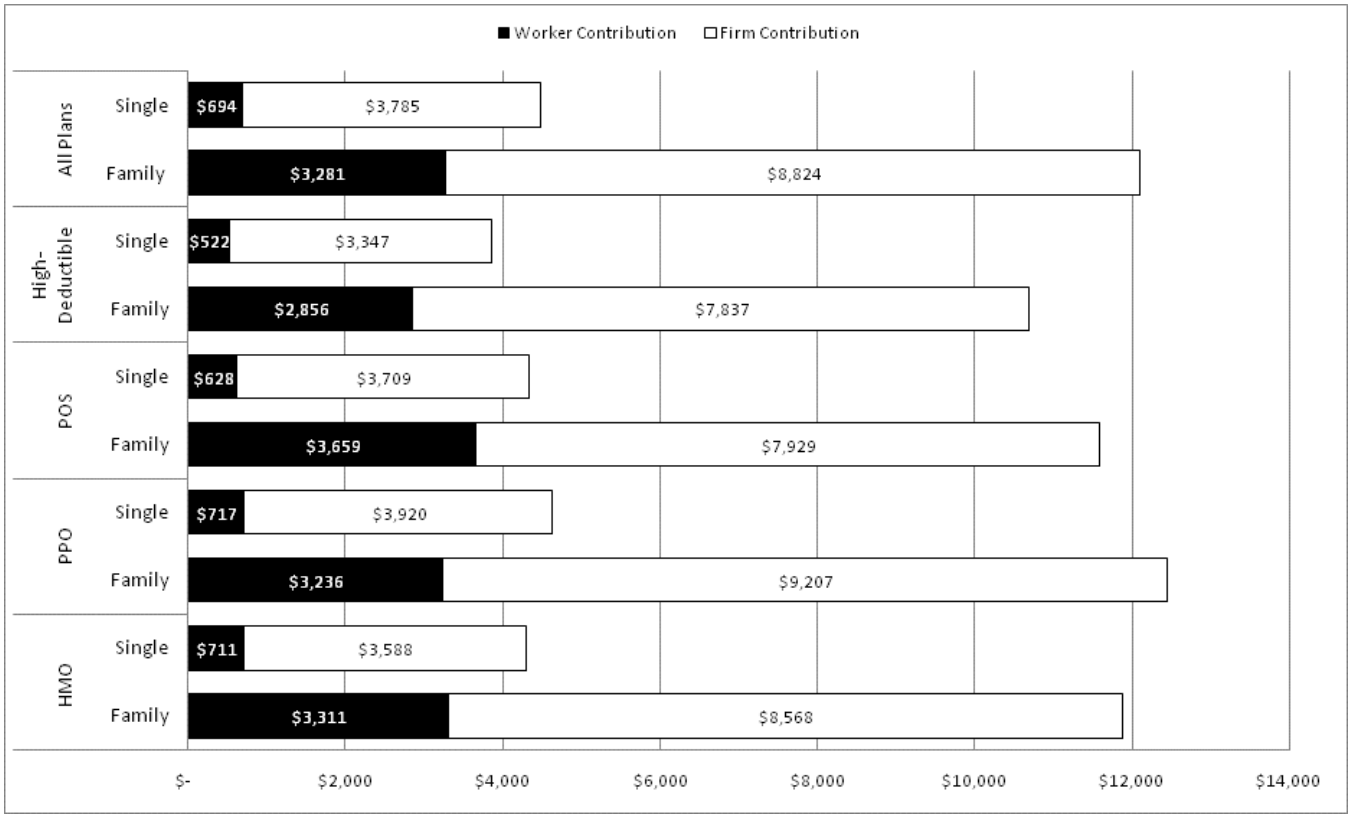
Average Monthly Contribution, Percentage *of Premiums Paid by* Covered Workers for Single and Family Coverage, and Average Deductible by Plan Type, Selected Years 1988-2004

	1988	1993	1996	2000	2001	2002	2003	2004
Monthly worker contribution								
Single	$ 8	$ 34	$ 37	$ 28*	$ 30	$ 39*	$ 42	$ 47
Family	$ 52	$ 124	$ 122	$ 135	$ 149	$ 178*	$ 201*	$ 222*
% of premiums paid by worker								
Single	11%	20%	20%	14%*	14%	16%	16%	16%
Family	29%	32%	27%	26%	26%	28%	27%	28%
Deductibles								
Conventional, individual	$ 163	$ 222	$ 264	$ 248	$ 239	$ 295	$ 384	$ 414
Conventional, family	$ 375	$ 495	$ 594	$ 580	$ 598	$ 700	$ 785	$ 861
HMO, individual							$ 30	$ 44
HMO, family							$ 65	$ 80
PPO, in network	$ 106	$ 170	$ 180	$ 175	$ 204*	$ 251*	$ 275	$ 287
PPO, out of network	$ 177	$ 289	$ 313	$ 340	$ 409*	$ 466	$ 561*	$ 558
POS, in network			$ 71	$ 70	$ 92	$ 54*	$ 113*	$ 210
POS, out of network			$ 324	$ 352	$ 407	$ 409	$ 442	$ 575

**p<.05*

Source: Gabel, Jon, et al, "Health Benefits in 2004: Four Years of Double-Digit Premium Increases Take Their Toll on Coverage," Health Affairs, Vol. 23, No. 5, September/October 2004.

Exhibit 3 Average Employer and Employee Premium Contributions by Plan Type, 2007



Source: "Employer Health Benefits 2007 Annual Survey", (#7672) The Henry J. Kaiser Family Foundation and HRET, September 2007

Exhibit 4 Planned Changes to Employee Benefits, 2008

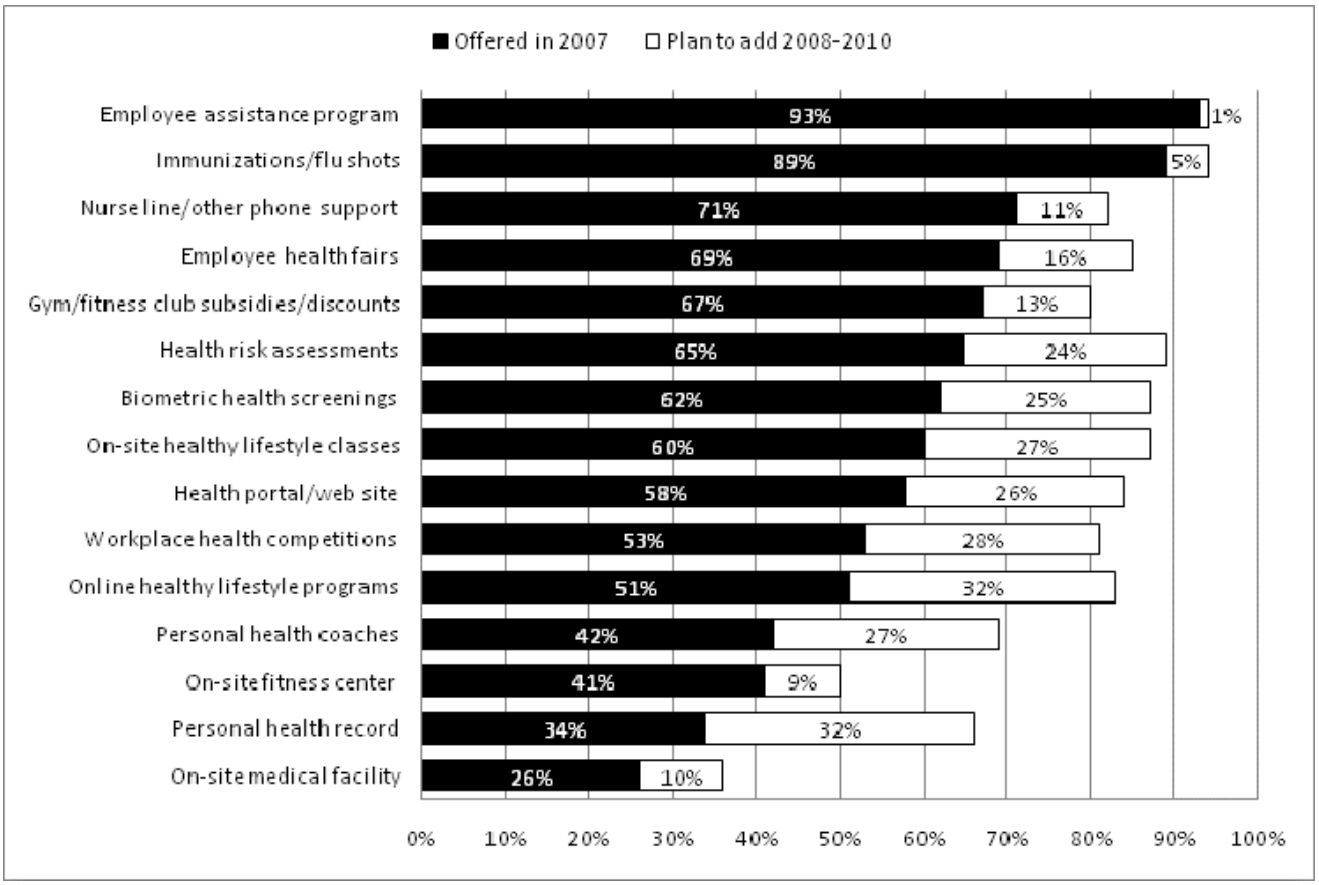
	Very Likely	Somewhat Likely	Not Too Likely	Not At All Likely	Don't Know
Increase the Amount Employees Pay for Health Insurance*					
All Small Firms (3-199 Workers)	21%	24%	21%	34%	<1%
All Large Firms (200 or more Workers)	39%	34%	17%	10%	<1%
All Firms	21%	24%	21%	33%	<1%
Increase the Amount Employees Pay for Prescription Drugs					
All Small Firms (3-199 Workers)	11%	30%	30%	26%	2%
All Large Firms (200 or more Workers)	9%	29%	41%	20%	1%
All Firms	11%	30%	31%	26%	2%
Increase the Amount Employees Pay for Deductibles*					
All Small Firms (3-199 Workers)	12%	25%	27%	35%	1%
All Large Firms (200 or more Workers)	9%	29%	40%	20%	1%
All Firms	12%	25%	28%	34%	1%
Increase the Amount Employees Pay for Office Visit Copays or Coinsurance*					
All Small Firms (3-199 Workers)	13%	29%	27%	29%	2%
All Large Firms (200 or more Workers)	7%	29%	43%	20%	1%
All Firms	13%	29%	28%	28%	2%
Introduce Tiered Cost Sharing for Doctor Visits or Hospital Stays					
All Small Firms (3-199 Workers)	7%	16%	39%	35%	3%
All Large Firms (200 or more Workers)	3%	16%	41%	39%	1%
All Firms	7%	16%	39%	35%	3%
Restrict Employees' Eligibility for Coverage					
All Small Firms (3-199 Workers)	<1%	4%	29%	64%	3%
All Large Firms (200 or more Workers)	1%	6%	28%	64%	<1%
All Firms	<1%	4%	29%	64%	3%
Drop Coverage Entirely*					
All Small Firms (3-199 Workers)	1%	2%	16%	81%	<1%
All Large Firms (200 or more Workers)	<1%	1%	5%	93%	<1%
All Firms	1%	2%	15%	82%	<1%
Offer High Deductible Health Plan/Health Reimbursement Account (among firms not currently offering)					
All Small Firms (3-199 Workers)	3%	21%	30%	46%	<1%
All Large Firms (200 or more Workers)	4%	21%	30%	45%	1%
All Firms	3%	21%	30%	46%	<1%

*Distributions are statistically different between All Small Firms and All Large Firms within category (p<.05)

Among firms offering health benefits, distribution of firms reporting the likelihood of making the following changes in the next year, by firm size, 2007

Source: "Employer Health Benefits 2007 Annual Survey", (#7672) The Henry J. Kaiser Family Foundation and HRET, September 2007

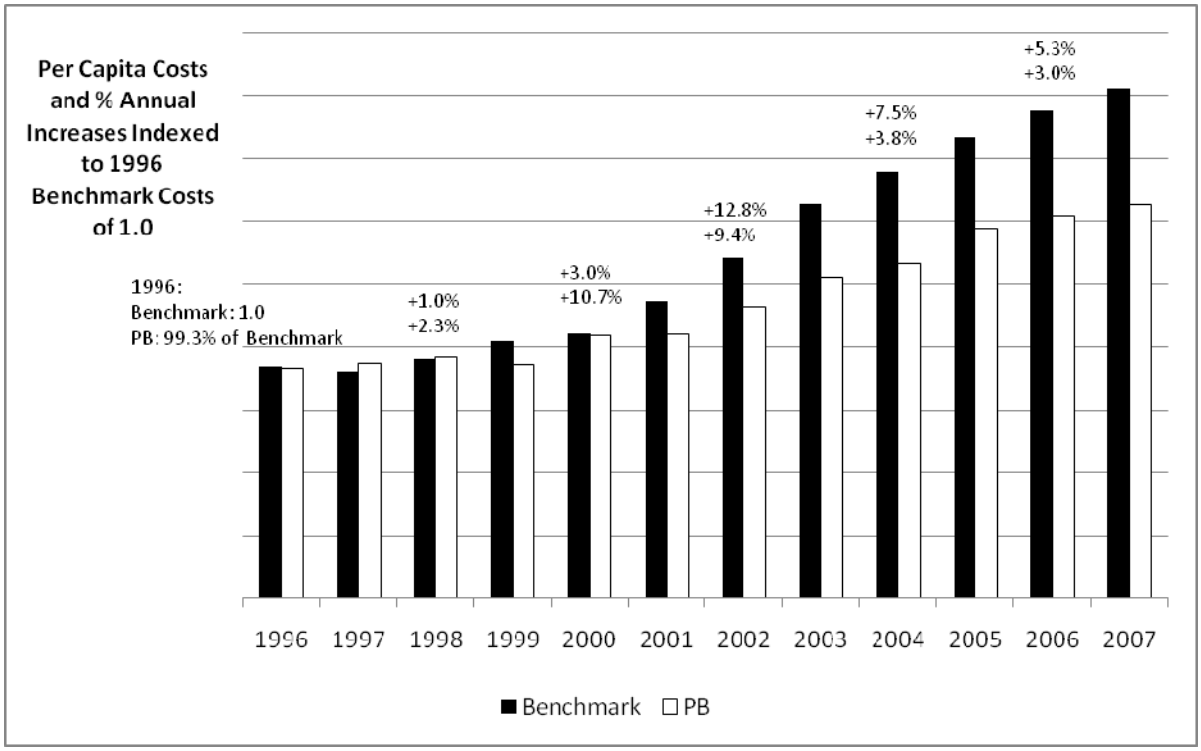
Exhibit 5 Large Employer Health and Wellness Offerings, 2007



From a survey of 466 employers with a mean of 12,500 employees.

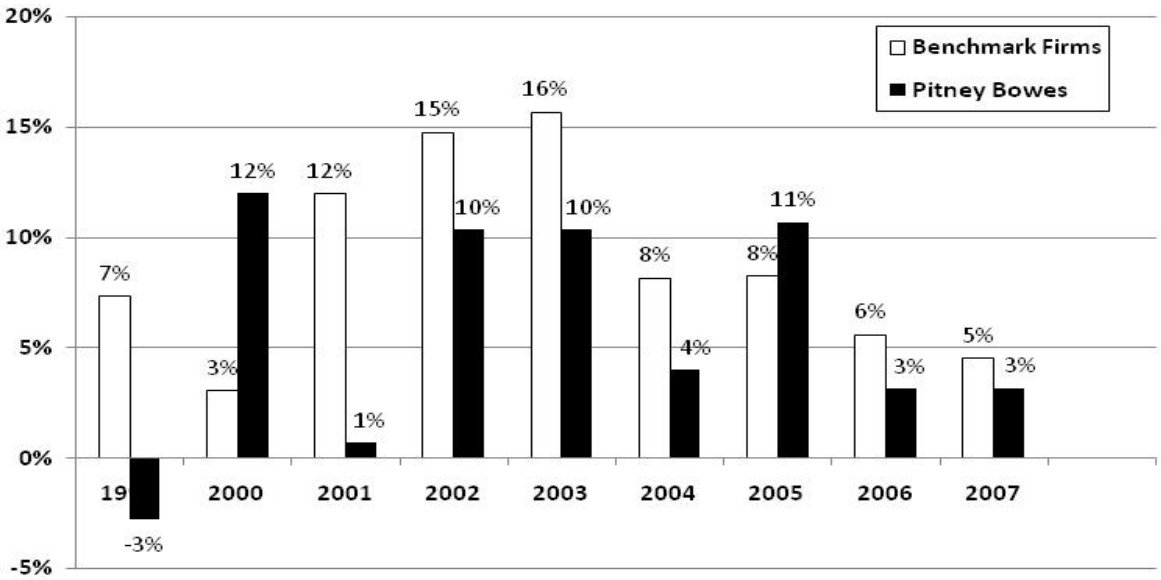
Source: Butcher, Lola, "Wellness Programs: No Longer Just an Add-On," Managed Care, February 2008.

Exhibit 6 Annual Per Employee Health Care Costs: Pitney Bowes vs. Benchmark



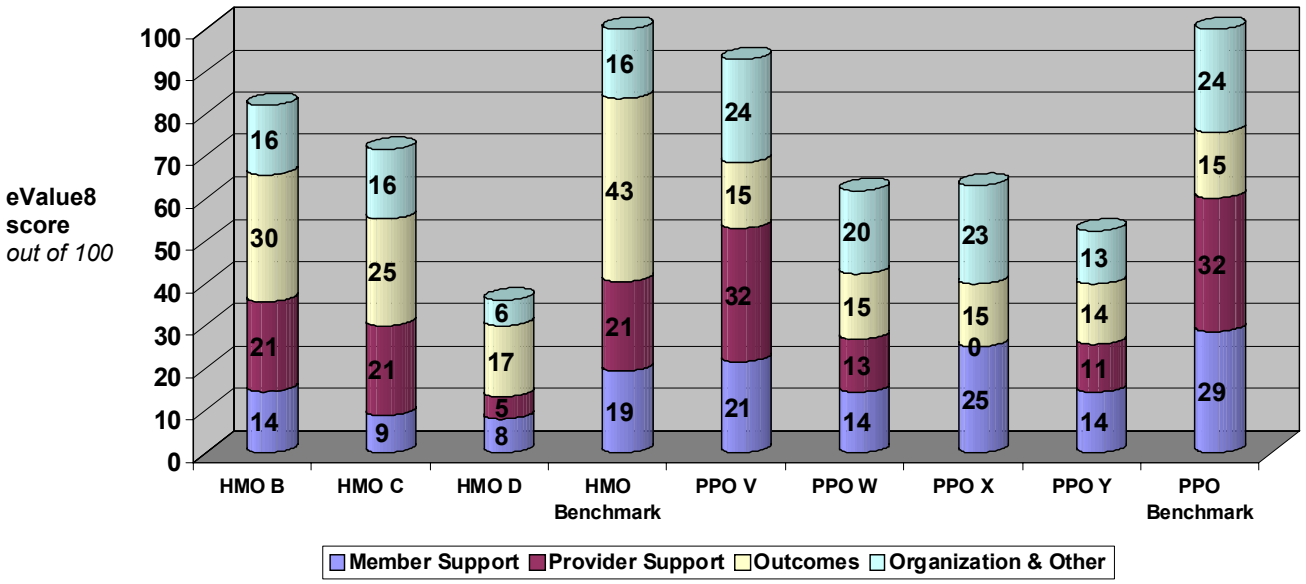
Source: Company documents.

Exhibit 7 Change in Employee Health Costs from Previous Year: Pitney Bowes vs. Benchmark



Source: Company documents.

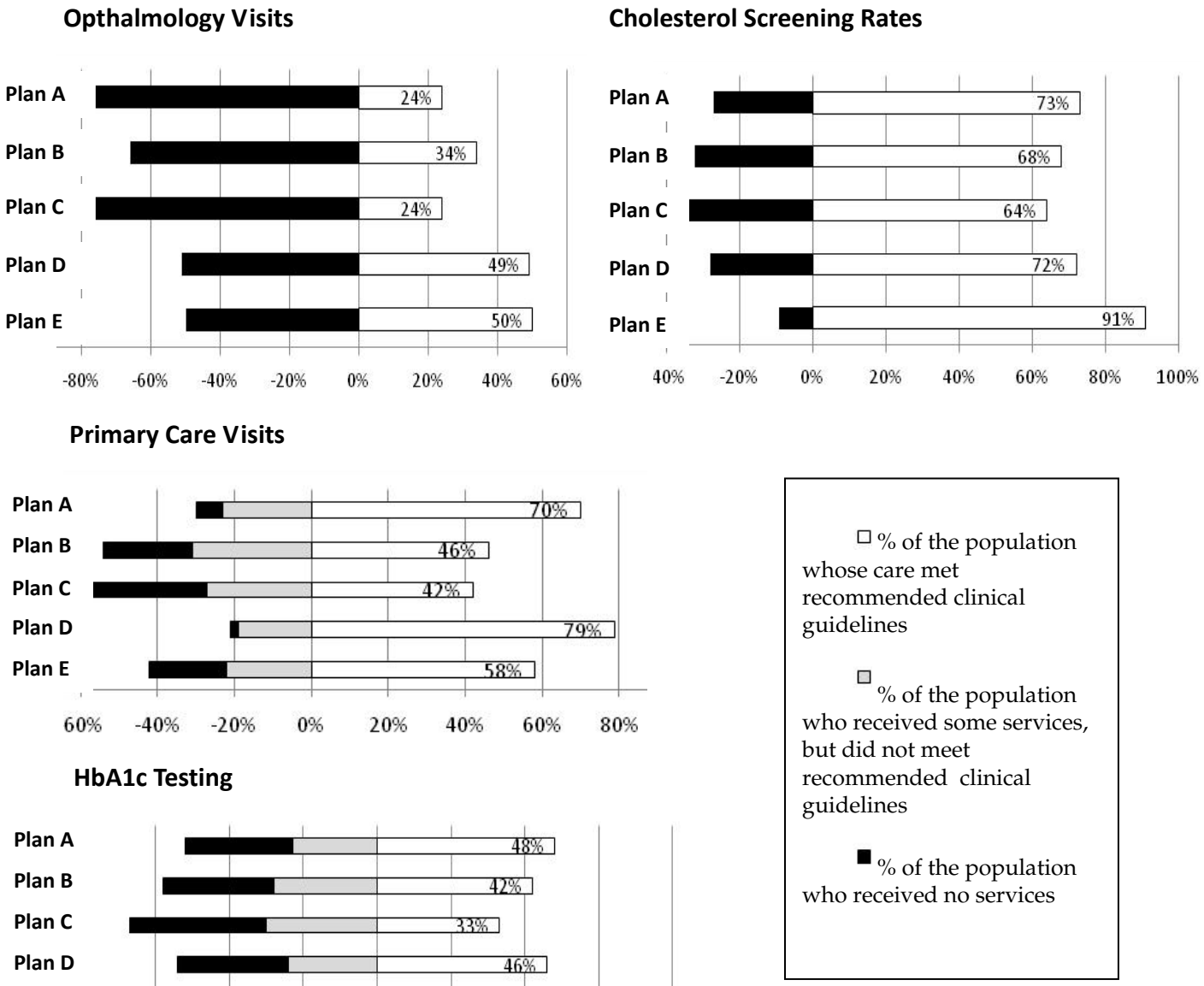
Exhibit 8 Sample eValue8 Health Plan Scoring: Chronic Disease Management, 2005



Benchmark refers to the plan with the highest eValue8 score, by plan type (e.g. HMO, PPO). All plans are eValue8 respondents.

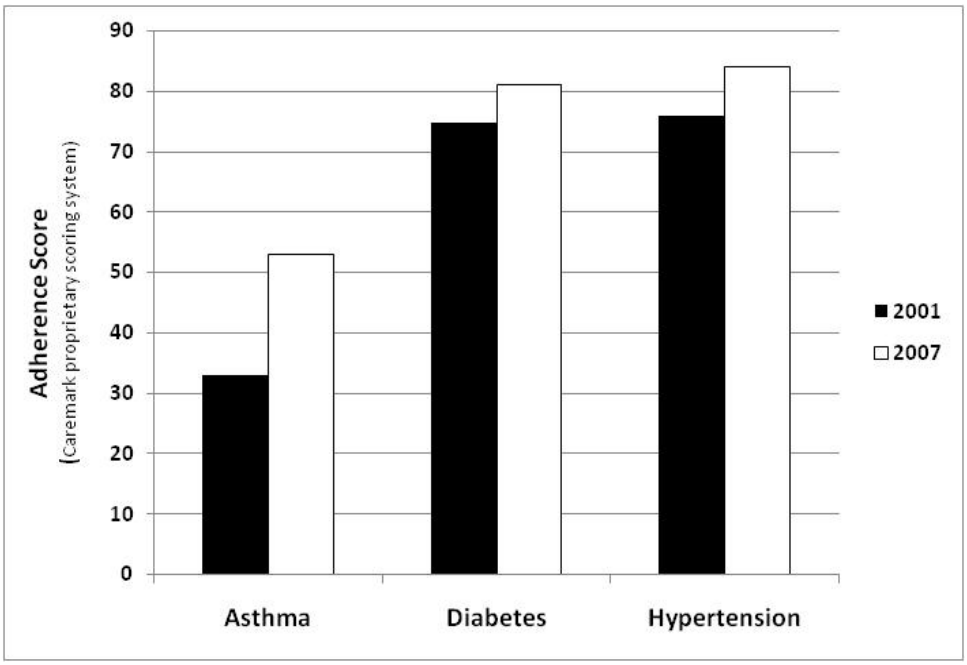
Source: Company documents, slides prepared by Mary Bradley of Pitney Bowes and Laurel Pickering of the New York Business Group on Health.

Exhibit 9 Pitney Bowes Employee Diabetes Care, by Health Plan



Source: Company documents, analysis from Thomson Reuters.

Exhibit 10 Change in Chronic Disease Medication Adherence for Pitney Bowes Employees



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