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CostRx: Investing in 'human assets'

WASHINGTON, May 11 (UPI) -- A few years ago postal-products giant Pitney Bowes revamped its health-benefits structure with a primary principle in mind: Pay more up front to keep chronic conditions like diabetes in check among the company's workforce, or pay much more later when an uncontrolled disease balloons into a costly drag on the company's bottom line -- both in terms of direct medical costs and the often greater indirect costs, including absenteeism, short-term disability and "presenteeism," where an employee with a chronic condition like asthma reports to work but cannot give 100 percent to the job.

That and other employee-healthcare maxims are the subject of a new book co-authored by Jack Mahoney, the company's corporate medical director and global healthcare management director, and David Hom, vice president in the strategic human-resources-initiatives department, entitled "Total Value, Total Return." The book crystallizes a plan for optimizing employee health benefits into seven rules, such as "The health of your organization begins with your people."

It details Pitney Bowes' bold strategies to maximize returns on its healthcare expenditures -- via a self-funded health plan -- such as offering low co-pays for all drugs (not just generics) that control a costly condition; throwing out health-plan mandates on generics and step therapy; collecting data on indirect health costs; and offering a reward-based employee-wellness program. In an interview with United Press International, Mahoney discussed the company's approach and its payoffs so far.

Q. Why did you decide to go public with the changes in employee health benefits at Pitney Bowes?

A. David and I had been working on this for a long time, and we've been totally transparent within the company about the changes, objectives and the philosophy behind them. And we've been asked by a number of (other companies) about what we were doing, and we felt there was really nothing that was all that proprietary. If you look at it in a broader perspective, we hope that others might be looking in this direction, too, in terms of purchasing or arranging for value in their (health) plans, instead of just looking at pricing.

Q. If a company wants to adopt these principles into its own benefits design for maximum value, how would you advise it to begin?

A. I would start with a rule that isn't one of the seven and that is, "Know thyself." Do an inventory of where you are. Get an assessment from senior management (and from) employee focus groups to find out what their (health plan) needs are. Then you can begin to apply the principles in terms of value.

I think one of the most important pieces in all of this is understanding that the employee actually influences the value chain of the company, and once you understand ... where that sits with senior management, then the rest flows from that.

Look at (your current) health plan and what it is doing to provide value to your employees, whether it's basic things like network access to the providers (or) what they are doing for quality improvements. The employer can join with one of the business coalitions -- there's a great tool, we use it ourselves, called the eValue8 tool - which a number of the regional business coalitions use to rate their health plans. Once you've started with the health plan, then you look at (employee) population and what you're doing to improve the health of your population.

Q. What is the best way for small and mid-size businesses to incorporate some of these valued-based principles?

A. I point them to the regional business coalitions, because there's strength in numbers. Even though you're a small employer, there are lots of other small employers that are probably interested in the same thing that you are; that is, value to your employees and effectiveness of the health plan.

So by banding together, you can make your needs known. A big employer can do a sophisticated employee-wellness program; a small employer may not be able to. But a small employer can do some very basic things, like a smoking-cessation program, and stress the value of nutrition and exercise. Wellness doesn't need to be a complicated thing; it can be a very straightforward process. (It can consist of) friendly reminders like, 'Did you wear your seatbelt today?' If you think about it, employee wellness is really knowing your needs (and stressing) exercise and nutrition and personal safety.

Q. In your own research, have you nailed down the top conditions that are simplest to control yet will cost the most down the line if not managed, and which yield the fastest results in terms of health-cost savings?

A. Diabetes, asthma, healthy maternity -- and a longer-range condition is hypertension. Most people, when they look at healthcare costs, they focus in on the 20 percent of the people that drive 80 percent of the costs -- these are your high-cost people. Well, most of those people got there over a period of time, and the resources you have to expend to manage that 20 percent are quite large. I'm not advocating that

you diminish that effort, but allocate some resources to keeping people healthy, because if you can keep people healthier, in the long run, you've delivered more value to the person and probably also saved yourself substantial amounts of money in the health plan.

Q. What data-mining approach did your company use to identify diabetes, asthma and hypertension as potentially the costliest?

A. We used predictive modeling; it was an artificial-intelligence model that we used. The premise was, if we looked at an entire population, what are the characteristics of people who this year would be normal cost but next year would be more than \$10,000 in total costs, direct and indirect. The only thing that came out were those three diseases, coupled with poor management of the condition and inadequate use of medication.

The secondary finding or predictor was: People who did not have their annual exams and routine screenings were at high risk in two to three years of being a high-cost claimant.

Q. Can you elaborate on the company's decision to offer all drugs that treat one of these costly conditions at the same low co-pay, rather than structuring the co-pays around whether the drug is brand or generic?

A. We chose not to get ourselves in the middle of the treatment process by just lowering the cost of some drugs that treat a condition, and not others. We felt that we had to lower the cost of everything, and then leave (treatment) up to the doctor/patient relationship.

Q. So are you saying that, if a company follows these guidelines, it won't have to raise worker co-pays and deductibles to save money?

A. No, I'm not saying that. We took a strategy of managing downward employee contributions to our pharmaceuticals to treat the conditions where we knew, if managed in the short term, we would keep them from developing into major cases. In our case, it was asthma, diabetes and hypertension. Since we've gone to this particular approach, if we look at our five-year experience, our cost-per-employee is roughly 10 to 15 percent lower than our benchmark (or the companies Pitney Bowes uses as comparators). This cost is the company cost plus the employee cost; we're not talking about cost-shifting.

So if you lower the total cost, that means that when you apply your cost-sharing formulas, both the employee and the employer pay less. People talk about managing

costs by shifting more costs to the employee. The real issue is: How do you manage the infrastructure? What's driving the total cost picture so you can pull down the costs for everybody?

The (employee) co-pays have actually been static all the way through this, and the deductibles have been static because we've had the same plan design. So the only way that the employee portion has gone up is on coinsurance; to the extent that the drug manufacturer raises cost, then (both employer and employee) share in that increase.

Q. How much has Pitney Bowes been able to reduce its health-benefits costs in those five years?

A. Our (health) costs have grown, but they have not grown at the same rate as our benchmark. Our annual rate of (health spending) growth over the past five years has been 7 percent, compared to the growth of our benchmark companies, which has been at least 12 percent.

Q. What is the biggest mistake companies make in managing their health benefits?

A. I think it's trying to manage every single line item so you're looking at your medical costs separate from your behavioral health, separate from your pharmacy (costs). We're not separated like that as people; one person has a constellation of things. So you've really got to look at the whole picture for the individual. I think the core message of the book is, you need to make investments to produce a good outcome. And that's an investment by the company -- in our case, it was subsidizing those medications -- and I think individuals need to make an investment, too; a commitment to improving their health.

Q. This emphasis on value in designing worker health benefits seems like common sense. How have companies missed this up until now?

A. People have been so fixated on how to manage each little line item downward that they haven't looked at the big picture. There's a much bigger picture in all of this, and that's our business competitiveness. We can talk all we want about, 'We've got the best technology, we've got the best systems, we've got the best services for our customers.' But if the (workers) aren't healthy and able to come to work, it's all for naught. While I think that everything in the book is focused on improving the health of the employee, we've also got to remember that by improving the employee's health, we should be able to improve our business performance.

Q. In the book, you refer to tracking so-called indirect worker health costs, like missed work days, to find which health conditions are most costly to the company. But isn't it difficult to track what conditions cause which worker absences?

A. I don't think you're going to be able to track it down to a diagnosis, (but) you can accumulate the data. Typically, a person who has a disability is also going to have some absentee days. In the pre-HR-automated days, you had breakdowns of sick days, personal days and holidays. Where we are now -- and we're in the same boat -- people have "time-off" days. (From the health plan), you can get health data aggregated on how many are employees and how many are dependents (for a given condition), and total utilization, hospitalization and emergency-room use.

Part II: CostRx: Healthy workers, healthy revenue

WASHINGTON, May 12 (UPI) -- Postal-products maker Pitney Bowes recently overhauled its employee healthcare program using two key strategies: encouraging workers to manage the chronic health conditions that will prove the costliest to the company if left unchecked, for example by offering workers low co-pays for all drugs -- brand and generic -- that treat disorders like asthma and diabetes; and keeping healthy workers healthy by giving the employees themselves a major role in that mission.

Jack Mahoney, the company's corporate medical director and global healthcare management director, has co-authored a book on Pitney Bowes' benefits restructuring entitled "Total Value, Total Return."

In Part 2 of an interview with United Press International Mahoney discusses Pitney Bowes' approach to maximizing returns on employee health benefits, based on the notion that "healthy people are key to a healthy organization."

Q. How has Pitney Bowes designed its own employee-wellness program?

A. It's built on a system where people can actually accrue credits for maintaining or improving their healthcare status in a given year. Those credits translate by a formula to additional (funds) to purchase their healthcare for a subsequent year. Literally, there's a built-in incentive for the individual, and to the extent that there's savings, we're sharing that back with the employee.

Q. What results are you seeing from the on-site clinics that Pitney Bowes recently launched?

A. We have seven clinics functioning right now. Last year they had 35,000 patient encounters. We know that we can cut the cost of care by about 30 percent, but the most important thing, where the clinics produce the biggest savings, is with absenteeism.

The patient can be seen on-site, and most of the time the problem can be resolved very quickly, and they can return to work. In the times when it can't be resolved, they can be referred right away to a specialist. So the biggest savings from the clinics, I would say, are from the decrease in absenteeism, and secondarily by lower costs in delivering care.

The clinics represent about 1.5 percent of our total healthcare costs. (At Pitney Bowes' Stamford, Conn., headquarters, the medical personnel) are all our own employees, and in the locations that are our call centers, we have subcontracted to local medical groups. The rationale is, that if somebody (gets care) there, we want there to be continuity of care if they're referred out. We don't want issues of somebody being referred out of network or having to repeat lab tests because they're jumping between providers.

Q. You say in your book that as pay-for-performance and the practice of using plan design to drive patients to low-cost, quality providers becomes more popular, physician and hospital networks will become obsolete. Can you explain?

A. A lot of networks (like that of HMOs, PPOs) and many of the big health plans spend a huge amount of their time on retro-analysis of claims, and retro-analysis of activity and I think once the system begins to focus on delivering quality, it's going to drive us in a very different direction.

I think the networks will still be there, but they'll be built on rewarding quality providers. The kind of network that would go away would be one that just pays claims.

Q. What health plans are ahead of the curve in using this valued-based, quality-driven design?

A. A good example is PacifiCare in California. They've got a value network of medical groups, and the people who go there see a lower co-pay than if they go elsewhere. We're seeing the same phenomenon in a number of health plans, United

Health is doing something similar, Aetna is doing something similar with their Excel networks, so it's a growing movement.

Q. You say in your book that offering health savings accounts alone is not the best way to empower your employees. What is the experience with HSAs at Pitney Bowes?

A. We've got about 1-percent enrollment. I think the issue is to look at the design of the HSA plan. We offer the preventative services free or at very low co-pays before the deductible. For the pharmacy component, we offer all of the preventative drugs, plus things for asthma and hypertension and diabetes at low coinsurance before the deductible.

So we think there's a way to design the plan, so that it still preserves our values, if you will, but we don't look at it as a silver bullet. We certainly aren't going to offer it as a replacement for all of our other plans. I think we'll have more (HSA) uptake, but I'm certainly not (anticipating) a steep curve.

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