

LAFARGE NORTH AMERICA

BUSINESS DESCRIPTION:

Lafarge North America, part of the France-based, global building conglomerate Lafarge Group, is the largest diversified supplier of construction materials in the United States and Canada. Headquartered outside of Washington, DC, Lafarge employs approximately 13,000 people who work at more than 900 Lafarge locations across the United States and Canada. Lafarge employees produce and sell cement, ready-mixed concrete, gypsum wallboard, aggregates, asphalt, and related products and services. These products are used in communities across North America to build homes, apartments, offices, schools, hospitals, banks, museums, roads, highways and bridges, as well as parks and swimming pools.¹ Lafarge North America accounts for about 20% of Lafarge Group's sales.²

INITIATION OF VALUE-BASED APPROACH:

In 2004, Lafarge put its medical, disability, and absence management programs out to bid because these programs were not well managed. There was an abundance of high cost claimants and members with chronic conditions that caused the medical cost trend to average a 13% increase annually from 2001 to 2006. Additionally, the company saw a \$5.8 million increase in catastrophic claims in 2006 and a 200% increase in the long-term disability rate. With this backdrop, Lafarge decided to develop an integrated health and productivity program in 2007 called "Building A Better You." Through financial incentives, free preventive screenings and a focus on total health management, prevention, and safety, the company aimed to reduce its annual medical cost trend to below the market average.

PROGRAM OBJECTIVES:

The Building A Better You program has the following four objectives:

1. To control health care costs without unnecessarily shifting costs to employees (ie, to reduce the trend to a level below the market average).
2. To improve/maintain the health of all plan participants (ie, to reduce the number of days missed due to disability and to ensure compliance to prescription regime for members with chronic conditions).
3. To create a culture of health.
4. To impact bottom-line company financial performance.

PROGRAM COMPONENTS:

All clinical resources and benefits are integrated through a dedicated team of Lafarge employees and vendors.

- Aetna provides disability management, disease management and group health coverage.
- Pharmacy benefits are provided through Express Scripts. Pharmacy data is integrated with Aetna's data through a Thomson Reuters database where disability and medical claims are reviewed for follow-up identification.
- Mercer performs the claims analysis of the short-term disability cases by condition and duration, and provides Lafarge with weekly or daily reports. Thus, Lafarge and its data partners use data rigorously to measure outcomes and monitor success.

As part of this program, Lafarge offers on-site screenings to help identify and increase awareness of health conditions. All preventive care is free. The company also uses an incentivized design to increase prescription drug compliance for certain chronic diseases

along with incentives to reward healthy actions. There is a three-tiered plan design for copayments; medicines and services listed on the first tier require a \$5 copay, second tier require a \$20 or \$30 copay, and third tier require a \$40 copay. For targeted groups identified by the Mercer claims analysis, the copay for all generics used to treat diabetes, asthma and hypertension has been dropped from \$20 to \$5, and individuals with those conditions are enrolled in disease management programs. Additionally, Lafarge offers 30 different disease management programs that are open to employees and their spouses.

A cornerstone of the program is the use of communication and education to impact employee health behaviors. Recognizing that most Lafarge employees do not have access to computers at work or at home, and that the spouse is often the benefits decision-maker/influencer, the company relies heavily on materials mailed to employees' homes. In fact, every piece of educational material is mailed to every employee, including an eight-page quarterly newsletter, and there are targeted mailings such as birthday postcards reminding employees to obtain annual health screenings. The company also has developed other educational materials that are available in the workplace, such as health care posters.

All Lafarge union employees in the US have waived their rights to bargain over health care benefits and are afforded the same plans and financial incentives for which salaried employees are eligible. This approach relies heavily on support from the operating plants/quarries, including operations managers, supervisors, and plant personnel, who are encouraged to motivate and educate employees about Lafarge's health care programs and initiatives.

PROGRAM RESULTS:

The Building A Better You program has saved Lafarge more than \$30 million in medical and pharmacy costs over three years, roughly \$10 million each year. The program doubled the percentage of patients complying with their pharmaceutical treatments. It also decreased the number of emergency room visits and inpatient visits and days. Having healthier, more compliant chronic disease members and more employees at work due to lower disability incidence has positively impacted Lafarge's bottom line.

Specific results include:

1. The actual trend in combined medical and pharmacy spending was reduced to 4.7% by 2006, from a high of 13% in 2001.
2. For high users of health care services with an average annual claim amount over \$50,000.
 - The most recent year was at the lowest level in the past five years.
 - The average claim has decreased annually since 2006.
 - The number of high utilization claimants using case management increased by 32% from 2006 to 2007.
3. Improved drug (Rx) compliance and other factors contributed to reduced resource utilization:
 - The medical cost per diabetic was reduced by 25%, driven by a reduction in emergency room (ER) visits per 1,000 every year since 2006, and a 28% decrease in hospital admissions per 1,000 from 2007 to 2008.
 - The medical cost per asthmatic was reduced by 36%, driven by a 37% reduction in ER visits per 1,000 since 2006.
 - ER visits for congestive heart failure were down 14%, and coronary artery disease admissions per 1,000 were down 10% from 2007 to 2008.

CASE STUDIES

4. Disease management participation increased, comparing June 2009 to December 2006:
 - 7,102 members were participating in disease management in 2009, as compared to 2,738 in 2006 (a 159% increase).
 - 565 members were participating at the nurse engagement level in 2009, as compared to 157 in 2006 (a 260% increase).
5. Year-over-year increase for all wellness exams and screenings metrics:
 - There were 2,116 on-site wellness screenings in 2009, through October.
 - The cholesterol screening rate was 32% higher than the benchmark.
 - Preventive exams were up 17%, year-over-year.
 - Prostate-specific antigen (PSA) screenings were up 9%.
6. Tobacco cessation utilization exceeded goals (January to October 2009):
 - Twenty percent were enrolled, as compared to a goal of 10%, and the vendor book of business (BOB) benchmark of 10%.
 - There was a quit rate of 44%, as compared to a goal of 30%, and the BOB benchmark of 48%. (There was no financial incentive for this program.)
7. Weight management utilization (January to October 2009): 462 were enrolled (3.9% utilization). (There was no financial incentive for this program.)
8. The health risk assessment (HRA) completion rate was 86% for 2009, through October, compared to 29% in 2006.
9. Short-term disability durations decreased by 9% from 2007 to 2008, due to a 20% decrease in durations for integrated health and disability (IHD) managed claims.
10. Long-term disability claims per 1,000 prior to moving to the IHD model were 6.6 per 1,000, compared to 4.8 per 1,000 in 2008.

PROGRAM CHALLENGES:

Although much progress has been made to date, it remains difficult to integrate the incentives for participation in the disease management program with the drug copay incentives for diabetes, asthma and hypertension, because of the limited data integration between the disease management dataset and the pharmacy utilization dataset. This is causing significant administrative problems for Lafarge's program vendors.

Eventually human resource absence records will also be added to the integrated database as important outcomes. Different business units will have different responses to absence. For example, at a manufacturing plant (cement) it might be easier to fill in when there is an absence without much effect on the business, but for ready-mix concrete with "just in time" delivery, an absence can shut down parts of the delivery service. Additionally, the ready-mix section has employees who are morbidly obese, employees with multiple chronic conditions, including low back pain and dislocated shoulders which can be exacerbated by the nature of the truck driving and the lifting work they do. Developing business-relevant measures for the different lines of products and services remains a key goal.