Summer 2023

Improving Obesity Management

Valuable Insights and Case Studies from Leading Purchasers

Authors: Emma Hoo, Rachel Brodie

Purchaser Business Group on Health

Contents

3 Introduction

5 Understanding Patient Experience

6 Benefit Design and Coverage Rules

7 **Case Study 1**
Improving Data, Vendor Collaboration and Benefit Strategy

9 **Case Study 2**
Designing an Integrated Well-being and Weight Management Program

11 **Case Study 3**
Building an Ecosystem for Success

13 Understanding the Evidence

14 Conclusion and Key Takeaways

15 Endnotes

Introduction

Obesity contributes to a wide range of chronic diseases and extensive direct and indirect health-care costs. The United States spends $147 billion annually on obesity-related health care.[1] Employers experience additional indirect costs in terms of lost work time, lower productivity and premature death. Research suggests that workplace presenteeism in some industries may be the single largest cost driver of obesity, regardless of body mass index (BMI).[2] Obesity increases the risk of many adverse health conditions, including cardiovascular disease, type 2 diabetes, multiple types of cancers, Covid-19 and impaired quality of life.

The Centers for Disease Control and Prevention reports that the prevalence of obesity is 41.9%,[3] affecting approximately 90 million U.S. adults. The national obesity rate has increased by 26% since 2008[4] and another 3% during the Covid-19 pandemic.[5] Black adults have the highest level of adult obesity nationally at 49.9%, and that rate is driven in large part by an adult obesity rate among Black women of 57.9%.[6] Obesity is also a significant risk factor for increasing the severity of Covid-19 and mortality rates. Moreover, obesity is disproportionately present in socioeconomically disadvantaged persons, which has important implications for strategies to improve health equity and clinical quality outcomes.[7] Obesity prevalence is lower among adults with family income of more than 350% of Federal Poverty Level (FPL) at 39.0% compared with those with family income more than 130% through 350% FPL, which occurs at 46.5%.[8]

Given the significant impact of obesity on health, medical spending, and lost productivity, many employers have made achieving healthy weight and addressing obesity a top priority for their well-being initiatives and benefit strategies. Many employers recognize the importance of providing counseling on diet and activity, while offering financial and other incentives to employees and their families to lose weight.

Beyond behavior change, ten years have elapsed since the American Medical Association (AMA) recognized obesity as a complex, chronic disease that can benefit from medical intervention. Even as evidence has emerged on a broader set of physiologic and in some cases, genetic factors, there is still significant stigma associated with a diagnosis of obesity. Many providers and employers increasingly acknowledge the important influence of environmental factors and social determinants of health. This has led to more expansive strategies that recognize obesity is not solely determined by personal choices in diet and activity.

Employers have made achieving healthy weight and addressing obesity a top priority for their well-being initiatives and benefit strategies.

The emergence of drugs previously approved by the U.S. Federal Drug Administration for diabetes management and blood sugar control, and now with expanded indications for weight management is a game changer. However, coverage of prescription weight loss drugs as part of the pharmacy benefit remains mixed. A 2016 employer survey found that while many employers offered behavior-focused weight loss programs (healthy eating, physical activity, stress management, etc.) and a bariatric surgery benefit, only one-third of employers covered prescription weight loss drugs.[9,10] A more recent survey that included smaller and mid-sized employer groups reported antiobesity medication (AOM) coverage at 22% compared to 45% covering bariatric surgery.[11] A survey among large self-funded employers reported 46% providing AOM coverage.[12]

Moreover, measuring the effective management of obesity in primary care settings lags other chronic conditions. Bariatric surgery outcomes have been researched extensively, but evaluating medical management of obesity care is often limited to capturing body mass index (BMI) and documenting a follow-up plan. However, a pragmatic randomized control trial at the Cleveland Clinic demonstrated that use of AOMs in conjunction with an employer-based weight management program yielded clinical benefits.[13] More research is needed to assess impact on work productivity and limitations. Implementing patient-reported outcomes measures and shared decision making could also help advance a patient-centered approach for obesity treatment.

What follows is a set of employer case studies based on a series of interviews and presentations by large public and private health care purchasers, including members of the Purchaser Business Group on Health and other prominent employers. Participants were selected to represent a range of manufacturing and service industries, diverse populations and varied geographies. These examples are designed to:

1. Provide a broad perspective on strategies that contribute to enhanced approaches to obesity care,
2. Inform benefit design and coverage policies,
3. Support the design of more effective worksite services and programs.

Understanding Patient Experience

Central to understanding the impact of benefit design and coverage rules for obesity care is acknowledging patient experience with accessing resources and help to manage obesity. Recognizing the range of emotions and experience of individuals is an important first step to addressing the navigational issues faced by patients. In the table below, patient advocate Ana Zebrick speaks to the need for not only changing perceptions about patients with obesity, but to encourage patients to view their condition differently.

Patients may have varied psychosocial issues or environmental barriers to treatment in the face of the stigma that accompanies obesity. Screening for mental health issues such as depression or anxiety is just one facet of whole-person health; additional tools include an assessment of social drivers of health, which may include isolation and loneliness, financial stress address some of these factors in turn may or may not be routinely covered.

Changing the Narrative about Obesity

Self-Talk Without Understanding *What Obesity Is*	**Self-Talk With the Knowledge and Understanding of *What Obesity Is***
I am obese.	I am a person who is affected by obesity.
It is my fault. I did this to myself.	Obesity is a complex disease with genetic, environmental, and behavioral causes.
My weight is solely my responsibility.	Obesity is a chronic disease with biological processes that make it resistant to treatment and that *contribute to relapse*.
Weight loss or gain is determined by choices and willpower. If I fail to make enough changes and control my weight, it is my personal failure.	My weight matters for my health, and I need help from healthcare professionals who understand the disease of obesity in order to treat it and help me manage my weight.
I know how to lose weight. I have done it before. This time I didn't do the right things, and I didn't do enough. I knew better, and I should feel ashamed.	Obesity is complex, everybody's body is different, and every person is complicated. Managing weight is not simple, and it's difficult. The more information, support, and "tools in the toolbox" I have, the better.

Presentation by Ava J. Zebrick, MSHCM, Patient Experience Supervisor, Ochsner Health Managing Obesity Risk: The Weight Epidemic Can't Wait, May 31, 2022

Benefit Design and Coverage Rules

Ava Zebrick, a patient advocate and individual who has experienced firsthand the challenges associated with getting obesity care, encourages employers to consider a more expansive benefit policy. She noted that even though she had benefits available to her, the available services did not necessarily align with her specific needs at any given moment in time. It is not uncommon, for example, to be limited in accessing a dietician with a standalone obesity diagnosis versus a diagnosis of diabetes, with only the latter automatically triggering a referral recommendation.

Zebrick's other benefit design recommendations include:

- Intensive behavioral therapy with professionals who are trained and understand obesity as a disease
- Covered visits with Board Certified Obesity Medicine Specialists (MDs)
- Coverage for FDA approved anti-obesity pharmacotherapy
- Affordable and comprehensive metabolic surgery program per guidelines of the AMA, American Board of Obesity Medicine (ABOM), and American Society for Metabolic and Bariatric Surgery (ASMBS)

Zebrick also advocates for employers providing education about weight bias in the workplace and to incorporate specialist led support groups and peer led support groups in corporate well-being and wellness programs.

Employee engagement in designing well-being programs may also be important for increasing their efficacy. In some cases, wellness programs may be oriented towards prevention instead of whole-person health. The Awareness, Care and Treatment in Obesity Management (ACTION) study found that while 72% of employers perceived wellness programs as beneficial, only 17% of employees felt the same way. Additionally, this study identified a disconnect between employers' knowledge of covered benefits for obesity treatment compared to employee awareness.[14]

Case Study 1

Improving Data, Vendor Collaboration and Benefit Strategy

Organizational Profile

Industry:
Public entity, state employees

Geography:
Southeast

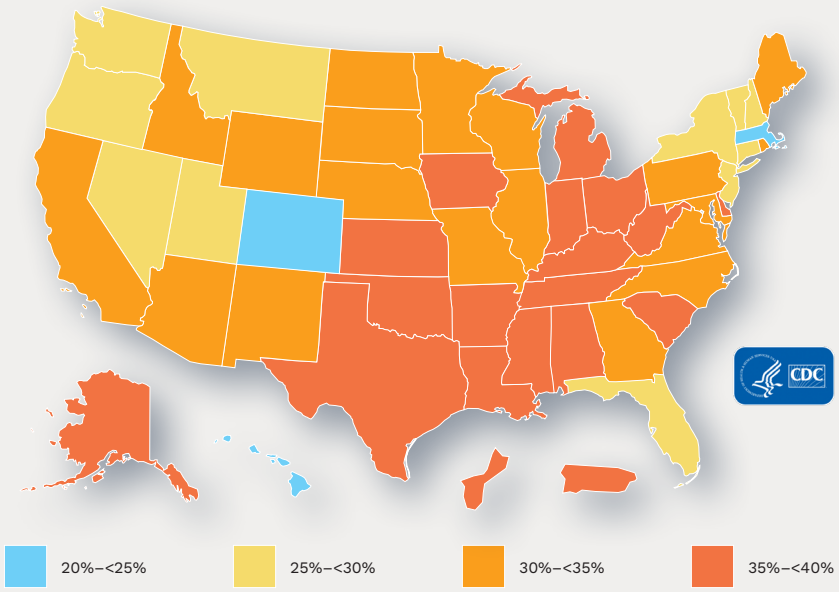
Size:
300,000 employees and retirees

Key Takeaways

- Know your data
- Collaborate with vendors
- Align benefit design
- Communicate employee benefits widely

One of the key challenges for this public purchaser was reconciling public data from the CDC with actual claims. In reviewing the CDC's obesity maps, the Southeastern U.S. clearly has high rates of obesity that exceed the national average.[15] Yet in reviewing their claims data, only 10% of the population was identified to have obesity. If anything, considering their race and ethnicity mix, their obesity rates should have been higher than geographic averages. In contrast, other chronic disease prevalence rates (e.g., diabetes, hypertension, cardiac, musculoskeletal) were similar to normative data. A holistic approach to data also entailed looking at workers compensation and short-term disability claims. Clearly, a longer-term strategy was needed to engage plans and providers in more comprehensive documentation of obesity diagnoses, while also addressing the stigma that providers might have associated with using these codes.

Prevalence* of Self-Reported Obesity Among U.S. Adults by State and Territory, BRFSS, 2020



* Prevalence estimates reflect BRFSS methodological changes started in 2011. These estimates should not be compared to prevalence estimates before 2011.

One approach to improving data included bringing health plan, pharmacy benefit manager, wellness and other vendors together. If obesity had been documented through a diabetes management program, that information needed to be captured more systematically. Employers may also have other point solutions, wellness programs and onsite clinics that generate separate sets of data.

Case Study 1

Improving Data, Vendor Collaboration and Benefit Strategy

Continued

Collectively, these data needed to be mined both for quality and cost information, including avoidable duplication of services as well as gaps in care that contributed to greater acuity in services such as emergency room visits for primary care. Specific co-morbidities were targeted along with consideration of how absenteeism, presenteeism and productivity, and workers compensation and short-term disability could be brought together. Evaluating employee engagement was also a priority. Bringing vendors together also facilitated discussions about improving health equity.

Engaging suppliers also entailed conducting a thorough review of benefits. Each supplier needed to be aware of the full scope of benefits, not only to identify appropriate referral opportunities, but also to explore potential gaps or barriers in the form of prior authorizations, or where the benefits could be more comprehensive. Considerations included how dieticians were accessed as well as behavioral health. Benefits were assessed for how lifestyle modifications were supported, access to anti-obesity medications and bariatric surgery. Anti-obesity medications were considered with respect to when they were made available and how people with qualifying diagnoses or co-morbidities were identified.

Once the full array of benefits was documented, communications were developed to educate employees and their families to increase awareness of the resources for obesity care that were available. An emphasis was placed on comprehensive care and a holistic approach that includes lifestyle modification to promote activity and consumption of healthier foods. These communications also served to reduce stigma. Efforts were also undertaken to educate providers; this is especially important for any employers with on-site clinics.

Case Study 2

Designing an Integrated Well-being and Weight Management Program

Organizational Profile

Industry:
Property & Casualty Insurance

Geography:
Primarily California + some Southwest and South

Size:
3,500 employees

Key Takeaways

- Align well-being and weight management programs
- Leverage corporate belonging and inclusion strategy
- Support employees in healthy eating and addressing food insecurity

This regional insurance group leverages its inclusion and belonging and volunteerism programs to promote a strong culture of health and overall employee engagement. The organization was an early adopter of a health plan-based weight management program, which they integrated with their overall well-being initiatives. Four pillars of well-being anchor their programs: mental, financial, social, and physical.

Over the years, the company has piloted programs such as Weight Watchers®, Real Appeal®, Livongo and a bariatric centers of excellence program. Employees can also access 24/7 online support, virtual group coaching and a mobile app to track progress on weight loss. While the weight loss programs have been offered through the health benefit plans, they have been promoted in conjunction with onsite events. Promoting a diabetes risk reduction program as a weight loss initiative also garnered wider engagement.

Working with its carrier, this employer has focused on preventive care and encouraged associates to select primary care physicians. An important lesson learned was that integration through the medical carrier facilitated administration and reporting through claims experience, compared to attendance tracking and incentive management by wellness coordinators. Provider engagement was also important as the programs could be marketed directly to medical plan participants and sometimes even targeted to overweight and obese populations through claims identification.

In addition to a dedicated online coach and availability of group sessions to help address psychosocial elements, the program offered a "success kit" which was also popular among employees. Onsite biometric screenings at health fairs and lobby events at their corporate headquarters also promoted engagement. Customized promotional materials included recipe cards with program information, take-home materials, and education on topic-specific informational campaigns. These communications also helped disseminate success stories, which highlighted the interplay of all four pillars. Posting stories and pictures on the company's intranet, sending information in a monthly email newsletter and packaging for well-being champions also help promote all the programs to colleagues.

The outcomes for those at risk (553 members) included a reported weight loss totaling 5,290 pounds. The average weight loss was 3.4%, which was in line with the carrier's book of business results. Also of note, 32% attended four or more sessions and had 5% or greater weight loss. Keeping the well-being program fresh is also a challenge and a new well-being vendor was selected last year.

Case Study 2

Designing an Integrated Well-being and Weight Management Program

Continued

To assist patients with diabetes with medication adherence, select medications were designated as Tier 1 in their formulary design and available at no cost to employees and their dependents. With respect to the broader array of anti-obesity medications, the company continues to work with their carrier to evaluate cost, potential utilization and access for their employees.

Weight loss programs address the physical pillar by promoting regular movement and healthy eating. With a large number of employees working in one call center, the company introduced well-being breaks and encouraged use of virtual fitness options to help staff incorporate movement throughout the day.

As part of its community impact initiatives, the company also works closely with food banks and other organizations that have a focus on food insecurity. In 2021, the company hosted a steps challenge through the well-being program where teams competed to make donations to local food banks. Volunteer opportunities resulted in a donation of over $30,000 to six local food banks, that included $7,000 in employee donations as part of a two-for-one match. With 14% employee engagement and participants logging almost 10,000 workouts, staff testimonials and shared success stories helped reinforce a strong culture of caring. The company also launched a food pantry for employees to address challenges during the Covid-19 pandemic.

Future frontiers include an expanded focus on health equity and how the social determinants of health can affect an individual's ability to engage in healthy habits.

Case Study 3

Building an Ecosystem for Success

Organizational Profile

Industry:
Manufacturing

Geography:
Northwest, Midwest and Southern California

Size:
140,000 employees and retirees

Key Takeaways

- Align well-being and health management
- Build culture of health and safety

As a manufacturer, having the right tools in the toolbox is an important starting point for addressing a multi-factorial condition like obesity. Addressing obesity as a co-morbid condition has important implications not only for health and quality of life, but also workplace safety. Anti-obesity medications that activate the GLP-1 receptor, which includes semaglutide, to manage glucose levels are the newest tools available. In light of the complexity of obesity and the role of psychosocial drivers, treatment approaches should complemented by a larger health and well-being strategy.

Whether services are delivered in-person or virtually, people-centric solutions are a necessity to meet individuals where they are in their health and weight loss journey. Addressing stigma has been critical to supporting the emotional and well-being needs of employees and their dependents, but physical preventive lifestyle health coaching matters as does mental behavior health coaching. Furthermore, our understanding of social drivers continues to evolve.

A focus on obesity has a multiplier effect in addressing chronic health conditions and mental health needs. A holistic approach is not only essential for the benefit of that individual employee or patient in the near-term, but also long term to achieve sustainable outcomes. There is a lot employers can do to address stigma and to help change the view that obesity is just a lifestyle condition by creating a broader focus on the continuum of care and integration among different specialties and support areas.

As a company that prioritizes a culture of health and safety, treating obesity requires an ecosystem that allows for multiple care interventions at different levels and different modalities. Understanding how employees and their dependents experience barriers is critical, as is meeting people where they are. Not everyone will take advantage of an onsite fitness centers. A co-worker's testimonial can go a long way toward engagement, but a supportive environment is needed to sustain that engagement. There can be diverse needs for the employee and spouse; adult dependent children or adolescent children.

It is important to create an environment where people can be successful. The medical plan address obesity and weight management so nutritional counseling through a registered dietician is covered and there is no requirement to meet a BMI minimum. Bariatric surgery is also covered when medically necessary in a national centers of excellence program, through which there is coverage for travel and reduced cost-sharing for employees.

Case Study 3

Building an Ecosystem for Success

Continued

Anti-obesity medications are covered, and it is important not to think of them as lifestyle medications, but part of overall chronic care management. Access to mental health services is equally important. Having specialists trained in obesity management as part of the network is also part of a comprehensive approach, but that also entails testing for appointment access and employee communications to increase awareness that such services are available.

Some employees may prefer self-monitoring and participation in consumer-facing voluntary programs. The organization has also partnered with best-in-class hospital weight loss programs and brought them on site to meet the preferences of employees who like the camaraderie of a group. Onsite health coaches have also provided one-on-one support. Much as employee feedback is incorporated to improve worksite safety, capturing input on well-being and weight management programs helps the organization to be seen as a trusted partner in designing these programs.

Finally, addressing anxiety, depression and other mental health needs is important in the construct of weight loss. Resilience training and other aspects of mental health support are just part of creating a supportive ecosystem.

Metrics and the ability to report outcomes can vary by partner, but it is also important to have the flexibility to iterate and refine services based on experience. For example, the first weight management was launched in 2015 as a pre-diabetes program, and it has now integrated diabetes management and other risk factors like hypertension. Most recently, the participants were reporting approximately 3.5% weight loss, and 70% of participants had sustained the weight loss a year later.

Understanding the Evidence

Across the varied employer interviews, there was a broad understanding of obesity as a co-morbidity. There is opportunity to highlight the impact of cost-avoidance from reduced risk and co-morbidities. A cohort study conducted at the Mayo Clinic documented total body weight loss percentages at 5.9% at three months and 10.9% at six months; a subset of patients with diabetes documented weight loss at 3.9% and 7.2%, respectively.[16] Because many large employers are reliant on their own data warehouses or carriers for reporting of key indicators and cost drivers, the cost of services related to obesity are often understated due to the low incidence in using the obesity diagnosis codes. The example below from a recent webinar highlights some of the clinical improvements in a number of conditions that employers state are high priority in their commercial populations.[17]

Such education and training should also extend to providers, who may avoid using the diagnosis code because patients may find the classification stigmatizing and be less responsive than a recommendation to "just lose a few pounds."

Weight Loss of 2% to >15% Yields Clinical Improvements in Many Comorbidities Associated With Obesity

2.5%	2% – 5%	2.5% – >15%	5% – 10%	5% – >15%
helps prevent progression to diabetes; maximal impact at 10%	improves ovulatory cycles and subsequent pregnancy, greater weight loss associated with greater improvement	greater weight loss associated with greater improvement; true for all BMI classes	improves knee functionality, speed, walk distance, and pain	greater weight loss associated with greater improvement
Glycemic improvement–diabetes prevention in impaired glucose tolerance	Polycystic ovarian syndrome and infertility	Glycemic improvement—type 2 diabetes[1]	Knee pain and function in OA	HDL cholesterol increase[2]
		Triglyceride reduction	may also reduce risk for emergent depression; individuals with depression lose as much weight as nondepressed individuals	Hepatic steatosis reduction
			Depression	Impact of weight on quality of life

HDL = high-density lipoprotein.

1 Improvement in fasting glucose and hemoglobin A1c is observed beginning at a weight loss of Ó2 to <5%.

2 Greater weight loss is not associated with greater improvement for BMI >40 kg².

Reference: Ryan DH, Yockey SR. *Curr Obes Rep.* 2017;6:187-194.

Conclusion and Key Takeaways

These case studies address success factors and measures that are applied to well-being and targeted obesity programs. PBGH members and other large public and private purchasers interviewed for this initiative include early adopters of health plan-based programs, nutrition and whole-person health services.

A common thread across these initiatives is a recognition of the complex science of obesity. The stigma associated with obesity can often make it difficult to identify the frequency in population via claims analysis relative to the prevalence as measured through public health and community-based surveys, but improving data and measures is an iterative process. Similarly, as digital solutions and web-based tools proliferate – and as many employers augmented EAP, mental health and other well-being programs – the need for coordination across vendors and education about benefit scope is a greater priority.

Key themes and takeaways include:

- Seek ways to reduce stigma around accessing services and using a diagnosis of obesity
- Improve and expand data sources
- Collaborate with carriers, vendors and suppliers to improve data exchange, coordination of services, and measuring outcomes
- Review benefit designs to address access and availability of services for diverse populations
- Communicate broadly to educate employees on benefits and services, while also sharing success stories, testimonials and co-worker experience
- Integrate across medical plans, prescription drug benefits, well-being, chronic care management, behavioral health, employee assistance programs and onsite clinics
- Seek ways to align with corporate culture, whether through belonging and inclusion initiatives, community benefit programs, or worksite health and safety
- Measure outcomes, including use of patient-centered measures, where possible, but iterate as needed based on available data
- Consider health equity and future strategies to address social determinants of health

Endnotes

1 National Center for Health Statistics, National Health and Nutrition Examination Survey, July 2022. Accessed at: https://www.cdc.gov/nchs/data/factsheets/factsheet_nhanes.pdf.

2 Kudel I, Huang JC, Ganguly R. Impact of Obesity on Work Productivity in Different US Occupations: Analysis of the National Health and Wellness Survey 2014 to 2015. J Occup Environ Med. 2018 Jan;60(1):6-11. Accessed at: https://pubmed.ncbi.nlm.nih.gov/29065062/

3 Stierman B, Afful J, Carroll M, et al. National Health and Nutrition Examination Survey 2017–March 2020 Prepandemic Data Files Development of Files and Prevalence Estimates for Selected Health Outcomes. Corporate Authors(s) : National Center for Health Statistics (U.S.), June 14, 2021. National Health Statistics Reports No. 158, Accessed at: https://stacks.cdc.gov/view/cdc/106273.

4 Hales CM, Carroll MD, Fryar CD, Ogden CL. Prevalence of obesity and severe obesity among adults: United States, 2017–2018. NCHS data brief no. 360. Hyattsville, MD: National Center for Health Statistics, 2020.

5 Restrepo B. Adult Obesity Prevalence Increased During the First Year of the COVID-19 Pandemic. U.S. Department of Agriculture Economic Research Service, July 5, 2022. Accessed at: https://www.ers.usda.gov/amber-waves/2022/july/adult-obesity-prevalence-increased-during-the-first-year-of-the-covid-19-pandemic/

6 Stierman, op. cit., p. 14.

7 Sanchis-Gomar F, Lavie CJ, Mehra MR, Henry BM, Lippi G. Obesity and outcomes in COVID-19: when an epidemic and pandemic collide. Mayo Clin Proc 2020;95:1445-53.

8 Stierman, op. cit., p. 6.

9 Greater Philadelphia Business Coalition on Health. Employer Action Brief: Covering Prescription Weight Loss Therapies to Address Obesity. March 2019.

10 Downey M, Kyle TK. Coverage of obesity treatment: costs and benefits. In: Wadden TA, Bray GA, eds. Handbook of obesity treatment. 2nd ed. New York: Guildford Press, 2018:425-36.

11 Patterson A. Employers Covering Prescription Drugs for Weight Loss, International Foundation of Employee Benefit Plans 2022 Survey, March 10, 2023 https://blog.ifebp.org/employers-covering-prescription-drugs-for-weight-loss/.

12 Khemlani, A. Large employers split on covering GLP-1 drugs for weight loss: Survey, Yahoo Finance. August 22, 2023. https://finance.yahoo.com/news/large-employers-split-on-covering-glp-1-drugs-for-weight-loss-survey-140004887.html.

13 Pantalone KM, Smolarz BG, Ramasamy A, et al. Effectiveness of Combining Antiobesity Medication With an Employer-Based Weight Management Program for Treatment of Obesity: A Randomized Clinical Trial. JAMA Netw Open. 2021;4(7):e2116595. doi:10.1001/jamanetworkopen.2021.16595.

14 Jinnett K, Kyle T, Parry T, Stevenin B, Ramasamy A; ACTION Steering Group. Insights into the Role of Employers Supporting Obesity Management in People with Obesity: Results of the National ACTION Study. Popul Health Manag. 2019 Aug;22(4):308-314. doi: 10.1089/pop.2018.0133. Accessed at: https://pubmed.ncbi.nlm.nih.gov/30383482/.

15 Adult Obesity Maps, Centers for Disease Control and Prevention. Accessed at: https://www.cdc.gov/obesity/data/prevalence-maps.html.

16 Ghusn W, De la Rosa A, Sacoto D, et al. Weight Loss Outcomes Associated with Semaglutide Treatment for Patients with Overweight or Obesity. JAMA Netw Open. 2022;5(9):e2231982. doi:10.1001/jamanetworkopen.2022.31982.

17 Ryan DH, Yockey SR. Weight Loss and Improvement in Comorbidity: Differences at 5%, 10%, 15%, and Over. Curr Obes Rep. 2017 Jun;6(2):187-194. doi: 10.1007/s13679-017-0262-y. Accessed at: https://pubmed.ncbi.nlm.nih.gov/28455679/.

Acknowledgments

This report and summary of case studies were prepared with support from Novo Nordisk. In addition to interviews with PBGH members and other large public and private purchasers, the report highlights key lessons from a joint symposium hosted by PBGH and the Integrated Benefits Institute.

About the Purchaser Business Group on Health (PBGH)

Purchaser Business Group on Health (PBGH) PBGH is a nonprofit coalition representing 40 private employers and public entities across the U.S. that collectively spend $350 billion annually purchasing health care services for more than 21 million Americans and their families. In partnership with its members, PBGH initiatives are designed to test innovative operational programs and scale successful approaches that lower health care costs and increase quality across the U.S.

Purchaser Business Group on Health