

Making Obesity Care Coverage Work:

Lessons From Employers

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National Alliance of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

Pulse of the Purchaser Research Institute

awhp Alliance for Women's Health & Prevention

An Introduction from the Alliance for Women's Health and Prevention and the National Alliance of Healthcare Purchaser Coalitions



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The Alliance for Women's Health and Prevention is committed to improving women's health across the lifespan and ensuring that treatment decisions are guided by patients and their healthcare providers. With obesity linked to more than 200 health complications, including conditions that disproportionately affect women, expanding access to comprehensive obesity care is an important part of our mission.

We recognize that employers face difficult decisions about obesity care benefits and costs. We also believe that managing costs and supporting employee health should not be viewed as competing priorities. That is why we partnered with the National Alliance of Healthcare Purchaser Coalitions to learn directly from employers navigating these challenges.

The experiences in this report are encouraging. They demonstrate that employers have options for meeting the needs of their workforces while managing financial considerations. But they also reinforce an important distinction: offering coverage for treatment does not necessarily mean employees can afford or access the care they need. The details of benefit design matter—from which treatments are covered to the costs employees face and the support available to help them navigate their care.

Through this research, we hope to give employers insights to help evaluate their own benefits and explore solutions that will support the health of their employees.



Jenny Goins

Interim President and CEO,
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Employers want to support their employees' health, but decisions about obesity care benefits are rarely straightforward. The National Alliance of Healthcare Purchaser Coalition works to help employers make informed healthcare purchasing and benefits decisions that support healthier workforces. This research is in service of that mission: highlighting approaches to financing and delivering obesity care, along with the considerations that shaped those choices.

There is no single solution for every employer. Decisions about obesity care benefits require looking beyond which treatments are covered to consider what employees will pay, how they can navigate their benefits and how to evaluate results over time.

The experiences laid out in this report offer practical lessons for employers looking to strengthen their obesity care benefits and better support employees living with obesity. By learning from one another and recognizing obesity care as an essential part of workforce health, employers can take meaningful steps toward making comprehensive, evidence-based care more accessible.

EXECUTIVE SUMMARY

Obesity is a serious, chronic disease that affects the health and well-being of millions of Americans, including a significant portion of the United States workforce. For employers, ensuring access to evidence-based obesity care can play an important part in supporting employee health, managing obesity-related health conditions and addressing long-term healthcare costs.

Yet as demand for obesity management medications, particularly GLP-1 agonists, has grown, concerns about medication spending have led some employers to restrict or eliminate obesity care coverage. While these financial pressures are real, decisions to discontinue coverage can create new barriers to medically appropriate treatment for employees and may overlook opportunities to address obesity and its related health complications over time.

The employers featured in this report demonstrate a strong commitment to providing comprehensive obesity care, including medications, because they recognize how much employees value access to treatment and view it as an investment in better health and lower healthcare costs over time. For some, leaders' own positive experiences with obesity medications have reinforced their determination to make treatment accessible to others.

As employers like Kalos Services, Patriot Rail and Concentra demonstrate, coverage does not have to be an all-or-nothing decision. Employers have a range of options for designing, financing and delivering obesity care benefits that support access while addressing financial considerations. The Alliance for Women's Health and Prevention (AWHP) partnered with the National Alliance of Healthcare Purchaser Coalitions' Pulse of the Purchaser Research Institute (PPRI) to examine how employers are navigating these choices. Drawing on findings from a survey of 49 employer and employer coalition representatives and 10 in-depth employer interviews, this report features case studies of a select group of employers that have maintained, introduced or adapted obesity care benefits. Their experiences illustrate different approaches to providing access to evidence-based obesity care, along with practical considerations for other organizations evaluating similar benefits. Additional information about the research methodology can be found in the Appendix at the end of this report.

Four key insights emerge from these employer experiences:

1. **Employers are exploring alternative approaches to finance and provide access to obesity management medications.**
   From direct manufacturer purchasing to employer-funded reimbursement, organizations are considering options beyond conventional pharmacy benefit arrangements.
2. **Providing employees access to comprehensive obesity care involves more than covering medications.**
   Employers offer different combinations of evidence-based treatments and support, while eligibility requirements, employee costs and benefit restrictions can affect employees' ability to access care.
3. **Employers are connecting obesity care with broader workforce health priorities.**
   Prevention, chronic disease management, employee demand and women's health needs are helping shape employers' decisions to offer or maintain obesity care benefits while managing costs.
4. **Measuring the success of obesity care benefits requires looking at multiple indicators.**
   Participation, employee feedback and available clinical measures are informing benefit decisions, while longer-term impacts on healthcare costs and employee health will require more time to assess.

Together, these findings illustrate that employers have options for addressing cost pressures while maintaining access to evidence-based obesity care. Although no single approach will work for every organization, the experiences highlighted in this report offer practical insights to help employers make informed benefit decisions that balance financial considerations with the long-term health needs of their workforce.



EMPLOYER LANDSCAPE CONTEXT

Leading health experts recognize obesity as a serious, chronic disease associated with more than 200 health complications such as diabetes and heart disease, as well as health risks particularly relevant for women, such as certain cancers, reproductive and maternal health complications, and more severe menopause symptoms.[1,2,3,4] Currently, it is estimated that over 100 million adults in the United States are living with obesity.[5] For employers, its impact on workforce health raises important questions about how to structure obesity care benefits and support employees while managing costs.

Employers are already absorbing many costs associated with overweight and obesity through higher healthcare spending, reduced workforce participation and poorer employee health. A 2024 study estimated that obesity and overweight were associated with $425.5 billion in healthcare and productivity-related costs to U.S. employers and workers in 2023.[6]

Comprehensive obesity care is key to supporting employee health and addressing these costs. This includes counseling or intensive behavioral therapy, nutrition or dietitian services, medications approved by the Food and Drug Administration (FDA), bariatric surgery and behavior modification support, such as facilitating physical activity. The treatment landscape is also rapidly evolving, with medicines offering patients new options to manage obesity and improve their overall health. Moreover, no single treatment is right for everyone, and patients' needs may change over time. Comprehensive care gives patients and providers the flexibility to choose the most appropriate evidence-based treatment approach.



Financial and Health Considerations: Companies take varying approaches to providing obesity care coverage as they consider their workforce's health needs, employees' ability to access and afford care and the financial realities of offering these benefits. Employers may weigh the financial considerations associated with providing coverage alongside the longer-term health needs of employees living with obesity and its related complications.[7] Access also depends on employees' out-of-pocket costs and the coverage requirements they face. Putting coverage into practice also means working with health plans/third-party administrators, pharmacy benefit managers and other benefits partners. These partners help administer the benefit, keep employees' care consistent, track clinical outcomes over time and support the treatment choices patients make with their providers.[8]



Competitiveness and Culture Considerations: Employee expectations and workplace experiences also factor into employers' decisions about obesity care benefits. Access to obesity care is becoming part of how employees evaluate workplace benefits: In a 9amHealth survey, 73% of employees surveyed said GLP-1 coverage was important when deciding whether to take or stay at a job.[9] These findings highlight the role obesity care benefits may play in recruitment and retention. Beyond benefits, employers also face questions about how their workplace culture supports employees living with obesity, who may experience weight bias and stigma. Women living with obesity can face additional workplace barriers, including lower earnings and fewer opportunities for promotion.[10]

The case studies that follow explore the decisions, challenges and lessons learned from six employers providing obesity care benefits. Human resources and employee benefits leaders can consider how these insights can be leveraged to inform their own approaches to obesity care coverage.

EMPLOYER CASE STUDIES

The case studies are organized to show the range of approaches employers are taking to obesity care coverage and financing. They progress from employers maintaining or adapting traditional insurance coverage to those exploring alternative purchasing and reimbursement arrangements, highlighting different ways to support access while managing costs. Each case study also highlights the considerations that shaped the employer's decisions and, where available, how the organization is evaluating its approach.

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CASE STUDY: CONCENTRA

Concentra retains obesity medication coverage with revised eligibility requirements and expanded support

When Concentra began operating its own benefits platform, the company prioritized maintaining consistent employee benefits throughout the transition. This approach was guided by a broader strategy focused on prevention, chronic conditions and women's health. Concentra chose to keep obesity management medication coverage in place, with clinical and lifestyle requirements to help manage costs, and added virtual weight-management support for employees who might not qualify for medication.



INDUSTRY

Medical, occupational health and urgent care



WORKFORCE

About 13,000 employees in 46 states; ~65% female



COVERED POPULATION

6,500 employees enrolled; about 11,000 members, including dependents



OBESITY BENEFITS

Obesity medication coverage subject to clinical eligibility and lifestyle requirements; bariatric surgery when medically necessary; an online weight-management program with integrated mental health support; additional services through the employee assistance program (EAP)

HOW CONCENTRA MAKES THE CASE

"We've covered it. We've chosen to cover it, and we need to continue to cover it. We need to keep supporting our colleagues and giving them the resources they need. There are plenty of programs out there that help employers manage GLP-1 costs, and we'll keep evaluating them and making adjustments as we go."

– Benefits Strategy Lead, on continuing coverage

Concentra continued offering obesity management medication coverage during its benefits transition.

Concentra's benefits strategy emphasizes prevention and chronic condition management. That's why when it launched its independent benefits platform, the company maintained obesity management medication coverage alongside other obesity care benefits and support services. A diabetes diagnosis is not required for obesity management medication coverage, although employees must meet the plan's coverage requirements.

Coverage requirements are paired with additional weight-management support.

Employees starting obesity management medication must meet BMI and weight-related health criteria and document six months of dietary changes and physical activity. Individuals who demonstrate clinical benefit may continue receiving medication coverage even if their BMI falls below the initial eligibility threshold. In 2026, Concentra also offers an integrated program with weight-management and mental health support, including for employees who do not meet the revised medication coverage requirements.



Midlife women's health needs inform Concentra's broader approach to weight management.

With women representing about two-thirds of its workforce, many in midlife, Concentra is expanding its women's health services, including maternity, perimenopause and menopause support. Recognizing the connection between midlife women's health needs and weight management, the benefits team views these services as complementary to its obesity care benefits and broader prevention strategy.

Navigation and vendor accountability support the broader strategy.

Concentra uses year-round communications to remind employees about available benefits and expects vendors to connect employees to relevant services. A care management platform will provide personal assistance and referrals across programs. The benefits team tracks engagement, clinical outcomes and healthcare spending trends, and relies on regular vendor reviews and financial performance guarantees. Clinical and financial outcomes are still being evaluated, and the benefits team recommends allowing approximately 18 months to assess program results.

CONSIDERATIONS FROM CONCENTRA'S EXPERIENCE

- **Explore additional weight-management support**, including for employees who do not meet medication coverage requirements.
- **Use repeated communication and navigation support** to help employees find relevant care and programs.
- **Allow time to evaluate new programs** and consider performance guarantees to hold vendors accountable.

CASE STUDY: INSURANCE BROKERAGE FIRM

An insurance brokerage firm lowers barriers to obesity treatment and pairs medication coverage with ongoing support

The firm starts from the belief that obesity is a medical condition and that employees who can benefit from treatment should be able to access it. Although the company already covered GLP-1 medications, high deductibles created financial barriers for some employees, while access to clinical support for prescribing and managing treatment was uneven. The firm introduced a virtually supported care pathway within its existing medical and pharmacy plans, complemented by coaching, nutrition and well-being resources.



INDUSTRY

Insurance



WORKFORCE

About 13,000 U.S. employees, about 10,000 enrolled in a health plan; median age 45; 53% female



HEALTH PLANS

About 95% of covered lives in self-insured plans; roughly 80% in high-deductible plans; covers employees and dependents



OBESITY BENEFITS

GLP-1 medications with virtual clinical support, bariatric surgery, nutrition counseling, wellness coaching, well-being platform and employee assistance program (EAP) offering behavioral therapy

HOW THE EMPLOYER MAKES THE CASE

"The coverage is just one thing … that opens the door, but that ongoing clinical support helps people stay in the program, which is what's critical."

– Director of Health Services, on medication coverage

Leadership sought to improve access to obesity treatment and ongoing clinical support.

With approximately 80% of plan members enrolled in high-deductible plans, leadership recognized that out-of-pocket expenses could create barriers to accessing obesity medications. Some primary care physicians were also reluctant to prescribe and manage these treatments. Several senior employees had personally experienced positive results from treatment and wanted others to have similar opportunities. After reviewing broader weight-management options, the firm built a program with a virtual care partner that offered the clinical oversight, convenience, data and flexibility it wanted to support employees over the long term.

The firm introduced a new pathway to support medication access.

The firm maintains coverage for GLP-1 medications through its existing medical and pharmacy plans and covers the full cost of the program. Adults enrolled in its self-insured U.S. health plans who meet clinical eligibility criteria can participate. Those new to GLP-1s need a BMI of at least 30, or 27 with a related condition such as prediabetes, heart disease or sleep apnea. Through the program, participants pay a flat



$200 monthly medication copay that bypasses the deductible. Manufacturer coupons may further reduce their out-of-pocket costs to approximately $100 per month. To maintain the preferred copay, participants are required to complete at least 75% of brief weekly check-ins each quarter.

Virtual clinical care and additional resources support employees throughout treatment.

Employees learn about the program through the annual benefits guide, periodic benefits newsletters, intranet communications and benefit navigators. Interested members complete an eligibility screening, medical-history review and at-home blood testing, followed by clinical review. Weekly digital check-ins track weight, medication use and side effects, while monthly virtual provider appointments support clinical follow-up and prescription management. Wellness coaching provides additional lifestyle support, and a resource guide directs employees to nutrition services, medical plan resources, the employee assistance program and the firm's well-being platform. Women make up a significant share of participants, and the program is designed to provide a judgment-free experience grounded in individual clinical needs.

Monthly reports track engagement and early health results.

Leaders are enthusiastic about the program and want data on its results, so the benefits team reports monthly on participation, engagement and clinical measures. Enrollment rose in the first year, as expected, and has since leveled off at about 1,040 active participants, roughly 11% of those eligible. Early data show 84% medication adherence among program participants, compared with rates in the 60s for other employees taking GLP-1s. Participants in the 18-month group have lost about 40 pounds on average, with sharp drops in diabetes and high-cholesterol risk.

CONSIDERATIONS FROM THIS EMPLOYER

- **Build on existing medication coverage** by identifying barriers that may prevent employees from accessing treatment.
- **Consider specialized clinical and support partners** that can help employees navigate treatment and manage ongoing care.
- **Pair medication access with clinical follow-up and lifestyle support** tailored to individual needs.
- **Clearly communicate** eligibility criteria, participation requirements and employee cost-sharing arrangements.
- **Use engagement and clinical data** to assess early experiences and inform future benefits decisions.

CASE STUDY: PATRIOT RAIL

Patriot Rail turned peer lessons and an initial pilot into a growing obesity care program

Patriot Rail, a rail service provider, wanted to address employee health before chronic or long-term health challenges took hold. It borrowed ideas from peers, built a set of partners to identify and support employees early and piloted a physician-led weight program. Encouraging participant experiences helped build confidence and led to a program expansion and the introduction of GLP-1 coverage.

INDUSTRY
Short line and excursion railroads

WORKFORCE
About 600 employees, mostly men ages 35 to 55; 31 railroads in about 26 states

HEALTH PLAN
Self-funded; ~770 covered members, including dependents

OBESITY BENEFITS
GLP-1 medication coverage subject to Ciba Health participation and clinical eligibility requirements; weight-management support through Ciba Health; nutrition counseling and digital support

HOW PATRIOT RAIL MAKES THE CASE

"You're either going to pay for the GLP-1 or the programs to get them in a good spot and be healthy, or you're going to pay for the disease down the road."

– Patriot Rail Director of Benefits and Compensation, on investing up front

Lessons from peer employers and a focus on prevention informed Patriot Rail's approach to obesity care.

Patriot Rail's employees work for railroads across the country. Many work in the field and have limited time to focus on their health. Claims data showed high rates of diabetes, hypertension and sleep apnea, and leadership wanted to address these conditions early. Patriot Rail's director of benefits and compensation is active in the Florida Alliance for Healthcare Value coalition and has brought back approaches that have worked for other employers.

Patriot Rail partners with vendors to identify and inform employees who may benefit.

First, the company's third-party administrator (TPA) supplies claims data. Converging Health, its clinical analytics partner, then sorts members by risk and cost and flags those who would benefit most from a program. Finally, a health concierge service that Patriot Rail offers at no cost prepares a health summary employees can take to their doctor and helps them find providers.

A small pilot built the confidence to expand obesity care coverage.

Patriot Rail first offered Ciba Health, a physician-led program that looks for the root causes of weight gain and related conditions, to 10 employees. Participants start with lab testing and receive a scale, blood



pressure cuff and other equipment to set a baseline, then meet regularly with a physician by video or in person. To qualify, employees must be actively employed by Patriot Rail for at least 12 months, be enrolled in one of its medical plans and have a risk score of at least 37, as determined by Converging Health. It is free to employees, and the company pays a monthly fee, covering testing, equipment and physician visits, as long as participants stay engaged. The benefits leader reported that during the 12-month pilot one participant lost 38 pounds, while others lost between 5 and 15 pounds. The company has expanded the program from 10 to 25 participants and expects further expansion next plan year.

GLP-1 medication coverage comes with program participation requirements.

Employees expressed interest in GLP-1 medications, and Patriot Rail introduced coverage for eligible Ciba Health participants. After six months in the program, Ciba reviews each participant's engagement, progress toward weight-loss and other clinical goals, along with overall treatment needs. If the program has not produced sufficient weight loss or other expected improvements, or if a metabolic issue or other clinical need suggests additional treatment may be appropriate, the Ciba physician and the employee's primary care provider assess whether a GLP-1 medication could help. Ciba then prepares a recommendation and supporting documentation for prior authorization. The employee's primary care provider writes the prescription, and the pharmacy benefit manager reviews and approves the request. Participants generally pay a $100 copay, while those enrolled in high-deductible health plans pay out of pocket until their deductible is met. Patriot Rail has not established a limit on how long medication coverage lasts.

CONSIDERATIONS FROM PATRIOT RAIL

- **Work with specialized vendors** to analyze claims, assess risk, conduct employee outreach and manage support programs.
- **Start with a small pilot** and expand as results come in.
- **Tie program payments to active participation** and help employees address barriers to engagement.
- **Make participation requirements clear** and provide personal support throughout the program.

CASE STUDY: HOSPITALITY EMPLOYER

A hospitality employer maintains access to comprehensive obesity care by purchasing medication directly from a manufacturer

A hospitality employer with its own medical center sought to maintain access to GLP-1 medications for eligible employees as part of its broader commitment to employee wellness. Working with a manufacturer, its pharmacy benefit manager (PBM) and internal pharmacy team, the company implemented a new purchasing arrangement while maintaining coverage for medications and other obesity care benefits.

INDUSTRY
Hospitality

WORKFORCE
Average age about 50; approximately 50% female

HEALTH PLAN
Self-funded, fewer than 5,000 covered lives

OBESITY BENEFITS
Medical and pharmacy coverage, including medications, bariatric surgery, nutrition counseling, behavioral support and coaching; coverage in place for more than five years

HOW THE EMPLOYER MAKES THE CASE

"Our culture, and it's even in our handbook, is that we believe in wellness. And this is a piece of it, the obesity care. … We know that people come to work for us because of our innovative programs."

– Healthcare Executive, on access to care

A direct manufacturer agreement helped the employer maintain medication coverage.

Wellness is written into the employer's handbook, and obesity care is an important part of its broader approach to employee health. Recognizing that direct-to-consumer purchasing options could leave some employees facing financial barriers to treatment, the employer pursued a direct arrangement with a manufacturer of obesity management medications to help sustain existing coverage. With its benefits committee's support, the team worked with its PBM and in-house pharmacy to implement the new arrangement and transition employees within about four months of first proposing it. More than 200 employees stayed on the same medication, while some switched to another. Coverage requirements and what employees pay did not change.

An in-house clinical team connects treatment with prevention.

The employer's medical center brings together clinicians, health coaches, dietitians and mental health professionals. The team reaches out when employees seek care to discuss treatment options, readiness and support needs with each patient. Patients see the medical center's lifestyle medicine physician before starting a GLP-1 medication, unless it is prescribed for diabetes, sleep apnea or heart failure. Coaches prepare patients for side effects and follow up during treatment. Broader services are promoted through outreach, email, texts



and health events. The employer views ongoing support as important to helping patients manage side effects and continue treatment when clinically appropriate. The goal is to prevent obesity-related conditions, such as diabetes, heart disease and joint problems, and keep employees out of emergency care. A system to connect pharmacy, medical claims and clinical records is being planned to examine weight changes, diabetes and blood pressure measures and healthcare use among participating patients.

A menopause partnership complements broader obesity and women's healthcare.

Women make up about half of the company's workforce. Recognizing the relationship between menopause and changes in weight and metabolic health, the employer identified a gap in menopause care and partnered with an OB-GYN certified in this area. This complements the company's broader employee health services, including obesity care and mammogram outreach.

CONSIDERATIONS FROM THIS EMPLOYER

- **Explore purchasing alternatives** with manufacturers.
- **Compare net costs and employee affordability** before changing access arrangements.
- **Work with the PBM, pharmacy and care team** to help patients transition smoothly to the new arrangement.
- **Pair treatment with support** for side effects and ongoing care.
- **Assess health changes across data sources** to look beyond weight loss.

CASE STUDY: KALOS SERVICES

Kalos Services introduces a capped reimbursement benefit for obesity medications

Kalos Services, a family-owned construction company, recognizes the physical demands of its workforce and has heard from employees interested in obesity treatment. This motivated the company to provide financial support for obesity medications. Leadership sought an approach that could help more employees access treatment while keeping costs predictable for the business. The company is introducing a capped annual household reimbursement benefit, leaving prescribing decisions to employees and their healthcare professionals.



INDUSTRY

Construction



WORKFORCE

385 to 410 employees, mostly male; varies seasonally in Florida, Georgia, Alabama, plus remote workers



HEALTH PLAN

Level-funded; covers employees, spouses, domestic partners and dependents



OBESITY BENEFITS

Up to $2,500 per household annually in reimbursement for GLP-1 medications prescribed for obesity; separate $50 monthly lifestyle account

HOW KALOS MAKES THE CASE

"Early dollars may sound scary, but they're cheaper than 911 dollars. When people engage with their care, we catch problems sooner, before they become emergencies."

– Human Resources Director, on prevention and early care

Leadership identified an opportunity to support employee health in a physically demanding work environment.

Recognizing the physical demands of its aging workforce, Kalos leadership saw earlier access to obesity treatment as an opportunity to address health concerns, including orthopedic issues, high blood pressure and heart disease. Some employees were already paying for obesity management medications themselves, while new hires had previously received coverage for these medications from other employers. An industry conference on women's health and obesity care, along with conversations with peer employers, also helped shape Kalos's approach.

Kalos is implementing a capped reimbursement benefit for GLP-1 medications.

Kalos already covered GLP-1 medications for diabetes through its pharmacy benefit, but not for obesity management. Its broker recommended creating a separate GLP-1 reimbursement account to help employees access these medications, regardless of the condition being treated. The account provides reimbursement of up to $2,500 per household annually. Employees need only a prescription, which they



can fill at a pharmacy of their choice. Employees retain receipts, then submit reimbursement requests monthly through an online portal. Employees pay any costs above the annual household reimbursement limit. A separate $50 monthly lifestyle account, which is not a condition of medication reimbursement, offsets the cost of gym memberships, dietitians and other wellness services, including support for women through perimenopause and menopause.

Modeling potential participation helped Kalos assess financial feasibility.

Kalos modeled the financial implications of every eligible household using the full $2,500 annual reimbursement and determined that the potential expense could be accommodated within its available health plan surplus. The annual cap provides a defined limit on the employer's contribution, allowing Kalos to budget for the benefit without taking on the full cost of medications through its pharmacy plan.

Simple framing and regular communication aim to drive participation.

The benefit carries a straightforward name (a GLP-1 reimbursement account), and Kalos plans to have a care coach identify employees with previously denied GLP-1 claims to encourage participation. The company will promote the new program when it is introduced and at key points throughout the year through its regular benefits communications.

CONSIDERATIONS FROM KALO SERVICES

- **Explore capped reimbursement arrangements** as one way to support medication access while managing employer spending.
- **Model full use** to assess the maximum employer cost.
- **Make reimbursement accounts easy to use** with clear instructions and payment timelines.
- **Track use and employee feedback** to guide outreach and benefit adjustment.

CASE STUDY: PUBLIC EMPLOYER

A public employer plans to transition to an alternative purchasing arrangement to maintain access to obesity medications

A public employer sought to balance its commitment to employee health with its responsibility to work within a budget funded by taxpayers. As part of its annual benefits renewal, the employer selected an alternative purchasing arrangement intended to maintain access to GLP-1 medications for obesity while managing overall benefit spending. The employer has long covered bariatric surgery and nutrition counseling, with additional coaching and exercise resources available through its well-being platform. Beginning in 2027, GLP-1 medications for obesity will move from its self-insured health plan to a separate direct-to-consumer purchasing channel supported by an employer subsidy.



INDUSTRY

Public employer in the western U.S.



WORKFORCE

About 2,400 employees, approx. 1,400 enrolled in a health plan



HEALTH PLANS

Self-insured and fully insured plans



OBESITY BENEFITS

GLP-1 medications currently covered under the self-insured plan, with a planned transition to a separate, employer-subsidized direct-to-consumer purchasing arrangement; bariatric surgery and nutrition counseling; additional support through a well-being platform

HOW THE EMPLOYER MAKES THE CASE

"We have an obligation not only to provide great benefits, but also to be financial stewards of taxpayer dollars and balance it as a whole."

– Total Rewards Manager, on public-sector stewardship

Leadership evaluated GLP-1 coverage options as part of its broader benefits renewal.

A benefits survey showed that employees valued predictable premiums, so leadership targeted an overall increase of 5% to 7% across health benefits. The benefits team presented several options for obesity management medication access and their implications for the annual renewal. Leadership selected a direct-to-consumer purchasing channel arranged through its pharmacy benefit manager, anticipating lower medication purchasing costs while preserving a pathway for eligible employees to obtain treatment.

A new purchasing channel replaces traditional plan coverage for obesity management medications.

Under the planned arrangement, employees will obtain GLP-1 medications for obesity management through a direct-to-consumer purchasing channel rather than through the employer's self-insured health plan. The employer will contribute $100 toward each prescription, and employees will be responsible for the



remaining cost. Purchases through the new channel will fall outside the health plan's deductible and out-of-pocket limits. Employees will continue to need a valid prescription and prior authorization.

Surgery, nutrition counseling and well-being support remain available.

Bariatric surgery and nutrition counseling will remain covered, while coaching and exercise classes will continue to be available through the employer's well-being platform. The employer plans to communicate these resources together to employees as part of the transition to the new medication purchasing arrangement.

Women's health is an established priority with links to obesity care.

Women's health has been a focus for the employer in recent years. The benefits team sees overlap with obesity care, including between menopause care and weight management, and views the women's employee resource group as a potential partner for future communication.

CONSIDERATIONS FROM THIS EMPLOYER

- **Show leaders how each option** affects the whole plan renewal.
- **Look for a lower-cost channel** before cutting coverage.
- **Tell employees why the change was made** and what remains covered.
- **Explain how a new purchasing channel changes** employee payments and out-of-pocket protections.

LESSONS LEARNED ACROSS CASE STUDIES

The experiences of the employers featured in this report illustrate that obesity care coverage does not have to be an all-or-nothing decision. These employers are finding practical ways to preserve or expand access to obesity care while navigating rising treatment costs, budget constraints and a changing benefits landscape. Their approaches demonstrate different options for financing treatment, determining which services are covered and connecting employees with care. The four findings below draw on these experiences to highlight considerations that can help other employers evaluate these choices and assess how well their benefits are meeting workforce needs.

1.

Alternative approaches to financing obesity medications give employers options in supporting access and managing costs.



As employers explore ways to maintain access to obesity management medications while balancing benefit spending, some are considering arrangements beyond traditional pharmacy benefit purchasing, including direct manufacturer agreements and employer-funded reimbursement. These approaches offer different ways to structure medication benefits, though some implications extend beyond employer costs to employees' ability to obtain and continue treatment.

The financing model can affect how employees pay for medication, whether their spending counts toward deductibles and out-of-pocket limits and how easily they can maintain treatment over time. A reimbursement arrangement, for example, may offset part of the expense while still requiring employees to pay substantial costs upfront or absorb spending above a defined cap. Purchasing arrangements outside the health plan can offer additional pathways to treatment, though care coordination and financial protections may differ from those in traditional plan arrangements.

For employers, evaluating alternative financing arrangements involves looking beyond the purchasing model to understand how those choices may impact access to treatment. Important considerations include employee cost sharing, how the arrangement interacts with existing health coverage and whether it supports continuity of medically appropriate care.

2.

Providing employees access to comprehensive obesity care involves more than covering medications.



Obesity is a chronic disease, and employees may need different forms of treatment and support at different points in their care. Medication access is important, but it does not, on its own, establish whether a benefit offers a comprehensive range of evidence-based options. Employers should also assess the availability of services such as nutrition

counseling, behavioral treatment and bariatric surgery, and whether employees can access the care recommended by their clinicians.

The details of benefit design matter as much as the list of covered services. Eligibility thresholds, participation requirements, cost sharing, reimbursement limits and restrictions on treatment duration can all influence who receives care and whether treatment can continue. These conditions often reflect an employer's need to manage utilization and costs, but they may also affect an employee's ability to initiate and sustain medically appropriate treatment.

Employers should continue to evaluate their obesity care benefits to determine which options are available, to whom, under what conditions and at what cost. That assessment provides a useful basis for identifying gaps and determining where changes could improve access.

3.

Employers are connecting obesity care with broader employee health priorities.



Employers' decisions to offer or maintain comprehensive obesity care, including medications, are driven by the importance employees place on treatment access and the belief that investing in care today can improve health and help avoid higher healthcare costs later. In some cases, leaders' own positive experiences with obesity medications have strengthened their commitment to expanding access. These motivations are shaping how employers connect obesity treatment with broader health services and help employees navigate care.

Virtual clinical services, employer-operated medical centers and personalized navigation offer different approaches to coordinating obesity treatment and care for other employee health needs. No single delivery model is appropriate for every workforce. What matters is whether the model helps employees find appropriate care and obtain support as their treatment needs evolve.

Employers should consider the employee's complete care pathway, from learning that a benefit exists to accessing a clinician, understanding treatment options, managing costs and receiving follow-up care. Making that pathway work takes coordination between an employer's benefits team and its partners, such as health plans, pharmacy benefit managers, clinical providers and other vendors. Employers and their partners must work together to ensure that employees do not have to sort out eligibility, billing or care-coordination questions on their own.

It is also important to distinguish services intended to support treatment from requirements that determine eligibility for coverage. Counseling and clinical follow-up can help employees manage their care, while mandatory participation rules may create additional steps they must complete to obtain or continue treatment. Clear communication about these differences—and about whom employees can contact for help—can make benefits easier to use and reveal barriers employers might otherwise overlook.

4.

Early results can inform benefit adjustments, while understanding long-term value requires time.

Employers' willingness to test approaches, examine results and adjust benefits provides useful learning for other organizations facing similar decisions. As others seek evidence about how obesity care benefits support employee health while managing costs, the case studies show why that evaluation is nuanced and evolving. Initial participation, employee experiences and early clinical findings can help employers identify implementation problems or promising approaches, but they do not necessarily demonstrate longer-term improvements in health or reductions in healthcare spending.

Employers should begin by deciding what they expect a benefit to accomplish, how progress will be measured and what data is required to evaluate success. Depending on those objectives, relevant measures may include awareness and use of services, treatment engagement, employee experience, clinical outcomes and spending trends. Measures should also reflect the limits of the available data and the period over which outcomes can reasonably be observed.

A useful evaluation approach allows employers to learn and adjust without treating early results as a final verdict. Reviewing participation and access barriers can inform near-term improvements, while longer-term clinical and financial measures can provide other assessments of the benefit. Because workforce needs, benefit designs and care models vary, findings from one employer should inform—not substitute for—an organization's view of its own experience.



CONCLUSION

Obesity is a serious, chronic disease that requires ongoing, individualized care. The experiences highlighted in this report show how employers are finding practical ways to support obesity care while navigating costs, budget constraints and evolving treatment options. There is no single model. Different approaches to financing, coverage and care delivery offer opportunities to introduce, preserve or expand access in ways that reflect workforce needs and organizational resources.

For employers considering their approach to obesity care benefits, five questions can help guide the discussion:

- **How can obesity care benefits support workforce health priorities?** Consider how obesity and related chronic conditions affect employees and what the organization hopes to achieve through treatment access and support.
- **What opportunities do we have to strengthen access to the full range of evidence-based obesity care?** Review coverage for medications, nutrition services, behavioral counseling and bariatric surgery, along with eligibility requirements, employee costs and restrictions, to identify where additions or adjustments could meet employee needs within available resources.
- **How can we help employees make the most of available obesity care benefits?** Explore ways to simplify navigation, explain coverage and costs and support ongoing treatment, including through alternative medication purchasing or reimbursement arrangements.
- **How can benefits and clinical partners help make obesity care easier to access and coordinate?** Identify opportunities for health plans, pharmacy benefit managers, clinical providers and other partners to improve communication, clarify responsibilities and support employees throughout treatment.
- **What can we learn from obesity care benefits over time?** Establish measures that reflect program goals, such as treatment access, engagement, employee experience, clinical outcomes and healthcare spending, recognizing that improvements in chronic disease management and potential financial impacts may take time to assess.

The employers featured in this report described employee needs and long-term workforce health as motivations for offering obesity care benefits. Their willingness to test approaches and adapt benefits illustrates how these priorities can translate into practical action, even amid financial pressures. These experiences can offer lessons for other employers seeking to make obesity care more accessible and sustainable.

METHODOLOGY

The Pulse of the Purchaser Research Institute (PPRI) conducted an online survey and in-depth interviews to examine employer approaches to obesity care coverage and identify practical lessons for employers considering how to introduce, maintain or expand benefits.

The combined findings informed this white paper, including six employer case studies illustrating different approaches to obesity care coverage. Employer representatives provided the information in these case studies. PPRI did not independently verify clinical or financial results, and these experiences may not reflect those of employers nationwide. Publication of identifying information, quotes and organization-specific data is subject to employer permission and review, with anonymity provided when requested.

Survey. PPRI collected 49 completed survey responses from July 15 through August 21, 2026, including 44 employer and five employer coalition leader respondents. Employer respondents described their own organizations' coverage and experiences; coalition leaders provided perspectives on coverage and decision-making among their employer members.

The 15-minute online questionnaire included closed- and open-ended questions about current coverage, covered services, eligibility and access requirements, decision drivers, implementation needs, cost and benefit trade-offs, measures of success and lessons learned. Comprehensive obesity care was defined as a range of evidence-based services and supports that may include behavioral counseling, nutrition support, obesity management medications, bariatric surgery and care navigation. Survey findings describe participating respondents and should not be interpreted as nationally representative estimates.

In-depth interviews. PPRI supplemented the survey with 10 interviews, 30 to 45 minutes, with employers to explore coverage decisions and implementation experiences in greater detail. A common discussion guide covered the business case, benefit design, clinical eligibility, employee access and communications, partner roles, cost management, available outcomes and advice for peer employers.

For questions about the research, contact **research@pulseofthepurchaser.org** or **info@WomensHealthandPrevention.org**.

1. https://www.ama-assn.org/topics/obesity
2. https://www.cancer.gov/about-cancer/causes-prevention/risk/obesity/obesity-fact-sheet
3. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/01/prepregnancy-counseling
4. https://pubmed.ncbi.nlm.nih.gov/42087841/
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National Alliance of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

For more than 30 years, the National Alliance has brought together business coalitions and their employer and purchaser members to drive high-quality healthcare that enhances patient experience, promotes health equity, and improves outcomes while lowering costs. Its members represent public and private sectors, nonprofits, and labor unions that provide health benefits to over 90 million Americans — more than half of the employer-sponsored insurance market — spending over $850 billion annually.

Pulse of the Purchaser Research Institute

The Pulse of the Purchaser Research Institute (PPRI) is a managed research panel of employer benefits decision-makers, backed by the National Alliance of Healthcare Purchaser Coalitions. Panelists come from members of more than 40 regional employer coalitions affiliated with the National Alliance, which collectively represent over 90 million covered lives. Membership is validated through the local coalitions and profiled against more than ten criteria, including job title, years of experience, certifications, involvement in benefits management, organization type, plan type, industry, size and location. The panel includes public and private sector purchasers as well as union and Taft-Hartley plans.

awhp Alliance for Women's Health & Prevention

The Alliance for Women's Health & Prevention (AWHP) is a nonprofit advocacy organization dedicated to advancing policies that improve equitable access to high-quality, affordable preventive care for all women and girls. Founded in 2022, AWHP focuses on women's preventive health across all life stages and disease areas. Working alongside leading women's health organizations, AWHP advocates for policies that help prevent disease and its progression and improve women's health.