

Benefits Insights

Communicating GLP-1 Coverage Decisions During Open Enrollment



Glucagon-like peptide-1 (GLP-1) medications, drugs commonly prescribed for weight loss and diabetes management, have moved from a pharmacy line item to one of the most closely watched topics of open enrollment. Employees are asking about eligibility, cost and criteria before they finish reading the rest of the benefits guide, and many are comparing notes with co-workers, friends at other employers and information gathered from social media, online forums and direct-to-consumer drug advertising.

The coverage decision itself is only half the work, whether the outcome is full coverage, coverage with guardrails, no coverage or a change from the prior year. How that decision is communicated shapes whether employees trust the process, use the benefit as intended and feel respected regardless of the outcome. This article outlines how organizations can approach GLP-1 communication during open enrollment.

The Current State of GLP-1 Coverage

Communication strategies cannot be built on last year's assumptions, as coverage positions keep shifting. According to a Business Group on Health survey, 1 in 10 large employers currently covering GLP-1 medications say they are likely to stop providing coverage for weight loss in 2027 due to rising costs. In contrast, 72% said they were likely to continue coverage.

Furthermore, although Mercer's research on employers with 500 or more employees put weight-loss coverage at 44% in 2024, the firm has since reported that a share of large employers are dropping or reconsidering that coverage for 2027 amid rising utilization and costs.

The takeaway is that no single coverage stance is standard, and employees increasingly know it. A workforce that includes people who previously worked at or have family or friends at organizations with different GLP-1 policies will bring outside comparisons into open enrollment conversations. As such, employer communication needs to withstand that scrutiny.

Matching the Message to the Decision

Communication best practices still matter, but each coverage position carries its own risks and requires a different emphasis.

Communicating Full Coverage

When an organization covers GLP-1 medications for weight management without significant restriction, the communication risk is less about resistance and more about setting realistic expectations. Employees who receive access without clinical context often expect faster results than the medication delivers or discontinue treatment once side effects appear, undermining both their outcomes and the value of the benefit.

Full coverage communication should include these elements:

- What the medication does and how it works, described in plain clinical terms rather than marketing language
- Realistic timelines for results and the role of nutrition, activity and behavioral support alongside the prescription
- How to access the benefit, including any enrollment steps, prior authorization requirements or point-of-care contacts
- Confirmation that engagement with the benefit is private and not visible to managers or HR

Communicating Partial Coverage With Criteria

Coverage that comes with body mass index thresholds, comorbidity requirements, prior authorization, step therapy, participation in a lifestyle program or a defined duration is the most common landing point for employers balancing cost against demand. It is also the hardest to communicate well because the criteria can be perceived as gatekeeping if the reasoning behind them is not clearly explained.

Effective communication in this scenario states the criteria plainly and pairs each requirement with its rationale. A duration limit, such as a plan covering GLP-1 medications for a maximum of two years before requiring reassessment, reads differently when paired with an explanation about long-term safety monitoring than when the same limit is presented without context.

Organizations should also be explicit about what happens at the edges of the criteria, such as what an employee should do if they do not meet the current threshold but believe they have a qualifying condition, and where they can direct clinical questions privately. Directing employees to a confidential channel for individual eligibility questions rather than requiring them to make their case to HR directly reduces both frustration and the appearance of arbitrary denial.

Communicating a Decision Not to Cover

Declining to cover GLP-1 medications for weight management while continuing coverage for diabetes remains the position of the majority of employers, according to the International Foundation of Employee Benefit Plans' 2026 employer survey. This decision does not need to be defensive, but it does need to be direct. Employees respond better to a clear explanation of the reasoning, typically cost sustainability across the health plan, than to a message that avoids the subject or buries it in a broader pharmacy update.

Communication for a non-coverage decision should:

- State the decision clearly rather than implying it through omission.
- Explain the reasoning in terms employees can evaluate, such as the impact on premium costs across the plan.
- Point to what is available instead, including nutritional counseling, health coaching, lifestyle spending accounts, or flexible spending account and health savings account eligibility for GLP-1 costs paid out of pocket.
- Highlight alternative payment solutions. For example, self-pay options have become a popular route for employees seeking GLP-1 medications outside employer coverage, often through manufacturer savings cards, cash-pay pharmacy programs or telehealth platforms that offer the medication at a set monthly price without requiring insurance.
- Avoid language suggesting the decision reflects a judgment about employees who are seeking these medications.

Communicating a Meaningful Year-over-Year Change

Whether coverage is being added, tightened or removed, a change from the prior year carries the highest communication stakes because it affects employees who are already using the benefit. These employees need advance notice, not a surprise at the point of sale or renewal.

Organizations making a significant change should communicate well ahead of the effective date, confirm what happens to employees currently in an active prescription or authorization and specify concrete next steps, such as whether a new prior authorization is required or whether an existing one transfers automatically.

For instance, the University of Minnesota's guidance on a midyear formulary transition for GLP-1 pens offers a useful model: it named the exact date of the change, clarified that existing authorizations would carry over, specified that diabetes prescriptions were unaffected and gave employees a direct contact for questions rather than leaving them to sort it out with their pharmacy alone. That level of specificity is what distinguishes a well-managed transition from one that generates a flood of confused calls to HR.

Communication Best Practices for Any Coverage

Regardless of where an organization lands on GLP-1 coverage, the following communication best practices remain relevant:

- **Lead with clinical context, not just plan mechanics.** Employees form opinions about GLP-1s from social media and advertising well before they see a benefits communication. Grounding the message in how the medication works and what it treats gives employees a more accurate frame than the one they likely already have.
- **Make confidentiality explicit.** Stating directly that engagement with a GLP-1 or weight-management benefit is private and not visible to managers or HR lowers a significant barrier to enrollment. This should be stated in the communication itself, not left as an assumption.
- **Create a channel for private questions.** Employees with questions about their own eligibility or health history need a way to ask without having to raise the issue in a team meeting or with a direct supervisor. An anonymous FAQ submission process, a dedicated support line through a benefits partner or an anonymous webinar in Q&A format all serve this purpose.
- **Use language that treats obesity as a clinical condition.** Terms such as weight management, metabolic health and access to care can help support engagement. Language implying that coverage must be earned through effort, or that frames the medication as a lifestyle shortcut, discourages the employees most likely to benefit from coverage.
- **Build in a feedback loop.** Because GLP-1 coverage decisions and the underlying clinical landscape continue to shift, benefits teams should plan to update employees again during the plan year rather than treating the open enrollment announcement as a one-time communication.

GLP-1 communication works best when it is not competing for attention with every other open enrollment update. Organizations should either prominently feature specifics about GLP-1s in benefits communications or consider a dedicated communication, sent ahead of the general open enrollment packet, that specifically addresses GLP-1 coverage. This sequencing gives employees time to absorb clinical context and criteria before they are also weighing plan costs, dependent coverage and every other open enrollment decision at once.

Employer Takeaway

There is no universal right answer to whether an organization should cover GLP-1 medications for weight management, and the data shows employers are genuinely split. What is consistent across coverage decisions is that those who communicate clearly, explain their reasoning, protect confidentiality and treat obesity as the clinical condition it is see fewer disputes, better-informed employees and stronger trust in the benefits program overall.

Contact us for more GLP-1 or open enrollment resources.