

Podcast: *Hiring to Firing* Podcast

Episode: Beyond BMI: Workplace Bias and Weight-Loss Drugs

Hosts: Tracey Diamond and Emily Schifter

Guest: Lynne Wakefield

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Tracey Diamond:

Dr. Robby how are we doing? We ready? Okay, here we go. Ready? One, two, three. Good breath sounds bilaterally. We need to protect. Apparently he jumped down to save the lady. When he climbed down, backed up, slipped, fell, hit his head. Okay, thanks. Omel. Right? I need you on the EFAS. Pupils 4 millimeters and reactive. That's encouraging. What do you want for meds? 120 ketamine, 80 of rock. A-fib on the monitor. Course is clear. There's a lot more blood than expected. He's probably anticoagulated for A-fib. Check his medical record. See if he's on DOAC. Standby with four factor PCC if there's a brain bleed.

Emily Schifter:

Whew. Tracey Diamond or Dr. Robby? I'm glad... Well, I'm so glad that you are able to play a doctor on our podcast as we take inspiration from one of our favorite doctors on TV, in *The Pit*, which is our jumping off point for what I think is a very interesting discussion on weight discrimination and GLP-1 drugs, featuring one of our partners, Lynne Wakefield, to talk about some of the benefits considerations. So tune in for an interesting episode ahead.

[INTRO]

Tracey Diamond:

Welcome to [Hiring to Firing](#), the podcast. I'm Tracey Diamond, a labor and employment partner at Troutman Pepper Lock, and I'm here with my partner and co-host Emily Schifter. Together we tackle all employment issues from hiring to firing.

Emily Schifter:

Today we're so excited to have as our guest Lynne Wakefield, our partner, who is not only an expert in her field, but also a seasoned repeat guest. Listeners may remember her from appearing on our *Handmaid's Tale* episode. So, Lynne, thank you so much for joining us. We're thrilled you're here and would love for you to introduce yourself and remind listeners about your practice.

Lynne Wakefield:

Hi Tracey and Emily, thanks so much for having me back to join you on today's podcast. So I'm a partner in our firm's employee benefits and executive compensation practice group. And my practice focuses on qualified retirement plan and health and welfare plan compliance. So I advise clients on the full spectrum of legal issues impacting their retirement and health and welfare plans.

So things like plan drafting, plan administration and disclosures, plan governance and plan contracting. So I'm excited to talk to you both today.

Tracey Diamond:

Well, thanks so much for joining us today, Lynne. And we asked Lynne to join us today to talk about a topic that is on a lot of people's minds, losing weight. Obesity is a huge problem in the U.S., pardon the pun, with approximately 37% of adults in the United States classified as obese according to body mass index standards. Studies have found that obese workers are more likely than non-obese workers to face discrimination in the workplace, with perceptions that they are lazy and lack self-discipline, leading to discrimination in hiring and promotions as well as unequal pay. For example, studies have shown that during the hiring process, recruiters are more likely to categorize job applicants with obesity as less suitable for a job than people who are not obese, which is really troublesome. Obese female workers face a double whammy of weight and gender bias, and in fact, a study by the economists reported that for an obese woman, losing 65 pounds has a compensation impact equivalent to earning a master's degree in her area of work, which is good motivation to go on a diet.

Emily Schifter:

And pretty unbelievable.

Tracey Diamond:

Yes.

Emily Schifter:

So this is a good time to introduce our first clip, and today we are again turning to the TV show *The Pit*, much lauded drama on HBO Max, starring Noah Wyle as Dr. Robby, who leads a team of residents and students through a day in the life of a very busy emergency room in downtown Pittsburgh. In season two, episode eight, an obese patient is wheeled into the ER as the team determines how to best treat him and obtain a CT scan of him, a patient who cannot breathe lying flat due to his weight. In fact, a medical student is overheard making several offensive comments. So let's take a listen.

[BEGIN CLIP]

Dr. Robby:

If surgery is necessary, then your weight could make things a little bit more complicated.

Patient:

I know, I'm sorry.

Dr. Robby:

Not to worry. We're going to take very good care of you. Team, let's try for a midline. Basilic vein with ultrasound guidance.

Dr. Whittaker:

Can ultrasound check for an appy?

Dr. McKay:

He's a little too large for ultrasound. Plus, our CT can only handle 450 pounds.

James:

And so if he's over that we send him to the zoo?

Dr. McKay:

He's right there.

[END CLIP]

Emily Schifter:

While this clip was about how a medical student was handling a patient, it raises issues that are analogous to those that employees and employers might see in the workplace. In light of the prevalence of bias against heavier workers, I think both in society generally, as we see in the clip, and in particular in the workplace, Tracey, as you've already noted, are there any laws that protect obese workers?

Tracey Diamond:

Well, to a limited extent, but probably not enough. For example, Title VII does not include weight as a protected category. However, the law on whether the ADA, or Americans with Disabilities Act, should be interpreted to include obesity as a disability is still evolving. For example, there are a few courts that have considered whether obesity limits life activities in any way, and there are also a handful of federal district courts, including in California, Louisiana, and Mississippi, that have held that obesity could be a disability under the ADA even in the absence of a physiological disorder or condition. But many courts have held that obesity is not a disability under the ADA in the absence of an underlying medical reason for the obesity, following interpretive guidance from the EEOC. In the absence of uniform protection under federal law, some states have stepped in to fill the gap. The Washington State Supreme Court, for example, has found that Washington's human rights statute protects workers from discrimination based on weight as a form of impairment. On the other hand, the Texas Supreme Court issued an opinion a few years ago finding that morbid obesity did not qualify as an impairment under the state's labor code in the absence of a physiological disorder or condition.

Emily Schifter:

Well, it's interesting that local jurisdictions once again are ahead of the pack in

implementing laws protecting workers, which can often be the case that we'll see cities or counties start to lead the way on new areas before we see states and ultimately federal courts deciding something like this, or federal statutes. But some local jurisdictions that have established ordinances finding that weight is a category protected from discrimination include New York City, San Francisco, Santa Cruz, Binghamton, Madison, Urbana, and Miami Beach. Interestingly, some of these ordinances, such as the one in Urbana, Illinois, for example, have prohibited weight discrimination as a form of discrimination based on personal appearance, rather than even getting into the debate about whether or not it is a disability. And that brings us to our next clip. In this one, a resident admonishes the student who was making the comments about the patient's weight to have more empathy. Let's take a listen.

[BEGIN CLIP]

Dr. McKay:

Maybe you could ease up with your comments about his weight.

James:

I was just wondering how he got so big and how we could help.

Dr. McKay:

We can help by finding out what's wrong with him and treating him with respect.

[END CLIP]

Tracey Diamond:

I would like to shift gears now to bring up a related topic, which is the rise in the use of GLP-1 drugs for weight loss purposes. And let's bring you into the conversation for this, Lynne. As an initial matter, what are GLP-1 drugs?

Lynne Wakefield:

Thanks, Tracey. So let me start by saying that I am not a doctor, nor am I playing one on this podcast. I have no medical training whatsoever, purely legal training. So the insights that I'll be sharing today regarding GLP-1s are solely based on my experience in helping clients analyze and navigate the various benefits implications associated with these drugs. So with that disclaimer, and at a high level, GLP-1s are medications that mimic a natural gut hormone to regulate blood sugar levels. They reduce appetite and promote feelings of fullness. Although GLP-1s were initially developed and prescribed primarily for the treatment of type 2 diabetes, the use of GLP-1s for weight loss purposes in the last couple of years has really skyrocketed.

Emily Schifter:

So how effective are these drugs?

Lynne Wakefield:

For many people, I think that GLP-1s have been a complete game changer in weight loss. Patients can lose 10 to 15% of their body weight over several months, with some trials showing up to 20% at the highest doses. Even Oprah has weighed in on her success with GLP-1s, bringing us to our third and final clip.

[BEGIN CLIP]

Oprah:

The reason why I'm doing this, even though I know I'm gonna get a lot of hateration for it, is because I just believe that these medications should be accessible to everybody.

Dr. Anya:

I agree.

Oprah:

I see how much they have changed my life. I have been in the struggle for a very long time. All of you who've watched me over the years know what that struggle has looked like. Up and down and yo-yoing and yo-yoing and yo-yoing. Feeling bad about myself, feeling shame, all that. And I just want everybody else to be released from that.

Dr. Anya:

Yes.

Oprah:

And to be released as young as possible. I think of all the years and time I wasted.

Dr. Anya:

Yes.

Oprah:

I wasted feeling embarrassed, feeling ashamed, feeling like even though I am Oprah and all that that means, and it's a pretty good thing, I will say that. But walking into a store and sensing that thing when the people just say, "May I show you the handbags? May I show you the gloves? May I show you the shoes?" You know, feeling like you don't belong in this store because you know that there's not one single thing in here that's gonna fit you. So no amount of money, no amount of success, no amount of fame can change that. So I am grateful that the medications have arrived in my lifetime. And I think about all the people who I've known who could have benefited from them.

[END CLIP]

Tracey Diamond:

What Oprah said is really very interesting. And I can relate to what she was saying about going into a store and saying, "Oh, I can only buy the shoes because nothing in here is going to fit me." I think a lot of, particularly women in this country, probably could relate to that statement. If the drugs here are so effective, it is surprising that obesity is still hovering around 37% of adults in the U.S. Lynne, why do you think more people aren't taking them?

Lynne Wakefield:

I think there are likely several contributing factors here. First, in the grand scheme of things, the use of these drugs to treat weight loss is still relatively new and the market is rapidly evolving with new drugs and new forms of the drugs continually being approved and introduced. The recent FDA approval of the drug that I just mentioned is a great example of this. But at the end of the day, I think for many people, it's really the cost of the medications that's the primary impediment to their usage.

Emily Schifter:

So why is that? What do these medications tend to cost people out of pocket?

Lynne Wakefield:

They cost a lot. There are certain drug manufacturers out there that are offering direct-to-consumer programs and manufacturers' coupons that can help to reduce the cost of the drugs. And at the same time, many employer-sponsored medical plans either don't cover GLP-1s prescribed for weight loss purposes at all, or cover them for weight loss purposes but only after the applicable out-of-pocket deductibles are satisfied, or only in connection with the completion of certain wellness program initiatives or disease management programs. For those employer-sponsored medical plans that have covered GLP-1s prescribed for weight loss purposes, limitations on the coverage have also become more prevalent as the use of these drugs for purposes of weight loss and resulting claims costs have increased. So basically it's a bit of a perfect storm, right?

Emily Schifter:

And some of our listeners may be familiar and some may not be with the distinction between self-insured and fully insured plans. So how does the type of plan that an employer have in place impact coverage for GLP-1s?

Lynne Wakefield:

That's a great question, Emily. And the type of medical coverage offered by an employer does impact GLP-1 coverage. So as a quick refresher for those who may not be familiar with the distinction between these types of plans, in a fully insured plan, the employer is paying premiums to an insurer for an insurance policy that has been filed with and approved by a state, and the insurer pays all claims that are incurred under that policy. In contrast, in a self-insured plan, the employer is paying a third party to administer medical claims under the plan, but

the plan generally is not subject to state law or filed with and approved by the state, and all claims are paid from the employer's general assets or a trust. And so because of these distinctions, employers with fully insured plans generally have less flexibility with respect to their medical plan design than self-insured plan sponsors, because the insurer is more likely to set the parameters regarding what is covered and what isn't.

Tracey Diamond:

Lynne, I have a question about the difference between fully insured and self-insured plans. That's something that's always kind of confused me. From the employee's perspective, if they have a health insurance card that says Cigna on it, or Aetna on it, or UnitedHealthcare, et cetera, does that mean that their plan is by definition fully insured? Or do self-insured plans also go through those kind of insurance companies to administer the plan?

Lynne Wakefield:

So that's a great question, Tracey. It's not gonna be apparent on the card itself whether the plan is self-insured or fully insured. But the same entities, the same companies that are out there in the marketplace providing fully insured coverage generally also provide self-insured coverage. So they act as insurers and they act as third-party administrators for self-insured plans.

Tracey Diamond:

That's interesting. So getting back to the GLP-1 issue, for those employers who have an option to provide coverage for GLP-1s prescribed for weight loss purposes as opposed to just for diabetes, I would think there must be an incentive for including this coverage in their plans, isn't there?

Lynne Wakefield:

As with many things in this space, I think it really comes down to a cost-benefit analysis. Offering the coverage could certainly be viewed as a recruitment and retention tool. But as I just mentioned, offering the coverage may not even be an option for employers with fully insured plans because those terms are dictated by the insurer. If providing the coverage for GLP-1s prescribed for weight loss is an option for employers with fully insured plans, providing the coverage may be cost-prohibitive given the impact on premiums. So despite the potential for recruitment and retention, it's often, I think, probably overshadowed by cost. And cost is also an issue for employers with self-insured plans. So some studies have indicated that only 20% of companies with 200 or more employees now cover GLP-1 drugs for weight loss. So it seems that many are still taking a wait-and-see approach. Due to the cost implications, we've actually even seen some companies that did offer coverage for GLP-1s prescribed for weight loss purposes cutting back on the benefit through the implementation of things like increased cost-sharing, higher deductibles, and other prerequisites for coverage.

Tracey Diamond:

Yeah, the 20% number is actually higher than I would have thought, but it's still pretty low when you think about it.

Lynne Wakefield:

Yeah.

Tracey Diamond:

Are there any legal considerations for employers to consider when covering GLP-1 drugs for diabetes but not for weight loss?

Lynne Wakefield:

There are always legal considerations when we're talking about medical plan coverage, Tracey. But yes, for employers with fully insured plans, whether GLP-1s can be covered to treat diabetes but not weight loss is primarily gonna be dictated by the state in which the policy is situated and the terms and provisions of the filed and approved insurance policy. For self-insured plans, there is nothing that legally requires that coverage be provided for GLP-1s prescribed for weight loss purposes. So the ACA doesn't require self-insured medical plans to cover GLP-1s for weight loss purposes, and there are no other federal mandates that require the coverage. Also, while some states have introduced legislation to require GLP-1s to be covered for weight loss purposes, self-insured plans should not have to comply with those state laws due to ERISA preemption.

Tracey Diamond:

And just to be clear, when you said ACA, did you mean the Affordable Care Act?

Lynne Wakefield:

I did. I think really the biggest legal consideration associated with covering GLP-1s for diabetes but not for weight loss is the ADA risk. And this is something that we would ultimately look to the two of you for guidance on, given that it's more within your area of expertise. But my understanding, and please correct me if I'm wrong, is that at a high level, in order for an employee to prevail on an ADA claim, the court would have to determine that obesity is a disability under the ADA and that the particular design at issue constitutes disability discrimination under the ADA. And the conclusion on these issues is likely gonna be fact-specific and jurisdiction-dependent. But as you all previously noted, there are some courts that have held that obesity could be a disability under the ADA, even in the absence of a physiological disorder or condition. I think, although courts in many circuits have held that a medical plan that provides different benefits for different types of disabilities does not violate the ADA's prohibition on discrimination as long as every employee, whether they are disabled or not, is able to access the same plan and the same benefits, that conclusion is not something that the Supreme Court has confirmed in the ADA context, and it's not established in all circuits.

Emily Schifter:

Yeah, I completely agree.

Tracey Diamond:

I just wanna unpack that for a little bit. So if an employee's in a jurisdiction where a court has held that being obese is a disability under the ADA, even in the absence of a physiological disorder, the theory would be that a plan that provides access to these drugs for diabetes but not for obesity, another disability under that court's definition, could be discrimination. Right?

Lynne Wakefield:

Right. That's right.

Tracey Diamond:

Got it.

Emily Schifter:

Yeah, disparate treatment of different disabilities, which is an unsettled question, as Lynne said, but kind of an interesting one that doesn't always come up outside of the context of providing benefits.

Tracey Diamond:

Yeah.

Emily Schifter:

Definitely a complicated question. And then when you've got the added complexities of state law versus, well, are you in a fully insured plan or a self-insured plan? Do you have ERISA preemption? It's a lot of questions. And I think you're right, plan design is not simple.

Tracey Diamond:

Right. But the analogy is providing someone with treatment for a back condition but not for a knee injury, and the idea being that you should be treating all types of disabilities the same in terms of the types of benefits offered to them.

Lynne Wakefield:

Right.

Lynne Wakefield:

When you start to get into benefit design, you also have to start to worry about things like the Affordable Care Act and HIPAA and how those requirements can impact these various design alternatives. So my colleague Lydia Parker and I did an in-depth analysis of these various design approaches and related legal considerations in a podcast last June addressing legal strategies for limiting GLP-1 access in self-insured medical plans that can be accessed through the

troutman.com website. That's available out there for those who may want more information on these approaches and considerations.

Tracey Diamond:

Hopefully the data will start to show in the years to come that GLP-1s are really starting to save money for benefit plans because people are losing weight and staying healthier and not needing other medical services.

Lynne Wakefield:

And I think there's also the question, and I alluded to this earlier in the discussion of the risks, but we don't know the long-term implications of these drugs as well. So that's another factor that will need to be analyzed as time goes by.

Emily Schifter:

Definitely. Well, thank you so much for joining us today. This was a really interesting discussion and I think a really timely issue that's only gonna become more and more prevalent as more and more of these drugs get approved and released and used. So thank you so much again for joining us, and thanks as always to our audience for listening to today's episode. Don't forget to visit our blog, hiringtofiring.law, and subscribe so you can get the latest updates. Please make sure to also subscribe to this podcast via Apple Podcasts, Google Play, Stitcher, or whatever platform you use. And don't forget to check out our firm's other podcasts on troutman.com/podcasts. We look forward to next time.

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