twin

Claims Analysis

The pharmacy savings from GLP-1 stewardship alone pay for themselves

Avoided GLP-1 fills returned 3.6x program cost at a large self-insured employer — a direct return measured from real-world pharmacy claims

At a glance

Employers evaluating GLP-1 management programs are routinely asked to accept a leap of faith: pay for a program today and trust that downstream savings will eventually justify the cost. This analysis makes a narrower and harder claim — **they don't have to wait.**

Over a 13-month window (March 2025 – March 2026) at a large self-insured employer in the entertainment industry (~12,200 covered lives), **Twin's GLP-1 stewardship program avoided an estimated 4,759 pharmacy fills versus the blended "without-Twin" scenario:** what an unmanaged plan of the same size would have filled. Stewardship here means managed access to GLP-1s: members receive GLP-1 coverage, every prescription is written and clinically supervised by Twin, and staying on therapy requires active participation in the Twin program.

At a conservative $650 per fill — a post-rebate benchmark set below what plans typically pay net of rebates — that is **$3.09M in gross pharmacy savings** and **$2.24M in net savings: a pharmacy-only ROI of 3.6x**. We stress-tested the comparison four different ways; even the most conservative keeps ROI above 3x.

Avoided Fills

4,759

Gross Savings

$3.09M

Pharmacy Savings ROI

3.6x

Zero leakage

every weight-loss fill occurred within the managed pathway

The GLP-1 cost problem

Weight-loss GLP-1 utilization is growing faster than nearly any other pharmacy line item. The Evernorth Research Institute reports national utilization growth of **+73.1% in 2025** and a projected **+52.9% in 2026**.[1] For a mid-sized plan, unmanaged adoption compounds into a seven-figure annual exposure within two years.

Stopping on its own is not saving: roughly two-thirds of members without diabetes stop therapy within a year, typically due to side effects or cost.[2]

Many later restart, returning those fills to the plan, and roughly 60% of lost weight is regained within a year of stopping.[3,4] Discontinuation with weight rebound isn't just disappointing for the patient — it is wasted spend for the plan. And there is no established clinical offramp: published guidance remains inadequate.[3]

Twin provides a tested medication de-escalation offramp that maintains clinical results for the patient and ROI for the plan.

The impact

This analysis is grounded in a real-world engagement: a large, national self-insured employer in the entertainment space (~12,200 covered lives) that launched GLP-1 weight-loss coverage and the Twin GLP-1 Stewardship program together in 2025. **The employer's priorities were explicit: contain GLP-1 spend, and give members a safe, clinically supervised offramp — avoiding the weight regain that typically follows unsupported discontinuation.**[3]

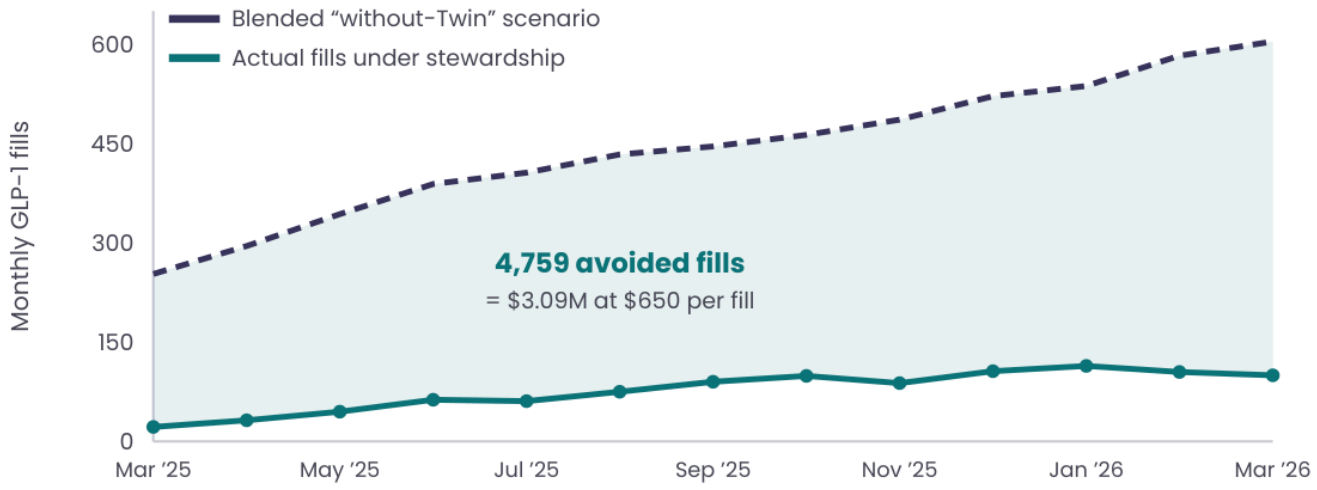
The employer launched the full Twin metabolic suite — type 2 diabetes, prediabetes, and healthy weight (HW) programs. Within HW, Twin was the sole prescriber of weight-loss GLP-1s, and receiving ongoing prescriptions required concurrent enrollment in the Twin program — the model we refer to as "GLP-1 Stewardship." The results presented here reflect the GLP-1 Stewardship program only. Over the study window, 282 members were actively enrolled in the HW program; 179 of those members had GLP-1 fills in claims, while the remainder participated in the program without GLP-1 use.

Actual fills in this analysis come from the employer's pharmacy claims over the 13-month operational window (March 2025 – March 2026). The claims confirmed **zero plan leakage**: because every prescription ran through Twin, no weight-loss GLP-1 fill occurred outside the managed pathway.

What must be estimated is the comparison: the fills that *would have* occurred without Twin. We estimate this from three real-world reference points — the actual experience of a comparable employer plan with no management program (~30,800 covered lives), national GLP-1 growth rates published by the Evernorth Research Institute,[1] and a high-growth trend observed at another large employer whose GLP-1 use more than doubled in a year — combined into one **blended "without-Twin" scenario**: a conservative, real-world-grounded estimate of what would have happened without Twin.

The chart below is the argument in one picture: managed fills hold low and steady while the unmanaged path climbs month after month — the widening gap between the two lines is the savings.

Monthly GLP-1 fills: stewardship vs. the without-Twin scenario



Building the without-Twin comparison

GLP-1 use in the absence of the program cannot be observed, so it must be estimated. Rather than relying on a single projection, we build three independent baselines and blend them into a consensus (Path D). Results are shown against all four, so the most conservative reading is always visible.

Path A — Comparator Employer Index. Real, observed fills at a comparator plan with no management program, adjusted for plan size — the most conservative comparison.[5]

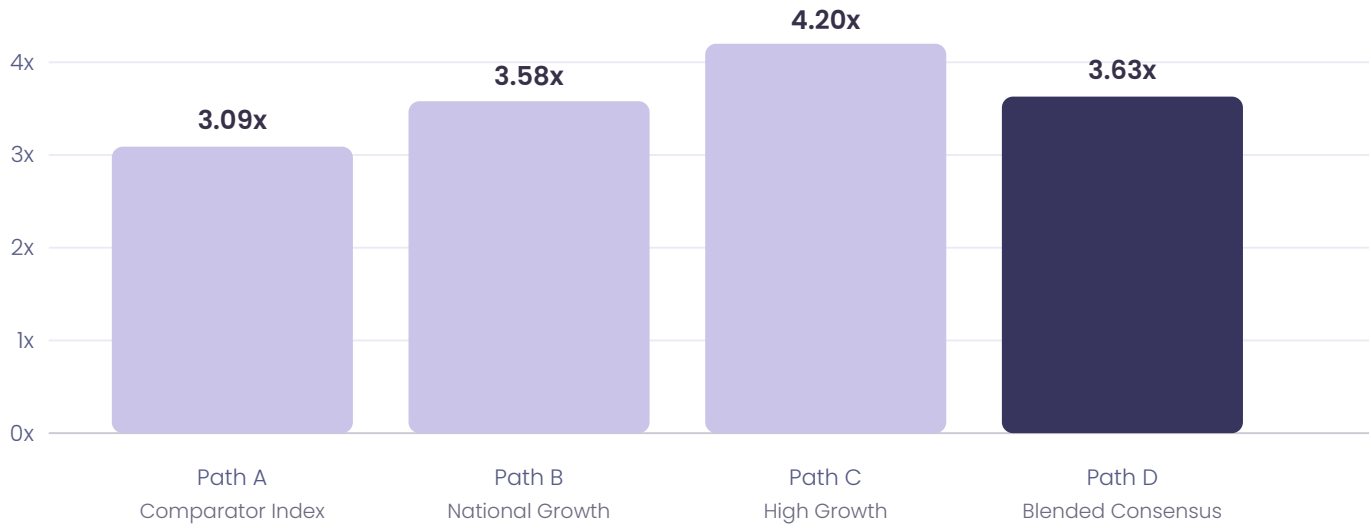
Path B — National Growth (Evernorth). The plan's own starting utilization, grown at national GLP-1 rates published by the Evernorth Research Institute.[1]

Path C — High-Growth Ceiling. The fastest-growth case: GLP-1 use growing as fast as observed at another large employer, where fills more than doubled (+115%) in a year.[6]

Path D — Blended Consensus
The equal-weight average of Paths A, B, and C — the blended "without-Twin" scenario, and the primary reported result.

Over the 13-month window, fills under the program remained below the blended "without-Twin" scenario in every single month — corresponding to **4,759 avoided fills, $3.09M in gross pharmacy savings, and a pharmacy-only ROI of 3.6x**. We stress-tested the comparison four different ways; **even the most conservative keeps ROI above 3x**.

Pharmacy-only ROI by scenario



Pharmacy-only ROI = gross avoided-fill savings relative to total program cost.

Conclusion

Twin Health combines sensor-based monitoring, an AI-powered Digital Twin metabolic model, and clinical coaching to improve metabolic health while safely managing and de-escalating high-cost medications. This analysis describes the real-world financial impact of the GLP-1 Stewardship program at a large self-insured employer through a claims-based evaluation.

Over a 13-month window, fills under stewardship remained below a conservatively modeled without-Twin scenario in every month, corresponding to **4,759 avoided fills, $3.09M in gross pharmacy savings, and a pharmacy-only ROI of 3.6x**.

The central finding stands on the narrower measure: for this employer, **pharmacy savings alone more than covered the cost of the program.** Notably, not all Healthy Weight members were on GLP-1 therapy; among non-GLP-1 users, Twin's lifestyle intervention produced substantial weight loss and favorable body recomposition, evaluated separately from the figures reported here.

$3.09M
gross pharmacy savings

3.6x
pharmacy-only ROI

4,759
avoided fills

Appendix

Population & window: ~12,200 covered lives at a large self-insured employer; 13-month operational window (Mar 2025–Mar 2026); ~1,000 managed fills observed with zero plan leakage (no weight-loss GLP-1 fill outside the managed pathway). Comparator plan: ~30,800 covered lives, no stewardship program.

Methodology: Four-path counterfactual model designed to quasi-experimental good practice.[10] All comparisons are adjusted for plan size (fills per 1,000 covered lives), so headcount growth cannot inflate the result. ROI figures reflect total program fees of $852,750 over the window, drawn from the audited financial system of record; fee structures vary by client.

Medical Savings: The model incorporates observed clinical outcomes and published literature: baseline medical costs are estimated from each member's starting BMI and pre-program medication spend, then compared with program-period costs reflecting BMI improvement, avoided progression to type 2 diabetes, and program fees. Pharmacy savings reported in this paper are excluded from that medical model to prevent double-counting. This is the same modeled approach reported for Twin's AI-enabled digital twin program in prediabetes and healthy weight management, which

combined observed clinical outcomes with published evidence on weight-loss-related medical cost reductions.[7] Estimates linking BMI reduction to medical expenditures are an additional input.[11]

Statistical strength: The gap between managed and unmanaged trajectories is positive in all 13 months and widens by +19.7 fills per month (heteroskedasticity- and autocorrelation-robust trend, $p < 0.0001$). A descriptive difference-in-differences comparison against the comparator

plan is directionally consistent ($\beta = -132.5$ fills/month, $p = 0.0095$).[10] Sensitivity analysis holds pharmacy-only ROI between 3.1x and 4.2x across a $550–$750 per-fill cost band, and 10,000-iteration Monte Carlo simulation per ISPOR-SMDM good-practice guidance[12] shows a 0% probability of negative return, with all 9 automated verification checks passing.

Conservative approach: The projected paths phase in gradually over the first three months (60/80/90%), so the model does not claim savings before demand would realistically have ramped up; the $650 per-fill benchmark is a post-rebate figure set below both this plan's observed net cost and the net prices most buyers see after rebates; and diabetes-maintenance prescriptions are excluded from all paths.

Limitations: Non-randomized observational comparison; $650/fill is a national post-rebate benchmark (sensitivity band $550–$750); T2D maintenance claims excluded from all paths.

De-identification: Comparator organizations are de-identified throughout; claims analyzed in compliance with HIPAA.

Citations

[1] Evernorth Research Institute. *Pharmacy in Focus*. 2025. GLP-1 utilization growth figures. [2] Rodriguez PJ, Zhang V, Gratzl S, et al. Discontinuation and Reinitiation of Dual-Labeled GLP-1 Receptor Agonists Among US Adults With Overweight or Obesity. *JAMA Netw Open*. 2025;8(1):e2457349. [3] Trajectory of weight regain after cessation of GLP-1 receptor agonists: a systematic review and nonlinear meta-regression. *eClinicalMedicine*. 2026.[4] Wilding JPH, Batterham RL, Davies M, et al. Weight regain and cardiometabolic effects after withdrawal of semaglutide: the STEP 1 trial extension. *Diabetes Obes Metab*. 2022;24(8):1553–1564. [5] Twin Health. Data on File — Comparator Employer Index: unmanaged comparator plan claims and eligibility analysis (Path A). 2026. [6] Twin Health. Data on File — High-Growth Ceiling: sector employer GLP-1 utilization benchmark (Path C). 2026. [7] Validation Institute. Twin Health savings validation report. 2025. validationinstitute.com/mp-files/twin_health_savings_2025_final.pdf [8] Wing C, Simon K, Bello-Gomez RA. Designing Difference in Difference Studies: Best Practices for Public Health Policy Research. *Annu Rev Public Health*. 2018;39:453–469. [9] Cawley J, Meyerhoefer C, Biener A, Hammer M, Wintfeld N. Savings in Medical Expenditures Associated with Reductions in Body Mass Index Among US Adults with Obesity, by Diabetes Status. *Pharmacoeconomics*. 2015;33(7):707–722. [10] Briggs AH, Weinstein MC, Fenwick EAL, et al. Model Parameter Estimation and Uncertainty: ISPOR-SMDM Modeling Good Research Practices Task Force–6. *Med Decis Making*. 2012;32(5):722–732.