LEVELS

METABOLIC HEALTH FOR EMPLOYERS

FOR SELF-INSURED EMPLOYERS, HEALTH PLANS & BENEFITS CONSULTANTS

Beyond the Prescription

Why personalization determines the return on your GLP-1 investment

A guide for self-insured employers, health plans, and benefits consultants managing metabolic health spend.

Executive Summary

GLP-1 medications are the fastest-growing line item in employer pharmacy spend, and the trend shows no sign of slowing. Most self-insured employers who cover them are absorbing $400 to $700 per member per month for a drug that, on its own, roughly half of members will stop taking within a year, often without ever building the habits that would make the results last. The medication works. A prescription alone is not a program.

A small but fast-growing body of clinical research points to the same conclusion from different directions: patients who get GLP-1 therapy paired with personalized nutrition, movement, and biomarker feedback lose more weight, keep more of it off, and retain more muscle than patients who get the injection alone. Whether that support also extends how long someone stays on therapy is a promising but still-open question; the outcome-quality difference is the part that's well documented. The organizations that win with GLP-1s, clinically and financially, will be the ones that pair the drug with a data layer that adapts to each person's biology and behavior, rather than the ones that simply make prescribing easiest.

This paper makes the case, using Levels' own longitudinal research alongside independently published literature, for treating GLP-1 coverage as a personalization problem as much as a formulary problem, and outlines what a metabolic health layer built for that purpose looks like in practice.

1. The Employer's Problem: Paying More, Seeing Less

Self-insured employers did not choose to become GLP-1 payers so much as they were pulled into it. Employees asked for coverage, competitors added it, and GLP-1s have become one of the fastest-growing categories in the pharmacy benefit, by one estimate accounting for roughly 14% of total U.S. prescription spending in 2026 and close to a third of all drug-spend growth. WTW's Rx Collaborative data shows employer-plan GLP-1 cost per member per month, blended across all covered lives, climbing from $4.34 in 2022 to $27.23 in the first quarter of 2025, more than a sixfold increase in three years.[1] At the plan level, the effect is concentrated: Blue Cross Blue Shield of Massachusetts has reported that GLP-1s made up roughly 20% of its total pharmacy spend in 2024, having doubled year over year.

For an individual employer, that translates into a real per-member cost that Levels' own conversations with self-insured plans consistently put in the $400 to $700 PMPM range for members actively on therapy, and 77% of large employers now call managing that spend a top benefits priority.

What makes this harder to plan around is that coverage itself is unstable. The Peterson-KFF Health System Tracker found 43% of firms with 5,000 or more workers covered GLP-1s for weight management in 2025, up from 28% the year before, while other industry surveys report figures closer to two-thirds of large employers.[2] Whichever number an individual employer's peer set lands closer to, the direction and the uncertainty are consistent: coverage is expanding, but it is not settled. In a 2026 survey of 105 self-insured employers, only 72% of those currently covering GLP-1s for weight management said they were likely to continue that coverage in 2027, while 10% said they likely would not.[3]

Some employers have already pulled back: HCA Healthcare, one of the largest hospital systems in the country, told employees in late 2025 it would stop covering Zepbound and Wegovy the following year after usage surged 90% in a single year, pointing them instead toward manufacturer cash-pay programs.[4]

And even where coverage holds, a large share of the spend is not converting into durable outcomes. The most rigorous published look at this, a JAMA Network Open study of 125,474 adults with overweight or obesity initiating GLP-1 therapy (Rodriguez et al., 2025), found that 46.5% of patients with type 2 diabetes and 64.8% of patients without it had discontinued therapy within one year; by two years, discontinuation reached 64.1% and 84.4%, respectively.[5] Looking further out, Prime Therapeutics has reported that only 1 in 12 patients using a GLP-1 for obesity remain on treatment at three years.[6] A population-level study of 77,310 first-time semaglutide users in Denmark, presented at the European Association for the Study of Diabetes' 2025 annual meeting, found more than half discontinued within a year, with the steepest drop-off between three and nine months.[7] Reinitiation is common but incomplete: in the JAMA Network Open cohort, roughly 36 to 47% of patients who stopped restarted within a year, typically after regaining weight, meaning the employer often pays for the stop-start cycle without the health outcome that justified the spend in the first place.

In short: the exposure isn't just the sticker price of the drug. It's unpredictable utilization, a treatment journey nobody is actively managing between the pharmacy and the scale, and no defined off-ramp when medication alone doesn't build something durable.

$400–700
Typical PMPM GLP-1 cost on a self-insured plan

77%
Of large employers call managing that spend a top priority

~50%
Discontinue within 12 months, usually without behavior support

2. Why the Prescription Alone Doesn't Hold

None of this is a knock on the medications, which are genuinely effective at what they are designed to do. The gap is what happens, or doesn't happen, around the prescription.

Muscle, not just weight, comes off. Any sustained calorie deficit causes some loss of lean body mass; that isn't unique to GLP-1s. But the scale of it is notable: a 2024 systematic review and network meta-analysis of 22 randomized controlled trials (2,258 participants) found that lean mass accounted for roughly 25% of total weight lost on GLP-1 monotherapy, a figure that can climb to 40% or higher on higher-dose compounds.[8] That matters for older employees and anyone already at risk of sarcopenia, and it's largely preventable: the Danish S-LITE trial, published in the *New England Journal of Medicine*, found that patients combining liraglutide with supervised resistance and aerobic training didn't just preserve muscle, they gained lean mass, an outcome not seen with medication alone.[9]

Most members aren't getting the nutrition support that changes this. A 2026 narrative review in *Clinical Obesity*, drawing on data from more than 480,000 adults with diabetes, obesity, or both, found meaningful rates of nutrient deficiency emerging within 12 months of starting therapy, 13.6% for vitamin D, with smaller but real rates of nutritional anemia, iron, and B-vitamin deficiency.[10] A companion study of GLP-1 users' actual food intake found

72% weren't meeting recommended calcium intake and 64% were under target for iron. Appetite suppression, the mechanism that drives weight loss, is also what makes it hard for members to hit the protein targets (generally cited in the 1.2–2.0 g/kg range) that would protect their muscle and nutritional status through the process. This is close to the default outcome absent active nutrition guidance, not a rare complication.

One dose doesn't fit every metabolism. A pragmatic clinical trial led by Dr. Andres Acosta at the Mayo Clinic identified four distinct obesity phenotypes: hungry brain (impaired satiation), hungry gut (impaired satiety), emotional or reward-driven hunger, and reduced metabolic rate (slow burn), each of which responds differently to a given intervention. In the trial, patients whose treatment was matched to their phenotype lost 1.75 times more weight at one year than those on a generic protocol, with 79% losing more than 10% of body weight versus 34% in the non-phenotyped group.[11] A single prescribing protocol, applied identically to every employee regardless of their underlying biology, leaves a meaningful amount of that outcome on the table.

The broader direction of the category points the same way. Prescribing a GLP-1 is quickly becoming table stakes; the platforms that matter going forward are the ones built around a patient's specific phenotype, biomarkers, and physiology, not just the prescription itself. For a benefits leader deciding what to build or buy in 2026, that's the fork in the road: a fulfillment pipeline for a drug, or a program that changes what the drug does for the person taking it.

There's early evidence this distinction shows up in claims data, too. Aon's analysis of claims from more than 192,000 GLP-1 users found that those with sustained adherence saw slower medical cost growth and fewer hospitalizations for major cardiovascular events than those with lower adherence.[12] That's a correlation in claims data, not a controlled study of what causes someone to stay adherent, but it reinforces that persistence, not just prescribing, is the outcome employers should be underwriting toward.

3. What Levels' Own Data Shows

Between June 2022 and August 2025, Levels ran the largest independent, participant-consented study connecting continuous glucose data, labs, food logs, and behavior to real-world metabolic outcomes that we're aware of: 62,236 IRB-consented participants and 1.15 billion glucose readings, collected over roughly three and a half years before the study formally concluded in December 2025.

This is an observational dataset, not a randomized clinical trial, and Levels is explicit about that distinction in how it reports the findings. With that caveat stated plainly: at one year, 22% of participants who started in the obesity category and 33% who started overweight with an additional qualifying risk factor no longer met FDA indication criteria for GLP-1 therapy, a considerably larger movement than the 2% and 5% seen in untreated natural-history comparison cohorts drawn from published literature.[13] Within that same population, 43% of participants who started with prediabetes reached a normal A1C at one year, and the cohort showed 67% lower progression from prediabetes to diabetes than would be expected from untreated natural-history data.[14]

22% / 33%
Exited FDA GLP-1 indication criteria at one year (obesity / overweight+risk)

43%
Of participants with prediabetes reached normal A1C at one year

67%
Lower progression to diabetes vs. untreated natural history

The practical implication for a benefits leader is straightforward: improving the underlying metabolic health of a population, independent of any GLP-1 prescribing decision, measurably shrinks the pool of people who go on to need, or continue needing, the medication. That's a lever available before the first prescription is ever written, and it's one most GLP-1 vendor conversations skip entirely because most GLP-1 vendors don't have the data infrastructure to measure it.

4. A Model Built Around Personalization, Not Just Prescribing

The research above points to a specific design requirement: a program that combines continuous, personal data (glucose, labs, food, activity, sleep) with real clinical guidance, wrapped around the medication rather than bolted onto it as an afterthought. That's the model Levels has built for employers, designed to work as one connected layer whether or not a given employee is ever on a GLP-1.

A workforce wellness benefit employees actually use. The foundation is CGM, labs, food logging, and AI-guided coaching in a single consumer product, not a clinical portal nobody opens. Employees get a real-time picture of what's driving their glucose, energy, and metabolic risk, the same behavioral foundation that protects outcomes for anyone who later starts a GLP-1.

A GLP-1 Companion for members on therapy. For employees who are prescribed a GLP-1 (whether through the employer's medical plan, a point solution, or their own physician), the Companion layer adds dose tracking, protein and nutrient guidance, appetite and side-effect management, CGM-informed trend monitoring, and structured preparation for an eventual taper or maintenance phase. This is the part of the journey the research above shows employers are otherwise paying for without getting anything back: the nutrition support that protects lean mass, the adherence support aimed at the roughly 50% one-year discontinuation employers are currently absorbing as waste, and the off-ramp planning that turns a silent stop into a managed transition instead of a restart eight months later.

Flexible control, matched to where the plan is today. Employers don't have to solve for maximum control on day one. Levels offers four layers that can be added as a plan year allows, each addressing a different source of cost:

- **Wellness + companion** — fastest to launch; no change to existing PBM or prescriber relationships.
- **Eligibility requirement** — ties coverage or renewal to meaningful participation.
- **Sole prescriber** — one clinical team owns eligibility, titration, and taper.
- **HRA direct access** — carves GLP-1s into a lower-cost, closed-loop purchasing channel.

Employers can start with the lowest-friction option and add control as their contract and plan year allow.

5. The Business Case, By Stakeholder

Every function that has to sign off on a benefits decision this size is optimizing for something different, and a personalization-first model gives each of them a real answer instead of a generic pitch:

- **Benefits and HR leadership** get a program employees will actually engage with, not another unused point solution, plus documented engagement and adoption data to report internally.
- **Finance and the CFO** get a bounded model: a spend-capped pilot, an employer-scale cost model built from the plan's own population data, and a measurement plan agreed to before the contract starts, rather than an open-ended prescribing commitment.
- **Legal and privacy** get a SOC 2 Type II and HIPAA-attested platform with a documented data-flow summary, so the review is procedural rather than exploratory.
- **Brokers and consultants** get a leave-behind they can re-share credibly, evidence-backed enough to recommend without staking their own reputation on an unproven point solution.

The throughline connecting all four is the same one this paper has made from the research: a program that improves the underlying metabolic health of the population reduces the number of people who need the drug, reduces prescribing and dosing leakage among people who are on it, and gives every stakeholder in the room a defensible reason to say yes.

6. Where to Start

None of this requires an employer to overhaul its pharmacy benefit or pick a fight with its PBM on day one. It requires treating GLP-1 spend as a personalization and data problem as much as a coverage-toggle problem, and building or buying the layer that closes the gap between a prescription and a result. Levels' enterprise team works with self-insured employers, health plans, and their consultants to map a population's current GLP-1 exposure against the four control options above, and to build a plan-specific view of where a metabolic health layer would reduce eligible starts, prescribing leakage, and medication cost.

To talk through what that looks like for your population, **contact the Levels enterprise team →**

Sources & Methodology Notes

Levels' own data. All Levels-attributed statistics (62,236 participants; 1.15 billion glucose readings; 22%/33% exiting FDA indication criteria at one year; 43% reaching normal A1C; 67% lower progression to diabetes) come from Levels' longitudinal, participant-consented, IRB-reviewed study, which enrolled from June 2022 through August 2025 and formally concluded in December 2025. This is an observational study, not a randomized clinical trial, and the natural-history comparison figures are drawn from separately published literature, not a matched control arm within the same study. Treat the comparison as directional, not causal.

1. WTW, "GLP-1 Drugs in 2025: Cost, Access and the Future of Obesity Treatment," April 2025. wtwco.com

2. Peterson-KFF Health System Tracker / 2025 KFF Employer Health Benefits Survey. kff.org

3. Business Group on Health, 2026 survey of 105 self-insured employers on GLP-1 coverage. businessgrouphealth.org

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5. 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 Network Open*, January 31, 2025 (n=125,474).

6. Prime Therapeutics, "Prime Therapeutics Leading Research Shows Only 1 in 12 Remain on a GLP-1 Drug for Obesity at Three Years." primetherapeutics.com

7. Danish national registry study of 77,310 first-time semaglutide users, presented at the European Association for the Study of Diabetes Annual Meeting, September 2025.

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9. Lundgren JR, Janus C, Jensen SBK, et al., "Healthy Weight Loss Maintenance with Exercise, Liraglutide, or Both Combined," *New England Journal of Medicine*, May 2021;384(18):1719–1730.

10. Urbina et al., "Micronutrient and Nutritional Deficiencies Associated With GLP-1 Receptor Agonist Therapy: A Narrative Review," *Clinical Obesity*, February 2026 (n≈480,825 pooled).

11. Acosta A, et al., "Selection of Antiobesity Medications Based on Phenotypes Enhances Weight Loss: A Pragmatic Trial in an Obesity Clinic," *Obesity*, 2021.

12. Aon, "Aon's Latest GLP-1 Research Reveals Long-Term Employer Cost Savings and Significant Reductions in Cancer Risk for Women," January 13, 2026. aon.mediaroom.com

13. NHANES; Kompaniyets et al., 2023 (natural-history comparison for GLP-1 indication criteria).

14. Kawahara et al., 2015 (natural-history comparison for diabetes progression).

A note on precision. Figures describing "roughly 25 to 40% of weight loss from lean mass" and "1.2–2.0 g/kg" protein ranges are reported in the literature as ranges, not single fixed numbers, and are presented here as such. Where two credible sources reported different figures for the same statistic (employer GLP-1 coverage rates, for instance), both are disclosed rather than collapsed into one number, because the underlying surveys use different populations and methodologies.