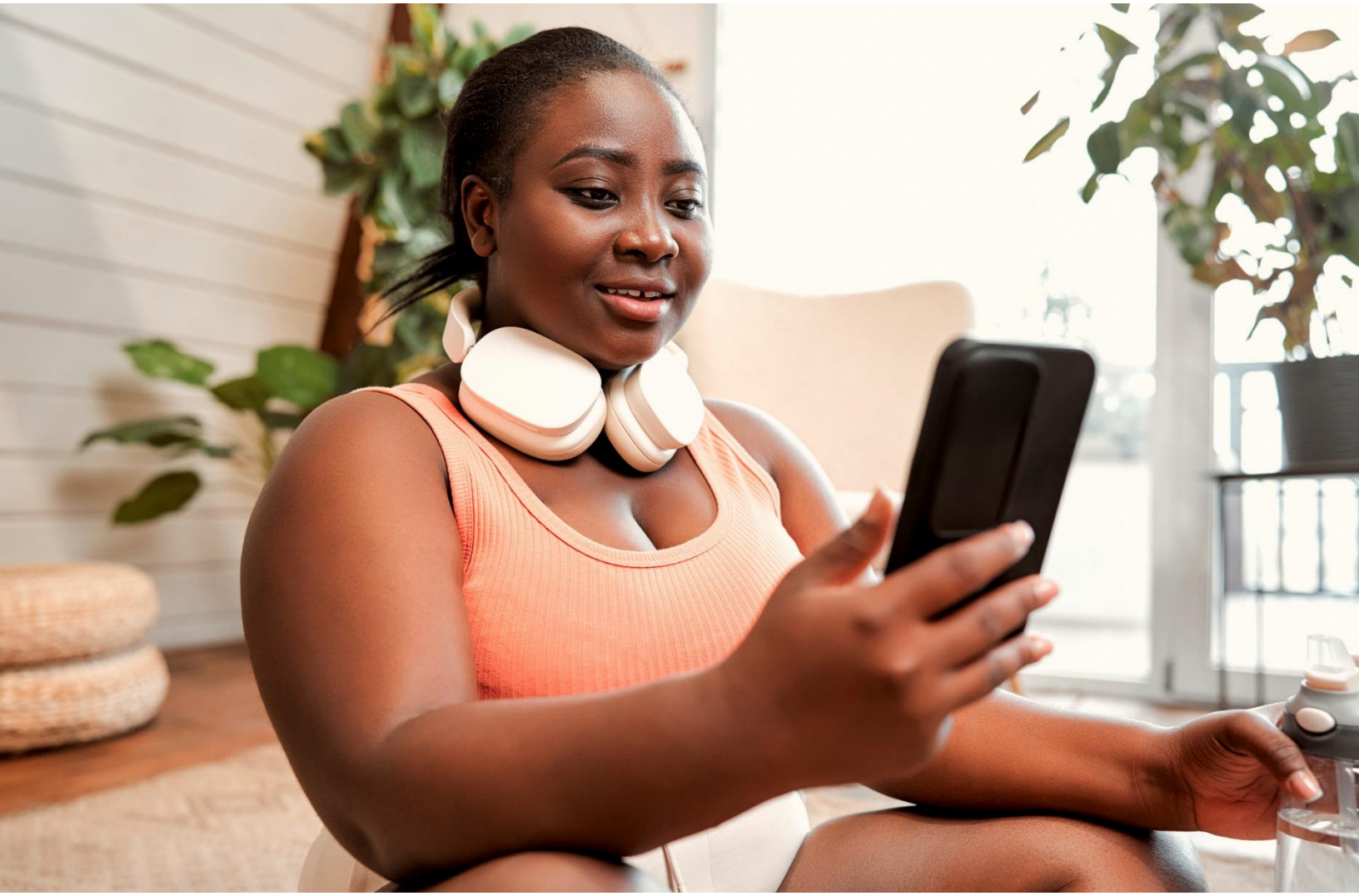

Omada Health | GlobalData Healthcare

Value of Integrated Virtual Lifestyle Care Plus GLP-1 Therapy: Modeled Clinical and Economic Outcomes in a Commercially Insured Population

Omada Health's GLP-1 Solutions: Clinical and Economic Value vs. Standard Care

August 2026

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Executive Summary

Obesity affects more than 40% of American adults and drives a growing burden of type 2 diabetes, hypertension, cardiovascular disease, and chronic kidney disease – representing a disproportionate and growing share of medical spending and faster growth in out-of-pocket spending for commercial health plan sponsors and self-insured employers. Though the approval and rapid adoption of GLP-1 receptor agonists have fundamentally altered the treatment landscape, the full clinical and economic value of these medications is only realized when medication is paired with structured lifestyle and behavior change support.[1,2] Without it, persistence erosion and post-discontinuation weight gain collectively undermine the return on GLP-1 investment.

This report presents modeled evidence on the value on investment (VOI), primarily clinical and economic value, and health equity, of Omada Health's GLP-1 solutions compared to standard care over a 5-year horizon, using GlobalData's Disease Prevention Microsimulation Model (DPMM). The standard care comparator is derived from the same population of individuals who enrolled with Omada Health, modeled as if they did not receive GLP-1s and did not derive the clinical benefits associated with participation in Omada's GLP-1 solutions. The analysis follows a commercially insured adult population with overweight and obesity that were persistent on a GLP-1 for at least six months. The report projects the downstream impacts on 5-year disease incidence (T2D, HTN, MACE, CKD, OSA), as well as total healthcare cost savings (including inpatient care, outpatient care, ER visits, and specialist visits) overall and by subgroups.

Clinical Outcomes: Members in Omada's GLP-1 solutions achieve substantially greater weight loss than standard care at 12 months (-12.4% vs. +1.4%, respectively). Among members with at least six months of GLP-1 persistence, the downstream clinical impact is substantial. The model projects a 49% reduction in new-onset type 2 diabetes and a 28% reduction in hypertension at five years compared to standard care, with meaningful reductions also observed in ischemic heart disease, stroke, chronic kidney disease, and obstructive sleep apnea. Clinical improvements are largest among members with higher baseline BMI, older age, and greater comorbidity burden, aligning with the populations driving disproportionate healthcare costs.

Economic Outcomes: Estimated cumulative medical cost savings compound over time as the clinical benefit of weight loss translates into reduced disease burden. Cumulative savings per member from the plan sponsor and/or employer perspective reach $1,448 at one year and $8,578 at five years for members with at least six months of GLP-1 persistence, rising to $1,881 at one year and $11,142 at five years for those with at least 12 months of persistence, indicating increased cost savings of approximately 30% with greater persistence. Savings are particularly strong among Black members ($9,971 at five years) and adults aged 65 and older ($10,969 at five years), reflecting Omada's potential to generate meaningful improvements to long-term outcomes and higher cost savings among members with greater baseline risk.

These results reflect the design of Omada's GLP-1 solutions, which support members across the medication journey – from initiation through active treatment and after discontinuation. Before GLP-1 use, Omada can provide tailored education and resources to members considering GLP-1s for weight loss. Health plan sponsors and employers also have the option to tie medication coverage with engagement requirements to concentrate GLP-1 investment in members prepared to adopt and sustain lifestyle change. During active treatment, a dedicated care team – including health coaches, cardiometabolic specialists, exercise specialists, and behavioral health specialists – supports side effect management,

lean mass preservation, and healthy nutrition patterns tailored to GLP-1 use. After discontinuation, continued specialized coaching, targeted lesson paths, and peer communities address the physiological and emotional challenges of stopping GLP-1 therapy, helping members maintain their weight rather than experiencing the weight regain that typically follows cessation without structured support.

Key Findings at a Glance

- Omada's GLP-1 solutions achieve substantially greater weight loss than the standard care comparator (not receiving GLP-1s or Omada's GLP-1 solutions), driving large 5-year reductions in new-onset type 2 diabetes (49%) and hypertension (28%), with additional benefits across cardiovascular and renal outcomes.
- For members with at least six months of GLP-1 persistence, cumulative per-member medical cost savings reach $1,448 at one year and $8,578 at five years, whereas for members with at least 12 months of GLP-1 persistence, cumulative per-member medical cost savings reach $1,881 at one year and $11,142 at five years. The greatest savings are realized in higher-risk, higher-cost subgroups such as older adults and Black members.
- By integrating support across the full GLP-1 medication journey, including intensive virtual lifestyle support, program engagement requirements, and specialized post-discontinuation coaching, Omada's GLP-1 solutions are associated with lower long-term disease burden and improved value on investment for plan sponsors and self-insured employers.

Results in Context

Prior analyses by Aon and Prime Therapeutics highlight that GLP-1 clinical and economic benefits – including reductions in medical cost growth and MACE-related hospitalizations – are largely contingent on sustained persistence and adherence. Omada's GLP-1 solutions are specifically designed to improve both medication adherence and persistence through structured behavioral and lifestyle support, helping members achieve and maintain healthy weight loss – which is estimated to lead to meaningful reductions in future disease onset and associated cost savings.

Omada's GLP-1 solutions deliver measurable clinical and economic value across the medication journey – from initiation through sustained use and beyond discontinuation – making it a compelling, evidence-based cost containment lever for plan sponsors and employers.

1. Introduction

Obesity represents one of the most significant and costly public health challenges facing the United States today. More than 40% of American adults live with obesity, and a further 30% are classified as overweight – together representing nearly three-quarters of the adult population.[3] Beyond its clinical consequences, obesity is a powerful driver of downstream disease burden, strongly associated with the development of type 2 diabetes (T2D), hypertension, cardiovascular disease (CVD), chronic kidney disease (CKD), and a range of other serious comorbidities.[4] The cumulative economic cost of obesity-related illness – including direct medical expenditures and lost productivity – runs to hundreds of billions of dollars annually across the US healthcare system.[5]

For commercial health plan sponsors and self-insured employers, obesity and its associated conditions represent a disproportionate and growing share of total and out-of-pocket medical spending. Members living with obesity incur more than 100% higher healthcare costs and faster growth in out-of-pocket costs than those at a healthy weight, driven by more frequent hospitalizations, greater utilization of specialist care, and higher rates of chronic disease.[6,7] As the prevalence of obesity-related comorbidities continues to rise, the pressure on plan sponsors and self-insured employers to identify effective, accessible, sustainable, and cost-efficient interventions has never been greater.

The approval and rapid adoption of glucagon-like peptide-1 receptor agonists (GLP-1s) and other anti-obesity medications (AOMs) has fundamentally altered the treatment landscape for obesity and its comorbidities. Clinical trial evidence, most notably from the SURMOUNT and SELECT trials, has demonstrated that GLP-1 therapies can achieve substantial and sustained weight loss, meaningfully reduce the risk of major adverse cardiovascular events (MACE), and slow the progression of obesity-related conditions including T2D and hypertension.[6,7]

While the existing clinical literature has not yet comprehensively addressed whether pairing GLP-1 therapy with structured lifestyle support amplifies both clinical effectiveness and its economic value, the American Diabetes Association 2026 Standards of Care in Diabetes, and other major health organizations, explicitly recommend that lifestyle interventions must be incorporated into all comprehensive obesity plans.[8] High-quality randomized controlled trial (RCT) evidence consistently demonstrates that GLP-1s combined with lifestyle modification produce superior weight loss outcomes compared to placebo with lifestyle modification alone.[9] Yet comparisons of this combined approach against usual care – the standard real-world benchmark for plan sponsors and employers – remain scarce. Additionally, the majority of published cost and cost-effectiveness analyses have focused on GLP-1 use versus non-use in isolation, without accounting for the role of a behaviorally-focused companion program.[9]

Critically, key drivers of long-term economic value in GLP-1 programs – including avoidance of medication waste, facilitating medication persistence to maximize health outcomes while on treatment, and promoting sustained weight maintenance after discontinuation are all areas where an effective companion program offering structured lifestyle support could play a meaningful role. Without accounting for these factors, existing cost analyses likely underestimate the true value achievable through an optimally supported GLP-1 program.

This report addresses this gap directly, presenting modeled evidence on the clinical and economic value of combining GLP-1 therapy with Omada's GLP-1 solutions, compared to standard care, over a 5-year horizon.

2. Omada's GLP-1 Solutions

Omada is a multi-condition virtual care provider offered through health plans and employers. The program combines human-led health coaching with an app-based platform that includes lifestyle education, peer communities, data from connected devices such as scales and blood pressure monitors, and AI-enhanced tools for meal tracking and nutrition guidance. Omada's GLP-1 solutions are designed to support members at each stage of GLP-1 treatment: members receive support for managing side effects and weight loss when first starting a GLP-1 and throughout the treatment phase, and continues with support for building the lifestyle habits associated with preserving muscle mass and maintaining weight loss after treatment ends. Omada also recently launched in-app prescribing, providing individualized GLP-1 and anti-obesity medication (AOM) prescribing with provider access, integrated care teams, and refill decisions informed by each member's clinical progress, labs, and engagement with lifestyle and behavior change. For health plans and employers, this capability offers the ability to manage GLP-1 prescribing and associated costs while maintaining a focus on clinical quality and lifestyle engagement. Given that the current analysis was conducted before Omada's guided medication care capability was launched, this report focuses on Omada's GLP-1 solutions outside of in-app prescribing.

2.1 Specialized Support During GLP-1 Initiation and Active Treatment

Members using Omada's GLP-1 solutions begin by logging a GLP-1 medication in the app.[*] From this point, members have access to a multidisciplinary care team, food and activity coaching, individualized exercise programming, GLP-1 education, and peer community support, structured around the needs of members taking GLP-1s for weight loss. Omada's GLP-1 solutions are designed to support a range of benefit strategies; health plan sponsors and employers can layer additional cost management features onto the core program, including requirements for ongoing program engagement.

An evaluation of Omada's GLP-1 solutions at 12 months found that combining GLP-1 medications with intensive virtual lifestyle support was associated with medication persistence and weight loss that met or exceeded published real-world estimates at one year.[10] In an analysis of 965 members, 67% were still taking their GLP-1 medication at one year; among those who persisted, members achieved an average of 18.4% weight loss at 12 months. Members who discontinued medication before one year maintained an average 13.1% weight loss at 12 months, suggesting that lifestyle support is associated with retained clinical benefit after stopping medication.[11]

Omada's program differs from other GLP-1 companion programs in its focus on both the quantity and the composition of weight loss – tracking not just how much weight members lose, but the proportion

[*] Omada recently individualized GLP-1 and anti-obesity medication (AOM) prescribing; however, the current report analysis was conducted before Omada's guided medication care capability was launched and is not considered here.

attributable to fat versus muscle mass. To support muscle mass preservation, Omada's GLP-1 solutions include exercise specialists who develop individualized, strength-focused activity plans, along with AI-enabled guidance focused on protein and nutrient-dense foods. In a 12-week comparative study of adults on GLP-1s,[12] members enrolled in Omada's GLP-1 solutions lost 1.8x more total weight and 2.1x more body fat while preserving muscle mass, than a comparison group not enrolled in Omada – indicating greater fat loss and reduced lean-tissue loss. Members in the Omada program also reported a 31% average reduction in anxiety and depression symptoms, a 20% average increase in well-being, and a 6% increase in self-efficacy (confidence in their ability to lose weight) at 12 weeks.

2.2 Preserving Weight Loss After GLP-1 Discontinuation

Internal research at Omada has found that members discontinuing a GLP-1 seek specific, targeted support rather than general weight loss guidance, particularly around managing cravings and maintaining behavior change after discontinuation.[10] Qualitative interviews and surveys of Omada members who recently stopped GLP-1 therapy suggest that this transition can be prolonged and emotionally difficult: members often describe GLP-1s as a "last resort," report anxiety about weight regain, and want support managing the return of appetite once medication stops. Omada's GLP-1 solutions include specialized lesson paths addressing the physiological and emotional changes associated with stopping GLP-1 therapy, alongside human-led coaching, nutrition support, and topic-based communities where members can share strategies for navigating access issues, side effects, and post-GLP-1 weight maintenance.

Published research indicates that people commonly regain about two-thirds of lost weight after discontinuing GLP-1 therapy.[13] By contrast, a real-world analysis of members enrolled in Omada's GLP-1 solutions found that at 12 months after discontinuation, members largely maintained their weight, with an average 0.8% weight change.[14] In addition, 63.5% of members maintained or continued to lose weight, suggesting that weight maintenance after discontinuation is achievable when members receive ongoing, specialized virtual lifestyle support after GLP-1 therapy ends.

3. Evaluating Omada's GLP-1 Value on Investment

As GLP-1 therapies reshape obesity treatment, evaluation has expanded beyond short-term weight loss outcomes to the broader value that GLP-1 treatment and companion programs can generate. For plan sponsors and other healthcare stakeholders, the central question has become whether GLP-1 programs produce durable clinical benefit and downstream reductions in healthcare utilization and cost.

A value on investment (VOI) framework provides a broader basis for evaluating GLP-1 programs than weight loss alone. In a prior report applying the American Medical Association's Return on Health framework,[2] Omada presented an assessment of its virtual cardiometabolic and musculoskeletal programs across clinical outcomes and safety, access to care, member and care team experience, and healthcare cost and utilization, incorporating a health equity lens. These domains are important for evaluating the value of a digital health solution in the context of GLP-1 treatment and weight health management. Supporting medication persistence during GLP-1 treatment and weight maintenance after discontinuation are factors that may influence downstream disease burden and long-term medical value. Evaluating outcomes across member subgroups can also help identify which members require more support and which experience the largest clinical or economic benefit.

This report evaluates several components of this VOI framework for Omada Health. It presents modeled evidence on the clinical and economic value of Omada's GLP-1 solutions compared with standard care, with attention to whether Omada's lifestyle modification program for members on GLP-1s is associated with real-world implementation benefits – supporting persistence, reducing avoidable inefficiencies, and sustaining clinical benefit over time.

Omada's Unique Value Across the GLP-1 Journey

Phase	Omada's Role	Cost Containment Mechanism
Initiation	**Provides** specialized education and support to members considering GLP-1 therapy for weight loss. **Sets** engagement requirements so members starting GLP-1s are ready to adopt and sustain lifestyle change.*	**Reduces** avoidable medication spend and waste from early discontinuation and non-use by directing GLP-1 use to appropriately selected members.
Active Treatment	**Delivers** specialized, human-led virtual care for GLP-1s through health coaches, cardiometabolic and exercise specialists. **Promotes** medication persistence, muscle mass preservation with strength-focused exercise plans, and healthy nutrition patterns tailored to GLP-1 use.	**Helps** members turn lifestyle changes into lasting habits that continue after GLP-1 discontinuation. **Sustains** persistence so GLP-1 spend produces durable clinical benefit.
Post-Discontinuation	**Provides** specialized post-GLP-1 support focused on managing cravings, “food noise,” and emotional adjustment after stopping the medication. **Helps** members maintain behavior change and preserve weight loss without ongoing medication.	**Prevents** cost rebound from weight regain that can follow GLP-1 discontinuation. **Limits** avoidable downstream utilization by helping maintain clinically meaningful weight loss and health improvements off-drug.

*Engagement requirements are a strategic choice by the health plan or employer and are not included in all Omada GLP-1 implementations.

4. Study Design & Methodology

4.1 Study Population

This report presents results from a Markov-based microsimulation model projecting the 5-year clinical and economic outcomes of Omada Health's GLP-1 solutions compared to a standard care comparator. The model employs a rigorous statistical framework for tracking interacting comorbidity pathways and conditioning future risk on each patient's accumulated clinical profile – important in obesity, where heterogeneity is high and economic returns unfold over years. The model tracks individual-level changes in body weight and cardiometabolic risk factors, projecting downstream impacts on disease incidence, complications, and mortality, and quantifying resulting economic benefits through healthcare cost savings.

Model Type	Markov-based microsimulation
Time Horizon	5 years
Comparator	Standard care (not receiving GLP-1s or Omada's GLP-1 solutions)
Perspective	Commercial health plan sponsor / self-insured employer
Discount Rate	3% annually applied to estimated healthcare cost outcomes

4.2 Simulation Model Scenarios

Two scenarios were modeled to estimate the clinical outcomes and costs associated with and without participation in Omada's GLP-1 solutions. Each scenario begins with the same cohort – clinical and demographic data is taken from Omada members with overweight and obesity at baseline, before any intervention has taken place. The difference in outcomes between the two scenarios represents the potential economic benefit of members engaging in Omada's GLP-1 solutions.

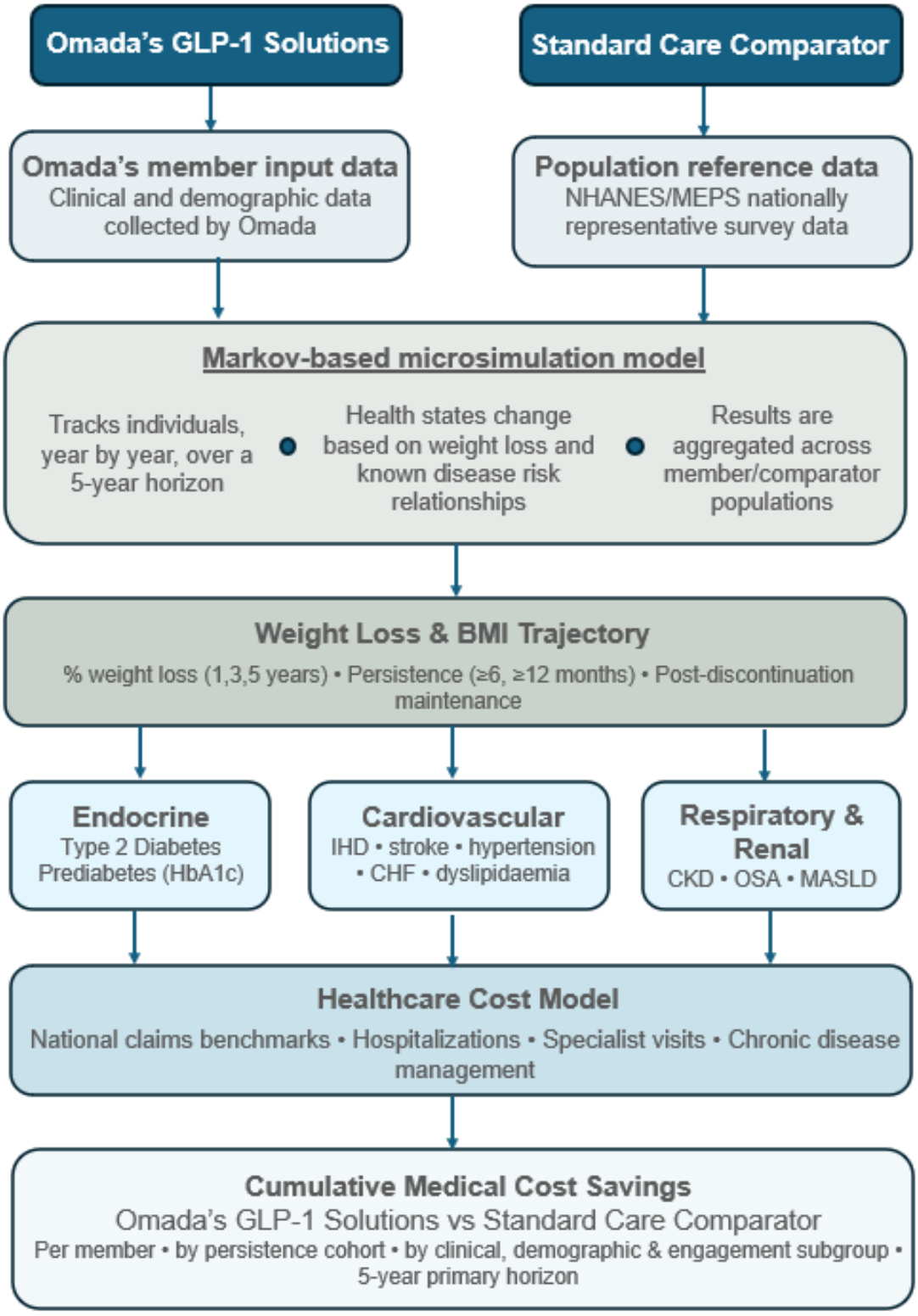
Omada GLP-1 Solutions Scenario (Intervention): The target population comprises adults with obesity or overweight who have been on a GLP-1 for a minimum of six months since the program started. Inclusion criteria included Omada members who were:

- Covered by a commercial health plan or self-insured employer program
- Had a BMI ≥25 kg/m² (≥23 kg/m² for Asian population)
- Persistent on GLP-1 medication for a minimum of six months from program start, and with objective weight data at 12 months

Standard Care Scenario (Comparator): The standard care comparator is derived from the same population of individuals who enrolled with Omada Health, modeled as if they did not receive GLP-1s and did not derive the clinical benefits associated with participation in Omada's GLP-1 solutions.[*] Annual changes in biometrics, including natural weight gain associated with aging, reflect the typical life course trajectory for this population, as derived from public survey data and published references.

The figure on the following page illustrates the analytical framework underlying the GlobalData Disease Prevention Microsimulation Model (DPMM), which projects health and economic outcomes over a 5-year horizon for two populations: participants in Omada's GLP-1 solutions and a standard care comparator. Beginning from their respective input data sources, individuals are tracked annually through a Markov-based microsimulation engine that translates weight loss trajectories and persistence patterns into disease state transitions across endocrine, cardiovascular, and renal/respiratory domains, producing cumulative medical cost savings estimates by persistence cohort and demographic subgroup.

[*] Given that less than 1% of adults received GLP-1s during the period used to calibrate the standard care comparator (2021–2023), their costs can be ignored in the model's cost estimates for the comparator group.



4.3 Model Structure & Key Assumptions

A published Markov microsimulation framework was used to project health and economic trajectories through annual cycles, with model inputs derived from published clinical trials, observational studies, and national data sources.[15] The model captures a range of obesity-related comorbidities and their associated economic impacts. The framework accounts for heterogeneity in treatment effects across program members with different baseline characteristics, weight loss, and multiple interconnected pathways through which obesity affects health outcomes.

The intervention arm reflects Omada's GLP-1 solutions supporting members across their medication journey. Key model inputs reflecting this intervention include:

- **Persistence rates** informed by Omada program data and prescription claims data, reflecting coaching and monitoring support
- **Post-discontinuation** weight maintenance trajectory reflecting sustained behavioral change

A sensitivity analysis was conducted to examine the impact of uncertainty in post-discontinuation weight maintenance on projected cost savings. The base case assumes members maintain their GLP-1-facilitated weight loss after discontinuation, consistent with Omada's real-world data. The sensitivity analysis tests the robustness of this assumption by applying a ±2% variation in weight maintenance from year two onward.

4.4 Outcomes Measured

The Markov-based microsimulation tracks individual members through a series of health states over the 5-year horizon, capturing:

- Cardiometabolic risk factor evolution: HbA1c, blood pressure, lipid profiles
- Probability of developing obesity-related comorbidities: T2D, hypertension, CVD events, CKD, etc.
- Associated direct medical and pharmacy cost impacts at each health state transition

Weight Loss	Derived from published RCT and real-world evidence on GLP-1 + lifestyle vs. standard care outcomes
Disease Progression	Comorbidity incidence/progression rates stratified by BMI and cardiometabolic profile
Medical Costs	National survey-based expenditure estimates with provider verification for total health expenditure, including on hospitalizations, office visits, outpatient services and emergency department visits

Clinical Outcomes

- Incidence of new-onset T2D, hypertension, MACE events, and CKD progression
- Post-discontinuation weight maintenance trajectories
- Outcomes by subgroups

Economic Outcomes

- Gross savings from total healthcare costs (medical + pharmacy) over five years per member. Pharmacy costs associated with GLP-1 and the cost of Omada's GLP-1 solutions were excluded

from the gross savings, as the primary focus is on downstream medical cost savings driven by improved weight outcomes and reduced disease burden.

5. Clinical Outcomes

5.1 Overall Weight Loss, BMI Reduction & Comorbidity Outcomes

The primary clinical question this analysis addresses is whether members in Omada's GLP-1 solutions for at least 12 months achieve meaningfully better health outcomes than those receiving standard care.

At 12 months, members in Omada's GLP-1 solutions achieve substantially greater weight loss than those receiving standard care (-12.4% vs. +1.4%, respectively). Because high medication persistence is a key driver of weight loss on GLP-1s Omada's GLP-1 solutions are designed to offer plan sponsors and employers the option to require lifestyle engagement alongside medication. These features result in higher persistence than is typically observed in other real-world settings using traditional prescribing pathways, likely contributing in part to the greater weight loss observed.[11]

Table 1. Sample Characteristics of Omada Members

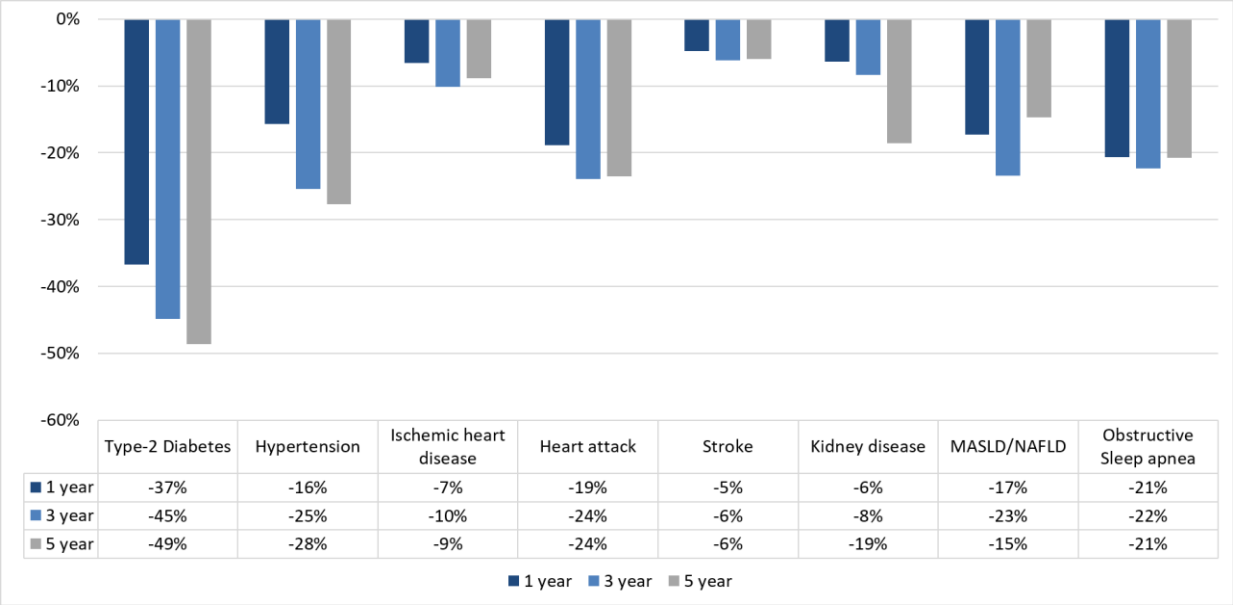
GLP-1 Persistence	≥6 months
N	24,595
Age, years	46.5
Male %	27%
Race/Ethnicity, %	
White	72%
Black	10%
Hispanic	7%
Asian	2%
Other and mixed races	9%
Baseline BMI, kg/m^2	35.5
Weight category, %	
Overweight	19%
Obesity class 1	34%
Obesity class 2	26%
Obesity class 3	21%
Baseline weight, lbs*	222
Baseline SBP, mm Hg	128
Baseline DBP, mm Hg	76
% in Prevention and Weight Health program	97%
Mean weight change at 12 months, %	

All	-12.4%
Hypertension program	-13.4%
Mean SBP change at 12 months (Hypertension program), mmHg	-5

* Not an input parameter of the simulation model. Demographic factors – including age, race, sex, and baseline BMI – were matched to the commercially insured NHANES subsample to impute missing clinical measurements, including blood glucose, blood pressure, and cholesterol levels (See Table S1).

The downstream clinical impact of maintaining the weight lost while enrolled in Omada's GLP-1 solutions is substantial. The figure below presents modeled reductions in disease incidence across eight obesity-related conditions among Omada members with at least six months of GLP-1 persistence, compared to standard care.

Figure 2. Reduction in Disease Incidence Among Populations with 6-month GLP-1 Persistence



	Type-2 Diabetes	Hypertension	Ischemic heart disease	Heart attack	Stroke	Kidney disease	MASLD/NAFLD	Obstructive Sleep apnea
1 year	-37%	-16%	-7%	-19%	-5%	-6%	-17%	-21%
3 year	-45%	-25%	-10%	-24%	-6%	-8%	-23%	-22%
5 year	-49%	-28%	-9%	-24%	-6%	-19%	-15%	-21%

The most pronounced effects are seen in type 2 diabetes and hypertension. Assuming that members maintain their weight loss from GLP-1s by continuing the lifestyle habits they established when using the Omada program, the risk reduction in T2D and hypertension in year 1 is 37% and 16%, respectively. This risk reduces to 49% and 28%, respectively, by year 5. Reductions in ischemic heart disease, stroke, and CKD are more modest in the near term but compound meaningfully over five years, a pattern consistent with the lag structure of cardiovascular risk modification following weight loss. Similar patterns in disease onset reduction are seen among members with 12-month GLP-1 persistence across obesity-related conditions (Figure S1).

These projections reflect the potential health effects of Omada's GLP-1 solutions, which are designed to support the medication persistence associated with clinically meaningful weight loss and to encourage lifestyle habits associated with weight maintenance after GLP-1 treatment.

5.2 Weight Loss by Demographic and Engagement Subgroups

Mean weight loss at 12 months varies across demographic and program engagement subgroups in ways that are both clinically meaningful and practically useful for plan sponsors and employers seeking to understand where Omada's GLP-1 solutions deliver the greatest value. The demographic and engagement breakdown is shown in Table 3.

Table 3. Average 12-Month Weight Loss for Members of Omada's GLP-1 Solutions by Demographic and Engagement Subgroups

	N	Initial BMI (kg/m^2)	12-Month Weight Loss
GLP-1 Type			
Semaglutide	7,933	35.2	-9.5%
Tirzepatide	16,626	35.6	-13.7%
GLP-1 Persistence Level+			
≥6 months	24,595	35.5	-12.4%
≥12 months	1,867	37.4	-17.0%
Gender			
Female	18,013	35.4	-13.0%
Male	6,582	35.7	-10.5%
Age			
<65 years	23,974	35.5	-12.4%
≥65 years	621	33.9	-11.6%
Race/ethnicity			
White	17,772	35.3	-12.7%
Black	2,418	37.1	-11.2%
Hispanic	1,845	35.9	-11.8%
Asian	431	33.4	-10.9%
Other or mixed races	2,560	35.4	-11.5%
Education Level			
Less than college	17,030	35.5	-12.3%
College and above	7,565	35.5	-12.4%
Income Level			
<$100,000	6,305	36.6	-13.0%
$100,000-$150,000	3,504	35.5	-12.5%
>$150,000	4,298	34.4	-11.4%
BMI Threshold (kg/m^2)			
BMI >30	19,985	37.2	-13.5%
BMI ≤30	4,610	28.0	-7.6%
Engagement Level*			
More engaged	5,384	36.3	-15.1%
Average	11,846	35.5	-12.5%
Less engaged	7,365	34.9	-10.2%

+ Persistence level indicates the minimum duration that program members remained on medication.

* Engagement level was defined by a cumulative total engagement index across 12 months, which summed across multiple types of member engagement like app logins, weigh-ins, lessons completed, meals tracked, and messages sent to their care team. Categories were created using cut points of 0.5 SD above and below the mean.

By Persistence and Medication Type

Both tirzepatide and semaglutide produce clinically meaningful weight loss within the Omada program. Controlling for demographics, tirzepatide users achieve greater mean weight loss (13.7%) than semaglutide users (9.5%), consistent with the differential efficacy established in the SURMOUNT and STEP trial programs and tirzepatide's dual GIP/GLP-1 receptor agonism.14,15 Persistence with treatment is a key determinant of outcomes: members who remain on medication for 12 months or more achieve a mean weight loss of 17%, underscoring that the magnitude of benefit associated with both agents is substantially greater when treatment is sustained, and that supporting long-term adherence may be as clinically important as the choice of agent itself.

By Clinical Parameters

Members with BMI ≥30 kg/m² lose more weight than those below this threshold (13.5% vs. 7.6%), reflecting greater physiological responsiveness to GLP-1 therapy at higher starting weight. Because higher BMI also tracks with greater comorbidity burden and healthcare costs, this group represents the largest clinical return on program investment.

By Demographic Parameters

Weight loss differences by age are small and clinically insignificant. Members under 65 lose 12.4% versus 11.6% among those aged 65 and older. This gap is consistent with published evidence suggesting that older adults may respond differently to GLP-1 medications, and does not diminish the clinically meaningful results observed in either group.

Weight loss ranges from 10.9% among Asian members to 12.7% among White members. This spread largely reflects differences in baseline BMI rather than differential program response: Asian members have the lowest mean baseline BMI in the cohort (33.4 kg/m²), which constrains absolute loss even when proportional response is comparable. Black members enter the program with the highest mean baseline BMI in the cohort and carry a disproportionately high burden of hypertension and cardiovascular disease relative to other racial and ethnic groups. This elevated baseline disease risk means that equivalent weight loss translates into greater avoided disease events than the weight loss figures alone would suggest.

Education level shows no meaningful effect. Members with and without a college degree achieve essentially identical 12-month weight loss (12.3% vs. 12.4%) at the same baseline BMI, indicating that Omada's structured coaching and digital delivery model performs consistently across educational backgrounds.

By Engagement Level

Greater engagement is the strongest predictor of weight loss within the program across the demographic and clinical factors examined. More engaged members (9.5 or more engagement actions per week on average) lose 15.1% of body weight at 12 months, compared to 10.2% among less engaged members (3.4 or less engagement actions per week on average). Notably, even less engaged members clear the 10% weight loss threshold, which is a clinically meaningful reduction that exceeds what would be expected under standard care.

6. Economic Outcomes

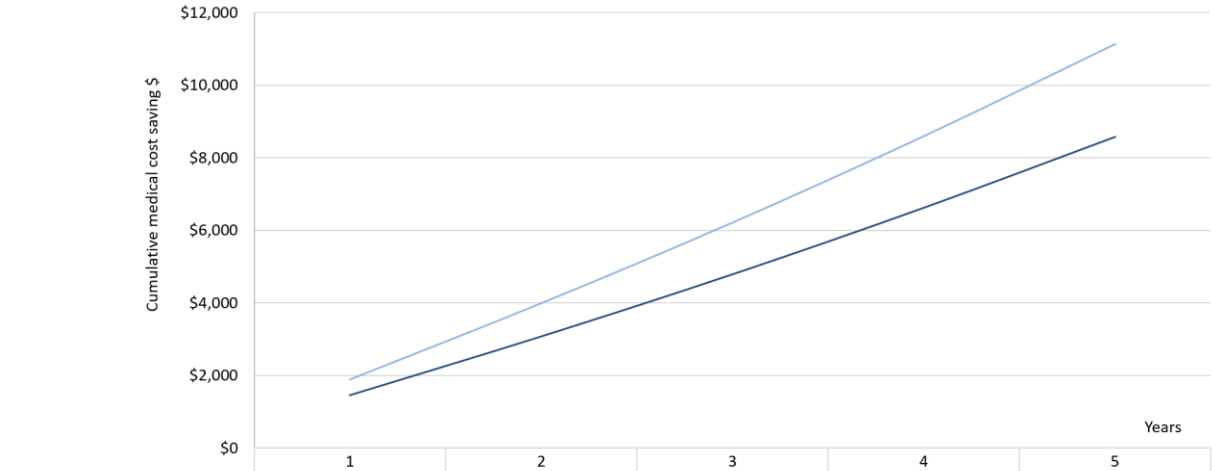
6.1 Total Healthcare Cost Savings

The economic case for Omada's integrated program rests on a straightforward mechanism: greater and more durable weight loss through a combination of GLP-1 treatment and a lifestyle program that promotes medication persistence during treatment and sustained lifestyle change after treatment generates lower rates of obesity-related disease, which translates into avoided medical costs over time.

By Persistence Level

The figure below presents cumulative medical cost savings per member for two GLP-1 persistence cohorts, those with at least six months of persistence and those with at least 12 months, compared to standard care, and assumes that Omada members maintain their weight loss from GLP-1s by sustaining the lifestyle habits they established when using the Omada program.

Figure 3. Cumulative Medical Cost Savings for Omada Members With GLP-1 Persistence of ≥6 months and ≥12 months ($)



	1	2	3	4	5
GLP-1 persistence ≥ 6 months	$1,448	$3,069	$4,784	$6,621	$8,578
GLP-1 persistence ≥ 12 months	$1,881	$3,986	$6,214	$8,600	$11,142

These gross medical cost savings reflect the avoided medical expenditure on hospitalizations, office visits, outpatient services and emergency department visits, relative to standard care, and do not include GLP-1 medication costs or program fees.

For the 6-month persistence cohort, cumulative medical cost savings reach $4,784 per member at year 3 and $8,578 at year 5. These savings remain robust even when post-discontinuation weight maintenance is varied by ±2% from year two onward (Figure S2), which highlights that modest differences in long-term weight maintenance can still translate into meaningful downstream cost containment. The 12-month persistence cohort generates meaningfully higher savings throughout: $6,214 at year 3 and $11,142 at year 5. The approximately 30% premium in savings associated with 12-month versus 6-month persistence reflects the dose-response relationship between medication duration and downstream

disease burden, and underscores why medication persistence is a central lever in Omada's cost containment model.

The gap between 6- and 12-month persistence curves in Figure 3 reflects the economic impact of the cardiometabolic benefit of GLP-1 therapy, and how it accrues in those who remain on medication long enough to achieve and consolidate weight loss. The 5-year projection in Figure 3 shows that the savings associated with persistence do not plateau, but continue growing, driven by compounding reductions in disease incidence and progression. Real-world GLP-1 persistence data consistently shows that 64.8% of patients initiating GLP-1 treatment for obesity (without type 2 diabetes) discontinue medication use within 12 months, often due to side effects, cost concerns, or loss of behavioral motivation.[16] Omada's GLP-1 solutions are specifically designed to address some of these concerns through program features that address side effect management and structured coaching that sustains the behavioral motivation that underpins medication persistence. Consistent with this, Omada program members demonstrate higher GLP-1 persistence rates than those reported in real-world evidence (67% vs. 47-49%, respectively), reflecting the integrated support provided across common barriers to adherence.[11,17]

By Medication Type

GLP-1 medication type also produces a smaller but consistent differential (Figure S6). Tirzepatide users generated $8,983 in cumulative savings at year 5 compared to $7,819 among semaglutide users, broadly proportional to the weight loss gap between the two agents. Both medication types produce savings that compound consistently across the projection horizon. Notably, the savings differential between medication types is smaller than the differential associated with engagement level – reinforcing that sustained engagement and behavioral support are at least as important as medication choice in determining long-run economic outcomes.

6.2 By Clinical Parameters

Baseline clinical severity is among the strongest predictors for economic return (Figure S3). Members with BMI ≥30 kg/m^2 generate $9,024 in cumulative savings at year 5, compared to $6,920 among those with BMI <30 kg/m^2 – a 30% difference driven by the larger absolute weight loss achievable at higher starting BMI and the corresponding greater reduction in downstream disease burden.

The savings gap increases steadily across the projection horizon, reflecting the compounding nature of avoided disease progression over time. This implies that the members that are currently driving the highest economic costs are those who will generate the largest long-term medical cost offset, making a strong case for prioritizing access to Omada's GLP-1 solutions for those with higher BMI and comorbidities.

6.3 By Demographic Characteristics

As shown in Figure 4, members aged 65 and older generate $10,969 in cumulative medical cost savings at year 5, above the under-65 cohort ($8,517) as shown in the figure below, despite older members achieving slightly lower weight loss at 12 months. Older members have higher baseline rates of obesity-related comorbidities such as hypertension, type 2 diabetes, and cardiovascular disease and have typically lived with obesity for longer, increasing their cumulative disease burden and the potential for meaningful cost savings from sustained weight loss. Because these conditions are more expensive to

treat, avoiding their onset and progression generates larger absolute cost savings than the same clinical gains would in a younger, healthier population.

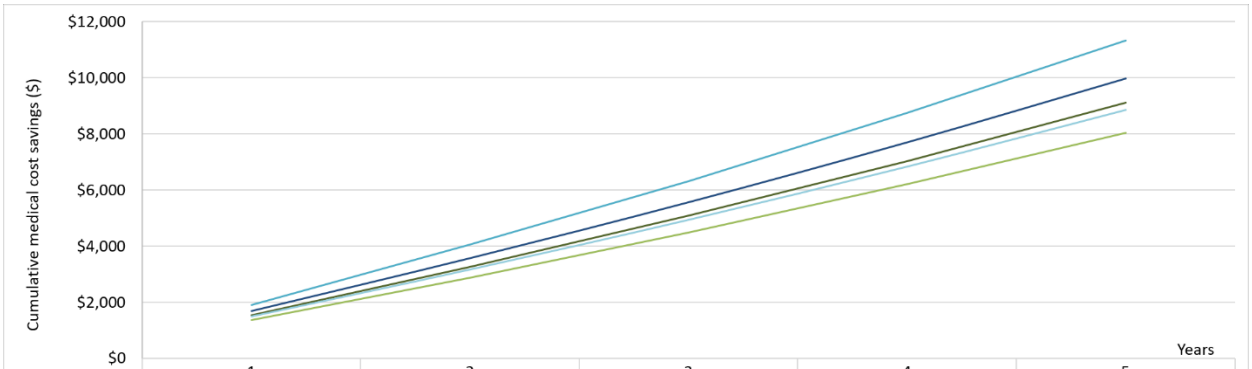
Figure 4. Cumulative Medical Cost Savings by Age Group ($)

	1	2	3	4	5
Age <65	$1,438	$3,047	$4,750	$6,574	$8,517
Age ≥65	$1,852	$3,925	$6,118	$8,467	$10,969

Cost savings vary across racial and ethnic subgroups in a pattern that is not fully explained by differences in weight loss outcomes alone (Figure 5). Using White members as the reference group ($8,032 in cumulative savings at year 5, the lowest of any racial or ethnic subgroup), Black members generate $9,971 in cumulative savings at year 5 (24% higher) and members categorized as Other races (e.g., American Indian or Alaska Native, Middle Eastern or North African, Native Hawaiian or Other Pacific Islander, Multiracial and others) generate $11,325 (41% higher). Hispanic and Asian members generate $8,864 and $9,107 respectively, 10% and 13% higher than White members, respectively.

The higher healthcare savings observed among members categorized as Other races reflect the heterogeneous and disproportionately high cardiometabolic risk profile of the racial/ethnic subgroups that make up this group. As the model captures the economic value of reducing comorbidity burden through sustained weight loss, the higher baseline disease risk in this group translates into greater potential healthcare savings when effective weight management is achieved. Despite showing similar weight loss outcomes to members categorized as Hispanic or Other race, Black adults carry disproportionately high rates of hypertension and cardiovascular disease in the US, and the model captures the economic value of reducing that burden when effective weight management is sustained. The lower savings among White members reflect their lower mean baseline BMI and correspondingly lower baseline disease risk.

Figure 5. Cumulative Medical Cost Savings by Race/Ethnicity ($)

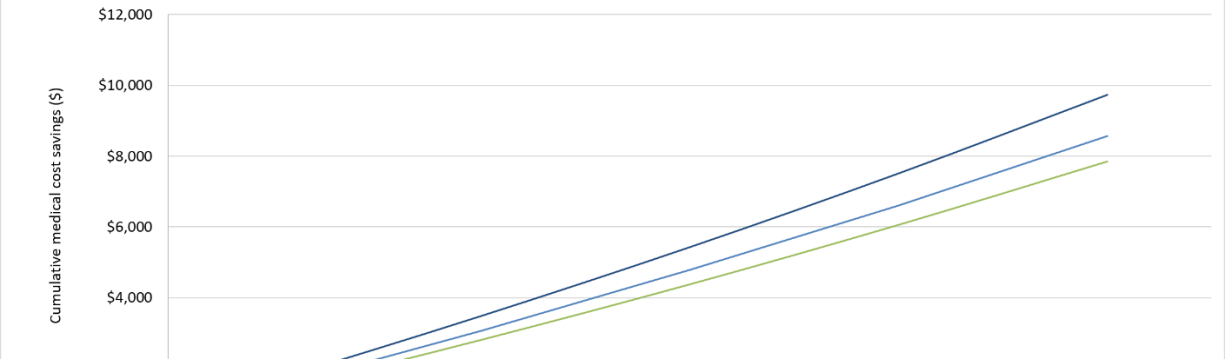


	1	2	3	4	5
Other races	$1,912	$4,053	$6,318	$8,743	$11,327
Black	$1,683	$3,568	$5,561	$7,696	$9,971
Asian	$1,538	$3,258	$5,079	$7,029	$9,107
Hispanic	$1,497	$3,171	$4,944	$6,842	$8,864
White	$1,356	$2,874	$4,480	$6,199	$8,032

Education level follows the same underlying logic (Figure S7). Members without a college degree generate $8,862 in cumulative savings at year 5 compared to $7,944 among college educated members. As weight loss at 12 months was identical in the two groups, the differential savings is likely attributed to the higher comorbidity burden in people without a college degree – a pattern well-documented in the literature, with adults at lower educational levels facing higher rates of cardiovascular disease, type 2 diabetes, and hypertension.[4] In sum, Omada's GLP-1 solutions are associated with downstream savings across age, race/ethnicity, and educational background, with the economic return modestly higher where baseline disease burden is greatest.

6.4 By Program Engagement Level

Figure 6. Cumulative Medical Cost Savings by Program Engagement Level



	1	2	3	4	5
More engaged	$1,644	$3,484	$5,432	$7,517	$9,739
Less engaged	$1,446	$3,065	$4,777	$6,611	$8,565
Average engaged	$1,325	$2,808	$4,377	$6,057	$7,848

More engaged members (9.5 or more engagement actions per week on average) generate $9,739 in cumulative medical cost savings at year 5, compared to $8,565 for average engagement (between 3.4 to

9.5 engagement actions per week on average, exclusive of endpoints) and $7,848 for less engaged members (3.4 or less engagement actions per week on average). The savings curves diverge progressively rather than running in parallel, meaning the economic premium associated with greater engagement compounds rather than stabilizes.

While more engaged members demonstrate the highest cost savings, members with average engagement and less engaged members generate comparable savings, suggesting that any level of engagement with Omada's GLP-1 solutions is associated with meaningful cost savings.

6.5 Subgroup Summary

There is a consistent pattern across all subgroups: Omada's GLP-1 solutions generate savings across the full plan sponsor and employer population, with the largest returns concentrated among members who present with higher baseline clinical risk, including older age, higher BMI, and greater comorbidity burden. These are the members driving the most healthcare cost today, and the group for which GLP-1 investment generates the most durable economic return. Deeper program engagement is associated with greater savings as a separate, additive factor – independent of a member's baseline cost profile – and, when properly supported, further strengthens the economic return.

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7. Comparison to Existing Evidence

Three key prior analyses provide the evidentiary context for this report's findings:

Aon (2024)	GLP-1 users showed a 3% improvement in medical cost growth vs non-users at 12-18 months; high persistence (≥80%) amplified this to 9 points. 37% reduction in MACE-related hospitalizations at 24 months post-initiation.
Prime Therapeutics (2024)	No statistically significant difference in medical spend trends between GLP-1 users and non-users – a finding the researchers attributed in large part to low real-world persistence and adherence rates.
SELECT Trial CEA (2025)	Savings identified from avoided T2D, CKD, and CV events. Net costs remained positive due to drug costs. Did not assess the impact of a structured lifestyle modification program.

This study addresses a meaningful gap in the current literature. Previous cost-analysis studies have focused on comparing GLP-1 use to non-users, without accounting for the use of a structured behavioral companion program. By modeling Omada's GLP-1 solutions alongside GLP-1 therapy, this study isolates the incremental economic value of behavioral support combined with medication, a comparison that has not previously been quantified.

This analysis also extends the scope of prior work in several important ways: it examines outcomes across clinical, demographic, and socioeconomic subgroups (including age, race/ethnicity, BMI, and program engagement level), offering plan sponsors and employers a more granular and actionable view

of where program investment generates the greatest return. Unlike analyses limited to 18–24-month follow-up windows, this study applies a 5-year modeling horizon, capturing long-term disease burden avoidance that shorter-term analyses cannot detect. Finally, the model explicitly incorporates medication persistence and post-discontinuation weight regain trajectories, factors absent from previously published cost analyses, providing a more complete picture of the total economic impact over a member's weight-health journey.

8. Conclusions

This report presents the first modeled evidence comparing Omada Health's GLP-1 solutions against standard care, over a 5-year horizon. The findings consistently favor the integrated model: Omada's GLP-1 solutions produce significantly greater weight loss and sustained BMI reduction than standard care, driven by high medication persistence and ongoing behavioral support, with meaningful downstream reductions in the incidence of T2D, hypertension, MACE events, and CKD progression that translate into substantial medical cost offsets. Beyond clinical outcomes, the higher medication persistence and weight loss observed in Omada's GLP-1 solutions relative to existing real-world evidence are associated with reduced disease onset, contributing to a more favorable cost profile for the bundled model compared with direct-to-consumer and traditional prescribing pathways. Post-discontinuation behavioral support is associated with continued preservation of weight loss and a smaller rebound in costs than is typically observed following GLP-1 discontinuation when structured support is not in place. These clinical and economic benefits are observed across demographic, socioeconomic, and clinical subgroups, with the greatest impact concentrated in higher-acuity and higher-engagement populations. This reinforces the value of Omada's GLP-1 solutions as both a population-level strategy and a targeted investment for plan sponsors and employers managing high-cost members.

Omada Health's GLP-1 solutions deliver measurable clinical and economic value across the full medication journey – from initiation through sustained use and beyond discontinuation – making it a compelling, evidence-based cost containment lever for commercial health plan sponsors and self-insured employers.

9. Limitations

As with all microsimulation analyses, these findings are derived from a model informed by published literature and program data rather than a prospective clinical trial, and results should be interpreted accordingly. The standard care comparator is constructed from nationally representative data and may include individuals who incidentally received some form of behavioral support, which could lead to an underestimate of Omada's incremental benefit. Because no real-world GLP-1-only cohort was available, the differential between Omada's GLP-1 solutions and GLP-1 alone draws on published RCT evidence rather than a matched comparator. The 5-year modeling horizon requires compounding assumptions about weight trajectories, disease progression, and cost trends that carry increasing uncertainty over time. Finally, the statistical precision of the subgroup analyses may vary due to sample size among

clinical subgroups, so these findings should be interpreted with caution. Additionally, these estimates reflect gross medical cost savings only: they do not net out the cost of GLP-1 medications or Omada's program fees, as the analysis is focused on downstream medical cost savings driven by improved weight outcomes and reduced disease burden rather than a full net-cost accounting.

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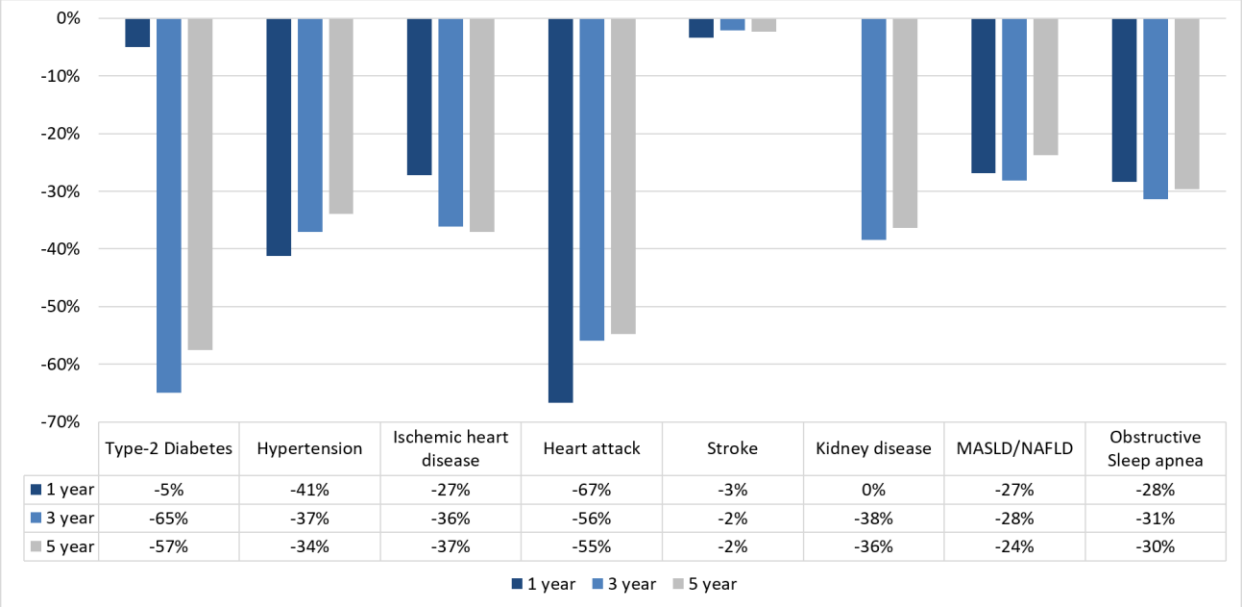
Appendix

Table S1. Sample Characteristics of Matched NHANES Cohort

GLP-1 Persistence	6 months
N	33,767
Age, years	46.3
Male %	27%
Race/Ethnicity, %	
White	70%
Black	12%
Hispanic	8%
Asian	2%
Other and mixed races	8%
Baseline BMI, kg/m^2	35.6
Weight category, %	
Overweight	20%
Obesity class 1	32%
Obesity class 2	25%
Obesity class 3	23%
Baseline weight, lbs*	227
Baseline SBP, mm Hg	
Baseline DBP, mm Hg	76
HDL, mg/dL	56
LDL, mg/dL	112
Mean weight change at 12 months, %	
All	-12.4%
HTN program	-13.4%
Mean SBP change at 12 months (Hypertension program), mmHg	-5

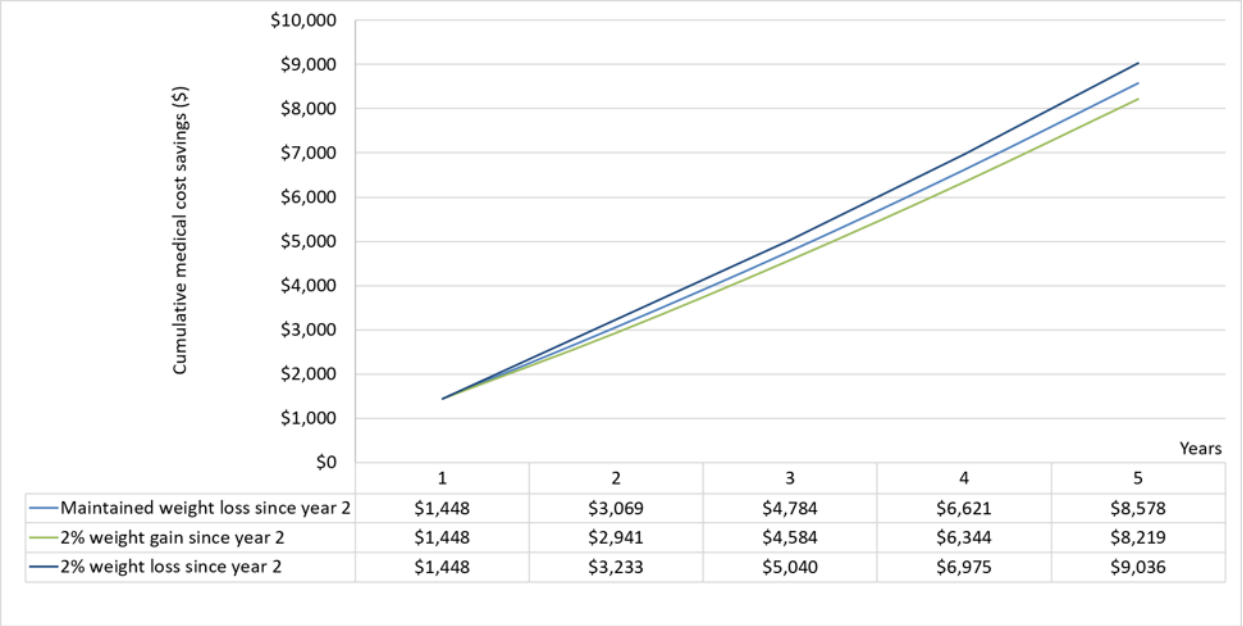
* Not an input parameter of the simulation model. Demographic factors among those with and without diabetes covered by commercial insurance including age, race, gender, initial BMI were matched to the NHANES sample to resolve inconsistencies.

Figure S1. Reduction in Disease Incidence Among Populations with 12-month GLP-1 Persistence



	Type-2 Diabetes	Hypertension	Ischemic heart disease	Heart attack	Stroke	Kidney disease	MASLD/NAFLD	Obstructive Sleep apnea
1 year	-5%	-41%	-27%	-67%	-3%	0%	-27%	-28%
3 year	-65%	-37%	-36%	-56%	-2%	-38%	-28%	-31%
5 year	-57%	-34%	-37%	-55%	-2%	-36%	-24%	-30%

Figure S2. Impact on Cost Savings of +/- 2% Weight Change Since Year 2



	1	2	3	4	5
Maintained weight loss since year 2	$1,448	$3,069	$4,784	$6,621	$8,578
2% weight gain since year 2	$1,448	$2,941	$4,584	$6,344	$8,219
2% weight loss since year 2	$1,448	$3,233	$5,040	$6,975	$9,036

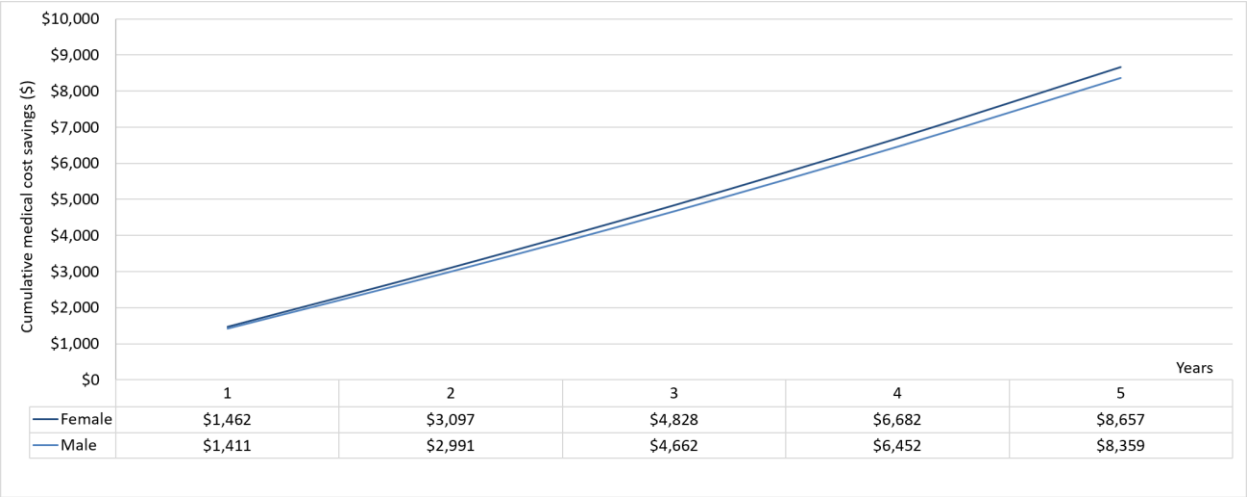
Figure S3. Cumulative Medical Cost Savings by BMI threshold

	1	2	3	4	5
BMI ≥30 kg/m2	$1,524	$3,229	$5,033	$6,965	$9,024
BMI<30 kg/m2	$1,168	$2,476	$3,860	$5,341	$6,920

Figure S4. Cumulative Medical Cost Savings by SBP Threshold (HTN program)

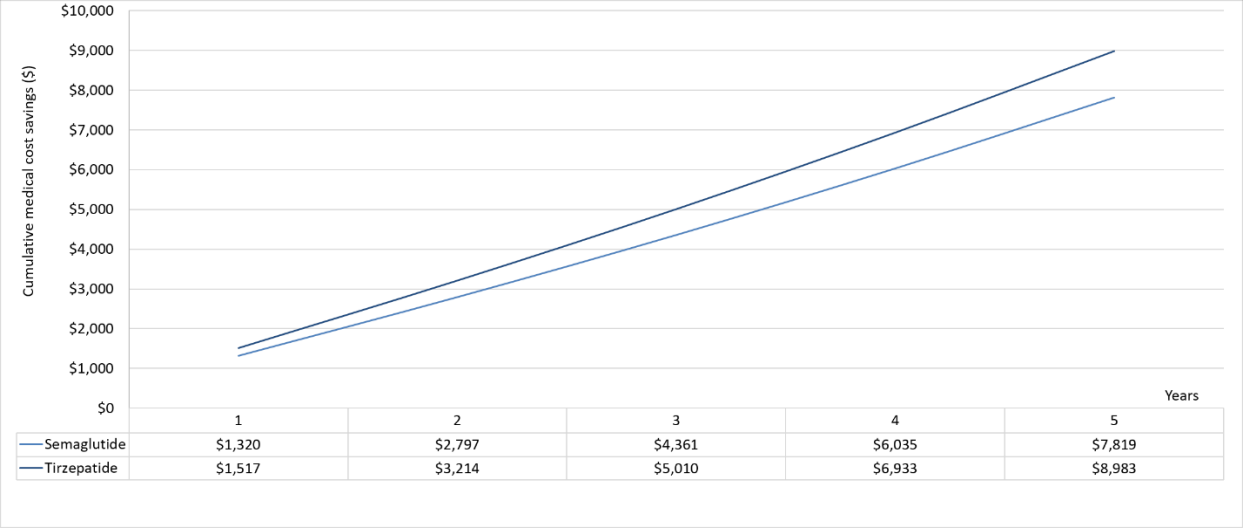
	1	2	3	4	5
Iinitial SBP <130 mmHg	$1,400	$2,967	$4,625	$6,401	$8,293
Initial SBP ≥130 mmHg	$1,669	$3,538	$5,515	$7,632	$9,888

Figure S5. Cumulative Medical Cost Savings by Gender



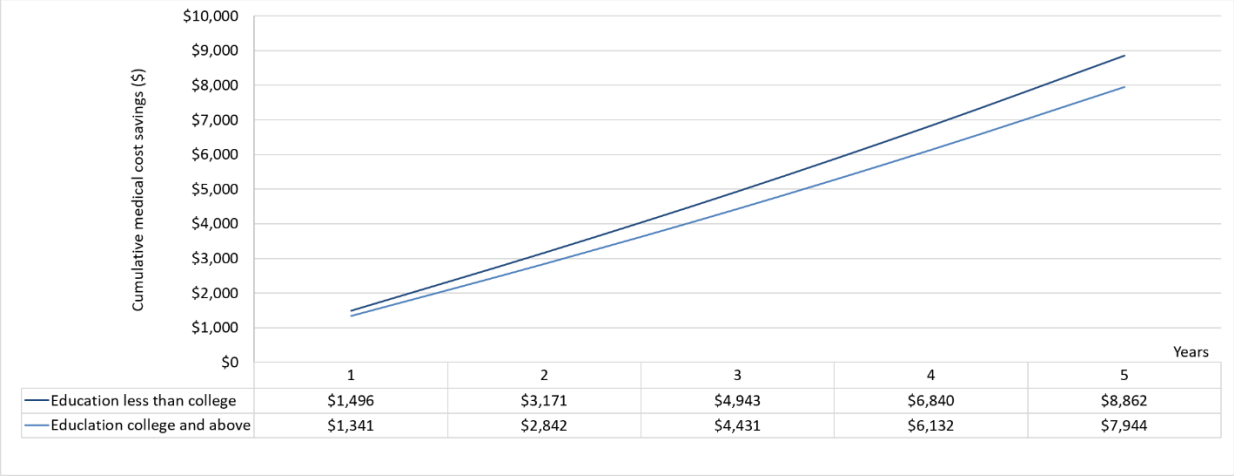
	1	2	3	4	5
Female	$1,462	$3,097	$4,828	$6,682	$8,657
Male	$1,411	$2,991	$4,662	$6,452	$8,359

Figure S6. Cumulative Medical Cost Savings by GLP-1 Type



	1	2	3	4	5
Semaglutide	$1,320	$2,797	$4,361	$6,035	$7,819
Tirzepatide	$1,517	$3,214	$5,010	$6,933	$8,983

Figure S7. Cumulative Medical Cost Savings by Education Level



	1	2	3	4	5
Education less than college	$1,496	$3,171	$4,943	$6,840	$8,862
Educlation college and above	$1,341	$2,842	$4,431	$6,132	$7,944

Figure S8. Cumulative Medical Cost Savings by Income Level

	1	2	3	4	5
<$100,000	$1,557	$3,313	$5,138	$7,086	$9,038
$100,000-$150,000	$1,390	$2,975	$4,635	$6,442	$8,400
≥$150,000	$1,372	$2,919	$4,568	$6,350	$8,024

