Older Americans Quit Weight-Loss Drugs in Droves

Stopping GLP-1 meds, such as Wegovy or Zepbound, usually means regaining weight and losing the associated health benefits.

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Year after year, Mary Bucklew strategized with a nurse practitioner about losing weight. “We tried exercise,” like walking 35 minutes a day, she recalled. “And 39,000 different diets.”

But five pounds would come off and then invariably reappear, said Bucklew, 75, a public transit retiree in Ocean View, Delaware. Nothing seemed to make much difference — until 2023, when her body mass index slightly exceeded 40, the threshold for severe obesity.

“There’s this new drug I’d like you to try, if your insurance will pay for it,” the nurse practitioner advised. She was talking about Ozempic.

Medicare covered it for treating type 2 diabetes but not for weight loss, and it cost more than $1,000 a month out-of-pocket. But to Bucklew’s surprise, her Medicare Advantage plan covered it even though she wasn’t diabetic, charging just a $25 monthly copay.

Pizza, pasta, and red wine suddenly became unappealing. The drug “changed what I wanted to eat,” she said. As 25 pounds slid away over six months, she felt less tired and found herself walking and biking more.

Then her Medicare plan notified her that it would no longer cover the drug. Calls and letters from her health care team, arguing that Ozempic was necessary for her health, had no effect.

With coverage denied, Bucklew became part of an unsettlingly large group: older adults who begin taking GLP-1s and related drugs — highly effective for diabetes, obesity, and several other serious health problems — and then stop taking them within months.

That usually means regaining weight and losing the associated health benefits, including lower blood pressure, cholesterol, and A1c, a measure of blood sugar levels over time.

Widely portrayed as wonder drugs, semaglutide (Ozempic, Wegovy, Rybelsus), tirzepatide (Zepbound, Mounjaro), and related medications have transformed the treatment of diabetes and

obesity.

The FDA has approved several GLP-1s for additional uses, too — including to treat kidney disease and sleep apnea, and prevent heart attacks and strokes.

“They’re being studied for every purpose you can conceive of,” said Timothy Anderson, a health services researcher at the University of Pittsburgh and author of a recent JAMA Internal Medicine editorial about anti-obesity medications.

(Drug trials have found no impact on dementia, however.)

People 65 and older represent prime targets for such medications. “The prevalence of obesity hovers around 40%” in older adults, as measured by body mass index, said John Batsis, a geriatrician and obesity specialist at the University of North Carolina School of Medicine.

The proportion of people with type 2 diabetes rises with age, too, to nearly 30% at age 65 and older. Yet a recent JAMA Cardiology study found that among Americans 65 and up with diabetes, about 60% discontinued semaglutide within a year.

Another study of 125,474 people with obesity or who are overweight found that almost 47% of those with type 2 diabetes and nearly 65% of those without diabetes stopped taking GLP-1s within a year — a high rate, said Ezekiel Emanuel, a health services researcher at the University of Pennsylvania and senior author of the study.

Patients 65 and older were 20% to 30% more likely than younger ones to discontinue the drugs and less likely to return to them.

What explains this pattern? As many as 20% of patients may experience gastrointestinal problems. “Nausea, sometimes vomiting, bloating, diarrhea,” Anderson said, ticking off the most common side effects.

Linda Burghardt, a researcher in Great Neck, New York, started taking Wegovy because her doctor thought it might reduce arthritis pain in her knees and hips. “It was an experiment,” said Burghardt, 79, who couldn’t walk far and had stopped playing pickleball.

Within a month, she suffered several bouts of stomach upset that “went on for hours,” she said. “I was crying on the bathroom floor.” She stopped the drug.

Some patients find that medication-induced weight loss lessens rather than improves fitness, because another side effect is muscle loss. Several trials have reported that 35% to 45% of GLP-1 weight loss is not fat, but “lean mass” including muscle and bone.

Bill Colbert’s cherished hobby for 50 years, reenacting medieval combat, involves “putting on 90 pounds of steel-plate armor and fighting with broadswords.” A retired computer systems analyst in

Churchill, Pennsylvania, he started on Mounjaro, successfully lowered his blood glucose, and lost 18 pounds in two months.

But “you could almost see the muscles melting away,” he recalled. Feeling too weak to fight well at age 78, he also discontinued the drug and now relies on other diabetes medications.

“During the aging process, we begin to lose muscle,” typically half a percent to 1% of muscle weight per year, said Zhenqi Liu, an endocrinologist at the University of Virginia who studies the effects of weight loss drugs. “For people on these medications, the process is much more accelerated.”

Losing muscle can lead to frailty, falls, and fractures, so doctors advise GLP-1 users to exercise, including strength training, and to eat enough protein.

The high rate of GLP-1 discontinuation may also reflect shortages; from 2022 to 2024, these drugs temporarily became hard to find. Further, patients may not grasp that they will most likely need the medications indefinitely, even after they meet their blood glucose or weight goals.

Re-initiating treatment involves its own hazards, Batsis cautioned. “If weight goes up and down, up and down, metabolically it sets people up for functional decline down the road.”

Of course, in considering why patients discontinue, “a large part of it is money,” Emanuel said. “Expensive drugs, not necessarily covered” by insurers. Indeed, in a Cleveland Clinic study of patients who discontinued semaglutide or tirzepatide, nearly half cited cost or insurance issues as the reason.

Some moderation in price has already occurred. The Biden administration capped out-of-pocket payments for all prescriptions that a Medicare beneficiary receives ($2,100 is the 2026 limit), and authorized annual price negotiations with manufacturers.

The reductions include Ozempic, Wegovy, and Rybelsus, though not until 2027. Medicare Part D drug plans will then pay $274, and since most beneficiaries pay 25% in coinsurance, their out-of-pocket monthly cost will sink to $68.50.

Perhaps even lower, if agreements announced in November between the Trump administration and drugmakers Eli Lilly and Novo Nordisk pan out.

The bigger question is whether Medicare will amend its original 2003 regulations, which prohibit Part D coverage for weight loss drugs. “An archaic policy,” said Stacie Dusetzina, a health policy researcher at the Vanderbilt University School of Medicine.

The Trump administration’s November announcement would expand Medicare eligibility for GLP-1s and related medications to include obesity, perhaps as early as spring. But key details remain unclear, Dusetzina said.

Medicare should cover anti-obesity drugs, many doctors argue. Americans still tend to think that “diabetes is a disease and obesity is a personal problem,” Emanuel said. “Wrong. Obesity is a disease, and it reduces life span and compromises health.”

But given the expense to insurers, Dusetzina warned, “if you expand the indications and extent of coverage, you’ll see premiums go up.”

For older patients, often underrepresented in clinical trials, questions about GLP-1s remain. Might a lower maintenance dose stabilize their weight? Can doses be spaced out? Could nutritional counseling and physical therapy offset muscle loss?

Bucklew, whose coverage was denied, would still like to resume Ozempic. But because of a recent sleep apnea diagnosis, she now qualifies for Zepbound with a $50 monthly copay.

She has seen no weight loss after three months. But as the dose increases, she said, “I’ll stay the course and give it a shot.”

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