How to Help People Stay on Their Weight-Loss Drugs

Only 8% of patients remain on GLP-1s after three years, according to a new review. A holistic approach may help.

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Roughly 40 percent of adult Americans are considered obese, and weight-loss drugs have come to play a central role in medical treatment over the past few years. As of the spring of 2024, one in eight U.S. adults had taken drugs including Wegovy, Zepbound, or Ozempic, among others, for weight loss. These products belong to a class of drugs known as glucagon-like peptide-1 agonists, or GLP-1s, which can be remarkably effective, but when patients go off GLP-1s, weight rebound occurs. And as it turns out, a relatively large portion of patients discontinue these medications within one year.

Prime Therapeutics, a company that manages prescription drug coverage benefits for insurers, employers, and government programs, has been documenting this phenomenon. In 2023, the company published research indicating that merely 32 percent of patients remained on their GLP-1 at the end of one year. A follow-up analysis found that by year two, only 15 percent remained on the drug. And in a new review, the company found that only 8 percent of patients remained on the drugs after three years.

The main reason for discontinuation — cited by almost half of patients in a large-scale survey — is concern about the medications' side effects. People may quit their medication after experiencing common side effects, such as uncomfortable gastrointestinal issues. They may also quit out of fear of more serious ones, like certain cancers — although research suggests GLP-1s are associated with a lower risk for many types of cancer. Additionally, some GLP-1 users may also be at risk of nutrient deficiency and muscle or bone loss without a proper diet and exercise regimen.

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Health and nutrition experts suggest that optimizing the benefits conferred by GLP-1s requires lifestyle interventions aimed at modifying patient behavior. GLP-1 medicines work for weight loss by curbing hunger and slowing digestion, but they don't replace the need for improved diet and increased physical activity. Rather, these prescription pharmaceuticals and other non-GLP-1 obesity drugs work together with nutrition and exercise to promote optimal health. In an email to Undark, Jody Dushay, an assistant professor at Harvard Medical School, wrote that "nutrition and exercise hugely benefit overall health" and increase the positive effects of the medications.

A holistic approach to medical care could ultimately address what some experts describe as a vicious circle: Many insurance policies appear reluctant to cover GLP-1s for weight loss in part because the medicines don't yet have a clear track record of long-term success. The Blue Cross Blue Shield Association, for example, recently cited high rates of patient discontinuation, which in turn lead to "wasted expense." Discontinuation can have implications for drug coverage, particularly if loss of weight isn't sustained after stopping medications. More data is needed, the insurer maintained, to ensure the medications offer durable value. But lack of insurance coverage — whether in the form of denials or switching of reimbursed products by insurers — can cause people to go off the drugs, creating the impression that they don't work over the long haul.

The latest Prime Therapeutics study did point to some good news: People are increasingly staying on GLP-1s for at least a year. While just over 30 percent of people on Wegovy made it to the one-year mark in 2021, the year it was approved for weight loss, that figure had nearly doubled by 2024. Zepbound, approved in 2023, had similar persistence rates. Time will tell whether this is a durable trend. Patrick Gleason, one of the study authors, told Undark that, among other things, persistence may be due to better physician management of side effects and increased use of disease or chronic care management programs, of which lifestyle medicine and medication therapy management are components. These programs can be offered by companies like Prime Therapeutics, by employers, or by independent vendors. They aim to help patients manage their chronic conditions by offering access to multidisciplinary teams that often include physicians, dieticians, and pharmacists.

If done comprehensively, they can help patients adopt healthier lifestyles, find the best dosing strategies, and manage any side effects. Opinions are mixed, however, on the success of insurer-based disease management programs. Spencer Nadolsky, an obesity and lipid specialist based in Michigan, wrote in an email to Undark that "they aren't actually comprehensive nor deliver a good service." He expressed concern about "lack of continuity with one physician and one dietitian" which he said can lead to disjointed care.

Farhad Mehrtash, a researcher in the Department of Nutrition at the Harvard T.H. Chan School of Public Health, offered another perspective: "The Prime paper is encouraging," he wrote in an email to Undark, "and such programs have theoretical merit in supporting adherence through counseling and side effect management." Still, he added, "its findings warrant cautious interpretation," given that there are "no control groups" and possible "selection bias," among other issues. Mehrtash thinks that the long-term impact of diet and exercise counseling should continue to be evaluated, with an eye for potential confounding factors, such as drug access and insurance status.

Indeed, most plans don't cover weight-loss drugs, in which case patients, even when insured, either pay the list price of a drug, which can be about $1,000 a month, or purchase certain drugs directly from the manufacturer, which for Wegovy and Zepbound cost $499 a month (except the starter dose for Zepbound, which is $349). This poses a problem for many patients, whether they're insured in the public sector by Medicare or Medicaid, or in the commercial sector by employer-sponsored plans or individual plans purchased directly from insurance companies or on Affordable Care Act exchanges. Almost a third of patients have cited financial and insurance barriers as the primary reason they discontinued use of GLP-1s.

Currently, Medicare can only pay for obesity drugs if they're prescribed for a related condition, such as diabetes or heart disease, though lawmakers have reintroduced legislation to partly lift the prohibition. And Medicaid, the state-federal insurance program for low-resourced people, only covers GLP-1s for obesity in 14 states as of November 2024. In the commercial sector, many employer-sponsored plans continue to be reluctant to reimburse GLP-1s for weight loss, as are health insurers generally.

High costs of drugs, insufficient patient persistence, and a corresponding perceived absence of long-term value appear to be the main factors that limit commercial insurance companies' willingness to provide coverage. In particular, insurers have expressed concern about patients who stop taking the medicines, which can lead them to regain weight and lose benefits such as blood pressure control. In the public sector, researchers have warned policymakers about the fiscal impact on future Medicare spending if the program permits Medicare Part D (outpatient drug) coverage of GLP-1s for obesity. They offer suggestions on different ways to mitigate such concerns, including pairing GLP-1 prescriptions with access to nutrition-based interventions.

At the moment, the cost estimates calculated by the Centers for Medicare and Medicaid Services assume that 52.5 percent of patients taking weight-loss drugs will stop taking them within two months. If persistence were to improve, however, presumably more patients could achieve clinically meaningful weight loss. This in turn could lead to passage of the proposed legislation in Congress to partly lift the coverage prohibition and insurers in both the public (Medicare and Medicaid) and commercial sectors being more willing to cover the drugs and accompanying services that encourage their long-term use.

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