

119TH CONGRESS
1ST SESSION

S. 1973

To amend title XVIII of the Social Security Act to provide for the coordination of programs to prevent and treat obesity, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 5, 2025

Mr. CASSIDY (for himself, Mr. LUJÁN, Mr. TILLIS, Mr. PADILLA, Mrs. BLACKBURN, Mr. FETTERMAN, Mrs. CAPITO, Mr. GALLEGO, Mrs. HYDE-SMITH, Mr. PETERS, Mr. WICKER, Ms. KLOBUCHAR, Mr. BOOKER, Mr. BLUMENTHAL, Mr. HEINRICH, Mr. VAN HOLLEN, Mr. COONS, and Mrs. SHAHEEN) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title XVIII of the Social Security Act to provide for the coordination of programs to prevent and treat obesity, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Treat and Reduce Obe-
5 sity Act of 2025”.

6 **SEC. 2. FINDINGS.**

7 Congress makes the following findings:

1 (1) According to the Centers for Disease Con-
2 trol and Prevention, about 41 percent of adults aged
3 60 and over had obesity in the period of 2015
4 through 2016, representing more than 27,000,000
5 people.

6 (2) The National Institutes of Health has re-
7 ported that obesity and overweight are now the sec-
8 ond leading cause of death nationally, with an esti-
9 mated 300,000 deaths a year attributed to the epi-
10 demic.

11 (3) Obesity increases the risk for chronic dis-
12 eases and conditions, including high blood pressure,
13 heart disease, certain cancers, arthritis, mental ill-
14 ness, lipid disorders, sleep apnea, and type 2 diabe-
15 tes.

16 (4) More than half of Medicare beneficiaries are
17 treated for 5 or more chronic conditions per year.
18 The rate of obesity among Medicare beneficiaries
19 doubled from 1987 to 2002, and nearly doubled
20 again by 2016, with Medicare spending on individ-
21 uals with obesity during that time rising proportion-
22 ately to reach \$50,000,000,000 in 2014.

23 (5) Men and women with obesity at age 65 have
24 decreased life expectancy of 1.6 years for men and
25 1.4 years for women.

1 (6) The direct and indirect cost of obesity was
 2 more than \$427,800,000,000 in 2014, and is grow-
 3 ing.

4 (7) On average, a Medicare beneficiary with
 5 obesity costs \$2,018 (in 2019 dollars) more than a
 6 healthy-weight beneficiary.

7 (8) The prevalence of obesity among older indi-
 8 viduals in the United States is growing at a linear
 9 rate and, if nothing changes, nearly one in two (47
 10 percent) Medicare beneficiaries aged 65 and over
 11 will have obesity in 2030, up from slightly more
 12 than one in four (28 percent) in 2010.

13 **SEC. 3. AUTHORITY TO EXPAND HEALTH CARE PROVIDERS**
 14 **QUALIFIED TO FURNISH INTENSIVE BEHAV-**
 15 **IORAL THERAPY.**

16 Section 1861(ddd) of the Social Security Act (42
 17 U.S.C. 1395x(ddd)) is amended by adding at the end the
 18 following new paragraph:

19 “(4)(A) Subject to subparagraph (B), the Sec-
 20 retary may, in addition to qualified primary care
 21 physicians and other primary care practitioners,
 22 cover intensive behavioral therapy for obesity fur-
 23 nished by any of the following:

1 “(i) A physician (as defined in subsection
2 (r)(1)) who is not a qualified primary care phy-
3 sician.

4 “(ii) Any other appropriate health care
5 provider (including a physician assistant, nurse
6 practitioner, or clinical nurse specialist (as
7 those terms are defined in subsection (aa)(5)),
8 a clinical psychologist, a registered dietitian or
9 nutrition professional (as defined in subsection
10 (vv))).

11 “(iii) An evidence-based, community-based
12 lifestyle counseling program approved by the
13 Secretary.

14 “(B) In the case of intensive behavioral therapy
15 for obesity furnished by a provider described in
16 clause (ii) or (iii) of subparagraph (A), the Secretary
17 may only cover such therapy if such therapy is fur-
18 nished—

19 “(i) upon referral from, and in coordina-
20 tion with, a physician or primary care practi-
21 tioner operating in a primary care setting or
22 any other setting specified by the Secretary;
23 and

24 “(ii) in an office setting, a hospital out-
25 patient department, a community-based site

that complies with the Federal regulations concerning the privacy of individually identifiable health information promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, or another setting specified by the Secretary.

“(C) In order to ensure a collaborative effort, the coordination described in subparagraph (B)(i) shall include the health care provider or lifestyle counseling program communicating to the referring physician or primary care practitioner any recommendations or treatment plans made regarding the therapy.”.

SEC. 4. MEDICARE PART D COVERAGE OF OBESITY MEDICATION.

(a) IN GENERAL.—Section 1860D–2(e)(2)(A) of the Social Security Act (42 U.S.C. 1395w–102(e)(2)(A)) is amended, in the first sentence—

(1) by striking “and other than” and inserting “other than”; and

(2) by inserting after “benzodiazepines),” the following: “and other than subparagraph (A) of such section if the drug is used for the treatment of obesity (as defined in section 1861(yy)(2)(C)) or for weight loss management for an individual who is

1 overweight (as defined in section 1861(yy)(2)(F)(i))
2 and has one or more related comorbidities,”.

3 (b) EFFECTIVE DATE.—The amendments made by
4 subsection (a) shall apply to plan years beginning on or
5 after the date that is 2 years after the date of the enact-
6 ment of this Act.

7 **SEC. 5. REPORT TO CONGRESS.**

8 Not later than the date that is 1 year after the date
9 of the enactment of this Act, and every 2 years thereafter,
10 the Secretary of Health and Human Services shall submit
11 a report to Congress describing the steps the Secretary
12 has taken to implement the provisions of, and amend-
13 ments made by, this Act. Such report shall also include
14 recommendations for better coordination and leveraging of
15 programs within the Department of Health and Human
16 Services and other Federal agencies that relate in any way
17 to supporting appropriate research and clinical care (such
18 as any interactions between physicians and other health
19 care providers and their patients) to treat, reduce, and
20 prevent obesity in the adult population.

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