

Written Testimony of

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Chairman, Ranking Member, and members of the Committee, thank you for the opportunity to speak today.

As a bariatric and general surgeon, I see the human cost of our current healthcare policy every day as I treat patients with obesity and metabolic disease—conditions that drive diabetes, heart disease, and hypertension, and represent a major share of our healthcare spending.

Our system is built for “sick care”—treating complications after they occur. We must pivot to true health care—shifting toward earlier, evidence-based treatment. By the time patients reach my operating room, they have already suffered years of preventable damage.

Treating obesity requires a coordinated approach that integrates surgery, medication, and prevention. Policies that support earlier screening, expand access to telehealth, and incentivize value-based care can help us intervene sooner and reduce long-term disease burden.

We already have many of the tools needed to improve health outcomes. By recognizing obesity as a chronic disease, expanding access to effective treatments, and supporting prevention and innovation, we can empower patients to live healthier lives while strengthening the sustainability of our healthcare system.

We are not lacking effective treatments—we are failing to deliver them to patients in time.

Thank you again for the opportunity to share my perspective. I look forward to answering your questions and discussing ways we can work together to improve the health of the American people.

I. Treat Obesity as a Chronic Disease

Obesity is a primary driver of Type 2 diabetes, hypertension, and heart disease, yet outdated policies still treat it as a lifestyle issue rather than a biological disease. Congress should expand coverage for evidence-based treatments, including medical weight management and bariatric surgery, to address the root cause rather than just downstream complications.

II. Expand Access to Proven Bariatric Treatments

Bariatric surgery is one of the most effective and durable treatments for severe obesity, yet access remains limited by insurance restrictions and referral barriers. Expanding access would improve outcomes and reduce long-term costs.

Newer medications, including GLP-1–based therapies such as semaglutide and tirzepatide, have expanded our ability to treat obesity and show real promise. These therapies can produce meaningful weight loss, often in the range of 15 to 20 percent, and should be part of a comprehensive treatment strategy. They are important clinical advances—but only one part of the toolkit.

However, surgery remains the most effective and durable option for severe obesity, typically producing 25 to 35 percent or more weight loss—roughly double that of medications—and achieving substantially higher rates of diabetes remission. These results are sustained over many years, while

medications require ongoing use to maintain their effect. Surgery provides sustained metabolic improvement.

As access expands, these medications should be used thoughtfully—prescribed by appropriately trained clinicians and integrated into long-term care focused on improving overall health, not just short-term weight loss.

Despite having effective treatments, patients and providers face significant barriers to care. Administrative requirements frequently delay or prevent timely, appropriate treatment. In many cases, the delay is not due to clinical uncertainty, but administrative friction.

III. Incentivize Preventive Care Over Sick Care

We continue to reimburse the treatment of disease more than prevention. Expanding coverage for nutrition counseling, metabolic screening, and medical nutrition therapy—including Medicare access to dietitians beyond diabetes and chronic kidney disease—would allow earlier intervention and reduce long-term costs.

IV. Encourage Earlier Screening for Metabolic Disease

Many patients develop complications long before receiving treatment. Medicare currently covers nutrition therapy and related services primarily for conditions like diabetes and kidney disease—typically after disease has already progressed.

Expanding screening and coverage to include:

- Obesity
- Prediabetes
- Metabolic syndrome
- Fatty liver disease

This would allow earlier intervention in at-risk patients before they reach a point of crisis. These are often the earliest signs of metabolic disease, yet they remain underdiagnosed and undertreated. Aligning coverage with early disease—not just advanced complications—would improve outcomes and reduce long-term costs.

V. Additional Priorities

- Expand community-based prevention programs
- Continue telehealth expansion
- Align payment models with outcomes
- Improve public education and reduce stigma

If we want to improve health and control long-term costs, we must treat obesity as a chronic disease, expand access to effective treatments, and intervene earlier.

We must apply the same clinical rigor to obesity that we apply to diseases like cancer and heart disease.

We have effective treatments—but access, not science, is now the limiting factor.