

My name is Dr. Kristen Connolly and I am a pediatrician at Timber Lane Pediatrics as well as member of the AAP Vermont Chapter Board and Vermont Medical Society. Timber Lane Pediatrics is part of Primary Care Health Partners, which includes several pediatric and adult primary care practices in Vermont. Our pediatric practice cares for over 8000 patients in three office locations—Burlington, South Burlington, and Milton, where I work and serve patients from Franklin, Grand Isle, Lamoille, and Chittenden Counties, and beyond.

Thank you to the Senate Health and Welfare Committee for the opportunity to talk today and voice my support for H.766. I would like to thank the Vermont House of Representatives and Chair Houghton for their work on Act H.766 and unanimous votes in favor and urge this Committee and the Senate to support it as well.

I am here before you today because in more than a decade serving as a primary care pediatrician in Vermont, barriers created by insurers have been one of the greatest obstacles to providing patient care. Insurance-required prior authorizations delay or block access to important treatments for patients, require significant time to address that diverts from direct patient care, and adds remarkable—and unnecessary—expense to an already too-expensive health care system.

Insurers frequently change their preferred formulary medication list and often it does not reflect best clinical practice. This is exasperating for health care providers and is particularly challenging for patients on long-term medications for chronic conditions.

One of the most egregious examples was the insurance coverage change for asthma medications on January 1, 2024. Asthma is the most common chronic condition of childhood. In January – in the height of respiratory virus season, on the tails of a global pandemic driven by the respiratory virus COVID19 – insurers changed their preferred medication formulary for asthma entirely. They removed coverage of the most commonly prescribed steroid maintenance inhaler for those with persistent asthma even though it became available as a generic medication. The only other similar steroid inhaler medication that could be administered with a spacer – as is needed for infants and young children – has experienced a substantial drug shortage and has been mostly unavailable. Physically and developmentally, infants and young children cannot be coached or physically execute breath-activated inhalers, but the insurer only offered these as alternatives. We use step-up therapy to guide appropriate asthma medication management but have been left without any age-appropriate options. Families who have seen their children hospitalized with asthma exacerbations have been frantic – as have we – trying to track down medications and approvals before another illness hits a vulnerable child with asthma. How can you deny a medication that enables a child to breathe? This is a direct safety issue that we in pediatrics are navigating daily right now.

Massive changes in preferred formulary medications for ADHD are ongoing as well. Many children with ADHD who have had social, academic or other struggles improved after starting ADHD medication have been overwhelmed when insurers decide not to cover that particular medication anymore. This has been further complicated by medication shortages

and has added significant stress for patients and families. These decisions have decreased access to medication and further exacerbated the mental health crisis we are navigating daily in primary care.

Children with complex health care needs – whose families are already under significant stress – often have to repeat the same prior authorization process for life-sustaining medications they have been on for years.

I once spent hours on the phone with an insurance company trying to advocate for a young infant who was malnourished because his gastrointestinal tract could not digest proteins in regular formula. He needed hydrolyzed formula – formula with the proteins more broken down for easier digestion – but I was told this could only be approved if the baby had a specific metabolic disorder or a gastrostomy feeding tube. Their decision had nothing to do with good medical care but with cost savings. It took hours of writing letters, phone calls, and signed prior authorization paperwork before they approved the needed formula and we were finally able to see this young infant gain weight. No family should ever be waiting on an insurance company to be able to feed their starving baby.

I was on the receiving end of these challenges as a patient myself, through three pregnancies complicated by severe nausea and vomiting. Each time, my obstetrician prescribed a generic anti-nausea medication to help enable me to continue working as a pediatrician and avoid hospitalization due to dehydration. Each time, I spent hours on the phone repeating the same conversation and process over several days of being violently ill before the prescription was approved. It astounded me my insurer would rather risk me being hospitalized and losing a pediatrician in the workforce than cover a generic medication.

These unnecessary prior authorizations and frequently changed medication formularies are not motivated by improving patient care or reducing patient cost. In fact, many are not even consistent with clinical guidelines. The effects on patients and risks to patient health are tremendous. The added burnout to an already thin primary care workforce is significant. The challenges with staffing that every primary care office in Vermont is facing is made harder when dealing with prior authorizations becomes someone's full time job, instead of providing direct patient care. When I find myself on the phone trying to explain why a medication is needed to feed a child, to help them breathe, to help support their mental and behavioral health and access their education, I wonder who would ever think this needed an explanation. And I wish I could just show the person on the other end of the line a photo of the child they are denying care to and see if they would reconsider.

I urge this Senate Committee to support this very important bill – which will require insurance companies to approve prior authorization requests quickly and allow someone to stay on a medication if they are stable without a new prior authorization or going back through step therapy – and bring it to the Senate for a vote as soon as possible. Thank you again for the opportunity to speak before you all.