Chairwoman Lyons and committee members, thank you for the opportunity to join you and speak today.

I am Dr. Wyll Everett. I grew up in small town southern Vermont and was fortunate to complete most of my education and medical training in the state. I now work as a family physician and hospitalist at Grace Cottage Family Health & Hospital – the rural health clinic and critical access hospital in Townshend, VT. Within the first three years of my career, I have been selected by my peers as medical director of the clinic and medical staff president. Also, I serve as president-elect for the Vermont chapter of the academy of family physicians. While I don't speak today specifically on behalf of these entities, I do speak as someone fully investing my career in primary care for Vermonters.

For this reason, S.197 is quite intriguing from my perspective as a rural family doctor. It feels like a significant step forward for belief in and investment in the bedrock of our healthcare system, primary care. I think it sets the tone that with upcoming policy progress, primary care will remain this essential foundation. I think it allows primary care to be the example of successful innovation and change as we often are, as we grow with the needs of our communities and patients.

I chose to work in a rural setting in Vermont, not just because it's home, but because of the role of primary care in the community. People trust the physicians that are part of their community and have continuity in their lives. Unfortunately, this trust and proximity does not always mean this care is easily accessible. In reviewing the bill, it reminded me of a patient, Sarah, who has been suffering from chronic shoulder pain and significant anxiety. We have navigated a treatment plan with physical rehabilitation, support, and medications for much of my time in practice. The greatest barrier is the fact that each office visit and prescription is a significant financial commitment. This has led to a balancing act between an evidence-based treatment approach with the realistic knowledge that following a strict plan to the letter could cause much more difficult circumstances in her life, perhaps preventing her from being able to access any care at all.

Something that became abundantly apparent as I recently transitioned from residency in a larger setting into practice in a rural one is the immense amount of work required to interact with insurance companies. At any point in training for family medicine or primary care it is easy to become acutely aware of the time suck and frustration regarding things like medication pricing, formulary lists, and prior authorizations. The difference for me at Grace Cottage is that I now share our small hallways with the multiple employees hired to navigate the complex system of simply getting paid for the work that we do. I witness the phone calls and direct messages and hours spent on hold trying to coordinate basic care. Also, it is much more transparent to see the differences in reimbursement based on insurance company – factors that, I have learned from peers in private practice, lead some providers to decide which patients they will see based on insurance type. As there are only more discussions about things like accessibility and

administrative costs, the notion that, we as a clinic would have appropriate funding without the struggle would significantly decrease the financial obligation of the administrative burden. For hospital based practices, this could also provide a needed stability in budgets that continue to need to tighten in our state.

In a fee for service system, primary care is never the money maker. The two major goals are true prevention or promoting stability of chronic disease. This does not lend itself to high cost – high reimbursement that drives many budgets. This had led primary care to use its only tool, volume, to stay afloat. Most primary care physicians working full time will see 18-20 some humans in a full day in order to make budget. To try and ensure that these appointment slots get filled, a provider's panel (patient's assigned to their care) needs to be large enough so that on average enough people are needing an appointment at any given time. As healthcare costs increase, budgets get tighter, and quite frankly people develop more chronic conditions, this leads to very full schedules which makes acute visits less available and preventative and new patient visits that get pushed numerous months into the future. If volume no longer needs to be the driver of the reimbursement for care, perhaps this vicious cycle can break and appropriate ratios and accessibility can be reached. Similarly, stable payment structure with realistic volume goals becomes a tremendous recruiting opportunity in a time when it's desperately needed and extremely difficult in places - such as the middle of nowhere in a small valley in southeastern Vermont. Quite frankly, the idea of getting consistent reimbursement and knowing the resources available to simply take good care of patients is a very appealing job opportunity for a primary care physicians and it mimics the older version of primary care that many in our communities miss.

I have strong views of what effective primary care consists of. A typical day for me includes seeing a couple wellness visits, a sick toddler, someone discharging from a hospital after a stroke, subacute shoulder pain that I treat with an injection, biopsying a pigmented skin growth, complex medication discussions for diabetes, and I run over to the local assisted living during lunch to have an end-of-life discussion, to then round out the day with a vasectomy consult that I will then perform next month. My afternoon today consists of back to back MAT visits helping people have consistent access to Suboxone and get support from our Spoke program. Simultaneously, in the office our counselors are helping support Sarah with her significant anxiety and our financial coordinator is helping to ensure that her insurance plan aligns with her income and connect her with local resources. To me, this supports key findings from the Primary Care Collaborative/Robert Graham Center's 2025 Evidence report (Closing the Distance in Rural Primary Care - Evidence Report | November 2025) which clearly noted that rural primary care is more comprehensive than urban primary care. Also, that rural primary care physicians save our patients money through the comprehensive, timely, and accessible care. S.197 has the opportunity to minimize administrative burden and costs for rural health centers, like Grace Cottage, while stabilizing funding that will keep these services in my community and keep my colleagues here next to me providing the highest quality of care. Thank you for your time today.