

Testimony before the House Energy and Commerce

Subcommittee on Health Hearing

Policies to Protect Our Communities from Illicit Drug Threats

March 26, 2026

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Good afternoon. Thank you, Chairman Guthrie, Chairman Griffith, Ranking Member Pallone, Ranking Member DeGette, and members of the Energy and Commerce Subcommittee on Health for inviting me to testify.

My name is Dr. Yngvild Olsen, and I most recently served as the Director for the Center for Substance Abuse Treatment (CSAT) at the Substance Abuse and Mental Health Services Administration (SAMHSA) from September, 2021 to early July, 2025. I am now a national adviser for Manatt Health Strategies.

I am also a general internist physician and board-certified addiction medicine specialist. For the past 15 years, I have cared for patients at a non-profit treatment program in Baltimore, Maryland where I served as Medical Director for 10 years. I also have served as the Secretary and Vice President for the American Society of Addiction Medicine (ASAM), worked as a consultant for the State of Maryland, and served in two local government positions: Deputy Health Officer for Maryland's Harford County and Vice President of Clinical Affairs for the nonprofit organization that oversees treatment in Baltimore City.

Today, I am testifying in my personal capacity and not representing any of the above organizations.

I appreciate the Committee's attention to the nation's overdose crisis, both historically and as demonstrated by holding this hearing here today. In my testimony, I will discuss three topics: (1) The importance of improving access to effective treatment for opioid use disorder and (2) the significant role that SAMHSA plays in this effort; and (3) The serious risk that pending Medicaid changes and reimbursement cuts will undermine access to effective treatment for substance use disorders.

The Importance of Improving Access to Effective Treatment for Opioid Use Disorder and the role of SAMHSA

Many people still think of opioid addiction as an untreatable, hopeless condition. In fact, treatment exists, and it works. I see success frequently in my clinical practice. Recently, I checked in on a patient who first came to me unhoused, unemployed, and at extremely high risk for overdose. After I started treating him with methadone and referred him to counseling, his cravings began to diminish and eventually stopped. It has taken time, but with counseling, peer support, and mental health treatment in addition to methadone, he recently celebrated 2 years of sustained recovery, has been promoted at work, and is looking forward to a future with his wife and children. I also take care of many women who lost custody of their children due to their addiction, but now, in treatment and with recovery support, have reunited with their kids and are able to be the parents they always dreamed of.

The evidence bears out my personal experience. Treatment of opioid use disorder with the medications methadone and buprenorphine reduces the risk of fatal overdose by over fifty percent. Treating individuals with opioid use disorder also reduces crime, increases employment, and improves the physical and mental health of people with opioid addiction.^{1,2}

The importance of treatment is now recognized across the country. When I worked at SAMHSA, I supported treatment expansions in states as diverse as Nevada, Nebraska, Maine, New Mexico, and Washington State. Most recently, President Trump issued an executive order stating, "The framework for addiction treatment should parallel that of other chronic diseases —

¹ Laroche MR, Bernson D, Land T, Stopka TJ, Wang N, Xuan Z, Bagley SM, Liebschutz JM, Walley AY. Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association With Mortality: A Cohort Study. *Ann Intern Med.* 2018 Aug 7;169(3):137-145

² Sordo L, Barrio G, Bravo MJ, Indave BI, Degenhardt L, Wiessing L, Ferri M, Pastor-Barriuso R. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ.* 2017 Apr 26;357:j1550.

utilizing evidence-based care, scientific advancement, continuous support, and community connection." I couldn't have said it better myself.

The President's Executive order recognizes that our country still must make progress before care for opioid addiction is similar to the care provided for other chronic conditions like diabetes, heart disease, and cancer. Only about a quarter of people who can benefit from treatment with medications for substance use disorders are able to access it.³ One of the major reasons is that the United States has imposed unnecessary and onerous regulations on the provision of this treatment that have limited its supply, created a massive stigma, and contributed to community friction.

That's why several years ago, Congress by a large bipartisan majority removed the unnecessary need for a special DEA registration to prescribe buprenorphine. And that's why in 2024, following an extensive public engagement and official, transparent rulemaking process, SAMHSA updated regulations establishing standards for treatment in opioid treatment programs.⁴

Before changing the regulations, we considered relevant published research on methadone safety and effectiveness not only for people with opioid use disorder, but also the demonstrated impacts, both positive and negative, on public health more broadly. In our close examination of the data and science, we paid particular attention to the evidence that came out of the COVID pandemic experience, starting in early 2020, when, under the first Trump

³ Dowell D, Brown S, Gyawali S, Hoenig J, Ko J, Mikosz C, Ussery E, Baldwin G, Jones CM, Olsen Y, Tomoyasu N, Han B, Compton WM, Volkow ND. Treatment for Opioid Use Disorder: Population Estimates - United States, 2022. *MMWR Morb Mortal Wkly Rep.* 2024 Jun 27;73(25):567-574.

⁴ Part 8 – Medications for the Treatment of Opioid Use Disorder. <https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-8>

administration, SAMHSA loosened the flexibilities on take-home methadone doses and allowed providers to start patients on buprenorphine using telehealth.^{5,6}

Forty-three states adopted those flexibilities, allowing opioid treatment programs to give up to a month or two weeks of methadone medication to stable and unstable patients, respectively. The data we found showed that these flexibilities allowed patients to stay in treatment, even somewhat better than before, and was not associated with harm to the public's health. To make sure we were accounting for other's potential concerns with the changes, we engaged in a lengthy series of discussions with relevant federal partners, particularly the DEA, and reviewed and incorporated feedback from hundreds of public comments that we received on the Notice of Proposed Rulemaking, almost all of which supported the changes we were proposing.

The idea was to make this life-saving treatment more accessible, based on innovations in care put into place during the pandemic. These innovations have been shown to be safe and effective. The regulation changes have the support of state officials from across the country, hundreds of treatment providers and professional associations, and the addiction medicine community.

Before I left SAMHSA, I traveled from one corner of the country to another, and heard so many people tell me what it meant to have better access to treatment. One person said that it allowed them to keep their job *and* be treated for opioid use disorder. Just imagine having to choose between life-saving treatment and your source of income.

⁵ Jones CM, Compton WM, Han B, Baldwin G, Volkow ND. Methadone-Involved Overdose Deaths in the US Before and After Federal Policy Changes Expanding Take-Home Methadone Doses From Opioid Treatment Programs. *JAMA Psychiatry*. 2022 Sep 1;79(9):932-934.

⁶ Jones CM, Shoff C, Blanco C, Losby JL, Ling SM, Compton WM. Association of Receipt of Opioid Use Disorder-Related Telehealth Services and Medications for Opioid Use Disorder With Fatal Drug Overdoses Among Medicare Beneficiaries Before and During the COVID-19 Pandemic. *JAMA Psychiatry*. 2023 May 1;80(5):508-514.

As treatment access has expanded, fatal overdoses have declined. In the last two years, overdose deaths have fallen by more than 25%, from a high of over 110,000 people per year in 2022.⁷ While the US is still losing way too many people to overdose, primarily driven by illicitly manufactured fentanyl, the improvements in life expectancy and other benefits of methadone and buprenorphine are recognized all over the world. I know many factors have contributed to the U.S. progress, but access to proven, effective treatment is one of them.

Ensuring that people with, or at risk for, substance use disorders get the quality services they deserve also requires a strong SAMHSA that has the robust infrastructure and workforce to provide the technical assistance, support, expert guidance, monitoring, and oversight that the public expects.

So as the Committee considers the list of bills today, some of which make changes to laws to address the ongoing opioid crisis, I urge you to ask whether each piece of legislation you consider is increasing access to effective treatment or reducing access – because increasing access will save lives, while reducing access will take us back and lead to terrible consequences for individuals, families, and communities across the country.

The Serious Risk that Pending Medicaid Changes Will Undermine Access to Effective Addiction Treatment and Increase Overdose Mortality

In passing H.R. 1, the One Big Beautiful Bill Act last summer, Congress made sweeping changes to the Medicaid program. At the same time, Congress took several steps to protect individuals with substance use disorders – and access to treatment – during this transition and reauthorized the majority of programs included in the SUPPORT for Patients Act. I am

⁷ <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>

concerned, however, that these steps won't be enough to protect my patients and others around the country.

Let me start with the good news. Congress made clear that people with substance use disorders will qualify as medically frail and be exempt from work requirements. Similarly, people receiving active treatment for addiction will be exempt from work requirements. All of these provisions will help maintain access to effective treatment for thousands of people.

However, there are also major concerns. Several aspects of the new law will jeopardize access to care. This is particularly concerning because of research showing that loss of coverage not only disrupts care but also increases the rate of fatal overdose. A recent study in *JAMA Psychiatry*⁸ found that for people receiving medications for opioid use disorder, being disenrolled from insurance was associated with significant increases in overdose mortality and total mortality. Medicaid is currently the largest funder of addiction treatment in the U.S. and thousands of people have come to depend on it to access life saving treatment and recovery services that can help them get their lives back together.

I'll mention four specific concerns. First, the requirement that individuals in the expansion population re-enroll every 6 months. This administrative burden can upend coverage for people who are eligible, given that people move frequently and may not receive notices of discontinuation. For people with substance use disorders, this requirement may be especially challenging given the sometimes chaotic life situations they are navigating, their lack of a consistent mailing address, phone, or access to a computer or stable internet, or the co-occurring mental health conditions that can impact concentration, focus, and organization. Second, demonstrating a diagnosis of substance use disorder may be challenging, as a result of

⁸ Nguyen AP, Binswanger IA, Narwaney KJ, et al. Health Plan Disenrollment and Mortality After Initiation of Medications for Opioid Use Disorder. *JAMA Psychiatry*. Published online March 04, 2026. doi:10.1001/jamapsychiatry.2026.0021

poor access to care and fear of potential stigma and discrimination. This will create a vicious cycle. People can't get into care without insurance, but they can't keep insurance because of challenges accessing care. This is particularly true for rural areas. Third, states are concerned that CMS will impose regulations that will make the medical frailty exemptions so restrictive that it leaves out large groups of eligible people. For example, CMS might exclude people in remission from substance use disorder from the medical frailty exemption even though the risk of relapse remains high for the first 3-5 years of recovery and most people with a substance use disorder have three or four attempts at treatment over several years before they achieve stable recovery. Fourth and finally, if states lose significant funding as a result of the bill as projected by the Congressional Budget Office, states may be forced to save money by cutting services or restricting benefits of various kinds for people with substance use disorders. States have been able to expand access to substance use disorder services across the continuum of prevention, treatment, and recovery in large part because of the support of Medicaid, including not only in specialty residential and outpatient treatment programs, but in hospitals, emergency departments, community health centers and primary care.

The implications of these concerns are several. First, Congress should work with states to prevent these problems before they happen. That could include ensuring that state and local lawmakers understand the intent of Congress in continuing to support people with substance use disorders and the need to protect treatment services in a variety of settings. Second, Congress should push CMS to implement the law in the most beneficial way to support the inclusion of all substance use disorder diagnoses, should conduct targeted outreach to providers and healthcare systems to encourage universal screening and accurate identification of individuals with substance use disorders, and to improve access to effective addiction treatment. Third, both Congress and the administration should closely monitor the provision of care and support research on the impacts of H.R. 1 policy changes on overdose, so that we can

closely see the repercussions of the new law. If it turns out that people with substance use disorders start losing coverage in a way not intended by Congress, then the onus needs to be on Congress to step in and take action to mitigate further coverage and care losses.

The U.S. has lost so many lives because of the overdose crisis, but after several years of sustained investment in preventing overdoses, getting patients the treatment they need, and supporting people in long-term recovery, we are finally seeing this turn around. Reducing access to effective treatment, including with methadone and buprenorphine, and having people with substance use disorders lose their health coverage, even if inadvertently, just as we're finally seeing progress on reducing overdoses, would be a grave mistake. On the other hand, passing legislation to help more people with addiction receive effective treatment will capitalize on our momentum - and save many lives. I urge you to keep this in mind as you consider the slate of proposed legislation before you.