AmericansFor SafeAccess
Advancing Legal Medical Marijuana Therapeutics and Research

Written Testimony to the Council of the District of Columbia Committee on Health

Health Roundtable on Medical Marijuana
Hearing Date, October 21, 2013
Written Testimony Submission Date, November 4, 2013

Introduction and Background on ASA's Involvement

Americans for Safe Access (ASA) would like to thank Committee Chair Yvette Alexander and the Committee on Health for this opportunity to comment on the District's Medical Marijuana Program (MMP).

ASA is the nation's largest membership-based medical marijuana advocacy organization. Along with other medical marijuana advocates, ASA worked to overturn the Barr Amendment, which allowed the District to move forward with Initiative-59 (1998). ASA was actively involved with organizing patients and lobbying during Council's work in 2010 on B18-06222 to amend Initiative-59. ASA held patient lobby days, organized press events, prepared patients to testify before the council, and turned out patients for hearings. Since that time, ASA has held monthly patient meetings and several town hall forums to promote the program. Additionally ASA hosted a CME program in Washington, D.C. in February 2013 for physicians, and continues to lobby and provide commentary on advancing medical marijuana therapy at the federal, state and local level.

The opening of dispensaries in June 2013 and the registering of 59 patients (as of October 21, 2013) on its face shows some level of success for the MMP; however, in spite of this milestone, at least 99.6% of the nearly 15,000 people in the District live with HIV-positive status are not enrolled in the program more than three years into implementation.[1]

While DOH officials deserve credit for getting the program up and running to some degree of functionality, the unfortunate reality is that the department has yet to meet several of its statutory and regulatory obligations. Understandably, being subject to the Constitutional plenary power of Congress holds over the District puts DOH in a position of scrutiny that no other state agency in charge of implementing a medical marijuana program must fact. That said, given the recently announced federal enforcement guidelines from the U.S. Department of Justice (DOJ) along with assurances from DOJ to the District Government that stating the D.C law and regulations are compliant with the new guidelines, there is no longer any reason for DOH to be overly cautious with implementation of the MMP to the detriment of patients.[2]

1 HIV/AIDS Policy Fact Sheet, The Henry J. Kaiser Family Foundation, July 2012, available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8335.pdf (last accessed Nov. 4, 2013).

Headquarters
1300 Clay Street, Suite 600, Oakland CA 94612
PHONE: 510.251.1856

National Office
1806 Vernon St. NW, Suite 100, Washington DC 20009
PHONE: 202.857.4272 **FAX:** 202.857.4273

General Information
WEB: www.AmericansForSafeAccess.org
TOLL FREE: 1.888.939.4367

With this background in mind, ASA offers the following comments on how to improve the MMP to work best for District patients who have been recommended medical marijuana therapy from their physician.

Areas to be Revisited and Reassessed by the Council and DOH

Seating the Advisory Committee

> "*Sec. 10. Medical Marijuana Advisory Committee.*
> "*(a) The Mayor shall establish a Medical Marijuana Advisory Committee ("Committee"), which shall monitor:*
> "*(1) Best practices in other states that allow the use of medical marijuana;*
> "*(2) Scientific research on the medical use of marijuana; and*
> "*(3) The effectiveness of the District's medical marijuana program.*
> "*(b)* ***No later than January 1, 2012****, the Committee shall submit a report to the Mayor and the Council recommending:*
> "*(1) Whether the District of Columbia should allow qualifying patients and caregivers to cultivate medical marijuana;*
> "*(2) How to implement and regulate cultivation of medical marijuana by qualifying patients and caregivers; and*
> "*(3) Any other comments the Committee believes to be important.*[3]

The District's patient population has been waiting for well over three years for formation of the Advisory Committee. Although B18-0622 contains an explicit provision for the Advisory Committee to issue a report on patient cultivation of medical marijuana "no later than January 1, 2012," DOH failed to address the Advisory Committee in its regulations until July 12, 2013, more than 18 months after the report was due. These rules called for the Advisory Committee to be made of the following seven members:

> *The Director of the Department of Consumer and Regulatory Affairs, the Chief of the Metropolitan Police Department, and the City Administrator shall each appoint one member, who shall be either himself or herself or a subordinate designee; the Director of the Department of Health shall appoint four (4) members, one of which shall be the Director himself or herself or a subordinate designee, and the other three (3) of which shall be residents of the District of Columbia that possess either medical or scientific*

2 Health Roundtable on Medical Marijuana, Hearing Before the D.C. Council Committee on Health, 20th District Council, Oct. 21, 2013 (statement of Councilmember Yvette Alexander and testimony of Senior Deputy Director of the Department of Health Feseha Woldu).

3 D.C. Code § 7-1671.09 (2013).

expertise that the Director of the Department of Health deems would be useful to the Committee.[4]

By the date of the October 21, 2013 Roundtable, none of the agencies had publicly announced any appointees, and the Advisory Committee still appeared to be dormant. On October 28, 2013, Mayor Vincent Gray issued an executive order on the formation of the Advisory Committee. The Mayor's order grouped the Advisory Committee into two subcommittees, Intergovernmental Operations (IO) and Scientific. The IO subcommittee is made up of the four department head appointments contained in the earlier DOH regulations on the Advisory Committee, while the Scientific subcommittee is comprised *at least* four members appointed by the Director of DOH who have scientific or medical expertise.

Although the Mayor's order is a sign of progress, there are still problems that may adversely affect patients. The IO subcommittee will examine best practices in other states and make recommendations on the amount of medicine a District patient may possess. However, the IO subcommittee has no requirement for expertise on medical marijuana as part of any of requirements of its membership. This means that the IO members will have the ability to make decisions on the amount of medicine a physician can recommend to their patient without having any prior experience or knowledge about the how much medical marijuana a particular patient needs for their treatment of their medical condition. Presumably the appointee from DOH will have some background on medical marijuana, and potentially the other members may have similar background knowledge, but this is left to the best intentions of the appointees, The amount of medicine a patient needs is more a question of science than government regulation, and the Scientific Subcommittee should have at least equal input on the matter of possession limits. Additionally, there is no new due date for the report on patient cultivation, nor a date imposed on department head's to make appointments.

Wisely, the Mayor's establishment of the Scientific Subcommittee to review new qualifying conditions for medical marijuana therapy in the District will be determined by those with medical and scientific expertise. New qualifying conditions are absolutely necessary for the District program to best serve the needs of its residents, however, the District need not wait until the formation of the Advisory Committee in order to add new and needed qualifying conditions.

Adding New Qualifying Conditions without the Advisory Committee

Neither B18-0622 nor Title 22-C of the DCMR require the Advisory Committee to be formed in advance of adding new qualifying conditions. Title 22-C requires the following conditions to be met in order to add a new qualifying condition:

4 D.C. Mun. Regis tit. 22-C § 1400.1 (2013).

Any other condition, as determined by rulemaking, that is:

(1) Chronic or long lasting;
(2) Debilitating or interferes with the basic functions of life; and
(3) A serious medical condition for which the use of medical marijuana is beneficial:

(A) That cannot be effectively treated by any ordinary medical or surgical measure; or
(B) For which there is scientific evidence that the use of medical marijuana is likely to be significantly less addictive than the ordinary medical treatment for that condition.

This definition does not require the formation of the Advisory Committee. In spite of the District having one of the strictest rules for adding new qualifying conditions, any qualifying conditions met this 3-part requirement. According to Chapter 14 of Title 22-C, the Advisory Committee merely makes a recommendation to the Director of DOH on the addition of new conditions. A close reading of the statute and regulations leads ones to the conclusion that there is nothing that prevent the Director of DOH from adding new conditions prior to the formation or recommendation of the Advisory Committee.

A solution that would remedy the need the for the Scientific Subcommittee to issue recommendations on new conditions would be for the Council to pass a bill that amends the qualifying conditions language in D.C. law to permit physicians to be in charge of which conditions can be legally treated with medical marijuana therapy. Such an approach allows any patient who could receive benefit from medical marijuana therapy to do so under the recommendation of their physician rather than being prohibited by an unnecessary bureaucratic hurdle that has already taken more than three years without yet being established. ASA recommends the following language from Massachusetts Department of Public Health, whose language was welcomed by the Massachusetts Medical Society.[5]

Debilitating Medical Condition means cancer, glaucoma, positive status for human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, and multiple sclerosis (MS), when such diseases are debilitating, and other debilitating conditions as determined in writing by a qualifying patient's certifying physician.[6]

Education program for doctors

5 Massachusetts Medical Society Statement Regarding Approval of Regulations for Medical Marijuana by the Public Health Council, Richard Aghababian, M.D., President, Massachusetts Medical Society, May 8, 2013 available at http://www.massmed.org/News-and-Publications/MMS-News-Releases/Massachusetts-Medical-Society-Statement--Regarding-Approval-of-Regulations-for-Medical-Marijuana-by-the-Public-Health-Council/#.UngK5fnkvKd (last accessed Nov. 4, 2013).

6 105 CMR 725.004, "Debilitating Medical Condition."

One of the biggest problems facing patients right now in the inability to find physicians willing to write recommendations for the four current qualifying conditions. The reasons for this are not fully known, but one likely reason is that physicians and medical institutions in the District are either unaware or unfamiliar with the medical marijuana science or the MMP itself. As a result, District patients currently living with HIV, AIDS, cancer, glaucoma or severe muscle spasms are being denied the benefit of the program. With only 59 patients in the program as of October 21, 2013, no more than 0.4% (or 1 in 250) of the approximately 15,000 people living with HIV in the District are enrolled in the program.

Thankfully, the MMP regulations contain a provision that ought to address this issue, but DOH has yet to fulfill this regulatory requirement. Title 22-C of the DCMR contains the following rule requiring physician training to be provided by DOH.

> *805 TRAINING PROGRAM FOR RECOMMENDING PHYSICIANS*
> *805.1 The Department shall make available an educational program for physicians on the medical indications, uses, and side effects of medical marijuana and the District's medical marijuana program, and may charge a fee for the training program.*
>
> *805.2 The program shall be made available to physicians licensed to practice medicine or osteopathy in the District of Columbia who recommend or intend to recommend the use of medical marijuana to qualifying patients.*
>
> *805.3 If approved by the District of Columbia Board of Medicine, the program may be used to satisfy continuing education requirements for the practice of medicine for the number of credits approved by the board.*

According to DOH officials, the Department has met this obligation by notifying some D.C. physicians of a one-time CME training the ASA was able to provide for physicians in February 2013, as well as announcing the program at a meeting of the D.C. Board of Medicine.[7] ASA appreciates these efforts, by themselves they are not sufficient to meet the obligation created by the aforementioned rule.

District patients and physicians would be well-served to have DOH develop the education program called for in Chapter 14 of Title 22-C. ASA recommends that DOH look to the CME created by the Massachusetts Medical Society as a basis for it's own program.[8]

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7 While the D.C. Council has no statutory obligation to promote the program to physicians, it is noteworthy the Committee on Health Chairperson Alexander also encouraged the Board of Health to promote the MMP to physicians.

8 Medical Marijuana CME, Massachusetts Medical Society, available at http://www.massmed.org/Continuing-Education-and-Events/Online-CME/Medical-Marijuana-CME/#.Unf-FPnkvKc (last accessed Nov. 4, 2013).

Streamlining Paperwork for Doctors and Patients, Accessibility of DOH Forms

Presently, D.C. physicians and patients face a difficult process when it comes to obtaining and filling out paperwork. Unlike any other medical marijuana program in the country, District physicians must request a specific number of recommendation forms rather than having ready access. This means that physicians may not be able to write recommendation in a timely manner, or may be discouraged from attempting to fill out forms all together. Moreover, the available FAQ for physicians on the DOH website dates to May 17, 2013, nearly a month prior to the availability of recommendation forms. Further complicating this matter are reports that health providers in the District are instructing their physicians not to write recommendation forms. If physicians and healthcare providers unable to get current information on their rights and ability to participate the program, even in the form of a simple FAQ, District patients with any of the qualifying conditions have little chance of obtaining a recommendation.

Paperwork for patients is also difficult. The current application is only available online or at the DOH office. The 9-page form requires patients to sign or initial 24 lines. In comparison, the series of paperwork required to legally register a firearm in the District is only 5 pages and requires about half of the number of signatures and initials. The lines that District patients must fill out include statements essentially forcing them to declare themselves as federal criminals, which likely has a chilling effect on qualifying patients who wish to receive the benefit of medical marijuana therapy. Considering the assurances given to the District government from US DOJ, this seems a completely unnecessary burden to impose upon patients. Additionally, the MMP forms are not yet available in Spanish, which is in apparent violation of the DC Language Access Act of 2004. Along with the lack of Spanish language forms, patients with glaucoma who do not receive any benefit from their available non-marijuana options may have difficulty reading and filling out the 9-page form.

To make the forms more readily available and user friendly to physicians and patients, DOH should look to the practices of other states. Physicians should have electronic access to recommendation forms, and patient application forms should be tailored to be as simple as necessary, including accessibility aspects of reading and completing the forms.

Adding Civil Discrimination Protections for Patients

At present, the District's MMP lacks explicit protections for several issues facing patients, including housing, education, employment, and organ transplants. Several states have included these protections without complications arising from federal funds received by landlords, educators, employers, or hospitals. Therefore, the D.C. Council should considering legislation to include these protections so that medical marijuana patients do not suffer discrimination simply for making use of the therapy recommended to them by their physicians. Additionally, parents who are medical marijuana patients should not be at increased risk for losing their children in custody proceedings merely for their patient status. Instead, medical marijuana

patient-parents should be protected unless their conduct constitutes a clear and articulable danger to the welfare of the child.

ASA recommends that the D.C. Council consider the following discrimination protection language in the Delaware medical marijuana statute.

> ***§ 4905A. Discrimination prohibited.***
> *(a)(1) No school or landlord may refuse to enroll or lease to, or otherwise penalize, a person solely for his or her status as a registered qualifying patient or a registered designated caregiver, unless failing to do so would cause the school or landlord to lose a monetary or licensing-related benefit under federal law or regulations.*
> *(2) For the purposes of medical care, including organ transplants, a registered qualifying patient's authorized use of marijuana in accordance with this chapter shall be considered the equivalent of the authorized use of any other medication used at the direction of a physician, and shall not constitute the use of an illicit substance or otherwise disqualify a qualifying patient from needed medical care.*
> *(3) Unless a failure to do so would cause the employer to lose a monetary or licensing-related benefit under federal law or federal regulations, an employer may not discriminate against a person in hiring, termination, or any term or condition of employment, or otherwise penalize a person, if the discrimination is based upon either of the following:*
> *a. The person's status as a cardholder; or*
> *b. A registered qualifying patient's positive drug test for marijuana components or metabolites, unless the patient used, possessed, or was impaired by marijuana on the premises of the place of employment or during the hours of employment.*
> *(b) A person otherwise entitled to custody of or visitation or parenting time with a minor shall not be denied such a right, and there shall be no presumption of neglect or child endangerment, for conduct allowed under this chapter, unless the person's actions in relation to marijuana were such that they created an unreasonable danger to the safety of the minor as established by clear and convincing evidence.*
> *(c) No school, landlord, or employer may be penalized or denied any benefit under state law for enrolling, leasing to, or employing a cardholder.*[9]

Restrictions on Where Patients May Purchase Medicine

At present District patients are restricted on where they may purchases their medical marijuana. The current rules under Title 22-C of the DCMR require that D.C. patient declare which dispensary they wish to purchase their medicine.

> *200.7 As part of the registration process, a qualifying patient shall designate the*

9 Del. Code 16 § 4905A (2013).

dispensary from which he or she will receive medical marijuana, and this designation shall appear on the qualifying patient's registration card and, if applicable, the caregiver's registration card.

200.9 Within fourteen (14) calendar days of any change in the qualifying patient's name, address, caregiver, recommending physician, or designated dispensary, a qualifying patient who has been issued a registration identification card shall:

(a) Submit a completed patient change of information form to the Department, and include as applicable:
(1) Designation of a new dispensary;...
...(d) Pay the required fee to receive a new registration identification card;

* * *

1300.1 The registration, renewal and replacement fees are as follows:

(a) Initial registration fee for a qualifying patient $100.00;
(b) Initial registration fee for a caregiver $100.00;
(c) Renewal fee for a qualifying patient $100.00;
(d) Renewal fee for a caregiver $100.00; and
(e) Replacement card fee $90.00

By requiring patients to register with a single dispensary from which they can purchase medicine, patients will be placed at risk of hardships or barriers to treatment. Medically, patients may not be able to find the particular strain that works best for them at their dispensary on a regular basis. Moreover, some dispensaries are likely to have better selections of non-flower forms of medical marijuana than other dispensaries, but patients will have little ability to know what their other options are if they stuck with a single dispensary where they can shop. Financially, due to the artificially restricted market, patients are at risk of high prices due to the lack of market competition. The restriction also would be a major problem to patients registered to a dispensary that is forced to go out of business due to non-transferability of ownership, as they would have to wait - and pay - for DOH to issue them new registration identification cards.

Strike all provisions pertaining to requiring patients to register with a single dispensary. If this provision must remain in place, DOH should take efforts to make sure that patients are approved and have the ability to shop at a newly designated dispensary on the same day as a transfer is request. The Department of Motor Vehicles is able to issue update driver licenses on the same day as information is updated to the the DMV, and the MMP should offer the same

level of service. Additionally, if the single-dispensary requirement must remain in place, patients should not have to pay a fee for transferring their dispensary of choice.

Sales Tax

Unlike sales of other medicines, pharmaceutical, or drugs in the District of Columbia, retail sales of medical marijuana subjugate D.C. patients to burdensome sales tax. Medical marijuana is often an expensive treatment option, and due to factors such as the limited ability to cultivate medicine and few patients being registered by DOH, retail prices for medical marijuana in the District at very close the street price for illicit marijuana. Moreover, with the physical ability to cultivate their own medicine and the caregivers of other patients do not have a legal right to cultivate medicine for themselves at the present time. While it is true that the District did include a provision to establish sliding scale prices for patients with great financial hardship, the cost of medicine remains burdensome to all but the most affluent of patients. In fact, insurance companies are not obligated, nor are they willing to reimburse qualifying patients for their medical marijuana expenses.

Because medical marijuana patients face financial burdens that those with other treatment options available are not subject to, DOH should consider adopting the following rule. If DOH is unable to promulgate a sales tax exemption, we would request that the Council consider the following for legislation.

> *Retail sales of medical marijuana shall qualify for the sales tax exemption afforded to "medicines, pharmaceuticals, and drugs" under Rule 9-449 of the DCMR.*

Transferability for Owners

While it appears that Chapter 50 of Title 22-C of the DCMR is written with the laudable intent of preventing operators from flipping their business for a quick profit, we believe that the unintended outcome of all of the changes proposed to this entire chapter may mean that patients end up with fewer operators providing them with medicine. If the punitive measures authorized by Chapter 50 are taken against operators, it would result in either a dispensary or cultivation site shutting down. Given that D.C. is currently operating well below it's statutory limit for dispensaries and cultivation locations (coupled the 95-plant limit per cultivation location), the availability of medicine in the D.C. medical marijuana program will instantly face serious stress of basic market forces. Removing any of these businesses purely for an attempted transfer of business interest could be devastating to the availability and price of medicine. The removal of dispensary would be even more harmful, as any patient registered to purchase medicine from a dispensary that is shut down will have to wait weeks before switching their dispensary location, and the additional patients flooding the still-open dispensaries would harm the availability of medicine to those patients already registered at those dispensaries.

Moreover, the highly restrictive natures of these proposed changes would make it impossible for dispensary or cultivation site operators to transfer their business interests, and it does not appear that there are any mechanisms to deal with very practical realities that all business face. For example, if one members of a dispensary ownership team passes away, who would obtain that deceased person's interest in the business? The same question applies to situations where a dispensary ownership team may need to remove a member of their ownership team for good cause. In fact, the inability to transfer any individual business interested may mean that one problem officer could cause the entire business to fail if they are unable to remove that person.

The ability to transfer medical marijuana business interests in the District of Columbia is already tightly controlled by the existing regulations. We request that DOH revert to the previous rules on transferability prior to the rules issued on July 12, 2013 in Chapter 50, and to strike all of the changes to Chapter that were published on that date.

Headquarters
1300 Clay Street, Suite 600, Oakland CA 94612
PHONE: 510.251.1856

National Office
1806 Vernon St. NW, Suite 100, Washington DC 20009
PHONE: 202.857.4272 **FAX:** 202.857.4273

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WEB: www.AmericansForSafeAccess.org
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