

July 15, 2015

**Testimony to the Council of the District of Columbia
Committee on Health and Human Services
Bill 21-192, the “Medical Marijuana Laboratory Testing Amendment Act of 2015”
Bill 21-210, the “Medical Marijuana Reciprocity Amendment Act of 2015”**

UPDATE OF TESTIMONY ORIGINALLY SUBMITTED ON JULY 2, 2015

Summary

ASA supports both bills, but seeks improvements to B21-210 to ensure adequate supply and address technical issues.

Introduction

Thank you to Chairperson Alexander and Councilmembers Cheh, Bonds, Grosso, and Orange for introducing and cosponsoring the Bill 21-192, the “Medical Marijuana Laboratory Testing Amendment Act of 2015” and to Councilmembers Orange and Grosso for cosponsoring Bill 21-210, the “Medical Marijuana Reciprocity Amendment Act of 2015.”

Both of these bills address deficiencies in the current program that adversely affect patients and are essentially remnants from the extremely cautious original bill passed in 2010. We have been pleased with gradual but substantial improvements both the Council and Department of Health have made to the existing program, and we think that with a few prudent modifications, these bills will keep the District program on the correct path.

Bill 21-192: “Medical Marijuana Laboratory Testing Amendment Act of 2015”

Americans for Safe Access (ASA) strongly supports testing requirements for medicine sold in medical marijuana dispensaries. Lab testing requirements are increasingly becoming the norm in medical marijuana laws. These provisions are necessary because patients deserve assurance that the products they are getting have accurate labeling for the cannabinoid profile of the products they rely on to treat their medical condition. While the cultivation centers have no-doubt been doing the best within their capabilities to provide the most accurate labeling they can provide, problems exist with self-reporting. Cultivation sites do not have the proper lab equipment or expertise in using such equipment to ensure that patients are getting the most accurate information possible. The best parties to be conducting lab testing are independent labs that meet requirements set forth by the Department of Health.

To ensure that labs are properly regulated and are calibrating their work to national standards, ASA recommends that the Department of Health use the best practices established by American Herbal Products Association’s recommendations for regulators

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on Cannabis Laboratory Operations¹ as well as the American Herbal Pharmacopoeia's cannabis monograph.² The AHPA guidelines have blueprint for regulations concerning lab testing that have been adopted by several states. The AHP monograph provides calibration standards for laboratories. Together, these guidelines can serve as the basis for DOH to implement a lab testing component to the current program that provides consistently reliable information that patients can benefit from in making the medicine purchase decisions. These standards have been substantially adopted in states such as Illinois, Maryland, Massachusetts, Nevada, New Hampshire, Oregon, Washington State.

Bill 21-210: "Medical Marijuana Reciprocity Amendment Act of 2015"

The idea of adding reciprocity to the District's Medical Marijuana Program is something that ASA has previously advocated for when testifying before the D.C. Council and we continue to support the concept. However, there are concerns and some technical issues that are not fully addressed in the bill that could present some challenges. These challenges can be overcome with some prudent additions to the bill that will make the program function better for District resident patients as well as patients visiting the District for periods of time.

The most glaring issue with the prospect of reciprocity is the available supply of medicine. Currently the District is still experiencing a significant medicine shortage.³ At present, the District program is still not producing enough medicine for patients to buy more than 2-4 grams per visit. Although the recent changes to the cultivation laws have allowed for 10-fold increase over the original plant count, the fact is that the original facilities sought out space with the thinking that they would only be able to grow 95 plants. Some of the newer cultivation sites may be better equipped to handle the great plants, but it often takes one or two crops for a facility to master the genetics of newly introduced plant strains. The main problem with the supply issue is the limited aggregate square footage of the current group of licensed cultivators. We agree with the Department of Health's position that the current cultivators should be encouraged to maximize their production abilities; however, we do not think this is an "either-or" type of situation. Cultivators should be encouraged to fully utilize their facilities, as all reasonable options to ease the supply shortage should be employed to complement one another. This is how patients will ultimately have an affordable supply of medicine with more product options.

The bill wisely gets rid of the arbitrary plant count rules, but this will only solve part of the equation due to the infrastructure issues at current facilities due to the limitations imposed by the original law. The Council and Department of Health should consider ways to allow existing cultivators expand their facilities beyond their single member ANC district along with possibility consider allowing for more cultivators to apply for licensure

¹ Cannabis Committee of the American Herbal Products Association, *Recommendations for Regulators – Cannabis Operations*, available at:

http://www.ahpa.org/Portals/0/pdfs/13_0709_Cannabis_Lab_Recommendations.pdf

² American Herbal Pharmacopoeia, *Cannabis Inflorescence & Leaf QC Revision: Standards of Identity, Analysis, and Quality Control*, available at: http://www.stcm.ch/files/us-herbal-pharmacopoeia_cannabis-monography.pdf

³ *D.C.'s medical marijuana shortage: A little noticed crisis amid legalization*, Washington Post, Feb. 26, 2015, available at: http://www.washingtonpost.com/local/dcs-medical-marijuana-shortage-a-little-noticed-crisis-amid-legalization/2015/02/26/000bc066-bde3-11e4-b274-e5209a3bc9a9_story.html

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and operation. The combination of all of these changes will allow for more plants to be harvested, which will lead to both more affordable medicine and greater variety of products for patients. However, a realistic outlook is that the program likely will not generate substantially increased output if the only barrier removed is the plant count. The number of licensees and the ability for current licensees to expand or move operation must also be addressed if the goal is to overcome the medicine shortage that is harming patients. Giving DOH the tools to increase the number of cultivation sites will enable them to more rapidly and accurately increase supply according to demand.

Offering reciprocity to non-resident patients is the right and proper thing to do, but that course of action will create market forces that are better addressed before implementation. In order to ensure that there is enough medicine available for current District resident patients enrolled in the program, dispensaries should not be compelled to sell to non-District patients until there is adequate supply for all. The only time it is appropriate to deny or restrict reciprocity from a patient-focused perspective is if there is not enough medicine available for the local population. Any moves toward formally adopting reciprocity should factor in this consideration, as it is a greater factor in DC than most other medical marijuana jurisdictions.

There are technical issues as well beyond the availability of medicine that should be addressed during the reciprocity implementation process. For example, how will the District continue the single dispensary registration requirement? Will out of town patients be able to shop at any dispensary? We think that's good policy, and that policy should be extended to District patients as well. The single-dispensary registration is one of the biggest complaints current patients have to the program and it seems like it would be difficult to regulate if required for non-residents as well. Therefore, we recommend an amendment to strike that provision in Sec. 6(1)(B)(i) of the current law. This will also bring about the benefit of choice and market competition, so patients will enjoy a greater variety of products and more affordable medicine.

If reciprocity is adopted, another issue to consider is where non-residents will be able to consume their medicine. Section 4(b)(1) of the statute states that patients may only consume their medicine in their own residences. This creates a legal impossibility for where non-residents could consumer medicine acquired through the program. Using Initiative 71 again as a reference point, it is fully legal for non-patients to use marijuana in any non-public setting where they have permission of the occupant. Patients should have at least the level rights when it comes to where they consume their medicine. Again, this is good policy for District patients, and non-resident patients as well.

During the hearing held before the Committee on July 2, 2015, several witnesses expressed support for delivery services. ASA strongly supports allowing patients to obtain their medicine through delivery services. Patients with mobility issues face difficulty when trying to go to any of the three limited locations of dispensaries in the District. While they are allowed to have a caregiver purchase their medicine and bring it to them, that means they are dependent on their volunteer caregiver's schedule. This is a common sense improvement to make.

If additional patient rights' issues are to be considered with this legislation, the Council should consider adopting civil discrimination protections in the areas of organ transplants, child custody, employment, housing, and education. At present, patients can

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be denied rights related to each of these simply based off of their registered patient status. Patients like Norman B. Smith have died after being denied an organ transplant.⁴ Patients in Michigan and elsewhere have had their children taken away due to their patient status without any actual showing of negligence to the child.⁵ Patients like Brandon Coats have been fired in Colorado simply for their patient status without negative performance on the job.⁶ To accomplish this goal, ASA urges the Council to adopt protections similar to the suggested language below that exists in Arizona's law.

A. No school or landlord may refuse to enroll or lease to and may not otherwise penalize a person solely for his status as a cardholder, unless failing to do so would cause the school or landlord to lose a monetary or licensing related benefit under federal law or regulations.

B. Unless a failure to do so would cause an employer to lose a monetary or licensing related benefit under federal law or regulations, an employer may not discriminate against a person in hiring, termination or imposing any term or condition of employment or otherwise penalize a person based upon either:

- 1. The person's status as a cardholder.*
- 2. 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.*

C. For the purposes of medical care, including organ transplants, a registered qualifying patient's authorized use of marijuana must be considered the equivalent of the use of any other medication under the direction of a physician and does not constitute the use of an illicit substance or otherwise disqualify a registered qualifying patient from medical care.

D. No person may be denied custody of or visitation or parenting time with a minor, and there is no presumption of neglect or child endangerment for conduct allowed under this chapter, unless the person's behavior creates an unreasonable danger to the safety of the minor as established by clear and convincing evidence.

Conclusion:

ASA supports both Bills 21-192 and 21-210, but urges the Council to make changes to 21-210 before adopting it into law. We thank the Council for continuing to look at ways to improve the Medical Marijuana Program, and we are happy to work with the Council to make sure the final legislation works best for all patients.

⁴ *Norman Smith: Cancer Patient Taken Off Of Liver Transplant List Because Of Medical Marijuana Use*, Huffington Post, Kathleen Miles, December 5, 2011, available at:

http://www.huffingtonpost.com/2011/12/05/norman-smith-cancer_n_1130619.html

⁵ *Does medical marijuana equal bad parenting?*, CNN, Stephanie Smith, March 14, 2014, available at: <http://www.cnn.com/2014/03/12/health/medical-marijuana-parents/>

⁶ *Even in Colorado Medical Marijuana Can Still Get You Fired*, Time, Bruce Barcott, June 15, 2015, available at: <http://time.com/3921738/coats-colorado-dish-medical-marijuana-work-law/>

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