

Introduction:

Americans for Safe Access (ASA) would like to thank the Illinois Department of Public Health (DPH) for the opportunity to comment on the proposed rules for *Title 77, Chapter 1, Subchapter u, Part 946: Compassionate Use of Medical Cannabis Patient Registry*. As the nation's largest organization working exclusively to advance safe and legal access to medical cannabis for therapeutic and research purposes, we are happy to see DPH move in a swift and thoughtful manner to implement the *Compassionate Use of Medical Cannabis Pilot Program Act*. However, ASA has significant concerns with several issues throughout the proposed regulations that we think will adversely affect patients. The following are areas we think DPH can improve to make these regulations the best possible for patients, given the statutory restrictions and mandates in the program.

1. Section 946.200 Application for Registry Identification Card for Qualifying Patients and Designated Caregivers

Problem: Section 946.200(d)(6) requires patients to declare a single dispensing organization from which they will purchase their medicine. By requiring patients to register with a single dispensing organization 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 dispensing organization on a regular basis. Moreover, some dispensing organizations are likely to have better selections of cannabis-infused products than others, but patients will have little ability to know what their other options are if they stuck with a single dispensing organization where they can shop. Financially, patients will be at risk of high prices due to the lack of market competition. Moreover, patients would apparently have to complete a new application and submit additional application fees if they wish to switch dispensing organizations.

Solution: Strike all provisions pertaining to requiring patients to register with a single dispensing organization.

2. Section 946.60 Confidentiality

Problem: Generally speaking we are satisfied with the proposed rules concerning confidentiality; however, Section 946.60(f)(2) would allow DPH to divulge information to law enforcement for "apparent" violations of the law. The term "apparent" is vague and subject to wide interpretation with respect to whether or not criminal activity is taking place. If law enforcement officers notify DPH that they suspect a patient is violating the law, but have no evidence to offer, this could be viewed as an "apparent" violation. The standard ought to be strengthened to protect the confidentiality and liberty of patients.

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

Solution: Strike "...about apparent criminal violations of this Part." to "...if they have probable cause to believe a there are criminal violations of this Part."

3. Section 946.300 Qualifications of the Recommending Physician

Problem: The requirement that physicians must review all of the patient's medical records for the previous 12 months is an onerous standard for physicians to meet and may have a chilling effect on the number of physicians willing to write recommendations. A physician would have to rely on the patient to provide them with an absolutely complete history of their previous 12 months of medical care, including dental visits, and if the patient makes a good-faith error in providing the previous 12-month medical history, the bona fide relationship becomes null and void. This could mean that patients might be subject to criminal prosecution because their cannabis conduct would no longer be considered medical. Moreover, any factor that reduces the number of willing physicians to write recommendations runs the unintended risk of creating a system where a relatively small number of physicians write a relatively high number of the state's medical marijuana recommendations.

Solution: Strike "including reviewing medical records from other treating physicians from the previous 12 months."

4. Section 946.30 Addition of Debilitating Medical Conditions

Problem: The set of rules required to successfully submit a petition to add new qualifying conditions is overly restrictive and can delay the consideration of new petitions for minor deficiencies in the petition. A patient with a condition that is not yet recognized by Illinois may have an petition package that is 99% complete, but any of the requirements are not met, for example, if they use 11-point font instead of 12-point, the entire petition is rejected and the patient cannot refile for another six months, meaning they will have to suffer with the effects of their condition without cannabis as a treatment option simply for a minor clerical error. Moreover, the listed requirements for a petition may make it difficult for patients to complete. The Medical Cannabis Advisory Board should be able to contemplate applications on the merits that such a petition provides.

Solution: We suggest using a less restrictive petition process for adding new conditions, such as the one provided for in the Maine Regulations. These rules allow for petitions to be submitted any time of year and have less stringent burdens to meet in order to have a petition considered. This language is provided below.

3.2 Public petitions: adding debilitating medical conditions: The department shall consider written public petitions to add a disease or medical condition to the list of debilitating medical conditions set forth in Section 3.1 of these rules.

3.2.1 A petition to add a disease or medical condition must be submitted on forms provided by the department.

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3.2.2 The petition must clearly identify the specific debilitating disease or medical condition.

3.2.3 The petition must include reputable scientific evidence that supports the use of marijuana for the treatment of the disease or medical condition.

3.2.4 The petition must include sufficient evidence to demonstrate that the medical use of marijuana would benefit qualifying patients with the disease or medical condition.

3.2.4.1 A petition to benefit an individual patient on whose behalf the petition is submitted that does not comply with the provisions in Sections 3.2.2, 3.2.3, 3.2.4 and 3.2.5 shall be denied by the department.

3.2.5 The petition must include sufficient evidence that marijuana therapy is effective enough to warrant its use.

3.3 Public hearing. *The department shall publish a notice indicating the date, time and place of the public hearing on the petition. The notice shall be posted on the department's webpage and electronically sent to individuals who contact the department to be placed on the department's interested parties' mailing list.*

3.4 Written comments. *The department shall accept written comments on the petition for 10 business days after the date of the public hearing.*

3.5 Commissioner's decision. *The commissioner shall approve or deny a petition within 180 days of its submission. The written decision shall include the factors supporting the decision. Factors considered by the commissioner include but are not limited to the following:*

3.5.1 The written petition including required documentation;

3.5.2 Public testimony and written comments; and

3.5.3 Consultation with physicians and additional research conducted by or on behalf of the department at its discretion.

3.6 Final agency action. *The approval or denial of a petition constitutes final agency action subject to judicial review. Jurisdiction and venue for judicial review are vested in the Superior Court.¹*

Problem: Another concern within the section on adding new conditions is the lack of patient representation on the Medical Cannabis Advisory Board. Additionally, it may be helpful to have the input of a nurse who works with patient populations that are likely to

¹ 10-144 CMR 122-3.2 et seq.

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use cannabis to treat their conditions. Nurses often work more directly with patients than physicians, and their perspective should be useful to the goals of the Advisory Board.

Solution: Add two (2) medical cannabis patients or people with conditions that could be treated by medical cannabis, and add one (1) registered nurse to the Advisory Board.

5. Section 946.210 Fees

Problem: The proposed fees that patients and caregivers would be required to pay are among the highest in the nation. Only two states charge more than \$150 for patients to register patients, Oregon and New Jersey. Maine does not charge patients a fee to register (although caregivers must pay), while Colorado recently slashed its registration fees from \$35 to \$15.² While ASA appreciates that DPH has proposed a lower fee for patients receiving public assistance, many states have lower reduced fees for financial hardship, some even allow waiving fees altogether for low-income patients.

Solution: Imposing fees upon patients is burden that patients should not be subjected to a fee, but if it is necessary to impose a fee, we ask that they be more in line with the rest of the nation. A fee of \$35 for regular registration and \$15 for financial hardship would better serve patient needs. Additionally, if patients must be registered to a single dispensing organization, patients should not be subjected to a fee for transferring their dispensing organization of choice.

6. Section 946.220 Fingerprint-Based Criminal History Records Check

Problem: It is a requirement of the statute to collect fingerprints of patient and caregiver applicants in order to run a criminal background check. What is not required is that patients must submit these fingerprints on an annual basis, as called for in Section 946.220(a). This is a particular burden for low-income patients because they would be required to pay the fees involved, per Section 946.220(a)(3). Of even greater concern is the requirement for DPH to retain criminal records, which could be used as evidence of “apparent” violations of law, which would allow DPH to divulge to law enforcement a patient’s confidential information.

Solution: Strike the requirement that fingerprinting is required on an annual basis, and allow all patients, or at the very least all low-income patients a way to submit their fingerprints free of charge. Additionally, it should be made clear that a patient’s criminal background check will not be used as evidence of any “apparent” violations under Section 946.60(f)(2).

7. Section 946.230 General Provisions

Problem: The requirement that patients must sign a written statement certifying all of the passages in Section 946.230(c) may have a chilling effect on patients being willing to

² <http://www.colorado.gov/cs/Satellite/CDPHE-CHEIS/CBON/1251593016680#>

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participate in the program. These requirements seem to be based upon of the regulations from the District of Columbia's program. The District recently dropped these required statements from their application for because it caused the form was the longest in the country and may have been a contributing factor to D.C. only having approximately 59 patients in the first four months of the program. The D.C. application used to be 9 pages and has since been reduced to 3 pages.³

Of these provisions, most troubling is the prohibition on patients and caregivers to possess a Firearm Owners Identification Card or a Concealed Carry Weapons Permit, per Section 946.230(c)(23). Patients who have prescriptions for intoxicating opioid medication are not subject to any firearms prohibitions and neither should medical cannabis patients. Furthermore, because medical cannabis businesses must operate in a cash-only manner due to federal law, patients and caregivers must travel to dispensing organizations with large sums of cash money, making them potentially subject to muggings. Patients and caregivers deserve the right to protect themselves like all residents in the state of Illinois.

Solution: Strike per Section 946.230(c)(23) in its entirety, and remove the signing statement requirements, or reduce them to the most essential statements necessary for a patient to sign, as was accomplished in the District.

8. "Public place" definition

Problem: The ability to consume medical cannabis in public is part of the statute; however, the extent to what is considered a public place is defined by the regulations. Under the proposed definition a public place "means any place where an individual could reasonably be expected to be observed by others." This goes beyond the actual places of public accommodation, such as parks and restaurants, or even a person's front walkway to their house, but to the interior of a patient's dwelling as well, unless visual access to the windows is blocked. Consequently, many patients will only be able to medicate inside of private residences with the window shades drawn. Patients should be able to use their medicine just as any other physician-recommended medication, and the rules should not further restrict the already limited by statute ability for patients to medicate.

Solution: Add a provision that clarifies that patients may use their medicine anywhere in a private residence. If medicating outdoors at a private residence is not acceptable, we urge DPH to make it clear that medicating anywhere indoors in a private residence does not violate the "reasonably be expected to be observed by others" standard.

9. Section 946.40 Limitations and Penalties

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<http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/140114MMP%20patientAppREVIS ED2.pdf>

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Problem: The civil fines for patients in who do not strictly adhere to the notification requirements to DPH are higher than necessary and are more likely to affect poor and elderly patients who might not be able to comply in a timely fashion, as they are less likely to have Internet access and may not be able to access the forms within the required time frames.

Solution: We ask for a maximum fine of \$25 dollars for violations Section 946.40(j), and to allow DPH to waive financial penalties for patients with hardship issues. Additionally, we ask that Section 946.50(a) be modified so that forms be made available at in-person locations, such as county and city public health departments and facilities.

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