House Majority Policy Committee

Rep. Kerry Benninghoff, Chairman

MEMORANDUM

To: Rep. Dave Reed, House Majority Leader

From: Rep. Kerry Benninghoff, House Majority Policy Chairman

Date: September 28, 2015

RE: Report of the Medical Marijuana Workgroup

Below, please find a summation of the bipartisan workgroup you established in July on the topic of medical marijuana in Pennsylvania.

History of Medical Marijuana Legislation in PA

Since the 2009-2010 legislative session, 13 bills were introduced addressing the use of marijuana for medical use:

- 2009-10 Legislative Session
  - House Bill 1393 (Cohen)
  - Senate Bill 1350 (Leach)
- 2011-12 Legislative Session
  - House Bill 1653 (Cohen)
  - Senate Bill 1003 (Leach)
- 2013-14 Legislative Session
  - House Bill 1181 (Cohen)
  - House Bill 2182 (Cox)
  - House Bill 2424 (Gainey)
  - Senate Bill 770 (Leach)
  - Senate Bill 1182 (Folmer)
- 2015-16 Legislative Session
  - House Bill 35 (Regan)
  - House Bill 1432 (Marsico, Regan, Delozer)
  - Senate Bill 3 (Folmer)
  - A preliminary draft of legislation authored by Rep. Jim Cox

The Senate and House combined to hold 8 public hearings over this time with more than 100 testifiers presenting information to the General Assembly on this issue. Testimony during the hearings was offered by proponents and opponents of the issue and archived testimony from those hearings offered a starting point of valuable information to begin the workgroup.

Nationwide, 23 states and the District of Columbia have approved medical marijuana programs. Aspects of several states' programs were discussed as potential models including New York, Illinois, Connecticut and Arizona, among others. The experiences

of other states, combined with the testimony obtained by the General Assembly through public hearings were considered during the formation of the workgroup's findings presented below.

Medical Marijuana in the 2015-2016 Legislative Session

Senate Bill 3 (SB 3) passed and was sent to the House on May 12, 2015. On May 14, 2015 the bill was assigned to the House Health Committee. On June 26, 2015 the House Health Committee voted to refer Senate Bill 3 to the House Rules Committee.

Formation of the Medical Marijuana Workgroup

As SB 3 was placed in the House Rules Committee at the end of June, House Majority Leader Dave Reed approached House Majority Policy Committee Chairman Kerry Benninghoff to facilitate a bipartisan workgroup to discuss the issue of medical marijuana. The request was made to see if the workgroup could build consensus around the key components of the issue that could then be the foundation of a developed proposal that could move through the House chamber.

The workgroup was comprised of a bipartisan group of House members who had a significant interest in working toward a final product that could move through the legislative process and provide symptom relief and benefit to individuals in need.

The workgroup consisted of the following members:

- House Republicans: Benninghoff, Cox, Delozier, Ellis, Kaufer, Marsico, Regan, Topper
- House Democrats: D. Costa, Daley, Gainey, Petrarca, Schweyer

Ten meetings were held over the summer between July and September offering a vetting of SB 3 and House Bill 1432 (HB 1432). The tremendous dedication of the members should be praised as each and every meeting was well attended. Members came prepared to listen, discuss and question a complex and emotionally driven issue.

Workgroup Findings

In the workgroup's first meeting, members' brainstormed issues that the workgroup needed to focus on to develop points of consensus. Below are those findings:

1. **What is the governing authority?**

   Existing Legislation: A starting point for the discussion on a governing authority began with use of an independent board under the proposal contained in SB 3. A program authorized under HB 1432 is administered by the Department of Drug and Alcohol Programs (DDAP).

   Discussion: Compromise and discussion focused on the use of the Department of Health as the governing agency to coordinate and run a medical marijuana program in Pennsylvania. Since the DOH currently licenses, monitors, and regulates health care facilities and medical personnel in PA already, members of the workgroup felt the department had the existing

capabilities to best accept the authority and responsibility of a medical marijuana program in the state. This recommendation also avoided the creation of a new, independent governing authority.

The DOH was approached to gauge its interest and confirm a willingness to operate this program. DOH felt they were the appropriate entity to oversee this program and Secretary Murphy and staff met with the full workgroup on September 9, 2015 to present their thoughts and answer questions of the members.

As the governing authority, the DOH would be responsible for implementing and administering the program, as well as establishing processes for reviewing, approving, denying or revoking all licenses and qualified patient cards. Licensed physicians participating in the program should be required to complete continuing education designed and administered by the DOH. The program would authorize the creation of a volunteer advisory board comprised of unpaid positions that would be charged with assisting the DOH in its implementation, administration, and oversight of the program.

Members also felt that any proposal should require the legislature to be provided periodic written updates from the DOH to monitor the program. Some states do yearly reports, while others do monthly.

Recommendation: Provide the governing and licensing authority of a medical marijuana program in PA to the DOH, advised by a voluntary board, and require at minimum, annual written reports to the legislature for review and monitoring purposes. In addition, provide for a timetable for the implementation of regulations. The volunteer advisory board should consist of no more than 19 members and have members representing physicians, nurses, pharmacists, medical research personnel, law enforcement, district attorneys, drug and alcohol treatment, and each of the legislative caucuses.

2. What should be the licensing structure?

Existing Legislation: SB 3 offers three license types: one license for growers, one license for processors, and a separate for dispensaries. HB 1432 offers one type of license with growers, processors and dispensaries fully integrated under that single license.

Discussion: The advantages of a fully integrated license structure provide for the strongest oversight of the seed-to-sale process. An independent license structure, however, allows for market-based forces to determine adequate numbers of growing, processing, and dispensing locations. The disadvantage of an independent licensing structure is the increased potential for diversion and other unlawful activity. The state of Connecticut was identified as a potential model during discussion as a state that uses a two-license system combining the growing and processing aspects under a single license. A separate license is offered in the state for dispensing locations.

As discussions continued on this topic, members coalesced around the concept of a two-license structure similar to the Connecticut model. This system offered a balance between the two existing bills.

Recommendation: A two-license system providing for one type of license for growing and processing entities and a separate license for dispensing entities. A fee-based structure should be implemented by the DOH for both initial licenses and the renewal of all licenses. Licenses should be renewed on an annual basis. Legislation should require seed-to-sale security tracking to prevent diversion and other unlawful activity. Legislation should also require penalties for non-compliance and unlawful activity, including the revocation of a license.

3. **How many growing, processing, and dispensary licenses should be offered?**

Existing Legislation: SB 3 proposes 65 growers, 65 processors and 130 dispensaries. HB 1432 offers five entity licenses fully integrating growing, processing, and dispensing operations. Each licensee under the bill would be permitted up to 4 dispensary locations (20 dispensaries total).

Discussion: This question was one of the more controversial topics the workgroup was asked to address.

Regarding growers/processors, arguments ranged in the discussion from 5 to 65 total entities. Those arguing for the smaller number sought a more restricted model favoring tighter regulation that lessens concerns of product diversion. Proponents of this model indicated the number of locations could be increased in the future depending on the demand. Those defending the larger number of growers/processors were concerned about a lack of supply for patients indicating a program that is too restricted may never get the product to the patients. The issue of patients or caregivers having to travel long distances to make a purchase was also a concern.

The discussion regarding the number of dispensaries ranged from 20 to 600-plus. Arguments for a small number of dispensaries were, again, based on a concern over product diversion and a desire to properly monitor the state's program. Members arguing for a larger number preferred patient convenience, patient access and expressed concerns over pricing. Another issue expressed by members arguing for a larger number of growers/processors and dispensaries was a great concern that if the number of outlets are too few, it will drive the price of the medicine up and push patients back to the black market.

All members agreed that no patient or caregiver should have to travel three hours to make a purchase. As a result, some discussion was given to creating regions in the state to properly disperse the dispensing locations across the state. Legislation should suggest regionalized locations for dispensaries to achieve this access. This regionalized approach may start based on population, but the DOH should also take into consideration the patient size group that the medical marijuana program would serve.

The biggest challenge of determining the number of licenses is attempting to identify the economic demand for the product. More specifically, how many resident patients will Pennsylvania serve? Much of that answer will be based on the number of approved ailments, but that alone will not dictate total patient need. The workgroup spent considerable effort attempting to determine the economic impacts including: total number of annual patient visits to a dispensary, possession limitations, product purchase price, number of dispensaries, and patient group size. An analysis included in the attachments provided with this memo.

Recommendation: In the workgroup's final meeting, the majority of members were seeking at least 65 dispensaries for the state that would be geographically dispersed based on the size of the patient group served by the medical marijuana program. However, this number was not supported by everyone. The Majority Leader should continue work to determine the need, access and internal caucus politics to allow a bill to move forward when pinpointing the number, or a range of numbers, of growers/processors and dispensaries.

4. **What are the qualifying conditions and who may qualify for a medical marijuana recommendation?**

Existing Legislation: SB 3 has 15 qualifying conditions for patients. HB 1432 has 10 qualifying conditions.

Discussion: After a lengthy discussion on ailments, the workgroup settled for a wide range of ailments consisting of those contained in SB 3 and HB 1432.

Workgroup members considered the medical efficacy of marijuana in treating or alleviating symptoms of the conditions and ailments that were discussed. Also considered in the discussions was the potential for a condition to be misrepresented by an individual patient. The two ailments that generated the most discussion were Chronic Pain and Post-Traumatic Stress Syndrome (PTSD).

Concerns were raised about what exactly constitutes "chronic pain" and members acknowledged that medical marijuana could be an option for some patients that are currently being prescribed highly addictive and potentially dangerous narcotics. Concerns were also made known regarding the potential for misuse of a medical marijuana recommendation through this condition. Discussion focused on how to tightly define "chronic pain" to provide recommending physicians the ability to offer access to a patient who could benefit, while limiting the potential for misuse and diversion by both doctor and patient. Workgroup members also felt, through a narrow definition, recommending physicians would also have discretion in determining whether a recommendation was a plausible course of treatment for a patient. As a result, the workgroup found it could recommend inclusion of chronic pain, so long as recommendations to the Leader included the workgroup's preference that any definition of chronic pain be narrowly written.

The consideration of PTSD followed similar discussion patterns to that of the pain discussion. Members of the workgroup expressed concerns about the potential for misuse and diversion, as well as an understanding that patients respond differently to existing prescription medications that have high potential for addiction. It was noted during the workgroup's discussion that the state of Colorado recently rejected inclusion of PTSD under their medical marijuana program, however, the workgroup felt comfortable with inclusion of this diagnosis in its recommendations to the Leader.

Recommendation: The workgroup recommends the inclusion of the following list of 14 ailments:

Cancer (includes spinocerebellara ataxia)
HIV/AIDS (includes cachexia/wasting syndrome)
Multiple Sclerosis
Damage to the nervous tissue of the spinal cord
Inflammatory bowel disease
Post-Traumatic Stress Syndrome (PTSD)
Crohn's Disease
Pain
ALS
Parkinson's Disease
Epilepsy and Seizures
Neuropathies
Huntington's Disease
Glaucoma
Chronic/Intractable

Through its rulemaking power, the DOH should be provided the ability to add additional ailments to the qualified list in the future.

To receive a recommendation, a patient must fulfill all of the following:

- Be a resident of PA
- Have a qualified ailment that is certified by a program-approved physician
- Receive a recommendation from a prescribing physician who is licensed in PA and in good-standing with the DOH
- Apply for and be approved for a fee-based, qualified patient card by the DOH
- Annually renew the qualified patient card

Patients are able to designate a caregiver who must also be approved and licensed annually by the DOH. Unlawful activity by a patient or caregiver should be subject to both criminal penalties and the revocation of the qualified patient card.

5. **What are the acceptable delivery methods for medical marijuana?**

Existing Legislation: SB 3 includes the following delivery methods: oils, ointments, tinctures, liquids, gels, pills, similar substances, and vaporization only for cancer. HB 1432 includes the following: oil, pills and vaporization (except in public places).

Discussion: Similar to the discussion of ailments, the workgroup wanted to include a larger list of delivery methods that would be options for potential patients. The group was concerned about diversion, the appearance of recreational use of a product, the attractiveness of products to minors, and

safety and security. Also, the group would ask that the Department of Health have rulemaking authority to grant additional delivery methods as research and medical advances develop in the future.

Recommendation: Pill, Oils, Topical (lotions, salves, etc.) and vaporization should be included as acceptable methods of delivery for patients. Smoking, and commercially produced edibles, should be prohibited as these methods present the greatest risk for diversion as well as contributes to the appearance of recreational use. To aid in the digestion of a product, the ability of a patient or caregiver to privately prepare a food or drink should not be prohibited. To address safety concerns, marketing and package restrictions should be included either legislatively, or through regulations, to assure proper labeling, packaging and warnings for patients. Finally, to address security concerns the workgroup recommends real-time tracking of purchases to prevent and deter the purchase of product in excess of the permitted amount.

6. **Pennsylvania needs a research component in the medical marijuana legislation**

Existing legislation: Prior to formation of the workgroup, Rep. Cox had drafted preliminary language for his own medical marijuana legislation. The workgroup had the opportunity to review his proposal and a major component was the concept of an extensive research program that permitted the state to apply for a federal waiver that, if approved, would allow the state to collect data any of our in-state research institutions could analyze and make conclusive findings.

Discussion: While worldwide research is being conducted on the medical benefits and other impacts of marijuana, those in opposition point to the lack of FDA approval here in the U.S. as a reason for being cautious with advancing a bill, or opposing it altogether. While the workgroup cannot compel the federal government to act and conduct scientific research, unanimously, every member of the workgroup prefers that a research and data collection component be included in any bill that moves forward in PA. It should be noted that, while organizations representing physicians in PA oppose medical marijuana legislation and prefer action by the FDA to reschedule the drug to allow for further clinical studies, those representatives support the concept of a robust research component should any legislation advance in PA. These organizations feel it is absolutely necessary to investigate the medical impacts and to aid doctors considering and/or making recommendations to patients.

Recommendations: Legislation should authorize the state to apply for and receive federal waivers to collect patient and clinical data as part of a research program funded by taxes and fees collected from the state's medical marijuana program. It is recommended that data be permitted to be shared with in-state research institutions for analysis and any conclusive findings. The legislation should provide recommending physicians access to aggregated information regarding recommended strains, ailments, efficacy, side effects and other clinical data to aid in the recommendation process. The legislation should also require the protection of patient identity.

7. **Should Pennsylvania have reciprocity with other states?**

Existing Legislation: SB 3 provides for reciprocity with other states. HB 1432 does not offer reciprocity.

Discussion: Reciprocity was another dividing issue for the workgroup. Proponents of reciprocity noted the length of time it takes for a state to setup regulations and business operations thus limiting a patient's ability from receiving treatment and relief of conditions. Those supportive of this concept also questioned whether out-of-state visitors would, or would not, be permitted to possess medical marijuana while in PA. Concerns expressed about reciprocity included; a doctor's ability to recommend prior to full operation of a medical marijuana program in PA; the risk of potential diversion; the impact and increased demand on law enforcement; and, the potential for federal government intervention which could indirectly hinder or delay the full implementation of PA's medical marijuana program.

Interesting research was identified during the workgroup's discussion regarding the state of Delaware's experience with this issue. While Delaware statute includes provisions regarding a visiting patient's or caregiver's ability to possess medical marijuana, dialogue with officials in Delaware has determined that those statutory provisions were not included in the state's final regulations. As a result, Delaware has not entered into reciprocal agreements with any other state recognizing out-of-state individuals' ability to possess medical marijuana. According to Delaware officials, these reciprocal agreements and visiting patient provisions were not included in final regulations because state officials believed the provisions to be in conflict with the federal government's enforcement priorities outlined in U.S. Department of Justice memos to U.S. attorneys.

Discussion moved toward the concept of a temporary identification card for resident patients who are approved by a physician and the Department of Health. This concept could grant resident patients the ability to possess medical marijuana in the state prior to the ability to obtain medical marijuana products in PA dispensaries. No evidence was found that this has been attempted in any other states.

Recommendation: The workgroup agreed not to include language that would permit reciprocity agreements with other states. However, there was a strong interest in exploring any available options that would permit existing resident patients to possess or use medical marijuana during the formalization of rules and regulations.

8. **Should Pennsylvania have a sunset provision to the law?**

Existing legislation: SB 3 does not include a sunset provision for a medical marijuana program. HB 1432 includes an expiration date of January 1, 2022.

Discussion: The sunset provision was discussed in several meetings without coming to a solid position or conclusion.

Opposition to a sunset was concerned about the appearance of medical marijuana being a temporary program. As such, there was a fear that businesses may be hesitant to invest significant money to set up operation as a result of the possibility that the law could face a sunset in the future.

Proponents discussed the sunset as a checkpoint for the legislature to monitor the program after it is up and running for several years. The sunset, along with the required reports that DOH must make to legislative leaders, offers the legislature the chance to modify, correct or expand parts of the law to improve the program.

Recommendation: No conclusion could be reached by the workgroup on the sunset provision. This is an issue the Leader should consider and discuss with members of the workgroup to determine if it is needed.

Attachments:

Included with this summary are the following work product attachments:

1) A state-by-state summary of legal medical marijuana states
2) Senate Bill 3
3) House Bill 1432
4) Preliminary draft of legislation prepared by Rep. Jim Cox
5) 8/29/2013 U.S. Department of Justice memo
6) Illinois 2014 Annual Report & summary statistics
7) Arizona program report – July 2015
8) Connecticut program overview and summary statistics
9) 7/16/2015 Rueters news report RE: Colorado rejecting PTSD
10) License integration model information for select states
11) Dispensary revenue/cost analysis