15.0765.02000

FISCAL NOTE
Requested by Legislative Council
02/13/2015

Amendment to: HB 1430

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues			$1,798,271	$56,330	$3,657,812	$56,330
Expenditures			$1,854,601		$3,714,142	
Appropriations			$1,854,601		$3,714,142	

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

The Engrossed Bill creates a new chapter of NDCC relating to the use of medical marijuana and designates the Department of Health (DoH) to oversee the registration of caregivers and patients and the licensing and regulation of medical cannabis establishments, and provides an effective date.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Throughout the new chapter the responsibilities of the DoH include the adoption of rules to oversee the program, issuing and tracking the registry cards for patients and caregivers, along with registering and issuing registration certificates to the prospective medical cannabis establishments. In our research we noted that this new legislation was most similar to the state of Colorado's medical cannabis program. We used a ratio of our population to that of Colorado's to arrive at the basis for the number of patients, caregivers and medical cannabis establishments.

Criminal background checks will be processed by the Bureau of Criminal Investigations (BCI) division of the Attorney General's Office. Background checks are included for caregivers and any principal officer, board member, agent, volunteer or employee of a medical cannabis establishment.

The fiscal impact on local law enforcement is not included in this fiscal note as the impact is unable to be determined at this time.

Section 19-24-05 further requires the DoH to consider petitions to add serious conditions or the condition's treatment to the list of debilitating medical conditions. This is far beyond the current capacity of the DoH to do the research and laboratory testing necessary in place of the Food and Drug Administration (FDA) to add such conditions or treatment and would place a tremendous liability on the state. The needed resources are unable to be estimated at this time and these costs are not reflected in this fiscal note.

The new legislation also defines a cannabis testing facility which is to be registered with the DoH to address the safety and potency of cannabis. At this time we are unable to estimate the costs associated with testing the safety and potency of cannabis and these costs are not reflected in this fiscal note.

All fiscal impacts that can be estimated are based on the June 30, 2016 effective date.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

A. Revenues: Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.

The bill requires that fees collected are sufficient to cover all costs of implementation and administration of this chapter and limits licenses of medical cannabis establishments at $5,000 per year.

For the 2015 – 17 biennium:
DoH will collect fees for registration cards in year 2 of the biennium from an estimated 4,068 caregivers and 8,135 patients at $119 for total revenue of $1.45 million.

DoH will collect registration fees from medical cannabis facilities annually. The fee can be increased each year by inflation. $175,000 is estimated to be collected in 2015-17 in year 2 based on 35 facilities at $5,000

DoH estimates $40,000 will be collected in replacement cards over the biennium at $20 a card as outlined in section 19-24-10 (3).

All DoH revenue will be deposited to the general fund since the bill does not specify otherwise.

BCI estimates collecting $188,870 in fees charged for background checks. $132,540 will be deposited into the general fund and $56,330 into the special fund as the cost for FBI fingerprinting expense is considered special revenue.

For the 2017 – 19 biennium:
DoH will collect fees for registration cards from caregivers and patients estimated to be collected annually at $54 for total revenue of $2.6 million.
Yr 1 – 8,136 caregivers Yr 2 –8,136 renewals and 500 new caregivers
Yr 1 – 16,270 patients Yr 2 – 16,270 renewals and 100 new patients

DoH will collect registration fees from medical cannabis facilities annually. The fee can be increased each year by inflation. $758,375 is estimated to be collected in 2017-19.
Yr 1 – 70 facilities at ($5,150 inflated 3%) - $360,500
Yr 2 – 70 facilities renewing at $5,305 (3%) inflation and 5 new facilities - $397,875

DoH estimates $120,000 will be collected in replacement cards over the biennium at $20 a card as outlined in section 19-24-10 (3).

BCI estimates collecting $188,870 in fees charged for background checks. $132,540 will be deposited into the general fund and $56,330 into the special fund as the cost for FBI fingerprinting expense is considered special revenue.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

2015 – 17:
DoH costs include 8 new staff to handle the registration of qualified patients and caregivers by the end of the biennium. 6 new FTE are needed to handle the Medical Marijuana Enforcement program by the end of the biennium. Operating costs for these 14 FTE include one-time computer and office furniture costs, rent, data processing and telephone costs. Additionally, there will be travel costs for the enforcement program staff, postage and printing related to the registration cards, one-time costs for the development of a registry to track the patients, caregivers and medical cannabis establishments, and subsequent software maintenance. Background checks will be required for 4,068 caregivers and an estimated 350 employees of 35 medical cannabis establishments at $42.75 for each background check. The department is also required to have an advisory committee with 9 members as outlined in section 19-24-20. The department will be responsible to reimburse meeting expenses for 6 of these 9 individuals.

DoH total expenses of $1,712,987 include salary costs of $943,341 and operating costs of $769,646.

BCI total expenses of $141,614 include salary costs for 1.5 new FTE to process the increase in background checks of $91,820 along with operating cost associated with these new FTE of $49,794.

2017-19:
DoH costs include the need for 5 additional staff to assist in the area responsible for the registration of qualified patients and caregivers and 3 additional staff to assist in the medical marijuana enforcement program along with the continuation of the 14 FTE inflated by 4%, the continuation of the operation costs for the FTE, the cost of the advisory committee, and the cost of background checks all inflated by 3%, along with one-time computer and office furniture costs for the new FTE. Note: background checks include an additional 4,038 caregivers, an estimated 350 employees of 35 medical cannabis establishments, and another estimated 1000 background checks.

DoH total expenses of $3,464,544 include salary costs for the 22 FTE of $2,914,709 and operating costs of $549,835.

BCI total expenses of $249,598 include continued salary costs for the 1.5 FTE of $205,981 along with operating cost associated with the FTE of $43,617.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

These expenditures are not included in the Executive Budget for the DoH (HB 1004) or the Office of the Attorney General (BCI) (SB 2003). Therefore, an appropriation would be needed.

Name: Brenda M Weisz

Agency: Department of Health

Telephone: 328-4542

Date Prepared: 02/16/2015

15.0765.01000

FISCAL NOTE
Requested by Legislative Council
01/19/2015

Revised
Bill/Resolution No.: HB 1430

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues			$3,745,924	$114,750	$3,541,002	$86,492
Expenditures			$3,860,674		$3,627,494	
Appropriations			$3,860,674		$3,627,494	

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This Bill creates a new chapter of NDCC relating to the use of medical marijuana and designates the Department of Health (DoH) to oversee the registration of caregivers and patients and the licensing and regulation of medical cannabis establishments.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Throughout the new chapter the responsibilities of the DoH include the adoption of rules to oversee the program, issuing and tracking the registry cards for patients and caregivers, along with registering and issuing registration certificates to the prospective medical cannabis establishments. In our research we noted that this new legislation was most similar to the state of Colorado's medical cannabis program. We used a ratio of our population to that of Colorado's to arrive at the basis for the number of patients, caregivers and medical cannabis establishments.

Criminal background checks will be processed by the Bureau of Criminal Investigations (BCI) division of the Attorney General's Office. Background checks are included for caregivers and any principal officer, board member, agent, volunteer or employee of a medical cannabis establishment.

Section 19-24-05 further requires the DoH to consider petitions to add serious conditions or the condition's treatment to the list of debilitating medical conditions as defined under section 19-24-01(8) in the same chapter. This is far beyond the current capacity of the DoH to do the research and laboratory testing necessary in place of the Food and Drug Administration (FDA) to add such conditions or treatment and would place a tremendous liability on the state. The needed resources are unable to be estimated at this time and these costs are not reflected in this fiscal note.

The new legislation also defines a cannabis testing facility which is to be registered with the DoH to address the safety and potency of cannabis. At this time we are unable to estimate the costs associated with testing the safety and potency of cannabis and these costs are not reflected in this fiscal note.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   The bill requires that fees collected are sufficient to cover all costs of implementation and administration of this chapter and limits licenses of medical cannabis establishments at $5,000 per year.

   For the 2015 – 17 biennium:
   DoH will collect fees for registration cards from caregivers and patients estimated to be collected annually at $77 for total revenue of $2.8 million.
   Yr 1 – 4,068 caregivers Yr 2 – 4,068 renewals and 4,068 new caregivers
   Yr 1 – 8,135 patients Yr 2 – 8,135 renewals and 8,135 new patients

   DoH will collect registration fees from medical cannabis facilities annually. The fee can be increased each year by inflation. $535,500 is estimated to be collected in 2015-17.
   Yr 1 – 35 facilities at $5,000 - $175,000 Yr 2 – facilities renewing at 5,150 (inflated 3%) - $180,250 and 35 new facilities - $180,250

   DoH estimates $120,000 will be collected in replacement cards over the biennium at $20 a card as outlined in section 19-24-10 (3).

   All DoH revenue will be deposited to the general fund since the bill does not specify otherwise.

   BCI estimates collecting $384,750 in fees charged for background checks. $270,000 will be deposited into the general fund and $114,750 into the special fund as the cost for FBI fingerprinting expense is considered special revenue.

   For the 2017 – 19 biennium:
   DoH will collect fees for registration cards from caregivers and patients estimated to be collected annually at $47 for total revenue of $2.38 million.
   Yr 1 – 8,636 caregivers (incl. 500 new) Yr 2 –8,636 renewals and 500 new caregivers
   Yr 1 – 16,370 patients (incl 100 new) Yr 2 – 16,370 renewals and 100 new patients

   DoH will collect registration fees from medical cannabis facilities annually. The fee can be increased each year by inflation. $834,995 is estimated to be collected in 2017-19.
   Yr 1 – 75 facilities (5 new) at ($5,305 inflated 3%) - $397,875 Yr 2 – 75 facilities renewing at $5,464 (3%) inflation and 5 new facilities - $437,120

   DoH estimates $120,000 will be collected in replacement cards over the biennium at $20 a card as outlined in section 19-24-10 (3).

   BCI estimates collecting $290,000 in fees charged for background checks. $203,508 will be deposited into the general fund and $86,492 into the special fund as the cost for FBI fingerprinting expense is considered special revenue.

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

   2015 – 17:
   DoH costs include 13 new staff to handle the registration of qualified patients and caregivers by the end of the biennium. 8 of those FTE would be needed on July 1, 2015 with an additional 5 joining July 1, 2016. 9 new FTE are needed to handle the Medical Marijuana Enforcement program by the end of the biennium. 6 of those FTE would be needed on July 1, 2015 with an additional 3 joining July 1, 2016. Operating costs for these 22 FTE include one-time computer and office furniture costs, rent, data processing and telephone costs. Additionally, there will be travel costs for the enforcement program staff, postage and printing related to the registration cards, one-time costs for the development of a registry to track the patients, caregivers and medical cannabis establishments, and subsequent software maintenance. Background checks will be required for 8,136 caregivers and an estimated 700 employees of 70 medical cannabis establishments at $42.75 for each background check. The department is also required to have an advisory committee with 9 members as outlined in section 19-24-20. The department will be responsible to reimburse meeting expenses for 6 of these 9 individuals.

DoH total expenses of $3,473,040 include salary costs of $2,350,295 and operating costs of $1,122,745.

BCI total expenses of $387,634 include salary costs for 2.5 new FTE to process the increase in background checks of $296,647 along with operating cost associated with these new FTE of $90,987.

2017-19:
DoH costs include the continuation of the 22 FTE inflated by 4%, the continuation of the operation costs for the FTE, the cost of the advisory committee, and the cost of background checks all inflated by 3%. Note: background checks were reduced to 1000.

DoH total expenses of $3,244,019 which include salary costs for the 22 FTE of $2,914,709 and operating costs of $329,310.

BCI total expenses of $383,475 include continued salary costs for the 2.5 FTE of $332,447 along with operating cost associated with the FTE of $51,028.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

These expenditures are not included in the Executive Budget for the DoH (HB 1004) or the Office of the Attorney General (BCI) (SB 2003). Therefore, an appropriation would be needed.

Name: Brenda M Weisz

Agency: Department of Health

Telephone: 328-4542

Date Prepared: 01/30/2015

Department of Health
Fiscal Note HB 1430
2015 - 2017 Biennium

Category	Salaries/ Fringe	IT Equip under $5,000	Office Equip Under $5,000	Lease - Build.	IT Data Processing	IT - Telephone	Various Operating	Total Costs
Registration of Qualified Patients and Caregivers								
1 - Division Director	201,794	1,250	2,000	3,216	2,101	672		211,033
2 - Professional Staff Members - both yrs	280,694	2,500	4,000	3,430	4,202	1,344		296,170
1 - Professional Staff Members - add 2nd yr	70,732	1,250	2,000	858	1,050	336		76,226
1 - Lead Admin Staff - both yrs	112,446	1,250	2,000	1,715	2,101	672		120,184
3 - Admin Staff - both yrs	294,246	3,750	6,000	5,145	6,303	2,016		317,460
4 - Admin Staff - add 2nd yr	197,556	5,000	8,000	3,432	4,200	1,344		219,532
1 - IT professional	140,347	1,250	2,000	1,715	2,101	672		148,085
	1,297,815	16,250	26,000	19,511	22,058	7,056		1,388,690
Medical Marijuana Enforcement Program								
1 - Program Lead	150,736	1,250	2,000	1,715	2,101	672		158,474
3 - Professional Staff Members - both yrs	421,041	3,750	6,000	5,145	6,303	2,016		444,255
2 - Professional Staff Members - add 2nd yr	141,464	2,500	4,000	1,716	2,100	672		152,452
1 - Admin Staff - both yrs	98,082	1,250	2,000	1,715	2,101	672		105,820
1 - Admin Staff - add 2nd yr	49,389	1,250	2,000	858	1,050	336		54,883
1 - Attorney - *would serve both oreos*	191,768	1,250	2,000	3,216	2,101	672		201,007
	1,052,480	11,250	18,000	14,365	15,756	5,040		1,116,891
Advisory Council								
6 members travel expenses							5,140	
Other Expenses								
Travel for enforcement staff							25,000	
Office supplies for all new staff							10,000	
Postage related to registration cards							3,080	
Printing of Registration cards							1,500	
Registry - $480,000 and maintenance of $65,000 per year							545,000	
Background checks							377,739	
							967,459	967,459
Total Department of Health Costs	2,350,295	27,500	44,000	33,876	37,814	12,096	967,459	3,473,040
					total operating		*1,122,745*	
BCI background checks								
Salaries - 2.5 FTE	296,647							
Operating							90,987	
Total BCI costs	296,647	-	-	-	-	-	90,987	387,634
Lab Costs								
unable to estimate								
Research Costs								
unable to estimate								
Total overall Costs	2,646,942	27,500	44,000	33,876	37,814	12,096	1,058,446	3,860,674

Department of Health
Fiscal Note HB 1430
2017 - 2019 Biennium

Category	Salaries/ Fringe	Lease - Build.	IT Data Processing	IT - Telephone	Various Operating	Total Costs
Registration of Qualified Patients and Caregivers						
1 - Division Director	209,866	3,312	2,164	692		216,034
3 - Professional Staff Members	437,883	5,298	6,492	2,076		451,749
1 - Lead Admin Staff	116,944	1,766	2,164	692		121,566
7 - Admin Staff	714,035	12,362	15,148	4,844		746,389
1 - IT professional	145,961	1,766	2,164	692		150,583
	1,624,689	24,504	28,132	8,996		1,686,321
Medical Marijuana Enforcement Program						
1 - Program Lead	156,766	1,766	2,164	692		161,388
5 - Professional Staff Members	729,805	8,830	10,820	3,460		752,915
2 - Admin Staff	204,010	3,532	4,328	1,384		213,254
1 - Attorney - *would serve both areas*	199,439	3,312	2,164	692		205,607
	1,290,020	17,440	19,476	6,228		1,333,164
Advisory Council						
6 members' travel expenses					5,294	
Other Expenses						
Travel for enforcement staff					25,750	
Office supplies for all new staff					10,300	
Postage related to registration cards					6,160	
Printing of Registration cards					3,000	
Registry - maintenance of $65,000 / yr					130,000	
Background checks - 1000 @ $44.03					44,030	
					224,534	224,534
Total Department of Health Costs	2,914,709	41,944	47,608	15,224	224,534	3,244,019
			total operating		329,310	
BCI background checks						
Salaries - 2.5 FTE	332,447					
Operating					51,028	
Total BCI costs	332,447	-	-	-	51,028	383,475
Lab Costs						
unable to estimate						
Research Costs						
unable to estimate						
Total overall Costs	3,247,156	41,944	47,608	15,224	275,562	3,627,494

Department of Health
Fiscal Note HB 1430
Revenue

2015-17 DoH Costs	3,860,674	
Medical Marijuana Facilities - 5000 annual fee - can be increased annually by inflation		
Yr 1 - 35 * 5000	175,000	
Yr 2 - 35 renewal *5150 (3% inflation)	180,250	
Yr 2 - 35 new * 5150	180,250	
	535,500	
Estimated replacement cards	120,000	
Revenue rec'd by BCI	384,750	
Remaining costs to be covered	2,820,424	
Caregivers - 50% yr 1	4,068	
Caregivers - 50% year 2 with 1st yr renewals	8,136	
Patients - 50% yr 1	8,135	
Patients - 50% year 2 with 1st yr renewals	16,270	
total registration cards to be issued for the biennium	36,609	
Cost per registration card annual renewal	77.04	$ 77.00
2017-19 Costs	3,627,494	
Medical Marijuana Facilities - Fees can be increased annually by inflation		
Yr 1 - 75 * 5305 (inflated by 3%)	397,875	
Yr 2 - 75 renewal + 5 new * 5464 (inflated by 3%)	437,120	
	834,995	
Estimated replacement cards	120,000	
Revenue rec'd by BCI	290,000	
Remaining costs to be covered	2,382,499	
Caregivers 500 add'l each year - Yr 1	8,636	
Caregivers 500 add'l each year - Yr 2	9,136	
Patients - 100 add'l each year - Yr 1	16,370	
Patients - 100 add'l each year - Yr 2	16,470	
total registration cards to be issued for the biennium	50,612	
Cost per registration card	47.07	$ 47.00

2015 HOUSE HUMAN SERVICES

HB 1430

2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1430
2/4/2015
Job #23219

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

To legalize the use of medical marijuana.

Minutes:

Testimonies 1-14

Chairman Weisz opened the hearing on HB 1430.

Rep. Pamela Anderson: From District 41 in Fargo introduced and supported the bill. (See Testimony #1) (Handout (amendment) #2) (Handout #3)

5:02
Chairman Weisz: Is it your intent to explain the amendments now?

Rep. P. Anderson: I summarized them. Do you want me to go through them?

Chairman Weisz: We can have that discussion later?

Rep. P. Anderson: There is a fiscal note attached to this. It shows it is basically a wash for the state. We would collect as much revenue as we would spend for 22 additional people to the Dept. of Health.

Rep. Hawken: From District 46 in Fargo. Testified in support of the bill. My son is epileptic and has a neurologist in Virginia who has said there is pretty good research that this might help. I did my research and this goes back as far as 2700-3000 years ago when a Chinese Emperor used cannabis tea to treat gout, rheumatism, malaria and poor memory. The drug popularity spread all through Asia and India and used for stress relief. It got to England and was popularized there. In the late 1800s with Morphine addiction ramped in the U.S. the attitudes towards drugs of any type were shifting. The FDA was formed and it included marijuana on the schedule 1 schedule. In 1937 there was a tax put on marijuana that was so extensive that doctors and pharmacists just felt it was not worth paying the tax to allow it to be continued and that further curtailed the use. It is difficult to know what the actual scientific results are because of being posted on the schedule 1. Congress removing the penalty in December. Now there is the opportunity for the studies to go forward. There is

research that says it does help with MS and with epilepsy. We do need to have that scientific based research so we can say emphatically, yes it does. It needs to be regulated and the pill you can take needs to be standardized. That hasn't happened yet. That is a concern of many. There is a concern of how do we control this? There are a lot of unanswered questions. The questions answered that it can be a valuable tool is the reason my name is on this bill. Maybe we are not ready for the bill. Maybe it is a study. There are 31 states that have some form of legalization. I hope you will look at this.

13:14
Rep. Kiefert: Previous testimony said the person who asked to bring this legislation really felt he might feel better if he had some marijuana and in your testimony regarding research you said it might help. Everything I read about it uses the words, possibly could, maybe.

Rep. Hawken: There are places you will find where doctors will say yes it does. Because there haven't been the studies, people say it might, to protect them.

Rep. Kiefert: Wouldn't it be better to have a positive research that it definitely helps people?

Rep. Hawken: That is my suggestion.

Rep. Kiefert: I'm having trouble with down the road and I think we should wait until we have positive research.

Rep. Hawken: That is one way of looking at it. I would like to see ND be more proactive.

Rep. Mooney: You said your son has epilepsy. I've done preliminary research on people with seizure disorders and some of the information I found on the component CBD of the plant opposed to the plant aspects that have THC in it that causes the high. In that research some of the states who have been looking at that have some data. Did you find that to be true?

Rep. Hawken: I did. There are 60 plus cannoids and we have a certain number of them in our bodies. They help reduce pain. There are different cannoids that will help with different diseases or conditions. Two drugs are on the market, Marinol and Cesamet.

17:19
Beth Larson-Steckler: Testified in support of the bill. (See Testimony #4)

24:05
Ashley Riggs: Testified in support of the bill (See Testimony #5)

30:20
Rep. Kiefert: Minnesota has made some of these treatments legal. Is it possible for somebody from ND to go over there and get a prescription and try it to see if it would help?

Rigs: Not being a resident of ND I don't know if it would work and bringing back to ND would be a risk.

Rep. Kiefert: If there was a chance to help my kids I go and try it regardless.

Rigs: If it does work, then what are we going to do? Travel to Minnesota every day, 3 times a day to distribute the 3 drops of cannabis oil?

32:45
Tracey Reargier: A physician's assistant testified in support of the bill. Told the story of his 12 year old daughter Paige who was born with her intestines outside of her body. She had a colostomy and when she went to have it taken down she had a hypoxic event and she had brain damage. When she woke from her coma she could not walk, talk and had constant seizures. She takes several medications and still has 12-15 seizures a day. He asked for the medicinal cannabis oil for his daughter so she can have some relief without side effects.

39:00
Sharon Krueger: Testified in support of the bill. Told that in 1996 she got Hepatitis C from a blood transfusion. She deals with chronic pain every day. Her immune system has suffered, has debilitating arthritis in her spine. She listed numerous afflictions she has and it was painful standing giving testimony. She asked for a chance to use the medical marijuana.

45:23
John Morgan: Read Testimony for brother Rilie Raymond Morgan III in support of the bill. (See Testimony #6)

52:05
Terrill Lepps: Testified in support of the bill. Spoke of THC being one of the main ingredients that cures cancer. There are hundreds of people it has cured. Believes the government and hospitals don't want the cure for cancer because they make big money on all the chemo treatments and other treatments people have to take to kill the cancer in their bodies.

Chairman Weisz: We will recess for 10 minutes.

58:15
Chairman Weisz: Reopened the hearing.

58:17
OPPOSITION

Wayne Stenehjem: Attorney of General testified in opposition of the bill. (See Handout #7) This bill will have real consequences and actual concerns in ND. This law is not even beginning to be enacted in ND. Under our current system where a physician prescribes a medication, the patient takes it to a pharmacist to be filled. The pharmacist gets that medication from the pharmaceutical company whose process is controlled by law and monitored for safety and precision. This bill even with the suggested amendments provides a new method whereby a physician prescribes the medication and then tells the patient to

feel free to go out and grow your own medication. Proper dosage and timing are critical in any medication, but totally absent in this legislation. This is especially alarming considering the potency of marijuana we are seeing in law enforcement across the nation has dramatically increased over the last decade. Marijuana is an addictive substance, but even under this bill you are not required to report an addictive substance to the prescription drug monitoring program. This is a serious oversight in this bill. In the State of Colorado from 2006-2008 there were about 1046 people who had medical marijuana cards. From 2009 until they legalized marijuana, there were 108,000 medical cards and now there are 283,000 people who have medical marijuana cards. Overall traffic fatalities decreased by 14.8% from 2007-2012, but during the same five year period the traffic fatalities involving operators testing positive of marijuana increased 100%. In 2007 traffic fatalities involving operators testing positive for marijuana represented 7.04% of the total traffic fatalities, but by 2012 that number had more than doubled. Youth marijuana use in Colorado is on the rise. Ages 12-17 reported past use of marijuana at 10.47% which is 39% higher than the national average. A 26% increase in youth age 12-17 monthly reporting marijuana use in the three years after medical marijuana was commercialized. Same for adult, a 20% increase in ages 18-25 monthly use and a 36% over the age 26 who were monthly marijuana users. Emergency room and hospital related admissions are up. In 2011-2013 there was a 57% increase in emergency room visits relating to marijuana. Our highways will be less safe and our citizens will not be healthier if we enact this legislation. The fiscal note only addresses the needs and expenses that the ND Dept. of Health. It doesn't discuss any effect on law enforcement in ND. In Colorado there are more people in the agency that regulates marijuana than there are agents in the Colorado Bureau of Investigation. After alcohol, marijuana is the most frequently detected psycho active substance among drivers. HB 1430 limits law enforcements ability to enforce our drug laws when it comes to medical cannabis. Under this bill individuals and (inaudible) involved with PHC including cultivation and manufacturing substances are not subject to inspection accept by the state health department. They are not subject to search and arrest by law enforcement for any reason. And not subject to prosecution, criminal penalty or asset forfeiture unless they are in violation of the chapter. Our agents cannot give information or logistical support to federal law enforcement or federal prosecutors under this bill. The bill has a number of flaws. This bill provides for local dispensaries for marijuana and individuals to grow it in their own home, but it does not allow for cities and counties to opt out and refuse to permit marijuana dispensary within that jurisdiction. It doesn't deal at all with driving under the influence of drugs. The bill in front of you says the law will take effect August 1, 2015 and gives the Dept. of Health 120 days to enact a regulatory scheme and all of the rules necessary to implement it. (Passed around Colorado's book of rules and regulations of 2013 and then another book of updates from 2014.) There is no way the Dept. of Health would be ready for this law to be implemented by August 1, 2015. You have to weigh the hope without scientific proof that this will help them against the real consequences that will result to us here in North Dakota. There will be more marijuana use, more impaired driving on the highway, and more people claiming they need this kind of relief than you can ever imagine. The fiscal note in front of you addresses only part of the cost to society. It is only a start. I urge you to reject this measure.

1:14
Rep. Mooney: Can we look at the oils?

Stenehjem: It would be better to have Health Dept. talk to you about that.

Rep. Mooney: Having the dispensary clearly identified back with the pharmaceutical ordinary that we are accustomed to process that helps with that?

Stenehjem: That is a regulatory scheme we have adopted over the course of the last 150 years that has served well.

1:16
Dr. Dwelle: State health Officer for the ND Dept. of Health testified in opposition of the bill. (See Testimony #8)

1:28
Rep. Fehr: Can you talk about the medications that are currently approved and legally prescribed in ND? In terms of off label use, to what extent could physicians use currently prescribed medications?

Dr. Dwelle: We often times use drugs that are off label, but we have to have as clinicians a good understanding of the potential use of drugs in that condition. We can go through an I and D process that we use in many of our hospitals. It is called an investigation of a new drug process. You have to make sure you inform the patient that the drug has not been approved by the FDA and monitor the patient for adverse reactions and would report any problems there might be to the pharmaceutical companies as well as the process within our institution that was overseeing that.

Rep. Fehr: How do they share the results of those case studies?

Dr. Dwelle: I was usually in communication with the pharmaceutical company itself. And learn from any information they received on the off label drugs. The pharmaceutical companies are on the oversight of the FDA.

Rep. Mooney: My reference is to thalidomide and laetrile. Are those organic or chemically created?

Dr. Dwelle: Almost all of our antibiotics come from nature. They are identified in various plants, animals and insects. Penicillin is from a mold. They purified the active ingredient from the mold and then it was synthesized. That's how many of our medications are identified. The same thing is true of cannabis. Laetrile came from peach pits, but it was synthesized after that. The cyanide poisoning has an active ingredient in the laetrile that was causing the cyanide toxicities that they saw in the 1982 study.

Rep. Mooney: In your testimony you had dronabinol. Is this an example of recommendations from FDA?

Dr. Dwelle: Yes. These are the kinds of monographs that are generated in almost all of the medications that we use as clinicians. This is the kind of information I use all the time when I am prescribing. I have to know that stuff.

1:34
Courtney Koebele: Executive Director of the ND Medical Association testified in opposition of the bill. (See Testimony #9)

1:36
Rep. Fehr: Have you or the physicians in the association have heard of what the impact is in other states where medical marijuana has been legalized?

Koebele: We have not. It is quite new in Minnesota and I'm sure we will hear some information from them.

Dr. Joan Connell: A pediatrician and President of the ND Chapter of the American Academy of Pediatrics testified in opposition of the bill. (See Testimony #10)

1:49
Rep. Mooney: Are you saying the CBD and THC are we not able to separate the two?

Dr. Connell: THC has been found to be the active ingredient of marijuana for euphoria. Endocannabinoids are those things we referred to earlier in those discussions here. Some of them might be eternally produced and those are THC like. What if there is something else in pot? That is the answer to why this mom wants to give her medical cannabis oil verses dronabinal which is pure THC. The answer to the question is unknown. We need to do this research. We are far from saying this is a great drug that has these kind of uses that we can't even answer that baseline question.

Rep. Mooney: There is work being done on the CBD component.

Dr. Connell: Yes there is. If you refer the article from the Colorado Docs, you will see there are quite a number of studies involving medical marijuana for seizures.

Rep. Rich Becker: Are you familiar with the affects in Montana and Minnesota making medical marijuana available? For pilot studies would anyone here today that testified have access to any medical facilities that do pilot studies?

Dr. Connell: Most prescribers in Colorado are naturopaths and not physicians. The answer is unlikely (to second question). Organizing these studies takes lots of money and effort and it hasn't been done by Departments of Health so far.

Chairman Weisz: Those living in Fargo can they get a card in Minnesota?

Dr. Connell: That is unlikely. Once in a while I can give a child a prescription for an antibiotic for someone going out of the state and they can fill it there.

Rep. Oversen: Clearly they did something wrong in Colorado. Other states have had this law on the books for 20 years. Have there been burns and accidents in those states to make them step back and look at how they are doing it?

Dr. Connell: I don't have an answer for it.

1:57
Carel Two Eagle: Testified in opposition to the bill. (See Testimony #11)

Chairman Weisz closed the hearing on HB 1430.

Handed in Testimony in Support

Leanne Grondahl #12
David C. Rennich #13

Handed in Testimony in Opposition

Mike Reitan, Chief of Police, West Fargo #14

2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1430
2/11/2015
Job #23644

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Minutes: Attachments 1-2

Chairman Weisz took up HB 1430. There are some amendments that were offered. (15.0765.01001) (See attachment #1) I believe the amendments cut the six plants to three plants and the ounces dropped to two ounces. They are taking out the part that refers to impaired.

Rep. Porter: The way it states now in the bill it says that this chapter does not authorize any person to engage in and does not prevent the imposition in the criminal or the penalties engaging in the following conduct. So if you remove the operating navigating or being in the physical control of the vehicle, aircraft or train; you are telling me we are taking out the component that says you can operate a train without being considered to be engaging in an illegal activity as long as you have a marijuana card? I understand "c" and what it does. If you are removing it then you can use it in public without it being a crime.

Rep. Oversen: It is just removing the letter "c" and moving that section up and not removing it. (Passes out another set of amendments 01003, See Attachment #2.)

Chairman Weisz: Let's deal with these (01001) amendments first. The amendments take the smoking out and reduce the amount that you can possess or grow.

Rep. Oversen: I move the amendment of 01001.

Rep. Mooney: Second.

VOICE VOTE: MOTION CARRIED

Rep. Oversen: (Goes through amendment 01003)

15:40
Chairman Weisz: Who gets to grow it?

Rep. Oversen: Only dispensaries.

Rep. Porter: On page 17, 19-24-11, we are saying that the defense must be presumed valid if the evidence shows. On page 18, on line 7, sub c and line 12, sub d we are saying that cultivation is ok. Yet we are removing cultivation and the growing of your own plants in way earlier in all those sections. Now we are saying that an individual may assert medical purposes for using cannabis as a defense to any prosecution involving cannabis and that defense must presume valid if the evidence shows that individual was engaged in the acquisition, possession, use, manufacture, cultivation or transportation of cannabis. And then on "d", any cultivation of cannabis. But earlier you were saying that you can't cultivate it.

Rep. Oversen: That would have been something we missed and could add to the amendments to remove "cultivation" on line 8, on line 7, page 18, and on line 8 and 12.

Rep. Porter: Goes down further than that. It goes down to "defense motion may dismiss".

Rep. Oversen: They would no longer be able to offer it as a defense, but we should remove that reference as well.

Rep. Porter: Line 25, sub 4, we are saying if an individual demonstrates they are using cannabis for medical purposes, that an occupation or professional licensing board cannot have disciplinary action against them.

Chairman Weisz: We will look at other changes to the amendment and if we need someone to come in and answer questions, we will have them come in. I do see that as a problem because it takes away the board's ability to determine if that person was legally taking it.

Rep. Oversen: Can we move my amendments separately and then do those?

Chairman Weisz: That is fine. We are eliminating smoking and growing. You took out the designated caregiver can assist no more than five. You redefined it so there is no limit anymore. Is that correct?

Rep. Oversen: I think if was to not allow them to care for up to five individuals.

Chairman Weisz: I don't think it is limiting it to one patient, but just saying it has to be for the wellbeing of a patient. I think you want that clarified.

Rep. Oversen: Should we limit it to two people or leave it at five?

Chairman Weisz: Who is the designated caregiver? Is that the parent of a minor?

Rep. Oversen: It is whoever has agreed to take care of the person.

Chairman Weisz: There must be an intent in the bill of who that person should be. Your intent was to at least limit the caregiver to one.

Rep. Oversen: Yes.

Rep. Porter: I am not comfortable adopting this other set of amendments. I think we should reconsider our action on the first one. They cross over each other and it is not clear to me at what we are doing. I'm not going to support this set because it isn't clean.

Chairman Weisz: This is a complicated bill. Kourtney could you come up here? The question was raised on page 18 it says, "if an individual demonstrates the individual's medical purpose for using cannabis.....it may not be subject to the following for the individual's use of cannabis for medical purposes. Disciplinary action by an occupational professional licensing board or bureau. If the physician is high and does something inappropriate, do you understand this that this language wouldn't allow them to be disciplined?

Kourtney Koebele: I think this came up on a bill that the board of medical examiners had an opinion on and they wanted to reserve the right if a physician was sharing something that was subject to immunity. But, the board of medicine wanted to protect their right to discipline for other reasons.

Rep. Porter: How would the process work over the internet acquisition of a medical card without actually being seen by a physician? We are creating a situation of allowing non-resident physician to have a non-resident patient who can legally possess and buy cannabis in the State of ND.

Koebele: What page are you looking on? It would create a huge problem. You have to have a license to practice in the state to do work on patients or clients in the state.

Rep. Porter: On page 5, line 20 the definition of practitioner on the top of page 5. Now we are extending into other states the ability to write these cards to someone who doesn't live here.

Rep. Muscha: If a Michigan resident comes to ND to hunt and has a medical card would fit under this and keep him from prosecution?

Koebele: I think that is the intent of this section to protect residents of other states and give them reciprocity in our state.

Chairman Weisz: If we had a practitioner who was abusing, the medical board couldn't discipline him.

Koebele: It opens up the question of what about other things?

Rep. Porter: I want to get back to version 01001.

Rep. Oversen: I move we reconsider our actions where we passed 01001.

Rep. Porter: Second.

VOICE VOTE: MOTION CARRIED

Chairman Weisz: Do you want to allow non-residents if they have the card?

Rep. Porter: You have a state like Colorado where it is legal and anybody can get a card, so is that card valid?

Chairman Weisz: I don't know how you can allow a non-resident. It opens up a huge.....

Rep. Porter: In removing the smoking component, in your own home you can't light it, but you can vaporize it?

Chairman Weisz: That would be my understanding.

Rep. Porter: If a person is a resident in the Alzheimer's unit, are the licensed medical providers required to give them an illegal drug based on the FDA and DEA's standard under this bill?

Chairman Weisz: Does the institution have the ability to say no?

Jerry Jurena: With the Hospital Association. To answer Rep. Porter's question, you can't bring your own drugs into the hospital and dispense them. We have to dispense the drugs coming out of our own pharmacy.

Chairman Weisz: You feel you are still protected even if this bill would pass?

Jurena: If the drugs are dispensed out of our pharmacy we can give them. You can't bring them in to give to the patients.

Rep. Oversen: I'm quite aware of where the bill is going. I was offering a way to address some of the concerns that were addressed during the hearings. I'm pretty sure the bill is not going to pass so we can continue to pick it apart page by page, but I don't think that is necessary.

Chairman Weisz: I've never objected to making it as well written as possible even if we know where it is going.

Rep. Oversen: I'm happy to clean up the amendments and if Rep. Porter has other concerns he would like to address.

Chairman Weisz: I think if we adopted your amendments they would take over from the first set of amendments.

Rep. Oversen: I would move the amendments 01003.

Rep. Mooney: Second.

VOICE VOTE: MOTION CARRIED

Rep. Muscha: Mike is going to try to call someone in Washington or Boston about the train. He did say that planes and trains are federally regulated so that would take care of that other issue. He said if someone were off doctoring and needed medical marijuana you would have to pass a clean test to ever get back on the train. There is zero tolerance for the railroad.

Chairman Weisz: Regardless what we would say here, he is not going to be allowed on the train anyway by the railroad.

Rep. Hofstad: I move a Do Not Pass as amended.

Rep. B. Anderson: Second.

ROLL CALL VOTE: 8 y 3 n 2 absent

MOTION CARRIED

Bill Carrier: Rep. Weisz

15.0765.01001
Title.

Prepared by the Legislative Council staff for
Representative P. Anderson
February 2, 2015

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1430

Page 1, line 2, remove "and"

Page 1, line 2, after "penalty" insert "; and to provide an effective date"

Page 1, line 9, remove "and one-half"

Page 1, line 12, after "plants" insert ", three or fewer being mature flowering plants producing a useable form of marijuana"

Page 3, line 1, replace "Has agreed to assist with a qualifying patient's medical use of cannabis" with "Has agreed to be responsible for managing the well-being of a patient with a debilitating medical condition; and"

Page 3, line 2, remove "; and"

Page 3, remove lines 3 through 5

Page 3, line 6, remove "designated caregiver is employed"

Page 4, line 16, remove "or"

Page 4, line 18, after "facility" insert: "; or

d. The smoking of cannabis"

Page 10, line 24, remove "Smoking cannabis:"

Page 10, remove lines 25 and 26

Page 10, line 27, remove "c."

Page 12, line 15, after the underscored semicolon insert "or"

Page 12, line 16, remove "Any person in lawful possession of property to allow a guest, client, customer, or"

Page 12, remove line 17

Page 12, line 18, remove "c."

Page 29, after line 11, insert:

"**SECTION 2. EFFECTIVE DATE.** This Act becomes effective on June 30, 2016."

Renumber accordingly

15.0765.01003
Title.02000

Prepared by the Legislative Council staff for
Representative Oversen
February 9, 2015

2/11/15
1/2

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1430

Page 1, line 2, remove "and"

Page 1, line 2, after "penalty" insert "; and to provide an effective date"

Page 1, line 9, remove "and one-half"

Page 1, line 9, after the underscored semicolon insert "or"

Page 1, line 10, remove the underscored semicolon

Page 1, remove lines 11 through 15

Page 1, line 16, remove "same property where the plants were cultivated"

Page 2, line 22, after the underscored semicolon insert "or"

Page 2, line 26, remove "; or"

Page 2, remove line 27

Page 2, line 28, remove "provided for in this chapter"

Page 2, line 31, after the underscored semicolon insert "and"

Page 3, line 1, replace "Has agreed to assist with a qualifying patient's medical use of cannabis;" with "Has agreed to be responsible for managing the well-being of a patient with a debilitating medical condition."

Page 3, remove lines 2 through 6

Page 4, line 14, remove "nonresident"

Page 4, line 15, remove "The cultivation of cannabis by a cardholder who is not designated as being"

Page 4, remove line 16

Page 4, line 17, remove "c."

Page 4, line 18, after "facility" insert: "; and

c. The smoking of cannabis"

Page 6, line 11, remove "and one-half"

Page 10, remove lines 8 through 15

Page 10, line 24, remove "Smoking cannabis:"

Page 10, remove lines 25 and 26

Page 10, line 27, remove "c."

Page 12, line 15, after the underscored semicolon insert "or"

2/17

Page 12, line 16, remove "Any person in lawful possession of property to allow a guest, client, customer, or"

Page 12, remove line 17

Page 12, line 18, remove "c."

Page 15, line 21, remove "A clear indication of whether the cardholder has been designated to cultivate"

Page 15, remove line 22

Page 15, line 23, remove "g."

Page 15, line 24, replace "h." with "g."

Page 16, line 16, remove "Whether the cardholder is permitted to cultivate cannabis plants;"

Page 16, line 17 remove "e."

Page 16, line 19, replace "f." with "e."

Page 17, line 25, replace "**canabis**" with "**cannabis**"

Page 18, line 4, remove "and one-half"

Page 18, line 5, after the first underscored comma insert "or"

Page 18, line 5, remove ", six"

Page 18, line 6, remove "cannabis plants, and the cannabis produced by those plants"

Page 18, line 12, remove "and one-half"

Page 20, line 16, remove "A local government may not prohibit dispensaries, either expressly or through the"

Page 20, remove lines 17 and 18

Page 20, line 19, remove "3."

Page 22, line 1, remove "and one-half"

Page 29, after line 11, insert:

"**SECTION 2. EFFECTIVE DATE.** This Act becomes effective on June 30, 2016."

Renumber accordingly

Date: 2-11-15
Roll Call Vote #: 1

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1430

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15.0765.01001

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Oversen Seconded By Rep. Mooney

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz			Rep. Mooney		
Vice-Chair Hofstad			Rep. Muscha		
Rep. Bert Anderson			Rep. Oversen		
Rep. Dick Anderson					
Rep. Rich S. Becker					
Rep. Damschen					
Rep. Fehr					
Rep. Kiefert					
Rep. Porter					
Rep. Seibel					

Voice Vote Motion Carried

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-11-15
Roll Call Vote #: 2

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1430

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15.0765.01001

Recommendation: ☐ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☒ Reconsider ☐ _____

Motion Made By Rep. Oversen Seconded By Rep. Porter

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz			Rep. Mooney		
Vice-Chair Hofstad			Rep. Muscha		
Rep. Bert Anderson			Rep. Oversen		
Rep. Dick Anderson					
Rep. Rich S. Becker					
Rep. Damschen					
Rep. Fehr					
Rep. Kiefert					
Rep. Porter					
Rep. Seibel					

Voice Vote
Motion Carried

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-11-15
Roll Call Vote #: 3

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1430

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15.0765.01003

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Oversen Seconded By Rep. Mooney

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz			Rep. Mooney		
Vice-Chair Hofstad			Rep. Muscha		
Rep. Bert Anderson			Rep. Oversen		
Rep. Dick Anderson					
Rep. Rich S. Becker					
Rep. Damschen					
Rep. Fehr					
Rep. Kiefert					
Rep. Porter					
Rep. Seibel					

Voice Vote
Motion Carried

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-11-15
Roll Call Vote #: 4

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1430

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description:

Recommendation: ☐ Adopt Amendment
☐ Do Pass ☒ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐

Motion Made By Rep. Hofstad Seconded By Rep. B. Anderson

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz	✓		Rep. Mooney		✓
Vice-Chair Hofstad	✓		Rep. Muscha		✓
Rep. Bert Anderson	✓		Rep. Oversen		✓
Rep. Dick Anderson	✓				
Rep. Rich S. Becker	A				
Rep. Damschen	✓				
Rep. Fehr	A				
Rep. Kiefert	✓				
Rep. Porter	✓				
Rep. Seibel	✓				

Total (Yes) 8 No 3

Absent 2

Floor Assignment Rep. Weisz

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1430: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO NOT PASS** (8 YEAS, 3 NAYS, 2 ABSENT AND NOT VOTING). HB 1430 was placed on the Sixth order on the calendar.

Page 1, line 2, remove "and"

Page 1, line 2, after "penalty" insert "; and to provide an effective date"

Page 1, line 9, remove "and one-half"

Page 1, line 9, after the underscored semicolon insert "or"

Page 1, line 10, remove the underscored semicolon

Page 1, remove lines 11 through 15

Page 1, line 16, remove "same property where the plants were cultivated"

Page 2, line 22, after the underscored semicolon insert "or"

Page 2, line 26, remove "; or"

Page 2, remove line 27

Page 2, line 28, remove "provided for in this chapter"

Page 2, line 31, after the underscored semicolon insert "and"

Page 3, line 1, replace "Has agreed to assist with a qualifying patient's medical use of cannabis;" with "Has agreed to be responsible for managing the well-being of a patient with a debilitating medical condition."

Page 3, remove lines 2 through 6

Page 4, line 14, remove "nonresident"

Page 4, line 15, remove "The cultivation of cannabis by a cardholder who is not designated as being"

Page 4, remove line 16

Page 4, line 17, remove "c."

Page 4, line 18, after "facility" insert: "; and

c. The smoking of cannabis"

Page 6, line 11, remove "and one-half"

Page 10, remove lines 8 through 15

Page 10, line 24, remove "Smoking cannabis:"

Page 10, remove lines 25 and 26

Page 10, line 27, remove "c."

Page 12, line 15, after the underscored semicolon insert "or"

Page 12, line 16, remove "Any person in lawful possession of property to allow a guest, client, customer, or"

Page 12, remove line 17

Page 12, line 18, remove "c."

Page 15, line 21, remove "A clear indication of whether the cardholder has been designated to cultivate"

Page 15, remove line 22

Page 15, line 23, remove "g."

Page 15, line 24, replace "h." with "g."

Page 16, line 16, remove "Whether the cardholder is permitted to cultivate cannabis plants;"

Page 16, line 17 remove "e."

Page 16, line 19, replace "f." with "e."

Page 17, line 25, replace "**canabis**" with "**cannabis**"

Page 18, line 4, remove "and one-half"

Page 18, line 5, after the first underscored comma insert "or"

Page 18, line 5, remove ", six"

Page 18, line 6, remove "cannabis plants, and the cannabis produced by those plants"

Page 18, line 12, remove "and one-half"

Page 20, line 16, remove "A local government may not prohibit dispensaries, either expressly or through the"

Page 20, remove lines 17 and 18

Page 20, line 19, remove "3."

Page 22, line 1, remove "and one-half"

Page 29, after line 11, insert:

"**SECTION 2. EFFECTIVE DATE.** This Act becomes effective on June 30, 2016."

Renumber accordingly

2015 TESTIMONY

HB 1430

2-4-15

#1

House Bill 1430

Pamela Anderson, District 41

Chairman Weisz and members of the House Human Services Committee, my name is Pamela Anderson and I represent District 41 in Fargo.

I am here to present House Bill 1430, with amendments. After the election I received an email from one of my constituents, Rilie Ray Morgan, inquiring whether I would consider introducing a bill to make medical marijuana legal in North Dakota. In his email he told me about his struggle with neuropathy and drop foot and associated pain. He really felt that he would have relief with medical marijuana, better alternative than oxycodone and morphine which are legal.

I did some research and found out that 32 states and the District of Columbia have legalized marijuana or its ingredients to treat medical issues. The states include our neighbors, Minnesota and Montana and red and blue states around the country. This is not a partisan issue.

I told Mr. Morgan I would introduce a bill to legalize medical marijuana. In doing my research I found out that the National Conference of State Legislatures had a model marijuana bill. This is the bill that I am introducing with some amendments. The amendments take out any reference to smoking marijuana, reduces the amount you may have in possession and takes out the five patients for one caregiver and moves the effective date to June 30, 2016. The January 2015 issue of their publication under the title, "What's Hot for 2015" marijuana is the second issue and I quote, "Legalizing marijuana is undeniably one of the hottest issues today." In the 23 states that allow the use of marijuana for medical

reasons, more than half were initiated and passed by legislatures. The states are included in the information packet I passed out. Also, included is an article that Congress has ended the federal government's ban on medical marijuana. Republican Rep. Dana Rohrabacher, coauthor of the measure, said "This is a victory for so many- the first time in decades that the federal government has curtailed its oppressive prohibition of marijuana."

After introducing the bill, I have had many emails and phone conversations with individuals, all but one thanking me for doing this. Their stories of their medical conditions that could be helped by marijuana are heart breaking and compelling.

This is a quality of life issue, not a drug issue, and I would ask for your support on HB 1430.

Mr. Chairman and members of the committee, I would be happy to answer any questions.

#2

15.0765.01001
Title.

2-4-15

Prepared by the Legislative Council staff for
Representative P. Anderson
February 2, 2015

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1430

Page 1, line 2, remove "and"

Page 1, line 2, after "penalty" insert "; and to provide an effective date"

Page 1, line 9, remove "and one-half"

Page 1, line 12, after "plants" insert ", three or fewer being mature flowering plants producing a useable form of marijuana"

Page 3, line 1, replace "Has agreed to assist with a qualifying patient's medical use of cannabis" with "Has agreed to be responsible for managing the well-being of a patient with a debilitating medical condition; and"

Page 3, line 2, remove "; and"

Page 3, remove lines 3 through 5

Page 3, line 6, remove "designated caregiver is employed"

Page 4, line 16, remove "or"

Page 4, line 18, after "facility" insert: "; or

d. The smoking of cannabis"

Page 10, line 24, remove "Smoking cannabis:"

Page 10, remove lines 25 and 26

Page 10, line 27, remove "c."

Page 12, line 15, after the underscored semicolon insert "or"

Page 12, line 16, remove "Any person in lawful possession of property to allow a guest, client, customer, or"

Page 12, remove line 17

Page 12, line 18, remove "c."

Page 29, after line 11, insert:

"**SECTION 2. EFFECTIVE DATE.** This Act becomes effective on June 30, 2016."

Renumber accordingly

HB 1430 Feb. 4, 2015 part of Testimony #1

23 Legal Medical Marijuana States and DC

Laws, Fees, and Possession Limits

I. Summary Chart: 23 states and DC have enacted laws to legalize medical marijuana

State	Year Passed	How Passed (Yes Vote)	Fee	Possession Limit	Accepts other states' registry ID cards?
1. Alaska	1998	Ballot Measure 8 (58%)	$25/$20	1 oz usable; 6 plants (3 mature, 3 immature)	No
2. Arizona	2010	Proposition 203 (50.13%)	$150/ $75	2.5 oz usable; 0-12 plants	Yes
3. California	1996	Proposition 215 (56%)	$66/$33	8 oz usable; 6 mature or 12 immature plants	No
4. Colorado	2000	Ballot Amendment 20 (54%)	$15	2 oz usable; 6 plants (3 mature, 3 immature)	No
5. Connecticut	2012	House Bill 5389 (96-51 House, 21-13 Senate)	$100	One-month supply (exact amount to be determined)	No
6. DC	2010	Amendment Act B18-622 (13-0 vote)	$100/ $25	2 oz dried; limits on other forms to be determined	No
7. Delaware	2011	Senate Bill 17 (27-14 House, 17-4 Senate)	$125	6 oz usable	No
8. Hawaii	2000	Senate Bill 862 (32-18 House; 13-12 Senate)	$25	3 oz usable; 7 plants (3 mature, 4 immature)	No
9. Illinois	2013	House Bill 1 (61-57 House; 35-21 Senate)	TBD	2.5 ounces of usable cannabis during a period of 14 days	No
10. Maine	1999	Ballot Question 2 (61%)	No fee	2.5 oz usable; 6 plants	Yes
11. Maryland	2014	House Bill 881 (125-11 House; 44-2 Senate)	TBD	30-day supply, amount to be determined	No
12. Massachusetts	2012	Ballot Question 3 (63%)	$50	60-day supply for personal medical use	unknown
13. Michigan	2008	Proposal 1 (63%)	$100/ $25	2.5 oz usable; 12 plants	Yes
14. Minnesota	2014	Senate Bill 2470 (46-16 Senate; 89-40 House)	$200/ $50	30-day supply of non-smokable marijuana	No
15. Montana	2004	Initiative 148 (62%)	$75	1 oz usable; 4 plants (mature); 12 seedlings	No
16. Nevada	2000	Ballot Question 9 (65%)	$100	1 oz usable; 7 plants (3 mature, 4 immature)	Yes
17. New Hampshire	2013	House Bill 573 (284-66 House; 18-6 Senate)	TBD	Two ounces of usable cannabis during a 10-day period	Yes
18. New Jersey	2010	Senate Bill 119 (48-14 House; 25-13 Senate)	$200/ $20	2 oz usable	No
19. New Mexico	2007	Senate Bill 523 (36-31 House; 32-3 Senate)	No fee	6 oz usable; 16 plants (4 mature, 12 immature)	No
20. New York	2014	Assembly Bill 6357 (117-13 Assembly; 49-10 Senate)	$50	30-day supply non-smokable marijuana	No
21. Oregon	1998	Ballot Measure 67 (55%)	$200/ $60	24 oz usable; 24 plants (6 mature, 18 immature)	No
22. Rhode Island	2006	Senate Bill 0710 (52-10 House; 33-1 Senate)	$75/$10	2.5 oz usable; 12 plants	Yes
23. Vermont	2004	Senate Bill 76 (22-7) HB 645 (82-59)	$50	2 oz usable; 9 plants (2 mature, 7 immature)	No
24. Washington	1998	Initiative 692 (59%)	No fee	24 oz usable; 15 plants	No

Notes: (click to expand)

1

a. Residency Requirement

b. Home Cultivation

c. Patient Registration: Mandatory vs. Voluntary

d. Cannabidiol (CBD) Bills (Alabama, Florida, Iowa, Kentucky, Mississippi, Missouri, South Carolina, Tennessee, Utah, Wisconsin)

e. Maryland Laws Prior to Legalization

f. United States Attorneys' Letters to Legal States

g. Symbolic Medical Marijuana Laws, 1979-1991

II. Details by State: 23 states and DC that have enacted laws to legalize medical marijuana	
State and Relevant Medical Marijuana Laws	Contact and Program Details
1. Alaska **Ballot Measure 8** (100 KB) – Approved Nov. 3, 1998 by 58% of voters **Effective:** Mar. 4, 1999 Removed state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess written documentation from their physician advising that they "might benefit from the medical use of marijuana." **Approved Conditions:** Cachexia, cancer, chronic pain, epilepsy and other disorders characterized by seizures, glaucoma, HIV or AIDS, multiple sclerosis and other disorders characterized by muscle spasticity, and nausea. Other conditions are subject to approval by the Alaska Department of Health and Social Services. **Possession/Cultivation:** Patients (or their primary caregivers) may legally possess no more than one ounce of usable marijuana, and may cultivate no more than six marijuana plants, of which no more than three may be mature. The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients. **Amended:** Senate Bill 94 (40KB) **Effective:** June 2, 1999 Mandates all patients seeking legal protection under this act to enroll in the state patient registry and possess a valid identification card. Patients not enrolled in the registry will no longer be able to argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges. **Update:** Alaska Statute Title 17 Chapter 37 (36 KB) Creates a confidential statewide registry of medical marijuana patients and caregivers and establishes identification card.	**Alaska Bureau of Vital Statistics** Marijuana Registry P.O. Box 110699 Juneau, AK 99811-0699 Phone: 907-465-5423 BVSSpecialServices@health.state.ak.us **Website:** AK Marijuana Registry Online **Information provided by the state on sources for medical marijuana:** No information is provided **Patient Registry Fee:** $25 new application/$20 renewal **Accepts other states' registry ID cards?** No **Registration:** Mandatory
2. Arizona **Ballot Proposition 203** (300 KB) "Arizona Medical Marijuana Act" – Approved Nov. 2, 2010 by 50.13% of voters Allows registered qualifying patients (who must have a physician's written certification that they have been diagnosed with a debilitating condition and that they would likely receive benefit from marijuana) to obtain marijuana from a registered nonprofit dispensary, and to possess and use medical marijuana to treat the condition. Requires the Arizona Department of Health Services to establish a registration and renewal application system for patients and nonprofit dispensaries. Requires a web-based verification system for law enforcement and dispensaries to verify registry identification cards. Allows certification of a number of dispensaries not to exceed 10% of the number of pharmacies in the state (which would cap the number of dispensaries around 124). Specifies that a registered patient's use of medical marijuana is to be considered equivalent to the use of any other medication under the direction of a physician and does not disqualify a patient from medical care, including organ transplants. Specifies that employers may not discriminate against registered patients unless that employer would lose money or licensing under federal law. Employers also may not penalize registered patients solely for testing positive for marijuana in drug tests, although the law does not authorize patients to use, possess, or be impaired by marijuana on the employment premises or during the hours of employment.	**Arizona Department of Health Services (ADHS)** Medical Marijuana Program 150 North 18th Avenue Phoenix, Arizona 85007 Phone: 602-542-1025 **Website:** Arizona Medical Marijuana Program **Information provided by the state on sources for medical marijuana:** "Qualifying patients can obtain medical marijuana from a dispensary, the qualifying patient's designated caregiver, another qualifying patient, or, if authorized to cultivate, from home cultivation. When a qualifying patient obtains or renews a registry identification card, the Department will provide a list of all operating dispensaries to the qualifying patient." ADHS, "Qualifying Patients FAQs," (150 KB) Mar. 25, 2010 **Patient Registry Fee:** $150 / $75 for Supplemental Nutrition Assistance Program participants

2

Approved Conditions: Cancer, glaucoma, HIV/AIDS, Hepatitis C, ALS, Crohn's disease, Alzheimer's disease, cachexia or wasting syndrome, severe and chronic pain, severe nausea, seizures (including epilepsy), severe or persistent muscle spasms (including multiple sclerosis). Starting Jan.1, 2015, PTSD will be added to the list. **Possession/Cultivation:** Qualified patients or their registered designated caregivers may obtain up to 2.5 ounces of marijuana in a 14-day period from a registered nonprofit medical marijuana dispensary.If the patient lives more than 25 miles from the nearest dispensary, the patient or caregiver may cultivate up to 12 marijuana plants in an enclosed, locked facility. **Amended:** Senate Bill 1443 (20 KB) **Effective:** Signed by Governor Jan Brewer on May 7, 2013 "Specifies the prohibition to possess or use marijuana on a postsecondary educational institution campus does not apply to medical research projects involving marijuana that are conducted on the campus, as authorized by applicable federal approvals and on approval of the applicable university institutional review board." [Editor's Note: On Apr. 11, 2012, the Arizona Department of Health Services (ADHS) announced the revised rules (1.1 MB) for regulating medical marijuana and set the application dates for May 14 through May 25. On Nov. 15, 2012, the first dispensary was awarded "approval to operate." ADHS Director Will Humble stated on his blog that, "[W]e'll be declining new 'requests to cultivate' among new cardholders in most of the metro area... because self-grow (12 plants) is only allowed when the patient lives more than 25 miles from the nearest dispensary. The vast majority of the Valley is within 25 miles of this new dispensary." On Dec. 6, 2012, the state's first dispensary, Arizona Organix, opened in Glendale.]	**Accepts other states' registry ID cards?** Yes, but does not permit visiting patients to obtain marijuana from an Arizona dispensary **Registration:** Mandatory
3. **California** **Ballot Proposition 215** (45 KB) -- Approved Nov. 5, 1996 by 56% of voters **Effective:** Nov. 6, 1996 Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess a "written or oral recommendation" from their physician that he or she "would benefit from medical marijuana." Patients diagnosed with any debilitating illness where the medical use of marijuana has been "deemed appropriate and has been recommended by a physician" are afforded legal protection under this act. **Approved Conditions:** AIDS, anorexia, arthritis, cachexia, cancer, chronic pain, glaucoma, migraine, persistent muscle spasms, including spasms associated with multiple sclerosis, seizures, including seizures associated with epilepsy, severe nausea; Other chronic or persistent medical symptoms. **Amended:** Senate Bill 420 (70 KB) **Effective:** Jan. 1, 2004 Imposes statewide guidelines outlining how much medicinal marijuana patients may grow and possess. **Possession/Cultivation:** Qualified patients and their primary caregivers may possess no more than eight ounces of dried marijuana and/or six mature (or 12 immature) marijuana plants. However, S.B. 420 allows patients to possess larger amounts of marijuana when recommended by a physician. The legislation also allows counties and municipalities to approve and/or maintain local ordinances permitting patients to possess larger quantities of medicinal pot than allowed under the new state guidelines. S.B. 420 also grants implied legal protection to the state's medicinal marijuana dispensaries, stating, "Qualified patients, persons with valid identification cards, and the designated primary caregivers of qualified patients ... who associate within the state of California in order collectively or cooperatively to cultivate marijuana for medical purposes, shall not solely on the basis of that fact be subject to state criminal sanctions." **Challenge to Possession Limits:** On Jan. 21, 2010, the California Supreme Court affirmed (S164830 (300 KB)) the May 22, 2008 Second District Court of Appeals ruling (50 KB) in the Kelly Case that the possession limits set by SB 420 violate the California constitution because the voter-approved Prop. 215 can only be amended by the voters. ProCon.org contacted the California Medical Marijuana Program (MMP) on Dec. 6, 2010 to ask 1) how the ruling affected the implementation of the program, and 2) what instructions are given to patients regarding possession limits. A California Department of Public Health (CDPH) Office of Public Affairs representative wrote the following in a Dec. 7, 2010 email to ProCon.org: "The role of MMP under Senate Bill 420 is to implement the State Medical Marijuana ID Card Program in all California counties. CDPH does not oversee the amounts that a patient may possess or grow. When asked what a patient can possess, patients are referred to www.courtinfo.ca.gov, case S164830 which is the Kelly case, changing the amounts a patient can possess from 8 oz, 6 mature plants or 12 immature plants to 'the amount needed for a patient's personal use.' MMP can only cite what the law says." According to a Jan. 21, 2010 article titled "California Supreme Court Further Clarifies	**California Department of Public Health** Public Health Policy and Research Branch Attention: Medical Marijuana Program Unit MS 5202 P.O. Box 997377 Sacramento, CA 95899-7377 Phone: 916-552-8600 Fax: 916-440-5591 mmpinfo@cdph.ca.gov **Website:** CA Medical Marijuana Program Guidelines for the Security and Non-diversion of Marijuana Grown for Medical Use (55 KB) **Information provided by the state on sources for medical marijuana:** "The MMP is not authorized to provide information on acquiring marijuana or other related products." "Medical Marijuana Program Frequently Asked Questions," cdph.ca.gov(accessed Apr. 24, 2014) "The California Department of Public Health administers the Medical Marijuana Identification Card (MMIC) program only and does not have any information regarding dispensaries, growing collectives, etc..." "Dispensaries, Cooperatives and Collectives," cdph.ca.gov (accessed Apr. 24, 2014) **Patient Registry Fee:** $66 non Medi-Cal / $33 Medi-Cal, plus additional county fees (varies by location) **Accepts other states' registry ID cards?** No **Registration:** Voluntary

Medical Marijuana Laws," by Aaron Smith, California Policy Director at the Marijuana Policy Project, the impact of the ruling is that people growing more than 6 mature or 12 immature plants are still subject to arrest and prosecution, but they will be allowed to use a medical necessity defense in court.] **Attorney General's Guidelines:** On Aug. 25, 2008, California Attorney General Jerry Brown issued guidelines for law enforcement and medical marijuana patients to clarify the state's laws. Read more about the guidelines here.	
4. Colorado **Ballot Amendment 20** -- Approved Nov. 7, 2000 by 54% of voters **Effective:** June 1, 2001 Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess written documentation from their physician affirming that he or she suffers from a debilitating condition and advising that they "might benefit from the medical use of marijuana." (Patients must possess this documentation prior to an arrest.) **Approved Conditions:** Cancer, glaucoma, HIV/AIDS positive, cachexia; severe pain; severe nausea; seizures, including those that are characteristic of epilepsy; or persistent muscle spasms, including those that are characteristic of multiple sclerosis. Other conditions are subject to approval by the Colorado Board of Health. **Possession/Cultivation:** A patient or a primary caregiver who has been issued a Medical Marijuana Registry identification card may possess no more than two ounces of a usable form of marijuana and not more than six marijuana plants, with three or fewer being mature, flowering plants that are producing a usable form of marijuana. Patients who do not join the registry or possess greater amounts of marijuana than allowed by law may argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges. **Amended:** House Bill 1284 (236 KB) and Senate Bill 109 (50 KB) **Effective:** June 7, 2010 Colorado Governor Bill Ritter signed the bills into law and stated the following in a June 7, 2010 press release: "House Bill 1284 provides a regulatory framework for dispensaries, including giving local communities the ability to ban or place sensible and much-needed controls on the operation, location and ownership of these establishments. Senate Bill 109 will help prevent fraud and abuse, ensuring that physicians who authorize medical marijuana for their patients actually perform a physical exam, do not have a DEA flag on their medical license and do not have a financial relationship with a dispensary."	**Medical Marijuana Registry** Colorado Department of Public Health and Environment HSV-8608 4300 Cherry Creek Drive South Denver, CO 80246-1530 Phone: 303-692-2184 medical.marijuana@state.co.us **Website:** CO Medical Marijuana Registry **Information provided by the state on sources for medical marijuana:** The Marijuana Enforcement Division (MED) website provides a list of licensed Medical Marijuana Centers, which are retail operations "from which Medical Marijuana Registry patients purchase Medical Marijuana and Medical Marijuana infused products." MED "is responsible for the regulation of both the Medical and Retail Marijuana industries, each of which have separate and distinct statute and rules under which they operate." "Medical Marijuana Licensing Information," colorado.gov/revenue/med (accessed Feb. 26, 2014) "Licensing Information," colorado.gov/revenue/med (accessed Feb. 26, 2014) **Patient Registry Fee:** $15 (effective Feb. 1, 2014) **Accepts other states' registry ID cards?** No **Registration:** Mandatory
5. Connecticut **HB 5389** (310 KB) – Signed into law by Gov. Dannel P. Malloy (D) on May 31, 2012 **Approved:** By House 96-51, by Senate 21-13 **Effective:** Some sections from passage (May 4, 2012), other sections on Oct. 1, 2012 "A qualifying patient shall register with the Department of Consumer Protection... prior to engaging in the palliative use of marijuana. A qualifying patient who has a valid registration certificate... shall not be subject to arrest or prosecution, penalized in any manner,... or denied any right or privilege." Patients must be Connecticut residents at least 18 years of age. "Prison inmates, or others under the supervision of the Department of Corrections, would not qualify, regardless of their medical condition." **Approved Conditions:** "Cancer, glaucoma, positive status for human immunodeficiency virus or acquired immune deficiency syndrome [HIV/AIDS], Parkinson's disease, multiple sclerosis, damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity, epilepsy, cachexia, wasting syndrome, Crohn's disease, posttraumatic stress disorder, or... any medical condition, medical treatment or disease approved by the Department of Consumer Protection..." **Possession/Cultivation:** Qualifying patients may possess "an amount of usable marijuana reasonably necessary to ensure uninterrupted availability for a period of one month, as determined by the Department of Consumer Protection." **Updates:** The Connecticut Medical Marijuana Program website posted an update on Sep. 23, 2012 with instructions on how to register for the program starting on Oct. 1, 2012. "Patients who are currently receiving medical treatment for a debilitating medical conditions set out in the law may qualify for a temporary registration certificate beginning October 1, 2012. To qualify, a patient must also be at least 18 years of age and a Connecticut resident."	**Medical Marijuana Program** Department of Consumer Protection (DCP) 165 Capitol Avenue, Room 145 Hartford, CT 06106 Phone: 860-713-6006 Toll-Free: 800-842-2649 dcp.mmp@ct.gov **Website:** CT Medical Marijuana Program **Information provided by the state on sources for medical marijuana:** "Only producers licensed by the Department of Consumer Protection will be authorized to cultivate marijuana. At any one time, the number of licensed producers shall be at least three and not more than 10." "Dispensary Facility and Producer FAQs," ct.gov, Sep. 11, 2013 **Patient Registry Fee:** $100 **Accepts other states' registry ID cards?** No **Registration:** Mandatory

4

Draft Regulations on Medical Marijuana (482 KB) were posted on Jan. 16, 2013. On Apr. 3, 2014, the Connecticut Department of Consumer Protection announced the names and locations (70 KB) of the first six dispensary facilities that will be authorized by the state. The first dispensary opened on Aug. 20, 2014.	
6. DC (District of Columbia) **Amendment Act B18-622** (80KB) "Legalization of Marijuana for Medical Treatment Amendment Act of 2010" -- Approved 13-0 by the Council of the District of Columbia on May 4, 2010; signed by the Mayor on May 21, 2010| **Effective:** July 27, 2010 [After being signed by the Mayor, the law underwent a 30-day Congessional review period. Neither the Senate nor the House acted to stop the law, so it became effective when the review period ended.] **Approved Conditions:** HIV, AIDS, cancer, glaucoma, conditions characterized by severe and persistent muscle spasms, such as multiple sclerosis; patients undergoing chemotherapy or radiotherapy, or using azidothymidine or protease inhibitors. **Possession/Cultivation:** "Patients are permitted to purchase up to two (2) ounces of dried medical marijuana per month or the equivalent of two ounces of dried medical marijuana when sold in any other form." ("Patient FAQ," doh.dc.gov, May 2013) **Updates:** On Apr. 14, 2011, Mayor Vincent C. Gray announced the adoption of an emergency amendment (450 KB) to title 22 of the District of Columbia Municipal Regulations (DCMR), which added a new subtitle C entitled "Medical Marijuana." The emergency amendment "will set forth the process and procedure" for patients, caregivers, physicians, and dispensaries, and "implement the provisions of the Act that must be addressed at the onset to enable the Department to administer the program." The final rulemaking (800 KB) was posted online on Jan. 3, 2012. On Feb. 14, 2012, the DC Department of Health's Health Regulation and Licensing Administration posted a revised timeline for the dispensary application process (180 KB), which listed June 8, 2012 as the date by which the Department intends to announce dispensary applicants available for registration. The first dispensary, Capital City Care, was licensed in Apr. 2013.	**Health Regulation and Licensing Administration** 899 N. Capitol Street, NE 2nd Floor Washington, DC 20002 Phone: 202-442-5955 doh.mmp@dc.gov **Website:** Medical Marijuana Program **Information provided by the state on sources for medical marijuana:** Patients and caregivers "may only obtain medical marijuana from the dispensary designated on your registration identification card and may not: (a)grow or cultivate medical marijuana); b)purchase medical marijuana through street vendors; or (c) obtain medical marijuana from other patients and caregivers." ("Patient FAQ," doh.dc.gov, May 2013) **Patient Registry Fee:** $100 initial or renewal fee/$25 for low income patients **Accepts other states' registry ID cards?** No **Registration:** Mandatory
7. Delaware **Senate Bill 17** (100 KB) -- Signed into law by Gov. Jack Markell (D) on May 13, 2011 **Approved:** By House 27-14, by Senate 17-4 **Effective:** July 1, 2011 Under this law, a patient is only protected from arrest if his or her physician certifies, in writing, that the patient has a specified debilitating medical condition and that the patient would receive therapeutic benefit from medical marijuana. The patient must send a copy of the written certification to the state Department of Health and Social Services, and the Department will issue an ID card after verifying the information. As long as the patient is in compliance with the law, there will be no arrest. The law does not allow patients or caregivers to grow marijuana at home, but it does allow for the state-regulated, non-profit distribution of medical marijuana by compassion centers. **Approved Conditions:** Approved for treatment of debilitating medical conditions, defined as cancer, HIV/AIDS, decompensated cirrhosis (Hepatitis C), ALS, Alzheimer's disease. Also approved for "a chronic or debilitating disease or medical condition or its treatment that produces 1 or more of the following: cachexia or wasting syndrome; severe, debilitating pain that has not responded to previously prescribed medication or surgical measures for more than 3 months or for which other treatment options produced serious side effects; intractable nausea; seizures; or severe and persistent muscle spasms, including but not limited to those characteristic of multiple sclerosis." "Post-traumatic stress disorder (PTSD) can qualify as a debilitating medical condition when it manifests itself in severe physical suffering, such as severe or chronic pain or severe nausea and vomiting, or otherwise severely impairs the patient's physical ability to carry on the activities of daily living." ("Medical Marijuana Questions & Answers," dhss.delaware.gov (accessed Apr. 21, 2014)) **Possession/Cultivation:** Patients 18 and older with certain debilitating conditions may possess up to six ounces of marijuana with a doctor's written recommendation. A registered compassion center may not dispense more than 3 ounces of marijuana to a registered qualifying patient in any fourteen-day period, and a patient may register with only one compassion center. Home cultivation is not allowed. Senate Bill 17 contains a provision that allows for an affirmative defense for individuals "in possession of no more than six ounces of usable marijuana." **Updates:** On Feb. 12, 2012, Gov. Markell released the following statement (presented in its entirety), available on delaware.gov, in response to a letter from US District Attorney Charles Oberly (2 MB):	**Delaware Department of Health and Social Services** Division of Public Health Phone: 302-744-4749 Fax: 302-739-3071 MedicalMarijuanaDPH@state.de.us **Website:** DE Medical Marijuana Program **Information provided by the state on sources for medical marijuana:** "The Department will issue a permit to the compassion center to begin growing medical marijuana on July 1, 2014. The policy change will allow medical marijuana patients in Delaware to buy the drug in a state-regulated center... The center will only be allowed to cultivate up to 150 marijuana plants, and keep inventory of no more than 1,500 ounces of the drug." ("Medical Marijuana Questions & Answers," dhss.delaware.gov (accessed Apr. 21, 2014)) **Patient Registry Fee:** $125 (a sliding scale fee is available based on income) **Accepts other states' registry ID cards?** No **Registration:** Mandatory

5

"I am very disappointed by the change in policy at the federal department of justice, as it requires us to stop implementation of the compassion centers. To do otherwise would put our state employees in legal jeopardy and I will not do that. Unfortunately, this shift in the federal position will stand in the way of people in pain receiving help. Our law sought to provide that in a manner that was both highly regulated and safe."

On Aug. 15, 2013, Gov. Markell announced in a letter to Delaware lawmakers (175 KB) his intention to relaunch the state's medical marijuana program, despite his previous decision to stop implementation. Markell wrote that the Department of Health and Social Services "will proceed to issue a request for proposal for a pilot compassion center to open in Delaware next year."

8. Hawaii

Senate Bill 862 (40 KB) – Signed into law by Gov. Ben Cayetano on June 14, 2000
Approved: By House 32-18, by Senate 13-12
Effective: Dec. 28, 2000

Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess a signed statement from their physician affirming that he or she suffers from a debilitating condition and that the "potential benefits of medical use of marijuana would likely outweigh the health risks." The law establishes a mandatory, confidential state-run patient registry that issues identification cards to qualifying patients.

Approved conditions: Cancer, glaucoma, positive status for HIV/AIDS; A chronic or debilitating disease or medical condition or its treatment that produces cachexia or wasting syndrome, severe pain, severe nausea, seizures, including those characteristic of epilepsy, or severe and persistent muscle spasms, including those characteristic of multiple sclerosis or Crohn's disease. Other conditions are subject to approval by the Hawaii Department of Health.

Possession/Cultivation: The amount of marijuana that may be possessed jointly between the qualifying patient and the primary caregiver is an "adequate supply," which shall not exceed three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant.

Amended: HB 668 (240 KB)
Effective: June 25, 2013

Establishes a medical marijuana registry special fund to pay for the program and transfers the medical marijuana program from the Department of Public Safety to the Department of Public Health by no later than Jan. 1, 2015.

Amended: SB 642 (95 KB)
Effective: Jan. 2, 2015

Redefines "adequate supply" as seven marijuana plants, whether immature or mature, and four ounces of usable marijuana at any given time; stipulates that physician recommendations will have to be made by the qualifying patient's primary care physician.

Department of Public Safety
Narcotics Enforcement Division
3375 Koapaka Street, Suite D-100
Honolulu, HI 96819
Phone: 808-837-8470
Fax: 808-837-8474

hawaiicsreg@ned.hawaii.gov

Website:
HI Medical Marijuana Application info

Information provided by the state on sources for medical marijuana:
"Hawaii law does not authorize any person or entity to sell or dispense marijuana... Hawaii law authorizes the medical use of marijuana, it does not authorize the distribution of marijuana (Dispensaries) other than the transfer from a qualifying patient's primary caregiver to the qualifying patient." ("Hawaii Medical Use of Marijuana Physician and Patient Information," dps.hawaii.gov, Sep. 2011)

Patient Registry Fee:
$25

Accepts other states' registry ID cards?
No

Registration:
Mandatory

9. Illinois

House Bill 1 (385 KB)
Approved: Apr. 17, 2013 by House, 61-57 and May 17, 2013 by Senate, 35-21
Signed into law by Gov. Pat Quinn on Aug. 1, 2013
Effective: Jan. 1, 2014

The Compassionate Use of Medical Cannabis Pilot Program Act establishes a patient registry program, protects registered qualifying patients and registered designated caregivers from "arrest, prosecution, or denial of any right or privilege," and allows for the registration of cultivation centers and dispensing organizations. Once the act goes into effect, "a tax is imposed upon the privilege of cultivating medical cannabis at a rate of 7% of the sales price per ounce."

Approved Conditions: "Debilitating medical conditions include 40 chronic diseases and conditions: cancer, glaucoma, positive status for human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, agitation of Alzheimer's disease, cachexia/wasting syndrome, muscular dystrophy, severe fibromyalgia, spinal cord disease (including but not limited to arachnoiditis), Tarlov cysts, hydromyelia syringomyelia, Rheumatoid arthritis, fibrous dysplasia, spinal cord injury, traumatic brain injury and post concussion syndrome, Multiple Sclerosis, Arnold-Chiari malformation and Syringomelia, Spinocerebellar Ataxia (SCA), Parkinson's Disease, Tourette Syndrome, Myoclonus, Dystonia, Reflex Sympathetic Dystrophy, RSD (Complex Regional Pain Syndromes Type I), Causalgia, CRPS (Complex Regional Pain Syndrome Type II), Neurofibromatosis, Chronic inflammatory Demyelinating Polyneuropathy, Chronic Inflammatory Demyelinating Polyneuropathy, Sjogren's Syndrome, Lupus, Interstitial Cystitis, Myasthenia Gravis, Hydrocephalus, nail-patella syndrome or residual limb pain; or the treatment of these conditions."
"Frequently Asked Questions," idph.state.il.us (accessed Apr. 23, 2014)

On July 20, 2014, Gov. Quinn signed Senate Bill 2636 (40 KB), which amended the Compassionate Use of Medical Cannabis Act to allow children under 18 to be treated with non-smokable forms of medical marijuana for the same conditions orginially approved for adults. An underage patient's parent or guardian must serve as

Illinois Department of Public Health
Division of Medical Cannabis
Illinois Department of Public Health
535 W. Jefferson Street
Springfield, IL 62761-0001
Attn: Rulemaking

DPH.MedicalCannabis@illinois.gov

Website:
Medical Cannabis Program

Information provided by the state on sources for medical marijuana:
Cultivation centers and dispensing organizations will be registered by the Department of Agriculture and Department of Financial and Professional Regulation, respectively.

Patient Registry Fee:
To be determined during the rulemaking process ($100 proposed)

Accepts other states' registry ID cards?
No

Registration:
Mandatory

6

caregiver, and signatures from two doctors are required. The bill, which becomes effective Jan. 1, 2015, also added seizures, including those related to epilepsy, to the list of approved conditions.

Possession/Cultivation: "Adequate supply" is defined as "2.5 ounces of usable cannabis during a period of 14 days and that is derived solely from an intrastate source." The law does not allow patients or caregivers to cultivate cannabis.

Updates: Governor Pat Quinn's Aug. 1, 2013 signing statement (25 KB) explains key points of the law and notes that it is a four-year pilot program.

On Jan. 21, 2014, the Department of Public Health released a draft of the proposed rules (415 KB) for public comments. The proposal included a fingerprint-based criminal history background check and an annual $150 application fee for qualifying patients. The rules also state that qualifying patients and caregivers "are not eligible for a Firearm Owners Identification Card or a Firearm Concealed Carry License."

On Apr. 18, 2014, the Department of Health released revised preliminary rules (240 KB) that removed from the previous versions the restrictions on gun owners applying for medical marijuana cards. The application fees were dropped to $100 ($50 for veterans and eligible patients on Social Security Insurance and Social Security Disability Insurance, and $25 for caregivers).

10. Maine

Ballot Question 2 – Approved Nov. 2, 1999 by 61% of voters
Effective: Dec. 22, 1999

Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess an oral or written "professional opinion" from their physician that he or she "might benefit from the medical use of marijuana." The law does not establish a state-run patient registry.

Approved diagnosis: epilepsy and other disorders characterized by seizures; glaucoma; multiple sclerosis and other disorders characterized by muscle spasticity; and nausea or vomiting as a result of AIDS or cancer chemotherapy.

Possession/Cultivation: Patients (or their primary caregivers) may legally possess no more than one and one-quarter (1.25) ounces of usable marijuana, and may cultivate no more than six marijuana plants, of which no more than three may be mature. Those patients who possess greater amounts of marijuana than allowed by law are afforded a "simple defense" to a charge of marijuana possession.

Amended: Senate Bill 611
Effective: Signed into law on Apr. 2, 2002

Increases the amount of useable marijuana a person may possess from one and one-quarter (1.25) ounces to two and one-half (2.5) ounces.

Amended: Question 5 (135 KB) – Approved Nov. 3, 2009 by 59% of voters

List of approved conditions changed to include cancer, glaucoma, HIV, acquired immune deficiency syndrome, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, Alzheimer's, nail-patella syndrome, chronic intractable pain, cachexia or wasting syndrome, severe nausea, seizures (epilepsy), severe and persistent muscle spasms, and multiple sclerosis.

Instructs the Department of Health and Human Services (DHHS) to establish a registry identification program for patients and caregivers. Stipulates provisions for the operation of nonprofit dispensaries.

[Editor's Note: An Aug. 19, 2010 email to ProCon.org from Catherine M. Cobb, Director of Maine's Division of Licensing and Regulatory Services, stated:

"We have just set up our interface to do background checks on caregivers and those who are associated with dispensaries. They may not have a disqualifying drug offense."]

Amended: LD 1062 (25 KB)
Effective: Enacted without the governor's signature on June 26, 2013

Adds post-traumatic stress disorder (PTSD) to the list of approved conditions for medical marijuana use.

Maine Medical Use of Marijuana Program (MMMP)
Division of Licensing and Regulatory Services
Department of Health and Human Services
11 State House Station
Augusta, ME 04333
Phone: 207-287-4325

medmarijuana. dhhs@maine.gov

Website:
Maine Medical Marijuana Program

Information provided by the state on sources for medical marijuana:
A list of dispensaries is available on the MMMP website. "The patient may either cultivate or designate a caregiver or dispensary to cultivate marijuana." ("Program Bulletin," Maine.gov, Sep. 28, 2011)

Patient Registry Fee:
$0
Caregivers pay $300/patient(limit of 5 patients; if not growing marijuana, there is no fee)

Accepts other states' registry ID cards?
Yes
"Law enforcement will accept appropriate authorization from a participating state, but that patient cannot purchase marijuana in Maine without registering here. That requires a Maine physician and a Maine driver license or other picture ID issued by the state of Maine. The letter from a physician in another state is only good for 30 days." (Aug. 19, 2010 email from Maine's Division of Licensing and Regulatory Services)

Registration:
Voluntary

"In addition to either a registry ID card or a physician certification form, all patients, including both non-registered and voluntarily registered patients, must also present their Maine driver license or other Maine-issued photo identification card to law enforcement, upon request." ("Program Bulletin," Maine.gov, Sep. 28, 2011)

11. Maryland

House Bill 881 (375 KB)
Approved: Apr. 8, 2014 by House, 125-11 and by Senate, 44-2
Signed by Gov. Martin O'Malley on Apr. 14, 2014
Effective: June 1, 2014

Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201
Phone: 410-767-6500

Website:
Natalie M. LaPrade Medical Marijuana

The Natalie M. LaPrade Medical Marijuana Commission and the Maryland Department of Health and Mental Hygiene are tasked with developing regulations for patient registry and identification cards, dispensary licensing, setting fees and possession limits, and more. The Commission will issue yearly request for applications from academic medical centers to operate medical marijuana compassionate use programs. **Approved diagnosis:** cachexia, anorexia, or wasting syndrome, severe or chronic pain, severe nausea, seizures, severe or persistent muscle spasms, or other conditions approved by the Commission. **Possession/Cultivation:** Patients are allowed to possess a 30-day supply (amount to be determined by the Commission). "Beginning June 1, 2016, the Commission may issue the number of [dispensary] licenses necessary to meet the demand for medical marijuana by qualifying patients and caregivers issued identification cards."	Commission **Information provided by the state on sources for medical marijuana:** "A qualifying patient or caregiver may obtain medical marijuana from a grower's facility or from a satellite facility of the grower." **Patient Registry Fee:** To be determined by the Commission during the rulemaking process **Accepts other states' registry ID cards?** No **Registration:** Mandatory
12. **Massachusetts** **Ballot Question 3 – Approved Nov. 6, 2012 by 63% of voters** **Effective:** Jan. 1, 2013 "The citizens of Massachusetts intend that there should be no punishment under state law for qualifying patients, physicians and health care professionals, personal caregivers for patients, or medical marijuana treatment center agents for the medical use of marijuana... In the first year after the effective date, the Department shall issue registrations for up to thirty-five non-profit medical marijuana treatment centers, provided that at least one treatment center shall be located in each county, and not more than five shall be located in any one county." **Approved diagnosis:** "Cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, multiple sclerosis and other conditions as determined in writing by a qualifying patient's physician." **Possession/Cultivation:** Patients may possess "no more marijuana than is necessary for the patient's personal, medical use, not exceeding the amount necessary for a sixty-day supply... Within 120 days of the effective date of this law, the department shall issue regulations defining the quantity of marijuana that could reasonably be presumed to be a sixty-day supply for qualifying patients, based on the best available evidence." "The Department shall issue a cultivation registration to a qualifying patient whose access to a medical treatment center is limited by verified financial hardship, a physical incapacity to access reasonable transportation, or the lack of a treatment center within a reasonable distance of the patient's residence. The Department may deny a registration based on the provision of false information by the applicant. Such registration shall allow the patient or the patient's personal caregiver to cultivate a limited number of plants, sufficient to maintain a 60-day supply of marijuana, and shall require cultivation and storage only in an enclosed, locked facility. The department shall issue regulations consistent with this section within 120 days of the effective date of this law. Until the department issues such final regulations, the written recommendation of a qualifying patient's physician shall constitute a limited cultivation registration." **Updates:** The DPH website wrote on Oct. 8, 2014 that "the Medical Use of Marijuana Online System (MMJ Online System) is now available for qualifying patients to register to possess marijuana for medical purposes. You will need to register with the MMJ Online System by January 1, 2015 in order to possess marijuana for medical purposes, even if you already have a paper written certification from your physician. Paper written certifications will no longer be valid as of February 1st, 2015."	**Department of Public Health of the Commonwealth of Massachusetts** One Ashburton Place 11th Floor Boston, MA 02108 Phone: 617-624-5062 medicalmarijuana@state.ma.us **Website:** www.mass.gov/medicalmarijuana **Information provided by the state on sources for medical marijuana:** The state will issue registrations for up to 35 nonprofit medical marijuana treatment centers **Patient Registry Fee:** $50 **Accepts other states' registry ID cards?** Unknown **Registration:** Mandatory The law stated that "Until the approval of final regulations, written certification by a physician shall constitute a registration card for a qualifying patient."
13. **Michigan** **Proposal 1** (60 KB) "Michigan Medical Marihuana Act" – Approved by 63% of voters on Nov. 4, 2008 **Approved:** Nov. 4, 2008 **Effective:** Dec. 4, 2008 **Approved Conditions:** Approved for treatment of debilitating medical conditions, defined as cancer, glaucoma, HIV, AIDS, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, agitation of Alzheimer's disease, nail patella, cachexia or wasting syndrome, severe and chronic pain, severe nausea, seizures, epilepsy, muscle spasms, multiple sclerosis, and PTSD. **Possession/Cultivation:** Patients may possess up to two and one-half (2.5) ounces of usable marijuana and twelve marijuana plants kept in an enclosed, locked facility. The twelve plants may be kept by the patient only if he or she has not specified a primary caregiver to cultivate the marijuana for him or her.	**Michigan Medical Marihuana Program** Bureau of Health Professions, Department of Licensing and Regulatory Affairs P.O. Box 30083 Lansing, MI 48909 Phone: 517-373-0395 BHP-MMMPINFO@michigan.gov **Website:** MI Medical Marihuana Program **Information provided by the state on sources for medical marijuana:** "This is not addressed in the MMMA,

Amended: HB 4856 (40 KB) **Effective:** Dec. 31, 2012 Makes it illegal to "transport or possess" usable marijuana by car unless the marijuana is "enclosed in a case that is carried in the trunk of the vehicle." Violation of the law is a misdemeanor "punishable by imprisonment for not more than 93 days or a fine of not more than $500.00, or both." **Amended:** HB 4834 (40 KB) **Effective:** Apr. 1, 2013 Requires proof of Michigan residency when applying for a registry ID card (driver license, official state ID, or valid voter registration) and makes cards valid for two years instead of one. **Amended:** HB 4851 (40 KB) **Effective:** Apr. 1, 2013 Requires a "bona fide physician-patient relationship," defined in part as one in which the physician "has created and maintained records of the patient's condition in accord with medically accepted standards" and "will provide follow-up care;" protects patient from arrest only with registry identification card and valid photo ID. **Amended:** State of Michigan vs. McQueen (90 KB) **Decided:** Feb. 8, 2013 The Michigan Supreme Court ruled 4-1 that dispensaries are illegal. As a result, medical marijuana patients in Michigan will have to grow their own marijuana or get it from a designated caregiver who is limited to five patients.	therefore; the MMP is not authorized to provide information regarding this issue... The MMMA provides for a system of designated caregivers... The MMP is not authorized to associate patients and caregivers nor release the names of registered caregivers." "Frequently Asked Questions," Michigan.gov (accessed Apr. 24, 2014) **Patient Registry Fee:** $100 new or renewal application / $25 Medicaid patients **Accepts other states' registry ID cards?** Yes The Office of Communications in the Department of Licensing and Regulatory Affairs told ProCon.org in an Oct.30, 2014 email: "The law says that cards from other states are recognized. However, the Michigan Medical Marihuana Program does not have any control over enforcement of that section of the statute." **Registration:** Mandatory
14. Minnesota SF 2470 (200KB) – Signed into law by Gov. Mark Dayton on May 29, 2014 **Approved:** By Senate 46-16, by House 89-40 **Effective:** May 30, 2014 **Approved Conditions:** cancer (if the underlying condition or treatment produces severe or chronic pain, nausea or severe vomiting, or cachexia or severe wasting), glaucoma, HIV/AIDS, Tourette's syndorme, ALS, seizures/epilepsy, severe and persistent muscle spasms/MS, Crohn's disease, terminal illness with a life expectancy of under one year. The commissioner will consider adding intractable pain and other conditions, and must report findings no later than July 1, 2016. **Possession/Cultivation:** The Commissioner of Health will register two in-state manufacturers for the production of all medical cannabis within the state. Manufacturers are required to ensure that the medical cannabis distributed contains a maximum of a 30-day supply of the dosage determined for that patient. "Medical cannabis" is defined as any species of the genus cannabis plant delivered in the form of (1) liquid, including, but not limited to, oil; (2) pill; (3) vaporized delivery method that does not require the use of dried leaves or plant form. Smoking is not a method approved by the bill.	**Minnesota Department of Health** **Website:** Medical Cannabis Program **Information provided by the state on sources for medical marijuana:** Manufacturers shall operate four distribution facilities in the state and must agree to begin supplying medical cannabis to patients by July 1, 2015 from at least one facility. **Patient Registry Fee:** $200 / $50 for patients on Social Security disability, Supplemental Security Insurance, or enrolled in MinnesotaCare **Accepts other states' registry ID cards?** No **Registration:** Mandatory
15. Montana Initiative 148 (76 KB) -- Approved by 62% of voters on Nov. 2, 2004 **Effective:** Nov. 2, 2004 **Approved Conditions:** Cancer, glaucoma, or positive status for HIV/AIDS, or the treatment of these conditions; a chronic or debilitating disease or medical condition or its treatment that produces cachexia or wasting syndrome, severe or chronic pain, severe nausea, seizures, including seizures caused by epilepsy, or severe or persistent muscle spasms, including spasms caused by multiple sclerosis or Crohn's disease; or any other medical condition or treatment for a medical condition adopted by the department by rule. **Possession/Cultivation:** A qualifying patient and a qualifying patient's caregiver may each possess six marijuana plants and one ounce of usable marijuana. "Usable marijuana" means the dried leaves and flowers of marijuana and any mixture or preparation of marijuana. **Amended:** SB 423 (100 KB) -- Passed on Apr. 28, 2011 and transmitted to the Governor on May 3, 2011 **Effective:** July 1, 2011 SB 423 changes the application process to require a Montana driver's license or state issued ID card. A second physician is required to confirm a chronic pain diagnosis. "A provider or marijuana-infused products provider may assist a maximum of three registered cardholders..." and "may not accept anything of value, including monetary remuneration, for any services or products provided to a registered cardholder." **Approved Conditions:** Cancer, glaucoma, or positive status for HIV/AIDS when the condition or disease results in symptoms that seriously and adversely affect the patient's health status; Cachexia or wasting syndrome; Severe, chronic pain that is	**Medical Marijuana Program** Montana Department of Health and Human Services Licensure Bureau 2401 Colonial Drive, 2nd Floor P.O. Box 202953 Helena, MT 59620-2953 Phone: 406-444-0596 jbuska@mt.gov **Website:** MT Medical Marijuana Program Medical Marijuana Program FAQs (35 KB) **Information provided by the state on sources for medical marijuana:** "The department does not have information about growing marijuana, but recommends using the internet, family and friends as resources to find information." "Frequently Asked Questions," dphhs.mt.gov, Nov. 29, 2011 **Patient Registry Fee:** $75 new application/$75 renewal **Accepts other states' registry ID cards?**

persistent pain of severe intensity that significantly interferes with daily activities as documented by the patient's treating physician; Intractable nausea or vomiting; Epilepsy or intractable seizure disorder; Multiple sclerosis; Chron's Disease; Painful peripheral neuropathy; A central nervous system disorder resulting in chronic, painful spasticity or muscle spasms; Admittance into hospice care. **Possession/Cultivation:** Amended to 12 seedlings (less than 12"), four mature flowering plants, and one ounce of usable marijuana. On Nov. 6, 2012, Montana voters approved initiative referendum No. 124 by a vote of 56.5% to 43.5%, upholding SB 423.	No (reciprocity ended when SB 423 took effect) **Registration:** Mandatory
16. Nevada **Ballot Question** 9 – Approved Nov. 7, 2000 by 65% of voters **Effective:** Oct. 1, 2001 Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who have "written documentation" from their physician that marijuana may alleviate his or her condition. **Approved Conditions:** AIDS; cancer; glaucoma; and any medical condition or treatment to a medical condition that produces cachexia, persistent muscle spasms or seizures, severe nausea or pain, and PTSD. Other conditions are subject to approval by the health division of the state Department of Human Resources. **Possession/Cultivation:** Patients (or their primary caregivers) may legally possess no more than one ounce of usable marijuana, three mature plants, and four immature plants. **Registry:** The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients. Patients who do not join the registry or possess greater amounts of marijuana than allowed by law may argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges. Legislators added a preamble to the legislation stating, "[T]he state of Nevada as a sovereign state has the duty to carry out the will of the people of this state and regulate the health, medical practices and well-being of those people in a manner that respects their personal decisions concerning the relief of suffering through the medical use of marijuana." A separate provision requires the Nevada School of Medicine to "aggressively" seek federal permission to establish a state-run medical marijuana distribution program. **Amended:** Assembly Bill 453 (25 KB) **Effective:** Oct. 1, 2001 Created a state registry for patients whose physicians recommend medical marijuana and tasked the Department of Motor Vehicles with issuing identification cards. No state money will be used for the program, which will be funded entirely by donations. **Amended:** Senate Bill 374 (280 KB) Signed into law by Gov. Brian Sandoval on June 12, 2013 "Provides for the registration of medical marijuana establishments authorized to cultivate or dispense marijuana or manufacture edible marijuana products or marijuana-infused products for sale to persons authorized to engage in the medical use of marijuana... From April 1, 2014, through March 31, 2016, a nonresident purchaser must sign an affidavit attesting to the fact that he or she is entitled to engage in the medical use of marijuana in his or her state or jurisdiction of residency. On and after April 1, 2016, the requirement for such an affidavit is replaced by computer cross-checking between the State of Nevada and other jurisdictions." Patients who were growing before July 1, 2013 are allowed to continue home cultivation until March 31, 2016. **Updates:** The Department of Health and Human Services adopted regulations (340 KB) based on the previous amendment on April 1, 2014.	**Nevada State Health Division** 4150 Technology Way, Suite 104 Carson City, NV, 89706 Phone: 775-687-7594 Fax: 775-684-4156 medicalmarijuana@health.nv.gov **Website:** NV Medical Marijuana Program **Information provided by the state on sources for medical marijuana:** "The NMMP is not a resource for the growing process and does not have information to give to patients." "Medical Marijuana Frequently Asked Questions," health.nv.gov, Mar. 20, 2014 **Patient Registry Fee:** $25 application fee, plus $75 for the card **Accepts other states' registry ID cards?** Yes, starting Apr. 1, 2014 with an affidavit **Registration:** Mandatory
17. New Hampshire **House Bill 573** (215 KB) **Approved:** May 23, 2013 by Senate, 18-6 and June 26, 2013 by House, 284-66 Signed into law by Gov. Maggie Hassan on July 23, 2013 **Effective:** Upon passage The bill authorizes the use of therapeutic cannabis in New Hampshire, establishes a registry identification card system, allows for the registration of up to four non-profit alternative treatment centers in the state, and establishes an affirmative defense for qualified patients and designated caregivers with valid registry ID cards. HB 573 also calls for the creation of a Therapeutic Use of Cannabis Advisory Council, which in five years will be required to "issue a formal opinion on whether the program should be continued or repealed." A valid ID card from another medical marijuana state will be recognized as allowing the visiting patient to possess cannabis for therapeutic purposes, but the "visiting qualifying patient shall not cultivate or purchase cannabis in New Hampshire or obtain cannabis from alternative treatment centers..."	**New Hampshire Department of Health and Human Services** Phone: 603-271-9234 **Website:** Therapeutic Use of Cannabis Program **Information provided by the state on sources for medical marijuana:** HB 537 requires DHHS to register two nonprofit alternative treatment centers within 18 months of the bill's effective date, provided that at least two applicants are qualified. There can be no more than four alternative treatment centers at one time. **Patient Registry Fee:** To be determined during the rulemaking process

Approved Conditions: Cancer, glaucoma, positive status for HIV, AIDS, hepatitis C, ALS, muscular dystrophy, Crohn's disease, agitation of Alzheimer's disease, multiple sclerosis, chronic pancreatitis, spinal cord injury or disease, traumatic brain injury, or "one or more injuries that significantly interferes with daily activities as documented by the patient's provider; and a severely debilitating or terminal medical condition or its treatment that has produced at least one of the following: elevated intraocular pressure, cachexia, chemotherapy induced anorexia, wasting syndrome, severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects, constant or severe nausea, moderate to severe vomiting, seizures, or severe, persistent muscle spasms."

Possession/Cultivation: "A qualifying patient shall not obtain more than 2 ounces of usable cannabis directly or through the qualifying patient's designated caregiver during a 10-day period." A patient may possess two ounces of usable cannabis and any amount of unusable cannabis.

Updates: On Apr. 3, 2014, the Department of Health and Human Services (DHHS) posted proposed Therapeutic Cannabis Program Registry Rules (130 KB) and began the formal rulemaking process.

As of Apr. 23, 2014, the DHHS website stated that it was not currently accepting applications for patient registry identification cards or for alternative treatment center registration certificates.

Accepts other states' registry ID cards?
Yes

Registration:
Mandatory

18. New Jersey

Senate Bill 119 (175 KB)
Approved: Jan. 11, 2010 by House, 48-14; by Senate, 25-13
Signed into law by Gov. Jon Corzine on Jan. 18, 2010
Effective: Six months from enactment

Protects "patients who use marijuana to alleviate suffering from debilitating medical conditions, as well as their physicians, primary caregivers, and those who are authorized to produce marijuana for medical purposes" from "arrest, prosecution, property forfeiture, and criminal and other penalties."

Also provides for the creation of alternative treatment centers, "at least two each in the northern, central, and southern regions of the state. The first two centers issued a permit in each region shall be nonprofit entities, and centers subsequently issued permits may be nonprofit or for-profit entities."

Approved Conditions: Seizure disorder, including epilepsy, intractable skeletal muscular spasticity, glaucoma; severe or chronic pain, severe nausea or vomiting, cachexia, or wasting syndrome resulting from HIV/AIDS or cancer; amyotrophic lateral sclerosis (Lou Gehrig's Disease), multiple sclerosis, terminal cancer, muscular dystrophy, or inflammatory bowel disease, including Crohn's disease; terminal illness, if the physician has determined a prognosis of less than 12 months of life or any other medical condition or its treatment that is approved by the Department of Health and Senior Services.

Possession/Cultivation: Physicians determine how much marijuana a patient needs and give written instructions to be presented to an alternative treatment center. The maximum amount for a 30-day period is two ounces.

Amended: SB 2842 (40 KB)
Signed into law by Gov. Chris Christie on Sep. 10, 2013 following legislative adoption of his conditional veto (10 KB)

Allows edible forms of marijuana only for qualifying minors, who must receive approval from a pediatrician and a psychiatrist.

Updates:
S119 was supposed to become effective six months after it was enacted on Jan. 18, 2010, but the legislature, DHHS, and New Jersey Governor Chris Christie had difficulty coming to agreement on the details of how the program would be run.

The New Jersey Department of Health and Senior Services released draft rules (385 KB) outlining the registration and application process on Oct. 6, 2010. A public hearing to discuss the proposed rules was held on Dec. 6, 2010 at the New Jersey Department of Health and Senior Services, according to the *New Jersey Register*.

On Dec. 20, 2011, Senator Nicholas Scutari (D), lead sponsor of the medical marijuana bill, submitted Senate Concurrent Resolution (SCR) 140 (25 KB) declaring that the "Board of Medical Examiners proposed medicinal marijuana program rules are inconsistent with legislative intent." The New Jersey Senate Health, Human Services and Senior Citizens committee held a public hearing to discuss SCR 140 and a similar bill, SCR 130, on Jan. 20, 2010.

On Feb. 3, 2011, the Department of Health proposed new rules (200 KB) that streamlined the permit process for cultivating and dispensing, prohibited home delivery by alternative treatment centers, and required that "conditions originally named in the Act be resistant to conventional medical therapy in order to qualify as debilitating medical conditions."

On Aug. 9, 2012, the New Jersey Medical Marijuana Program opened the patient registration system on its website. Patients must have a physician's recommendation, a government-issued ID, and proof of New Jersey residency to register. The first

Department of Health (DOH)
P. O. Box 360
Trenton, NJ 08625-0360
Phone: 609-292-0424

Contact form

Website:
Medicinal Marijuana Program

Information provided by the state on sources for medical marijuana:
Patients are not allowed to grow their own marijuana. On Mar. 21, 2011, the New Jersey DOH announced the locations of six nonprofit alternative treatment centers (ATCs) (100 KB) from which medical marijuana may be obtained.

Medical marijuana is not covered by Medicaid.

Patient Registry Fee:
$200 (valid for two years). Reduced fee of $20 for patients qualifying for state or federal assistance programs

Accepts other states' registry ID cards?
No

Registration:
Mandatory

dispensary is expected to be licensed to open in September. On Oct. 16, 2012, the Department of Health issued the first dispensary permit (24 KB) to Greenleaf Compassion Center, allowing it to operate as an Alternative Treatment Center and dispense marijuana. The center opened on Dec. 6, 2012, becoming New Jersey's first dispensary. As of Apr. 23, 2014, there were Alternative Treatment Centers with permits to operate in all three regions of the state as designated by the medical marijuana program: north, central, and south.	
19. **New Mexico** **Senate Bill 523** (71 KB) "The Lynn and Erin Compassionate Use Act" **Approved:** Mar. 13, 2007 by House, 36-31; by Senate, 32-3 **Effective:** July 1, 2007 Removes state-level criminal penalties on the use and possession of marijuana by patients "in a regulated system for alleviating symptoms caused by debilitating medical conditions and their medical treatments." The New Mexico Department of Health designated to administer the program and register patients, caregivers, and providers. **Approved Conditions:** As of Apr. 23, 2014, the 19 current qualifying conditions for medical cannabis were: severe chronic pain, painful peripheral neuropathy, intractable nausea/vomiting, severe anorexia/cachexia, hepatitis C infection, Crohn's disease, Post-Traumatic Stress Disorder, ALS (Lou Gehrig's disease), cancer, glaucoma, multiple sclerosis, damage to the nervous tissue of the spinal cord with intractable spasticity, epilepsy, HIV/AIDS, hospice patients, cervical dystonia, Inflammaory Autoimmune-mediated Arthritis, Parkinson's disease, and Huntington's disease **Possession/Cultivation:** Patients have the right to possess up to six ounces of usable cannabis, four mature plants and 12 seedlings. Usable cannabis is defined as dried leaves and flowers; it does not include seeds, stalks or roots. A primary caregiver may provide services to a maximum of four qualified patients under the Medical Cannabis Program.	**New Mexico Department of Health** Medical Cannabis Program 1190 Saint Francis Drive Suite S-3400 Santa Fe, NM 87502 Phone: 505-827-2321 medical.cannabis@state.nm.us **Website:** NM Medical Cannabis Program **Information provided by the state on sources for medical marijuana:** "The production and distribution of medical cannabis is provided by Licensed Non-Profit Producers (LNPP) throughout the state. A Qualified Patient may also obtain a Personal Production License (PPL) to grow medical cannabis for personal use." "General Information," Medical Cannabis Program website (accessed Apr. 23, 2014) **Patient Registry Fee:** No fee **Accepts other states' registry ID cards?** No **Registration:** Mandatory
20. **New York** **Assembly Bill 6357** (85 KB) **Approved:** June 19, 2014 by Assembly, 117-13; June 20, 2014 by Senate, 49-10 Signed into law by Governor Andrew Cuomo on July 5, 2014 **Effective:** Upon Governor's signature The Department of Health has 18 months to establish regulations and register dispensing organizations. Marijuana will be taxed at 7%, to be paid by the dispensary. The law automatically expires after seven years. **Approved Conditions:** Cancer, HIV/AIDS, ALS (Lou Gehrig's disease), Parkinson's disease, multiple sclerosis, spinal cord damage causing spasticity, epilepsy, inflammatory bowel disease, neuropathies, or Huntington's disease. The Department of Health commissioner has the discretion to add or delete conditions and must decide whether to add Alzheimer's, muscular dystrophy, dystonia, PTSD, and rheumatoid arthritis within 18 months of the law becoming effective. **Possession/Cultivation:** 30-day supply to be determined by the health commissioner during the rule making process or by the physician. Smoking is not a method approved by the bill.	**New York Department of Health** **Website:** New York State Medical Marijuana Program **Information provided by the state on sources for medical marijuana:** The health commissioner will register up to five organizations to manufacture medical marijuana, each of which may own and operate no more than four dispensing sites. **Patient Registry Fee:** $50 **Accepts other states' registry ID cards?** No **Registration:** Mandatory
21. **Oregon** **Ballot Measure 67** (75 KB) – Approved by 55% of voters on Nov. 3, 1998 **Effective:** Dec. 3, 1998 Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess a signed recommendation from their physician stating that marijuana "may mitigate" his or her debilitating symptoms. **Approved Conditions:** Cancer, glaucoma, positive status for HIV/AIDS, or treatment for these conditions; A medical condition or treatment for a medical condition that produces cachexia, severe pain, severe nausea, seizures, including seizures caused by epilepsy, or persistent muscle spasms, including spasms caused by multiple sclerosis. Other conditions are subject to approval by the Health Division of the Oregon Department of Human Resources. **Possession/Cultivation:** A registry identification cardholder or the designated primary caregiver of the cardholder may possess up to six mature marijuana plants and 24 ounces of usable marijuana. A registry identification cardholder and the designated primary caregiver of the cardholder may possess a combined total of up	**Oregon Department of Human Services** Medical Marijuana Program PO Box 14116 Portland, OR 97293 Phone: 855-244-9580 (toll-free) medmj.dispensaries@state.or.us **Website:** Oregon Medical Marijuana Program (OMMP) **Information provided by the state on sources for medical marijuana:** The Oregon Medical Marijuana Dispensary Program publishes a directory of approved dispensaries n its website.

12

to 18 marijuana seedlings. (per Oregon Revised Statutes ORS 475.300 – ORS 475.346) (52 KB)

Amended: Senate Bill 1085 (52 KB)
Effective: Jan. 1, 2006

State-qualified patients who possess cannabis in amounts exceeding the new state guidelines will no longer retain the ability to argue an "affirmative defense" of medical necessity at trial. Patients who fail to register with the state, but who possess medical cannabis in amounts compliant with state law, still retain the ability to raise an "affirmative defense" at trial.

The law also redefines "mature plants" to include only those cannabis plants that are more than 12 inches in height and diameter, and establish a state-registry for those authorized to produce medical cannabis to qualified patients.

Amended: House Bill 3052
Effective: July 21, 1999

Mandates that patients (or their caregivers) may only cultivate marijuana in one location, and requires that patients must be diagnosed by their physicians at least 12 months prior to an arrest in order to present an "affirmative defense." This bill also states that law enforcement officials who seize marijuana from a patient pending trial do not have to keep those plants alive. Last year the Oregon Board of Health approved agitation due to Alzheimer's disease to the list of debilitating conditions qualifying for legal protection.

In August 2001, program administrators filed established temporary procedures further defining the relationship between physicians and patients. The new rule defines attending physician as "a physician who has established a physician/patient relationship with the patient;... is primarily responsible for the care and treatment of the patients... has reviewed a patient's medical records at the patient's request, has conducted a thorough physical examination of the patient, has provided a treatment plan and/or follow-up care, and has documented these activities in a patient file."

Amended: SB 281 (25 KB)
Signed by Gov. John Kitzhaber on June 6, 2013

Adds post-traumatic stress disorder (PTSD) to the list of approved conditions for medical marijuana use.

Amended: HB 3460 (50 KB)
Signed by Gov. John Kitzhaber on Aug. 14, 2013

Creates a dispensary program by allowing the state licensing and regulation of medical marijuana facilities to transfer marijuana to registry identification cardholders or their designated primary caregivers.

Updates: On March 3, 2014, the program began accepting applications from people seeking a license to operate a medical marijuana dispensary.

On March 19, 2014, Senate Bill 1531 (30 KB) was signed into law. The bill allows local governments to restrict the operation of medical marijuana dispensaries, including the moratoriums up through May 1, 2015.

On April 18, 2014, the Medical Marijuana Dispensary Program approved 15 dispensary applications, bringing the total number of approved applications to 58.

Patient Registry Fee:
$200 for new applications and renewals; $100 for application and annual renewal fee for persons receiving SNAP (food stamp) and for Oregon Health Plan cardholders; $20 for persons receiving SSI benefits

An additional $50 grow site registration fee is charged if the patient is not his or her own grower.

Accepts other states' registry ID cards?
No

Registration:
Mandatory

22. Rhode Island

Senate Bill 0710 – Approved by state House and Senate, vetoed by the Governor. Veto was over-ridden by House and Senate.

Timeline:

1. June 24, 2005: passed the House 52 to 10
2. June 28, 2005: passed the State Senate 33 to 1
3. June 29, 2005: Gov. Carcieri vetoed the bill
4. June 30, 2005: Senate overrode the veto 28-6
5. Jan. 3, 2006: House overrode the veto 59-13 to pass the Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act (48 KB) (Public Laws 05-442 and 05-443)
6. June 21, 2007: Amended by Senate Bill 791 (30 KB) **Effective:** Jan. 3, 2006

Approved Conditions: Cancer, glaucoma, positive status for HIV/AIDS, Hepatitis C, or the treatment of these conditions; A chronic or debilitating disease or medical condition or its treatment that produces cachexia or wasting syndrome; severe, debilitating, chronic pain; severe nausea; seizures, including but not limited to, those characteristic of epilepsy; or severe and persistent muscle spasms, including but not limited to, those characteristic of multiple sclerosis or Crohn's disease; or agitation of Alzheimer's Disease; or any other medical condition or its treatment approved by the state Department of Health.

If you have a medical marijuana registry identification card from any other state, U.S. territory, or the District of Columbia you may use it in Rhode Island. It has the same force and effect as a card issued by the Rhode Island Department of Health.

Possession/Cultivation: Limits the amount of marijuana that can be possessed and grown to up to 12 marijuana plants or 2.5 ounces of cultivated marijuana. Primary

Rhode Island Department of Health
Office of Health Professions Regulation,
Room 104
3 Capitol Hill
Providence, RI 02908-5097
Phone: 401-222-2828

mmp@health.ri.gov

Website:
RI Medical Marijuana Program (MMP)

Information provided by the state on sources for medical marijuana:
The Department of Health had approved three compassion centers to be licensed. but only two were operational as of Apr. 24, 2014.

Patient Registry Fee:
$75/$10 for applicants on Medicaid or Supplemental Security Income (SSI)

Accepts other states' registry ID cards?
Yes, but only for the conditions approved in Rhode Island

Registration:
Mandatory

caregivers may not possess an amount of marijuana in excess of 24 marijuana plants and five ounces of usable marijuana for qualifying patients to whom he or she is connected through the Department's registration process.

Amended: H5359 (70 KB) - The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act (substituted for the original bill)

Timeline:

1. **May 20, 2009:** passed the House 63-5
2. **June 6, 2009:** passed the State Senate 31-2
3. **June 12, 2009:** Gov. Carcieri vetoed the bill (60 KB)
4. **June 16, 2009:** Senate overrode the veto 35-3
5. **June 16, 2009:** House overrode the veto 67-0

Effective June 16, 2009: Allows the creation of compassion centers, which may acquire, possess, cultivate, manufacture, deliver, transfer, transport, supply, or dispense marijuana, or related supplies and educational materials, to registered qualifying patients and their registered primary caregivers. Rules & Regulations (60 KB) last updated Dec. 2012.

The first dispensary, the Thomas C. Slater Compassion Center, opened on Apr. 19, 2013. Compassion centers must be operated on a not-for-profit basis.

23. Vermont

Senate Bill 76 (45 KB) – Approved 22-7; House Bill 645 (41 KB) – Approved 82-59 **"Act Relating to Marijuana Use by Persons with Severe Illness"** (Sec. 1. 18 V.S.A. chapter 86 (41 KB) passed by the General Assembly) *Gov. James Douglas (R), allowed the act to pass into law unsigned on May 26, 2004*
Effective: July 1, 2004

Amended: Senate Bill 00007 (65 KB)
Effective: May 30, 2007

Approved Conditions: Cancer, AIDS, positive status for HIV, multiple sclerosis, or the treatment of these conditions if the disease or the treatment results in severe, persistent, and intractable symptoms; or a disease, medical condition, or its treatment that is chronic, debilitating and produces severe, persistent, and one or more of the following intractable symptoms: cachexia or wasting syndrome, severe pain or nausea or seizures.

Possession/Cultivation: No more than two mature marijuana plants, seven immature plants, and two ounces of usable marijuana may be collectively possessed between the registered patient and the patient's registered caregiver. A marijuana plant shall be considered mature when male or female flower buds are readily observed on the plant by unaided visual examination. Until this sexual differentiation has taken place, a marijuana plant will be considered immature.

Amended: Senate Bill 17 (100 KB) "An Act Relating To Registering Four Nonprofit Organizations To Dispense Marijuana For Symptom Relief"
Signed by Gov. Peter Shumlin on June 2, 2011

The bill "establishes a framework for registering up to four nonprofit marijuana dispensaries in the state... A dispensary will be permitted to cultivate and possess at any one time up to 28 mature marijuana plants, 98 immature marijuana plants, and 28 ounces of usable marijuana."

On Sep. 12, 2012, the State of Vermont Department of Public Safety announced conditional approval (65 KB) of two medical marijuana dispensaries. In June 2013, two dispensaries opened in Vermont.

Marijuana Registry
Department of Public Safety
103 South Main Street
Waterbury, Vermont 05671
Phone: 802-241-5115

DPS.VTMR@state.vt.us

Website:
VT Marijuana Registry Program

Information provided by the state on sources for medical marijuana:
"The Marijuana Registry is neither a source for marijuana nor can the Registry provide information to patients on how to obtain marijuana." (accessed Apr. 24, 2014)

Patient Registry Fee:
$50

Accepts other states' registry ID cards?
No

Registration:
Mandatory

24. Washington

Chapter 69.51A RCW (4KB) **Ballot Initiative I-692** – Approved by 59% of voters on Nov. 3, 1998
Effective: Nov. 3, 1998

Removed state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess "valid documentation" from their physician affirming that he or she suffers from a debilitating condition and that the "potential benefits of the medical use of marijuana would likely outweigh the health risks."

Approved Conditions: cachexia; cancer; HIV or AIDS; epilepsy; glaucoma; intractable pain (defined as pain unrelieved by standard treatment or medications); and multiple sclerosis. Other conditions are subject to approval by the Washington Board of Health. **Additional conditions as of Nov. 2, 2008:** Crohn's disease, Hepatitis C with debilitating nausea or intractable pain, diseases, including anorexia, which result in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms, or spasticity, when those conditions are unrelieved by standard treatments or medications. **Added as of Aug. 31, 2010:** chronic renal failure

Amended: Senate Bill 6032 (29 KB)
Effective: 2007 (rules being defined by Legislature with a July 1, 2008 due date)

Amended: Final Rule (123 KB) based on Significant Analysis (370 KB)
Effective: Nov. 2, 2008

Department of Health
PO Box 47866
Olympia, WA 98504-7866
Phone: 360-236-4700
Fax: 360-236-4768

MedicalMarijuana@doh.wa.gov

Website:
Medical Marijuana (Cannabis)

Information provided by the state on sources for medical marijuana:
"The law allows a qualifying patient or designated provider to grow medical marijuana. It is not legal to buy or sell it... The law does not allow dispensaries." "General Frequently Asked Questions," doh.wa.gov (accessed Apr. 24, 2014)

Note: Washington now allows state-licensed retail stores to sell marijuana. The state website says that qualified patients "can still grow their own marijuana or participate in a collective garden if they don't want to buy from a state-licensed retail store."

14

Possession/Cultivation: A qualifying patient and designated provider may possess a total of no more than twenty-four ounces of usable marijuana, and no more than fifteen plants. This quantity became the state's official "60-day supply" on Nov. 2, 2008. **Amended:** SB 5073 (375 KB) **Effective:** July 22, 2011 Gov. Christine Gregoire signed sections of the bill and partially vetoed others, as explained in the Apr. 29, 2011 veto notice. (50 KB) Gov. Gregoire struck down sections related to creating state-licensed medical marijuana dispensaries and a voluntary patient registry. **Updates:** On Jan. 21, 2010, the Supreme Court of the State of Washington ruled that Ballot Initiative "I-692 did not legalize marijuana, but rather provided an authorized user with an affirmative defense if the user shows compliance with the requirements for medical marijuana possession." *State v. Fry* (125 KB) ProCon.org contacted the Washington Department of Health to ask whether it had received any instructions in light of this ruling. Kristi Weeks, Director of Policy and Legislation, stated the following in a Jan. 25, 2010 email response to ProCon.org: "The Department of Health has a limited role related to medical marijuana in the state of Washington. Specifically, we were directed by the Legislature to determine the amount of a 60 day supply and conduct a study of issues related to access to medical marijuana. Both of these tasks have been completed. We have maintained the medical marijuana webpage for the convenience of the public. The department has not received 'any instructions' in light of State v. Fry. That case does not change the law or affect the 60 day supply. Chapter 69.51A RCW, as confirmed in Fry, provides an affirmative defense to prosecution for possession of marijuana for qualifying patients and caregivers." On Nov. 6, 2012, Washington voters passed Initiative 502, which allows the state to "license and regulate marijuana production, distribution, and possession for persons over 21 and tax marijuana sales." The website for Washington's medical marijuana program states that the initiative "does not amend or repeal the medical marijuana laws (chapter 69.51A RCW) in any way. The laws relating to authorization of medical marijuana by healthcare providers are still valid and enforceable."	**Patient Registry Fee:** No state registration program has been established **Accepts other states' registry ID cards?** No **Registration:** None

For a detailed list of sources used to compile this information, please see our sources page.

15

Congress quietly ends federal government's ban on medical marijuana

By EVAN HALPER

DECEMBER 16, 2014, 4:00 AM | REPORTING FROM WASHINGTON

Tucked deep inside the 1,603-page federal spending measure is a provision that effectively ends the federal government's prohibition on medical marijuana and signals a major shift in drug policy.

The bill's passage over the weekend marks the first time Congress has approved nationally significant legislation backed by legalization advocates. It brings almost to a close two decades of tension between the states and Washington over medical use of marijuana.

Under the provision, states where medical pot is legal would no longer need to worry about federal drug agents raiding retail operations. Agents would be prohibited from doing so.

The Obama administration has largely followed that rule since last year as a matter of policy. But the measure approved as part of the spending bill, which President Obama plans to sign this week, will codify it as a matter of law.

Pot advocates had lobbied Congress to embrace the administration's policy, which they warned was vulnerable to revision under a less tolerant future administration.

More important, from the standpoint of activists, Congress' action marked the emergence of a new alliance in marijuana politics: Republicans are taking a prominent role in backing states' right to allow use of a drug the federal government still officially classifies as more dangerous than cocaine.

"This is a victory for so many," said the measure's coauthor, Republican Rep. Dana Rohrabacher of Costa Mesa. The measure's approval, he said, represents "the first time in decades that the federal government has curtailed its oppressive prohibition of marijuana."

By now, 32 states and the District of Columbia have legalized pot or its ingredients to treat ailments, a movement that began in the 1990s. Even back then, some states had been approving broader decriminalization measures for two decades.

16

The medical marijuana movement has picked up considerable momentum in recent years. The Drug Enforcement Administration, however, continues to place marijuana in the most dangerous category of narcotics, with no accepted medical use.

Congress for years had resisted calls to allow states to chart their own path on pot. The marijuana measure, which forbids the federal government from using any of its resources to impede state medical marijuana laws, was previously rejected half a dozen times. When Washington, D.C., voters approved medical marijuana in 1998, Congress used its authority over the city's affairs to block the law from taking effect for 11 years.

Even as Congress has shifted ground on medical marijuana, lawmakers remain uneasy about full legalization. A separate amendment to the spending package, tacked on at the behest of anti-marijuana crusader Rep. Andy Harris (R-Md.), will jeopardize the legalization of recreational pot in Washington, D.C., which voters approved last month.

Marijuana proponents nonetheless said they felt more confident than ever that Congress was drifting toward their point of view.

"The war on medical marijuana is over," said Bill Piper, a lobbyist with the Drug Policy Alliance, who called the move historic.

"Now the fight moves on to legalization of all marijuana," he said. "This is the strongest signal we have received from Congress [that] the politics have really shifted. ... Congress has been slow to catch up with the states and American people, but it is catching up."

The measure, which Rohrabacher championed with Rep. Sam Farr, a Democrat from Carmel, had the support of large numbers of Democrats for years. Enough Republicans joined them this year to put it over the top. When the House first passed the measure earlier this year, 49 Republicans voted aye.

Some Republicans are pivoting off their traditional anti-drug platform at a time when most voters live in states where medical marijuana is legal, in many cases as a result of ballot measures.

Polls show that while Republican voters are far less likely than the broader public to support outright legalization, they favor allowing marijuana for medical use by a commanding majority. Legalization also has great appeal to millennials, a demographic group with which Republicans are aggressively trying to make inroads.

Approval of the pot measure comes after the Obama administration directed federal prosecutors last year to stop enforcing drug laws that contradict state marijuana policies. Since

17

then, federal raids of marijuana merchants and growers who are operating legally in their states have been limited to those accused of other violations, such as money laundering.

"The federal government should never get in between patients and their medicine," said Rep. Barbara Lee (D-Oakland).

evan.halper@latimes.com

Twitter: @evanhalper

18

Why is Marijuana Illegal?

http://www.drugwarrant.com/articles/why-is-marijuana-illegal/

Many people assume that marijuana was made illegal through some kind of process involving scientific, medical, and government hearings; that it was to protect the citizens from what was determined to be a dangerous drug.

The actual story shows a much different picture. Those who voted on the legal fate of this plant never had the facts, but were dependent on information supplied by those who had a specific agenda to deceive lawmakers. You'll see below that the very first federal vote to prohibit marijuana was based entirely on a documented lie on the floor of the Senate.

You'll also see that the history of marijuana's criminalization is filled with:

- **Racism**
- **Fear**
- **Protection of Corporate Profits**
- **Yellow Journalism**
- **Ignorant, Incompetent, and/or Corrupt Legislators**
- **Personal Career Advancement and Greed**

These are the actual reasons marijuana is illegal.

Background

For most of human history, marijuana has been completely legal. It's not a recently discovered plant, nor is it a long-standing law. Marijuana has been illegal for less than 1% of the time that it's been in use. Its known uses go back further than 7,000 B.C. and it was legal as recently as when Ronald Reagan was a boy.

19

The marijuana (hemp) plant, of course, has an incredible number of uses. The earliest known woven fabric was apparently of hemp, and over the centuries the plant was used for food, incense, cloth, rope, and much more. This adds to some of the confusion over its introduction in the United States, as the plant was well known from the early 1600's, but did not reach public awareness as a recreational drug until the early 1900's.

America's first marijuana law was enacted at Jamestown Colony, Virginia in 1619. It was a law "ordering" all farmers to grow Indian hempseed. There were several other "must grow" laws over the next 200 years (you could be jailed for not growing hemp during times of shortage in Virginia between 1763 and 1767), and during most of that time, hemp was legal tender (you could even pay your taxes with hemp — try that today!) Hemp was such a critical crop for a number of purposes (including essential war requirements – rope, etc.) that the government went out of its way to encourage growth.

The United States Census of 1850 counted 8,327 hemp "plantations" (minimum 2,000-acre farm) growing cannabis hemp for cloth, canvas and even the cordage used for baling cotton.

The Mexican Connection

In the early 1900s, the western states developed significant tensions regarding the influx of Mexican-Americans. The revolution in Mexico in 1910 spilled over the border, with General Pershing's army clashing with bandit Pancho Villa. Later in that decade, bad feelings developed between the small farmer and the large farms that used cheaper Mexican labor. Then, the depression came and increased tensions, as jobs and welfare resources became scarce.

One of the "differences" seized upon during this time was the fact that many Mexicans smoked marijuana and had brought the plant with them, and it was through this that California apparently passed the first state marijuana law, outlawing "preparations of hemp, or loco weed."

However, one of the first state laws outlawing marijuana may have been influenced, not just by Mexicans using the drug, but, oddly enough, because of Mormons using it. Mormons who traveled to Mexico in 1910 came back to Salt Lake City with marijuana. The church's reaction to this may have contributed to the state's marijuana law. *(Note: the source for this speculation is from articles by Charles Whitebread, Professor of Law at USC Law School in a paper for the Virginia Law Review, and a speech to the California Judges Association (sourced below). Mormon blogger Ardis Parshall disputes this.)*

Other states quickly followed suit with marijuana prohibition laws, including Wyoming (1915), Texas (1919), Iowa (1923), Nevada (1923), Oregon (1923), Washington (1923), Arkansas (1923), and Nebraska (1927). These laws tended to be specifically targeted against the Mexican-American population.

When Montana outlawed marijuana in 1927, the Butte Montana Standard reported a legislator's comment: "When some beet field peon takes a few traces of this stuff... he thinks he has just been elected president of Mexico, so he starts out to execute all his political enemies." In Texas, a senator said on the floor of the Senate: "All Mexicans are crazy, and this stuff [marijuana] is what makes them crazy."

Jazz and Assassins

In the eastern states, the "problem" was attributed to a combination of Latin Americans and black jazz musicians. Marijuana and jazz traveled from New Orleans to Chicago, and then to Harlem, where marijuana became an indispensable part of the music scene, even entering the language of the black hits of the time (Louis Armstrong's "Muggles", Cab Calloway's "That Funny Reefer Man", Fats Waller's "Viper's Drag").

Again, racism was part of the charge against marijuana, as newspapers in 1934 editorialized: "**Marihuana influences Negroes to look at white people in the eye, step on white men's shadows and look at a white woman twice.**"

Two other fear-tactic rumors started to spread: one, that Mexicans, Blacks and other foreigners were snaring white children with marijuana; and two, the story of the "assassins." Early stories of Marco Polo had told of "hasheesh-eaters" or hashashin, from which derived the term "assassin." In the original stories, these professional killers were given large doses of hashish and brought to the ruler's garden (to give them a glimpse of the paradise that awaited them upon successful completion of their mission). Then, after the effects of the drug disappeared, the assassin would fulfill his ruler's wishes with cool, calculating loyalty.

20

By the 1930s, the story had changed. Dr. A. E. Fossier wrote in the 1931 New Orleans Medical and Surgical Journal: "Under the influence of hashish those fanatics would madly rush at their enemies, and ruthlessly massacre every one within their grasp." Within a very short time, marijuana started being linked to violent behavior.

Alcohol Prohibition and Federal Approaches to Drug Prohibition

During this time, the United States was also dealing with alcohol prohibition, which lasted from 1919 to 1933. Alcohol prohibition was extremely visible and debated at all levels, while drug laws were passed without the general public's knowledge. National alcohol prohibition happened through the mechanism of an amendment to the constitution.

Earlier (1914), the Harrison Act was passed, which provided federal tax penalties for opiates and cocaine.

The federal approach is important. It was considered at the time that the federal government did not have the constitutional power to outlaw alcohol or drugs. It is because of this that alcohol prohibition required a constitutional amendment.

At that time in our country's history, the judiciary regularly placed the tenth amendment in the path of congressional regulation of "local" affairs, and direct regulation of medical practice was considered beyond congressional power under the commerce clause (since then, both provisions have been weakened so far as to have almost no meaning).

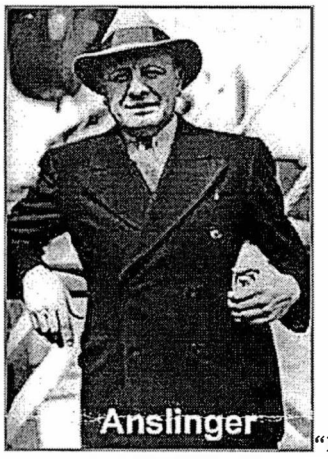
Since drugs could not be outlawed at the federal level, the decision was made to use federal taxes as a way around the restriction. In the Harrison Act, legal uses of opiates and cocaine were taxed (supposedly as a revenue need by the federal government, which is the only way it would hold up in the courts), and those who didn't follow the law found themselves in trouble with the treasury department.

In 1930, a new division in the Treasury Department was established — the Federal Bureau of Narcotics — and Harry J. Anslinger was named director. This, if anything, marked the beginning of the all-out war against marijuana.

Harry J. Anslinger

Anslinger was an extremely ambitious man, and he recognized the Bureau of Narcotics as an amazing career opportunity — a new government agency with the opportunity to define both the problem and the solution. He immediately realized that opiates and cocaine wouldn't be enough to help build his agency, so he latched on to marijuana and started to work on making it illegal at the federal level.

Anslinger immediately drew upon the themes of racism and violence to draw national attention to the problem he wanted to create. He also promoted and frequently read from "Gore Files" — wild reefer-madness-style exploitation tales of ax murderers on marijuana and sex and... Negroes. Here are some quotes that have been widely attributed to Anslinger and his Gore Files:



"There are 100,000 total marijuana smokers in the US, and most are Negroes, Hispanics, Filipinos, and entertainers. Their Satanic music, jazz, and swing, result from marijuana use. This marijuana causes white women to seek sexual relations with Negroes, entertainers, and any others."

"... the primary reason to outlaw marijuana is its effect on the degenerate races."

"Marijuana is an addictive drug which produces in its users insanity, criminality, and death."

"Reefer makes darkies think they're as good as white men."

"Marihuana leads to pacifism and communist brainwashing"

"You smoke a joint and you're likely to kill your brother."

"Marijuana is the most violence-causing drug in the history of mankind."

And he loved to pull out his own version of the "assassin" definition:

"In the year 1090, there was founded in Persia the religious and military order of the Assassins, whose history is one of cruelty, barbarity, and murder, and for good reason: the members were confirmed users of hashish, or marihuana, and it is from the Arabs' 'hashashin' that we have the

21

76
1
By Natural Society
Contributor profile | More stories

Story Views

Now:	1
Last Hour:	1
Last 24 Hours:	1
Total:	105

Did Congress End the Federal Ban on Medical Marijuana?

Friday, January 30, 2015 1:20

(Before It's News)

Natural Society

While many states in the U.S. have successfully passed bills "legalizing" marijuana for medical and even recreational use, cannabis is still illegal on a nation-wide, federal level. In fact, cannabis is even classified as a Schedule I drug with "no medicinal value," along with heroin, LSD, and ecstasy. But recurring evidence is showing that this could all change very soon. Reportedly tucked deep inside the 1,603-page federal spending measure is a provision that effectively ends the federal government's prohibition on medical marijuana.

The bill's passage over the weekend marks the first time Congress has approved nationally significant legislation backed by legalization advocates. It brings almost to a close two decades of tension between the states and Washington over medical use of marijuana.

"This is a victory for so many," said the measure's coauthor, Republican Rep. Dana Rohrabacher of Costa Mesa. The measure's approval, he said, represents "the first time in decades that the federal government has curtailed its oppressive prohibition of marijuana."

Under the provision, states with legal medical marijuana would no longer need to worry about federal drug agents raiding retail operations. Agents would be prohibited from doing so.

"The war on medical marijuana is over. Now the fight moves on to legalization of all marijuana. This is the strongest signal we have received from Congress [that] the politics have really shifted. ... Congress has been slow to catch up with the states and American people, but it is catching up," said Bill Piper, a lobbyist with the Drug Policy Alliance, who called the move historic.

And evidence suggests that president Obama is all for such a provision, as he has repeatedly said the federal government would use minimal resources to strike at dispensaries. The Obama Administration has unofficially made it part of their policy to neither indict nor raid medical marijuana dispensaries and growers.

"What you're seeing now is Colorado, Washington through state referenda, they're experimenting with legal marijuana," the president said in response to a question from YouTube host Hank Green. "The position of my administration has been that we still have federal laws that classify marijuana as an illegal substance, but we're not going to spend a lot of resources trying to turn back decisions that have been made at the state level on this issue. My suspicion is that you're gonna see other states start looking at this."

Today's Top Stories

- JIM WILLIE – THE QUICKENING: Systemic Breakdown, It's Coming Apart At The Seams
- Davos Forum: "Very Powerful People Are Telling Us They're Scared"
- We're Living on Borrowed Time!! NWO Scientists Meet to... As it Was in the Days of Noah So It Is Now! Major Move That Will Anger You to the Core...
- "WILL PAY A PRICE": Valerie Jarrett Promises To Hurt Israel, Netanyahu For "Spitting In Obama's Face" Over Iran Nukes
- Five Banned Websites You Should Definitely Read
- AGENDA 21 Exposed: American Concentration Camps 2/2/2015 (Video)
- Alien Attacks Policeman Explained (Must See Video)
- Strange Creature Freaks Out Plantation Workers In Sarawak (Video)
- Tribulation To Begin 2015-16? This Is So Spot On, It Is Chilling To the Bone! The Earth Is About To Reel Like Never Before and the Time To Prepare Is RIGHT NOW! (Stunning Videos)
- Must See: Mystery Booms -The War In Heaven

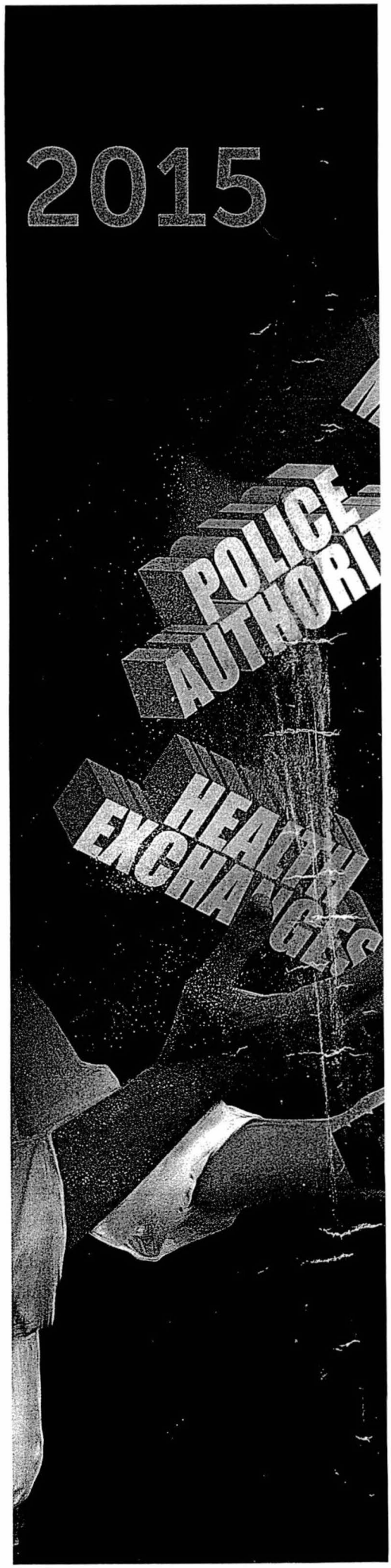
Most Recent Stories

- BO Is Openly Colluding with the Enemy
- CRN Reports : Vembu Named Coolest Software Vendor(s) for the Year 2015
- UK MKULTRA Links to 1950's British Intelligence Anti-Communist groups Sponsored by CIA under Allen Dulles and Bill Donovan
- ★Katy Perry Draws Blood To Commemorate Super Bowl
- The Ghosts Of Florida And Haunted Places In Florida

22

What's Hot for 2015

Lawmakers have a slew of hot issues to juggle as sessions rev up around the country this month.



BY JULIE LAYS

The overall economy is improving. Gas prices are down and state revenues are up. Things are better, but they're not great.

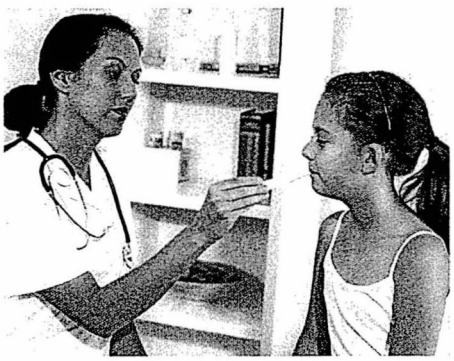
Lawmakers are reporting for duty with partisanship and polarization casting longer than normal shadows down revered statehouse hallways. Social issues continue to divide, voters' cynicism grows for all things "government" and federal inaction threatens states' stability.

Still, state lawmakers find ways to get things done. They look for areas of agreement, they learn from experiences in other states and they find solutions to fairly serious problems, often quite innovatively and almost always more effectively than their federal counterparts.

As lawmakers roll up their sleeves to begin work on many important issues, state fiscal conditions, at least, are stronger than they have been for several years. With only a few exceptions, state finances continue to improve slowly but steadily from the depths of the Great Recession. NCSL's most recent fiscal survey of the states found most spending in line with appropriated levels for FY 2015. In fact, as the New Year approached, only Medicaid and corrections in a couple of states were running over-budget.

The same survey found that the top funding issues state legislatures are expected to address during 2015 legislative sessions are education (from preschool to university), Medicaid, and transportation infrastructure. Other hot fiscal issues include tax reform and gaming.

As we do this time each year, we've listed the topics—many new and emerging—that will likely occupy a majority of lawmakers' time and energy across the country.



1. HEALTH EXCHANGES

It's a given that some aspect of health care policy will always make it onto a top state policy list. From costs to care, it's always hot. Along with debates over expanding Medicaid, bolstering the workforce and cutting costs, health insurance exchanges will be in the spotlight again. A pending U.S. Supreme Court case could have a big influence on state action this year. In *King v. Burwell*, the justices will determine whether the tax credits under the Affordable Care Act (ACA) for low- and middle-income health insurance purchasers apply if they use the federal exchange rather than a state exchange. If the justices rule the credits don't apply, some say it could kill the ACA as we know it. Others say it may only encourage states to convert their federally run exchanges into state-run versions. Currently, 16 states and the District of Columbia have state-run exchanges. At least seven other states partner with the federal government to run their exchanges. These may be the most likely to switch to a full state-run marketplace. This is only the second case regarding the ACA to make it to the high court, so the ruling is highly anticipated.

Julie Lays is the magazine's editor. NCSL policy research staff contributed ideas and information for this article.

2. MARIJUANA

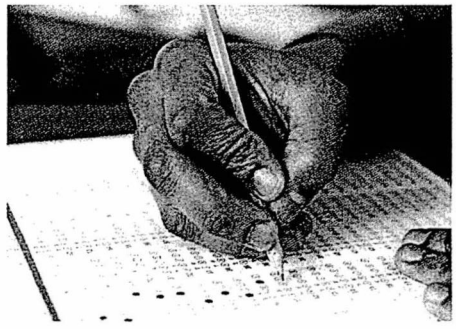
Legalizing marijuana is undeniably one of the hottest issues today. In the first states to legalize small amounts, the proliferation of retail marijuana stores and the growth of the related industry would have been hard to imagine just a few years ago. New stores and emerging businesses are popping up offering pot users everything from exclusive tours to cooking classes, limo rides to ski trips. Voters, so far, have been the drivers behind these proposals. They passed the first initiatives to legalize, regulate and tax small amounts of marijuana in 2012 in Colorado and Washington, as did voters in Alaska, Oregon and D.C. last November. Bills to legalize recreational marijuana were introduced in 15 legislatures in 2014, and in 13 the year before, but none advanced.

In addition, 23 states and D.C. allow the use of marijuana for medical reasons, with more than half those proposals initiated and passed by legislatures. And 19 states and D.C. have changed their laws so that anyone caught with a small amount of marijuana is charged with only a civil or local infraction, with no possibility of jail time. Some of these laws date back to the 1970s, but many reflect a recent renewed interest that will continue in 2015.

The U.S. Department of Justice, meanwhile, continues to maintain that marijuana is illegal under the federal Controlled Substances Act and expects states to enact and implement laws that include "strong and effective regulatory and enforcement systems" to address any threat legal pot could have on public safety, public health and other law enforcement interests. Native American tribes are permitted to grow and sell marijuana on tribal lands as long as they follow federal rules already in place in states that allow recreational use, according to Justice guidelines issued in December.

Will 2015 be the year that a state legislature legalizes recreational use of marijuana? Questions on the minds of lawmakers include: Should the growing cannabis-related tourism industry be regulated more? How should drugged driving be defined and penalized? How should taxes be structured?

Other drugs under the policy spotlight are prescription pain killers and heroin. At least 22 state legislatures and D.C., mostly in the last two years, have enacted "Good Samaritan" laws to encourage people to call 911 by granting limited criminal immunity to both the person who overdosed and the one who seeks help. More states will be looking at these laws this year. Similar bills have been introduced in Congress.



3. STUDENT ASSESSMENTS

As a handful of states continue to debate the merits of and motivation behind the common academic standards, inescapable are the federal and state laws requiring schools to assess students' mastery of the English and math standards. What's more, the majority of states promised the federal government they would administer newly created "next generation" assessments during the 2014-15 school year in exchange for flexibility with other federal education requirements.

Since 2010, two federally funded, state-led consortia—Partnership for Assessment of Readiness for College and Careers (PARCC) and Smarter Balanced—have developed and field-tested assessments intended to measure not just students' knowledge, but also their ability to communicate, reason, analyze and synthesize data, make complex inferences, and develop strategies to solve complex problems. Twenty-seven states and D.C. will administer either the PARCC or Smarter Balanced assessment during this school year and another 20 states will use assessments developed themselves or by private vendors. Three states remain undecided.

Anderson, Pamela K.

From: John Schmidt <john.schmidt.3@ndsu.edu>
Sent: Thursday, January 22, 2015 11:35 AM
Anderson, Pamela K.
Subject: HB 1430

Good afternoon Representative Anderson,

I am emailing you because I am very thankful for your efforts on introducing the bill HB 1430. My father also suffers from neuropathy in his foot. He is in constant pain 24/7. He too believes that cannabis does relieve his pain and it has worked for him and been a great success. He is relieved of his pain after "self medicating". The doctors have given him other pharmaceutical medications that have made him suffer more but other effects of the medications. He recently decided he was going to just deal with the pain but if HB 1430 passes it would be such a relief for him and my entire family. Also, wanted to mention that I am a friend of your daughter Murphy and she is great! Thanks so much for starting the process!

Sincerely,

John Schmidt

25

Anderson, Pamela K.

From: May <mjpomeroy@cableone.net>
Sent: Friday, January 23, 2015 10:31 AM
To: Anderson, Pamela K.; Hawken, Kathy K.
Subject: House Bill 1430

Dear Legislators,
Thank you for your courage in sponsoring House Bill 1430 which would allow for the use of medical marijuana in ND. I see no merit in tolerating extreme pain and other medical issues which diminish the quality of life when there is an alternative treatment.
Sincerely,
May Pomeroy
Dist. 16

. 26

Anderson, Pamela K.

From: rskrueger@wtc-mail.net
Sent: Thursday, January 22, 2015 1:13 PM
Anderson, Pamela K.
Subject: House Bill 1430 -Medical Marijuana

Dear Representative Anderson,

I felt compelled to lend my voice and story to this very important issue. Being a chronic pain sufferer I deal every day with the ineffective ways our health system manages patients like myself. I have a long medical history that began when I was very young, however in 1996, I was diagnosed with Hepatitis C from a blood transfusion. I underwent many different courses of treatment and moved from the east coast to the Fargo area in 1998. Through Mayo Clinic I began my last course of treatment. The injections I undertook was an extremely harsh form of chemo that is no longer used. They didn't know if I was going to live past Christmas of 2001 but miraculously I not only survived I went into remission.

The treatment for my Hepatitis C may have worked but unfortunately it came at a great cost. My immune system took a hit and put my body into what they now call a "lupus state". I also have severe osteoarthritis that rapidly advanced and causes constant paint throughout my spine. I have exhausted every type of procedure at Sanford Pain Clinic from trigger point injections, epidural steroid injections, medial branch blocks, radio ablations and finally the implantation of a morphine pain pump. I have had cervical fusion surgery and last year required lumbar fusion as my vertebrae were unstable and I could not walk without the assistance of a cane. After the surgery, my pain was uncontrollable due to the pain pump level of morphine and we realized due to resistance and other physical complications I must find another method of pain control. Over the next several months I worked with my doctors to decrease the levels in the pump and in December the pump was removed. Now my body is in constant pain. I'm on an oral narcotic medication. It does little to control the pain but may do harm in the long run as the longer I take narcotics, they can reduce the length of my life. I have multiple drug allergies and other health issues along with being monitored every 6 months by my eye doctor for developing glaucoma due to the condition of my optic nerves and pressures. Daily living is difficult and can be described in a word; moderation. The little things most people take for granted as rote are an effort and amplifies the pain. You have to modify every aspect of your life because the pain will wear you out and wear you down. How would you feel to not be able to lift your grandchild. It has affected my relationship with my husband. He has been wonderful and supportive but our life plans are uncertain. I am 54 years old, I don't know what my life will be like 5 years from now. Medical marijuana may be my last hope for relief and a chance at living life.

I know there are many supporters of this bill and for good reason, but it didn't sound like there was much hope for it to pass this session. I want to express and weigh on those voting that we live every second of every day with pain or other ailments and time is not forgiving of that fact. Two years to wait, is a lifetime, two hours or even two minutes when your consumed by pain or watching your child have another seizure is a lifetime. North Dakota needs to at least start by following Minnesota and allow the pill form and something to help children with seizures. Too many of us have no where else to turn and can't afford to wait.

Thank you for your time and effort regarding this crucial issue. If I can help further, please let me know.

Sharon Krueger
6058 170th Ave SE
Galcott, ND 58077
701-640-1257

8 27

Anderson, Pamela K.

From: Leanne Grondahl <leanne.grondahl@minot.k12.nd.us>
Sent: Thursday, January 22, 2015 6:12 PM
To: Maragos, Andrew G.; Nelson, Marvin E.; Strinden, Marie J.; Schneider, Mac J.; Hawken, Kathy K.
Cc: Anderson, Pamela K.; Glassheim, Eliot A.
Subject: FW: House Bill 1430

Thank you for introducing the bill to make medical marijuana legal in ND. PLEASE try very hard to pass this.

My husband (54 at the time) had a stroke in May of 2011, the same month we had to move out of our house for the devastating flood. He did not lose
any of his mobility but due to severe and permanent nerve damage he has constant pain, 24/7. He has the same neuropathy that Rile Morgan described on the entire right side of his body. He is still trying to work full time but it is getting harder all the time. He is on so many painkillers but he tries to take the lowest dose possible. I have tears in my eyes just typing this as I think of what he has to endure every day of his life.

He was referred to the Mayo clinic in August of 2013 to see if he was eligible for a new exploratory surgery that they are trying on some Parkinson patients but the surgery is too new and they don't think it will work on his type of nerve damage from the stroke. They recommended that he move to a state with Medical marijuana because that is the best thing to help his type of pain. (He even has this in writing! From a prestigious Dr. with many awards and diplomas in her office) He has tried it and he said it really does help. He said the painkillers never take all the pain away but the marijuana did. And the painkillers have too many side effects. The only time he is not in pain is when he is sleeping.

We can't just pick up and move to a different state. I am a few years from retirement and we now have new loans to
for our 2011 flood damage.
This would be a life changer for my husband, for the good for a change, if this bill passes. He can't wait two more years until the next session.

Leanne Grondahl
Leanne.grondahl@gmail.com
517 12th St SW
Minot, ND 58701

Shane Grondahl
Shane.grondahl@iflafleur.com

Anderson, Pamela K.

From: Gretchen Dobervich <gdobrs@gmail.com>
Sent: Monday, January 26, 2015 8:29 PM
To: Anderson, Pamela K.
Subject: HB 1430 Thank You

Dear Representative Anderson,

I cannot thank you enough for introducing HB 1430, legalization of medical marijuana. I have lived for 32 years with Rheumatoid Arthritis, a debilitating autoimmune disease. As a result I have progressive joint disfigurement, Chronic Pancreatitis, liver damage and side effects of long term steroid use. I live with extreme fatigue and in excruciating pain. Medial marijuana offers additional treatment options.

I work full time and am unable to take the narcotic pain medication, Vicodin, that best treats the pain I experience before or after work. The same would apply to medical marijuana, but, it would offer a non narcotic option for easing pain as I rest each night in recuperation to work and live the next day.

Thank you again for introducing HB 1430.

Sincerely,
Gretchen Dobervich
District 11 Fargo

Anderson, Pamela K.

From: The Derek <keredeht@gmail.com>
Sent: Friday, January 23, 2015 1:55 PM
Anderson, Pamela K.
Subject: HOUSE BILL NO. 1430

Bravo on introducing this bill. Is there much support for this among your fellow legislators? Any chance it will actually pass?

I have been following legalization in the US for a while and find it very encouraging that peoples attitudes are changing so rapidly. Unfortunately there may not be as much support for this by legislators, as there would be in the general population.

Good luck with this!

Derek

30

Anderson, Pamela K.

From: Leanne Grondahl <leanne.grondahl@minot.k12.nd.us>
Sent: Thursday, January 22, 2015 6:12 PM
Maragos, Andrew G.; Nelson, Marvin E.; Strinden, Marie J.; Schneider, Mac J.; Hawken, Kathy K.
Cc: Anderson, Pamela K.; Glassheim, Eliot A.
Subject: FW: House Bill 1430

Thank you for introducing the bill to make medical marijuana legal in ND. PLEASE try very hard to pass this.

My husband (54 at the time) had a stroke in May of 2011, the same month we had to move out of our house for the devastating flood. He did not lose
any of his mobility but due to severe and permanent nerve damage he has constant pain, 24/7. He has the same neuropathy that Rile Morgan described on the entire right side of his body. He is still trying to work full time but it is getting harder all the time. He is on so many painkillers but he tries to take the lowest dose possible. I have tears in my eyes just typing this as I think of what he has to endure every day of his life.

He was referred to the Mayo clinic in August of 2013 to see if he was eligible for a new exploratory surgery that they are trying on some Parkinson patients but the surgery is too new and they don't think it will work on his type of nerve damage from the stroke. They recommended that he move to a state with Medical marijuana because that is the best thing to help his type of pain. (He even has this in writing! From a prestigious Dr. with many awards and diplomas in her office) He has tried it and he said it really does help. He said the painkillers never take all the pain away but the marijuana did. And the painkillers have too many side effects. The only time he is not in pain is when he is sleeping.

We can't just pick up and move to a different state. I am a few years from retirement and we now have new loans to pay for our 2011 flood damage.
This would be a life changer for my husband, for the good for a change, if this bill passes. He can't wait two more years until the next session.

Leanne Grondahl
Leanne.grondahl@gmail.com
517 12th St SW
Minot, ND 58701

Shane Grondahl
Shane.grondahl@iflafleur.com

31

Anderson, Pamela K.

From: Mark Strand <mark.strand@ndsu.edu>
Sent: Friday, January 23, 2015 10:23 AM
To: Anderson, Pamela K.
Subject: RE: Concerned citizen

Thank you for the reply.
It is clear that we disagree on this issue.
Good luck in the legislative session. You are doing very important and great work.

Mark A. Strand, PhD
Associate Professor
Pharmacy Practice
MPH Program
NORTH DAKOTA STATE UNIVERSITY

Sudro Hall 118L
Fargo, ND 58108-6050
Phone: 701-231-7497
Email: Mark.Strand@ndsu.edu
www.ndsu.edu

NDSU NORTH DAKOTA STATE UNIVERSITY

From: Anderson, Pamela K. [mailto:pkanderson@nd.gov]
Sent: Thursday, January 22, 2015 2:41 PM
To: Mark Strand
Subject: RE: Concerned citizen

Thank you Dr. Strand for your email and comments. My bill would only allow medical marijuana in North Dakota prescribed by health care professionals. This bill does not legalize marijuana for recreational use. I do not want high school kids using marijuana either.

Other bills I have sponsored include no-interest student loans, early childhood education and Head Start. I will support legislation for permanent flood protection for Fargo and property tax relief when those bills come before the House. Thanks again. Pamela

---

From: Mark Strand [mailto:mark.strand@ndsu.edu]
Sent: Thursday, January 22, 2015 8:38 AM
To: Anderson, Pamela K.
Subject: Concerned citizen

Representative Anderson:
I live in your district and I voted for you last fall. I am sorry that your first public action is a bill to allow marijuana use in North Dakota.
As a state and a city, we have so many needs in the areas of healthcare for the underserved, preschool and afterschool education programs, racial harmony in our rapidly changing city, and the list goes on. Are you serious that your best contribution is to jump on advocate for legalization of marijuana?

First, the active ingredients of marijuana are available in pill form, so they can be properly prescribed and regulated.
Second, smoking or vaping marijuana is harmful irrespective of the effects of THC.
Third, marijuana is now common among high school kids. Do we really want to normalize it's use, so that it becomes as common among high school kids as alcohol?

Please seriously consider whether you shouldn't pursue more noble and broadly health-enhancing legislation.

Regards,

Mark A. Strand, PhD
Associate Professor
Pharmacy Practice
MPH Program
NORTH DAKOTA STATE UNIVERSITY

Sudro Hall 118L
Fargo, ND 58108-6050
Phone: 701-231-7497
Email: Mark.Strand@ndsu.edu
www.ndsu.edu

NDSU NORTH DAKOTA STATE UNIVERSITY

Anderson, Pamela K.

From: eric dailey <farmer_lion@yahoo.com>
Sent: Tuesday, January 27, 2015 8:21 PM
: Anderson, Pamela K.
Subject: ND. Marijuana Reform.

Pamela, I want to encourage you to be strong in this fight for North Dakotans. My wife and I have both suffered serious injuries and live with chronic pain. My concern is not for recreational use. I do not have any long term concerns about recreational use. The benefits of this medicine long term are much safer than traditional pharmicuticles. I work in the oilfields of ND. and my wife is in the medical industry as a physical therapy assistant. We do not use marijuana at this time as we both do regular and random UA testing. It is my opinion I have less than two years of physical functioin in a working enviroment. We don't want to buy this medicine when we have the time to grow it ourselves. Then I would know for a fact of it's quality and that it is organically grown. Outside of special circumstances let traditional medicine serve patients until the age of 25. At that time Americans should be able to determine what has worked and what does not.I know of 3 other people like Lisa and I within our family circle. They all would support this for North Dakotans too. You are not alone in this struggle of rights.

Thank you for your efforts and time to read this e mail.
God Bless, Eric B Dailey

If you wish to contact us by phone for any reason please call (701) 664-8449

#4

2-4-15

Beth Larson-Steckler22

Support of House Bill 1430

My name is Beth Larson-Steckler and I am here in support of House Bill 1430. I am here on the behalf of my beautiful 16 year old daughter, Ellyse and my amazing 13 year old son Josh. Both my children have diminished quality of life due to chronic and debilitating pain caused by a genetic condition as well as interventions for this condition which have failed and sadly caused more issues.

My husband, my daughter Elly and my son Josh all have hereditary pancreatitis. Hereditary pancreatitis is a very rare condition. It is one of the most painful diseases a person can have. Besides pain, hereditary pancreatitis can cause nausea, weight loss and malnutrition and is linked to pancreas cancer and diabetes. There is no cure only treatment.

My husband's pancreatitis reared its head two years into our marriage. He became extremely ill. His pain was uncontrollable, he was nauseated, and his eyes turned yellow as well as his skin. At that time we were not sure what we were dealing with. Fortunately we got a diagnoses and the intervention which was provided at this time, placement of a stent, relieved the symptoms. Only a few months later our beautiful daughter, Ellyse was diagnosed with hereditary pancreatitis. We did our best to manage the symptoms. Her illness only progressed. During this period we had our son Josh. We were told by the top specialist that the likelihood of another child having this genetic condition would be extremely rare. They were wrong.

While my husband and our little boy remained stable except for a few flares, my daughter became increasingly sicker. We sought out top experts who treated her. Finally, the indicated that the only intervention left was to remove half of her pancreas and transplant the islet cells into her liver. It was not a common surgery but they indicated it was the only answer for our daughter – she was 9 years old. As parents we were devastated. She was living in the hospital and constantly in pain but we were terrified of the surgery. We finally consented not wanting our daughter to live in pain. We wanted our daughter to have a life, to have hope – all of which she did not have. It was about this time when she came to me and told me that she was never going to be a mommy because she didn't want her babies to have what she did. What child thinks that way? We needed to do whatever we could to give her the chance of a pain free life. The surgery initially worked. She was pain free for the first time, she participated in activities and went to school – she was happy. She was smiling. This lasted for a year.

I thought this disease could not rip anymore away from my family than it already had but I was wrong. On the 4th of July my daughter became violently sick. Sicker than I had ever seen her before. The pain was so difficult to control. We were sent to experts who recommended taking the entire pancreas, spleen, appendix gallbladder and a few other organs. The remaining islets would be placed into her liver. Also at the same time my husband started becoming ill. He was diagnosed with pancreas cancer. On the day my husband finished his chemo, our baby girl was wheeled in for her surgery. I was in the

Cities with our baby girl while my husband was fighting for his life in Bismarck. And my baby boy was staying with family.

My daughter's surgery was not a success. She had to have another surgery a year later to deal with complications. She has not been pain free since and she does not have any quality of life at this point. My beautiful girl should be going to school, going out with friends. She should be dealing with the dramas of high school not the realities of a life a pain. My daughter had plans for her life. She wanted to go to school to be a pediatrician, a GI doctor or anesthesiologist. I have seen her distance herself from this. She talks less about her dreams for her future and instead questions if she has a future or what it will look. Our life is dictated by her pain. Diagnoses have been thrown out left and right; bile reflux, scar tissue, ulcers, re-occurring c –dif, chronic pain syndrome. My little girl is 16 years old and there seems to be no hope. We have gone to the best and brightest and they do not know how to proceed. Many of the kids who have had auto islet total pancreactomies are left like my daughter – some do have good outcomes – but those who have complications are left to struggle.

During this period my husband passed after a three year battle with this disease. A year before my husband passed my son started to become sicker. His symptoms were unlike my husbands or daughters so for a year I searched out a different diagnosed. I prayed for a different diagnosed and they all told me the same thing – pancreatitis. They also told me that he needed surgery. You may ask why we consented as my daughter's surgery did not go well. They had improved upon the surgery and two; without the surgery my son and daughter had approximately a 75% of pancreas cancer. My son was on continuous feeds as he was malnurioused and his pain was becoming uncontrollable. He could not attend school or participate in any activities. I could not bear to see my babies die of this. A month after my son's surgery he was diagnosed with re – occurring c diff. He also lives in chronic pain and his life is diminished. My children do not have a life. They deserve a life.

While many are familiar with the positive effects of medical marijuana on seizures and tumor growth, research has also demonstrated positive results on GI issues. The use of oil/vapors can prove helpful on inflammation of the GI system thus decreasing the pain. My daughter has horrendous motility issues which are made worse by the pain medications she needs to take. It is a vicious cycle. Oil/vapors would not have this side effect. They can assist with nausea and other issues. My children deserve a change. I cannot definitively say that this will help them; however, I have researched this. I have talked to others who suffer with pancreatitis and those who have had auto islets total pancreatectomyies and they have related that with the use of oil that pain levels have gone from an 8/9 on a pain scale to a 3 or 4. If my children's pain could be managed they could get back some of their life – They deserve this. I can't convey how horrid it is to see your child and pain and you can do absolutely nothing about it.

#5

February 4, 2015

Testimony in favor of HB1430

Chairmain Representative Weisz and Members of the House Human Service Committee, My name is Ashley Riggs and I am a parent of two children with MPS IIIA or Sanfilippo Syndrome. My testimony today is in favor of HB1430 relating to medical marijuana.

I am a stay at home mother to 3 beautiful little boys from Minot, ND.

Our two oldest sons, Landon, age 8, and Blake, age 5, were diagnosed in April of 2010 with a terminal and progressive genetic condition called MPS IIIA or sanfilippo syndrome.

Children diagnosed with sanfilippo syndrome are missing an enzyme necessary to break down complex sugar chains. Because they are unable to remove this waste material in their cells, it accumulates in all the cells of their bodies, causing irreversible damage to their brains and vital organs. Currently, there are no treatments and no cure for sanfilippo syndrome. When our sons were diagnosed at ages 4 yrs and 6 mo. old, we were told their life expectancy would be about 10-15 years.

The damage done to the brain and central nervous system of children with sanfilippo syndrome causes a wide array of neurological issues. Seizures and movement disorders are very common in children who are affected. Sanfilippo syndrome is often likened to Ahlzeimers disease, because children often suffer from dementia, high anxiety, and can lack the ability to regulate their emotions properly. The brain damage done by the disease also causes erratic behavior and insomnia. It is emotionally and physically debilitating for both child and caregiver.

Both Landon and Blake have severe hearing loss as a result of damage done by this disease. Neither boy has ever had the ability to speak. They never have and never will be toilet trained. They are completely dependent on us to meet 100% of their needs. Because this condition is progressive, they will also lose their ability to walk and feed themselves, and will ultimately lose their lives to this devastating disorder.

At the time of diagnosis, Landon was already showing signs of progression related to the disease. Many nights, and for months at a time, Landon would sleep 5 or less hours a night, and often woke up multiple times within those 5 hours. Because of the damage caused by sanfilippo, he had the mind of a 12 month old child but the strength of typical child his age and no fear or understanding of danger. He could not be left alone for a moment. Medications for behavior modification and anxiety unfortunately do not work for children with sanfilippo syndrome.

For years, we have lived on broken sleep, watching our children grow physically but regress in every other way. This past year has been especially painful for our family. Landon has begun having seizures, which is a very common part of sanfilippo syndrome. Landon suffers from what are believed to be gelastic seizures; a rare form of seizures that are marked by an outburst of emotion typically either being uncontrollable laughing, crying, or both. We currently have Landon on a seizure medication called

lamictal, but because these seizures don't always respond to traditional anti seizure medications, we have been unable to eliminate the episodes. In addition to the development of seizures, Landon has also begun experiencing uncontrollable muscle movements and spasms which are most likely caused by dystonia, a movement disorder caused by progressed brain damage and also common in children with sanfilippo. We are currently waiting on approval to see a movement specialist in another state for this condition.

I can't tell you how absolutely heartbreaking it is, and how helpless we feel as parents watching our child suffer. To see him laughing to the point of tears, knowing he wants desperately to stop but not having the ability to, is something I would wish on no one. When he lays down to sleep at night, he is unable to stay still long enough to fall asleep, and when he finally does fall asleep, the involuntary movements startle him awake. I have seen him exhausted and still be unable to settle himself or get comfortable because the spasms just won't stop. Currently available prescription medication is hit and miss with our children because of the way their bodies metabolize things. What may work for a period of time can suddenly become ineffective, and the side effects of prescription medication often do as much harm to our already fragile children as they do good. These movements and seizure episodes leave him drained and tired throughout the day, making it difficult to enjoy his everyday life at times. He often falls asleep in the daytime while he should be enjoying things like school, his friends, and activities that children his age enjoy.

Our younger son, Blake, fortunately has not been affected by seizure and movement issues at this time although we know that these will most likely be issues in his future because of the progressive nature of the brain damage sanfilippo syndrome causes. Unfortunately, Blake suffers from something else that is seen often in children with sanfilippo syndrome; anxiety.

Blake has a very difficult time in unfamiliar places, being around unfamiliar people for long periods of time, or any places he perceives to be too crowded or restrictive. Simply being away from the house can be difficult and stressful for Blake and it is so sad to see him upset in environments that most children find joy in. Blake will be starting school in the fall, and we are seriously concerned with his ability to cope and thrive in an unfamiliar environment. As I mentioned before, anxiety medications have proven ineffective in doses that leave a child able to function properly. We have tried weighted objects, such as blankets and vests, commonly used for children with autism for calming and relieving of anxiety to no effect. Our son is left in the difficult position of being afraid and anxious outside his own home. Last February, we took Blake to Disney World for his Make-A-Wish trip. He cried through almost everything: rides, character meet and greets, and shows, because of the anxiety he suffers from. Something that should have been the highlight of his life, a time full of happiness and excitement, was instead scary and stressful. No child should have to live life in a constant state of fear and anxiousness.

We have researched options for symptom alleviation for the issues that ail our sons. In states where medical cannabis has been legalized for use, children suffering from the effects of seizures, movement disorders, and anxiety caused by sanfilippo syndrome have seen dramatic reduction of these symptoms.

Within in minutes of administering medical cannabis, these children are feeling relief and parents have said they notice amazing improvement in their child's over all well being and comfort. This medical treatment should be available to any child who could benefit and have a better life.

Our children deserve to live their lives as comfortably and happily as possible. They have already been handed what is in essence, a death sentence. To know there is an alternative medicinal option out there that we are barred access from, seems unacceptable to me as a parent who is watching their children suffer from a variety of ailments that have not been relieved by medications that are currently available. Our children deserve the right to seek a treatment that is effective and gives them a better quality of life.

This bill and this issue is not about being conservative or liberal; it's about giving people from all walks of life the power and the choice to access viable treatment options that could potentially improve their quality of life without fear of prosecution and condemnation. Safe and legal access to medical cannabis should be a right afforded to anyone who suffers without relief from currently available treatments.

On behalf of Landon and Blake, and the many people of North Dakota who suffer from a variety of conditions that could be helped by medical cannabis, I ask that you would look past the preconceived notions of stereotyped marijuana use and see the people of this state who's lives could be dramatically different, and inexplicably better, with access to medical cannabis.

Thank you for your time.

I am more than happy to answer any questions you may have.

Ashley Riggs

701 Dogwood Dr.

Minot, ND 58701

2-4-15
HB 1430

#6

Hello – My name is Rilie Raymond Morgan III. I want to thank a few people today before we get started with my testimony. First I want to thank my brother, John, who traveled from Grafton to read my story today. Next I want to thank my legislator, Pamela Anderson, who introduced the medical marijuana bill to the North Dakota legislature this session. And finally, I would like to thank the committee for listening to all of the citizens of the state concerning this pending legislation.

While the medical marijuana issue is relatively new to our state, our sister states of Minnesota and Montana along with another 21 states and the District of Columbia have allowed physicians to prescribe medical marijuana to their patients.

Let me tell you about my journey with pain. About three years ago, I had for whatever reason developed severe back pain. I don't know how or where I injured my back but I had a severely herniated disc.

When consulting with my doctors, their answer was to do a spinal fusion, which is one of the answers to my disc problems. The other answer was to go overseas to do a disc replacement surgery, which is the course of action we decided upon.

The disc replacement surgery was a success but I did end up with a staph infection, that I ultimately beat. At some point during the disc replacement surgery, the doctor damaged the nerve at the L5 vertebra of my back. That nerve controls the electrical impulses down the leg to the thigh, calf, ankle and foot.

I was left with a condition called Drop Foot. My lower leg and foot were for all practical purposes paralyzed. My doctors told me that in four to six months the nerves in my back would regenerate and I would get back use of my leg. Well after that period of time the nerves did grow back slightly but I am left with only about 30% use of my right leg, from the knee down, and my right foot.

I was also left with neuropathy in that area as well.

For those of you who are unfamiliar with neuropathy, imagine your right foot is constantly "waking up." It tingles and zings all day long with occasional shooting pain. It will never get better. It will never go away.

The spine surgeon who did my THIRD procedure to fix previous mistakes, said "If the feeling of the nerves in your foot doesn't come back in six months to two years...They never will." So after 26 months and three surgeries...my nerves are damaged beyond regeneration.

When I'm at work or active at home and my mind is busy, the pain lessens. I can get six to seven hours of somewhat restful sleep. But the minute I wake up, the pain is back to haunt me.

I am taking a nerve pain reliever for my neuropathy but it is rather ineffective.

My doctor has assured me that the painkiller I am using is well tolerated by the human body but in researching the painkiller on the Internet; I have found there is some evidence that long-term use of this particular drug can cause liver damage or liver cancer.

Many prescription drugs on the market today have disclaimers a mile long. It makes you think that you have to be in perfect health to take them.

While we don't know what the long-term effects of medical marijuana are, we do know that marijuana in not made up of artificial chemical compounds, of which we can't even pronounce their names. With medical marijuana, you have two active compounds. THC gives the user a "high" and CBD which has the pain-relieving and anti-inflammatory properties. It is also good for seizures as demonstrated in the recent CNN documentary hosted by Dr. Sanjay Gupta.

I recently attended my son's wedding in Grafton and ran into an old friend who told me he was suffering with neuropathy in his feet and hands. He asked me about medical marijuana and if it could help him with his pain. I told Bill that I didn't know if it would help or not but it might be worth a try. His biggest

concern was that he quit smoking thirty years ago and didn't want to start smoking again. I assured him that marijuana comes in many forms and he need not worry about starting smoking again.

I would like the members of the committee to reflect upon family members, friends or colleagues who may have long-term pain issues.

I would guess that you could have an uncle who might have arthritis, a niece who may suffer from seizures, a friend who is fighting cancer or undergoing chemotherapy or an employee who has Crohns disease. Think about the hundreds and possibly thousands of North Dakotans who wake up every day with no hope of feeling any better.

I am asking you to let doctors and patients have the option of using medical marijuana in their mutually agreed upon course of treatment for their illness or condition.

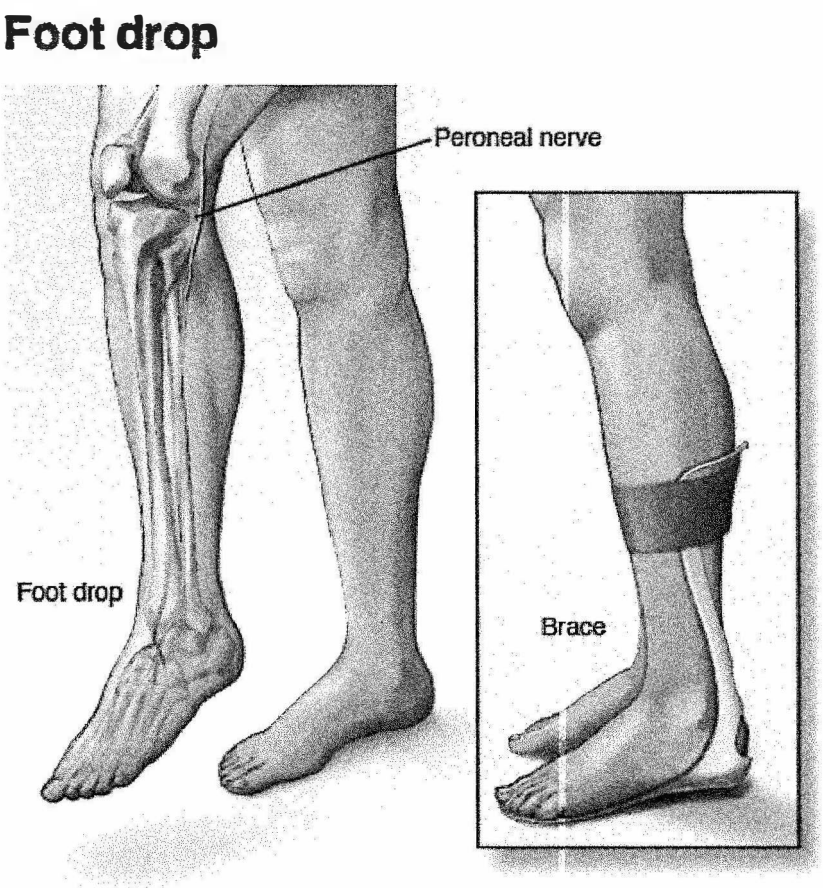
Thank you again for your kind consideration and I wish you and your loved ones good health and happiness.

Rilie Raymond Morgan III

Submitted 04 February 2105

Mayo Clinic describes drop foot as:

The most common type of foot drop is caused by injury to the peroneal nerve, which controls the muscles that lift your foot. Foot drop can be temporary or permanent. A brace can help hold your foot in a more normal position.



Peripheral neuropathy

http://www.mayoclinic.org/diseases-conditions/peripheral-neuropathy/basics/definition/con-20019948

Fargo lawmaker submits bill to regulate marijuana from farm to pharmacy to patient

Reprinted from Fargo Forum
01.21.2015

Ray Morgan, a 64-year-old Fargoan has neuropathy, a neurological condition that for the last two years has left him with a constant tingling sensation, sometimes punctuated by shooting pains.
Photo Dave Wallis / The Forum

Fargo- If you ask Rilie Morgan, it's time for North Dakota to make medical marijuana legal.

The affable silver-haired financial planner, who goes by middle name, Ray, has neuropathy.

The neurological affliction has for the past two years given the 64-year-old Fargo man constant tingling in his feet and calves, sometimes punctuated by sharp shooting pains.

"It's like when your hand or foot falls asleep and you get a tingling sensation. It's constant. It's 24/7," Morgan said.

"If your mind is busy, then it's not too bad. But once in a while there is some pain, a shooting pain that's like, 'Wow! Where did that come from?'" he said. "You always know it's there."

Morgan, a partner in a Fargo financial firm, said a painkiller he uses can cause liver damage. He used morphine for several months after a back surgery. That's a route he doesn't want to take again.

He said medical cannabis may make the pain "a little more tolerable. I'd like to explore the possibility anyway."

State Rep. Pamela Anderson, a Fargo Democrat, has taken up Morgan's cause, and introduced House Bill 1430 on Monday.

The bill would allow patients and caregivers to possess up to 2 ½ ounces of cannabis – or products such as cannabis oils, beverages, vapors, extracts, ointments or pills – for medical use.

It also has a provision that allows people who have obtained a prescription for medical marijuana to cultivate up to six marijuana plants.

The bill lists a number of ills eligible for treatment: cancer, glaucoma, HIV, hepatitis C, amyotrophic lateral sclerosis (Lou Gehrig's disease), Chrohn's disease, ulcerative colitis, agitation due to Alzheimer's disease and post-traumatic stress disorder.

Conditions that lead to wasting, severe debilitating pain or nausea, seizures, or severe and persistent muscle spasms, including those characteristic of multiple sclerosis are also listed, with an option for more to be added.

HB 1430 was crafted from information on what other states have done to regulate medical marijuana that was provided by the Council for State Governments, Anderson said.

She said she's heard from people suffering from glaucoma, multiple sclerosis or seizures who would support legalizing medical cannabis in North Dakota.

To date, 23 states and the District of Columbia allow the use of medical cannabis, including neighboring Minnesota and Montana.

Rep. Kathy Hawken, R-Fargo, a co-sponsor of the bill, has her own connection to the issue – a son who suffers from seizures.

"More than one neurologist has said that if he could, he would prescribe medical marijuana," Hawken said. "They think it does work."

She said the bill contains controls on medical marijuana products from farm to pharmacy.

But she's unsure of its fate – at least this year.

"I think it is something that will eventually pass. This session? Well, stranger things have happened," Hawken said. "Realistically, at least the discussion will start."

The 29-page bill provides for:

-Exemptions from prosecution for the possession, manufacture or sale of medical marijuana for those licensed, and for people certified as in need of medical marijuana by a physician.

-Creating a system to license manufacturing and distribution of medical marijuana products.

-Criminal penalties for violating provisions of the medical marijuana law.

-Protections from discrimination in schooling and housing for medical cannabis users, unless allowing the use would violate federal law or regulations.

Rep. Eliot Glassheim, D-Grand Forks, another bill sponsor, said he used to smoke a joint now and then 30 years ago.

"It seems to me the whole hysteria was misplaced," Glassheim said.

Now, he's being treated for cancer.

"It's not in remission, but it's not spreading. I feel OK," he said. He understands that others dealing with the side effects of cancer treatments could benefit from having medical marijuana available as an option.

"I certainly could imagine a situation where you're nauseous or where you're in unbearable pain," Glassheim said.

Supporting the bill, "just seemed to me to be a rational thing to do," he said.

Glassheim expects some resistance.

"It may have to wait until next session. I expect it will pass one of these days," he said. "It's one of these bills people have to get their minds around."

Morgan, meanwhile, is planning a trip to Arizona to test-drive the idea of becoming a snowbird as he nears retirement. Arizona also allows medical cannabis to treat a number of ailments, he said.

But he will hop on a plane to Bismarck to testify for HB 1430, he said.

"I think medical marijuana has been understudied for its efficacy," Morgan said. "I think it's time to explore the options and let pharmaceutical companies see what they can come up with. It's time."

Other sponsors of HB 1430 are Andrew Maragos, R-Minot; Marvin Nelson, D-Rolla; Mary Schneider, D-Fargo; and Marie Strinden, D-Grand Forks.

2-4-15 Handed out by Wayne Stenehjem #7

SUMMARY OF HOUSE BILL 1430, MEDICAL CANNABIS

House Bill 1430 relating to medical marijuana creates a new chapter under Title 19 of the North Dakota Century Code, Chapter 19-24. Chapter 19-24 as set forth in House Bill 1430 has twenty-one sections. Medical marijuana, or medical cannabis, would be regulated by the North Dakota Health Department. Chapter 19-24 purports to only allow edible medical cannabis products that may only be consumed by oral ingestion and not by inhalation.

1. **Section 19-24-01**
   Section 19-24-01 is a definition section and includes twenty-three definitions.

   The term "cardholder: is used throughout Chapter 18-24. It means a qualifying patient or designated caregiver who has been issued and possesses a valid registry identification card, which is an identification card issued by the Health Department to registered qualifying patients or registered designated caregivers.

   A "qualifying patient" means an individual who has been diagnosed by a practitioner as having a debilitating medical condition, which includes cancer, glaucoma, positive HIV, Hep C, ALS, Crohn's Disease, ulcerative colitis, agitation of Alzheimer's disease, p.t.s.d,, chronic or debilitating diseases or medical conditions, or any other medical condition or treatment added by the department by rule.

   A "practitioner" to mean an individual who is licensed with authority to prescribe drugs and

   The definition section defines what is the allowable amount of cannabis: (1) two and one-half ounces of cannabis; (2) the quantity of cannabis established by Department of Health Regulations; (3) if cultivation is allowed, six cannabis plants; and (4), if cultivation is allowed, the amount of cannabis and cannabis products which were produced from the cardholder's allowable plants.

   The definitions usually refer to cannabis and cannabis products, and not medical marijuana, but define "medical cannabis" or cannabis" to have the same meaning given to the term "marijuana" in section 19-03.1-01(17), which means all parts of the cannabis plant whether growing or not; its seeds; the resinous product of the combustion of the plant cannabis; and every compound, manufacture, salt, derivative, mixture, or preparation of the cannabis plant or its seeds.

2. **Section 19-24-02**

Section 19-04-02 provides immunity from arrest, prosecution, and criminal penalty to cardholders, i.e., qualifying patients or designated caregivers who have a valid registry identification card, which is a document issued by the Health Department that identifies an individual as a registered qualifying patient or registered designated care giver. It provides the same immunity, and also immunity against adverse professional license action, for practitioners, lawyers, dispensaries or dispensing agents, cannabis cultivating and manufacturing facilities, and testing facilities, and it also provides that cannabis, cannabis products, cannabis paraphernalia, or "acts incidental to that use" may not be seized or forfeited.

Subsection 3 of § 19-24-02 creates a rebuttable presumption a qualifying patient or designated caregiver is engaged in the medical use of cannabis if they are in possession of a registry identification card and the amount of cannabis allowed in chapter 19-24.

Subsection 13 of § 19-24-02 states that possession of, or application, for a registry identification card does not provide probable cause or reasonable suspicion to conduct a search of the individual or the individual's property.

Subsection 15 prohibits state and local law enforcement officers and agencies from conducting investigations for purposes of enforcement of the federal Controlled Substances Act. {NOTE: This is very difficult because North Dakota Drug Task Forces are multi-jurisdictional and include DEA officers. Also, many operations will involve multiple controlled substances, including methamphetamine, cocaine, psilocybin, and marijuana (cannabis).

3. **Section 19-24-03**

§ 19-24-03 states that chapter 12-24 does not authorize any person to do any work under the influence of cannabis if by doing the work, it would constitute negligence or professional malpractice.

§ 19-24-03 prohibits the possession or use of cannabis in any correctional facility

§ 19-24-03 prohibits smoking cannabis on any form of public transportation or in an area open to the public

§ 19-24-03 prohibits operation of, or actual physical control of motor vehicles, aircraft, planes, trains, or motor boats while under the influence, but the presence of metabolites or components of cannabis that are not of sufficient concentration

to cause impairment is not illegal. [**Note:** there really is not a legal standard for "insufficient concentration" and the North Dakota Crime Laboratory does not have a way of measuring concentration, only presence.]

4. **Section 19-24-04**
   § 19-24-04 is an anti-discrimination section that prohibits discrimination against individuals who are cardholders

5. **Section 19-24-05**
   § 19-24-05 allows the Department of Health to add other serious medical conditions or treatments to the list of debilitating medical conditions in accordance with Health Department rules.

6. **Section 19-24-06**
   § 19-24-06 provides that a medical assistance or private insurer is not required to reimburse an individual for the costs associated with medical cannabis.
   § 19-24-06 also provides that a property owner is not required to allow individuals to smoke cannabis on the property
   Finally, § 19-24-06 states that Chapter 19-24 does not prohibit an employer from disciplining an employee for ingesting cannabis in the work place or for working while under the influence of cannabis.

7. **Section 19-24-07.**
   § 19-24-07 provides an administrative process for the issuance of registry identification cards to qualifying patients. If the Health Department denies a registry identification card, the individual would have the right of judicial review. [**Note:** This section does not provide for an administrative review under Chapter 28-32 or before an OAH Administrative Law Judge.}

8. **Section 19-24-08**
   § 19-24-08 specifies the requirements for a registry identification cards, including the name, date of issue, date of expiration, a random ten-digit identification number, and whether the cardholder may cultivate cannabis plants.

9. **Section 19-24-09**
   § 19-24-09 requires the Department of Health to establish a confidential list of registry identification cardholders, including addresses, phone numbers, and registry identification numbers, and to establish a secure telephone or web-based verification system for law enforcement and medical cannabis establishments to determine whether there is a current valid registry identification card.

10. Section 19-24-10

§ 19-24-10 requires registered qualifying patients and registered caregivers to provide notice to the Department of Health of changes in information, including change of name, address, caregiver, or health status, and a medical cannabis establishment is required to notify the Department of Health within one business day of any theft or "significant" loss of cannabis.

11. Section 19-24-11

§ 19-24-11 creates an affirmative defense to prosecutions involving cannabis.. The affirmative defense is presumptively valid if the evidence shows compliance with Chapter 19-24.

12. Section 19-24-12

§ 19-24-12 relates to the registration and regulation of medical cannabis establishments, which include cultivation facilities, cannabis testing facilities, cannabis product manufacturing facilities, or cannabis dispensing facilities.

13. Section 19-24-13

§ 19-24-13 allows local governing bodies to enact ordinances that are not in conflict with Chapter 19-24, including fees and permits.

14. Section 19-24-14

§ 19-24-14 relates to requirements for medical cannabis establishments, including requirements for criminal history background checks for officers, board members, agents, volunteers, and employees, requirements for accurate record keeping and security measures. § 19-24-14 requires medical cannabis establishments to be subject to inspection by the Health Department during regular business hours.

15. Section 19-24-15

§ 19-24-15 requires the "health council" (a likely drafting error and should be the Health Department) to adopt administrative rules no later than 120 days after the effective date of the act. § 19-24-15 also includes with a great deal of specificity what must be included in the rules. [**Note:** Unless there is a delayed effective date, the 120 day time frame may be optimistic enacting administrative rules.]

16. Section 19-24-16

§ 19-24-16 creates criminal penalties for violations of Chapter 19-24 ranging from a "civil infraction" with a fine of up to $150.00 for failure to provide required notices to the Health Department, a class B misdemeanor for making a false

statement to law enforcement officers [**Note:** this is a class A misdemeanor under Section 12.1-11-03]; a class B misdemeanor to violate the confidentiality requirements of the chapter [Note: violation of confidentiality is a class C felony under Section 12.1-13-01]; a class C felony to sell or transfer cannabis to an individual other than a card holder or a medical cannabis establishment; a class C felony for submitting false records or documentation about a medical cannabis establishment to the Department of Health, and civil fines up to $1000.00 for a practitioner who holds a financial interest in a medical cannabis establishment; and a civil fine up to $1000.00 for medical cannabis establishments that violate Chapter 19-24 and no other penalty has been specified.

17. Section 19-24-17

§ 19-24-17 provides for an administrative suspension and revocation process for medical cannabis establishments for violations of Chapter 19-24 and the rules promulgated under the chapter. The section only authorizes judicial review, and there is no administrative review or reconsideration process or hearing before OAH.

18. Section 19-24-18

§ 19-24-18 specifies that data and information submitted by qualifying patients, designated caregivers, nonresident cardholders, and medical cannabis establishments, is confidential and exempt from Section 44-04-18. Disclosure to law enforcement is authorized for criminal violations, and disclosure is authorized to the state board of medical examiners if the Department has reason to believe the practitioner violated the standard of care.

19. Section 19-24-19

§ 19-24-19 authorizes a deduction from state taxes for the ordinary and necessary expenses incurred in carrying on a trade or business as a medical cannabis establishment.

20. Section 19-24-20

§ 19-24-20 establishes a nine-member oversight committee, including legislative representatives, a representative of the Health Department, a nurse, a board member or principal officer of a cannabis testing facility, an individual with experience in policy or development in the field of medical cannabis, and three qualifying patients. The board is required to meet at least two times per year.

21. Section 19-24-21

§ 19-24-21 requires the Health Department to report to the Legislative Management Committee before June 1 of each year regarding the findings of recommendations of what is referred to as an advisory committee, and not the oversight committee in Section 19-24-20, and also report on registry cards issued, number of qualifying patients and designated caregivers, registry identification cards revoked, the number of each type of medical cannabis established registered with the Department, and the Departments expenses and revenues from the medical cannabis program.

#8

Testimony
House Bill 1430
House Human Services Committee
February 4, 2015; 9:00 a.m.
North Dakota Department of Health

Good morning chairman Weisz and members of the House Human Services Committee. My name is Terry Dwelle. I am the State Health Officer for the North Dakota Department of Health. I am here to testify in opposition to House Bill 1430.

The Food and Drug Administration (FDA) has been a critical part of the health care system since 1906. FDA is responsible for protecting and promoting public health through the regulation and supervision of food safety, tobacco products, dietary supplements, prescription and over-the-counter pharmaceutical drugs (medications), vaccines, biopharmaceuticals, blood transfusions, medical devices, electromagnetic radiation emitting devices (ERED), cosmetics, animal foods and feed and veterinary products.

The FDA's role of rigorous oversight of medications has protected the American public from several medications in the past that would have caused significant harm to our citizens. I would like to remind the committee of just two of those drugs; thalidomide and laetrile.

Thalidomide was developed and patented in 1954 by a German pharmaceutical company. The initial clinical trials found that thalidomide was a particularly effective antiemetic (anti-vomit medication) and had an inhibitory effect on pregnancy associated morning sickness. In 1957, the company launched an aggressive marketing campaign which proclaimed thalidomide a "wonder drug." There was significant public sentiment around the approval and use of this wonder drug in the United States, but the FDA refused to approve thalidomide for marketing and distribution, though they did release some for clinical testing purposes.

While initially considered safe, the drug was eventually responsible for the deaths of over 2,000 children and serious birth defects in more than 10,000 children. The birth defects were serious, with many children suffering from phocomelia (born without arms and legs) after expectant mothers used the drug primarily early in pregnancy to treat morning sickness. Unfortunately, 17 of the 10,000 children were from the United States, many of whom apparently received their thalidomide exposure from drugs obtained in Europe. This disastrous experience underlines the

importance of a rigorous drug evaluation and approval process. Even drugs that appear to be helpful at first, if not fully tested, can do much more harm than good.

Laetrile, or amygdalin, provides another example of how the FDA protects us from the consequences of taking untested drugs. Amygdalin was first discovered in 1830. It was used as a cancer treatment in Russia in the 1840s and in the United States in the 1920s, but its use was discontinued after it appeared to be poisonous.

In the 1950s, a purportedly non-toxic, synthetic amygdalin was patented for use as a meat preservative, and was later marketed as laetrile for cancer treatment. In 1972, a major cancer treatment center in the United States, Memorial Sloan Kettering Hospital, demonstrated in several clinical trials in mice covering 14 different types of cancer that laetrile showed no more effect on cancer than a placebo. In other words it did not work. The FDA prohibited the interstate shipment of laetrile in 1977. Following an FDA ban of the interstate shipment of laetrile in 1977, a public outcry regarding the availability of the drug for cancer treatment led to the legalization of the use of laetrile in 27 states. Many people made special trips to Mexico to obtain laetrile.

A 1982 trial by the Mayo Clinic of 175 patients found that tumor size increased in all but one patient, and the authors reported that "the hazards of amygdalin (laetrile) therapy were evidenced in several patients by symptoms of cyanide toxicity or by blood cyanide levels approaching the lethal range." The ultimate conclusion from studies from multiple institutions over a number of years was that "amygdalin or laetrile is a toxic drug that is not effective as a cancer treatment." Laetrile has now disappeared from medical use once again.

The history of the use of laetrile demonstrates the value of using FDA trials to evaluate and determine whether drugs work and whether they produce side effects. As with thalidomide, laetrile ended up doing more harm than good.

With regard to the use of cannabis, the FDA has approved two medications that are derivatives from cannabis; dronabinol (Marinol) and nabilone (Cesamet). Both nabilone and dronabinol are approved for treatment of nausea and vomiting mainly associated with chemotherapy, and dronabinol is approved to stimulate the appetite for those AIDS patients who have anorexia (loss of appetite). There is also an oromucosal (nasal) spray that is currently under clinical trials in the United States. So some testing on drugs derived from cannabis has been done and some drugs have been approved, but the approved uses at this time are limited.

I have attached the drug monographs for both of these drugs. The monographs summarize the detail FDA requires for determining appropriate use, efficacy and safety, to assure clinicians will be helping and not hurting patients when they prescribe these drugs. The monographs also include critical drug information for clinicians, including the following: how the drug is supplied; pharmacologic actions; indications for use; contraindications; administration and dosage; storage and stability; interactions with other substances; lab test interferences; adverse reactions; warning and precautions, including such things as what to monitor clinically when a patient is on the drug and whether the drug is safe in pregnancy or in women breast feeding; disease related concerns; concurrent drug usage issues; and key education to provide to the patient and family. This is the kind of information the FDA feels is necessary to protect patient health.

HB 1430 allows the use of cannabis products for "debilitating medical conditions" as defined on page 2, 19-24-01 (8). This provision by-passes the FDA process for determining efficacy and safety of drugs and puts a tremendous liability on the state and any of the practitioners prescribing them.

Page 12, 19-24-05, requires the department of health to consider petitions to add serious medical conditions or conditions' treatments in a manner required by department regulation and to add or deny these petitions within one hundred eighty days of submission. Since the FDA has not produced monographs for any medical use of marijuana that would be allowed by HB 1430, the Department of Health would need to generate this information in order for the practitioners defined on page 5, 19-24-01 (20), to prescribe to "qualifying patients". Generating adequate monographs for the use of medical marijuana, as envisioned by HB 1430, will require that the Department of Health perform the duties of the FDA, something that would take an astronomical level of resources and infrastructure, way beyond the current capacity of the department.

The fiscal note for HB 1430 was prepared by the Department of Health with input from the Attorney General's Office. It shows revenue and expenditures of $3,860,674 and 24.5 FTE for the 2015-17 biennium and revenue and expenditures of $3,627,494 for the 2017-19 biennium. Costs are related to the registration of designated caregivers and qualifying patients and the regulation of medical cannabis establishments. Note that these figures do not include the financial and staffing resources necessary to add conditions or a condition's treatment to the list of debilitating medical conditions as defined on page 2, 19-24-01(8).

It is far beyond the current capacity of the department to do the research and laboratory testing necessary , in place of the Food and Drug Administration, to add such conditions or treatments. We are unable to estimate the costs for these activities at this time. According to www.drugs.com (http://www.drugs.com/fda-approval-process.html), "It takes, on average, 12 years and over $350 million to get a new drug from the laboratory onto the pharmacy shelf. Only one in 1000 of the compounds that enter laboratory testing will ever make it to human testing."

I encourage you to recommend that House Bill 1430 not be passed. This concludes my testimony. I am happy to answer any questions you may have.

Dronabinol

Pronunciation

(droe NAB i nol)

Class

- Antiemetic
- Appetite Stimulant

How Supplied

Excipient information presented when available (limited, particularly for generics); consult specific product labeling.

Capsule, Oral:

Marinol: 2.5 mg, 5 mg, 10 mg [contains sesame oil]

Generic: 2.5 mg, 5 mg, 10 mg

Action

PHARMACOLOGY:

Unknown, may inhibit endorphins in the brain's emetic center, suppress prostaglandin synthesis, and/or inhibit medullary activity through an unspecified cortical action. Some pharmacologic effects appear to involve sympathimometic activity; tachyphylaxis to some effect (eg, tachycardia) may occur, but appetite-stimulating effects do not appear to wane over time. Antiemetic activity may be due to effect on cannabinoid receptors (CB1) within the central nervous system.

PHARMACOKINETICS / DYNAMICS:

Absorption:

Oral: 90% to 95%; 10% to 20% of dose gets into systemic circulation

Distribution:

V_d: 10 L/kg; dronabinol is highly lipophilic and distributes to adipose tissue

Metabolism:

Hepatic to at least 50 metabolites, some of which are active; 11-hydroxy-delta-9-tetrahydrocannabinol (11-OH-THC) is the major metabolite; extensive first-pass effect

Excretion:

Feces (35% as unconjugated metabolites, 5% as unchanged drug); urine (10% to 15% as acid metabolites and conjugates)

Onset:

Within 1 hour; Peak effect: 2-4 hours

Peak:

Serum: 0.5-4 hours

5

Duration:

24 hours (appetite stimulation)

Half-Life elimination:
Dronabinol: 25-36 hours (terminal); Dronabinol metabolites: 44-59 hours

Protein binding:
97% to 99%

Indications

Chemotherapy-associated nausea and vomiting refractory to other antiemetic(s); AIDS-related anorexia

Unlabeled use(s):
Cancer-related anorexia

Contraindications

Hypersensitivity to dronabinol, cannabinoids, sesame oil, or any component of the formulation, or marijuana; should be avoided in patients with a history of schizophrenia

Administration and Dosage

DOSAGE:
Refer to individual protocols. Oral:

Antiemetic: Children and Adults: 5 mg/m^2 1-3 hours before chemotherapy, then 5 mg/m^2/dose every 2-4 hours after chemotherapy for a total of 4-6 doses/day; increase doses in increments of 2.5 mg/m^2 to a maximum of 15 mg/m^2/dose.

Appetite stimulant: Adults: Initial: 2.5 mg twice daily (before lunch and dinner); titrate up to a maximum of 20 mg/day.

Dosage adjustment in renal impairment: No dosage adjustment provided in manufacturer's labeling.

Dosage adjustment in hepatic impairment: Usual dose should be reduced in patients with severe liver failure.

DIETARY CONSIDERATIONS:
Capsules contain sesame oil.

STORAGE / STABILITY:
Store under refrigeration (or in a cool environment) between 8°C and 15°C (46°F and 59°F); protect from freezing.

Interactions

Alcohol (Ethyl): Dronabinol may enhance the CNS depressant effect of Alcohol (Ethyl). *Monitor therapy*

Anticholinergic Agents: May enhance the tachycardic effect of Cannabinoid-Containing Products. *Monitor therapy*

CNS Depressants: Dronabinol may enhance the CNS depressant effect of CNS Depressants. *Monitor therapy*

Cocaine: May enhance the tachycardic effect of Cannabinoid-Containing Products. *Monitor therapy*

CYP2C9 Inhibitors (Moderate): May increase the serum concentration of Dronabinol. *Monitor therapy*

CYP2C9 Inhibitors (Strong): May increase the serum concentration of Dronabinol. *Monitor therapy*

CYP3A4 Inducers (Strong): May decrease the serum concentration of Dronabinol. *Monitor therapy*

CYP3A4 Inhibitors (Moderate): May increase the serum concentration of Dronabinol. *Monitor therapy*

CYP3A4 Inhibitors (Strong): May increase the serum concentration of Dronabinol. *Monitor therapy*

MAO Inhibitors: May enhance the orthostatic hypotensive effect of Orthostatic Hypotension Producing Agents. **Exceptions:** Linezolid; Tedizolid. *Monitor therapy*

Ritonavir: May increase the serum concentration of Dronabinol. *Monitor therapy*

Sympathomimetics: Cannabinoid-Containing Products may enhance the tachycardic effect of Sympathomimetics. *Monitor therapy*

Lab Test Interferences:
Decreased FSH, LH, growth hormone, and testosterone

Adverse Reactions

Frequency not always specified.

>1%:

Cardiovascular: Palpitations, tachycardia, vasodilation/facial flushing

Central nervous system: Euphoria (8% to 24%, dose related), abnormal thinking (3% to 10%), dizziness (3% to 10%), paranoia (3% to 10%), somnolence (3% to 10%), amnesia, anxiety, ataxia, confusion, depersonalization, hallucination

Gastrointestinal: Abdominal pain (3% to 10%), nausea (3% to 10%), vomiting (3% to 10%)

Neuromuscular & skeletal: Weakness

<1% (Limited to important or life-threatening): Conjunctivitis, depression, diarrhea, fatigue, fecal incontinence, flushing, hypotension, myalgia, nightmares, seizure, speech difficulties, tinnitus, vision difficulties

Warnings and Precautions

Monitoring:

CNS effects, heart rate, blood pressure, behavioral profile

Pregnancy:

Pregnancy Risk Factor:

C

Pregnancy Considerations:

Adverse events have been observed in animal reproduction studies.

Lactation:

Enters breast milk/not recommended

Concerns related to adverse effects:

- CNS depression: May impair physical or mental abilities; patients must be cautioned about performing tasks which require mental alertness (eg, operating machinery or driving).

Disease-related concerns:

- Drug abuse: Use with caution in patients with a history of drug abuse or acute alcoholism; potential for drug dependency exists (drug is psychoactive substance in marijuana). Tolerance, psychological and physical dependence may occur with prolonged use.

- Hepatic impairment: Use with caution in patients with hepatic impairment; reduce dosage with severe impairment.

- Psychiatric disorders: Use with caution in patients with mania, depression, or schizophrenia; careful psychiatric monitoring is recommended.

- Seizure disorder: Use with caution in patients with a history of seizure disorder; may lower seizure threshold.

Concurrent drug therapy issues:

- CNS depressants: Effects may be potentiated when used with other psychoactive drugs, sedatives and/or ethanol.

Special populations:

- Elderly: Use with caution in the elderly; may cause postural hypotension.

Other warnings/precautions:

- Withdrawal: May cause withdrawal symptoms upon abrupt discontinuation.

Patient / Family Education

- Discuss specific use of drug and side effects with patient as it relates to treatment. (HCAHPS: During this hospital stay, were you given any medicine that you had not taken before? Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? How often did hospital staff describe possible side effects in a way you could understand?)

- Patient may experience fatigue, dyspepsia, nausea, or asthenia. Have patient report immediately to prescriber illogical thinking, severe dizziness, syncope, considerable headache, behavioral changes, mood changes, tachycardia, arrhythmia, hallucinations, memory impairment, vision changes, or change in balance (HCAHPS).

- Educate patient about signs of a significant reaction (eg, wheezing; chest tightness; fever; itching; bad cough; blue skin color; seizures; or swelling of face, lips, tongue, or throat). **Note:** This is not a comprehensive list of all side

effects. Patient should consult prescriber for additional questions.

Should not be printed and given to patients. This information is intended to serve as a concise initial reference for healthcare professionals to use when discussing medications with a patient. You must ultimately rely on your own discretion, experience and judgment in diagnosing, treating and advising patients.

Nabilone

Pronunciation

(NA bi lone)

Class

- Antiemetic

How Supplied

Excipient information presented when available (limited, particularly for generics); consult specific product labeling.

Capsule, Oral:

Cesamet: 1 mg [contains fd&c blue #2 (indigotine)]

Action

PHARMACOLOGY:

Antiemetic activity may be due to effect on cannabinoid receptors (CB1) within the central nervous system.

PHARMACOKINETICS / DYNAMICS:

Absorption:

Rapid and complete

Distribution:

~12.5 L/kg

Metabolism:

Extensively metabolized to several active metabolites by oxidation and stereospecific enzyme reduction; CYP450 enzymes may also be involved

Excretion:

Feces (~60%); renal (~24%)

Peak:

Serum: Within 2 hours

Half-Life elimination:

Parent compound: ~2 hours; Metabolites: ~35 hours

Special Populations:

Note -

Hepatic and Renal Function Impairment -

Effects have not been determined.

Indications

Treatment of refractory nausea and vomiting associated with cancer chemotherapy

Contraindications

Hypersensitivity to nabilone, other cannabinoids, or any component of the formulation

Administration and Dosage

DOSAGE:

Refer to individual protocols. Oral:

Children >4 years (off-label use; Dupuis, 2003):

<18 kg: 0.5 mg every 12 hours

18-30 kg: 1 mg every 12 hours

>30 kg: 1 mg every 8-12 hours

Adults: 1-2 mg twice daily (maximum: 6 mg divided in 3 doses daily); begin with the lower dose in the range and increase if needed. May administer 2 or 3 times per day during the entire chemotherapy course; continue for up to 48 hours after the last chemotherapy dose. A dose of 1-2 mg the night before chemotherapy may also be of benefit.

Elderly: Refer to adult dosing. Use the lower end of the dosing range (to minimize adverse events).

Dosage adjustment in renal impairment: No dosage adjustment provided in manufacturer's labeling (has not been studied).

Dosage adjustment in hepatic impairment: No dosage adjustment provided in manufacturer's labeling (has not been studied).

ADMINISTRATION:

Initial dose should be given 1-3 hours before chemotherapy.

STORAGE / STABILITY:

Store at 25°C (77°F); excursion permitted to 15°C and 30°C (59°F and 86°F).

Interactions

Alcohol (Ethyl): Nabilone may enhance the CNS depressant effect of Alcohol (Ethyl). *Monitor therapy*

Anticholinergic Agents: May enhance the tachycardic effect of Cannabinoid-Containing Products. *Monitor therapy*

CNS Depressants: Nabilone may enhance the CNS depressant effect of CNS Depressants. *Monitor therapy*

Cocaine: May enhance the tachycardic effect of Cannabinoid-Containing Products. *Monitor therapy*

Sympathomimetics: Cannabinoid-Containing Products may enhance the tachycardic effect of Sympathomimetics. *Monitor therapy*

Adverse Reactions

11

>10%:

Central nervous system: Drowsiness (52% to 66%), dizziness (59%), vertigo (52% to 59%), euphoria (11% to 38%), ataxia (13% to 14%), depression (14%), concentration decreased (12%), sleep disturbance (11%)

Gastrointestinal: Xerostomia (22% to 36%)

Ocular: Visual disturbance (13%)

1% to 10%:

Cardiovascular: Hypotension (8%)

Central nervous system: Dysphoria (9%), headache (6% to 7%), sedation (3%), depersonalization (2%), disorientation (2%)

Gastrointestinal: Anorexia (8%), nausea (4%), appetite increased (2%)

Neuromuscular & skeletal: Weakness (8%)

<1% (Limited to important or life-threatening) and frequency not reported: Abdominal pain, abnormal dreams, akathisia, allergic reaction, amblyopia, anemia, anhydrosis, anxiety, apathy, aphthous ulcer, arrhythmia, back pain, cerebral vascular accident, chest pain, chills, constipation, cough, diaphoresis, diarrhea, dyspepsia, dyspnea, dystonia, emotional disorder, emotional lability, epistaxis, equilibrium dysfunction, eye irritation, fatigue, fever, flushing, gastritis, hallucinations, hot flashes, hyperactivity, hypertension, infection, insomnia, joint pain, leukopenia, lightheadedness, malaise, memory disturbance, mood swings, mouth irritation, muscle pain, nasal congestion, neck pain, nervousness, neurosis (phobic), numbness, orthostatic hypotension, pain, palpitation, panic disorder, paranoia, paresthesia, perception disturbance, pharyngitis, photophobia, photosensitivity, polyuria, pruritus, psychosis (including toxic), pupil dilation, rash, seizure, sinus headache, speech disorder, stupor, syncope, tachycardia, taste perversion, thirst, thought disorder, tinnitus, tremor, urination decreased/increased, urinary retention, visual field defect, voice change, vomiting, wheezing, withdrawal, xerophthalmia

Warnings and Precautions

Monitoring:

Blood pressure, heart rate; signs and symptoms of excessive use, abuse, or misuse

Pregnancy:

Pregnancy Risk Factor:

C

Pregnancy Considerations:

Adverse events have been observed in animal reproduction studies.

Lactation:

Excretion in breast milk unknown/not recommended

Concerns related to adverse effects:

- Cardiovascular effects: May cause tachycardia and/or orthostatic hypotension; use with caution in patients

with cardiovascular disease.

- CNS effects: May impair physical or mental abilities; patients must be cautioned about performing tasks which require mental alertness (eg, operating machinery or driving). Dizziness, drowsiness, ataxia, depression, hallucinations, and psychosis have been reported. Use with caution in patients with mania, depression, or schizophrenia; cannabinoid use may reveal symptoms of psychiatric disorders. Careful psychiatric monitoring is recommended; psychiatric adverse reactions may persist for up to 3 days after discontinuing treatment.

Disease-related concerns:

- Substance abuse: Use with caution in patients with a history of substance abuse; potential for dependency exists. Tolerance, psychological and physical dependence may occur with prolonged use.

Concurrent drug therapy issues:

- CNS depressants: Effects may be potentiated when used with other psychoactive drugs, sedatives and/or ethanol.

Special populations:

- Elderly: Use with caution in the elderly; may cause postural hypotension.

Patient / Family Education

Discuss specific use of drug and side effects with patient as it relates to treatment. (HCAHPS: During this hospital stay, were you given any medicine that you had not taken before? Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? How often did hospital staff describe possible side effects in a way you could understand?)

- Patient may experience asthenia, fatigue, xerostomia, or insomnia. Have patient report immediately to prescriber signs of depression (ie, suicidal ideation, anxiety, emotional instability, illogical thinking), severe dizziness, syncope, behavioral changes, mood changes, tachycardia, hallucinations, memory impairment, significant change in balance, or vision changes (HCAHPS).

- Educate patient about signs of a significant reaction (eg, wheezing; chest tightness; fever; itching; bad cough; blue skin color; seizures; or swelling of face, lips, tongue, or throat). **Note:** This is not a comprehensive list of all side effects. Patient should consult prescriber for additional questions.

Should not be printed and given to patients. This information is intended to serve as a concise initial reference for healthcare professionals to use when discussing medications with a patient. You must ultimately rely on your own discretion, experience and judgment in diagnosing, treating and advising patients.

#9

NDMA
Est.1887 NORTH DAKOTA MEDICAL ASSOCIATION

House Human Service Committee
HB 1430
February 4, 2015

Chairman Weisz and Committee Members, I am Courtney Koebele and I serve as Executive Director for the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents, and medical students.

The North Dakota Medical Association is in strong opposition to HB 1430, providing for the medicinal use of Marijuana.

NDMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.

NDMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical and public health research and development of cannabinoid-based medicines, and alternate delivery methods.

NDMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions.

Until such time when marijuana is approved for use by the Food and Drug Administration and is no longer classified in schedule I by the Drug Enforcement Administration, the NDMA cannot support legislation intended to involve physicians in certifying, authorizing, or otherwise directing persons in the area of medicinal marijuana outside of scientific clinical trials.

For all of the above stated reasons, we oppose HB 1430. I'd be happy to answer any questions. Thank you.

#10

February 4, 2015
Human Services Committee
Testimony Against North Dakota House Bill 1430

Chairman Weisz, members of the Committee, my name is Joan Connell. I am a pediatrician and currently serve as president of the North Dakota chapter of the American Academy of Pediatrics (AAP). The following is my testimony against House Bill 1430, which would legalize medical marijuana outside the regulatory process of the US Food and Drug Administration(FDA). My testimony reflects the position of the AAP, as well as my education and experience acquired in degrees earned as a pharmacist, biomedical researcher, and medical doctor.

My first argument against this bill is that it is unnecessary. Dronabinol, the FDA approved form of tetrahydrocannibinol (THC), the active ingredient in marijuana, has been available for patients for many years (see attached package insert). It is currently approved for the conditions of anorexia causing weight loss in AIDS patients as well as for nausea and vomiting associated with chemotherapy in patients who have not had good responses to conventional treatments. Keep in mind that many medications are used for purposes for which they have not yet been FDA approved. This dosage form of THC has been, and continues to be studied so that we may optimize its use. This dosage and packaging is also consistent, which are important safety considerations that I will discuss momentarily. Given this medication, it seems unnecessary and potentially hazardous to liberalize our dosage forms and producers.

This leads to my second argument, which relates to the fact that local production of marijuana makes regulation of production as well as consistency of dosing impossible. Given the variability in the amount of THC per gram of cannabis, there can be no standardization of dose. This then makes it impossible to perform quality research to determine the benefits and adverse reactions- short and long term of medical marijuana. If supporters of this bill are truly interested in this drug's benefits for patients, this limitation should make it impossible to support this bill. Please remember that there is no solid research to support the use of marijuana for the majority of conditions listed in this bill. How will we ever collect this data if we proceed with legalization for medical uses in the manner this bill suggests?

My third argument against this bill involves the documented adverse outcomes observed since legalization of medical, then recreational marijuana (see attached Implications...article.) Note that this sequence of events, medical... then recreational legalization seems to be the trend. Keep this in mind when considering moving this bill forward... it is a slippery slope. After liberalization of medical marijuana laws in Colorado, a significant increase in the following injuries related to marijuana production/use have been observed:

1. Significant burns
2. Cyclic vomiting syndrome

3. Adverse reactions in children- most often due to unintentional ingestion- primarily via edible marijuana which often resembles candy but contains a hugely variable dose of THC as well as being almost impossible to childproof once it is opened (14 hospitalizations in 2years prior to recreational legalization, 14 in 1st 9months since recreational legalization (7 children in the PICU). Marijuana can affect memory and learning in adolescents, which will make it harder to finish high school and earn a college degree. Legalization of medical marijuana will increase access, as well as sending a message that marijuana use is okay.

As anticipated, marijuana seems to be exacerbating underlying psychiatric disorders. It is also important to note that the combination of marijuana and ethanol increases the risk for motor vehicle accidents far more than either substance alone. This bill contains several sections that refer to measurable concentrations of marijuana... this is not a readily available test. Who will be responsible for paying for this test when it is obtained due to concerns related to a car accident? How about a job performance issue?

I also find it contradictory that proponents of this bill support people with debilitating conditions further injuring themselves by allowing this "medication" to be smoked, which has well documented negative effects on lung function.

In closing, I would like to remind everyone that laws are made for the betterment of society. No clear evidence exists to prove that medical marijuana will better society. However, data does exist, and is accumulating, proving that legalization of marijuana puts people, including our children, at risk. Please do NOT move this bill forward.

500012 Rev Sep 2004

MARINOL® C III

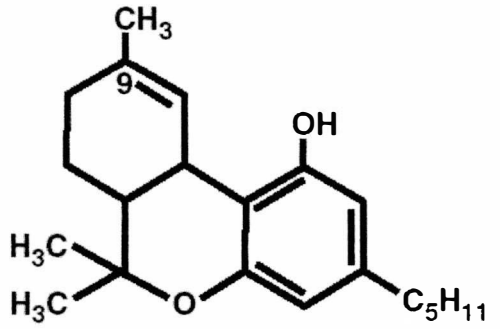
(Dronabinol)

Capsules

R_x only

DESCRIPTION

Dronabinol is a cannabinoid designated chemically as (6*aR-trans*)-6a,7,8,10a-tetrahydro-6,6,9-trimethyl-3-pentyl-6*H*-dibenzo[*b,d*]pyran-1-ol. Dronabinol has the following empirical and structural formulas:



$C_{21}H_{30}O_2$ (molecular weight = 314.47)

Dronabinol, the active ingredient in MARINOL® Capsules, is synthetic delta-9-tetrahydrocannabinol (delta-9-THC). Delta-9-tetrahydrocannabinol is also a naturally occurring component of *Cannabis sativa L.* (Marijuana).

Dronabinol is a light yellow resinous oil that is sticky at room temperature and hardens upon refrigeration. Dronabinol is insoluble in water and is formulated in sesame oil. It has a pKa of 10.6 and an octanol-water partition coefficient: 6,000:1 at pH 7.

Capsules for oral administration: MARINOL® Capsules is supplied as round, soft gelatin capsules containing either 2.5 mg, 5 mg, or 10 mg dronabinol. Each MARINOL® Capsule is formulated with the following inactive ingredients: FD&C Blue No. 1 (5 mg), FD&C Red No. 40 (5 mg), FD&C Yellow No. 6 (5 mg and 10 mg), gelatin, glycerin, methylparaben, propylparaben, sesame oil, and titanium dioxide.

CLINICAL PHARMACOLOGY

Dronabinol is an orally active cannabinoid which, like other cannabinoids, has complex effects on the central nervous system (CNS), including central sympathomimetic activity. Cannabinoid receptors have been discovered in neural tissues. These receptors may play a role in mediating the effects of dronabinol and other cannabinoids.

Pharmacodynamics

Dronabinol-induced sympathomimetic activity may result in tachycardia and/or conjunctival injection. Its effects on blood pressure are inconsistent, but occasional subjects have experienced orthostatic hypotension and/or syncope upon abrupt standing.

Dronabinol also demonstrates reversible effects on appetite, mood, cognition, memory, and perception. These phenomena appear to be dose-related, increasing in frequency with higher dosages, and subject to great interpatient variability.

After oral administration, dronabinol has an onset of action of approximately 0.5 to 1 hours and peak effect at 2 to 4 hours. Duration of action for psychoactive effects is 4 to 6 hours, but the appetite stimulant effect of dronabinol may continue for 24 hours or longer after administration.

Tachyphylaxis and tolerance develop to some of the pharmacologic effects of dronabinol and other cannabinoids with chronic use, suggesting an indirect effect on sympathetic neurons. In a study of the pharmacodynamics of chronic dronabinol exposure, healthy male volunteers (N = 12) received 210 mg/day dronabinol, administered orally in divided doses, for 16 days. An initial tachycardia induced by dronabinol was replaced successively by normal sinus rhythm and then bradycardia. A decrease in supine blood pressure, made worse by standing, was also observed initially. These volunteers developed tolerance to the cardiovascular and subjective adverse CNS effects of dronabinol within 12 days of treatment initiation.

Tachyphylaxis and tolerance do not, however, appear to develop to the appetite stimulant effect of MARINOL® Capsules. In studies involving patients with Acquired Immune Deficiency Syndrome (AIDS), the appetite stimulant effect of MARINOL® Capsules has been sustained for up to five months in clinical trials, at dosages ranging from 2.5 mg/day to 20 mg/day.

Pharmacokinetics

Absorption and Distribution: MARINOL® (Dronabinol) Capsules is almost completely absorbed (90 to 95%) after single oral doses. Due to the combined effects of first pass hepatic metabolism and high lipid solubility, only 10 to 20% of the administered dose reaches the systemic circulation. Dronabinol has a large apparent volume of distribution, approximately 10 L/kg, because of its lipid solubility. The plasma protein binding of dronabinol and its metabolites is approximately 97%.

The elimination phase of dronabinol can be described using a two compartment model with an initial (alpha) half-life of about 4 hours and a terminal (beta) half-life of 25 to 36 hours. Because of its large volume of distribution, dronabinol and its metabolites may be excreted at low levels for prolonged periods of time.

The pharmacokinetics of dronabinol after single doses (2.5, 5, and 10 mg) and multiple doses (2.5, 5, and 10 mg given twice a day; BID) have been studied in healthy women and men.

Summary of Multiple-Dose Pharmacokinetic Parameters of Dronabinol in Healthy Volunteers (n=34; 20-45 years) under Fasted Conditions

Mean (SD) PK Parameter Values			
BID Dose	**Cmax ng/mL**	**Median Tmax (range), hr**	**AUC(0-12) ng•hr/mL**
2.5 mg	1.32 (0.62)	1.00 (0.50-4.00)	2.88 (1.57)
5 mg	2.96 (1.81)	2.50 (0.50-4.00)	6.16 (1.85)
10 mg	7.88 (4.54)	1.50 (0.50-3.50)	15.2 (5.52)

A slight increase in dose proportionality on mean Cmax and AUC (0-12) of dronabinol was observed with increasing dose over the dose range studied.

Metabolism: Dronabinol undergoes extensive first-pass hepatic metabolism, primarily by microsomal hydroxylation, yielding both active and inactive metabolites. Dronabinol and its principal active metabolite, 11-OH-delta-9-THC, are present in approximately equal concentrations in plasma. Concentrations of both parent drug and metabolite peak at approximately 0.5 to 4 hours after oral dosing and decline over several days. Values for clearance average about 0.2 L/kg-hr, but are highly variable due to the complexity of cannabinoid distribution.

Elimination: Dronabinol and its biotransformation products are excreted in both feces and urine. Biliary excretion is the major route of elimination with about half of a radio-labeled oral dose being recovered from the feces within 72 hours as contrasted with 10 to 15% recovered from urine. Less than 5% of an oral dose is recovered unchanged in the feces.

Following single dose administration, low levels of dronabinol metabolites have been detected for more than 5 weeks in the urine and feces.

In a study of MARINOL® Capsules involving AIDS patients, urinary cannabinoid/creatinine concentration ratios were studied bi-weekly over a six week period. The urinary cannabinoid/creatinine ratio was closely correlated with dose. No increase in the cannabinoid/creatinine ratio was observed after the first two weeks of treatment, indicating that steady-state cannabinoid levels had been reached. This conclusion is consistent with predictions based on the observed terminal half-life of dronabinol.

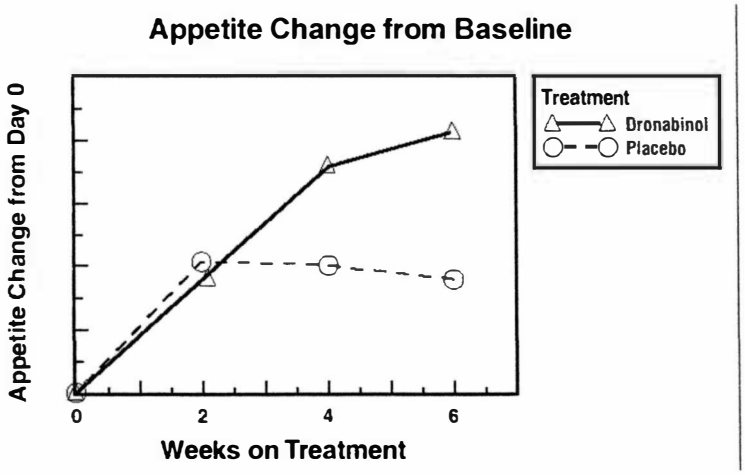
Special Populations: The pharmacokinetic profile of MARINOL® Capsules has not been investigated in either pediatric or geriatric patients.

Clinical Trials

Appetite Stimulation: The appetite stimulant effect of MARINOL® (Dronabinol) Capsules in the treatment of AIDS-related anorexia associated with weight loss was studied in a randomized, double-blind, placebo-controlled study involving 139 patients. The initial dosage of MARINOL® Capsules in all patients was 5 mg/day, administered in doses of 2.5 mg one hour before lunch and one hour before supper. In pilot studies, early morning administration of MARINOL® Capsules appeared to have been associated with an increased frequency of adverse experiences, as compared to dosing later in the day. The effect of MARINOL® Capsules on appetite, weight, mood, and nausea was measured at scheduled intervals during the six-week treatment period. Side effects (feeling high, dizziness, confusion, somnolence) occurred in 13 of 72 patients (18%) at this dosage level and the dosage was reduced to 2.5 mg/day, administered as a single dose at supper or bedtime.

As compared to placebo, MARINOL® Capsules treatment resulted in a statistically significant improvement in appetite as measured by visual analog scale (see figure). Trends toward improved body weight and mood, and decreases in nausea were also seen.

After completing the 6-week study, patients were allowed to continue treatment with MARINOL® Capsules in an open-label study, in which there was a sustained improvement in appetite.



Antiemetic: MARINOL® (Dronabinol) Capsules treatment of chemotherapy-induced emesis was evaluated in 454 patients with cancer, who received a total of 750 courses of treatment of various malignancies. The antiemetic efficacy of MARINOL® Capsules was greatest in patients receiving cytotoxic therapy with MOPP for Hodgkin's and non-Hodgkin's lymphomas. MARINOL® Capsules dosages ranged from 2.5 mg/day to 40 mg/day, administered in equally divided doses every four to six hours (four times daily). As indicated in the following table, escalating the MARINOL® Capsules dose above 7 mg/m^2 increased the frequency of adverse experiences, with no additional antiemetic benefit.

MARINOL® Capsules Dose: Response Frequency and Adverse Experiences*
(N = 750 treatment courses)

MARINOL® Capsules Dose	Response Frequency (%)			Adverse Events Frequency (%)		
	Complete	Partial	Poor	None	Nondysphoric	Dysphoric
<7 mg/m^2	36	32	32	23	65	12
>7 mg/m^2	33	31	36	13	58	28

*Nondysphoric events consisted of drowsiness, tachycardia, etc.

Combination antiemetic therapy with MARINOL® Capsules and a phenothiazine (prochlorperazine) may result in synergistic or additive antiemetic effects and attenuate the toxicities associated with each of the agents.

INDIVIDUALIZATION OF DOSAGES

The pharmacologic effects of MARINOL® (Dronabinol) Capsules are dose-related and subject to considerable interpatient variability. Therefore, dosage individualization is critical in achieving the maximum benefit of MARINOL® Capsules treatment.

Appetite Stimulation: In the clinical trials, the majority of patients were treated with 5 mg/day MARINOL® Capsules, although the dosages ranged from 2.5 to 20 mg/day. For an adult:

1. Begin with 2.5 mg before lunch and 2.5 mg before supper. If CNS symptoms (feeling high, dizziness, confusion, somnolence) do occur, they usually resolve in 1 to 3 days with continued dosage.

2. If CNS symptoms are severe or persistent, reduce the dose to 2.5 mg before supper. If symptoms continue to be a problem, taking the single dose in the evening or at bedtime may reduce their severity.

3. When adverse effects are absent or minimal and further therapeutic effect is desired, increase the dose to 2.5 mg before lunch and 5 mg before supper or 5 and 5 mg. Although most patients respond to 2.5 mg twice daily, 10 mg twice daily has been tolerated in about half of the patients in appetite stimulation studies.

The pharmacologic effects of MARINOL® Capsules are reversible upon treatment cessation.

Antiemetic: Most patients respond to 5 mg three or four times daily. Dosage may be escalated during a chemotherapy cycle or at subsequent cycles, based upon initial results. Therapy should be initiated at the lowest recommended dosage and titrated to clinical response. Administration of MARINOL® Capsules with phenothiazines, such as prochlorperazine, has resulted in improved efficacy as compared to either drug alone, without additional toxicity.

Pediatrics: MARINOL® Capsules is not recommended for AIDS-related anorexia in pediatric patients because it has not been studied in this population. The pediatric dosage for the treatment of chemotherapy-induced emesis is the same as in adults. Caution is recommended in prescribing MARINOL® Capsules for children because of the psychoactive effects.

Geriatrics: Caution is advised in prescribing MARINOL® Capsules in elderly patients because they are generally more sensitive to the psychoactive effects of drugs. In antiemetic studies, no difference in tolerance or efficacy was apparent in patients >55 years old.

INDICATIONS AND USAGE

MARINOL® (Dronabinol) Capsules is indicated for the treatment of:

1. anorexia associated with weight loss in patients with AIDS; and

2. nausea and vomiting associated with cancer chemotherapy in patients who have failed to respond adequately to conventional antiemetic treatments.

CONTRAINDICATIONS

MARINOL® (Dronabinol) Capsules is contraindicated in any patient who has a history of hypersensitivity to any cannabinoid or sesame oil.

WARNINGS

Patients receiving treatment with MARINOL® Capsules should be specifically warned not to drive, operate machinery, or engage in any hazardous activity until it is established that they are able to tolerate the drug and to perform such tasks safely.

PRECAUTIONS

General: The risk/benefit ratio of MARINOL® (Dronabinol) Capsules use should be carefully evaluated in patients with the following medical conditions because of individual variation in response and tolerance to the effects of MARINOL® Capsules.

MARINOL® Capsules should be used with caution in patients with cardiac disorders because of occasional hypotension, possible hypertension, syncope, or tachycardia (see **CLINICAL PHARMACOLOGY**).

MARINOL® Capsules should be used with caution in patients with a history of substance abuse, including alcohol abuse or dependence, because they may be more prone to abuse MARINOL® Capsules as well. Multiple substance abuse is common and marijuana, which contains the same active compound, is a frequently abused substance.

MARINOL® Capsules should be used with caution and careful psychiatric monitoring in patients with mania, depression, or schizophrenia because MARINOL® Capsules may exacerbate these illnesses.

MARINOL® Capsules should be used with caution in patients receiving concomitant therapy with sedatives, hypnotics or other psychoactive drugs because of the potential for additive or synergistic CNS effects.

MARINOL® Capsules should be used with caution in pregnant patients, nursing mothers, or pediatric patients because it has not been studied in these patient populations.

Information for Patients: Patients receiving treatment with MARINOL® (Dronabinol) Capsules should be alerted to the potential for additive central nervous system depression if MARINOL® Capsules is used concomitantly with alcohol or other CNS depressants such as benzodiazepines and barbiturates.

Patients receiving treatment with MARINOL® Capsules should be specifically warned not to drive, operate machinery, or engage in any hazardous activity until it is established that they are able to tolerate the drug and to perform such tasks safely.

Patients using MARINOL® Capsules should be advised of possible changes in mood and other adverse behavioral effects of the drug so as to avoid panic in the event of such manifestations. Patients should remain under the supervision of a responsible adult during initial use of MARINOL® Capsules and following dosage adjustments.

Drug Interactions: In studies involving patients with AIDS and/or cancer, MARINOL® (Dronabinol) Capsules has been co-administered with a variety of medications (e.g., cytotoxic agents, anti-infective agents, sedatives, or opioid analgesics) without resulting in any clinically significant drug/drug interactions. Although no drug/drug interactions were discovered during the clinical trials of MARINOL® Capsules, cannabinoids may interact with other medications through both metabolic and pharmacodynamic mechanisms. Dronabinol is highly protein bound to plasma proteins, and therefore, might displace other protein-bound drugs. Although this displacement has not been confirmed *in vivo*, practitioners should monitor patients for a change in dosage requirements when administering dronabinol to patients receiving other highly protein-bound drugs. Published reports of drug/drug interactions involving cannabinoids are summarized in the following table.

CONCOMITANT DRUG	CLINICAL EFFECT(S)
Amphetamines, cocaine, other sympathomimetic agents	Additive hypertension, tachycardia, possibly cardiotoxicity
Atropine, scopolamine, antihistamines, other anticholinergic agents	Additive or super-additive tachycardia, drowsiness
Amitriptyline, amoxapine, desipramine, other tricyclic antidepressants	Additive tachycardia, hypertension, drowsiness
Barbiturates, benzodiazepines, ethanol, lithium, opioids, buspirone, antihistamines, muscle relaxants, other CNS depressants	Additive drowsiness and CNS depression
Disulfiram	A reversible hypomanic reaction was reported in a 28 y/o man who smoked marijuana; confirmed by dechallenge and rechallenge
Fluoxetine	A 21 y/o female with depression and bulimia receiving 20 mg/day fluoxetine X 4 wks became hypomanic after smoking marijuana; symptoms resolved after 4 days
Antipyrine, barbiturates	Decreased clearance of these agents, presumably via competitive inhibition of metabolism
Theophylline	Increased theophylline metabolism reported with smoking of marijuana; effect similar to that following smoking tobacco

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenicity studies in mice and rats have been conducted under the US National Toxicology Program (NTP). In the 2-year carcinogenicity study in rats, there was no evidence of carcinogenicity at doses up to 50 mg/kg/day, about 20 times the maximum recommended human dose on a body surface area basis. In the 2-year carcinogenicity study in mice, treatment with dronabinol at 125 mg/kg/day, about 25 times the maximum recommended human dose on a body surface area basis, produced thyroid follicular cell adenoma in both male and female mice but not at 250 or 500 mg/kg/day.

Dronabinol was not genotoxic in the Ames tests, the *in vitro* chromosomal aberration test in Chinese hamster ovary cells, and the *in vivo* mouse micronucleus test. It, however, produced a weak positive response in a sister chromatid exchange test in Chinese hamster ovary cells.

In a long-term study (77 days) in rats, oral administration of dronabinol at doses of 30 to 150 mg/m^2, equivalent to 0.3 to 1.5 times maximum recommended human dose (MRHD) of 90 mg/m^2/day in cancer patients or 2 to 10 times MRHD of 15 mg/m^2/day in AIDS patients, reduced ventral prostate, seminal vesicle and epididymal weights and caused a decrease in seminal fluid volume. Decreases in spermatogenesis, number of developing germ cells, and number of Leydig cells in the testis were also observed. However, sperm count, mating success and testosterone levels were not affected. The significance of these animal findings in humans is not known.

Pregnancy: Pregnancy Category C. Reproduction studies with dronabinol have been performed in mice at 15 to 450 mg/m^2, equivalent to 0.2 to 5 times maximum recommended human dose (MRHD)

of 90 mg/m^2/day in cancer patients or 1 to 30 times MRHD of 15 mg/m^2/day in AIDS patients, and in rats at 74 to 295 mg/m^2 (equivalent to 0.8 to 3 times MRHD of 90 mg/m^2 in cancer patients or 5 to 20 times MRHD of 15 mg/m^2/day in AIDS patients). These studies have revealed no evidence of teratogenicity due to dronabinol. At these dosages in mice and rats, dronabinol decreased maternal weight gain and number of viable pups and increased fetal mortality and early resorptions. Such effects were dose dependent and less apparent at lower doses which produced less maternal toxicity. There are no adequate and well-controlled studies in pregnant women. Dronabinol should be used only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Use of MARINOL® Capsules is not recommended in nursing mothers since, in addition to the secretion of HIV virus in breast milk, dronabinol is concentrated in and secreted in human breast milk and is absorbed by the nursing baby.

Geriatric Use: Clinical studies of MARINOL® (Dronabinol) Capsules in AIDS and cancer patients did not include the sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, increased sensitivity to psychoactive effects and of concomitant disease or other drug therapy.

ADVERSE REACTIONS

Adverse experiences information summarized in the tables below was derived from well-controlled clinical trials conducted in the US and US territories involving 474 patients exposed to MARINOL® (Dronabinol) Capsules. Studies of AIDS-related weight loss included 157 patients receiving dronabinol at a dose of 2.5 mg twice daily and 67 receiving placebo. Studies of different durations were combined by considering the first occurrence of events during the first 28 days. Studies of nausea and vomiting related to cancer chemotherapy included 317 patients receiving dronabinol and 68 receiving placebo.

A cannabinoid dose-related "high" (easy laughing, elation and heightened awareness) has been reported by patients receiving MARINOL® Capsules in both the antiemetic (24%) and the lower dose appetite stimulant clinical trials (8%) (see **Clinical Trials**).

The most frequently reported adverse experiences in patients with AIDS during placebo-controlled clinical trials involved the CNS and were reported by 33% of patients receiving MARINOL® Capsules. About 25% of patients reported a minor CNS adverse event during the first 2 weeks and about 4% reported such an event each week for the next 6 weeks thereafter.

PROBABLY CAUSALLY RELATED: Incidence greater than 1%.
Rates derived from clinical trials in AIDS-related anorexia (N=157) and chemotherapy-related nausea (N=317). Rates were generally higher in the anti-emetic use (given in parentheses).

Body as a whole: Asthenia.
Cardiovascular: Palpitations, tachycardia, vasodilation/facial flush.
Digestive: Abdominal pain*, nausea*, vomiting*.
Nervous system: (Amnesia), anxiety/nervousness, (ataxia), confusion, depersonalization, dizziness*, euphoria*, (hallucination), paranoid reaction*, somnolence*, thinking abnormal*.

*Incidence of events 3% to 10%

PROBABLY CAUSALLY RELATED: Incidence less than 1%.
Event rates derived from clinical trials in AIDS-related anorexia (N=157) and chemotherapy-related nausea (N=317).

Cardiovascular: Conjunctivitis*, hypotension*.
Digestive: Diarrhea*, fecal incontinence.
Musculoskeletal: Myalgias.
Nervous system: Depression, nightmares, speech difficulties, tinnitus.
Skin and Appendages: Flushing*.
Special senses: Vision difficulties.

*Incidence of events 0.3% to 1%

CAUSAL RELATIONSHIP UNKNOWN: Incidence less than 1%.
The clinical significance of the association of these events with MARINOL® Capsules treatment is unknown, but they are reported as alerting information for the clinician.

Body as a whole: Chills, headache, malaise.
Digestive: Anorexia, hepatic enzyme elevation.
Respiratory: Cough, rhinitis, sinusitis.
Skin and Appendages: Sweating.

DRUG ABUSE AND DEPENDENCE

MARINOL® (Dronabinol) Capsules is one of the psychoactive compounds present in cannabis, and is abusable and controlled [Schedule III (CIII)] under the Controlled Substances Act. Both psychological and physiological dependence have been noted in healthy individuals receiving dronabinol, but addiction is uncommon and has only been seen after prolonged high dose administration.

Chronic abuse of cannabis has been associated with decrements in motivation, cognition, judgement, and perception. The etiology of these impairments is unknown, but may be associated with the complex process of addiction rather than an isolated effect of the drug. No such decrements in psychological, social or neurological status have been associated with the administration of MARINOL® Capsules for therapeutic purposes.

In an open-label study in patients with AIDS who received MARINOL® Capsules for up to five months, no abuse, diversion or systematic change in personality or social functioning were observed despite the inclusion of a substantial number of patients with a past history of drug abuse.

An abstinence syndrome has been reported after the abrupt discontinuation of dronabinol in volunteers receiving dosages of 210 mg/day for 12 to 16 consecutive days. Within 12 hours after discontinuation, these volunteers manifested symptoms such as irritability, insomnia, and restlessness. By approximately 24 hours post-dronabinol discontinuation, withdrawal symptoms intensified to include "hot flashes", sweating, rhinorrhea, loose stools, hiccoughs and anorexia.

These withdrawal symptoms gradually dissipated over the next 48 hours. Electroencephalographic changes consistent with the effects of drug withdrawal (hyperexcitation) were recorded in patients after abrupt dechallenge. Patients also complained of disturbed sleep for several weeks after discontinuing therapy with high dosages of dronabinol.

//

OVERDOSAGE

Signs and symptoms following MILD MARINOL® (Dronabinol) Capsules intoxication include drowsiness, euphoria, heightened sensory awareness, altered time perception, reddened conjunctiva, dry mouth and tachycardia; following MODERATE intoxication include memory impairment, depersonalization, mood alteration, urinary retention, and reduced bowel motility; and following SEVERE intoxication include decreased motor coordination, lethargy, slurred speech, and postural hypotension. Apprehensive patients may experience panic reactions and seizures may occur in patients with existing seizure disorders.

The estimated lethal human dose of intravenous dronabinol is 30 mg/kg (2100 mg/ 70 kg). Significant CNS symptoms in antiemetic studies followed oral doses of 0.4 mg/kg (28 mg/70 kg) of MARINOL® Capsules.

Management: A potentially serious oral ingestion, if recent, should be managed with gut decontamination. In unconscious patients with a secure airway, instill activated charcoal (30 to 100 g in adults, 1 to 2 g/kg in infants) via a nasogastric tube. A saline cathartic or sorbitol may be added to the first dose of activated charcoal. Patients experiencing depressive, hallucinatory or psychotic reactions should be placed in a quiet area and offered reassurance. Benzodiazepines (5 to 10 mg diazepam *po*) may be used for treatment of extreme agitation. Hypotension usually responds to Trendelenburg position and IV fluids. Pressors are rarely required.

DOSAGE AND ADMINISTRATION

Appetite Stimulation: Initially, 2.5 mg MARINOL® (Dronabinol) Capsules should be administered orally twice daily (b.i.d.), before lunch and supper. For patients unable to tolerate this 5 mg/day dosage of MARINOL® Capsules, the dosage can be reduced to 2.5 mg/day, administered as a single dose in the evening or at bedtime. If clinically indicated and in the absence of significant adverse effects, the dosage may be gradually increased to a maximum of 20 mg/day MARINOL® Capsules, administered in divided oral doses. Caution should be exercised in escalating the dosage of MARINOL® Capsules because of the increased frequency of dose-related adverse experiences at higher dosages (see **PRECAUTIONS**).

Antiemetic: MARINOL® Capsules is best administered at an initial dose of 5 mg/m^2, given 1 to 3 hours prior to the administration of chemotherapy, then every 2 to 4 hours after chemotherapy is given, for a total of 4 to 6 doses/day. Should the 5 mg/m^2 dose prove to be ineffective, and in the absence of significant side effects, the dose may be escalated by 2.5 mg/m^2 increments to a maximum of 15 mg/m^2 per dose. Caution should be exercised in dose escalation, however, as the incidence of disturbing psychiatric symptoms increases significantly at maximum dose (see **PRECAUTIONS**).

STORAGE CONDITIONS

MARINOL® (Dronabinol) Capsules should be packaged in a well-closed container and stored in a cool environment between 8° and 15°C (46° and 59°F) and alternatively could be stored in a refrigerator. Protect from freezing.

HOW SUPPLIED

MARINOL® Capsules (dronabinol solution in sesame oil in soft gelatin capsules)

2.5 mg white capsules (Identified UM or RL).

NDC 0051-0021-21 (Bottle of 60 capsules).

5 mg dark brown capsules (Identified UM or RL).
NDC 0051-0022-11 (Bottle of 25 capsules).

10 mg orange capsules (Identified UM or RL).
NDC 0051-0023-21 (Bottle of 60 capsules).

MARINOL® is a registered trademark of Unimed Pharmaceuticals, Inc. and is Manufactured by Banner Pharmacaps, Inc.
High Point, NC 27265

500012 Rev Sep 2004

A Solvay Pharmaceuticals, Inc. Company
Marietta, GA 30062

VIEWPOINT

The Implications of Marijuana Legalization in Colorado

A. Monte, MD
ent of
ncy Medicine, University of Colorado, Aurora; and Rocky Mountain Poison and Drug Center, Denver, Colorado.

Richard D. Zane, MD
Department of Emergency Medicine, University of Colorado, Aurora.

Kennon J. Heard, MD, PhD
Department of Emergency Medicine, University of Colorado, Aurora; and Rocky Mountain Poison and Drug Center, Denver, Colorado.

Author Reading at jama.com

orresponding uthor: Andrew A. lonte, MD, epartment of mergency Medicine, niversity of Colorado, :prino Bldg, Seventh oor, Campus Box 215, 12401 E 17th Ave, urora, CO 80045 ndrew.monte ucdenver.edu).

The legalization of marijuana in Colorado has had complex effects on the health of its citizens. Physicians have the responsibility to present a balanced perspective, identifying both the potential health benefits and risks associated with marijuana use. In this Viewpoint, we discuss the history of marijuana policy in Colorado and the expected and unexpected effects of increased marijuana availability. Other states considering marijuana policy liberalization may learn from the experiences in Colorado.

History of Colorado Marijuana Policy

In November 2000, the Colorado state constitution was amended to allow for the use of medical marijuana by patients with "chronic debilitating medical conditions."[1] Few patients used medical marijuana until October 2009, when the US Attorney General distributed guidelines for federal prosecution of the possession and use of marijuana, ceding jurisdiction of marijuana law enforcement to state governments. The combination of permissive local law and the federal policy change effectively liberalized the sale and use of medical marijuana in Colorado. Anyone with one of the conditions outlined by Colorado law could be issued a medical marijuana license with no expiration date. The number of licenses increased from 4819 on December 30, 2008, to 116 287 on September 30, 2014.

In November 2012, Amendment 64, which legalized the retail sale, purchase, and possession of marijuana for state residents and visitors older than 21 years, was approved by 55% of voters. During the following year, the state legislature appointed policy advisors to determine a tax structure, outline dispensary regulations, and determine the public health implications of the legalization. Retail marijuana stores began sales to consumers on January 1, 2014. Medical and retail marijuana products are the same, although regulations vary between the 2 marketplaces. For example, there is no minimum age restriction, and only state residents can legally buy medical marijuana in Colorado. As of November 3, 2014, 497 medical marijuana dispensaries and 292 retail dispensaries were licensed in Colorado.[2]

Expected Health System Effects of Legalization

Increased availability led to increased health care utilization related to marijuana exposure.[3] Exacerbation of chronic health conditions was expected. Tetrahydrocannabinol (THC) is associated with psychosis, anxiety, and depression symptoms, making exacerbation of underlying psychiatric disorders inevitable. However, it is difficult to fully quantify the scope of this increased health care utilization because marijuana use is often coincident with other behaviors that contribute to health care visits. For example, the combination of marijuana plus ethanol increases the risk of motor vehicle collisions more than either substance alone. Serum THC concentrations are not readily available, so assessing causality is difficult.

However, there has been an increase in visits for pure marijuana intoxication. These were previously a rare occurrence, but even this increase is difficult to quantify. Patients may present to emergency departments (EDs) with anxiety, panic attacks, public intoxication, vomiting, or other nonspecific symptoms precipitated by marijuana use. The University of Colorado ED sees approximately 2000 patients per week; each week, an estimated 1 to 2 patients present solely for marijuana intoxication and another 10 to 15 for marijuana-associated illnesses.

Medical Marijuana Use

Patients with some seizure disorders may benefit from the cannabidiol component in marijuana, and several clinical trials will soon enroll patients (NCT02224690, NCT02224560, NCT02224703, NCT02091375, NCT02224573). Marijuana likely has anti-inflammatory effects[4] and may benefit some patients with inflammatory bowel disease.[5] Marijuana may have a safer therapeutic window than opioids for pain control, and an observational study found fewer opioid-related deaths in states with liberal marijuana laws.[6] However, it is unlikely that marijuana is effective for the wide range of health problems approved under Colorado law.[1]

Legalization of marijuana has increased opportunities for clinician scientists to study the positive health effects of marijuana due to increased availability; however, federal designation of marijuana as a Schedule I drug continues to limit investigators' ability to conduct high-quality, nationally funded clinical trials. The use of medical marijuana for a wide range of disorders is inconsistent with the science supporting its effectiveness, highlighting the need for high-quality research.

Unexpected Health System Effects of Legalization

Experimentation with new ways to use and produce THC products has resulted in unexpected health effects, including an increased prevalence of burns, cyclic vomiting syndrome, and health care visits due to ingestion of edible products.

The University of Colorado burn center has experienced a substantial increase in the number of marijuana-related burns. In the past 2 years, the burn center has had 31 admissions for marijuana-related burns; some cases involve more than 70% of body surface area and 21 required skin grafting. The majority of these were flash

14

burns that occurred during THC extraction from marijuana plants using butane as a solvent.

The frequent use of high THC concentration products can lead to a cyclic vomiting syndrome. Patients present with severe abdominal pain, vomiting, and diaphoresis; they often report relief with hot showers. A small study at 2 Denver-area hospitals revealed an increase in cyclic vomiting presentations from 41 per 113 262 ED visits to 87 per 125 095 ED visits (prevalence ratio, 1.92) after medical marijuana liberalization (A. A. Monte, MD, unpublished data, December 2014).

The most concerning health effects have been among children. The number of children evaluated in the ED for unintentional marijuana ingestion at the Children's Hospital of Colorado increased from 0 in the 5 years preceding liberalization to 14 in the 2 years after medical liberalization.[3] This number has increased further since legalization; as of September 2014, 14 children had been admitted to the hospital this year, and 7 of these were admitted to the intensive care unit. The vast majority of intensive care admissions were related to ingestion of edible THC products.

Challenges of Edible Marijuana Products

Edible products are responsible for the majority of health care visits due to marijuana intoxication for all ages. This is likely due to failure of adult users to appreciate the delayed effects of ingestion compared with inhalation. Prolonged absorption complicates dosing, manufacturing inconsistencies lead to dose variability, and the appealing product forms lead to unintentional ingestion by children.

Smoking marijuana results in clinical effects within 10 minutes, peak blood concentrations occur between 30 and 90 minutes, and clearance is complete within 4 hours of inhalation.[7] Oral THC does not reach significant blood concentration until at least 30 minutes, with a peak at approximately 3 hours, and clearance approximately 12 hours after ingestion.[7]

Ten to 30 mg of THC is recommended for intoxication depending on the experience of the user; each package, whether it is a single cookie or a package of gummy bears, theoretically contains 100 mg of THC. Because many find it difficult to eat a tenth of a cookie, unintentional overdosing is common. Furthermore, manufacturing practices for marijuana edible products are not standardized. This results in edible products with inconsistent THC concentrations, further complicating dosing for users. According to a report in the *Denver Post*, products described as containing 100 mg of THC actually contained from 0 to 146 mg of THC.[5]

Initially, nonmedical edible products were required to be sold in a childproof package, although medical marijuana did not have this requirement. Childproof packaging requirements are now consistent across both retail and medical products, but there is no dosing recommendation for medical marijuana. To complicate matters further, the packaging is inconsistently effective and not applied to a dosing unit. This means that a product may be sold in a childproof container, but once the package is opened, the product is readily accessible to children. Although ingestion of 100 mg of THC in an adult may result in delirium or severe physiologic impairment, this dose is unlikely to cause respiratory arrest, which may occur in children at this dose.

Edible or capsule formulations may be a preferable route of administration when compared with inhalation for individuals with legitimate medical indications for the drug. However, there is no reason these products should be packaged in a manner that is appealing to children or makes them easily confused with nonmarijuana products. Furthermore, the concentration of THC must be systematically measured and reported. No one would tolerate a medication that contained a variable amount of the active ingredient. Standardizing the production and premarket testing of edible products may help limit inadvertent overdoses.

Conclusions

While many users feel they have benefited from marijuana legalization in Colorado, there have also been untoward adverse health effects. The risks of use must be consistently communicated through health care practitioners and public health officials, especially for edible products that pose unique risks for exposed adults and children. Ultimately, additional research is needed to quantify the benefits and risks of marijuana utilization so health care professionals can have well-informed discussions with medical and recreational users.

ARTICLE INFORMATION

Published Online: December 8, 2014. doi:10.1001/jama.2014.17057.

Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Monte reported that he sits on the Colorado Retail Marijuana Public Health Advisory Committee coordinated through the Colorado Department of Public Health and Environment. Dr Heard reported having received grants from McNeil Consumer Healthcare. No other disclosures were reported.

Funding/Support: Dr Monte's work is supported by grants from the National Institutes of Health (1K23GM110516-01, UL1 TR001082, and 1R56DA038366-01).

Role of the Funder/Sponsor: The funder had no role in the preparation, review, or approval of the manuscript.

REFERENCES

1. Col Const art XVIII, § 14.

2. MED licensed facilities. Colorado Dept of Revenue. https://www.colorado.gov/pacific/enforcement/med-licensed-facilities. Accessed November 8, 2014.

3. Wang GS, Roosevelt G, Heard K. Pediatric marijuana exposures in a medical marijuana state. *JAMA Pediatr*. 2013;167(7):630-633.

4. Nagarkatti P, Pandey R, Rieder SA, Hegde VL, Nagarkatti M. Cannabinoids as novel anti-inflammatory drugs. *Future Med Chem*. 2009; 1(7):1333-1349.

5. Esposito G, Filippis DD, Cirillo C, et al. Cannabidiol in inflammatory bowel diseases: a brief overview. *Phytother Res*. 2013;27(5):633-636.

6. Hayes MJ, Brown MS. Legalization of medical marijuana and incidence of opioid mortality. *JAMA Intern Med*. 2014;174(10):1673-1674.

7. Grotenhermen F. Pharmacokinetics and pharmacodynamics of cannabinoids. *Clin Pharmacokinet*. 2003;42(4):327-360.

8. Baca R. Edibles' THC claims versus lab tests reveal big discrepancies. *Denver Post*. March 9, 2014.


Rastaleers
Twixed
Munchy Way
Rasta Reese's
KeefKat
Buddahfinger
Tri-Chrome
CRUNCH

16

HB 1430
2-4-15

#11

In recent years, there has been a great deal of noise about brain damage from a variety of causes. If you ride a bicycle, motorcycle, or atv of any kind, wear a helmet to prevent brain damage. Cars have more air bags to prevent brain damage in crashes. Concussions are a big thing in the football sector. Yet when it comes to dope, particularly marijuana, there seems to be a great deal of silence.

Keeping mind that such materials aren't called "dope" for no reason, then, this is suspect. Marijuana & other forms of dope *cause brain damage.*

As a Traditional healer with a lifetime of experience and training, as well as constant pain from fibromyalgia for over 40 years, and a variety of injuries which still often cause me deep pain, I know there are far safer things to use and to do to relieve pain than use marijuana. We Traditional healers devise all treatments around the practice of causing no new damage. Marijuana has a long dark history in the middle and far east; where governments there strive to eliminate this material.

In the far east, marijuana is the material of choice for beginning the euthanasia of the elderly and crippled when they cannot be productive. In the far east, casual use has spread to lazy younger people, causing them to lose the will to thrive or strive, thus costing the healthy elements of society there even greater burdens, and the governments of the far eastern nations have gone to great lengths to get rid of marijuana. Laziness being what it is, they will have to continue to battle the attitudes that someone owes the doper a living.

Among dealers of this material in both the far and middle east, dealers are said to 'never' use it, partly because the folklore teaches, (speaking to men only, since women don't appear to 'count', there, except as baby machines and scapegoats), "If you use marijuana, your 'thing' will turn to pus, and *if* you sire any children, they will be monsters (ie, defective)". Scientific studies in the West have repeatedly shown that marijuana does cause genetic changes in users as well as in any children they may produce, be the users male or female. Few studies have been done on the effects of second-hand marijuana smoke, but it is logical that if second-hand smoke from non-spiritual tobacco use causes disease, then the same is true for marijuana & such.

Yet here in the West, some people would sell you a bill of goods and pull the wool over your eyes promoting that marijuana is 'harmless' or 'safe'. This is flatly a lie. The history of this material proves it well enough, but modern scientific tools enable us to have more proof, as shown in the accompanying photos.

I testified earlier that I suffered from fibromyalgia for over 40 years. Note that I spoke in the past tense. In 2014 I more or less accidentally added one safe natural material to my decades-old regimen of nutritional and herbal supplements that I had developed to ease my suffering as well as support my better health, *and in less than a week, my fibromyalgia pain – indeed, the fibromyalgia itself – was gone*.

No 'dope', just safe nutritional and herbal materials available in any health products store, or in some cases, your local supermarket. We are not talking about some minor pain, here.. fibromyalgia causes pain so profound it literally puts people in bed for days on end, or sometimes lifts them off the mattress. Holding a job is often impossible, and some days, getting from the bed

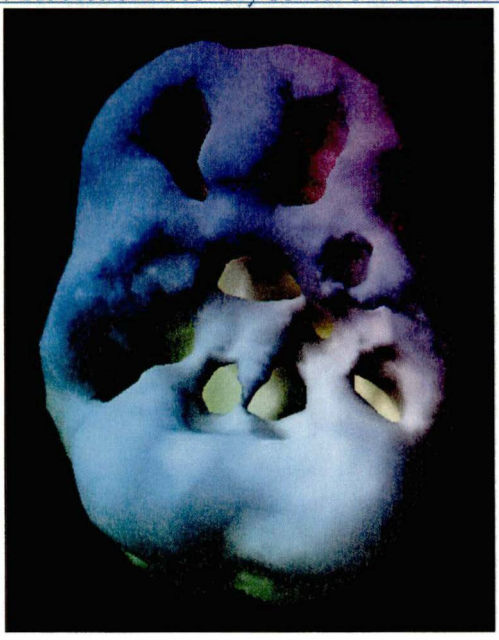
to the bathroom is a major accomplishment. I've been there and done that; although my force of "will and won't" is so strong that I pushed myself to get through it, mostly successfully, for those 40-some years.

I wrote a book detailing my fibromyalgia miracle – It's title is, "My Fibromyalgia Miracle – And Maybe, Yours". It is for sale on its website and on various sales sites. I priced it at a mere $5 in order to enable more exhausted pain-ridden people to have easy access to it, in the hope that I could help more miracles of this kind to occur in the world. I do not doubt that the ingredients in it will work on any pain, since I also have great pain from a variety of serious injuries, and my pain from them is also diminished. Rolling stones gather no moss, but we do gather dings and dents. I am a 'ding and dent special', and I know soul-grinding pain intimately.

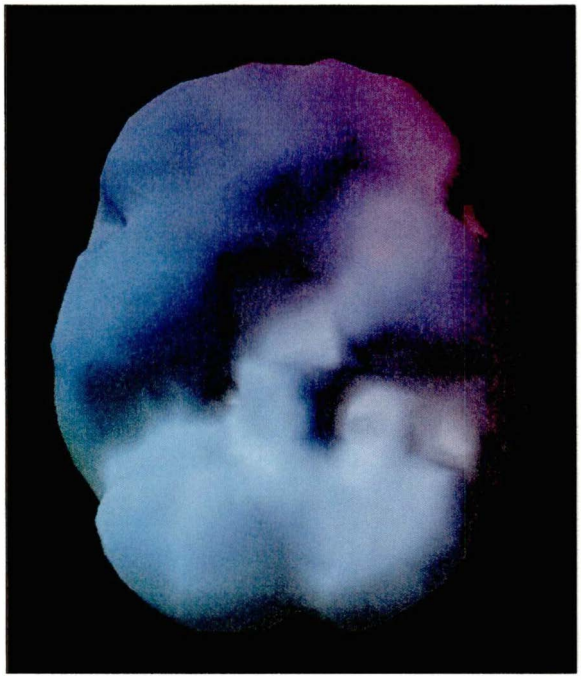
Included in my remaining pain sources are bones spurs around the left hip joint. A couple of them are at least ¾" tall. Yet when I take my supplement regimen, I have almost no pain from them. If it works for me, it can work for others. Keep in mind, that while my regimen is successful for a good number of people, there are assuredly others available, since no one way works for everyone. Still, marijuana use is not an acceptable answer. It causes damage to the only brain anyone will ever have, as you can clearly see from the handful of brain scans I have included. A Search of the Internet yielded a large number of such scans and studies.

INSOFAR AS NAUSEA IS CONCERNED, AGAIN—THERE IS A WIDE VARIETY OF SAFE NATURAL MEANS TO RELIEVE IT.

CT SCANS OF BRAINS OF NON-DOPERS VS MARIJUANA USERS
(WWW.AddictionRecoveryCenterOfTemecula.COM)



Bottom View, Typical Marijuana User's Brain



Bottom View, Brain of Those Who Have Never Used Marijuana

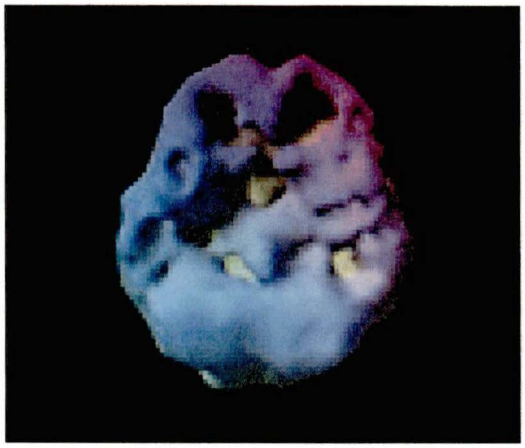
"The effects of smoking marijuana use typically cause decreased activity in the posterior temporal lobes bilaterally.For more information see Dr. Amen's article High Resolution Brain SPECT Imaging in Marijuana Smokers with AD/HD, Journal of Psychoactive Drugs, Volume 30, No. 2 April-June 1998. Pgs 1-13.

... The 57-year-old physician had abused marijuana for 30 years. We performed this SPECT series because he had been unable to stop using without feeling very angry, irritable, agitated and anxious.

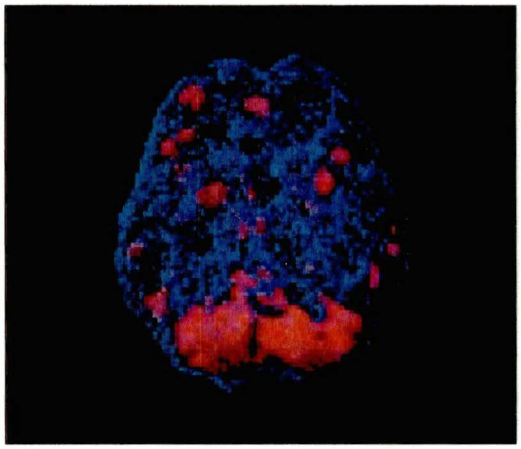
The first study was performed after he came to the clinic intoxicated from 3 straight days of heavy usage. The second study was performed after he abstained from marijuana usage for 1 month.

Notice the study without marijuana shows decreased temporal lobe activity (likely from the chronic marijuana usage), but also increased activity in the deep left temporal lobe (often associated with anger, irritability and anxiety).

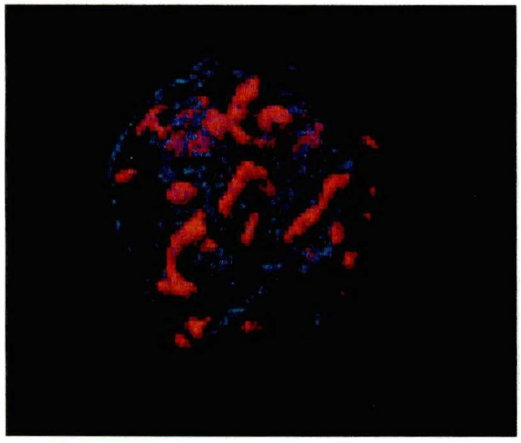
The study with heavy marijuana usage shows marked overall decreased activity, especially in the prefrontal cortex and temporal lobes (associated with attention, memory and motivational problems) but also there is a decrease in the overactive areas noted in the "off marijuana" study.



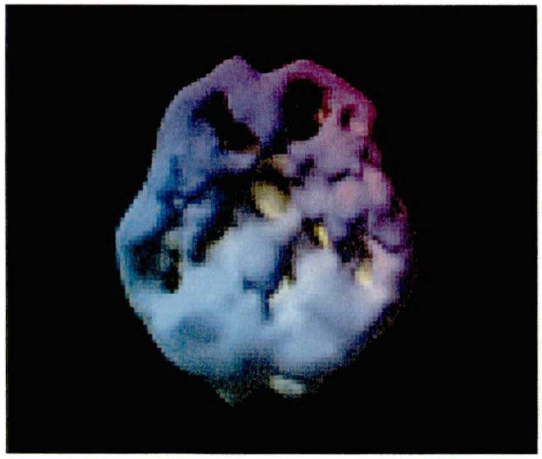
Underside surface view, off THC.
Decreased PFC & Temporal Lobe activity



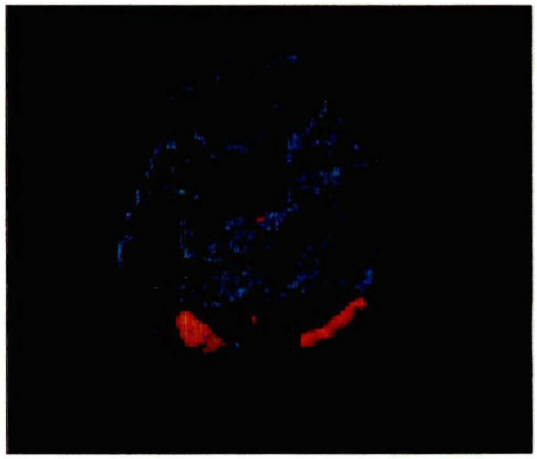
Underside active view, off THC.
Increased deep left temporal lobe activity



Top-down active view, off THC.
Increased overall activity.

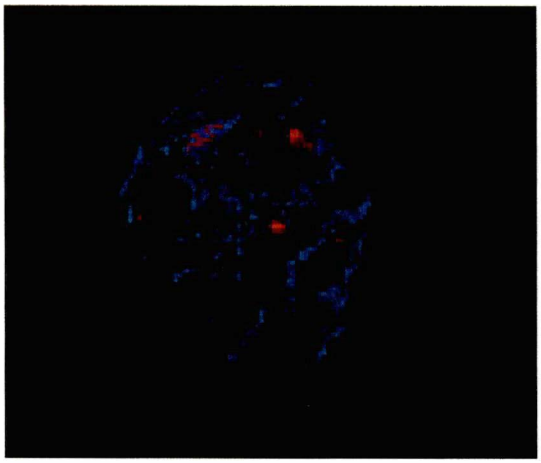


Underside surface view, on THC.
Severe decrease of activity



Underside active view, on THC. Overall decrease of activity

15
COLOR



Top-down active view, on THC. Severe overall decreased activity."

It is easy to *see* the danger marijuana use poses to the only brain anyone ever gets. The law holds that a person has no 'right' to poison or endanger themselves; certainly then, they have no 'right' to poison or endanger others, nor do they have a 'privilege' to do so either.

I cannot urge you strongly enough to recommend Do NOT Pass on this bill, and then do everything you can to stop the passage of it and similar bills. Thank you for hearing me in a good way now. I stand available to answer any questions from the Committee.

Carel Two-Eagle, Mandan, ND

1/6 B/W

In recent years, there has been a great deal of noise about brain damage from a variety of causes. If you ride a bicycle, motorcycle, or atv of any kind, wear a helmet to prevent brain damage. Cars have more air bags to prevent brain damage in crashes. Concussions are a big thing in the football sector. Yet when it comes to dope, particularly marijuana, there seems to be a great deal of silence.

Keeping mind that such materials aren't called "dope" for no reason, then, this is suspect. Marijuana & other forms of dope ***cause brain damage.***

As a Traditional healer with a lifetime of experience and training, as well as constant pain from fibromyalgia for over 40 years, and a variety of injuries which still often cause me deep pain, I know there are far safer things to use and to do to relieve pain than use marijuana. We Traditional healers devise all treatments around the practice of causing no new damage. Marijuana has a long dark history in the middle and far east; where governments there strive to eliminate this material.

In the far east, marijuana is the material of choice for beginning the euthanasia of the elderly and crippled when they cannot be productive. In the far east, casual use has spread to lazy younger people, causing them to lose the will to thrive or strive, thus costing the healthy elements of society there even greater burdens, and the governments of the far eastern nations have gone to great lengths to get rid of marijuana. Laziness being what it is, they will have to continue to battle the attitudes that someone owes the doper a living.

Among dealers of this material in both the far and middle east, dealers are said to 'never' use it, partly because the folklore teaches, (speaking to men only, since women don't appear to 'count', there, except as baby machines and scapegoats), "If you use marijuana, your 'thing' will turn to pus, and *if* you sire any children, they will be monsters (ie, defective)". Scientific studies in the West have repeatedly shown that marijuana does cause genetic changes in users as well as in any children they may produce, be the users male or female. Few studies have been done on the effects of second-hand marijuana smoke, but it is logical that if second-hand smoke from non-spiritual tobacco use causes disease, then the same is true for marijuana & such.

Yet here in the West, some people would sell you a bill of goods and pull the wool over your eyes promoting that marijuana is 'harmless' or 'safe'. This is flatly a lie. The history of this material proves it well enough, but modern scientific tools enable us to have more proof, as shown in the accompanying photos.

I testified earlier that I suffered from fibromyalgia for over 40 years. Note that I spoke in the past tense. In 2014 I more or less accidentally added one safe natural material to my decades-old regimen of nutritional and herbal supplements that I had developed to ease my suffering as well as support my better health, *and in less than a week, my fibromyalgia pain – indeed, the fibromyalgia itself – was gone*.

No 'dope', just safe nutritional and herbal materials available in any health products store, or in some cases, your local supermarket. We are not talking about some minor pain, here.. fibromyalgia causes pain so profound it literally puts people in bed for days on end, or sometimes lifts them off the mattress. Holding a job is often impossible, and some days, getting from the bed

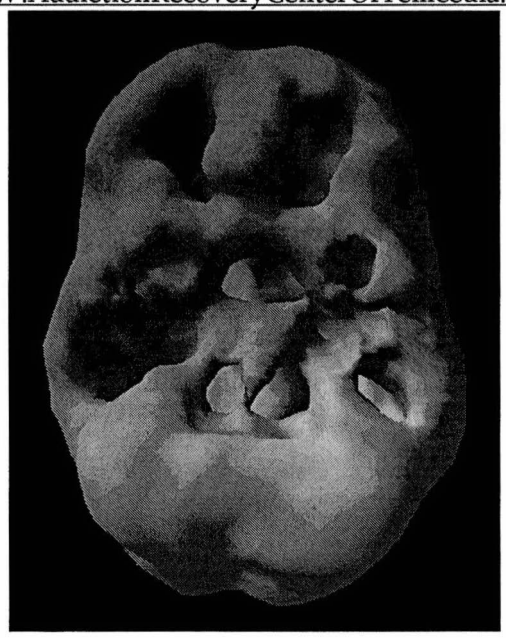
to the bathroom is a major accomplishment. I've been there and done that; although my force of "will and won't" is so strong that I pushed myself to get through it, mostly successfully, for those 40-some years.

I wrote a book detailing my fibromyalgia miracle – It's title is, "My Fibromyalgia Miracle – And Maybe, Yours". It is for sale on its website and on various sales sites. I priced it at a mere $5 in order to enable more exhausted pain-ridden people to have easy access to it, in the hope that I could help more miracles of this kind to occur in the world. I do not doubt that the ingredients in it will work on any pain, since I also have great pain from a variety of serious injuries, and my pain from them is also diminished. Rolling stones gather no moss, but we do gather dings and dents. I am a 'ding and dent special', and I know soul-grinding pain intimately.

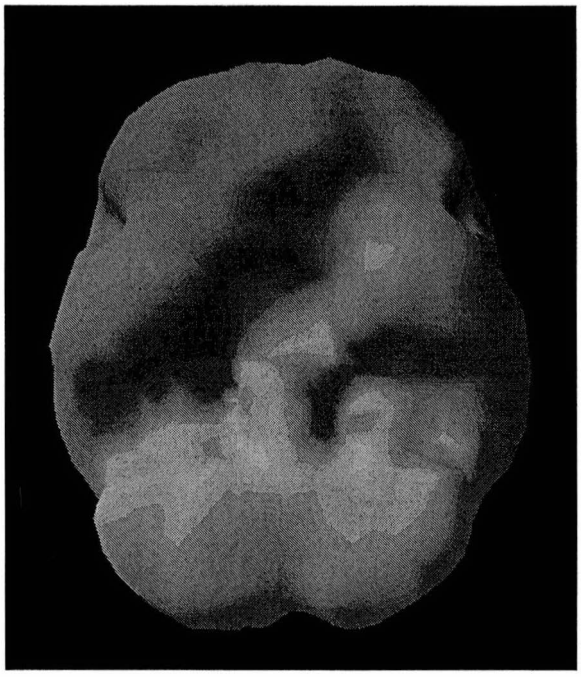
Included in my remaining pain sources are bones spurs around the left hip joint. A couple of them are at least ¾" tall. Yet when I take my supplement regimen, I have almost no pain from them. If it works for me, it can work for others. Keep in mind, that while my regimen is successful for a good number of people, there are assuredly others available, since no one way works for everyone. Still, marijuana use is not an acceptable answer. It causes damage to the only brain anyone will ever have, as you can clearly see from the handful of brain scans I have included. A Search of the Internet yielded a large number of such scans and studies.

INSOFAR AS NAUSEA IS CONCERNED AGAIN – THERE IS A WIDE VARIETY OF SAFE, NATURAL MEANS TO RELIEVE IT.

CT SCANS OF BRAINS OF NON-DOPERS VS MARIJUANA USERS
(WWW.AddictionRecoveryCenterOfTemecula.COM)



Bottom View,Typical Marijuana User's Brain



Bottom View, Brain of Those Who Have Never Used Marijuana

"The effects of smoking marijuana use typically cause decreased activity in the posterior temporal lobes bilaterally.For more information see Dr. Amen's article High Resolution Brain SPECT Imaging in Marijuana Smokers with AD/HD, Journal of Psychoactive Drugs, Volume 30, No. 2 April-June 1998. Pgs 1-13.

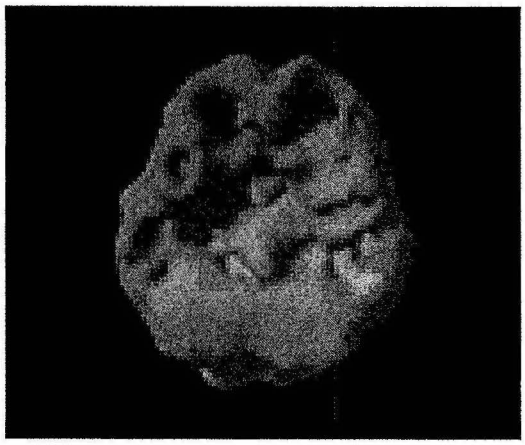
... The 57-year-old physician had abused marijuana for 30 years. We performed this SPECT series because he had been unable to stop using without feeling very angry, irritable, agitated and anxious.

The first study was performed after he came to the clinic intoxicated from 3 straight days of heavy usage. The second study was performed after he abstained from marijuana usage for 1 month.

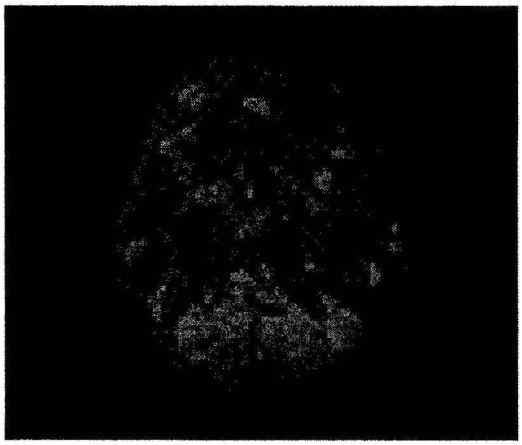
Notice the study without marijuana shows decreased temporal lobe activity (likely from the chronic marijuana usage), but also increased activity in the deep left temporal lobe (often associated with anger, irritability and anxiety).

The study with heavy marijuana usage shows marked overall decreased activity, especially in the prefrontal cortex and temporal lobes (associated with attention, memory and motivational problems) but also there is a decrease in the overactive areas noted in the "off marijuana" study.

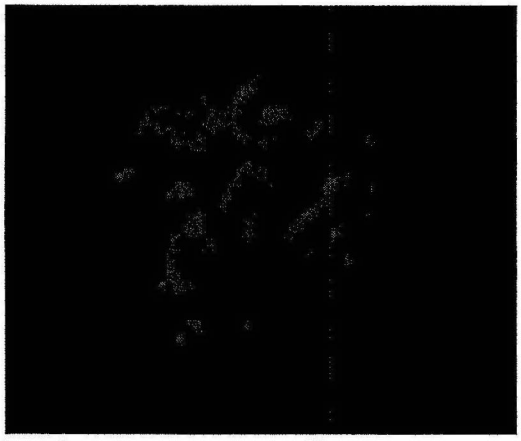
4/5
B/W



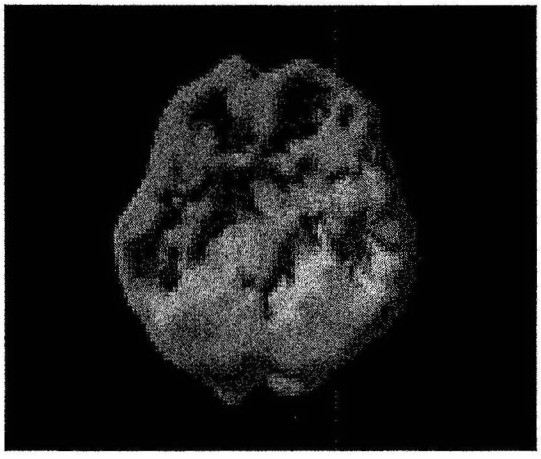
Underside surface view, off THC.
Decreased PFC & Temporal Lobe activity



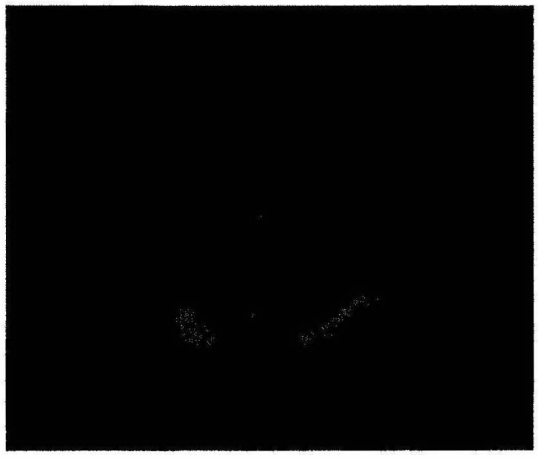
Underside active view, off THC.
Increased deep left temporal lobe activity



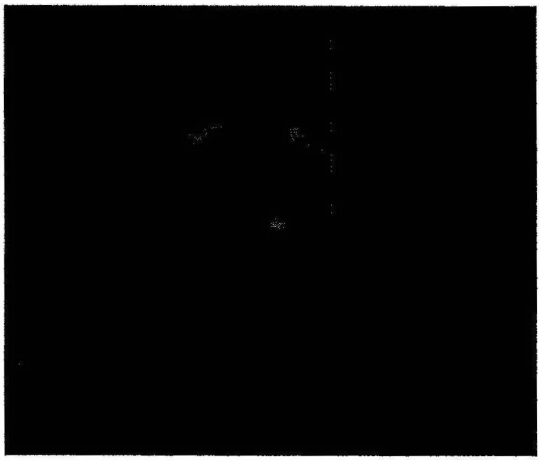
Top-down active view, off THC.
Increased overall activity.



Underside surface view, on THC.
Severe decrease of activity



Underside active view, on THC. Overall decrease of activity



Top-down active view, on THC. Severe overall decreased activity."

It is easy to *see* the danger marijuana use poses to the only brain anyone ever gets. The law holds that a person has no 'right' to poison or endanger themselves; certainly then, they have no 'right' to poison or endanger others, nor do they have a 'privilege' to do so either.

I cannot urge you strongly enough to recommend Do NOT Pass on this bill, and then do everything you can to stop the passage of it and similar bills. Thank you for hearing me in a good way now. I stand available to answer any questions from the Committee.

Carel Two-Eagle, Mandan, ND

2-4-15

In support of HB 1430 #12

House Bill 1430

Leanne Grondahl [leanne.grondahl@minot.k12.nd.us]

Sent: Tuesday, February 03, 2015 6:29 PM
To: Maragos, Andrew G.
Cc: Anderson, Pamela K.; Glassheim, Eliot A.; Nelson, Marvin E.; Strinden, Marie J.; Schneider, Mac J.; Hawken, Kathy K.
Attachments: Mayo neurologist Recommend~1.pdf (51 KB)

Mr. Maragos - Thank you for talking with Shane at the Legislative forum on Saturday. He said that you requested more information on his condition so here it is.

I am attaching page four of Shane's clinical documents from Mayo where Dr. Sandroni subscribed medical marijuana for Shane's condition. If you would like all six pages of the clinical documents please let me know and I will send them.

My husband (54 at the time) had a stroke in May of 2011, the same month we had to move out of our house for the devastating flood. He did not lose any of his mobility but due to severe and permanent nerve damage he has constant and permanent pain, 24/7. He also has neuropathy on the entire right side of his body which causes pins and needles constant discomfort. He is still trying to work full time but it is getting harder all the time. He is on so many painkillers but he tries to take the lowest dose possible. Some days he has to use all his energy and take all of his daily pain pills just to get through the work day and then he has to come home and sleep until the next morning when he takes his pain pills and goes back to work. I have tears in my eyes just typing this as I think of what he has to endure every day of his life.

He was referred to the Mayo clinic in August of 2013 to see if he was eligible for a new surgery called Deep Brain Stimulation. After all of his tests he was told that this surgery would be a last resort because of the risks and seriousness and that there is only a 50% chance that this would even work for Central pain Syndrome and if it does it would probably only take away 50% of the pain anyway. Dr. Paola Sandroni, an accomplished neurologist at Mayo recommended that he use marijuana to ease his pain. She said is it very unfortunate that this has not been approved for medical use in North Dakota yet. He did try this, it did work and he was ecstatic. He said it was the first time since 2011 that he did not feel any pain! He said the painkillers never take all the pain away but the marijuana did. And the painkillers have too many side effects. The only time he is not in pain is when he is sleeping.

This would be a life changer for my husband, for the good for a change, if this bill passes. He would not have to go home every evening and take a tranquilizer to sleep half of his life away just so that he doesn't have to feel pain any longer.

Please do not deny this help to people who desperately, desperately need it to maintain a productive and less pain full life. It has been proven many times over to help many people and I do not think prestigious neurologists and neurosurgeons at the Mayo clinic would subscribe this if it was not necessary and helpful. I can't imagine why anyone would not want to help someone who needs this type of help.

Leanne Grondahl
Leanne.grondahl@gmail.com
517 12th St SW
Minot, ND 58701

Indication, Site, and Additional Prescription Instructions:
1 cap daily for 5-7 days, then increase to 150 mg

venlafaxine 225 mg tablet sustained release 24 hour 1 TABLET by mouth one time daily.

These are the patient's medications as of Wednesday, 14-Aug-2013 at 13:41.

SYSTEMS REVIEW

PAIN SCALE
Patient's pain was reported using the numeric pain scale. Patient rates right side of body pain at 6/10.

TOBACCO STATUS
Tobacco Status: Patient reports past use of cigarettes.
Tobacco Cessation: Tobacco cessation information provided to the patient/caregiver (MC7027).

VITAL SIGNS

Height: 168 cm. Weight: 84.0 kg. BSA(G): 1.9388 M2. BMI: 29.76 KG/M2. (14-Aug-2013 13:05)

Blood Pressure: 110/69 mmHg, single reading, left arm sitting. Pulse Rate: 69/minute (14-Aug-2013 13:05)

PHYSICAL EXAMINATION

Neuro: Neurological exam is as per the electronic neuro sheet from today. The exam is significant for the fact the patient has a hemisensory syndrome with impairment particularly of the touch and vibration on the right side. He has impairment of pinprick and heat sensation, but cold, if anything, is felt more, although not to a painful degree. He has allodynia to light touch. The rest of the exam is actually unremarkable.

IMPRESSION/REPORT/PLAN

#1 Central pain syndrome
#2 Diabetes
#3 Thoracic radiculopathy secondary to diabetes

At this point, looking at the MRI, the lesion is a little bit more anterior than I would have expected, but clearly he has a central pain syndrome secondary to the stroke. In terms of management, I see that Dr. Sampson just started him on Effexor. I think it is a very good idea. That can also help the pain. In terms of medication that could be tried, I would suggest them in this sequence. Baclofen first starting at 5 mg three times a day and increasing up to 20 mg three times a day if tolerated. Another option would be Lamictal starting at 25 mg twice a day and increase gradually up to 200 mg or even 400 mg divided doses per day. Then if those drugs are not effective, then we need to consider either something like Gabitril or Zonegran or just jump straight to an opiate such as methadone. Another thing that really could help is marijuana. The patient admitted he had tried it, and in was clearly helpful. Unfortunately, it is not approved for medical use in North Dakota. That is unfortunate, but that is definitely something that could help him. Also, acupuncture, massage, and exercise would be beneficial. The next step would be also with our pain rehab. I think that would be quite helpful for Mr. Grondahl. From a neuromodulation standpoint, I think he would be definitely a candidate, but I would rather exhaust the noninvasive options first. The patient also agrees with that plan.

It has been a pleasure to visit with him.

ADVANCE DIRECTIVES
Patient would like additional information. Advance Directive information packet provided to the
patient/caregiver (MC2107-04, MC2107-05, MC2107-07, MC2107-08).

#13
Support

February 4, 2015 House Bill 1430

Representative Pamela Anderson, and committee members,

Please consider a green vote on HB 1430. My son , Samuel, has had a severe seizure disorder for 23 years. It has taken away most of his ability to speak and function. We have travelled across the country to find any hope from the top specialists in America, but the only potent FDA approved drugs we can access, have not stopped his seizures; among the numerous deadly side –effects he has suffered from, he has also been subjected to surgeries and painful tests and injections,- to no avail.

Please help our Sam, and many other individuals who might actually find hope and great relief, in the Cannabis plant. Many stunning reports are showing such great promise with the use of CBD oil, which is low in THC- the mind altering chemical. We do not want our state to allow recreational use, just the ability to help those that could benefit medically.

Please give us the chance to give Sam the HOPE and healing with a safe alternative as many other parents have found, now that their states are legally dispensing medical marijuana to their suffering family members.

Thank you for your consideration.

Sincerely,

David C Rennich

David C. Rennich
Father of Samuel Rennich
7060 Horseshoe Bend
Bismarck, ND 58503
701-258-2064

HB 1430

Handed In #14

2-4-15

House Bill 1430
Sixty-fourth Legislative Assembly
Testimony of Mike Reitan, Chief of Police, West Fargo Police Department

Good morning Chairman Weisz, Vice Chair Hofstad and members of the Human Services Committee.

My name is Mike Reitan and I am the Chief of Police of the West Fargo Police Department. I express my grave concern with the language of HB 1430 and the unidentified fiscal burden and liability placed upon the state of North Dakota. I respectfully request your opposition of HB 1430.

As noted in the prepared Fiscal Note HB 1430, 2 B paragraphs 3 and 4:

Paragraph 3
Section 19-24-05 further requires the DoH to consider petitions to add serious conditions or the condition's treatment to the list of debilitating medical conditions as defined under section 19-24-01(8) in the same chapter. This is far beyond the current capacity of the DoH to do the research and laboratory testing necessary in place of the Food and Drug Administration (FDA) to add such conditions or treatment and would place a tremendous liability on the state. The needed resources are unable to be estimated at this time and these costs are not reflected in this fiscal note.

Paragraph 4
The new legislation also defines a cannabis testing facility which is to be registered with the DoH to address the safety and potency of cannabis. At this time we are unable to estimate the costs associated with testing the safety and potency of cannabis and these costs are not reflected in this fiscal note.

The Food and Drug Administration has extensive rules and regulations to ensure the safety of the consumer relating to prescription and over the counter medications. Those rules include proper oversight of research and testing, production, labeling and product recall when an approved product is found to be harmful. As noted in the Fiscal Note, DOH indicate the required oversight to be, *"This is far beyond the current capacity of the DoH to do the research and laboratory testing necessary in place of the Food and Drug Administration (FDA) to add such conditions or treatment and would place a tremendous liability on the state."* In addition, the proposed 19-24-15, page 22 line 8, requires DoH to have such oversight in place *"no later than one hundred and twenty days after the effective date of this act."* DoH may be able to have in place rules within the 120 day requirement but in no way would they have the funding, personnel, equipment or facilities to implement the rules.

Also noted in the Fiscal Note was DoH research indicated this new legislation was most similar to the state of Colorado's medical cannabis program. Colorado has experienced a significant number of issues relating to their medical cannabis program to include overdose incidents; violent crimes associated with the industry and some unusual types of incidents. An unintended consequence of marijuana production in Colorado is highlighted in the New York Times headlight: Odd byproduct of legal marijuana: Homes that blow up (CO) http://www.nytimes.com/2015/01/18/us/odd-byproduct-of-legal-marijuana-homes-blow-up.html.

If the intent is to move to a medical cannabis program I would propose the state of North Dakota follow the state of Minnesota's more regulated program limiting the number of production facilities and restricting the types of usable products to allow for more effective control and quality assurance. The State of Minnesota has taken a different approach to the use of marijuana for medical purposes.

Legislation passed during the 2014 Minnesota legislative session created a new process allowing seriously ill Minnesotans to use marijuana to treat certain conditions. The marijuana will not be available through a pharmacy. Instead, patients with one of the qualifying conditions will be eligible to enroll in a patient registry maintained by the State. Patients on this registry will be able to get marijuana directly from one of eight dispensaries set up around the state. Marijuana for medical treatment will be provided to patients as a liquid, pill or vaporized delivery method produced in a laboratory and that does not require the use of dried leaves or plant form.

Under HB 1430 a person could possess 2.5 ounces of marijuana and 6 marijuana plants (19-24-01 (1)). Web sites relating to the use and cultivation of marijuana indicate 1 ounce of marijuana can be rolled into 37 to 54 marijuana cigarettes or joints at .5 to .75 grams per joint. The 2.5 ounces allowed by statute would equate to up to 135 joints. Each of the 6 marijuana plants should product 1 to 2 ounces of usable marijuana. If the grower uses a more sophisticated technique the yield could be up to 5 ounces per plant. The 6 plants allowed would result in 12 to 30 ounces of usable marijuana. The growth cycle from planting the marijuana seed to harvest of the crop averages 4 to 5 months. In addition, a person could file to be a care giver for up to 5 other people allowing the 1 person to possess 15 ounces of marijuana and 36 plants (19-24-01(10)). This marijuana grow operation and dispensary would be allowed in the home, garage or shed belonging to your next door neighbor. Local ordinances regulating such facilities would be restricted under (19-24-13).

The law would allow for the manufacture and possess of edible marijuana products and other derivatives of marijuana. Colorado, a state where marijuana use is legal, is currently drafting legislation relating to the packaging and labeling of edibles containing cannabis. As the production methods have become more refined the potency of the marijuana has greatly increased. Dosing units have been a problem in Colorado with numerous overdoses of the highly concentrated product. Another concern is the marijuana product being marketed as baked goods or as candies which can be easily misidentified by children.

A number of the effective FDA approved prescription medications in use today get their origin in plant or animal material. The scientific analysis relating to the health benefits and risks of marijuana as it is currently being used remains unclear. Through the scientific laboratory development, testing and approval process there may be a similar benefit found in marijuana.

I respectfully ask your opposition of HB1430.

I thank you for your time and stand available for any questions you may have.

Michael D Reitan
Chief of Police, West Fargo
701-433-5521 Office
701-367-1708 Mobile
Mike.reitan@westfargond.gov

#1

15.0765.01001
Title.

Prepared by the Legislative Council staff for
Representative P. Anderson
February 2, 2015

2-11-15

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1430

Page 1, line 2, remove "and"

Page 1, line 2, after "penalty" insert "; and to provide an effective date"

Page 1, line 9, remove "and one-half"

Page 1, line 12, after "plants" insert ", three or fewer being mature flowering plants producing a useable form of marijuana"

Page 3, line 1, replace "Has agreed to assist with a qualifying patient's medical use of cannabis" with "Has agreed to be responsible for managing the well-being of a patient with a debilitating medical condition; and"

Page 3, line 2, remove "; and"

Page 3, remove lines 3 through 5

Page 3, line 6, remove "designated caregiver is employed"

Page 4, line 16, remove "or"

Page 4, line 18, after "facility" insert: "; or

d. The smoking of cannabis"

Page 10, line 24, remove "Smoking cannabis:"

Page 10, remove lines 25 and 26

Page 10, line 27, remove "c."

Page 12, line 15, after the underscored semicolon insert "or"

Page 12, line 16, remove "Any person in lawful possession of property to allow a guest, client, customer, or"

Page 12, remove line 17

Page 12, line 18, remove "c."

Page 29, after line 11, insert:

"**SECTION 2. EFFECTIVE DATE.** This Act becomes effective on June 30, 2016."

Renumber accordingly

15.0765.01003
Title.

2-11-15

Prepared by the Legislative Council staff for
Representative Oversen
February 9, 2015

#2

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1430

Page 1, line 2, remove "and"

Page 1, line 2, after "penalty" insert "; and to provide an effective date"

Page 1, line 9, remove "and one-half"

Page 1, line 9, after the underscored semicolon insert "or"

Page 1, line 10, remove the underscored semicolon

Page 1, remove lines 11 through 15

Page 1, line 16, remove "same property where the plants were cultivated"

Page 2, line 22, after the underscored semicolon insert "or"

Page 2, line 26, replace "; or" with an underscored period

Page 2, remove lines 27 and 28

Page 2, line 31, after the underscored semicolon insert "and"

Page 3, line 1, replace "Has agreed to assist with a qualifying patient's medical use of cannabis;" with "Has agreed to be responsible for managing the well-being of a patient with a debilitating medical condition."

Page 3, remove lines 2 through 6

Page 4, line 14, remove "nonresident"

Page 4, line 15, remove "The cultivation of cannabis by a cardholder who is not designated as being"

Page 4, remove line 16

Page 4, line 17, remove "c."

Page 4, line 18, after "facility" insert: "; and

c. The smoking of cannabis"

Page 6, line 11, remove "and one-half"

Page 10, remove lines 8 through 15

Page 10, line 24, remove "Smoking cannabis:"

Page 10, remove lines 25 and 26

Page 10, line 27, remove "c."

Page 12, line 15, after the underscored semicolon insert "or"

Page 12, line 16, remove "Any person in lawful possession of property to allow a guest, client, customer, or"

Page 12, remove line 17

Page 12, line 18, remove "c."

Page 15, line 21, remove "A clear indication of whether the cardholder has been designated to cultivate"

Page 15, remove line 22

Page 15, line 23, remove "g."

Page 15, line 24, replace "h." with "g."

Page 16, line 16, remove "Whether the cardholder is permitted to cultivate cannabis plants;"

Page 16, remove "e."

Page 16, line 19, replace "f." with "e."

Page 17, line 25, replace "**canabis**" with "**cannabis**"

Page 18, line 4, remove "and one-half"

Page 18, line 5, after the first underscored comma insert "or"

Page 18, line 5, remove ", six"

Page 18, line 6, remove "cannabis plants, and the cannabis produced by those plants"

Page 18, line 12, remove "and one-half"

Page 20, line 16, remove "A local government may not prohibit dispensaries, either expressly or through the"

Page 20, remove lines 17 and 18

Page 20, line 19, remove "3."

Page 22, line 1, remove "and one-half"

Page 29, after line 11, insert:

"**SECTION 2. EFFECTIVE DATE.** This Act becomes effective on June 30, 2016."

Renumber accordingly