To :	California Senator Lou Correa
From :	Americans for Safe Access
	Mayor Robert Jacob, City of Sebastopol
Date:	March 10, 2014
Re:	SB 1262 – Suggested Improvements

Summary

Americans for Safe Access (ASA), the nation's leading medical cannabis patients' advocacy organization, strongly supports the sensible regulation of commercial medical cannabis cultivation, processing, provision, and testing. We are encouraged by the decision of the League of California Cities and the California Police Chiefs Association to sponsor Senator Lou Correa's SB 1262, a bill that will regulate doctors who recommend medical cannabis and the cultivation and provision of medicine.

While the inclination to regulate medical cannabis activity is a good one, the bill needs improvements to ensure that the interests of legal medical cannabis patients are respected. Our recommendations for changes to make the bill work best for California's patients include:

1. Adding incentives for local jurisdictions that choose to regulate medical cannabis cultivation, processing, provision, and testing.

2. Providing for sliding scale licensing fees to protect smaller cooperative patient cultivation in the state.

3. Adding language to ensure that those patients' cooperatives and collectives qualified to operate under Measure D, adopted by voters in the City of Los Angeles in 2013, or other similar local ordinances will also be qualified under this measure.

4. Making significant changes to the regulations for doctors who recommend medical cannabis to ensure that the bill does not inadvertently choke off access to medicine for legitimate patients.

5. Other smaller changes, as described below.

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Local Authority to Ban Licensed Dispensing Facilities

SB 1262 authorizes local jurisdictions to regulate and ban Licensed Dispensing Facilities (LDF). This preserves the status quo established by the California Supreme Court decision in *City of Riverside v. Inland Empire Patients Health and Wellness Center* (2013, 56 Cal. 4th 729). ASA acknowledges the state of the law in light of the *Riverside* decision. However, while bans are permitted under SB 1262, ASA holds that policies banning local access to medical cannabis are harmful and burdensome to both patients and neighboring communities that must bear the burden of supplying a greater patient population than they would otherwise have to (traffic, parking, utilities, public transportation, etc.).

Unfortunately, the landscape of access to medical cannabis in California is bleak. Although more than fifty local governments have adopted and successfully implemented local distribution regulations, more than 200 localities have banned it outright. This patchwork landscape of unequal access has led to significant hardship for hundreds of thousands of patients, who are being punished based simply on where they live. Therefore, the state should provide incentives to encourage cities and counties to adopt sensible regulations for LDF and Licensed Cultivation Facilities (LCF).

Research conducted by ASA and the experience from nearly ten years of local ordinances show that regulations reduce crime and complaints around medical cannabis facilities. Greater detail about the outcomes of local regulation of medical cannabis can be found in our report, updated in 2011, entitled *Medical Cannabis Dispensing Collectives and Local Regulation*. Elected officials and law enforcement officers interviewed for this report acknowledged that regulating medical cannabis activity is beneficial for the community as a whole, so encouraging regulation is sound public policy. Download the report at http://www.safeaccessnow.org/asa_reports or call (916) 449-3975 for a hardcopy. Another report recently issued by the University of Colorado Denver School of Public Affairs about the impact of medical cannabis dispensaries in Colorado similarly found that medical cannabis dispensing operations do not harm local communities. You can read the abstract for "Do medical marijuana centers behave like locally undesirable land uses? Implications for the geography of health and environmental justice," Lyndsay N. Boggess, *et al*., 2014, at http://tinyurl.com/Univ-CO-Study

Because sensible regulation preserves access for legal patients and reduces crime and complaints in communities, ASA urges the Author to include incentives for local governments to opt-in by effectively regulating LDF and LFC activity pursuant to SB 1262. ASA is committed to working with the Author and other stakeholders to create incentives for cities and counties to adopt regulations with the aim of creating a more equitable statewide system of access:

1. Special allocations – The legislature can create special allocations of funds for cities and counties that choose the better policy of regulating LFC and LDF. These allocations might include a larger share of local sales tax revenue, a portion of annual licensing fees designated for local mitigation (traffic, parking, utilities, public transportation, etc.), regional transportation funds, and funds for the District Attorney's Office.

2. Development agreements – A development (or mitigation) agreement is a contract between a local jurisdiction and a person who has ownership or control of property within the jurisdiction. The purpose of the agreement is to specify the standards and conditions that will govern development or use of the property. These agreements are already used for development projects in California and could be adapted to give jurisdictions leeway in using funds generated by a permitting or licensing LDF and LDC pursuant to SB 1262 for system-wide community improvements or projects, including roads, schools, and public safety.

Sliding Scale Licensing

Some lawmakers and other stakeholders interpret Health and Safety Code 11362.765(a), which states that "nor shall anything in this section authorize any individual or group to cultivate or distribute marijuana for profit" to require the nonprofit operation of LCF and LDC. Indeed, many of California's existing medical cannabis patients' cooperatives and collectives operate on a non-for-profit or nonprofit basis. These patient-operated associations may struggle to compete with better-financed commercial medical cannabis organizations. Protecting small, not-for-profit patient cultivation is an important part of preserving self-reliance in the state's medical cannabis community and protecting economically disadvantaged patients. The legislature should empower the Department of Health to create a sliding scale to accommodate smaller scale quasi-commercial patient cultivation and a set of criteria to determine which patients' associations qualify for reduced fees.

Limited Immunity Ordinances

In *Pack v. City of Long Beach (199 Cal.App.4th 1070, 2011)*, the Appellate Court held that the city's authorization of medical cannabis cooperatives and collectives by issuing business licenses was preempted. The California Supreme Court later dismissed the case on procedural grounds, and while the issue of federal preemption has generally been resolved, concerns among local officials remain. In response to an ordinance banning medical cannabis facilities outright, voters in Los Angeles approved Measure D in 2013 to allow for a limited number of facilities in the city. Measure D was crafted to avoid a legal challenge asserting federal preemption based on an argument like that in the *Pack* decision.

Measure D bans all medical cannabis activity in Los Angeles, but creates limited immunity for cooperatives and collectives that meet certain criteria, including restrictions on location, date of opening, hours of operation, etc. Because the city does not authorize medical cannabis activity, there is no business license, permit, or other document issued by the city to demonstrate compliance with Measure D. This would be problematic for more than 100 facilities qualified to operate under the measure, since they would be unable to produce a certified copy of the city's approval to operate required under Section 111657.1(c)(4) of the Act.

Last year, the Los Angeles City Attorney and City Council initially opposed AB 604 by Assembly Member Tom Ammiano because language in that bill also required local authorization before an applicant received a state registration for medical cannabis activity. The City Attorney and City Council feared that cooperatives and collectives qualified under Measure D would not qualify under AB 604. To address that concern, this language was added to Section 26055 of AB 604:

> *"Entities that are provided immunity under Measure D, approved by the voters of the City of Los Angeles on the May 21, 2013, ballot, shall be considered the equivalent of entities that are registered, permitted, or licensed as a medical marijuana business, dispensary, or other entity involved in providing medical marijuana to patients under a local ordinance and shall be considered in compliance with a local ordinance for the purposes of the implementation of the act adding this section and any regulations promulgated by the department."*

ASA recommends including similar language in AB 1262 to allow patients' associations immunized under Measure D and similar ordinances to qualify for a state license.

<u>Regulations for Doctors Recommending Medical Cannabis</u>

There are instances in which doctors in California have failed to uphold the accepted standards for recommending medical cannabis published by the California Medical Board in 2004. Since ASA believes that the California Medical Board should take the lead in enforcing those standards, we see a limited benefit to legislative action in this arena. As such, we urge caution in adopting regulations governing doctors recommending medical cannabis because:

- Physicians will be discouraged by the proposed restrictions from recommending cannabis to their patients, and may also be discouraged from learning more about its benefits.
- Onerous or unworkable regulations such as these could prevent legitimate patients from obtaining a recommendation for medical cannabis use.
- Some of the proposed regulations for doctors may be construed by the courts to be an unconstitutional restriction to a voter-approved initiative, Proposition 215.

Section 2525 ("Recommending Medical Marijuana") establishes numerous regulations for doctors recommending medical cannabis. As written, the regulations will severely limit the number of patients who receive a recommendation for medical cannabis use in California. ASA encourages the Author to make the changes described below to ensure that the bill addresses the concerns raised by the sponsors and others, while preserving the ability of patients to find physicians who are willing to recommend medical cannabis:

1. Section 2525(a)(1) requires that a recommendation be made by the patient's primary care physician or a doctor to whom the patient was referred by his or her primary care physician. Due to personal beliefs or employer policies, some doctors are unable or unwilling to write a recommendation or make a referral. Other patients may not have a primary care physician to consult. ASA recommends adding language to this Section that specifies that a patient can receive a recommendation from a doctor who meets the following criteria, even if the doctor is not the patient's primary care physician or a doctor to whom the patient was referred by his or her primary care physician:
    a. The recommending doctor is licensed to practice medicine in California.
    b. The recommending doctor's license is not suspended or revoked.
    c. There are no restrictions regarding making medical cannabis recommendations imposed by the California Medical Board.

2. Sections 2525(b)(1) and 2525(b)(2) require the doctor making a medical cannabis recommendation to specify the quantity, route of administration, side effects, and type of medical cannabis to be used by the patient. Unfortunately, legal issues have stymied clinical research into medical cannabis for decades. While scientific and clinical data is emerging, doctors have little formal training and relatively no practical experience with regards to dosage, route of administration, side effects, and the relative efficacy of various types of medical cannabis. Doctors may justifiably fear that such specificity could leave them vulnerable to claims of malpractice or legal consequences for operating outside the First Amendment protection affirmed by the federal courts in Conant *v. Walters* (9th Cir.2002) 309 F.3d 629. That decision protects a doctor's right to recommend medical cannabis under federal law, but cautions against aiding and abetting patients in obtaining medical cannabis. ASA recommends limiting the requirements for doctors to providing patients with scientifically-valid disclosures discussing dosage, route of administration, side effects, and the efficacy of various strains of medical cannabis in general terms.

3. Section 2525(c) requires that the medical cannabis approved for minors be for plant strains high in cannabidiol (CBD). ASA recommends instructing the Department to research the science and clinical data on medical cannabis use by minors before issuing guidelines and should only do so as needed. The Department should be instructed to base any subsequent rules, in part, on clinical data contained in the *Cannabis Monograph*, which will be published by the American Herbal Pharmacopeia in 2014.

4. Section 2525.1(a) requires that doctors report all recommendations, with supporting documentation, to the California Medical Board. This requirement will produce an unreasonable burden on the staff at the Medial Board. It would be more prudent to require doctors who make recommendations to retain all required records for review if required as part of an audit or investigation.

5. Section 2525.1(b) requires a mandatory audit by the California Medical Board of any doctor that issues more than 100 medical cannabis recommendations. ASA recommends that audits be triggered by the existing mechanism of complaints to the California Medical Board, as opposed to an arbitrary numeric trigger. The Board could then investigate meritorious complaints, regardless of the number of recommendations issued, based on the records required to be kept under the SB 1262.

6. Section 2525.2 requires the California Medical Board to establish a certification process for doctors writing medical cannabis recommendations. ASA believes that a physician registry is unnecessary, burdensome for doctors, and because of this chilling to their participation in the program. A real unintended consequence of such requirements could curtail the ability of patients to easily and affordably obtain a recommendation. If the program is included in the bill, there should at least be a one-year delay in making certification mandatory. This will provide sufficient time to create the program, if needed, and certify enough doctors to provide annual recommendations to legitimate patients. Furthermore, if this provision is imposed, the Act should authorize the California Medical Board to contract with an independent organization to certify doctors. A similar measure for certifying staff at medical cannabis facilities in Washington, DC, could be a model for a program that shifts the time and expense away from the Medical Board.

Cultivating and Dispensing Medical Cannabis

1. Section 111657.1 prohibits anyone from engaging in commercial medical cannabis activity without local and state approval. The effective date of this requirement should be delayed for one year to allow the Department to develop the state licensing process, solicit applications, and approve LDF,LCF, and other applications. Without a delayed effective date for this Section, there will not be any legal access when SB 1262 becomes effective. This disruption in access for qualified patients would be harmful and unnecessary.

2. Section 111657.2 requires the Department, after consulting with outside entities as needed, to create standards for quality assurance testing. ASA strongly recommends that the standards already established by the American Herbal Products Association (AHPA) for cultivating, processing, providing, and testing medical cannabis be

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incorporated into these standards. AHPA is the leading voice in the national herbal products industry, and their standards represent the emerging professional and scientific consensus for the field of medical cannabis. You may download copies of the AHPA guidelines and other relevant documents here: http://www.patientfocusedcertification.org/ or call (916) 449-3975.

3. Section 111657.3(b) requires that LDF only acquire medicine from a LCS. If this provision is necessary, its effective date should be one year after the effective date of the Act. This will allow sufficient time for regulations for and licensing of cultivation sites. Without a delayed effective date, LDF will be unable to legally obtain medicine for legitimate patient members.

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Additional Resources Online

Report: Medical Cannabis Dispensing Collectives and Local Regulation –
ASA report on the outcomes of regulations in California cities
http://www.safeaccessnow.org/asa_dispensary_report

Report: Do medical marijuana centers behave like locally undesirable land uses? Implications for the geography of health and environmental justice –
University of Colorado Denver School of Public Affairs report on the impact of medical cannabis facilities on communities
http://tinyurl.com/Univ-CO-Study

Patient Focused Certification–
Third-party certification and training for the medical cannabis field, recommendations for regulators
http://www.patientfocusedcertification.org/

American Herbal Products Association –
Leading voice of the herbal products industry, published standards for medical cannabis
http://ahpa.org/ or call (301) 588-1171

American Herbal Pharmacopeia –
Published the *Cannabis Monograph* concerning testing and clinical use of medical cannabis
http://herbal-ahp.org/ or call (831) 461-6318

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