Written Statement of Kris Krane, President of 4Front Ventures
Wednesday, January 15, 2020,
House Energy and Commerce Subcommittee on Health legislative hearing on
"Cannabis Policies for the New Decade."

Thank you to Chair Eshoo and the Energy and Commerce Subcommittee on Health for holding this hearing on cannabis policies, its schedule status in the Controlled Substance Act ("CSA"), and the related barriers to research that are impeding public health knowledge. With 33 states with regulated medical cannabis programs and 11 with regulated adult-use systems, millions of Americans are purchasing cannabis that is packaged and sold in accordance with state law. Support for these programs is substantial with 91% of Americans supporting medical cannabis 67% supporting adult use, including majority support across nearly every age group and political ideology.[1] But in the two-and-a-half decades since states began to permit legal access to cannabis, federal law has not kept up with the states or the American public.

Despite the lack of evolution in federal law, this session of Congress has seen substantial movement on the issue, with the SAFE Banking Act (H.R. 1595) passing on the House floor with strong bipartisan support and the MORE Act (H.R.3884) which would remove ("deschedule") cannabis from the CSA, receiving a favorable markup in House Judiciary. We appreciate the Health Subcommittee holding this hearing to examine impacts of changing the CSA status of cannabis and barriers to research.

Schedule Status of "Marihuana"

Cannabis has been a Schedule I drug since the CSA was signed into law in 1971; however, lawmakers only placed it in the most restrictive schedule as a placeholder. It ended up there permanently for political reasons. President Nixon convened the National Commission on Marihuana and Drug Abuse (more commonly known as the Shafer Commission) to examine the potential harms of cannabis legalization and make a recommendation on schedule placement within the CSA. The Shafer Commission recommended that personal possession of cannabis be decriminalized and even recommended fines over prison for amounts greater than personal possession.[2] Nixon ignored the commission's recommendation. In a lawsuit challenging the president's decision, the DEA's own administrative law judge ruled: "Marijuana, in its natural form, is one of the safest therapeutically active substances known to man," while recommending that it's placement in Schedule I was inappropriate.[3]

To date, neither Congress nor any administration has implemented these recommendations. However, states have taken it upon themselves to remove criminal penalties for cannabis. In 1996, California became the first of 33 states to enact medical cannabis laws. By 2018, 2.3 million Americans were

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[1] "Nearly eight-in-ten Democrats and Democratic-leaning independents (78%) say marijuana use should be legal. Republicans and Republican leaners are less supportive, with 55% in favor of legalization and 44% opposed."https://www.pewresearch.org/fact-tank/2019/11/14/americans-support-marijuana-legalization/

[2] The Shafer Commission report is available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1749335/pdf/bullnyacadmed00168-0058.pdf

[3] United States Department of Justice, Drug Enforcement Administration, in the Matter Of Marijuana Rescheduling Petition," Opinion and Recommended Ruling, Findings of Fact, Conclusions of Law and Decision of Administrative Law Judge Francis L. Young, Administrative Law Judge, Sept. 6, 1988, http://www.druglibrary.org/schaffer/library/studies/young/young4.html.

registered as patients in state-legal medical cannabis programs.[4] Under these programs, physicians recommend cannabis to treat conditions ranging from cancer to seizure disorders. Among the 33 state programs, there are well over 100 conditions that physicians can legally recommend cannabis to their patients as a therapeutic treatment option.[5] And yet, the CSA claims Schedule I drugs have no currently accepted medical use.

The fact that millions of patients are using cannabis to treat a medical condition based on a physician's recommendation means that its Schedule I status does not meet the laugh test, let alone scientific rigor. Therefore, the placement of cannabis in Schedule I undermines the integrity of the CSA itself. As a result, the conversation then turns to whether cannabis should be rescheduled elsewhere in the CSA or whether it should be descheduled and removed from the CSA.

Rescheduling vs. Descheduling

It may seem like a reasonable initial step to move cannabis to a less restrictive schedule status; however, that could have disastrous unintended consequences. If Congress were to move cannabis to Schedule II, as would be done under the LUMMA Act (H.R. 171), the state medical and adult-use laws could be preempted and nullified. This could lead to federal agencies aggressively shutting down the regulated cannabis programs, which could have adverse health consequences for patients and adult-use customers, alike.

For medical cannabis patients, shutting off state-regulated access to their physician-recommended treatment option would leave them with two options: either they would stop using medical cannabis and would likely replace it with pharmaceutical options that may be more harmful or expensive, or two, they could turn to unregulated sources of cannabis. In other words, rescheduling means that Congress would be getting in the way of decisions between doctors and patients, while simultaneously driving patients towards unregulated and untested products.

There is evidence to suggest that shutting off access to regulated medical cannabis would create substantial burdens on Medicare Part D expenditures. Research has shown that in 2013, when there were just 17 medical cannabis programs operating, there was a savings of $165.2 million and that if expanded to all 50 states, the savings would be closer to $468.1 million.[6] As the nation's Baby Boomer population ages, there will be increased strain on Medicare Part D expenditures. Rescheduling cannabis to Schedule II or even Schedule V (the least restrictive schedule) could impose even greater stress on the prescription drug program.

Additionally, evidence suggests that cutting off access to medical cannabis would worsen opioid abuse issues. States that have created medical cannabis access have seen significant decreases in the total

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[4] Number of Legal Medical Marijuana Patients (as of May 17, 2018), Pro-Con.org, https://medicalmarijuana.procon.org/number-of-legal-medical-marijuana-patients/.

[5] A current list of each of the approved conditions under the various state medical cannabis laws is compiled by Americans for Safe Access, available here: https://www.safeaccessnow.org/condition.

[6] "Medical Marijuana Laws Reduce Prescription Medication Use In Medicare Part D," HEALTH AFFAIRS 35, NO. 7 (2016): 1230–1236, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2015.1661.

number of opioid doses prescribed in the state.[7] Moreover, states with regulated cannabis programs have been demonstrated to have significantly fewer fatal opioid overdoses.[8] This shows that preemption of state cannabis laws could have fatal implications for concerns around opioid use.

For both medical cannabis patients and adult-use consumers, shutting down the state-regulated systems would mean they will no longer have access to tested products from programs featuring recall mechanisms and chain-of-custody traceability. The recent news around illnesses caused by vaping illustrates the public health differences between criminalization and regulation. The overwhelming majority of the cases were from unregulated cannabis sources. States were able to pull potentially dangerous products off the shelves of stores and were able to investigate the likely source of the problem and have begun to ban Vitamin E acetate and other contaminants from vaping products.

Under the unregulated market, consumers do not have the advantages of lab testing and product safety recalls. Preemption of state cannabis programs by rescheduling the plant elsewhere within the CSA could lead to a situation where untested products that have a greater likelihood of being dangerous are the only ones available. Given the hundreds of thousands of cannabis arrests each year, we know that millions of Americans would continue to use cannabis if the state programs were to be preempted. Instead, Congress should deschedule and look at ways to empower Alcohol and Tobacco Tax and Trade Bureau to regulate cannabis in manner similar to alcohol.

Barriers to Research

There is a bit of a paradox when it comes to the volume of peer-reviewed cannabis research that has been conducted. There are over 700 peer-reviewed studies examining the medical efficacy of cannabis, making it one of the most studied substances on the planet.[9] The majority of the studies show evidence of medicinal benefits from cannabis to treat certain conditions or symptoms.

The paradox is that there is hardly any federally approved clinical research. This is almost exclusively due to the Schedule I status of cannabis under the CSA. Schedule I status presents significant red tape for researchers to get projects approved. Once approved, researchers can only obtain cannabis from one federally approved source. Researchers have reported that the cannabis available from this source is of low quality and does not mirror the types of cannabis millions of Americans are purchasing from tested and regulated state-licensed sources.

Scientific research on cannabis should more accurately reflect the types of cannabis that are being used every day by Americans. If cannabis remains in Schedule I, clinical research will continue to be compromised. But given that rescheduling cannabis to somewhere between Schedule II and V could risk the aforementioned public health problems that would likely arise if the state programs are preempted by rescheduling, the prudent step to take would be to remove cannabis from the CSA.

Public Health and Criminalization

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[7] "Association Between US State Medical Cannabis Laws and Opioid Prescribing in the Medicare Part D Population" JAMA Intern Med. 2018;178(5):667-672, https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2676999

[8] "The Effects of Recreational Marijuana Legalization and Dispensing on Opioid Mortality," Economic Inquiry, August 2019. https://onlinelibrary.wiley.com/doi/abs/10.1111/ecin.12819

[9] Compiled list of peer reviewed studies available here: https://www.cannabis-med.org/studies/study.php.

The conversation around cannabis and public health is often framed by examining the possible negative health consequences that could come with ending criminalization. This is a prudent thing to examine but it should not exclusively dominate the public health narrative around ending cannabis criminalization. In addition, we should also be examining the adverse public consequences of maintaining criminalization. We know that cannabis criminalization leads to incarceration and we know that incarceration raises the risk of contracting infectious diseases.[10] This demonstrates a clear link between criminalization causing negative public health consequences.

Additionally, a cannabis conviction can make it more difficult to obtain employment, leading to both unemployment and underemployment.[11] There is evidence that shows a link between unemployment and negative public health consequences.[12] This factor is exasperated by Aid Elimination Penalty in the Higher Education Act, which strips away federal student loan money if a currently enrolled student is convicted for a crime involving a controlled substance. If cannabis were to be rescheduled, this penalty will still apply.

Federal resources should be directed toward studying the public health consequences of cannabis criminalization and the full array of ancillary consequences. Thankfully, none of the barriers to clinical research of cannabis would stand in the way of these types of studies.

For these reasons, 4Front strongly urges Congress to take action to pass legislation that would remove cannabis from the Controlled Substances Act. We urge the members of the Subcommittee on Health to support the MORE Act to remove cannabis from the CSA, which would serve the dual benefit of enabling greater research while not endangering cannabis consumers by shutting off their tested and regulated sources.

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[10] "…prison places inmates at a disproportionate risk of acquiring infectious diseases such as tuberculosis, hepatitis, HIV, sexually transmitted infections, and methicillin-resistant Staphylococcus aureus." https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6124689/pdf/nihms981983.pdf

[11] Study observed a call-back rate for job seekers without a drug conviction was 13.6%, while those with a drug conviction only had an 8.5% call back rate. https://repository.law.umich.edu/cgi/viewcontent.cgi?article=2892&context=articles

[12] https://www.hindawi.com/journals/isrn/2012/483432/