# FY2026 APPROPRIATIONS MEDICAL CANNABIS POLICY & LEGISLATIVE CONSIDERATIONS FOR THE 119TH CONGRESS

**Prepared by:** Americans for Safe Access

**Updated: Aug 15, 2025**

The following is an overview of key policy developments in FY2026 Appropriations and the 119th legislative session that may impact medical cannabis patients, providers, researchers, and state-regulated programs.

## I. FY 2026 APPROPRIATIONS

### A. COMMERCE, JUSTICE, SCIENCE, & RELATED AGENCIES


## ACTIONS NEEDED: FY2026 CJS APPROPRIATIONS

### 1. TECHNICAL OVERSIGHT – ADD NEBRASKA (Sec. 529(a)):

This appears to be an oversight: In November 2024, Nebraska voters approved ballot initiatives establishing a medical cannabis program, which Governor Jim Pillen signed into law in December 2024. Nebraska now meets the criteria for protection under this section and should be explicitly added.

### 2. REMOVE SEC. 529(b):

This new language undermines the Congressional intent behind the medical cannabis protections upheld for over a decade. Regulation of dispensary locations is the responsibility of individual states. Adding federal penalties risks destabilizing established, well-regulated programs and unfairly jeopardizes patient access.

***SEC. 529(b): "Funds made available under this Act to the Department of Justice may be used to enforce violations of 21 U.S.C. 860.***

**"21 U.S.C. 860"**

Any person who is distributing, possessing with intent to distribute, or manufacturing a controlled substance in or on, or **within one thousand feet of, a public or private elementary, vocational, or secondary school or a public or private college, junior college, or university, or a playground, or housing facility owned by a public housing authority**, or **within 100 feet of a public or private youth center, public swimming pool, or video arcade facility**, is subject to: (1) twice the maximum punishment and (2) at least twice any term of supervised release for a first offense.

### 3. REMOVE SEC. 607:

This section threatens to derail the federal cannabis rescheduling process, which has been underway since 2022. This effort has involved extensive scientific review, public engagement, and is currently under administrative review. Congress maintains oversight authority, **but interrupting a robust, science-based process midstream undermines both evidence-based policymaking and public trust.**

***SEC. 607. None of the funds appropriated or otherwise made available by this Act may be used to reschedule marijuana (as such term is defined in section 102 of the Controlled Substances Act (21 U.S.C. 802)) or to remove marijuana from the schedules established under section 202 of the Controlled Substances Act (21 U.S.C. 812).***

**RATIONALE: Since 2014, the CJS Amendment has protected state medical cannabis programs, patients, and healthcare providers from federal prosecution, arrest, asset forfeiture, and harassment.** The provision has received bipartisan support for over a decade and serves as a critical safeguard as Congress works toward comprehensive medical cannabis legislation. In 2024, attempts were made to scale back these protections, making their omission in Trump's FY2026 proposed budget especially concerning —this could jeopardize access for **more than six million Americans**. This year, the CJS Appropriations Subcommittee passed amendments that would block efforts to reschedule cannabis, and modified the Medical Cannabis Amendment that could open the door for federal interference in state medical cannabis programs again (with double penalties).

## B. AGRICULTURE, RURAL DEVELOPMENT, FOOD & DRUG ADMINISTRATION, & RELATED AGENCIES

The 2018 Farm Bill legalized hemp and its derivatives, creating a market for CBD and other hemp-derived cannabinoids. However, in 2023, the FDA informed Congress that it lacked the regulatory framework to oversee this market effectively. The result is a rapidly expanding and largely unregulated industry that now presents public health challenges. In response, amendments were added to the 2024 Farm Reauthorization Bill to better define the hemp marketplace and close loopholes for intoxicating hemp products.

Key among these was "the Miller Amendment", which has now passed in both the House and Senate FY2026 Agriculture subcommittee appropriations bills. While the bill seeks to refine the hemp program and exclude intoxicating or synthetically derived cannabinoids, we have learned from states attempting to regulate this market that this approach can have unintended consequences. We have provided suggested amendments to ensure CBD and other non-intoxicating cannabinoid products are not also banned.

### HR 4121- FISCAL YEAR 2026 AGRICULTURE, RURAL DEVELOPMENT, FOOD & DRUG ADMINISTRATION, & RELATED AGENCIES BILL

**SEC. 759. Section 297A of the Agricultural Marketing Act of 1946 (7 U.S.C. 1639o) is amended—**

(1) by redesignating paragraphs (2) through (6) as paragraphs (4) through (8), respectively; and
(2) by striking paragraph (1) and inserting the following:

**(1) HEMP.—**

**(A) IN GENERAL.—**The term 'hemp' means the plant Cannabis sativa L. and any part of that plant, including the seeds thereof and all derivatives, extracts, cannabinoids, isomers, acids, salts, and salts of isomers, whether growing or not, with a ~~delta-9~~ total tetrahydrocannabinol concentration (including tetrahydrocannabinolic acid) of not more than 0.3 percent in the plant on a dry weight basis.

**(B) INCLUSION.**—Such term includes industrial hemp.

**(C) EXCLUSIONS.** —Such term does not include— (i) any viable seeds from a Cannabis sativa L. plant that exceeds a total tetrahydrocannabinol concentration (including tetrahydrocannabinolic acid) of 0.3 percent in the plant on a dry weight basis; or (ii) any hemp-derived cannabinoid products containing—

**(I)** cannabinoids that are not capable of being naturally produced by a Cannabis sativa L. plant;

**(II)** cannabinoids that—(aa) are capable of being naturally produced by a Cannabis sativa L. plant; and (bb) were synthesized or manufactured outside the plant;

**(III)** quantifiable amounts based on substance, form, manufacture, or article (as determined by the Secretary of Health and Human Services in consultation with the Secretary of Agriculture) of—(aa) tetrahydrocannabinol (including tetrahydrocannabinolic acid); or (bb) any other cannabinoids that have similar effects (or are marketed to have similar effects) on humans or animals as tetrahydrocannabinol (as determined by the Secretary of Health and Human Services in consultation with the Secretary of Agriculture).

**(2) INDUSTRIAL HEMP.—THE TERM 'INDUSTRIAL HEMP' MEANS HEMP—**

**(A)** grown for the use of the stalk of the plant, fiber produced from such a stalk, or any other non-cannabinoid derivative, mixture, preparation, or manufacture of such a stalk;

**(B)** grown for the use of the whole grain, oil, cake, nut, hull, or any other non-cannabinoid compound, derivative, mixture,preparation, or manufacture of the seeds of such plant;

**(C)** grown for purposes of producing microgreens or other edible hemp leaf products intended for human consumption that are derived from an immature hemp plant that is grown from seeds that do not exceed the threshold for total tetrahydrocannabinol concentration specified in paragraph (1)(C)(i);

**(D)** that is a plant that does not enter the stream of commerce and is intended to support hemp research at an institution of higher education (as defined in section 101 of the Higher Education Act of 1965 (20 U.S.C. 8 1001)) or an independent research institute; or

**(E)** grown for the use of a viable seed of the plant produced solely for the production or manufacture of any material described in sub-paragraphs (A) through (D).

**(3) HEMP-DERIVED CANNABINOID PRODUCT.–**

**(A) IN GENERAL.**–The term 'hemp-derived cannabinoid product' means any intermediate or final product derived from hemp (other than industrial hemp), that– (i) contains cannabinoids in any form; and (ii) is intended for human or animal use through any means of application or administration, such as inhalation, ingestion, or topical application.

**(B) EXCLUSION.**–Such term does not include a drug that is the subject of an application approved under subsection (c) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355)."

## ACTIONS NEEDED & ASA RECOMMENDATIONS- FY2026 AG APPROPRIATIONS

### PROCESSING REALITIES FOR PRODUCING CBD PRODUCTS :

During the concentration of compliant hemp biomass, or Work in Progress (WIP), THC levels will temporarily exceed the 0.3% threshold. Without clear guidelines, producers risk non-compliance despite the final product meeting legal standards. Congress would need to direct the DEA to take action to conform the current interim rule with the new definition of Intermediate Hemp Extract under the inclusion of Hemp.

**Existing State Example:** Utah is the first state to develop a framework related to WIP via their regulation R66-36-2(8) for transportable hemp concentrate.

### 1. TO ADDRESS THIS ISSUE, INCLUDE THE FOLLOWING:

**"SEC. 759. SECTION 297A OF THE AGRICULTURAL MARKETING ACT OF 1946 (7 U.S.C. 16390) IS AMENDED–**

**(4) INTERMEDIATE HEMP EXTRACT -**

**(A) IN GENERAL.**–The term 'intermediate hemp extract' means hemp extract that –

(i)is used in the making of a hemp-derived cannabinoid product;
(ii) has not been packaged as a final form, finished product;
(iii) is not intended for sale to or sold to consumers;
(iv) is in excess of any quantifiable amount of cannabinoids set by the Secretary for hemp-derived cannabinoid products;
(v) is stored, transported, and processed in accordance with section 297F

**(B)** The secretary shall issue regulations to carry out this section, including but not limited to licensing and traceability procedures."

### 2. KEEP THE HOUSE REPORT LANGUAGE BELOW OUT OF THE FINAL BILL

"Marijuana Rescheduling. (pg. 84)–The Committee is concerned about deviations from established drug scheduling evaluation standards in the FDA 2023 marijuana scheduling review. The Committee directs the HHS Inspector General to complete a report on the 2023 marijuana scheduling review including but not limited to: deviations from the established five-factor currently accepted medical use test, justification for a new, two-factor currently accepted medical use test and whether this will be the standard for all future reviews, use of a limited number of hand-selected comparator substances, and inclusion of research results that are not statistically significant or inconclusive. The Committee is concerned about reports of the mental health hazards of regular use of high-potency marijuana, particularly among adolescents. The Committee encourages the FDA to support research on high-potency marijuana and its effects on the adolescent brain, specifically regarding addiction and mental illness, such as schizophrenia or psychosis."

**RATIONALE:** This report language originates from the same authors behind the proposed CJS Sec. 607 amendment, which seeks to block the current cannabis rescheduling process. The request is disingenuous, as the DEA's definition of "currently accepted medical use" (CAMU) is not defined in the Controlled Substances Act (CSA). Instead, in 1988, when DOJ Administrative Law Judge Francis Young recommended rescheduling cannabis, he concluded that, "Marijuana, in its natural form, is one of the safest therapeutically active substances known... It would be unreasonable, arbitrary, and capricious for the DEA to continue to stand between those sufferers and the benefits of this substance." Rather than adopt Judge Young's findings, the DEA created a new five-factor CAMU test to avoid rescheduling cannabis, an extra-statutory framework that has been used ever since to delay action.

## 3. FDA TO REQUIRE HEMP PRODUCT LABELING

**ADD** language requiring the FDA to issue protocols that require manufacturers of CBD and other hemp-derived cannabinoids to comply with basic federal labeling and safety disclosure requirements.

**Labels would include:**

- The source of the cannabinoid (e.g., hemp extract)
- A statement noting whether the product has been evaluated for safety by the FDA
- A warning that the product has not been tested for contaminants or adulterants (or a QR code linking to a Certificate of Analysis)
- A batch number for tracking and transparency

**RATIONALE:** The abundance of availability of these products on the market has created a false sense of security for patients and consumers about the safety of these products. While the FDA cannot regulate these products without Congress creating a new pathway, the FDA can ensure consumers are informed of the absence regulation and oversight.

## 4. FRAMEWORK FOR FDA'S REAL-WORLD EVIDENCE PROGRAM & MEDICAL CANNABIS

**Direct the FDA to utilize its Real-World Evidence framework**—through the Center for Biologics Evaluation and Research and the Center for Drug Evaluation and Research—to generate a comprehensive report on the current use, knowledge base, and educational integration of medical cannabis in the United States. This report should include:

- An overview of medical cannabis research currently underway in the U.S., including NIH-funded studies and research conducted at accredited cannabis research centers;
- A summary of ongoing international medical cannabis research;
- A status update on the inclusion of medical cannabis and endocannabinoid system education across U.S. institutions, including pre-med, medical schools, CME, and other graduate programs;
- An assessment of the impact of the 2018 ACCME guidelines on continuing medical education related to cannabis;
- Recommendations for state medical cannabis programs to (1) harmonize data collection and (2) identify and address key gaps necessary for the integration of cannabis-based therapies into U.S. healthcare systems.

**RATIONALE:** In light of the fact that the current FDA drug approval process does not work for cannabis medicines, and millions of patients and their medical professionals report positive patient outcomes often when no other treatment is available, Congress will have to look at other regulatory avenues to support the health and safety of their constituents.

**Over 40% of people with a cancer diagnosis** report cannabis use for sleep, mood, stress, anxiety, depression, and pain.

***1 MILLION AMERICANS WITH CANCER UNDERGO CHEMOTHERAPY ANNUALLY***

**3 out of 10 patients with Chronic pain,** including fibromyalgia, use cannabis to manage pain and improve daily function, potentially reducing opioid dependency.

***OVER 68 MILLION AMERICANS LIVE WITH CHRONIC PAIN***

**22% of Veterans use cannabis to manage these symptoms from PTSD, chronic pain, and sleep disorders** in states with medical cannabis programs.

***THERE ARE 15.8 MILLION VETERANS, 31% HAVE AT LEAST ONE DISABILITY***

**About 1 in 5 older adults use cannabis (AARP). In medical cannabis states, they frequently report benefits for chronic pain, arthritis, sleep, and appetite..**

***57.8 MILLION AMERICANS ARE 65+ POPULATION***







## C. MILITARY CONSTRUCTION, VETERANS AFFAIRS, & RELATED AGENCIES

The American Legion reports that approximately 22% of veterans currently use cannabis to treat medical conditions, 40% of caregivers know a veteran who uses medical cannabis for symptom relief, and 82% of veterans want to have medical cannabis as a federally legal treatment option. Many veterans find medical cannabis beneficial for managing PTSD, chronic pain, other service-related health issues, and all the other conditions that civilians use cannabis to treat. However, federal restrictions significantly limit their access. Although advocates have successfully removed the risk of losing VA benefits for veterans enrolled in state medical cannabis programs, Veterans who need cannabis medicines are on their own.

**H. REPT. 119-161- HOUSE REPORT LANGUAGE:**

"Direct the Department of Veterans Affairs (VA) to authorize VA health care providers to (1) provide veterans with recommendations and opinions regarding participation in their state's marijuana programs, and (2) complete forms reflecting such recommendations and opinions".

**"VA health care providers are prohibited from recommending, making referrals to, completing forms, or registering Veterans for participation in a State-approved marijuana program. AUTHORITY: 38 U.S.C. § 7301(b)-**"Access to VHA Clinical Programs for Veterans Participating in State-Approved Marijuana Programs (111 KB, PDF)." (VHA Directive 1315)

**EVERY DAY 19 VETERANS & ACTIVE MILITARY MEMBERS DIE BY SUICIDE**

**H.R.3944 — MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES APPROPRIATIONS ACT, 2026:**

**SEC. 421.** None of the funds appropriated or otherwise made available to the Department of Veterans Affairs in this Act may be used to enforce Veterans Health Directive 1315 as it relates to—

(1) the policy stating that "VHA providers are prohibited from completing forms or registering Veterans for participation in a State-approved marijuana program";

(2) the directive for the "Deputy Under Secretary for Health for Operations and Management" to ensure that "medical facility Directors are aware that it is VHA policy for providers to assess Veteran use of marijuana but providers are prohibited from recommending, making referrals to or completing paperwork for Veteran participation in State marijuana programs"; and

(3) the directive for the "VA Medical Facility Director" to ensure that "VA facility staff are aware of the following" [t]he prohibition recommending, making referrals to or completing forms and registering Veterans for participation in State-approved marijuana programs".

**Passed the House of Representatives June 25, 2025.**

*"The U.S. Department of Veterans Affairs is required to follow all federal laws, including those regarding marijuana. As long as the Food and Drug Administration classifies marijuana as Schedule I, VA healthcare providers may not recommend it or assist Veterans in obtaining it."*

**-VA's webpage, "VA and Marijuana – What Veterans Need to Know"**

**S. REPT. 119-43: SENATE REPORT LANGUAGE:**

"Medical Marijuana.--The Committee recognizes that the Department of Justice's Drug Enforcement Agency has concurred with the Department of Health and Human Services' 2023 recommendation to reschedule cannabis in the Controlled Substances Act from its current placement in Schedule I to the less restrictive Schedule III. Should cannabis be rescheduled to a lower Schedule, VA should consider issuing guidance allowing VHA doctors and other personnel to discuss, recommend, and facilitate access to medical marijuana in States with state-legal medical marijuana programs to the extent allowable under Federal law."

## ACTIONS NEEDED & ASA RECOMMENDATIONS-FY2026 VETERANS APPROPRIATIONS

### 1. RETAIN: SEC. 421

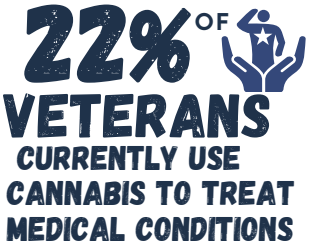
### 2. UPDATE THE VHA'S ELECTRONIC MEDICAL RECORD SYSTEM TO INCLUDE A CODE FOR "MEDICAL CANNABIS USE."

### 3. VHA & MEDICAL CANNABIS REPORT:

a. Utilizing data from state and international medical cannabis programs, explore cost savings to VHA physicians having medical cannabis as a tool for their patients.

b. Education and protocols would be required to implement:

- VHA physicians and staff are utilizing cannabis medicines with patients
- VA pharmacies ability to dispense cannabis medicines
- VA hospitals and hospices accommodating medical cannabis patients
- VHA coverage of cannabis medicine costs




**RATIONALE:** For veterans relying solely on the Veterans Health Administration (VHA) for healthcare, their providers are prohibited from recommending medical cannabis. As a result, veterans must pay out-of-pocket not only for cannabis treatments and state ID card fees but also for consultations with cannabis specialists. Veterans unable to afford these expenses often turn to adult-use markets without medical oversight, unregulated hemp-derived products, or the illicit market. 22% of Veterans report using medical cannabis, VHA medical professionals should have more tools to serve them, and the VA should be learning more from the Veterans' experiences.

## D. LABOR, HEALTH & HUMAN SERVICES, EDUCATION, & RELATED AGENCIES

Cannabis medicines are used to treat a variety of medical conditions in the U.S., with patients consistently reporting improved quality of life, reduced pain, better sleep, enhanced mood, and increased mobility with fewer side effects. These experiences have been validated through a growing body of scientific evidence and by HHS, FDA, NIH, and the National Academies of Science. HHS is the natural oversight agency for medical cannabis and they should find ways to learn more about the experiences patients and medical professionals are having with cannabis medicines as they wait for Congress to create a framework for nationwide access and healthcare integration strategies

## ASA RECOMMENDATIONS- FY2026 HHS APPROPRIATIONS

**1.** Create instructions for the immediate addition of cannabis to intake forms and electronic medical record systems when inquiring about current patient medications and guidelines for physicians and other relevant staff on proper intake for medical cannabis patients.

**2.** Centers for Medicare & Medicaid Services (CMS) and Medical Cannabis Report-

**a)** Utilizing data from state and international medical cannabis programs, explore cost savings to Medicare from integrating medical cannabis into care.

**b)** Education and protocols would be required to implement the integration of medical cannabis into CMS health services, including covering the cost of medical cannabis like any other prescription medication.

**RATIONALE:** Millions of Americans are turning to cannabis medicines. Older adults use cannabis in states with medical cannabis programs, to manage chronic pain, arthritis, sleep disturbances, and appetite issues and represent the fastest-growing demographic utilizing cannabis medicines. Medical professionals need better tools to serve them.



> **CANNABIS HAS CURRENTLY ACCEPTED MEDICAL USE IN THE U.S.**
> DEA, DOJ: Notice of proposed rulemaking: Schedules of Controlled Substances: Rescheduling of Marijuana May 21, 2024

**FEDERAL POLICY DEBATE SHOULD EVOLVE FROM PROVING "IF CANNABIS HAS MEDICAL VALUE" TO "HOW CAN PATIENTS ACCESS CANNABIS."**

## II. 119TH LEGISLATIVE CONSIDERATIONS

In recent years, cannabis reform bills—such as the Cannabis Administration and Opportunity Act (CAOA) and the Marijuana Opportunity Reinvestment and Expungement (MORE) Act introduced in the 118th Congress, and the States Reform Act 2.0 introduced in the 119th—have primarily focused on decriminalization, criminal justice reform, and expanding industry access. While critical, these proposals fail to address the specific needs of medical cannabis patients and are steering Congress toward a regulatory model that could undermine the future of cannabis as medicine.

Although broad legalization or decriminalization measures may still be years away from passage, Congress is facing immediate pressure to regulate hemp-derived cannabinoid products due to the gaps left by the 2018 Farm Bill. That law legalized hemp but failed to fully define or regulate cannabinoid products, leading to a largely unregulated market. For example, in the 118th Session, the Cannabinoid Safety & Regulation Act (CSRA) was introduced to regulate hemp products, which unfortunately included language like the COA, MORE Act, and States Act 2.0 of placing the regulation of these products under the FDA. A few of these bills propose creating a center for cannabinoid products in the FDA, using a similar framework to the 2009 Tobacco Control Act, which created the Center for Tobacco Products, giving the FDA regulatory authority over tobacco.

This approach poses significant risks. The FDA has already acknowledged it lacks both the resources and statutory authority to effectively regulate products like CBD. Turning over full regulatory control to an agency that has struggled to manage analogous product categories—such as flavored nicotine and e-cigarettes—could have disastrous consequences for public health, patient access, and responsible businesses. Despite the FDA's efforts to curb youth nicotine use through restrictions and product registrations, a thriving illicit market has emerged to fill the regulatory gaps. There is little reason to believe cannabis would be treated differently—especially given its complicated legal history and persistent stigma.

### NEW TOBACCO PRODUCT APPLICATION

**Submission of Health Information to the Secretary**

Listing all ingredients added to the tobacco product; description of the nicotine; listing all constituents identified as harmful or potentially harmful to health; documents related to research on health, toxicological, behavioral, or physiologic effects of tobacco products; documents on research on risk reduction; new additives and changes to additive amounts; must publish understandable list of harmful and potentially harmful constituents; and do consumer research to ensure list is not misleading.

### NEW DRUG APPLICATION

**Submission of information to the FDA**

Whether the drug is safe and effective in its proposed use(s), and whether the benefits of the drug outweigh the risks, the drug's proposed labeling (package insert) is appropriate, and what it should contain, and the methods used in manufacturing the drug and the controls used to maintain the drug's quality are adequate to preserve the drug's identity, strength, quality, and purity.

**CANNABINOID SAFETY & REGULATION ACT (CSRA)**

*To amend the Federal Food, Drug, and Cosmetic Act to provide for the regulation of cannabis and cannabinoid products, and for other purposes.*

**TITLE I—Food & Drug Administration regulation of cannabinoid products**

**SEC. 101. FDA REGULATION OF CANNABINOID PRODUCTS.**
**(a) IN GENERAL.**—The Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) is amended by adding at the end the following:

**CHAPTER XI—CANNABINOID PRODUCTS**
**SEC. 1101. CENTER FOR CANNABIS PRODUCTS.**

"Not later than 90 days after the date of enactment of the 'Cannabis Administration and Opportunity Act', the Secretary shall establish within the Food and Drug Administration the Center for Cannabis Products, which shall report to the Commissioner of Food and Drugs in the same manner as the other agency centers within the Food and Drug Administration. The Center shall be responsible for the implementation of this chapter and related matters assigned by the Commissioner."

**CANNABIS ADMINISTRATION & OPPORTUNITY ACT**
To decriminalize and deschedule cannabis, to provide for reinvestment in certain persons adversely impacted by the War on Drugs, to provide for expungement of certain cannabis offenses, and for other purposes

**TITLE V—Public Health, Cannabis Administration, & Trade Practices Subtitle A—Public Health**

**SEC. 501. FDA REGULATION OF CANNABIS.**

**(a) IN GENERAL.**—The Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) is amended by adding at the end the following:

**CHAPTER XI—CANNABIS PRODUCTS**
**SEC. 1101. CENTER FOR CANNABIS PRODUCTS.**

Not later than 90 days after the date of enactment of the 'Cannabis Administration and Opportunity Act', the Secretary shall establish within the Food and Drug Administration the Center for Cannabis Products, which shall report to the Commissioner of Food and Drugs in the same manner as the other agency centers within the Food and Drug Administration. The Center shall be responsible for the implementation of this chapter and related matters assigned by the Commissioner.

## FDA & MEDICAL CANNABIS

**Regulating medical cannabis will require more than just enforcement—it demands robust oversight of research to support product development and establish clinical standards of care.** While the FDA and USDA are primarily responsible for finished products, the National Institutes of Health (NIH) oversees biomedical research. The FDA, at its core, is a consumer protection agency. It was originally created to ensure that food and drug labels are accurate and that products are free from harmful adulterants. Over time, this authority evolved into a system for evaluating health claims, ultimately forming the modern FDA drug approval pathway. In today's healthcare landscape, the label "FDA-approved" has become virtually synonymous with "medicine."

However, **the FDA currently lacks a clear regulatory pathway for botanical medicines like cannabis.** The agency's existing drug approval process is designed for synthetic compounds, based on the single-target/single-drug model of pharmacology. This model—while successful for many conventional pharmaceuticals—is poorly suited to the complex therapeutic profiles of whole-plant cannabis products. **Efforts to isolate and synthesize individual cannabinoids for approval have consistently produced results that fall short of the therapeutic outcomes reported with natural, full-spectrum cannabis. This gap is reflected in the strong preference among both patients and healthcare providers for botanical cannabis over currently available cannabinoid-based prescription drugs.**

***Medical Cannabis represents a new product type (not a dietary supplement, foodstuffs, FDA-approved drug, etc.) whose supply chain falls under several agencies; efficiently implementing a federal medical cannabis program would require an agency with the power of oversight.***

## ADULT USE MARKETS DO NOT SERVE PATIENTS

Adult-use markets are primarily designed to generate tax revenue for states and serve a clientele aged 21 and older, focusing on recreational consumers. When states pass laws merging recreational cannabis programs with existing medical markets, **the result is often a loss of integrity in the medical cannabis program and neglect of the specific needs of medical patients.**

Medical patients require consistent access to standardized formulations and dosages tailored to their health conditions, while recreational consumers are typically interested in "what's new," which is prioritized in these markets. **Forcing patients to navigate adult-use markets trivializes their medical needs and fails to respect their right to access treatment with dignity, privacy, and without stigma.**

## MARIJUANA OPPORTUNITY REINVESTMENT & EXPUNGEMENT ACT

To decriminalize and deschedule cannabis, to provide for reinvestment in certain persons adversely impacted by the War on Drugs, to provide for expungement of certain cannabis offenses, and other purposes.

**SEC.. 3 DECRIMINALIZATION OF CANNABIS**

**(e) Effect on other law.—Nothing in this subtitle shall affect or modify—**

**(3)** the authority of the Commissioner of Food and Drugs and the Secretary of Health and Human Services—

**(A) under—**

**(i) the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.); or**

**(ii) section 351 of the Public Health Service Act (42 U.S.C. 262); or**

**(B)** to promulgate Federal regulations and guidelines that relate to products containing cannabis or cannabis-derived compounds under the Act described in subparagraph (A)(i) or the section described in subparagraph (A)(ii).

**"SEC. 5942. Criminal penalties.**

"(a) Fraudulent Offenses.—Whoever, with intent to defraud the United States— (1-5) shall, for each such offense, be fined not more than $10,000, or imprisoned not more than 5 years, or both.

## STATES 2.0 ACT

**SEC. 7.** Regulation of marijuana products by Food and Drug Administration.

**(a)** Definitions.—

**(1) MARIJUANA PRODUCT DEFINED.—**In this section, the term "marijuana product" means any product made or derived from marijuana that is intended for human or animal consumption, including any component of marijuana (except for raw materials other than such marijuana used in manufacturing a component of such product).

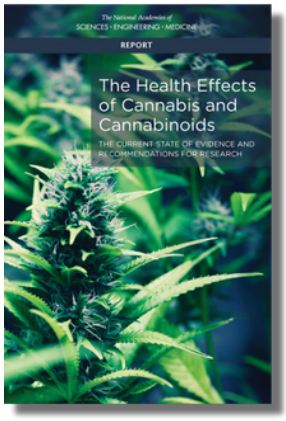
b) Drugs.—A marijuana product meeting the definition of a drug shall be treated as a drug for purposes of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.).

(c) Food; dietary supplements.—The Secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, shall have the same authorities under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) and other applicable law to regulate a marijuana product that is food or a dietary supplement as the Food and Drug Administration has with respect to food containing alcohol.

**(4) NO PREMARKET APPROVAL REQUIRED.—**The regulation under paragraph (2) shall not require premarket approval of marijuana products described in paragraph (1)

***Without comprehensive medical cannabis legislation, medical cannabis patients are denied fundamental federal rights. Unfortunately, when faced with this harsh reality, millions of Americans can't afford to risk their housing, education, and financial stability to prioritize their health, even under the advice of their medical professional.***

| | |
|---|---|
| **DENIAL OF SERVICES** | Federal prohibition prevents medical cannabis patients from accessing services such as subsidized housing, Veterans Affairs benefits, and Medicare. |
| **PURSUIT OF HAPPINESS** | Federal cannabis laws restrict the geographical mobility of patients, affecting their ability to travel, relocate for work, or pursue higher education. |
| **HEALTHCARE AUTONOMY** | Federal restrictions also extend to healthcare settings, where cannabis use is frequently prohibited in hospitals, hospices, and assisted living facilities. |
| **ADA** | Medical cannabis patients are not protected under the Americans with Disabilities Act (ADA) or the Fair Housing Act (FHA). |
| **2ND AMENDMENT RIGHTS** | Federal laws restrict the rights of medical cannabis patients to own firearms, conflating responsible medical use with unlawful drug use. |




"There is **conclusive or substantial evidence** that cannabis or cannabinoids are effective for the treatment of chronic pain in adults, as anti-emetics in the treatment of chemotherapy-induced nausea and vomiting, and for improving patient-reported multiple sclerosis spasticity symptoms."

National Academies of Sciences, Engineering, and Medicine: The Health Effects of Cannabis & Cannabinoids, January 2017

"None of the evidence from the systematic reviews included in our analysis demonstrated substantial safety concerns that would argue against the use of marijuana in any of the indications where there exists some support for its benefit."

FDA's Center for Drug Evaluation and Research (CDER) "Considerations for Whether Marijuana Has a Currently Accepted Medical Use in the United States for Purposes of Section 202(b) of the Controlled Substances Act"

## III. THE PATH FORWARD: ASA'S MEDICAL CANNABIS & CANNABINOID ACT (MCCA)

To address the patchwork of state laws, the regulatory void at the federal level, and the growing demand for access, Americans for Safe Access has drafted **the Medical Cannabis and Cannabinoid Act (MCCA)—a comprehensive federal framework to recognize, regulate, and integrate medical cannabis into the U.S. healthcare system.** The MCCA establishes a centralized regulatory structure to oversee cultivation, manufacturing, testing, labeling, distribution, and patient access to medical cannabis. It promotes research, harmonizes safety standards, protects patients and providers from federal interference, and ensures that cannabis medicines are treated like any other healthcare tool—based on science, governed by evidence, and delivered with dignity. **MCCA creates a national medical cannabis program through two primary functions: establishing the Office of Medical Cannabis & Cannabinoid Control (OMC) housed under the U.S. Department of Health and Human Services (HHS) and changing the schedule of cannabis to a newly created schedule (Schedule VI).**

**Learn more: SafeAccess4All.org**

**10%** OF AMERICANS HAVE INTRACTABLE PAIN
from migraines, cancer, degenerative disc disease, central pain syndrome, or rheumatoid arthritis

**2/3** MEDICAL PROFESSIONALS RECOGNIZE CANNABIS HAS MEDICAL VALUE

**1/3** AMERICANS LIVE WITH CHRONIC PAIN

**1/2** AMERICANS 65 OR OLDER TAKE **5–20** MEDICATIONS DAILY

UNCONTROLLED EPILEPSY EFFECTS AT LEAST 1 MILLION PEOPLE IN THE U.S.

**1 MILLION** AMERICANS ARE LIVING WITH MULTIPLE SCLEROSIS (MS)

**129 MILLION** AMERICANS HAVE AT LEAST ONE CHRONIC DISEASE

**750** Every Day Americans, 65+ Are Hospitalized Due To Serious Side Effects from Medications

**OVER 50%** 65+ HAVE ONE OR MORE RHEUMATIC CONDITIONS

**30 MILLION** Americans live with a Rare Disease

FOR MORE INFORMATION

# OPEN LETTER TO HOUSE AND SENATE COMMERCE, JUSTICE, SCIENCE, AND RELATED AGENCIES SUB-COMMITTEES AND THE COMMITTEES ON APPROPRIATIONS:

## PROTECT MEDICAL CANNABIS PROGRAMS AND THE 6 MILLION PATIENTS THEY SERVE

**Chairman Hal Rogers, Ranking Member Grace Meng, Chairman Jerry Moran, Ranking Member Chris Van Hollen, Chairman Tom Cole, Ranking Member Rosa DeLauro, Chairwoman Susan Collins, Vice Chair Patty Murray, and Honorable Members of the Committees:**

We, the undersigned organizations and individuals, **representing millions of Americans who depend on state-authorized medical cannabis programs,** urge you to extend the critical protections in the FY2026 Commerce, Justice, Science, and Related Agencies (CJS) Appropriations bill until Congress creates a permanent solution to align federal medical cannabis policy with state laws.

Since 2014, bipartisan Congressional action has protected patients, caregivers, state regulators, and legitimate cannabis businesses from federal prosecution, arrest, asset forfeiture, and harassment. The Medical Cannabis CJS Amendment, also referred to as the Rohrabacher-Farr Amendment, serves as a crucial safeguard, preventing interference by the Department of Justice (DOJ) and Drug Enforcement Administration (DEA) in states with medical cannabis programs. **President Trump's proposed FY2026 budget omits these longstanding protections, which would put the health of more than six million Americans and those who support their treatment at risk.**

Forty states, the District of Columbia, and four U.S. territories have passed laws creating medical cannabis programs to provide a regulated pathway for individuals living with chronic pain, epilepsy, PTSD, multiple sclerosis, chemotherapy-induced nausea, and other severe medical conditions to access cannabis medicines under the care of their healthcare providers. **The removal of these federal protections would subject patients and the programs they rely upon to unacceptable uncertainty and harm.**

**Medical cannabis patients are living with one or more medical conditions or experiencing symptoms for which cannabis or a cannabinoid-based product may be the only treatment option, a more suitable option, or work as an adjunct treatment, including side-effect mitigation from other medications in their treatment plans.** Patients consistently report improved symptom relief, better daily functioning, and enhanced mental health with access to medical cannabis.

Medical cannabis programs have become a lifeline for millions of Americans, including many of the 30 million Americans living with one of 7,000 known rare diseases (95% of which have no FDA-approved treatment available) as well as the one-third of Americans who live with chronic pain and the 10% of Americans living with debilitating, intractable pain. In fact, **research generated from the state programs suggests medical cannabis may help some patients reduce or avoid certain high-risk medications, including opioids, contributing to lower rates of overdose and medication-related complications.**

**Over the last decade, significant barriers to cannabis reform have been dismantled**. Advocates have successfully championed regulatory changes enabling U.S.-based cannabis research, debunked outdated misconceptions in federal agencies, changed the scheduling of cannabis under United Nations treaties, established rigorous safety standards, and demonstrated clear medical benefits recognized by the FDA.

**You have the power to protect the health, safety, and dignity of millions of Americans.** Until comprehensive, permanent federal legislation is enacted to align federal cannabis policy with state laws and integrate medical cannabis into mainstream healthcare, maintaining the Medical Cannabis CJS Amendment is essential.

We respectfully request your active participation in ensuring these vital protections are renewed in the FY2026 budget. Millions of patients are counting on your leadership.

Sincerely,

**Steph Sherer,** Founder & Executive Director
**Americans for Safe Access**

**Stephen Dahmer, MD,** Director
**Andrew Weil Center for Integrative Medicine**

**Deondra Asike, MD,** Clinical Associate
**Johns Hopkins School of Medicine**

**Melissa Chubbuck, MD, Hospice Physician**

**Bonni Goldstein, MD**
**Goldstein Wellness**

**Michelle Novack, Caregiver & Parent**

**Karen Jaynes, Integrative Health Professional**

**Anton Harb Jr , Disabled Veteran/1Lt (Ret) USA**

**Graham Rigby,** President & CEO
**American Herbal Products Association (AHPA)**

**Marshall Clabeaux,** Vice Chair
**Republican Cannabis Caucus**

**David Hairston,** Chairman
**Safe Access Tennessee**

**Gretchen Bergman.** Executive Director
**A New PATH**

**Sunil Aggarwal, MD** Co-Founder
**AIMS Institute**

**Brandy Zink,** Chair
**Americans for Safe Access, Michigan Chapter**

**Leigh Vinocur, MD, MS**
**Ananda Medical Practice**

**Sasha Kalcheff-Korn,** Executive Director
**Realm of Caring**

**Heather Jackson** Founder, Board President
**Realm of Caring Foundation**

**Jill Swing** President
**SC Compassionate Care Alliance**

**Mark Harrington,** Executive Director
**Treatment Action Group**

**Ellen and Stuart Smith,** Co-Directors
**Cannabis Advocacy, US Pain Foundation**

**Yolanda Bennett, Co-Founder**
**Georgia Medical Cannabis Society**

**Angela Weston, Co-Founder**
**Georgia Medical Cannabis Society**

**Robert Head,** Chair
**Hemp for Victory**

**Laurie Kappe,** President,
**i.e. Communications**

**Erin Kirk**
**Connecticut Cannabis Ombudsman**

**Michael Brennan**
**CMM-New Jersey**

**Ryan Vandrey, PhD,** Professor
**Johns Hopkins School of Medicine**

**Shanetha Lewis,** Executive Director
**Veterans Initiative 22**

**Rene Reisinger,** NP
**Veterans Initiative 22**

**Anthony Bowles,** Chair
**Bay Area Chapter of ASA**

**Elisabeth Mack, RN,** Co-founder
**Holistic Caring**

**Jennifer Bailey,** Founder
**Homegrown4Heroes**

**Jeremiah MacKinnon,** Executive Director
**MPPA**

**Eric Foster,** National Policy Director
**M4MM**

**Laura Barrett, RN** Executive Director
**National Clinical Director Consortium**

**Jan Whitney,** Executive Director
**Parkinson's Association of N. California**

**Mary Lynn Mathre, RN** President
**Patients Out of Time**

**Americans for Safe Access**
**Safe Access Tennessee**
**AIDS Action Baltimore**
**AIDS Foundation Chicago**
**AIDS United**
**American Cannabis Nurses Association**
**American Herbal Products Association (AHPA)**
**American Legion Blue Sky Post 426**
**Americans for Safe Access, Michigan Chapter**
**Asian Cannabis Roundtable**
**Bay Area Chapter of Americans for Safe Access**
**Cannabis Business for National Medical Cannabis**
**Caregivers for National Medical Cannabis**
**Coalition for Medical Marijuana-New Jersey, Inc.**
**Epilepsy Foundation of America**
**Firefighters for Plant Medicine**
**Global Cannabis Network Collective**
**Georgia Medical Cannabis Society**
**Hemp for Victory**
**Holistic Carings**
**International Society of Cannabis Pharmacists**
**A New PATH (Parents for Addiction Treatment & Healing)**
**The Advanced Integrative Medical Science (AIMS) Institute**
**International Cannabis Bar Association**
**Iraq and Afghanistan Veterans of America**
**Minority Cannabis Business Association**
**Minorities for Medical Marijuana**
**Montel Media, Inc.**
**National Clinical Director Consortium**
**National Multiple Sclerosis Society**
**Nebraskans for Medical Marijuana**
**Parkinson's Association of Northern California**
**Patients Out of Time**
**Pharmacists' Cannabis Coalition of California**
**Realm of Caring**
**Rhode Island Patient Advocate Coalition (RIPAC)**
**Republican Cannabis Caucus**
**Safe Access Virginia**
**San Diego Chapter of Americans for Safe Access**
**SC Compassionate Care Alliance**
**Society of Cannabis Clinicians**
**State Officials of Connecticut**
**State of Maine**
**Texans for Safe Access**
**Tourette Association of America**
**Treatment Action Group**
**US Pain Foundation**
**Veterans Initiative 22**