PROTECTING PATIENT ACCESS

ASSESSING STATE MEDICAL CANNABIS PROGRAMS READINESS TO ACCOMMODATE PATIENTS IMPACTED BY NEW FEDERAL HEMP LAWS

POLICY BRIEFING & GUIDANCE DOCUMENT

FOR STATE POLICYMAKERS

To identify the patient populations affected by new federal hemp laws,

Evaluate the capacity of medical cannabis programs to serve them, and

Implement policy solutions needed to ensure a compassionate transition before November 2026.

Americans for Safe Access
Advancing Legal Medical Cannabis Therapeutics

Americans for Safe Access

Advancing Legal Medical Cannabis Therapeutics

Founded in 2002, Americans for Safe Access (ASA) is the largest national organization of patients, medical professionals, scientists, providers, and concerned citizens promoting safe and legal access to cannabis for therapeutic use and research. ASA utilizes a variety of tactics, including legislation, education, litigation, research, grassroots empowerment, advocacy, and services for medical cannabis stakeholders to meet the immediate needs of patients while clearing the way for a national medical cannabis program.

ASA offers a platform for medical cannabis, wellness, and healthcare stakeholders to engage in projects and programs that address knowledge, policy, and regulatory gaps to improve access to medical cannabis. Our work is guided by a shared vision of a national framework that closes the divide between wellness and medicine by fostering the integration of cannabis into patient care as a frontline treatment option that creates pathways to insurance coverage, invests in the development of standardized cannabis-based products, ensures a safe and consistent supply, and eliminates employment, housing, parental, and healthcare discrimination.

This report and other resources can be downloaded at

www.SafeAccessNow.org/Protect_Patient_Access

ACKNOWLEDGEMENTS

Thank you to ASA members, donors, and sponsors for making this briefing possible and to ASA Advisors and volunteers for their contributions, especially **Karen Jaynes, Nicky Robins, Amy Marasco, Brandy Zink, Dr. Patricia Frye,** and **Codi Peterson, PharmD**.

A LETTER FROM ASA'S EXECUTIVE DIRECTOR








Dear Governors, State Legislators, Regulators, and Policy Leaders,

In November 2025, Congress fundamentally changed federal hemp law in ways that will significantly affect patient access to cannabinoid medicines. The FY2026 Agricultural Appropriations bill included long-anticipated clarifications to hemp laws enacted seven years earlier in the 2018 Farm Bill. **While additional federal guidance on hemp policy was overdue, the approach Congress took to closing loopholes in federal law—without providing a viable pathway for product oversight—carries serious consequences for patients in every state.**

Without a thoughtful transition, the tens of millions of patients who rely on cannabinoid-based therapies from the hemp market—including seniors, veterans, people with disabilities, children with complex medical conditions, and individuals managing chronic or life-threatening illnesses—could face sudden disruption in access. A significant portion of these patients turned to the hemp marketplace only after being displaced from their state medical cannabis programs. For states, this is not a theoretical concern or a distant deadline. It is a foreseeable public health challenge that will arrive quickly if left unaddressed.

Americans for Safe Access (ASA) has prepared this briefing to help state leaders navigate this moment with clarity, accuracy, and compassion. We are here to support policymakers in ensuring patients are not collateral damage from policy shifts that were never designed with medical access in mind. Effective responses must account not only for patients currently dependent on the unregulated hemp marketplace, but also for the conditions that made it their only viable option. Barriers such as cost, access deserts, and limited product availability, driven by competition for shelf space in adult-use markets, left patients with few options. Confronted with obstacles, **the hemp marketplace filled an access gap—not by design, but by default.**

For more than three decades, states carried the responsibility of protecting patient access to medical cannabis in the absence of federal leadership. In the face of prohibition and the lack of federal pathways for complex botanicals, patients turned to their states for protection—and eventually, access. **In doing so, states became laboratories of democracy for medical cannabis, building systems for product safety, testing, labeling, and patient registration that generated valuable real-world data.**

These state programs did more than serve patients. **They disproved long-standing myths embedded in federal policy and produced the clinical experience and data that ultimately led the Department of Health and Human Services and the Food and Drug Administration to conclude that cannabis has "currently accepted medical use".** In effect, state experimentation produced what the federal government would not: a proof of concept for cannabis-based medicines.

Now that medical value has been recognized, responsibility follows. The central question before federal policymakers is no longer whether cannabis has accepted medical use, but how to integrate cannabis and cannabinoid therapies into the nation's healthcare infrastructure. Until Congress answers that question with a coherent federal framework, **states remain on the front lines—managing the consequences of federal decisions while continuing to protect patients.**

A note about this briefing: Even before the hemp provisions were enacted in November and President Trump's Executive Order was issued in December, federal medical cannabis policy was shifting. While Americans have been grappling with adult-use measures and the unregulated intoxicating hemp market, **patient advocates have been steadily building the foundation for a national medical cannabis program. HHS's recognition of cannabis as having accepted medical use marked the final milestone needed to begin that transition**. ASA saw the thirty-year anniversary of the first medical cannabis law approaching as an opportunity to take stock of our progress, but more importantly, refocus policymakers on the goals of the medical cannabis movement.

To ensure this briefing reached states in time—and with the resources needed to address immediate access risks—ASA prioritized its release over Laboratories of Democracy: 30 Years of the Medical Cannabis Experiment, which we expect to publish in November. A spin-off of ASA's State of the States report series, that publication will include report cards, policy analysis, and guidance to help states prepare for the shift toward a national medical cannabis framework and understand their role before, during, and after that transition.

In addition to providing analysis and emergency legislative and regulatory options for state lawmakers, this briefing places the current policy crisis in the broader context of the movement to secure safe, reliable access to cannabis medicines. Federal hemp reform serves as a timely cautionary tale for state and federal policymakers alike. For many states, hemp was not simply an agricultural or consumer policy challenge—it was an early warning of what happens when federal law changes without a parallel, patient-centered access strategy in place.

The good news is that federal agencies will not have to start from scratch. Over three decades, states have developed many of the tools a national medical cannabis program will require—systems for patient access, product oversight, clinical integration, and real-world evidence. Those frameworks provide a foundation for federal action. States can play a meaningful role in advising federal agencies as Congress and the Executive Branch work to construct a coherent national approach—one that restores patients' rights and dignity with consistency, equity, and legal certainty.

We recognize the complexity of this moment and the leadership it requires. ASA stands ready to support state leaders with technical assistance, patient impact analysis, and policy guidance grounded in nearly twenty-four years of experience advocating for safe and legal access to medical cannabis.

Patients have waited long enough for clarity. Together, we can ensure that progress at the federal level translates into protection on the ground.

Sincerely,

Steph Sherer
Executive Director
Americans for Safe Access

Americans for Safe Access

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EXECUTIVE SUMMARY

On November 12, 2025, Congress amended hemp laws by establishing statutory definitions for "industrial hemp" and "hemp-derived cannabinoid products" and imposing a new "total THC" standard. Together, when they go into effect on November 11, 2026, these clarifications will close the "loophole" that allowed unregulated intoxicating products to proliferate—but they will also remove most full-spectrum cannabinoid products from lawful commerce, **cutting off access for millions of patients who rely on these products as their medicine.**

Across the country, seniors, veterans, people with disabilities, cancer patients, children with rare diseases, and people living with chronic pain rely on full-spectrum cannabinoid products purchased from the hemp market. These are not casual consumers. They are patients who turned to hemp because state medical cannabis programs were unavailable, unaffordable, geographically inaccessible, or stripped of the products they need. In many states. adult-use product demand crowded out high-CBD and non-intoxicating formulations. For millions of patients, products from the hemp market filled a gap, even if by default.

President Trump's December 2025 Executive Order advanced the rescheduling of Cannabis and even acknowledged the issue H.R. 5371 creates for patients, but it will not prevent the pending disruption. Executive actions cannot override statutory limits, and rescheduling alone does not legalize medical cannabis, restore patient rights, or integrate access into federal systems. Patients remain legally vulnerable, excluded from federal healthcare programs, housing protections, and employment safeguards. Millions of patients still face losing access to a source of cannabinoid medicines this year.

This briefing explains how the current crisis emerged, who is at risk, and why states on the front lines must act to address patient access or risk another public health crisis.

For more than thirty years, states served as laboratories of democracy for medical cannabis. **They built patient registries, safety standards, testing regimes, labeling systems, and clinical pathways—generating the real-world evidence that finally compelled HHS and FDA to recognize cannabis as having "currently accepted medical use."** These state-based experiments proved what federal policy refused to test.

This changes the central policy question for Congress: no longer if cannabis has medical value; it is now how to ensure Americans have access. Until Congress takes on the responsibility of this new recognition and integrates cannabis and cannabinoid therapies into U.S. healthcare systems, patient access remains in the states' hands. **This means managing federal policy changes while protecting patients and public health. ASA has created this briefing to help. It provides:**

- A clear explanation of the new hemp provisions and their real-world impact
- Limitations of Trump's Executive Order
- An analysis of why millions of patients depend on the hemp marketplace
- Data on who cannabinoid medicines serve
- Draft emergency legislation and executive actions to preserve access
- State's role in a national medical cannabis program

This briefing has been designed to equip state leaders with the tools they need for a compassionate response to the changing federal hemp laws that will protect current and future patient access.

NEW HEMP LAWS IMPACT PATIENTS NATIONWIDE

For years, millions of Americans have accessed cannabinoid therapies through full-spectrum hemp products sold online and in retail shops. Patients who rely on hemp-derived cannabinoid medicine are sitting on a fragile lifeline. These aren't "CBD customers." These are people managing seizures, cancer symptoms, neuropathy, chronic pain, PTSD, autism, sleep disorders, and other chronic medical conditions.

Access for these patients will change in 2026. Without intervention, patients who already live at the margins of the healthcare system risk losing one of the few therapeutic options available to them.

On November 12, 2025, Congress passed **H.R. 5371—the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026**—to reopen the federal government. Included in the Agriculture provisions was a long-anticipated policy correction: statutory definitions for "industrial hemp," "intermediate hemp-derived cannabinoid products," and "hemp-derived cannabinoid products" that had been omitted from the 2018 Farm Bill.

U.S. SENATE COMMITTEE ON APPROPRIATIONS

APPROPRIATIONS
CHAIRMAN TOM COLE

Those provisions bring long-overdue clarity and will close the "hemp loophole" that allowed intoxicating and synthetic cannabinoid products to proliferate nationwide through an unregulated marketplace. They also start a clock for patients.

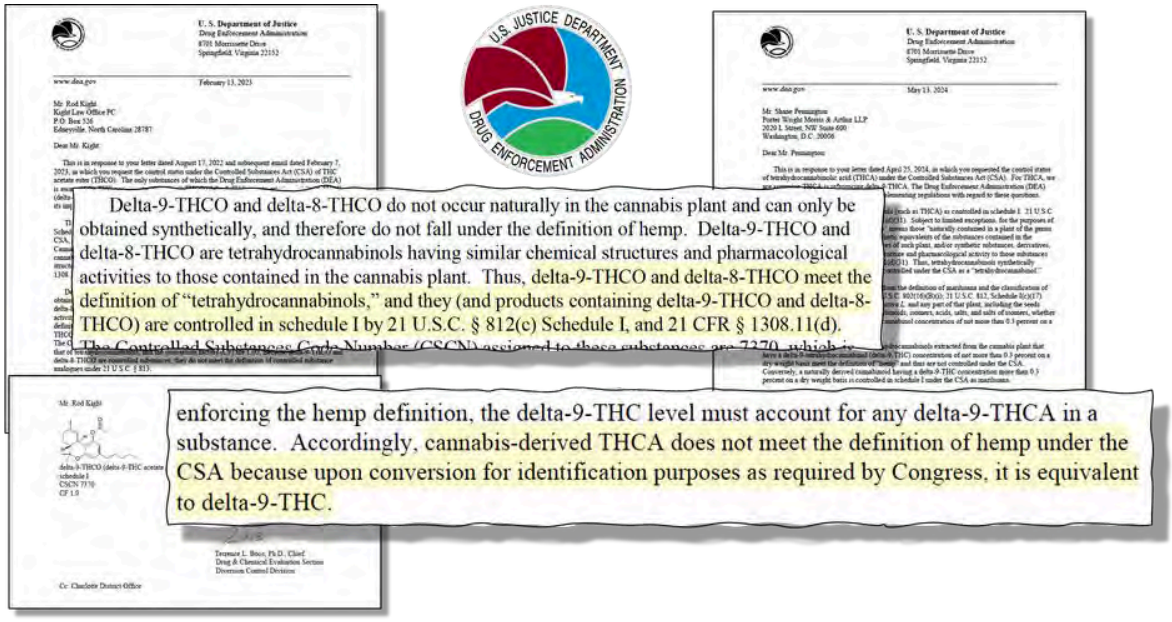
Beginning November 11, 2026, **most hemp-derived full-spectrum cannabinoid products currently relied upon by patients will disappear from lawful commerce.** H.R. 5371 changed the federal definition of hemp and hemp products by amending the Agricultural Marketing Act of 1946, these provisions will not expire with the FY2026 budget.

For many patients, these changes will come as a shock. Hemp-derived full-spectrum products—often purchased online—have become a primary source of cannabinoid therapeutics for patients nationwide. This population includes those who reside in states without medical cannabis laws, but also the millions of patients for whom the cannabis programs in their state are not serving their needs.

HEMP PROVISIONS IN FY2026 AG BILL: H.R. 5371: SEC 781

- **Amends Section 297A of the Agricultural Marketing Act of 1946** (7 U.S.C. § 1639o); provisions do not expire with FY2026
- **Effective Date: November 11, 2026**
- Establishes new definitions for **industrial hemp, intermediate hemp-derived cannabinoid products, and hemp-derived cannabinoid products**
- Explicitly excludes cannabinoid products from the definition of industrial hemp
- Revises the THC threshold to include **"total THC" (<0.3%),** capturing all detectable tetrahydrocannabinol compounds, including THCa, on a dry-weight basis
- **Prohibits all synthetic cannabinoids**
- Prohibits products containing **more than 0.4 mg THC per container**
- Prohibits seeds capable of producing cannabis varieties exceeding 0.3% THC

Since 2018, the Drug Enforcement Administration (DEA) has consistently maintained that many of these products are illegal while manufacturers assured patients otherwise, resulting in seven years of confusion, mixed messaging, and inconsistent enforcement.



PRESIDENT TRUMP'S EXECUTIVE ORDER WON'T ADDRESS THIS ISSUE FOR PATIENTS

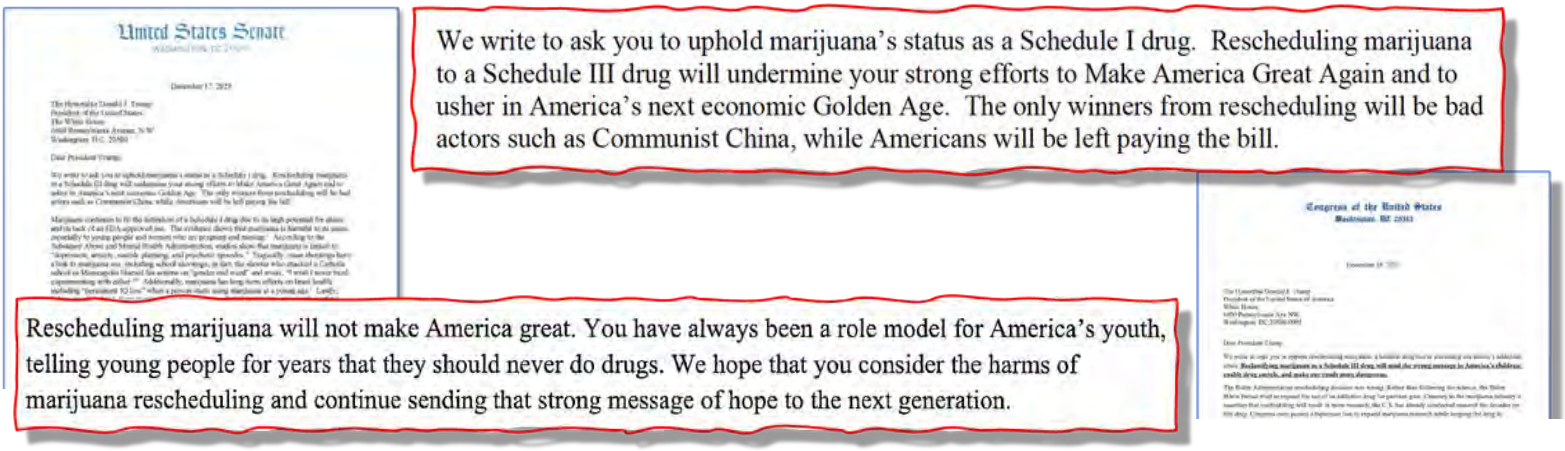
On December 18, 2025, President Trump signed an **Executive Order titled "Increasing Medical Marijuana and Cannabidiol Research."** The Order directs federal agencies to advance research, policy coordination, and legislative engagement related to medical cannabis and cannabinoid products. It acknowledges the medical value of cannabis, directs the Department of Justice to move forward with the existing rescheduling process, expand access to appropriate full-spectrum CBD products, and instructs the Department of Health and Human Services to develop research methods—including real-world evidence models—to inform standards of care for cannabinoid-based therapies.

However, the Executive Order does not reschedule cannabis, legalize medical use, or create new patient protections. Any change to cannabis' classification under the Controlled Substances Act will occur only if and when the Drug Enforcement Administration (DEA) completes its formal rulemaking process. The Order further makes clear that expanded access to full-spectrum CBD products will require congressional action, not executive or agency discretion.

ACCESS FULL SPECTRUM PRODUCTS

Expanding access to full-spectrum CBD products will require congressional action—specifically, amendments to H.R. 5371. Executive action alone cannot override statutory limits.

Amending the legislation will be difficult. The chairs of the House and Senate Commerce, Justice, Science, and Related Agencies and Agriculture Committees remain strongly opposed to cannabis reform. In fact, many of them were signatories to letters condemning Schedule III, which were delivered to the White House the day before the Executive Order, signed by 22 U.S. Senators and 26 House Members.


United States Senate

We write to ask you to uphold marijuana's status as a Schedule I drug. Rescheduling marijuana to a Schedule III drug will undermine your strong efforts to Make America Great Again and to usher in America's next economic Golden Age. The only winners from rescheduling will be bad actors such as Communist China, while Americans will be left paying the bill.

Congress of the United States

Rescheduling marijuana will not make America great. You have always been a role model for America's youth, telling young people for years that they should never do drugs. We hope that you consider the harms of marijuana rescheduling and continue sending that strong message of hope to the next generation.

Schedule III & Patients

Under Schedule III, cannabis remains illegal under federal law outside of tightly regulated federal channels. Patients remain vulnerable to loss of housing, employment, parental rights, and other serious consequences simply for following a physician's recommendation.

In practice, Schedule III does not meaningfully change patients' legal status or access to care. While rescheduling acknowledges what patients and clinicians have long known—that cannabis has medical value.

Schedule III does NOT:

- **Legalize medical cannabis**
- **Improve state medical cannabis programs**
- **Restore federal rights for patients**
- **Protect patients from discrimination**
- **Ensure nationwide access**
- **Integrate cannabis into federal healthcare systems**

> **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

Under Schedule III, cannabis manufacturing and distribution outside federal protocols remain classified as drug trafficking under federal law.

For Schedule III substances, penalties can include:

- **Up to 10 years in prison and a $500,000 fine for a first offense**
- **Up to 20 years and $1 million for subsequent offenses**

Since 2014, Congress has prohibited the Department of Justice (DOJ) from enforcing cannabis laws on participants in the state medical cannabis programs through an amendment to the Commerce, Justice, Science, and related Agencies (CJS) appropriations bill. This provision applies only to medical programs and must be reauthorized each year. (Adult-use programs have no federal protections at this time.)

Under Schedule III, state-authorized medical cannabis products would remain outside federally regulated medical frameworks unless Congress acts. There is no automatic registration pathway, no prescription model, no federal recognition of state products as lawful medicines, and no clear route for these products to be used in federally sanctioned clinical efficacy trials.

In short, federal policy now acknowledges the problem created by H.R. 5371 —but it does not prevent patients from losing access to full-spectrum cannabinoid medicines in November 2026 .

HOW DID WE GET HERE?

Many Uses of *Cannabis sativa L.*

FLOWER, LEAVES & ROOTS: Terpenes, Flavonoids, & Cannabinoids: Medicinal Preparations

NON-CANNABINOID USES

FLOWER- Terpenes/ aromatic Essential oils, Perfumes, Flavorings in Foods & Beverages

SEEDS: Foodstuffs**:** Hemp seed, Hempseed oil, Hemp Milk Products, Flour, Nutritional Powders

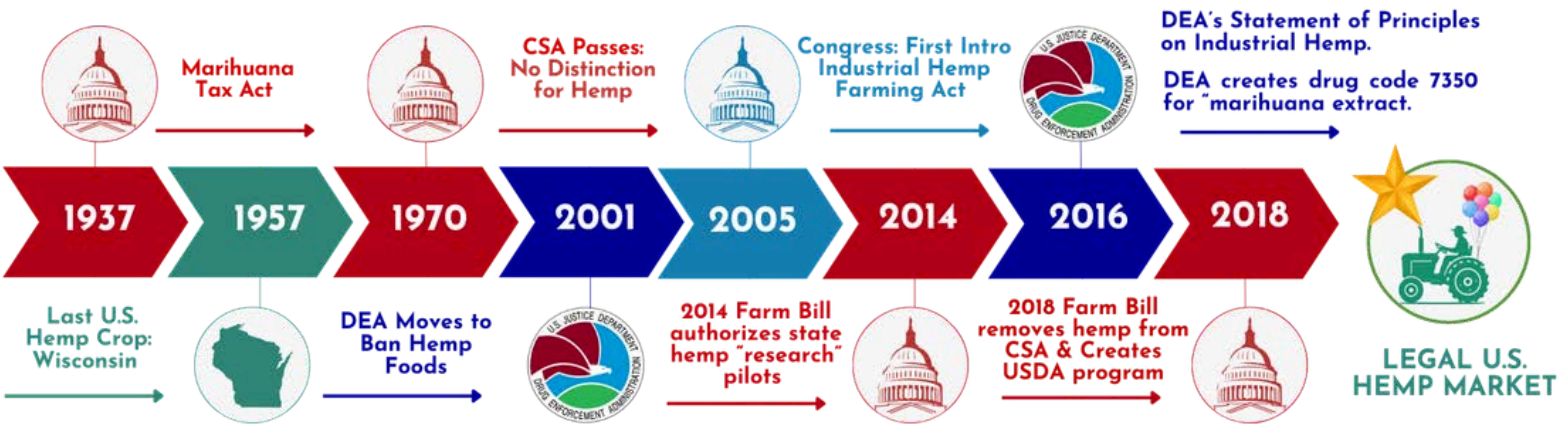
STALKS: Fiber: Paper, Clothing, Rope, Plastics, Animal Feed, Building Materials

ROOTS: Benefits Crop Rotation, Improves & Chelates Soil, & Reduces Water Pollution

In parallel to the fight for safe access to medical cannabis, another use of the plant—hemp for fiber, food, and commodities—has faced its own regulatory obstacles. Many of the same laws that criminalized medical cannabis also suppressed domestic hemp production, despite the growing global demand for hemp's foodstuffs, textiles, paper, and increasingly, climate-sustainable building materials.

The 2018 Farm Bill was intended to correct that history. It removed "hemp"—defined globally as *Cannabis Sativa L.* containing less than 0.3% THC—from the Controlled Substances Act. But while the Farm Bill legalized hemp cultivation, it failed to define hemp products. **That omission proved consequential.**

THE ROAD TO THE LEGAL HEMP MARKET

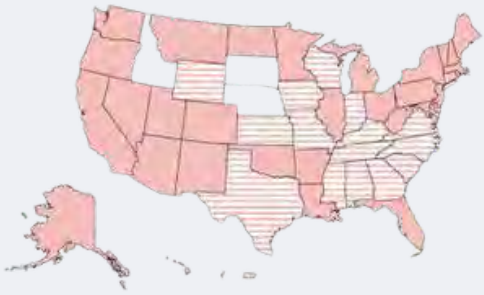


THE CURRENT CRISIS DID NOT EMERGE IN A VACUUM.

At the same time hemp was legalized, demand for cannabidiol (CBD) was surging. Beyond Washington, D.C., the U.S. territories, and the 33 states with recognized medical cannabis programs, fourteen additional states enacted narrow "CBD-only" laws. These laws allowed possession of limited cannabis oil extracts rich in CBD—primarily for pediatric seizure disorders—while continuing to criminalize access to other therapeutically relevant compounds from the plant.

August 5th, 2013 Dr Sanjay Gupta aired a special on CBD igniting national demand

Medical Cannabis & CBD Laws 2018



Pink- Medical Cannabis States
Pink strips- CBD States

The CBD laws were not designed to function as access systems. Most lacked in-state production, quality control, testing requirements, or distribution pathways. They raised a fundamental and unresolved question: how were patients expected to obtain a steady, safe supply of medicine if they could not legally produce or purchase it in their own state?

The hemp market answered that question—imperfectly, but at scale.

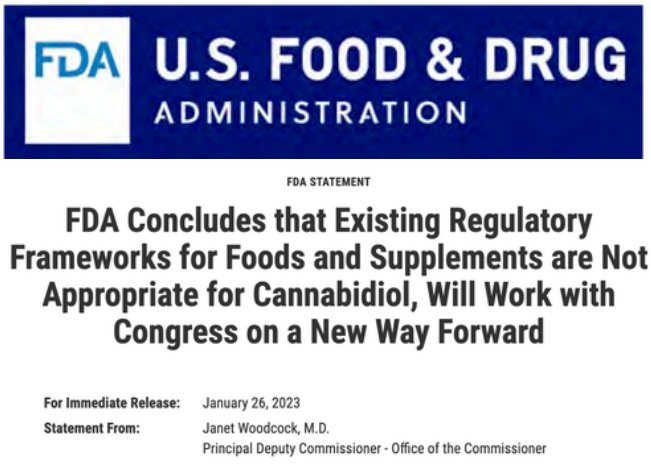
While adult-use markets expanded, dispensaries increasingly deprioritized or eliminated high-CBD and non-intoxicating formulations that patients relied on. Products disappeared from shelves. For seniors, veterans, people with disabilities, and low-income patients, these barriers were often insurmountable.

Even though forty states have medical cannabis laws with access programs, millions of patients remain functionally excluded. **For many patients, access is blocked by cost, geography, employment restrictions, limited product availability, or competition with adult-use markets.**

Hemp-derived full-spectrum products—often purchased online— has become a workaround. They are accessible, affordable, and widely marketed as legal. **Patients did not choose hemp products because they were novel. They chose it because it worked and it was available.**

The 2018 Farm Bill assumed that the FDA would regulate hemp products. This proved to be another consequential mistake. In 2019, the FDA held hearings on the topic and solicited input from stakeholders. Congressional oversight committees regularly questioned the Agency about progress toward issuing product guidelines. Meanwhile, this unregulated market spread across the country, seemingly unchecked. **States that tried to regulate hemp products found themselves in court.**

In January 2023, almost 5 years after hemp was legalized, the FDA formally concluded that existing regulatory frameworks for foods and dietary supplements are not appropriate for CBD. After convening a high-level internal working group, the FDA announced that a new regulatory pathway would be required and stated it was prepared to work with Congress to develop one. The agency simultaneously denied citizen petitions requesting that CBD be allowed as a dietary supplement.



"Given the growing cannabidiol (CBD) products market, the U.S. Food and Drug Administration convened a high-level internal working group to explore potential regulatory pathways for CBD products. Today we are announcing that after careful review, the FDA has concluded that a new regulatory pathway for CBD is needed that balances individuals' desire for access to CBD products with the regulatory oversight needed to manage risks. The agency is prepared to work with Congress on this matter. "

That determination left patients stranded between regulatory systems—unable to access cannabinoid medicines through healthcare systems, but also unsupported by food and supplement regulatory frameworks.

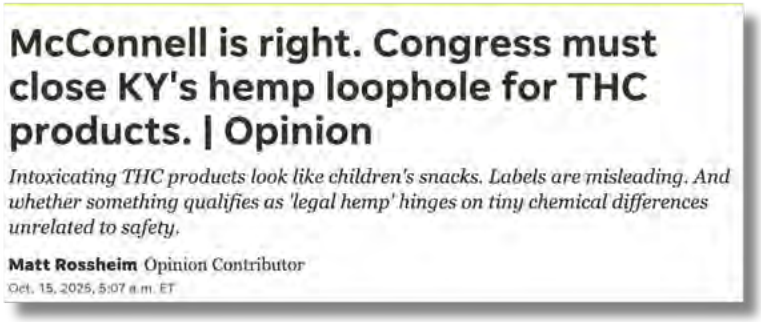
States struggling to control hemp markets put increased pressure on Congress to close the loopholes that were hampering their ability to regulate these products, which by 2023 were perceived as a public health crisis. Congresswoman Miller (R-IL) moved to address their concerns by including the same hemp provisions in H.R. 5371, in an amendment to the House 2024 Farm bill, but the bill stalled before becoming law.


Forbes

Republican-Led House Committee Passes Bill To Ban Hemp Products With THC

By Dario Sabaghi, Contributor. © Dario Sabaghi covers the cannabis industry ... Follow Author

Published Jun 06, 2025, 01:34pm EDT


McConnell is right. Congress must close KY's hemp loophole for THC products. | Opinion

Intoxicating THC products look like children's snacks. Labels are misleading. And whether something qualifies as 'legal hemp' hinges on tiny chemical differences unrelated to safety.

Matt Rossheim Opinion Contributor

Oct. 15, 2025, 5:07 a.m. ET

Leading up to the 2025 government shutdown, the fate of hemp-derived products seemed uncertain. Although the House Agriculture Committee voted to close the hemp loophole, the provision was removed from the Senate version through a last-minute amendment by Senator Rand Paul. **However, a letter signed by a bipartisan group of 39 Attorneys General on October 24th, urging congressional action, all but sealed the inclusion of clarifying definitions in the final minibus language.**


39 State and Territory Attorneys General Call for Clarification of Federal "Hemp" Definition

"Unless Congress acts, this gross distortion of the 2018 Farm Bill's hemp provision will continue to fuel the rapid growth of an underregulated industry that threatens public health and safety and undermines law enforcement nationwide."

WHAT DOES THIS MEAN FOR PATIENTS IN YOUR STATE?

For years, millions of Americans have accessed cannabinoid therapies through full-spectrum hemp products sold online and in retail shops. **Patients who rely on hemp-derived cannabinoid medicines are sitting on a fragile lifeline. These aren't "CBD customers." These are people managing seizures, cancer symptoms, neuropathy, chronic pain, PTSD, autism, sleep disorders, and other chronic medical conditions.**

Access for these patients will change in 2026. **Without intervention, patients who already live at the margins of the healthcare system risk losing one of the few therapeutic options available to them.**

WHO ARE CANNABINOID MEDICINES HELPING

MEDICAL CANNABIS PATIENT-

[me-di-kəl ka-nə-bəs pā-shənt] n. a person living with a medical condition or experiencing symptoms for which cannabis or a cannabinoid-based therapeutic is the only treatment option, a more suitable option, or works as an adjunct treatment including side-effect mitigation to other available care options.

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.

It is estimated that more than 6 million Americans utilize state medical cannabis programs, and millions more use cannabis therapeutically without registering due to stigma, cost, or legal complexity. These patients represent all demographic groups: young and old, urban and rural, military and civilian.

MEDICAL CANNABIS PATIENTS DO NOT HAVE FEDERAL RIGHTS

For the past decade, medical cannabis patients have been protected from federal prosecution thanks to an amendment to the Justice Department's budget that Congress must pass every year (CJS Amendment). However, without comprehensive medical cannabis legislation, medical cannabis patients are denied basic 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.

FEDERAL LAWS SHOULD FACILITATE, NOT HINDER, PATIENT ACCESS TO VITAL MEDICAL CARE & THEIR PURSUIT OF A BETTER LIFE.

DENIAL OF SERVICES

Federal prohibition currently prevents medical cannabis patients from accessing essential services, impacting the most vulnerable Americans, particularly those who rely on these federal programs for their well-being and survival.

HEALTHCARE AUTONOMY

Federal restrictions also extend to healthcare settings, where medical cannabis is frequently prohibited in hospitals, hospices, and assisted living facilities. These limitations severely restrict patients' treatment options, particularly in critical care situations.

CIVIL PROTECTIONS

Federal courts have ruled that medical cannabis patients are not afforded protections under the Americans with Disabilities Act (ADA) or the Fair Housing Act (FHA). Employers and landlords may prohibit patient use of medica cannabis, conduct drug tests, and take disciplinary actions against patients, undermining employment security and housing stability.

PURSUIT OF HAPPINESS

Federal cannabis laws restrict the geographical mobility of patients, affecting their ability to travel, relocate for work, or pursue higher education. These restrictions can stifle personal and professional growth and exacerbate economic disparities.

2ND AMENDMENT RIGHTS

Federal laws restrict the rights of medical cannabis patients to own firearms, conflating responsible medical use with unlawful drug use and denying them their constitutional rights under the Second Amendment.

Comprehensive legislation is necessary to ensure that patients receive the best possible medical treatment without fear of repercussions or interruption in their care. Restoring these constitutional rights ensures that patients access the care they need, no matter where they live, their stage of life, or their economic status.

THE CASE FOR A NATIONAL MEDICAL CANNABIS PROGRAM

129 MILLION
AMERICANS HAVE AT LEAST ONE
CHRONIC DISEASE

1/3
AMERICANS LIVE WITH
CHRONIC PAIN

CHRONIC PAIN
2x
RISK OF DEATH BY SUICIDE

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

95% OF THE **7,000** KNOWN RARE DISEASES HAVE **NO** FDA-APPROVED TREATMENT

30 MILLION
Americans live with a Rare Disease

OVER 50%
65+ HAVE ONE OR MORE
RHEUMATIC CONDITIONS

CHRONIC PAIN COSTS AMERICANS
$560–$635 BILLION
ANNUALLY

1/3
Veterans have conditions related to Chronic Pain

1 MILLION
AMERICANS ARE LIVING WITH
MULTIPLE SCLEROSIS (MS)

CHRONIC & MENTAL HEALTH CONDITIONS ARE RESPONSIBLE FOR
90% OF THE **$4 TRILLION**
SPENT ANNUALLY ON U.S. HEALTHCARE

9 out of 10
FDA-Approved Drugs are
PALLIATIVE.

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

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

$35 BILLION
Cost of
OPIOID MISUSE
& Related Healthcare Issues.

10% OF AMERICANS
HAVE INTRACTABLE PAIN
FROM MIGRAINES, CANCER, DEGENERATIVE DISC DISEASE, CENTRAL PAIN SYNDROME, OR RHEUMATOID ARTHRITIS

WHO ARE MEDICAL CANNABIS PATIENTS

Over 40% of patients diagnosed with cancer report using cannabis for sleep, mood, stress, anxiety, depression, and to manage pain.

18,000,110 PEOPLE ARE LIVING WITH CANCER IN THE UNITED STATES.

1 out of 5 older adults use cannabis. Older adults use cannabis in states with medical cannabis programs to manage chronic pain, arthritis, sleep disturbances, and appetite issues.

THE 57.8 MILLION OLDER AMERICANS (65+) REPRESENT THE FASTEST-GROWING DEMOGRAPHIC UTILIZING CANNABIS MEDICINES.

22% of Veterans use cannabis to manage their 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.

Approximately 5% of registered medical patients in states with medical programs are children. This does not count those who are administering CBD to their children through non-registered programs.

APPROXIMATELY 300K CHILDREN DEPEND ON MEDICAL CANNABIS PROGRAMS.

3 out of 10 patients with Chronic pain use cannabis to manage pain and improve daily function.

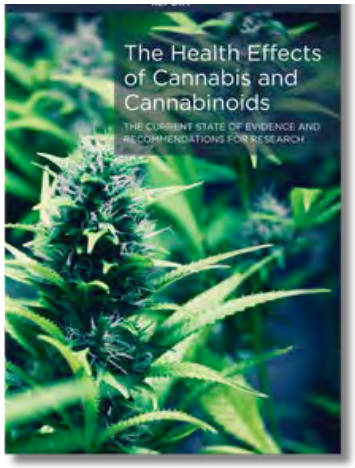
OVER 68 MILLION AMERICANS LIVE WITH CHRONIC PAIN.

10-20% those with Autism Spectrum Disorder use medical cannabis, CBD in particular, regularly used to manage anxiety and behavioral challenges in autism.

5.4 MILLION ADULTS & 1 OUT OF 31 CHILDREN LIVE WITH AUTISM SPECTRUM DISORDER.

MEDICAL CANNABIS & THE U.S. PAIN CRISIS

"THERE IS CONCLUSIVE EVIDENCE THAT CANNABIS OR CANNABINOIDS ARE EFFECTIVE FOR THE TREATMENT OF CHRONIC PAIN IN ADULTS."



According to the Institute of Medicine's (IOM) Relieving Pain in America, **chronic pain affects approximately one-third of the U.S. adult population, with an economic burden of $560–$635 billion annually. This is because the impact of untreated chronic pain extends beyond the individual, affecting workforce participation, education, and childcare, all of which increase strains on government services.** A 2023 study from the National Institutes of Health shows that new cases of chronic pain occur more often among U.S. adults than new cases of several other common conditions, including diabetes, depression, and high blood pressure. Among people who have chronic pain, almost two-thirds still suffer from it a year later.

Overall, the study found that the rate of chronic pain and high-impact chronic pain (HICP) among adults is approximately 21% and 8%, respectively. Chronic pain is pain that is experienced on most days or every day in the past three months; and HICP is pain that limits life or work activities on most days or every day during the past three months.

In 2017, The National Academies of Sciences, Engineering, and Medicine released "The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research, which compiled research from over 10,000 studies on cannabis and its components. The report states:

> **"In adults with chronic pain, patients who were treated with cannabis or cannabinoids are more likely to experience a clinically significant reduction in pain symptoms… 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."**

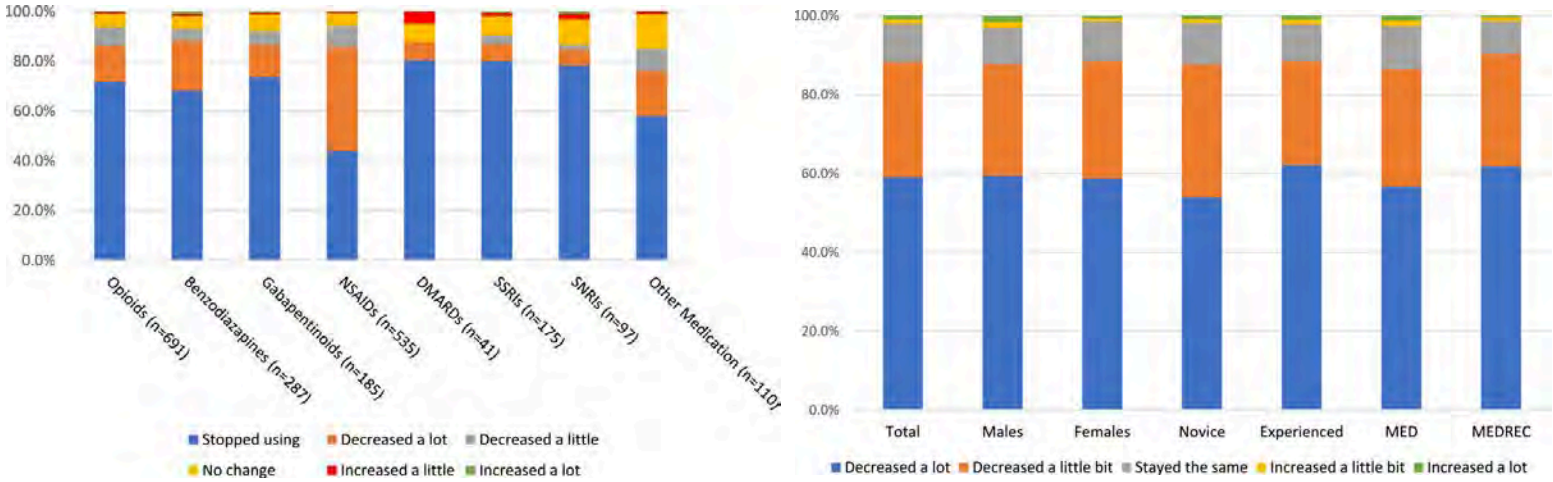
Cannabis and cannabinoids have a robust safety profile compared to many treatment options. **Unlike other prescription pain medications, cannabinoid receptors do not regulate respiratory or cardiac functions, making lethal overdoses virtually impossible.**

"State Medical Cannabis Laws (MCL)s were associated with a statistically significant reduction in aggregate opioid prescribing of 144,000 daily doses (19.7% reduction) annually (95% confidence interval). States with MCLs allowing access to in-state dispensaries had a statistically significant reduction in total opioid prescriptions of 96,000 daily doses (13.1%) annually. Specifically, MCLs were associated with a statistically significant reduction of 72,000 daily doses of hydrocodone annually."

Lopez, Cesar D. BS; Boddapati, Venkat MD; Jobin, Charles M. MD; Hickernell, Thomas R. MD. State Medical Cannabis Laws Associated With Reduction in Opioid Prescriptions by Orthopaedic Surgeons in Medicare Part D Cohort. Journal of the American Academy of Orthopaedic Surgeons 29(4):p e188-e197, February 15, 2021. | DOI: 10.5435/JAAOS-D-19-00767

Studies show that states with medical cannabis programs have experienced reductions in opioid prescriptions and overdose deaths. Expanding access to medical cannabis is a crucial strategy in addressing both the pain crisis and the opioid epidemic. The U.S. healthcare system spends approximately $35 billion annually on opioid misuse and related healthcare costs (Pew Charitable Trust, 2021).

SUBSTITUTION OF CANNABIS FOR PAIN MEDICATION



Pills to Pot: Observational Analyses of Cannabis Substitution Among Medical Cannabis Users With Chronic PainKevin F. Boehnke, J. Ryan Scott, Evangelos Litinas, Suzanne Sisley, David A. Williams, Daniel J. Clauw; The Journal of Pain Volume 20 Issue 7 Pages 830-841 (July 2019)

MEET ELLEN LENOX SMITH

Ellen Lenox Smith was a competitive swimmer and dedicated teacher and coach when, at age 42, it became clear something was wrong. She had pain that could not be identified or treated but worsened over the next dozen years until she was finally diagnosed with Ehlers-Danlo Syndrome. This rare, incurable, painful, and progressive condition attacks the body's connective tissue and the ability to metabolize typical medications to help with the pain.

In the 25 years since her medical journey with this condition began, surgery after surgery has been required to deal with its effects, now totaling 24. In 2007, Ellen decided she couldn't take the pain anymore. She was preparing to leave for another surgery with a specialist in Wisconsin when she asked her primary care physician for a referral to a pain clinic. At the clinic, her doctor confided that cannabis might help. She had never considered cannabis as an option for pain, and her minimal experience with it in college suggested the effects would be unpleasant. But now she was desperate for relief.

"Because individuals with chronic pain are at least twice as likely to report suicidal behaviors or to complete suicide, it is of utmost importance to target which risk factors contribute the most to increasing suicidality."

Mélanie Racine (2018) Chronic pain and suicide risk: A comprehensive review, Progress in Neuro-Psychopharmacology and Biological Psychiatry, Volume 87, Part B, 2018, Pages 269-280, https://doi.org/10.1016/j.pnpbp.2017.08.020..

Rhode Island had just enacted a medical cannabis law the year before, but it did not then allow for anything other than home cultivation, so Ellen's doctor suggested she find some cannabis on the illicit market and try it to see if it worked. For the first time in years, she'd slept through the night. With the help of her pain specialist, she enrolled in the Rhode Island medical cannabis program. Ellen is able to do things and smile again.

> **"Since the legalization of medical cannabis in 2018, there has been a noticeable decrease in deaths related to prescription opioids in the state. This shift suggests that the introduction of cannabis as a therapeutic alternative may have contributed to a reduction in opioid use among patients seeking pain relief."**

Management Science Associates, "Impact of Cannabis on Opioid Prescriptions in Chronic Pain: Insights from Recent Research in Utah," 2024. www.utah.gov/pmn/files/1194859.pdf.

MEET AMY CATTERTON

Pain and nausea have been part of Amy Catterton's life since 2015. That's when, at age 28, she was diagnosed with stage-3 invasive breast cancer. The mother of five had a mastectomy and 32 lymph nodes removed, 19 of which showed cancer. That led to more surgeries and four rounds of chemotherapy with doxorubicin, a drug known as the Red Devil. Amy and her husband Greg decided to try cannabidiol (CBD) to mitigate the intense nausea, even though their state of North Carolina had approved CBD use only for childhood epilepsy.

The CBD allowed her to tolerate the chemo without other anti-nausea medications and only limited use of opioid painkillers. In August 2017, Amy was hit by intense pain throughout her body. The cancer had metastasized into inoperable stage-4 bone cancer. Her doctors advised acting fast, which meant 18 rounds of chemo over 10 weeks and Percocet and fentanyl patches to control the pain.

"It did her in really, really bad this time," said Greg. "I was watching her decline in front of me. She was basically lying in bed dying."

Greg researched making cannabis oil extracts and got a donation of two ounces of cannabis. Within five days of using the extract he made for her, Amy stopped taking the Percocet. Within a week, she said she wanted to get off the fentanyl patches. Two weeks after starting whole-plant therapy, Amy was off all the opioids with minimal withdrawal.

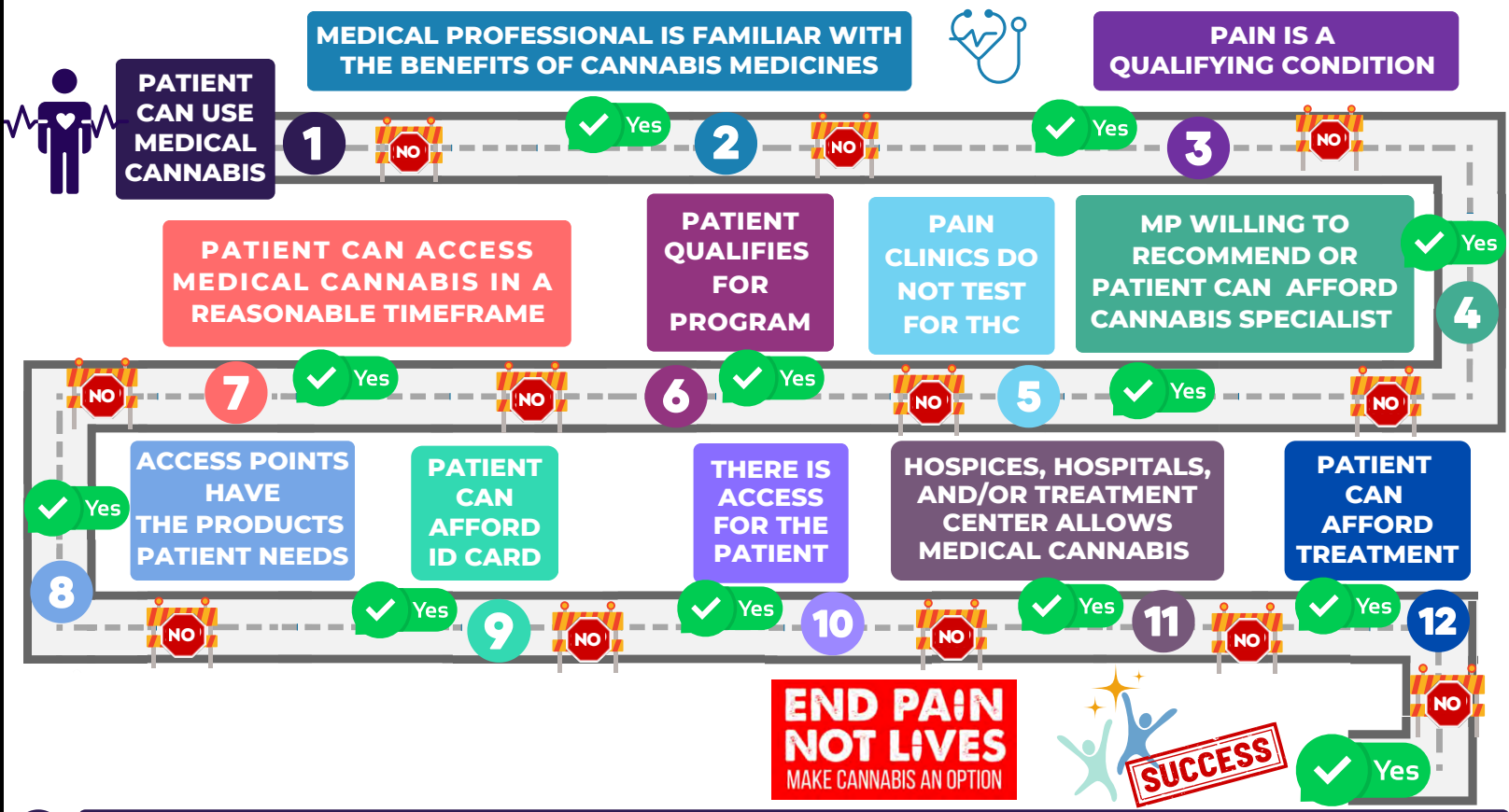
"Among 8165 patients with chronic pain receiving long-term opioid therapy, receiving medical cannabis for a longer duration was associated with prescription opioid dosage reduction, which may lower their risk of opioid-related morbidity and mortality."

Nguyen T, Li Y, Greene D, Stancliff S, Quackenbush N. (2023). Changes in Prescribed Opioid Dosages Among Patients Receiving Medical Cannabis for Chronic Pain, New York State, 2017-2019. JAMA Netw Open. 2023;6(1):e2254573.

DETERMINING IF CANNABIS IS AN OPTION FOR PAIN TREATMENT

68 million Americans are living with chronic pain.
80% of Americans live in a state with a medical cannabis program.
The National Academies of Medicine found conclusive evidence that cannabis treats pain.
HHS cited treatment of "pain" as proof that cannabis has "Currently Accepted Medical Use."
Only 2% of Americans are utilizing medical cannabis programs.

The gap is the result of federal prohibition and significant hurdles for medical professionals and their patients from fully utilizing medical cannabis as a tool to combat pain. The following graphic is an illustration of how those hurdles compound into barriers that can prohibit patients from choosing cannabis as an option to treat their pain.



1 PATIENT CAN USE CANNABIS MEDICINES

Federal employees/contractors, many employees in the public and private sector, and patients on probation or parole are still subject to drug testing even in states with medical cannabis laws. Individuals in assisted living, hospice, or federally subsidized facilities are barred from using medical cannabis. Active military personnel are barred from using all cannabis medicines, including CBD products.

2 MEDICAL PROFESSIONAL FAMILIAR WITH THE BENEFITS OF CANNABIS MEDICINES

Few medical professionals learn about medical cannabis treatments in their formal education. Medical professionals in states with medical cannabis programs may not know about the program, how to participate, or about medical cannabis treatments and protocols for treating pain.

3 PAIN IS A QUALIFYING CONDITION IN THE MEDICAL CANNABIS PROGRAM

Thanks to patient advocates, most states with medical cannabis programs now include some form of pain as a qualifying condition. However, the definitions can be narrow, such as limiting to only pain that results from cancer or requiring that the patient has not responded to traditional therapies.

DETERMINING IF CANNABIS IS AN OPTION FOR PAIN TREATMENT

4 MEDICAL PROFESSIONAL WILL NOT RECOMMEND/ PATIENT CAN AFFORD CANNABIS SPECIALIST

A 2022 survey found that while over two-thirds (68.9%) of clinicians believe that cannabis has medicinal uses, just over a quarter (26.6%) had ever recommended cannabis to a patient. Despite protections upheld under the 1st Amendment and granted in the Medical Marijuana and Cannabidiol Research Expansion Act of 2022 (Title III section 301), many large medical practices prohibit their physicians from recommending cannabis to their patients. Seeing a cannabis specialist requires an out-of-pocket cost for patients ranging from $100-$250.

5 PAIN CLINICS TEST FOR THC

Pain clinics often require patients to sign "pain contracts" that prohibit the use of cannabis even for medical use. If the patient tests positive for THC, they are denied treatment and abruptly cut off all pain medications. This practice still persists despite the Centers for Disease Control's (CDC) March 2016 "Guidelines for Using Opioids for Treating Chronic Pain" advising clinicians against prohibiting the use of cannabis as a criterion for eligible care. CDC warns clinicians that dismissing a patient from care based solely on a urine drug test result could have adverse consequences for the patient's health and safety.

6 PATIENT QUALIFIES FOR PROGRAM

Some states restrict individuals who have drug convictions, are on probation, or have special job requirements (police, firefighters, etc) from participating in the state's medical cannabis program. Also, some laws only allow medical cannabis to be recommended after every other medication has been tried, rather than allowing medical professionals, and patients to choose cannabis as front line treatment.

7 THE PATIENT CAN ACCESS MEDICAL CANNABIS IN A REASONABLE TIME FRAME

When patients receive a prescription, they can often pick it up at a local pharmacy immediately to begin their course of treatment. Unfortunately, medical cannabis has been treated differently in many states, requiring patients to wait as long as 90 days to access their medicine.

8 PATIENT CAN AFFORD ID CARD

Patient ID cards are an out-of-pocket cost that can be over a hundred dollars annually. Some states offer discounts and reduced fees for low-income individuals.

9 THERE IS ACCESS FOR THE PATIENT

A critical part of a successful medical cannabis program is ensuring that patients can access their medicine. This is accomplished by providing an ample number of dispensaries that are accessible to patients all across a state, not just in urban or rural areas. Creating laws with reasonable zoning provisions, providing for the delivery of medicine to patients with mobility issues, and allowing patients to grow their own medicine increase the availability and access for patients.

10 ACCESS POINTS HAVE PRODUCTS THE PATIENT NEEDS

Medical cannabis is not a one-size-fits-all medicine. Some patients need a medicine with a high concentration of CBD, while others need a medicine that has a stronger THC content. Patients differ in the route of administration that is best for them, ranging from inhaled products to tinctures to chewable tablets, lotions, and ointments.

11 HOSPICES, HOSPITALS, AND/OR TREATMENT CENTER ALLOWS MEDICAL CANNABIS USE

For patients living outside their home, the centers where they reside for treatment, recovery, rehabilitation, or end-of-life care may not allow the use of medical cannabis. The majority of medical cannabis programs limit the administration of cannabis to the patients themselves or to a designated caregiver. However, the designation of caregiver is limited to individuals.

12 PATIENT CAN AFFORD TREATMENT

Without insurance coverage, the cost of medicine can be prohibitively expensive. Aside from financial costs, patients have to consider costs such as losing their jobs, professional licenses, homes, or custody of their children due to their status as medical cannabis patients as well.

VETERANS, ACTIVE MILITARY & MEDICAL CANNABIS

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, the Department of Defense maintains a zero-tolerance policy for any cannabinoid-based medicines, including federally legal hemp-derived products.

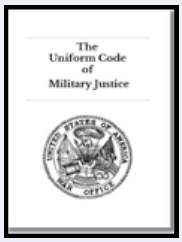
For veterans relying solely on the Veteran Health Administration (VHA) for healthcare, their providers are prohibited from recommending medical cannabis. As a result, veterans must pay out-of-pocket not only for cannabis treatments, and state ID card fees but also for consultations with cannabis specialists. Veterans unable to afford these expenses often turn to adult-use markets without medical oversight, unregulated hemp-derived products, or the illicit market.

The DEA's classification of cannabis as a Schedule I drug underpins the VA's refusal to recommend or assist with state medical cannabis programs. As of July 28, 2023, **VHA Directive 1315 explicitly states:**

> *"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).*

The VA's webpage, "VA and Marijuana – What Veterans Need to Know," further clarifies:

> *"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.*



For active-duty military members, cannabis use is prohibited under Article 112a of the Uniform Code of Military Justice (UCMJ), which forbids:

> *"the knowing use, possession, or distribution of marijuana and marijuana-derived products, including CBD. This prohibition applies at all times and in all locations. Violations are punishable under Article 92 of the UCMJ."*

Each branch enforces this policy as follows:

Army: AR600-85, section 4-2p

Air Force: AFMAN 44-197, Paragraph 1.2.2.1

Navy & Marines: ALNAV 057/19, Paragraph 3

Coast Guard: COMDTINST M1000.10A, Chapter 5, Section D.1

"OPIOID DOSES & RISK OF SUICIDE-In a 2016 study, researchers with the VA Ann Arbor Healthcare System and University of Michigan found that Veterans receiving the highest doses of opioid painkillers were more than twice as likely to die by suicide, compared with those receiving the lowest doses."

Ilgen MA, Bohnert ASB, Ganoczy D, Bair MJ, McCarthy JF, Blow FC. Opioid dose and risk of suicide. Pain. 2016 May;157(5):1079-1084. doi: 10.1097/j.pain.0000000000000484. PMID: 26761386; PMCID: PMC4939394.

MEET JOSE BELEN

Jose Belen is a decorated United States Army combat veteran. Jose enlisted in the Army at age 19 and deployed to Iraq in 2003 during the initial Operation Iraqi Freedom invasion and spent 14 consecutive months in combat. After his honorable discharge in 2005, Jose began silently battling post-traumatic stress disorder. The VA began to treat him with antidepressants, mood stabilizers, sleeping pills, SSRI's, and other prescription drugs. The side effects of every medication that he took had adversely accelerated his symptoms and nearly drove him to suicide a number of times.

His inner battle almost robbed him of everything; his career, his family, nearly his own life. Ultimately, however, Jose was able to overcome his personal demons with the help of cannabis. Medical cannabis gave him the ability to function and find peace without the constant thoughts of the horrors of war and all of its baggage. Although he does not consider it a "cure" for PTSD, he finds cannabis to be vital in his recovery. He believes he would not be here and would have fallen victim to other medications had he not been introduced to medical cannabis.

17.5 VETERANS COMMIT SUICIDE EVERY DAY

(19 TOTAL IF YOU INCLUDE ACTIVE DUTY)

1 IN 3 VETERANS HAVE A CONDITION RELATED TO CHRONIC PAIN.

1 IN 10 VETERANS REPORTS SEVERE PERSISTENT PAIN.

SUICIDE IS THE 2ND LEADING CAUSE OF DEATH FOR VETERANS UNDER 45.

www.hsrd.research.va.gov/for_researchers/cyber_seminars/archives/2351-notes.pdf
www.mentalhealth.va.gov/docs/data-sheets/2024/2024-Annual-Report-Part-2-of-2_508.pdf

"Veterans deserve the right, like everyone else, to access medical cannabis as an alternative to the pills that are currently being given to them. PTSD does not have to be a death sentence."

MEET SHANETHA MARABLE - LEWIS

Shanetha Marable-Lewis, a West Virginia native, joined the U.S. Army in 1999 straight out of high school. Two years later, as she watched the towers fall on September 11th, she knew her military service—and her life—were about to change. Her unit was deployed the following year in support of Operation Enduring Freedom and Operation Iraqi Freedom.

While still on active duty, Shanetha was diagnosed with depression and later PTSD. After receiving an honorable discharge, she began using cannabis—this time with a new awareness. She quickly realized it helped ease her symptoms, especially insomnia and recurring nightmares.

"At the time, I couldn't fully describe all the ways cannabis helped me," she explains. "I just knew it made me feel better. I was calmer. I slept. When I medicated, I was far more patient—with others, and more importantly, with myself."

As Shanetha began her journey as a medical cannabis patient, the opioid epidemic was rapidly sweeping the country, with its epicenter in her home state of West Virginia. Watching friends and family struggle with addiction—and too many losing their lives to fentanyl poisoning—combined with her own lived experience, propelled her into the study and practice of cannabis science and therapeutics.

While her family was stationed at Joint Base Lewis-McChord, Shanetha worked directly with medical cannabis patients and built strong connections with veteran-focused, cannabis-centered organizations. After her husband retired from the military, she returned to the East Coast and earned a Master of Science in Medical Cannabis Science and Therapeutics from the University of Maryland.

Soon after graduating, Shanetha became Executive Director of Veterans Initiative 22, an organization dedicated to suicide prevention through safe, affordable access to medical cannabis for veterans. Through her advocacy, she works tirelessly to advance education, dismantle stigma, and expand patient-centered access to medical cannabis—for veterans, for those struggling with addiction, and for all patients.

“To me, it’s simple,” Shanetha says. “Cannabis saves lives—mine included.”

“Chronic pain is more prevalent and of greater intensity in the Veteran population than in the general population. It is often accompanied by co-existing mental health conditions. Unrelieved and persistent chronic pain can contribute to depression, anxiety, poor sleep patterns, decreased quality of life, and substance use disorder. It is also a risk factor for suicide. The consequences of chronic pain include lost work productivity, disability, and increased health care costs.”

-Veterans Administration www.research.va.gov/topics/pain.cfm

MEET TODD LARKIN

In 2011, ten years after enlisting in the U.S. Army and serving tours of duty in Egypt and Afghanistan, Todd Larkin was discharged an E5 Sergeant and returned to his wife and kids in his hometown of Ardmore, Oklahoma, between Oklahoma City and Dallas. He had joined the military straight out of high school, and returned to work and coach at that school, but within a year, the Veterans Health Administration diagnosed him with post-traumatic stress disorder (PTSD) and depression. His mental health deteriorated over the next few years until his mood problems got him suspended from coaching football, and he became suicidal.

“I was going down a road that wasn’t me,” he says. That’s when a friend from high school intervened, telling him repeatedly that he needed to try cannabis. “I didn’t think it would do anything,” Todd says. “My wife was pretty adamant about me not trying it.”

“Treatment with cannabis based medicinal products reduced the prevalence & intensity of suicidal ideation.”

Lynskey, M. T., Thurgur, H., Athanasiou-Fragkouli, A., Schlag, A. K., & Nutt, D. J. (2024). Suicidal Ideation in Medicinal Cannabis Patients: A 12-Month Prospective Study. Archives of Suicide Research, 1–15. https://doi.org/10.1080/13811118.2024.2356615

But Todd began to do research and became convinced it was worth a try, and broached the idea with his wife again. They decided to do a short trial of using cannabis obtained on the underground market, as there was not legal access in Oklahoma at the time. “After about a month, we were completely sold,” Todd says. “We both saw a complete change in my mentality and mood. It was night and day from the VA meds.” Todd was being prescribed nine separate medications, including Xanax, Prozac, a sleeping medicine and two more drugs to control the stomach problems from the other medications. To identify and obtain the types of cannabis medicine that work for him, Todd and his wife made trips to neighboring Colorado.

“If you’d told me 10-15 years ago this would be the medicine that helped, I wouldn’t believe it,” he says. “What has helped the most in Oklahoma has been education. It’s not what we were told all our lives--far from it. I want to make it more normal for my kids, so we need to not whisper about it,” Todd says. “We talk about Xanax in the open, so why not this?”

AGING POPULATIONS & CANNABIS MEDICINES

Half of adults aged 65 and older take between five and twenty or more medications daily, expounding the potential harmful impacts of polypharmacy. So, it is no surprise that they represent the fastest-growing demographic turning to cannabis for relief from several common conditions, including chronic pain, arthritis, sleep disorders, and other age-related health issues. Research suggests that cannabis may provide significant relief for these ailments and could serve as a viable alternative to traditional medications, which often have more severe side effects for older adults. Cannabis medicines could play a key role in the emerging field of deprescribing.

Despite its potential benefits, several barriers hinder access to medical cannabis for this population. A lack of education among both patients and healthcare providers, combined with the high out-of-pocket costs, limits its widespread adoption. Additionally, federal prohibition complicates the integration of cannabis-based treatments into care plans, particularly for those living in assisted living facilities, nursing homes, or hospices.

AARP®

HEALTH

1 in 5 Older Adults Uses Cannabis

AARP-supported research shows many people 50-plus try THC to aid health

Data indicates that incorporating medical cannabis into healthcare systems, such as Medicare, could lead to improved health outcomes for the nation's fastest-growing demographic. Such integration would provide a compassionate approach to addressing age-related health issues while enhancing the quality of care for older adults.

CANNABIS: AN EMERGING TREATMENT FOR COMMON SYMPTOMS IN OLDER ADULTS.

Half (53%) reported using cannabis regularly on a daily or weekly basis, and reported using cannabidiol (CBD)-only products (46%). The majority (78%) used cannabis for medical purposes only with the most common targeted conditions/symptoms being pain/arthritis (73%), sleep disturbance (29%), anxiety (24%) and depression (17%). Most older adults in the sample initiated cannabis use after age 60 and used it primarily for medical purposes to treat pain, sleep disturbance, anxiety and/or depression. Cannabis use by older adults is likely to increase due to medical need, favorable legalization and attitudes.

Yang, K.H., Kaufmann, C.N., Nafsu, R., Lifset, E.T., Nguyen, K., Sexton, M., Han, B.H., Kim, A. and Moore, A.A. (2021), Cannabis: An Emerging Treatment for Common Symptoms in Older Adults. J Am Geriatr Soc, 69: 91-97. https://doi.org/10.1111/jgs.16833

MEET DAWN-MARIE STEENSTRA, LPN

Dawn-Marie is a hospice nurse who had run her own assisted-living facility for 21 years. She was already a strong patient advocate who had learned something about state regulatory processes. But she knew little about medical cannabis. At a conference, she heard about the latest international research and the experiences of patients, gaining insights into the potential of cannabis to treat the side effects of cancer chemotherapy and a myriad of conditions. She was also introduced to the endocannabinoid system – all things she had not been taught in nursing school.

"As a nurse, I was just sitting there with my mouth open," she recalls. "**In long-term palliative care and hospice, the four drugs provided as a standard in my nursing bag did not work for everyone for pain, anxiety, or nausea**. I became an advocate that day, a very determined advocate."

She has found that cannabis can be the answer to many maladies of her own. After a car accident in 1999 left her with a severe back injury that required cervical fusion, she had been a pain patient for 18 years, treated with a variety of shots, therapy, and pain, anti-anxiety, and muscle-relaxant medications. Because of her nursing license, she was wary of using whole-plant cannabis but asked her doctor if she could try a combination of a full-spectrum CBD oil and Marinol, which is a prescribed synthetic THC drug. He agreed. Within two months, she was completely weaned off all her other medications.

CANNABINOID-BASED THERAPIES ARE 80-90% EFFECTIVE AT RELIEVING THE CHALLENGES THAT COME WITH AGING, INCLUDING CHRONIC PAIN, SLEEP ISSUES, & ANXIETY.

"So many people saw cannabis as a threat to humanity, but it's a savior. For myself, as well as the patients I now meet with every day." Dawn-Marie says. **She continues to care for seriously ill homebound patients in private practice and has seen doctors change their minds, as evidenced by the results in her patients**. "This is the greatest moment of all, when a doctor who was afraid or hesitant suddenly asks for every educational resource I have," Dawn says. "Of course, the very first resource I refer them to is Americans For Safe Access!"

MEET JOHN BELVILLE

John Belville, 77, became a drug and alcohol counselor in his forties after a career as a musician traveling with various famous and not-so-famous bands. In 1974, he returned to Idaho to raise his own family, but his drug and alcohol abuse were running his life. In 1982, at the age of 40, he entered inpatient treatment and got sober. Three years later, he returned to college and completed a degree in Social Work and a minor in Abnormal Psychology at Boise State University. John worked with clients for 14 years until health problems forced an early retirement.

Those health problems were numerous and life-threatening. He nearly died from complications due to diabetes and a double femoral artery blockage in both legs, plus an attack of necrotizing fasciitis, better known as flesh-eating bacteria, all at the same time. The lack of blood flow in his legs left John with excruciating peripheral neuropathy in his legs that resulted in prescriptions for morphine, hydrocodone and occasionally oxycodone, and more drugs to treat the side effects. A full complement of opioids would reduce his pain but not eliminate it. Walking was painful, and he couldn't sleep.

Then he went to visit his son in Oregon. "He said try this, and handed me some cannabis tincture, a 50/50 CBD and THC," John says. "Yeah sure, right,' I said. I knew drugs, and a little weed wasn't going to do anything." Like many people, **John had to overcome misconceptions about what the medical use of cannabis means--all the more so because of his background as a recovering alcoholic and a counselor.**

"Five minutes later I was pain free. From a five on the pain scale with the morphine to a zero. I was amazed." Adding the cannabinoids achieved what the opioids alone could not, and with no side effects, including intoxication. The tincture didn't get him high; it just eliminated the pain.

"Morphine and hydrocodone helped with pain, but I couldn't think, and sleep was always a problem," John says. "I'd take a time-release morphine before bed, but six hours in, I'd be awake with pain and have to get a hydrocodone. A little tincture, and I'd go right back to sleep with no pain."

There is an estimated 78% risk of experiencing adverse reactions to opioids, including constipation or nausea, with a 7.5% risk of severe adverse reactions, ranging from immunosuppression to respiratory depression.

Els C, Jackson TD, Kunyk D, Lappi VG, Sonnenberg B, Hagtvedt R, Sharma S, Kolahdooz F, Straube S. Adverse events associated with medium- and long-term use of opioids for chronic non-cancer pain: an overview of Cochrane Reviews. Cochrane Database Syst Rev. 2017 Oct 30;10(10):CD012509.

In a study of 2736 patients above 65 years of age, they began cannabis treatment and answered the initial questionnaire. The most common indications for cannabis treatment were pain (66.6%) and cancer (60.8%). After six months of treatment, 93.7% of the respondents reported improvement in their condition, and the reported pain level was reduced from a median of 8 on a scale of 0–10 to a median of 4. Most common adverse events were: dizziness (9.7%) and dry mouth (7.1%). After six months, 18.1% stopped using opioid analgesics or reduced their dose.

Abuhasira R, Schleider LB, Mechoulam R, Novack V. Epidemiological characteristics, safety and efficacy of medical cannabis in the elderly. Eur J Intern Med. 2018 Mar;49:44-50. doi: 10.1016/j.ejim.2018.01.019. PMID: 29398248.

MEET FRANK BURESS

You have 72 hours to start anti-virus medicine after the shingles rash appears. Miss that window, and your odds of developing painful post-herpetic neuralgia skyrocket. That's what happened to Frank Buress, whose case of shingles was so severe, covering every bit of his body but the palms of his hands, soles of his feet, and his face, that his doctor misdiagnosed it as hives. When they figured out the diagnosis, it was too late, and the excruciating nerve condition set in and has plagued him for more than 15 years since.

His doctor in Wisconsin was sympathetic, prescribing a raft of opiate painkillers to deal with the condition, including Percocet, Fentanyl, oxyContin, and oxycodone, until Frank was up to 540 morphine equivalents a day – enough to kill a horse. In 2014, **Frank went to the pain rehab program at the Mayo Clinic to learn new ways to cope with pain. The meditation, guided imagery, biofeedback and relaxation techniques all helped distract him from the constant pain but did not really reduce it.**

Then, he was diagnosed with cancer of the colon and the kidney, a growth on his lung, and six basal cell carcinomas on his chest. Doctors recommended the removal of his sigmoid colon, followed by ablation on his kidney because it could not be treated with chemo or radiation due to stage 4 renal disease.

That's when Frank moved to Portland, Oregon, for 90 days to try medical cannabis. Once he had an Oregon card, he started with 5mg of 3% THC three times a day, doubling every four days and increasing in potency, until he was using 70% THC at 1000mg a day. The effects were dramatic. Three days after starting the treatment, he was pain-free.

"**I'd been in pain for over 10 years. It wasn't distracted by the cannabis. The pain was just plain gone."** Frank is hoping to see Wisconsin join the 39 states with a robust medical cannabis program that will give him access to the only medicine that gives him relief.

According to the National Survey on Drug Use and Health, between 2009-2019 the number of people 65 & older reporting to have consumed cannabis in the past year tripled rising from 11% to 32% representing the largest increase in age group & increasing to 35% in 2021.

Medical cannabis use was associated with clinical improvements in pain, function, and quality of life with reductions in prescription drug use; 73% either ceased or decreased opioid consumption and 31% discontinued benzodiazepines. Importantly, 52% of patients did not experience intoxication as a side effect of cannabis therapy. Significant clinical benefits of cannabis occurred within 3 months of initiating cannabis therapy and plateaued at the subsequent follow-ups.

Greis A, Larsen E, Liu C, Renslo B, Radakrishnan A, Wilson-Poe AR. Perceived Efficacy, Reduced Prescription Drug Use, and Minimal Side Effects of Cannabis in Patients with Chronic Orthopedic Pain. Cannabis Cannabinoid Res. 2022 Dec;7(6):865-875. doi: 10.1089/can.2021.0088. Epub 2021 Nov 12. PMID: 34767730;

COMPASSIONATE USE: RARE DISEASES & PEDIATRIC DISORDERS

Over 30 million Americans are living with rare diseases without cures, and many do not have effective treatments. **90% of rare diseases lack FDA-approved treatments. Many of these individuals, including pediatric populations, have found relief in cannabis medicines.** Cannabis-based therapies have shown efficacy in treating conditions where no other pharmaceutical options exist or where current treatments are ineffective or produce intolerable side effects. This is particularly important in cases of combination drug treatments that increase the likelihood of adverse events, side effects, tolerance and dependence, and drug resistance.

30 MILLION
Americans live with a Rare Disease

MEET CONNOR SHEFFIELD

Afflicted from a very young age by digestive and eating problems, Connor was finally diagnosed at age 11 with pediatric gastrointestinal dysmotility, a rare autoimmune disorder that had him in and out of hospitals for much of his young life. Connor's slow GI system results in pseudo-obstructions of his bowels and other painful, life-threatening problems. In 2018, after years on a feeding tube, he spent a month in the hospital, where he was fed through his veins for 20 days. **His doctors at Johns Hopkins had given up hope and suggested to his family that there was nothing left to try. It was time for palliative care.**

That's when a family friend urged the Sheffields to consider cannabis. They'd exhausted their options, including many types of alternative medicine, but they remained deeply skeptical of cannabis.

"We didn't think it would work," Connor says. On December 27, 2018, they tried it anyway, administering a medicinal cannabis tincture containing 15mg of THC. **"Within 20 minutes, I felt better," Connor says. "No pain, no nausea, and I had an appetite."** Over the next month, Connor's parents continued the cannabis treatment and carefully monitored and recorded his daily progress, documenting weight gains from the mere 76 pounds he'd dropped to during his month in the hospital. **But they kept it secret from everyone out of fear of arrest or loss of custody to Child Protective Services.**

95% OF THE 7,000 KNOWN RARE DISEASES HAVE NO FDA-APPROVED TREATMENT

On their next visit, his doctor said, "Wow, Connor, you look amazing," and began patting himself on the back for Connor's recovery. **His mother, Tricia, knew it was time to tell him what had actually made the difference. "His doctor was like, 'Really?!'" Tricia recalls. "He said he couldn't sign off on it, but keep doing what you're doing."**

This study suggests a favorable association between medical cannabis treatment and quality of life among patients with a diverse range of conditions.

Arkell TR, Downey LA, Hayley AC, Roth S. Assessment of Medical Cannabis and Health-Related Quality of Life. JAMA Netw Open. 2023;6(5):e2312522. doi:10.1001/jamanetworkopen.2023.12522

After missing an average of 150 out of 180 days of school over the previous five years, Connor was able to return to school full time in 2019. In this, his sophomore year in high school, he's only missed 12.

"I'm a living example that this works," Connor says. As many other patients also report, Connor says his microdoses of cannabis do not leave him feeling high, just out of pain. Tricia says cannabis has transformed her son's life, not just helping him eat and digest food but allowing him to grow more confident and social. And in the last year using cannabis, he's grown a foot in height. Connor finally had his feeding tube removed. "He's well," says Tricia. "He's not sick anymore."

MEET SCOTT ROBERTS

The twitches in Scott Roberts' head started when he was just 12. His involuntary head movements were misdiagnosed as Tourette's Syndrome, and for 17 years, he took medication prescribed for that condition, as the twitches progressed to violent twists that affected his whole back.

Even his gait was affected, causing him to lean to the right. By 2008, the symptoms had become so severe that he needed assistance walking, and, at age 27, he had to start using a wheelchair and take a medical leave from work that would stretch to two-and-a-half years.

During that leave, Scott's physician determined that it was not Tourette's at all that was producing his problems, but a rare disorder called cervical dystonia or spasmodic torticollis that most often occurs in middle-aged women. The severity of the involuntary muscle contractions, which twisted his back so hard that he would fall, made it even rarer. **"The pain from the twisting was so bad it felt like I was waiting for my spine to snap," says Scott.**

Cervical dystonia is a newer diagnosis, only recognized in the past 30 years or so. That, combined with the rarity of the condition, results in low patient numbers and few studies. So, for six months, his doctors tried medication after medication to control his symptoms, but nothing worked.

"They were dumping toxins in me. I felt like a guinea pig," says Scott. "Nothing against the doctors. I understand that's just how it is." All the doctors could offer were a host of opioid narcotics for the pain. After exhausting the pharmaceutical options, the next step was deep-brain stimulation surgery to implant an electrode that would block the signals that were causing his muscles to contract.

All in all, Scott was out of work for more than three years, battling pain and, as his girlfriend describes it, "walking around like a zombie" from all the opioids and other medications: Tramadol, Percocet, Valium, Flexeril, Gabapentin, Klonopin, morphine, and others." **Instead of flooding myself with pharmaceuticals, I decided to give medical cannabis a try," Scott says. It worked. Soon, he was reducing or eliminating the other medications and experiencing pain relief.**

MEET CRISTA EGGERS

Crista Eggers became a committed activist because cannabis is prohibited in her state, even for her seriously ill child with intractable epilepsy. “We are in a state where there is no medical cannabis law, where there is no CBD law, so we still do not know if this is an option that can help our child,” says Crista. “But it’s helping people like our son in states next to us, so we hope to bring that option, that access, that right to Nebraska.”

Colton, at age 7, suffers from constant seizures on a daily basis, ranging from the violent tonic-clonic to absence and complex partial seizures. Since he was diagnosed with epilepsy at age 2, **Colton has been prescribed 20 different medications in nearly 100 different combinations. Nothing has worked. In fact, his condition has worsened, and many of the medications have produced side effects, including nausea, dizziness, and headaches.** The worst was a serious allergic reaction that put Colton in the hospital for 11 days.

Novel pharmacological treatments for the core and comorbid symptoms of ASD are urgently needed. Preclinical studies implicate the endocannabinoid system in the pathophysiology of ASD. In a controlled study of 150 participants, we found that BOL-DP-O-01-W, a whole-plant extract which contains CBD and THC in a 20:1 ratio, improved disruptive behaviors on one of two primary outcome measures and on a secondary outcome, an index of ASD core symptoms, with acceptable adverse events.

Aran A, Harel M, Cassuto H, Polyansky L, Schnapp A, Wattad N, Shmueli D, Golan D, Castellanos FX. Cannabinoid treatment for autism: a proof-of-concept randomized trial. Mol Autism. 2021 Feb 3;12(1):6. doi: 10.1186/s13229-021-00420-2. PMID: 33536055;

“His body shut down from a medication that is studied and FDA approved. We came close to losing our child because of this medication,” says Crista. “Every day my stomach churns knowing we’re making the decision that we think is best, which is continuing these meds, even though they don’t seem to be doing a lot.” **Colton’s doctors say they’ve exhausted all available pharmaceutical treatments, all anti-convulsant and epilepsy medications. Except for cannabis, because it’s not legal in Nebraska. Obtaining it illegally could result in criminal charges for Crista and the loss of parental rights.**

“We don’t want to be criminals, but unfortunately, so many people are forced to become criminals as patients,” says Crista. “We’re struggling to know if we’re helping him with these meds or hurting him, particularly now that he’s older and can tell us how incredibly sick he feels.” The number of medications Colton takes requires constant bloodwork to monitor their effects, bloodwork that could reveal if he had been given any cannabis-based medications. In 2019, once it became clear the doctors in their state couldn’t offer any more help, the Eggers went to Minnesota to see epilepsy specialists. After testing Colton, the subject of cannabis came up.

“Those conversations were very limited and very difficult,” says Crista. “The doctors said, ‘I would suggest you either move to a state where medical cannabis is legal, so that we can try this for Colton, or you go back home, and you try to get it legalized.” Rather than become another family of medical refugees, the Eggers decided to return home and fight for safe access for Colton and other families.

Nebraska voters passed a medical cannabis bill in 2024 that Crista is now fighting the state to implement.

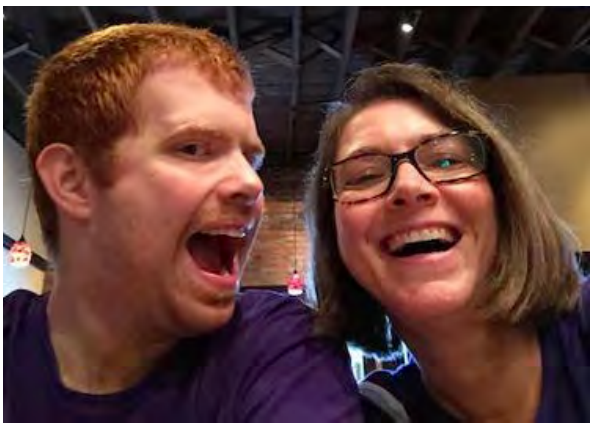
Children and adolescents with ASD treated with CBD-rich cannabis exhibit significant improvements particularly in social symptoms: an open label study... these findings suggest that treatment with CBD-rich medicinal cannabis can lead to significant improvements in social communication skills of some ASD individuals, particularly those with more severe initial symptoms.

Hacohen M, Stolar OE, Berkovitch M, Elkana O, Kohn E, Hazan A, Heyman E, Sobol Y, Waissengreen D, Gal E, Dinstein I. Children and adolescents with ASD treated with CBD-rich cannabis exhibit significant improvements particularly in social symptoms: an open label study. Transl Psychiatry. 2022 Sep 9;12(1):375. doi: 10.1038/s41398-022-02104-8. PMID: 36085294

MEET MICHELLE & IAN

Michelle describes her 29-year-old son Ian as a grown man who still watches Barney, plays with stuffed animals, and needs help with everything from getting dressed to using the bathroom. His speech is also limited to that of a 2 to 3-year-old, which can increase his frustration when trying to communicate.

Ian's behavior deteriorated in his early 20s. He had been on a few medications most of his life, with manageable side effects. But after leaving school at 21, he started to develop more self-injurious behaviors, which resulted in more medications being added. He also experienced weight gain and tremors from his medication.



"We tried switching out his one anti-psychotic drug, but that just made things worse," said Michelle. The doctors tried everything they could think of – neuroleptics, anti-depressants, mood stabilizers, blood pressure, anti-anxiety and anti-seizure medications (though he has never had a seizures). Then medications to manage the side effects. Ian developed facial tics and became extremely self-injurious, beating his head so severely he had to start wearing a helmet. He was also becoming more aggressive, lashing out in pain at family members. **Between the ages of 25 and 27, Ian cycled through a cocktail of 13 different medications and lost 40 pounds.**

"He was so thin. He became catatonic at times and wouldn't eat or use the bathroom," Michelle remembers. "Other times he would be violent and harm himself or punch a hole in the wall. It was so awful to watch my baby suffer. We were truly desperate. We had to try something different."

Luckily, medical cannabis became operationalized in Maryland in 2017. Michelle had read about medical cannabis helping patients like her son, and the side effects seemed less than the drugs he was on. "We thought, we've tried so many things. Shouldn't we try cannabis before moving to even more intensive drugs and treatment?"

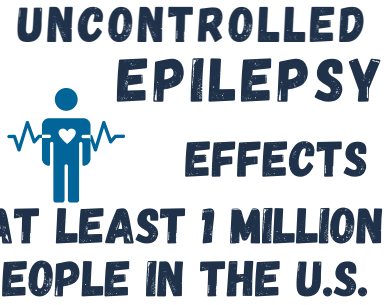
Once they started, Michelle saw improvement in Ian. Within a few weeks, he needed less of the anti-anxiety medications he was taking four to six times a day. He began sleeping more and gradually emerged from the relentless psychotic and catatonic episodes.**"I'd see the light in his eyes every once in a while," says Michelle. "I'd wait for those few minutes a day of seeing my big guy again. I would say to my husband, 'There he is!'"**

After two years, Ian had weaned off all but one pharmaceutical medication that he takes at a lowered dose. He's gained 20 pounds, and almost all of the medication side effects have stopped. "He has agency again. He wakes up happy, not screaming and banging his head," Michelle says. "We take walks, and he holds my hand. He communicates more than he ever did before, expressing his wants and needs."

"It was never about curing Ian of his autism. That is who he is," says Michelle. "But cannabis has helped him be more of his best self. That is what we want for him. That is what we hope for others."

MEET JILL & MARY LOUISE SWING

Like many parents of children with severe seizure disorders, Jill Swing discovered the potential of medical cannabis through the 2013 CNN special report Weed, in which medical correspondent Dr. Sanjay Gupta reported the near-miraculous effects of CBD. Jill had no experience with cannabis before considering it as a treatment for her daughter, so the stories she heard of its broader therapeutic potential for so many types of medical conditions provided new perspective.



Her lack of experience also meant she had a steep learning curve trying to find medicine for her daughter. She networked with other desperate parents to find CBD extracts out of Colorado, but got burned several times, highlighting for her the critical importance of regulated state programs that ensure patients can both obtain cannabis medicines and have confidence that what they obtain is what it says it is.

With a verifying letter from Mary Louise's physician at the Medical University of South Carolina, Jill was able to take her daughter to Maine, which has a provision for recognizing out-of-state patients. There, she was able to try extracts of various varieties and combinations that included THC. **The results were dramatic. Mary Louise started babbling and standing, and showed improved motor skills. Her pharmaceutical medications have been substantially reduced or changed as a result**. After returning from Maine, Jill started an advocacy group, South Carolina Compassionate Care Alliance (SCCCA) which is still fighting to pass federal legislation.

MEET RYLIE & JANIE MAEDLER

Rylie's parents first grew concerned when, as a seven-year-old, she began exhibiting unusual symptoms: first, what looked like a persistent cold, then a blocked nostril, then losing her teeth. After months of uncertainty, a CAT scan found an aggressive tumor attacking one side of Rylie's face. Then, as she was being prepped for surgery and chemotherapy, a final bone biopsy came back negative. It wasn't a malignant cancer, after all.

Forty-seven tests later, doctors concluded it was a very rare form of tumor, aggressive giant cell granuloma. Surgery and chemotherapy were still the treatments, so the Maedler family began a complementary treatment with cannabis. Janie had done some research on what her young daughter was facing and had decided cannabis could be effective in fighting Rylie's recurrent tumors.

A year later, in 2014, Rylie was speaking at Rotary Clubs and other groups, raising funds and support to start a nonprofit, Rylie's Smile Foundation, for children suffering from rare diseases. Then she and her mother turned their attention to the Delaware legislature, campaigning for a medical cannabis law that would allow access for other children, such as Rylie, who had now also developed a seizure disorder that cannabis extracts helped control, along with her tumors. After months of testifying at hearings and speaking to the media, Delaware passed "Rylie's Law" in 2015, establishing legal access to medical cannabis on the recommendation of a pediatrician.

Approximately 5% of registered medical patients in states with medical programs are children. This does not count those who are administering CBD to their children through non-registered programs.

Colorado Department of Public Health and Environment (2019). Colorado Medical Marijuana Program Annual Report. California Department of Public Health (2020). Medical Cannabis Program Data Report

RHEUMATIC & CHRONIC CONDITIONS & MEDICAL CANNABIS

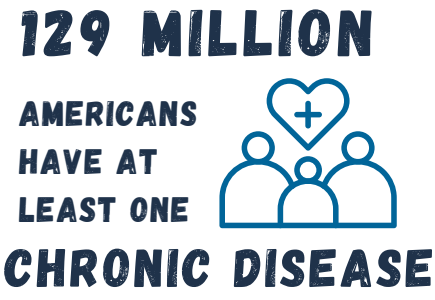
The THC-CBD spray improved spasticity and pain in secondary progressive Multiple Sclerosis (MS) patients. The spray prolonged CSP duration, which appears a promising tool for assessing and monitoring the analgesic effects of THC-CBD in MS.

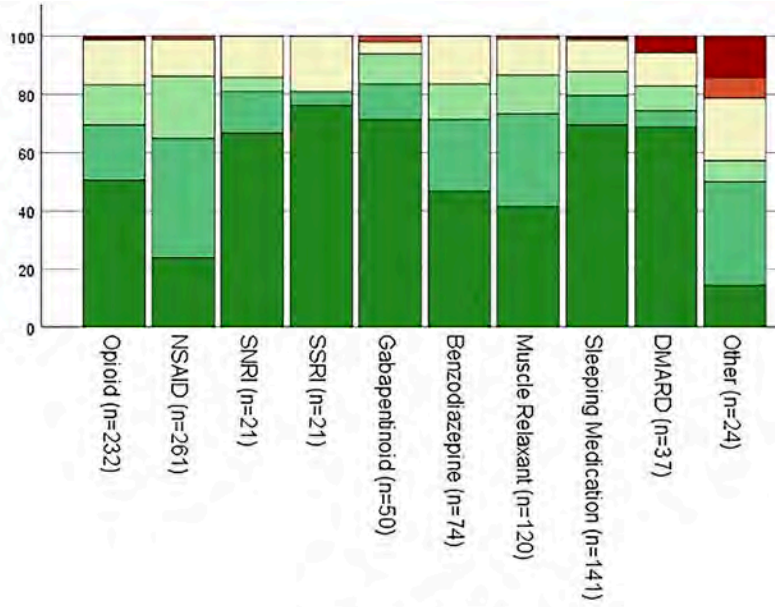
Vecchio D, Varrasi C, Virgilio E, Spagarino A, Naldi P, Cantello R. Cannabinoids in multiple sclerosis: A neurophysiological analysis. Acta Neurol Scand. 2020 Oct;142(4):333-338. doi: 10.1111/ane.13313. Epub 2020 Jul 21. PMID: 32632918.

Chronic and mental health conditions are the primary drivers of U.S. healthcare costs, accounting for 90% of the $4.1 trillion spent annually. A**n estimated 129 million Americans have at least one chronic disease, and over half of the adults aged 65 and older report having one or more rheumatic conditions, such as rheumatoid arthritis, ankylosing spondylitis, and psoriatic arthritis, that affect mobility, productivity, and quality of life.**

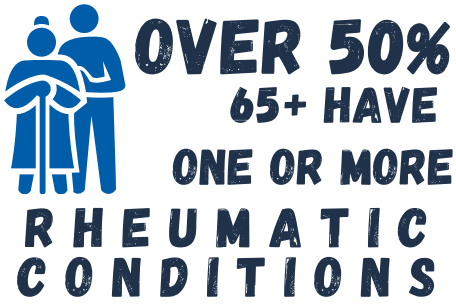
Despite extensive pharmacological efforts, treatments for diseases such as metabolic syndrome, psychiatric disorders, degenerative central nervous system (CNS) disorders, cancer, and neurodegenerative diseases—including Parkinson's disease, Alzheimer's disease, Huntington's disease, multiple sclerosis (MS), amyotrophic lateral sclerosis (ALS), stroke, traumatic brain injury (TBI), pain, and epilepsy—remain inadequate, in part due to the limited understanding of their complex mechanisms. These individuals often take between five and twenty or more medications daily, the majority of which—nine out of ten—are palliative.

Current treatment options are often insufficient, leaving patients reliant on costly biologics or high-risk medications. Furthermore, these conditions are frequently accompanied by chronic pain, which has driven patients toward medications with risk of addiction and overdose. Medical cannabis offers a promising alternative for addressing these unmet needs, interacting directly with the endocannabinoid system to modulate inflammation, alleviate pain, and improve mood.





Change in medication use since starting medical cannabis. DMARD, disease-modifying antirheumatic drug; NSAID, nonsteroidalanti-inflammatory drug; SNRI, serotonin norepinephrine uptake inhibitor; SSRI, selective serotonin reuptake inhibitor.



Boehnke, K.F., Scott, J.R., Martel, M.O., Smith, T., Bergmans, R.S., Kruger, D.J., Williams, D.A. and Fitzcharles, M.-A. (2024), Substituting Medical Cannabis for Medications Among Patients with Rheumatic Conditions in the United States and Canada. ACR Open Rheumatology.

MEET CARLA BASANTE

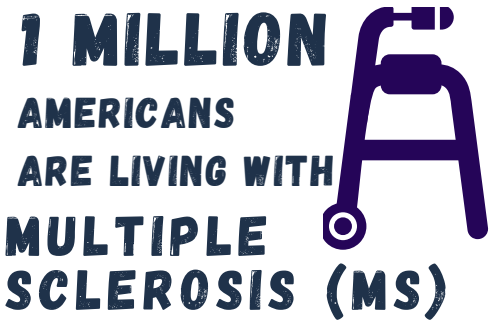
Carla Basante began using cannabis about 15 years ago to manage chronic pain from a severe back injury and symptoms of multiple sclerosis. A breast cancer survivor, Carla has had two back surgeries to treat the damage caused by a bad car crash when she was in her early 40s, as well as a nerve ablation and other procedures.

After doctors had trouble explaining the various symptoms she was experiencing after that accident, an MRI revealed she was also suffering from multiple sclerosis. The trauma of the back injury had "activated" her lurking MS, leading to seizures and other debilitating problems. What followed was a medicine cabinet full of powerful pharmaceutical drugs.

"Oxy, Percocet, valium – they'd prescribe anything, even steroids," Carla remembers. The unpleasant side effects of the medications she was initially prescribed for her conditions led her to investigate alternatives. "My son was a factor. I wanted to be a mother, but I didn't recognize myself," Carla says. She found that cannabis provided relief without the many side effects of other medications. Once she found a cannabis regimen that worked, she was able to go off 10 other drugs. **"It's horrible to live with chronic illness and chronic pain, but it's been years since I've had to take steroids, and I haven't had MS episodes. If I weren't medicating with cannabis, I couldn't function."**

Carla has faced discrimination in hospitals and rehabilitation centers as well as issues with subsidized housing forcing her to have to move.

"I'm the healthiest unhealthy person, thanks to cannabis use."



Some studies suggest that pathological conditions in pain modulation such as fibromyalgia, migraine, and irritable bowel syndrome, among others, may be, at least in part, related to the deregulation of the endocannabinoid system. In this context, manipulation of the endocannabinoid system, which is associated with the immunomodulatory effect of cannabinoids, strengthens the role of these compounds as promising therapeutic agents... Phytocannabinoids can be a low-cost and well-tolerated therapy to reduce symptoms and increase the quality of life of patients with fibromyalgia.

Chaves C, Bittencourt PCT, Pelegrini A. Ingestion of a THC-Rich Cannabis Oil in People with Fibromyalgia: A Randomized, Double-Blind, Placebo-Controlled Clinical Trial. Pain Med. 2020 Oct 1;21(10):2212-2218. doi: 10.1093/pm/pnaa303. PMID: 33118602; PMCID: PMC7593796.

It was just a routine vaccination. As a pediatric nurse, Nikki Lawley had done more than she could count, including with kids like this one, who really didn't want the shot. But the child turned combative and suddenly headbutted her, snapping her head back against the wall. She didn't realize it immediately, but the double impact and whiplash would change her life.

She'd just sustained a serious traumatic brain injury and now had cervical instability. Headaches, memory loss, insomnia, mood disturbance, anxiety, and depression took control of her life. Even though she was a medical professional, getting a diagnosis and appropriate care was a battle. She was a woman with invisible injuries facing off with a series of skeptical physicians. Because the injury occurred on the job, she was also caught between New York state's workers' compensation and her private insurance company. Her insurance wouldn't pay for anything to do with it, and workers' comp had many restrictions on what it would cover.

She cycled through more than 50 different medications, many with side effects more serious than the symptoms of her injury. But workers' comp refused to pay for any alternative treatments, forcing Nikki to tap into her life savings. Within three short months, Nikki was at her wits' end. **The side effects of the medications were excruciating, the battles with medical professionals were exhausting and humiliating, and the loss of her sense of self and her ability to work left her with no purpose in life. "I was suicidal," she says.**

Her struggle was obvious to those who cared about her. In an attempt to lift her spirits, her husband booked the two of them a trip to a favorite place: Las Vegas. She was in no real shape to travel, but couldn't say no to a loving gesture. Once they got to the hotel, she couldn't leave the room. After trying and failing to convince her to try doing something fun, her husband went for a walk, and Nikki found herself on the balcony, seven stories up, frightened but making a plan to end it. As she looked down at the street below, a billboard truck rolled by for medical cannabis. She made an appointment with a local doctor and was able to access medical cannabis from a local dispensary.

TBI is a public health epidemic with inconsistent clinical diagnostic criteria. Due to its complex mechanism of injury (primary and secondary) and varying severity, there is currently no single effective pharmacological treatment for TBI. CBD targets many of the cellular, molecular, and biochemical changes associated with TBI by mediating the regulation of neurotransmitters. Via a variety of targets, CBD appears to reduce cognitive (changes in memory, attention, and mood) and physiological symptoms associated with TBI, and lessen TBI-induced nociception…There is strong mechanistic support that CBD could be an effective pharmacological intervention for TBIs.

Aychman MM, Goldman DL, Kaplan JS. Cannabidiol's neuroprotective properties and potential treatment of traumatic brain injuries. Front Neurol. 2023 Feb 2;14:1087011. doi: 10.3389/fneur.2023.1087011. PMID: 36816569; PMCID: PMC9932048

In nursing school, Nikki had learned nothing about the endocannabinoid system or cannabis, and like many medical professionals, did not consider cannabis to be medicine. **Having exhausted every pharmaceutical treatment possible and every alternative treatment she could find and afford, she was out of options. Cannabis got Nikki off the ledge – figuratively and literally.**

MEET DEB MCCAULEY

Deb McCauley had been a medical professional for more than two decades, and had juggled her own seizure medications for nearly as long, when a friend approached her in the summer of 2018 with an alternative she'd not considered.

" 'Just say no' was my life," Deb says. "But I was just so tired, I was willing to try anything, even though it was illegal then in Virginia."

After her epilepsy-related discharge from the Air Force, Deb had moved to northern Virginia, where she met her husband, with whom she had two sons, now ages 9 and 11. She worked in acute care and every aspect of hospitalization over the years that followed but retired from bedside nursing due to burnout and physical injury.

For patients with seizures associated with certain epilepsy syndromes and for patients with pain from spasticity from MS, Class I evidence exists that has demonstrated both efficacy and tolerability of the products studied.

Patel AD. Cannabinoids in Neurologic Illnesses. Neurol Clin. 2021 Feb;39(1):231-241. doi: 10.1016/j.ncl.2020.09.012. Epub 2020 Nov 7. PMID: 33223086.

She knew her neurologist not just as a patient but as a nurse from working in the same hospital, so she brought him scientific articles and asked if he knew we have an endocannabinoid system. (He didn't.) "**He couldn't fully endorse it because it was still illegal then, but he was really supportive." Together, they made a plan for tapering off the prescription drugs she took to control her epilepsy.**

MEET RITA LYNN LAWRENCE

Rita Lynn Lawrence has faced a lifelong struggle with painful congenital medical conditions that have proven difficult to treat. Even accepting the diagnosis of muscular dystrophy and the winged scapula that resulted from weakened back muscles was difficult. Doctors could offer no real treatment or medical solution, just palliative care.

"I said yes to everything they recommended, but my health declined," Rita Lynn says. "I was in lots of pain, losing function, and couldn't drive. I tried to focus on parenting my children, but even that was a struggle."

Rita Lynn was living in Wisconsin at this time and when a friend suggested she try medical cannabis. Her experience with cannabis was a revelation.

"People say, I need a miracle, and that's how I felt for years. I had to believe something miraculous could happen and take me out of this pain, something other than taking my own life. As a parent, I knew I couldn't do that. I was a mom," Rita Lynn says. "I had to learn what to do to still function and continue to be a parent. **Cannabis took me out of the mindset that I just couldn't do this. It brought hope.**"

"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"

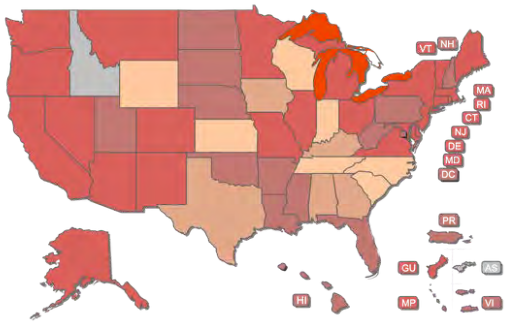
Since she lived then in Wisconsin, she had no legal way to obtain cannabis. She was also on a fixed disability income, so she had to rely on the kindness of friends to help her try this medicine that no insurance would cover. When she learned that lawmakers in Maryland had approved a medical cannabis program, a state she had roots in, she immediately made plans to leave Wisconsin and move to Maryland.

"I was so limited in my disability thinking, and I really struggled with my surgeries. **There was a time when there was no hope for the future," says Rita Lynn. "The future is bright. I can actually feel merry. There is so much opportunity for me now.."**

THE ROLE OF STATES IN PROTECTING PATIENT ACCESS

> For many states, hemp was not simply an agricultural or consumer policy challenge; it became an early warning of what happens when federal law changes without a parallel, patient-centered access strategy.

STATE PROGRAMS HAVE DEMONSTRATED THE POTENTIAL OF MEDICAL CANNABIS



Over the last 30 years, patient advocates have utilized state governments as laboratories of democracy to answer key logistical issues about safely distributing this complex botanical to patients, including the development of product safety protocols for the supply chain, education for stakeholders in utilizing this medication, and basic research to monitor patient and healthcare outcomes.

STATE MEDICAL CANNABIS PROGRAMS HAVE YIELDED IMPRESSIVE RESULTS, SHOWCASING THE POTENTIAL FOR MEDICAL CANNABIS TO REDUCE HEALTHCARE COSTS AND IMPROVE QUALITY OF LIFE.

LOWER HEALTHCARE COSTS

A study published in Health Affairs in 2017 found that states with medical cannabis laws saw a reduction of $165.2 million annually in Medicare Part D prescription drug spending. If implemented nationally, these savings could approach $1 billion per year.

IMPROVED PATIENT OUTCOMES

Patients participating in medical cannabis programs report better symptom management, fewer side effects, and improved mental health. For instance, rheumatic disease patients using medical cannabis report decreased pain, enhanced mobility, and improved sleep.

ECONOMIC BENEFITS TO THE WORKFORCE

States with medical cannabis programs have seen a 13% decline in workers' compensation claims, reflecting improved workforce participation and productivity.

REDUCED OPIOID DEPENDENCY

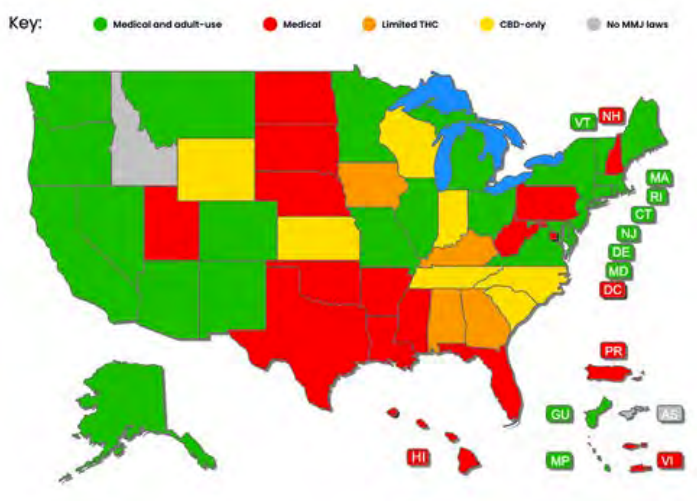
States with medical cannabis laws experienced a 23% reduction in opioid overdose deaths, according to a 2021 study published in JAMA Network Open (Wilson et al., 2021). Patients using medical cannabis as part of their treatment report a significant decrease in opioid use, with some studies showing a 64% reduction in opioid consumption.

Comprehensive federal legislation would expand these benefits nationwide and ensure patients have access to the care they need, regardless of where they live, their life stage, or their economic status.

THE ROLE OF STATES IN PROTECTING PATIENT ACCESS

For more than thirty years, states have stepped in where federal prohibition left patients without care. In the absence of a comprehensive federal medical cannabis framework, states have served as laboratories of democracy—developing, testing, and refining patient-centered policies under real-world conditions.

These policy experiments have led to evidence-based reform, dismantling significant barriers and, most notably, demonstrating clear medical benefits now formally recognized by the U.S. Food and Drug Administration. This progress did not occur despite federal inaction—it occurred because states acted. **Until permanent federal legislation aligns federal cannabis policy with state laws and integrates medical cannabis into mainstream healthcare, states will continue to bear responsibility for protecting patient access, safety, and continuity of care.**



"From a pharmacological standpoint, the 'hemp products' patients are taking to treat medical conditions are medical cannabis. Patients chose hemp products because they were told they were legal—and like medical cannabis, they worked. The hemp market filled a gap that our medical cannabis laws left wide open."- **Dr. Codi Peterson, PharmD, pediatric pharmacist and cannabis science educator.**

ONGOING BURDEN ON PATIENTS

Congress' action closes an unregulated and often unsafe marketplace. That is a legitimate policy goal. But it also exposes a hard truth: many patients have been accessing cannabis medicines through a legal fiction—and that fiction now has an expiration date.

Without state-level intervention, patients managing epilepsy, cancer symptoms, chronic pain, PTSD, autism, sleep disorders, and other serious conditions risk abrupt treatment disruption. These are not casual consumers. These are patients maintaining stability, functionality, and quality of life—often with no clinically viable alternative.

PRODUCT SAFETY CONCERNS

While cannabis (hemp) in its natural form is inherently safe for most patients, it is susceptible to contaminants during cultivation, manufacturing, handling, and storage. Like all agricultural commodities, cannabis is susceptible to contamination, but due to the high value of cannabis, it is also not uncommon for unscrupulous producers to improperly use pesticides or to use additives or adulterants to add weight, fragrance, or even dilute their products.

Regulated cannabis markets address these risks through comprehensive safety protocols, mandatory testing across the supply chain, track-and-trace systems, and recall procedures. Patients who are forced to rely on unregulated markets, however, are left with no such protections—exposed to unknown contaminants, inconsistent potency, and mislabeled products—conditions that can quickly escalate into a public health nightmare.

MAKING PROGRAMS WORK FOR PATIENTS

As a national medical cannabis program comes into view, states will remain responsible for patient access in the near term. **As they confront the impending access crisis, states should also address the well-documented policy gaps—within federal constraints—that have limited patient participation and enrollment, and prepare for national integration.**

Since 2002, ASA has worked with local, state, and federal officials, courts, and regulators to develop and improve access to cannabis and cannabinoid medicine. Each state differs significantly in how patients access medication, where they can obtain it, and which products are available. Despite decades of advocacy—and often due to political compromise—no state program can be considered ideal from a patient standpoint.

Logistically, patients face access deserts, interstate travel barriers, workplace drug testing, and prohibitive costs. Medically, many clinicians remain hesitant to recommend cannabis, insurance does not cover it, and few products are standardized or consistently available.

Over the past decade, the expansion of adult-use laws slowed—or halted—improvements to medical programs, driven by the false assumption that recreational markets can meet patient needs. While tax reductions have been used to incentivize medical enrollment, meaningful savings often take months or years to materialize, particularly after factoring in physician visits and registration costs.

Systemic gaps created by prioritizing the adult-use market:

- Adult-use programs exclude patients under 21, including pediatric patients with seizure disorders.
- Municipalities are more likely to block adult-use dispensaries, deepening access deserts.
- Adult-use rules often lack employment and child-custody protections, forcing patients to choose between medicine and livelihood.
- Providers increasingly prioritize adult-use consumers, diverting products from medical programs.
- Medical patients rely on condition-specific products often unavailable in adult-use markets, including:
  - Suppositories, sublinguals, and inhalers
  - High-CBD/low-THC ratios, 1:1 CBD/THC, and other therapeutic profiles
  - Patients require a safe, consistent supply of these formulations.
- Patients need guidance from trained medical cannabis professionals on chemovar selection, dosing, and administration—expertise typically absent in adult-use settings.

The draft emergency legislation and executive rulemaking that follow are designed to manage this transition responsibly and ensure that states address issues that pushed patients into the hemp and illicit market. **They do not reopen the hemp loophole. They do not undermine the new federal law. Instead, they provide states with lawful, patient-centered tools to address access issues, stabilize supply, and prevent avoidable harm before federal changes take effect**.

The clock is already ticking.
States can either manage the transition or manage the fallout.

PROTECTING ACCESS TO CANNABINOID MEDICINES: EMERGENCY ACTION

Whether through legislation or executive action, the goal of emergency action is to transition patients out of an unregulated market and into state-regulated programs—without disrupting care, forcing stockpiling, or pushing vulnerable patients into illicit markets. T**hese policy options offer a measured, patient-centered response that prioritizes safety and ensures that people who rely on cannabinoid medicines are not left behind.**

Incentivize Cannabis Cultivators & Manufacturers to Produce Affordable Cannabinoid Products

States can encourage licensed medical cannabis manufacturers to **produce full-spectrum, non-intoxicating cannabinoid formulations** (such as 16:1 non-intoxicating cannabinoid: THC ratios) that are often overlooked in adult-use markets. Targeted tax credits, grants, or no-interest loans can rapidly expand availability of these medically necessary products—without changing who is licensed or what is legal.

AND/OR

Allow Regulated Use of In-State Hemp Biomass for Medical Products

States can permit medical cannabis manufacturers to purchase non-intoxicating cannabinoid hemp biomass from USDA-licensed, in-state farmers, **provided those materials meet the same safety, inspection, and testing standards required for medical cannabis.** Once processed, all products are regulated as medical cannabis —closing the unregulated gap while protecting patients.

AND

Address Barriers Limiting Patient and Medical Professional Participation

After thirty years of experimentation, there is clarity about which policies foster access. Addressing state deficiencies is a longer-term solution to patient exclusion. These reforms are necessary to prevent future displacement into unregulated markets.

AND

Call on Congress to Create a National medical cannabis program

These policy options are designed to:

- Preserve access to non-intoxicating cannabinoid medicines;
- Ensure products meet medical-grade safety and testing standards and are accurately labeled;
- Stabilize supply before federal changes take effect;
- Give patients, providers, and regulators time to adjust responsibly; and
- Address the systemic barriers that have prevented patients from utilizing state programs.

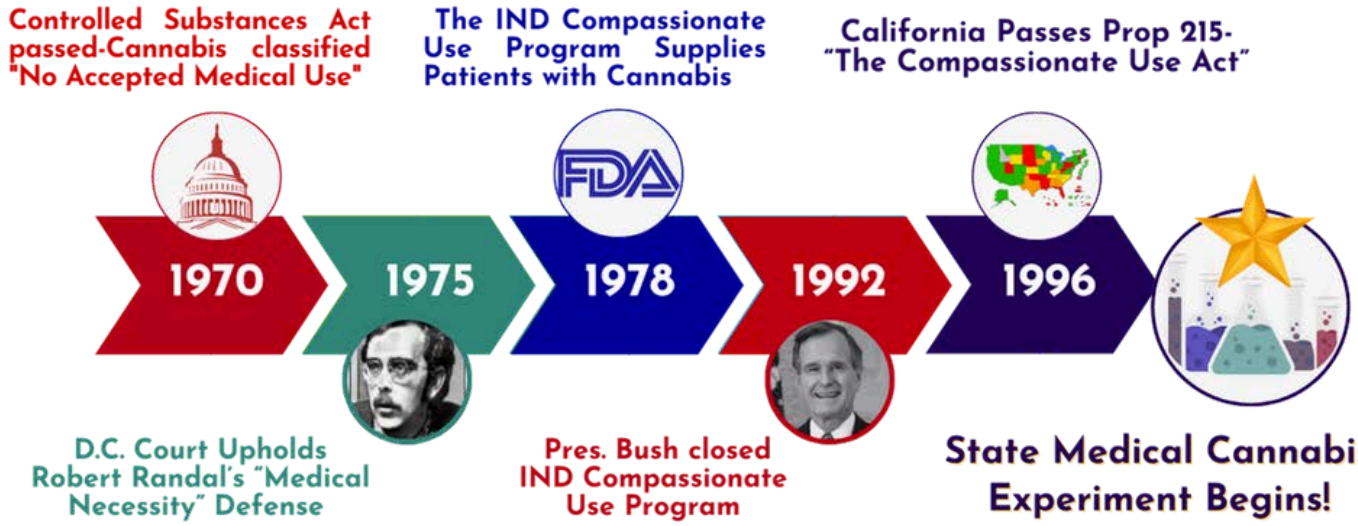
Congress has set the date: November 11, 2026. States can either manage the transition or manage the fallout.

See page 70 for Draft Legislation and Talking Points

See page 79 for Draft Emergency Executive Action and Talking Points

FROM STATE EXPERIMENT TO NATIONAL FRAMEWORK

The modern medical cannabis movement was born the moment Congress closed the door on federal medical access. When cannabis was classified as a Schedule I substance under the Controlled Substances Act of 1970—defined as having "no currently accepted medical use"—patients were left without legal pathways for care. The first crack in that wall came in 1978, when **a federal court recognized medical necessity in the case of patient Bob Randall, leading to the creation of the federal Compassionate Investigational New Drug (IND) program.** For a brief moment, cannabis entered U.S. healthcare under FDA supervision, offering proof that regulated medical use was possible.



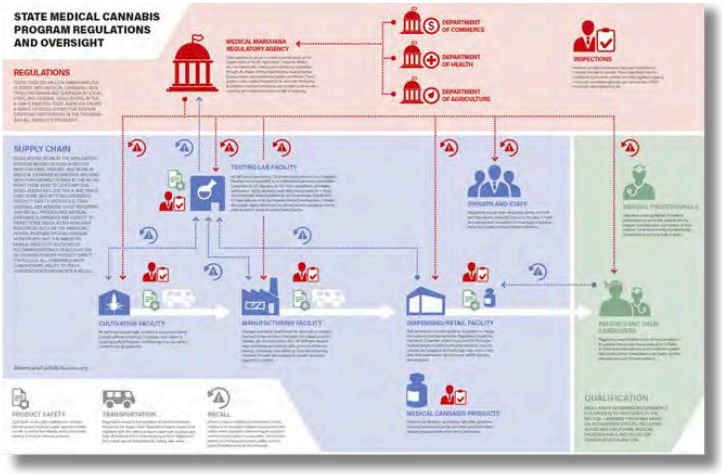
Unfortunately, in 1992, the federal government terminated the IND program under pressure from Drug War advocates, abandoning patients once again and signaling that federal leadership on medical cannabis was not forthcoming. Faced with that vacuum, patients and advocates turned to the states—not out of preference, but necessity. Early state efforts focused on compassionate use protections and legal defenses, with California's Compassionate Use Act of 1996 marking the first durable state response to federal inaction.

When Americans for Safe Access (ASA) was founded in 2002, only eight states had medical cannabis laws, all were limited to narrow criminal exemptions that offered little more than a courtroom defense. Patient collectives emerged to meet urgent needs, often operating underground and under constant threat of federal enforcement. Raids, arrests, and prosecutions made clear that state action was operating in the shadow of prohibition.

ASA was formed with a clear understanding of this reality: state programs were never the goal. They were triage—an emergency response to protect patients while advocates worked to dismantle the federal barriers that made those stopgaps necessary in the first place. Through local access laws, regulatory standards, research advocacy, and sustained pressure on federal institutions, states—guided by patient advocates—began building the infrastructure that federal policy refused to provide.

States did not choose to become the primary architects of medical cannabis policy; they were forced into that role when patients were left without protection or care. What followed was one of the most consequential public policy experiments of the modern era.

Over the next three decades, states did far more than decriminalize use; they have served as laboratories of democracy for medical cannabis policy. They created systems for product safety, testing, labeling, patient registration, provider oversight, and real-world evidence generation. They not only disproved long-standing myths embedded in federal policy, but ultimately produced the data that led HHS and the FDA to conclude in 2023 that cannabis has "currently accepted medical use." In effect, states did what the federal government would not: they proved the concept.



FROM EMERGENCY ACTION TO ENDURING REFORM

The moment we face now—managing the fallout of federal hemp restrictions, protecting patients from abrupt loss of access, and filling gaps left by incomplete federal action—is not an anomaly. It is the predictable result of a thirty-year state-led experiment born out of federal prohibition. **The recent evolution of federal hemp policy has given states a rare, unfiltered glimpse of what happens when federal laws change absent of a coherent national framework.**

Hemp reform exposed both the necessity and the difficulty of navigating fragmented authority—USDA rules layered onto state agriculture laws, FDA jurisdiction without a viable product pathway, DEA enforcement ambiguity, and states left to manage the downstream consequences for patients and consumers. **For many states, hemp was not simply an agricultural or consumer policy challenge; it became an early warning of what happens when federal law changes without a parallel, patient-centered access strategy.**

Yet unlike hemp, medical cannabis is not an unknown quantity. This is what makes the transition to a national medical cannabis program fundamentally different—and far more achievable—than the scramble now unfolding around hemp. Medical cannabis policy does not need to be invented; it needs to be aligned. The lessons are known. The data exists. The failures are documented. **What remains is to translate decades of state experience into a coherent federal framework that restores patient rights, integrates cannabis into healthcare, and replaces regulatory improvisation with durable standards. The path forward is not speculative—it has already been paved by the states.**

This is precisely what makes the transition envisioned by the Medical Cannabis and Cannabinoid Act (MCCA) both necessary and achievable. The MCCA does not require states to start over. It recognizes the investments that states have made in developing medical cannabis programs and provides the federal framework needed to align, standardize, and build on that work.

The last step in this decades-long experiment is for Congress to act, and this patchwork of state laws, born out of prohibition, will become the foundation of a national medical cannabis program built on evidence, access, and patient rights.

TRANSITIONING TO A NATIONAL PROGRAM: THE MEDICAL CANNABIS & CANNABINOID ACT

The Medical Cannabis and Cannabinoid Act (MCCA) offers a path forward for cannabis medicines that honors both the scientific understanding and the experiences of millions of Americans. Drafted by Americans for Safe Access with input from patient organizations, regulators, researchers, and medical professionals, the 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).

A NATIONAL MEDICAL CANNABIS PROGRAM

Cannabis medicines have become a lifeline for millions of Americans, offering relief when conventional treatments fail or pose risks. The absence of a national medical cannabis program hinders access for many, and unregulated markets pose potential health threats for many more. **Integrating cannabis into healthcare systems will expand the definition of medicine, improve access, and pave the way for insurance coverage for these treatments, enhancing the overall quality of healthcare in the United States.** Creating a regulatory pathway that acknowledges cannabis as a medicine will allow healthcare stakeholders to adapt to evolving scientific knowledge and offer patients comprehensive care.

The creation of a national medical cannabis program is essential for patient safety, public health, and scientific advancement. With a federal framework, the United States can ensure that all patients have access to a consistent supply of standardized cannabis-based therapies, backed by a robust system of regulation and research. Congress has the opportunity and responsibility to enact legislation that reflects the modern understanding of cannabis as a valuable medical resource, eliminating the current disparities and legal uncertainties faced by patients across the country. **A national medical cannabis program will advance the nation's approach to medical cannabis, firmly based on evidence and compassion.**

FEDERAL MEDICAL CANNABIS & CANNABINOID POLICY MUST:

EXPAND ACCESS

Create a unified national framework, ensuring that all patients, regardless of their state, have legal and safe access to medical cannabis.

MODERNIZE APPROACHES TO MEDICINE

Recognize cannabis as a complex botanical medicine and create necessary policies to integrate its use in healthcare systems.

ENSURE PRODUCT SAFETY

Create and enforce stringent safety standards for all cannabis and cannabinoid products, protecting patients from contaminated or mislabeled medicines.

END DISCRIMINATION

Eliminate the barriers for federal employees, veterans, residents in restrictive states, and those who can't afford to prioritize their health over federal protections and rights, ensuring equal access to medical cannabis for all who need it.

UNIFY CANNABIS POLICY

Harmonize state, federal, and international medical cannabis laws, creating a consistent, national policy that resolves the current legal conflicts and disparities across the country.

RESTORE PATIENTS RIGHTS

Patients currently must choose between their health and basic federal rights, restoring these rights ensures that patients can live freely and access the care they need without fear of repercussions.

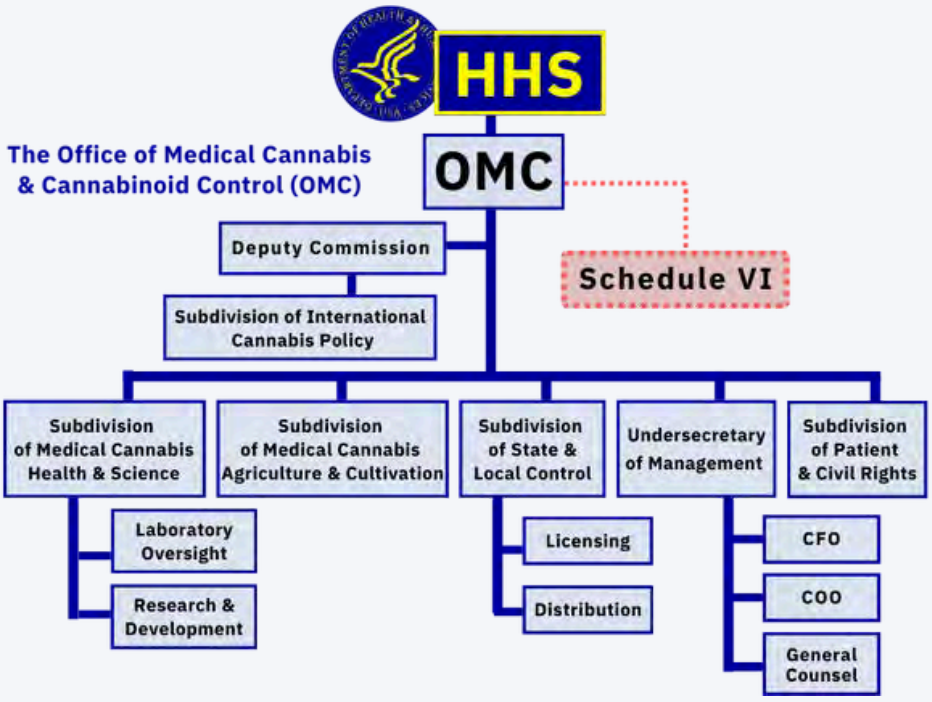
- **Ability to Travel, Relocate for work, or Pursue Higher Education in Any State.**
- **Choice of Medicine in Hospitals, Hospices, and Assisted Living Facilities.**
- **Access to Federal Services**
- **2nd Amendment Rights**
- **Protections under the Americans with Disabilities Act (ADA) or the Fair Housing Act (FHA).**

THE MEDICAL CANNABIS & CANNABINOID ACT

The Medical Cannabis and Cannabinoid Act (MCCA) offers a path forward for cannabis medicines that honors both the scientific understanding and the experiences of millions of Americans. Drafted by Americans for Safe Access with input from patient organizations, regulators, researchers, and medical professionals, the 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).**

THE OFFICE OF MEDICAL CANNABIS & CANNABINOID CONTROL (OMC)

The establishment of the Office of Medical Cannabis and Cannabinoid Control is a crucial step towards integrating cannabis into the national healthcare system. By centralizing oversight, the OMC will provide the necessary framework to support the evolving landscape of medical cannabis, ensuring that all Americans have access to its therapeutic benefits while maintaining high safety standards. The OMC's comprehensive approach will also facilitate the ongoing evaluation of cannabis' medical applications, driving further advancements in treatments and product development.

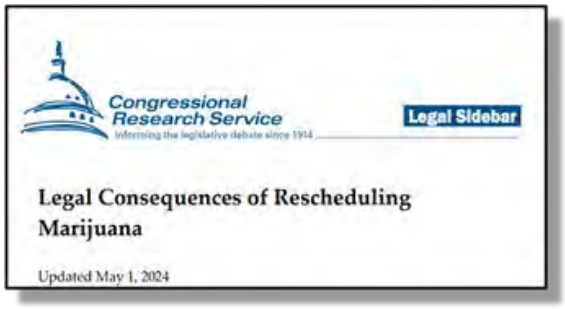


Housed in HHS

Brings US in compliance with UN Drug Treaties

Coordinates cannabis matters across federal agencies & with state regulators

Funded by agency reorganization, licensing & permitting fees, & public-private partnerships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Legal Sidebar

Legal Consequences of Rescheduling Marijuana

Updated May 1, 2024

"FDA regulates certain cannabis products under the Federal Food, Drug, and Cosmetic Act, Congress might also consider whether to alter that regulatory regime or create some alternative regulatory framework."

"LEGAL CONSEQUENCES OF RESCHEDULING MARIJUANA".

CRS Report: January 16th, 2024 (updated May 1, 2024)

WHY CREATE A NEW AGENCY?

Medical cannabis is a new product category (not a dietary supplement, foodstuff, or FDA-approved drug) with a supply chain that spans multiple agencies; effectively enforcing regulations would require an agency with oversight authority. Regulating cannabis medicines will entail more than simply enforcing regulations; it will also require oversight of research to improve product development and inform standards of care. Embracing medical cannabis as part of a national healthcare strategy will demand innovation to forge a new path in American medicine. Botanical medicines are used worldwide but represent a significant departure from allopathic medicine and pharmaceutical protocols.

THE WORLDWIDE TREND OF USING BOTANICAL DRUGS & STRATEGIES FOR DEVELOPING GLOBAL DRUGS

"Botanical drugs are, by nature, plant-derivative materials and their complexes. This makes them unfit for conventional "single-target/single-drug" development processes and thus have been largely disregarded in the field of medicine. However, it is widely understood in synthetic medicine that the single-drug "magic bullet" strategy is not adequate for treating chronic illnesses (e.g. cancers, immune disorders, mental illnesses, cardiovascular diseases, lifestyle diseases) due to their complex pathogenetic mechanisms and that a "multi-target/multi-component" approach involving control over a number of target sites is more effective."

Ahn K. The worldwide trend of using botanical drugs and strategies for developing global drugs. BMB Rep. 2017 Mar;50(3):111-116. doi: 10.5483/bmbrep.2017.50.3.221. PMID: 27998396; PMCID: PMC5422022.

TREATY OBLIGATIONS

According to the International Narcotics Control Board (INCB), signatories to 1961 International Drug treaties should have a designated agency to oversee medical cannabis programs.

The INCB Report 2022 stated:

"The Convention requires that States license and control cannabis production for medical use, establish a national cannabis agency, provide estimates of the national requirements for cannabis for medical purposes, and ensure that medicinal cannabinoids are used in accordance with evidence on their safety and effectiveness and under medical supervision. As far as the specific control measures for cannabis are observed, these medical cannabis programmes are in compliance with the conventions."

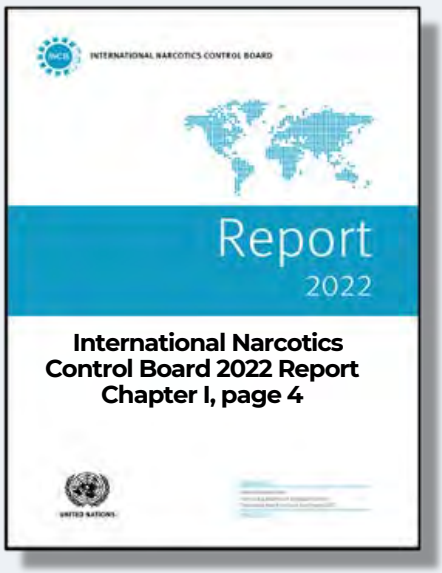
WHY NOT PUT OVERSIGHT IN THE FDA?

Today, "FDA-approved" has become synonymous with "medicine" in the U.S. healthcare lexicon. **However, at its core, the Food and Drug Administration (FDA) is a consumer protection agency.** It was initially established in 1906 by the Pure Food and Drug Act to ensure that food and drug labels sold across state lines were accurate and free of harmful adulterants. In 1962, Congress expanded its authority to evaluate health claims through the Kefauver-Harris Drug Amendment for new drugs, ultimately shaping the modern FDA drug approval pathway.

The Act also instructed the FDA to conduct a retrospective review for drugs already on the market. At the time, approximately 19 percent of the U.S. Pharmacopeia's medicinal preparations were plant-based. The majority were synthetic drugs whose efficacy was based on the "single-target/single-drug" or "magic bullet" approach to commercial drug development. **The Kefauver-Harris Drug Amendment did not give the FDA the mandate to determine which medicines work best, but rather to assess whether a company's claims about a drug are accurate, leaving only commercially backed products with sufficient capital to pursue "FDA approval."**

In turn, the FDA drug approval was developed to accommodate synthetic "single-target/single-drugs." approaches. 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.

In recent years the the FDA has pointed to it's Botanical Drug Development Guidance for Industry as a pathway for cannabis medicines. However, this would not be a viable option, as the document concedes that it is often "not feasible" to determine each component's contribution to efficacy in complex botanicals. This is why, in the twenty years since that guidance was issued, only a handful of botanical products—such as Veregen (green tea extract) and Fulyzaq (crofelemer)—have achieved drug approval, all as single-compound therapeutics rather than full-spectrum medicines.



MCCA ADHERES TO U.S. OBLIGATIONS UNDER INTERNATIONAL DRUG TREATIES

"The 1961 Convention (in its article 28) allows States parties to cultivate and use cannabis for medical purposes under certain conditions. The Convention requires that States license and control cannabis production for medical use, establish a national cannabis agency, provide estimates of the national requirements for cannabis for medical purposes and ensure that medicinal cannabinoids are used in accordance with evidence on their safety and effectiveness and under medical supervision. As far as the specific control measures for cannabis are observed, these medical cannabis programmes are in compliance with the conventions. "

"However, in some States "medical cannabis programmes" are operated without the necessary control required by the conventions or by the standards recommended by WHO in relation to good manufacturing and good prescribing guidelines."

MCCA ALIGNS U.S. CANNABIS POLICIES WITH INTERNATIONAL STANDARDS

RESPONSIBILITIES OF THE OFFICE OF MEDICAL CANNABIS & CANNABINOID CONTROL

The Office of Medical Cannabis and Cannabinoid Control (OMC) will facilitate the integration of cannabis medicines into the national healthcare infrastructure, as the federal authority responsible for the governance of all medical cannabis and cannabinoid-based therapeutics. The OMC would be positioned to coordinate between federal and state agencies, harmonize product safety requirements, and provide a centralized licensing and registration system for the entire cannabis supply chain — including hemp-derived and synthesized cannabinoids.

The OMC would establish national classification guidelines distinguishing controlled-access therapeutic cannabis products from those appropriate for over-the-counter availability. It would also create a standardized frameworks for clinical prescribing, compassionate-use pathways, and evidence-based health claims for botanical cannabis medicines.

The FDA would retain its essential functions in labeling oversight and post-market safety monitoring and would continue to evaluate cannabinoid-based products seeking approval through traditional drug pathways. OMC and FDA will collaborate to create new federal pathways that appropriately reflect the nature of botanical therapeutics.

REGULATORY COORDINATION

The OMC will coordinate with other federal agencies, including the FDA, DEA, and USDA, to align regulations and policies across the government, ensuring consistent enforcement and clear guidance.

RESEARCH & DEVELOPMENT

One of the primary roles of the OMC will be to promote and fund research on the medical uses of cannabis. This will include clinical trials to better understand its efficacy and potential side effects and studies to explore new medical applications of cannabis.

PRODUCT SAFETY PROTOCOLS & STANDARDS

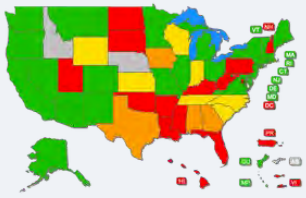
The OMC will adopt comprehensive safety protocols for cannabis cultivation, production, and distribution, including limits on contaminants, labeling requirements, and testing standards for all cannabis products.

REGULATORY COMPLIANCE

Overseeing the entire cannabis supply chain, from cultivation to distribution, including issuing licenses, monitoring compliance, and enforcing standards to prevent misuse and ensure patient safety.

CENTRALIZED LICENSING SYSTEM

A centralized licensing system will standardize the requirements for cannabis producers and processors. This system will facilitate compliance with national standards, simplify the regulatory burden on businesses, and enhance monitoring to ensure that products reaching consumers are safe and high-quality.



MCCA WILL HARMONIZE EXISTING LICENSES & PERMIT PROGRAMS

MEDICAL & PATIENT EDUCATION

The OMC will also be responsible for educating healthcare providers and patients about the benefits and risks of cannabis based on the latest scientific research.

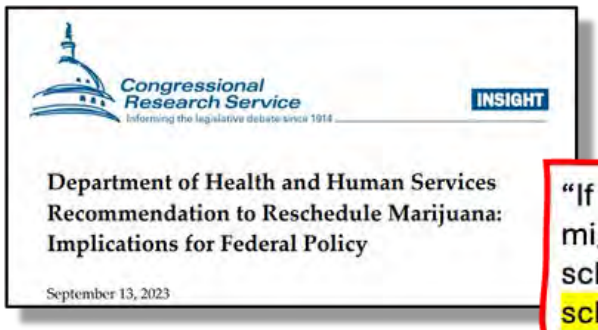
SCHEDULE VI: A NEW SCHEDULE FOR CANNABIS & CANNABINOIDS

MCCA creates a new schedule, a Schedule VI for cannabis and cannabinoids. This not just a legal formality—it's a critical development that acknowledges that cannabis is not just another drug—it's a botanical medicine with a unique profile. Placing cannabis in its own category would allow for regulations to be tailored to its specific properties and uses. Under Schedule VI, the OMC would oversee these regulations, providing a centralized authority dedicated to cannabis.

SCHEDULE VI-

- Regulated by the Office of Medical Cannabis and Cannabinoid Control (OMC).
- Covers ALL cannabinoid products intended for human and animal consumption.
- Includes oversight for non-intoxicating cannabinoid products (Schedule VI-A).
- Schedule VI permits: laboratory, pharmacy, research, and transportation.
- Schedule VI licenses: cultivation, manufacturing, and distribution (Phase II).
- No restrictions for prior drug convictions for permits or licenses.
- Schedule VI specialty pharmacy licenses for access points/dispensaries in Phase II.
- Interstate commerce allowed between Schedule VI permits/licenses.
- No criminal penalties associated with Schedule VI.
- Patients would have all protections granted to any other prescription recipient.
- State-based "physician recommendations" to become specialized prescriptions.
- Schedule VI "provisional permits" granted to state-licensed medical cultivators, manufacturers, and dispensaries, and USDA hemp production licenses in Phase 1 for continuity of access.

"HHS RECOMMENDATION TO RESCHEDULE MARIJUANA: IMPLICATIONS FOR FEDERAL POLICY"
September 13, 2023, CRS Report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INSIGHT
Department of Health and Human Services Recommendation to Reschedule Marijuana: Implications for Federal Policy
September 13, 2023

"If Congress removed marijuana from Schedule I, it might (1) place marijuana on one of the other schedules of controlled substances, (2) create another schedule or separate classification for marijuana under the CSA, or (3) remove marijuana as a controlled substance altogether."

WHY SCHEDULE VI?

Cannabis was placed in Schedule I as a political decision in 1970, not based on scientific evidence. Creating Schedule VI will correct this historical wrong, allowing cannabis to be classified based on its actual medicinal value and safety profile.

Creating Schedule VI acknowledges that cannabis is not just another drug—it's a botanical medicine with a unique profile. Placing cannabis in its own category, Schedule VI, would allow for regulations tailored to its specific properties and uses and would expedite research.

Cannabis is a complex botanical medicine with multiple active compounds that interact with the body in unique ways. A new Schedule VI will recognize its distinct nature, allowing for appropriate regulation that doesn't force it into an ill-fitting category designed for synthetic and single-compound drugs.

A Schedule VI classification would resolve the issues of regulating "hemp-derived" cannabinoid products by formally codifying cannabis as medicine and extending protections for patients under the Americans with Disabilities Act. **This approach would prioritize patient rights alongside business interests, creating a framework that balances commercialization with the essential protections that patients deserve.**

SCHEDULE VI & OTHER SCHEDULES

CANNABIS FEDERAL CLASSIFICATION	DE-	SCHEDULES I	III	VI
Recognizes Medical Use of Cannabis			✓	✓
Regulation & Access for Hemp-Derived Cannabinoid Products				✓
Increases & Improves Patient Access				✓
Expands U.S. Definition of Medicine				✓
Removes Federal Criminal Penalties for Possession	✓			✓
Removes Federal Criminal Penalties for Cultivation & Distribution	✓			✓
Ensures Product Safety Across the Supply Chain				✓
Ensures Employment Protections				✓
Ensures Healthcare Rights				✓
Ensures Housing Protections				✓
Harmonizes State & Federal Medical Cannabis Laws				✓
Levels the Playing field for Research, Development,& Innovation				✓
Improves Access to Cannabis for Research	✓		✓	✓
Improves Quality of Cannabis Research				✓

If marijuana is transferred into schedule III, the manufacture, distribution, dispensing, and possession of marijuana would remain subject to the applicable criminal prohibitions of the CSA.

DEA, DOJ: Notice of proposed rulemaking: Schedules of Controlled Substances: Rescheduling of Marijuana May 21, 2024

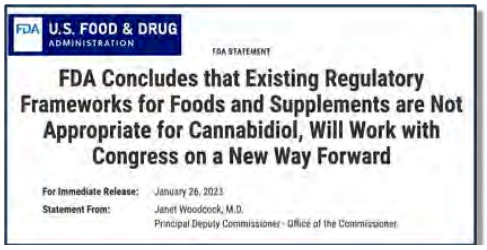
RESCHEDULING ALONE WON'T HELP PATIENTS

Rescheduling cannabis has the potential to positively shift social attitudes, reduce stigma, and foster greater acceptance among medical professionals, employers, and policymakers. These changes could help normalize medical cannabis use and create a more supportive environment for patients.

Rescheduling would undeniably be a victory for medical cannabis patients and advocates. By recognizing cannabis' "currently accepted medical use in treatment in the United States," the federal government has validated decades of patient-led advocacy and the role of state programs as "laboratories of democracy." These programs, built with compassionate use in mind, were essential in overcoming barriers raised by HHS, DEA, and DOJ denials of rescheduling petitions over the past 50 years.

Patient advocates have worked tirelessly to establish product safety standards, collaborate with regulators on labeling requirements, and partner with medical professionals to create continuing education and dosage guidelines. Their efforts even contributed to international drug treaty reforms that acknowledged cannabis' medical value. This advocacy paved the way for the recent HHS recommendation to reschedule cannabis, representing a significant milestone for patient rights.

However, while rescheduling marks progress, rescheduling alone will not address the systemic challenges faced by patients or businesses in the current state medical cannabis programs. Schedule III does not legalize medical cannabis, improve state medical cannabis programs, or restore federal rights for patients. Instead, it shifts the conversation from debating cannabis' medical value to exploring how patients can safely access it. But this shift does little to address the structural barriers limiting patient access today.



MCCA ADDRESSES HEMP-DERIVED CANNABINOID PRODUCT REGULATIONS

Short-term: MCCA requires the FDA to issue labelling requirements for products containing cannabinoids to include: 1) The source of the cannabinoids, 2) "The safety of this product has not been evaluated by the FDA," 3) "This product has not been tested for contaminants," or a QR code to Certificate of Analysis, and 4) Batch number on labels.

Long-term: Through oversight over the new schedule, Schedule VI, the OMC will issue classification guidelines for over-the-counter as well as controlled access products (Schedule VI (A) vs Schedule VI). **Additionally, the OMC would issue product and system guidelines for compassionate use prescriptions and the framework for full-spectrum cannabis-based products to achieve evidence-based health claims.**

NATIONAL MEDICAL CANNABIS PROGRAM ROLE OUT-PHASE I

Title I- Office of Medical Cannabis & Cannabinoid Control

Sec. 801- Amend Controlled Substance Act

Sec. 802- Amend Hemp Authorization Act.

FIRST 60 DAYS

Sec. 602- Notification to Agencies
Title VII- Implementation
Sec. 604- Continuity of care
Sec. 603- Reorganization Plan
Sec. 705– Advisory Committee

- New Schedule Created: Schedule VI
- Office of Cannabis & Cannabinoid Control (OMC) established
- Commissioner & Under Secretary of OMC Appointed
- Direct agencies to update cannabis policies
- Provisional Schedule VI permits & specialty pharmacy permits, issued with protocols for interstate distribution

= FINISHED PRODUCTS

= RAW INGREDIENTS

= PERMITTED BY STATE

= SCHEDULE VI PROVISIONAL PERMIT

= STATE/TRIBAL LICENSE

REQUIRE (except B2B Transport)

Schedule VI products with permits can move across US between permitted businesses

MCCA WILL HARMONIZE EXISTING LICENSING & PERMIT PROGRAMS

USDA

STATE-ID CARDS REMAIN VALID

HOME CULTIVATION

CULTIVATION

PROCESSORS

MANUFACTURERS

TESTING LABS

B2B TRANSPORT

RESEARCHERS

DISPENSARY

HOSPITAL/HOSPICE ASSISTED LIVING

CBD

CBD & Hemp-derived products will remain available in retail markets as they transition into a regulated market, but will be subject to FDA labeling requirements and any state regulations.

ALL FEDERAL AGENCIES- Current or past cannabis use shall not be a factor in hiring, continuity of employment, or promotions, or determining the security clearance eligibility or any suitability determination under part 731 of Title 5, Code of Federal Regulations for an officer or employee of a Federal agency, a member of the Army, Navy, Air Force, or Marine Corps who is on active duty or is in active status; or an officer or employee of a contractor of a Federal agency as described in section 3002 of the Intelligence Reform and Terrorism Prevention Act of 2004 50 U.S.C. 3343 and Drug-free Federal Workplace-51 FR 32889, 3 CFR, 1986.

OFFICE OF PERSONNEL MANAGEMENT- Update hiring and employment policies concerning past or current cannabis use and create a process for agencies to reinstate or appeal past actions.

HOUSING & URBAN DEVELOPMENT- Exempt cannabis from drug-free housing policies and tax credits, and issue a non-discrimination policy for patients.

VETERAN AFFAIRS- Update policies to allow agency physicians to recommend medical cannabis, amend policies that impact VA benefits, and add cannabis therapeutics to intake forms. Provide the OMC with protocols needed for VHA to administer, dispense, and cover the cost of medical cannabis for patients under their care.

HEALTH & HUMAN SERVICES- Inform hospitals, health clinics, rehabilitation centers, hospice services providers, their medical professionals, or any other patient service provider that is participating in medical cannabis programs or allowing clients/patients in their care to lawfully possess and/or consume cannabis products in their care will not jeopardize HHS funding or any accreditations.

DEPARTMENT OF JUSTICE- Review and formalize guidelines in the 2013 DOJ Cole Memo and expunge all non-violent federal cannabis convictions and adjudications for and any arrests associated with each.

DEPARTMENT OF AGRICULTURE- Agriculture Marketing Services of the Department of Agriculture will instruct USDA-licensed hemp producers and state partners that they will be required to notify the department within 60 days if their crops are intended to produce cannabinoid-containing products for human or animal consumption.

SEC. 601 NOTIFICATIONS TO AGENCIES

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)- Provide the OMC with protocols needed to cover the cost of medical cannabis, like any other prescription medication.

INDIAN HEALTH SERVICES- Update all applicable regulations, guidance, memoranda, and policies of the Indian Health Service to authorize healthcare providers to provide recommendations and opinions to patients relating to the participation of those patients in State or Tribal cannabis programs authorized under Federal or State law and to complete forms reflecting those recommendations and opinions.

STATE DEPARTMENT- Work visa eligibility includes employment with any businesses with a Schedule VI permit/license.

BUREAU OF ALCOHOL, TOBACCO, FIREARMS & EXPLOSIVES- Remove cannabis warning from Form 4473.

SMALL BUSINESS ADMINISTRATION- Notify all development centers and program administrators that all services and support granted under the Small Business Act apply to qualifying businesses with Schedule VI or Schedule VI (A) permits or licenses.

FOOD & DRUG ADMINISTRATION- Issue requirements for products containing cannabinoids to include 1) source of the cannabinoid, 2) "The safety of this product has not been evaluated by the FDA," 3) "This product has not been tested for contaminants," or a QR code to Certificate of Analysis, and 4) Batch number on labels.

TRANSPORTATION SECURITY ADMINISTRATION- Cannabis does not need to be confiscated.

DEPARTMENT OF THE TREASURY- Provide guidance for financial institutions on providing banking services, loans, and any other financial services to Schedule VI licensed businesses.

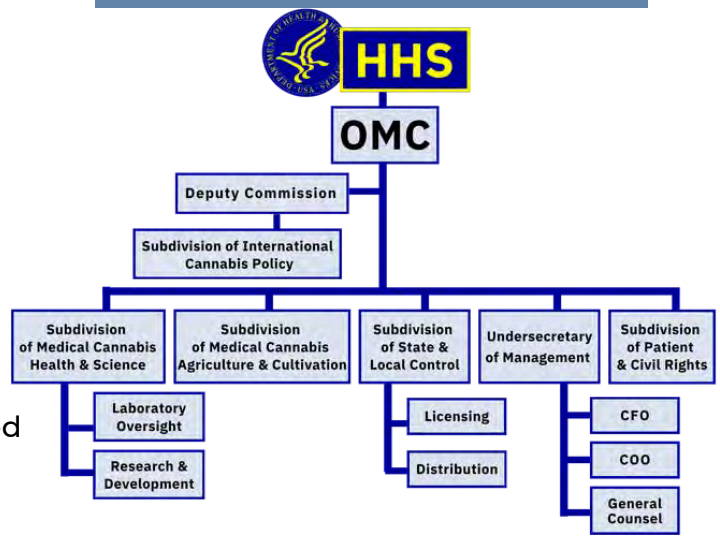
INTERNAL REVENUE SERVICE- Permit medical cannabis businesses with Schedule VI permits/licenses to file as legal businesses and create a process for these businesses to refile tax returns with deductions to lower or eliminate tax debt.

NATIONAL MEDICAL CANNABIS PROGRAM ROLE OUT-PHASE II

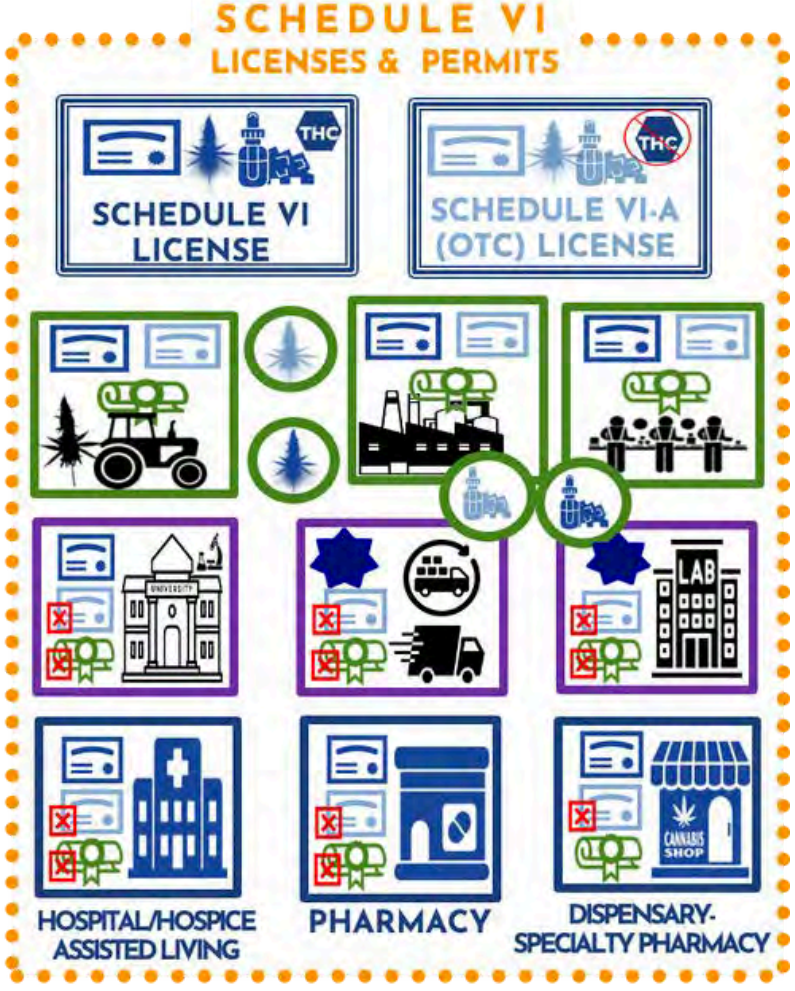
Title I, Title II, Title III, Title IV, Sec. 404, Sec. 501
Sec. 504- Staffing Subdivisions

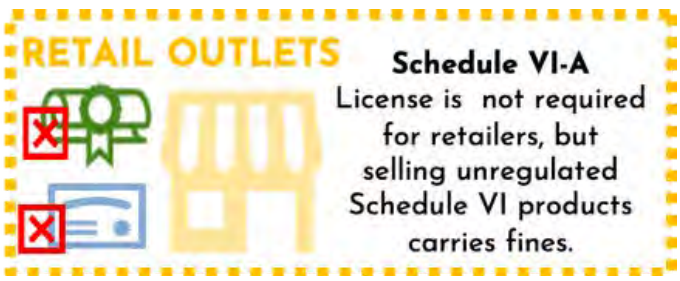
Sec. 303- Transfer of Functions
Sec. 701- Licensing & Permits; General Provisions
Sec. 305- Cannabis Production; State & Tribal Plans
Sec. 306- Effect on Industrial Hemp
Sec. 701- Licensing & Permits; General Provisions
Sec. 702- Specialty Licensing

FIRST 12 MONTHS



- Agency Staffed Schedule VI licensing program launched
- Advisory groups seated
- Initiate research priority map with NIH
- OTC guidelines for cannabinoid products
- Determination of NDA requirements for synthetic cannabinoid and terpene products
- Establish safe additive list for Schedule VI products
- Labeling, research, and testing requirements for Schedule VI products established
- Determine if additional permits/licenses needed





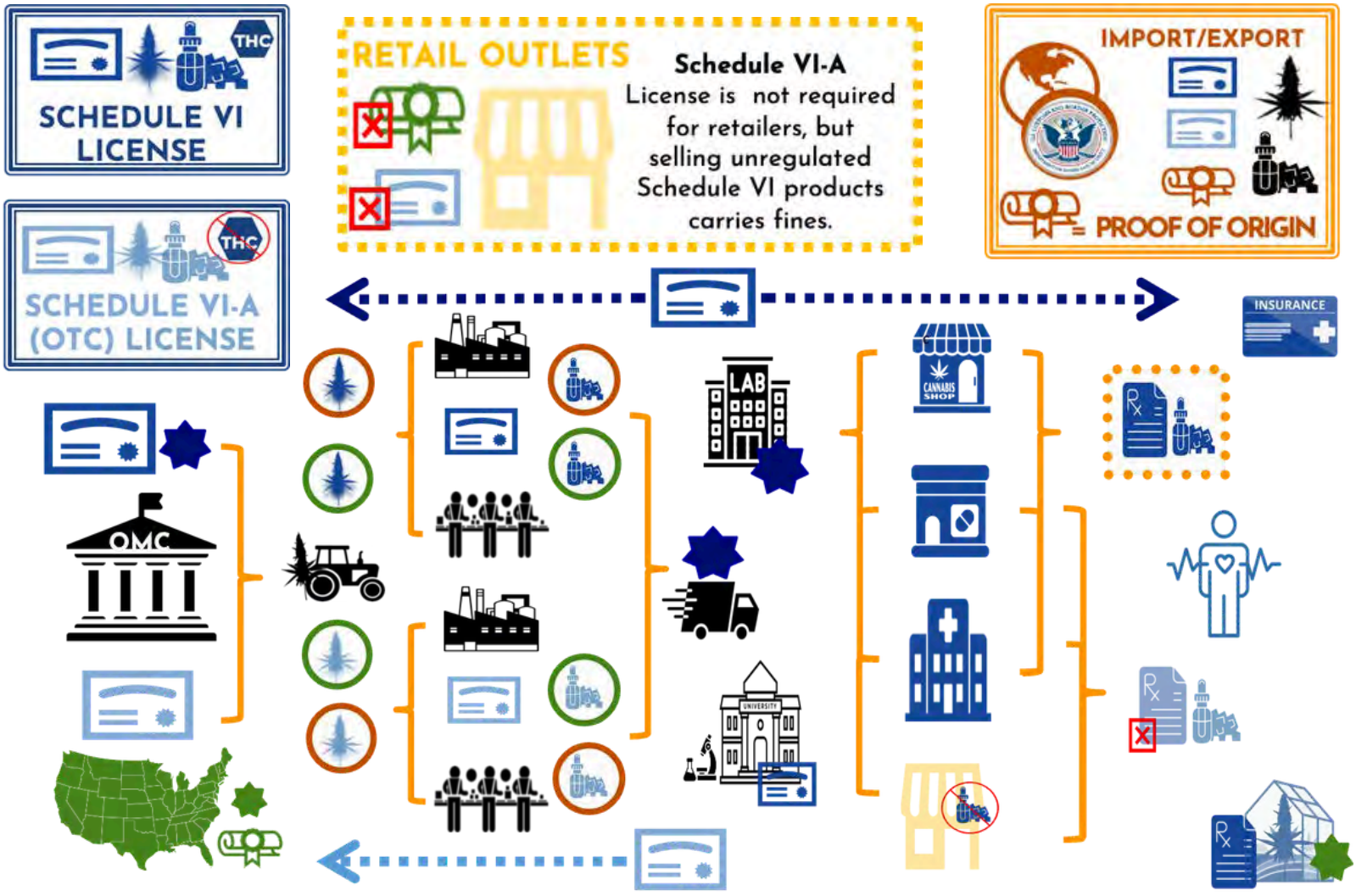
NATIONAL MEDICAL CANNABIS PROGRAM ROLE OUT-PHASE III

Sec. 701- Licensing & Permits
Title VI-Transition
Subtitle A- Coordination with Agencies

Sec. 306- Effect on Industrial Hemp
Sec. 701(d)- Imports, Exports
Sec. 204- Research & Development Center
Sec. 704– Prescription Protocols

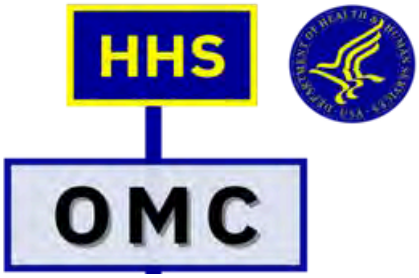
FIRST 24 MONTHS

USDA · DEPARTMENT OF JUSTICE · NIH · SBA · DEPARTMENT OF VETERANS AFFAIRS · CMS CENTERS FOR MEDICARE & MEDICAID SERVICES



- Guidance for "prescription system"
- Guidance for importation/exportation of Schedule VI ingredients and products
- Guidance from the Centers for Medicare and Medicaid Services for Schedule VI product coverage
- OMC establishes private-public partnerships for research with NIH
- Each federal district completes a comprehensive review and expungement of all adjudicated and non-adjudicated cannabis cases
- Initiate process for producing guidance document for health claims for Schedule VI products
- Guidance for environmental impact and sustainable agricultural practices
- VHA Medical Cannabis Program Role Out

TITLE I- OFFICE OF MEDICAL CANNABIS & CANNABINOID CONTROL



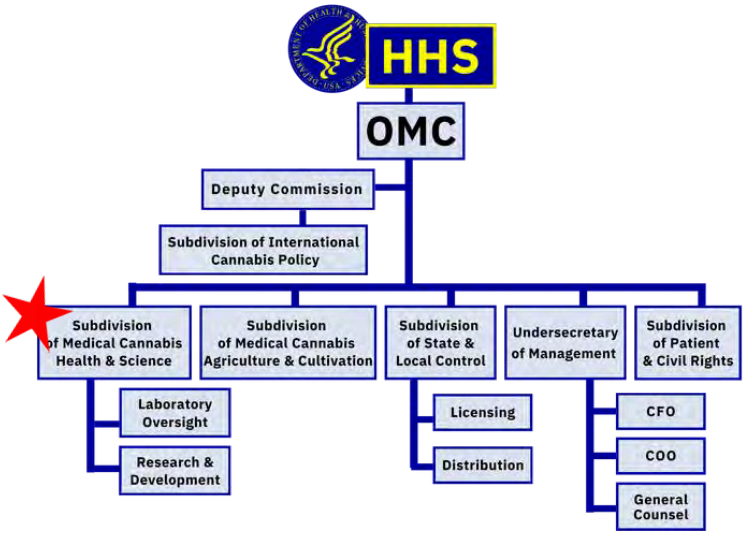
Establishes the **Office of Medical Cannabis and Cannabinoid Control (OMC)** as a central agency under the Department of Health and Human Services. Defines the OMC's legislative mission to regulate and oversee the medical cannabis supply chain, outlines the roles and duties of the Commissioner and other officers, and sets forth responsibilities, including regulatory oversight, public health protection, and enforcement of standards. This structure ensures that all aspects of medical cannabis are centrally managed and consistently regulated across the nation.

TITLE II- SUBDIVISION OF MEDICAL CANNABIS HEALTH & SCIENCE

Creates a subdivision dedicated to the scientific research and health implications of medical cannabis, led by an Under Secretary. This subdivision oversees federally funded research and development centers, conducting comprehensive research, development, testing, and evaluation of medical cannabis. Its mission is to advance the understanding of cannabis' medical benefits and its integration into healthcare practices, ensuring that policy development is informed by rigorous scientific evidence.

OMC STRUCTURE & AGENCY TRANSITION

Sec. 201-206
Sec. 603- Reorganization Plan
Title VII- Implementation
Sec. 704– Prescription Protocols
Sec. 205- Research, Testing, & Evaluation
Sec. 705- Advisory Committee



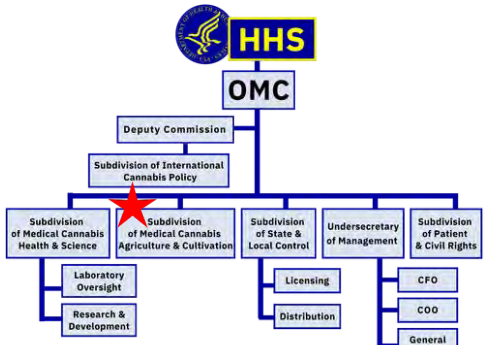
- Work across agencies to create and fund a research priority map
- Spearhead guidelines for standardization of testing and labeling
- Issue permits to laboratories for cannabis (Schedule VI)
- Create prescription protocols and educate physicians

TITLE III- SUBDIVISION OF CANNABIS AGRICULTURE & CULTIVATION

Defines a subdivision focusing on the agriculture and cultivation aspects of cannabis, headed by an Under Secretary. It details responsibilities such as developing sustainable cultivation practices, overseeing federally funded subsidies and crop insurance programs, and ensuring that state and tribal cannabis production plans align with federal standards. This subdivision is essential for managing the agricultural lifecycle of cannabis and supporting farmers through regulatory guidance and financial aid.

OMC STRUCTURE & AGENCY TRANSITION

Sec. 301-306
Sec. 603- Reorganization Plan
Title VII- Implementation
Sec. 305- Cannabis Production; State & Tribal Plans



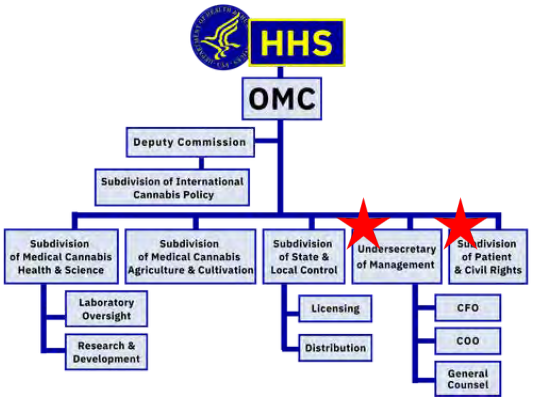
- Pesticides guidance for cannabis for human consumption
- Train inspectors
- Create research and marketing orders
- Work across agencies to create seed registry

TITLE IV - MANAGEMENT

Outlines the infrastructure of the Office of Medical Cannabis and Cannabinoid Control, detailing the roles of key managerial positions, including the Under Secretary for Management, Chief Financial Officer, Chief Information Officer, and an Officer for Patient and Civil Rights. These roles are critical for the efficient administration of the OMC, ensuring effective financial management, information security, and the protection of patient and civil rights within the medical cannabis framework.

OMC STRUCTURE & AGENCY TRANSITION

Sec. 401- Under Secretary for Management
Sec. 402- Chief Financial Officer
Sec. 403- Chief Information Officer
Sec. 404- Establishment of Officer for Patient and Civil Rights



SEC. 404- SUBDIVISION OF PATIENT & CIVIL RIGHTS

- Review and monitor the implementation to ensure patient rights are protected
- Work across agencies to ensure that patient rights are included in their policies
- Work with CMS to ensure cannabis medications are covered

TITLE V- COORDINATION WITH NON-FEDERAL ENTITIES

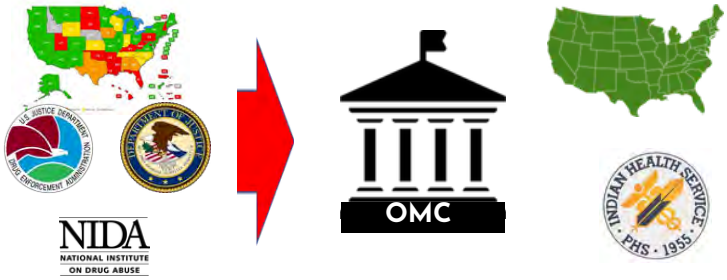
Emphasizes the importance of coordination between the OMC and state, local, and international bodies. It sets up a subdivision for state and local government coordination, addresses the role of advisory committees, and delineates the office's involvement in military and international cannabis policies. This title ensures that federal cannabis policies are harmonized with non-federal entities, facilitating a cohesive approach to cannabis regulation and policy across different levels of government and international borders.

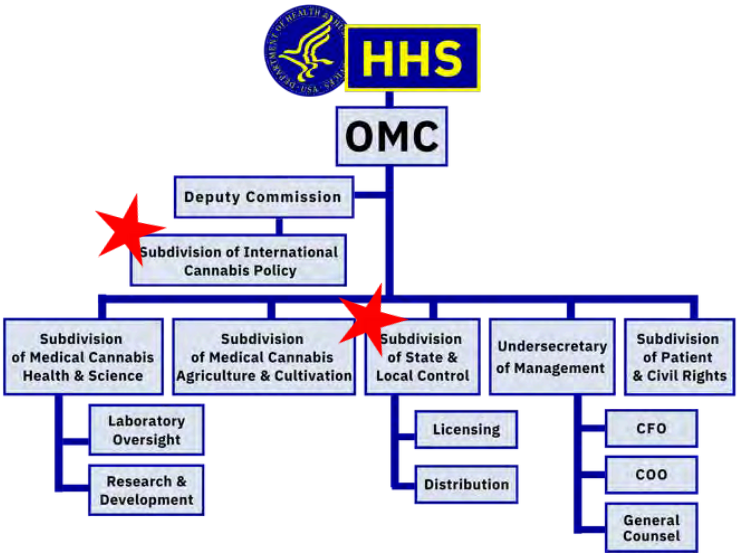
SEC. 501-SUBDIVISION OF TRIBAL, STATE, & LOCAL CONTROL

OMC STRUCTURE & AGENCY TRANSITION

Sec. 603- Reorganization Plan
Title VII- Implementation
Sec. 305- Cannabis Production; State & Tribal Plans
Sec. 705– Advisory Committee

- Work with state regulators on Schedule VI Permits for state-licensed medical cannabis businesses
- Create protocols for interstate sales and transportation
- Create vendor/licensee database





SEC. 504-OFFICE OF INTERNATIONAL POLICY

OMC STRUCTURE & AGENCY TRANSITION

Sec. 603- Reorganization Plan
Title VII- Implementation
Sec. 701(d)- Imports, Exports

- OMC designated agency for Cannabis under UN single treaty
- Report to INCB on cannabis
- Establish and oversee cannabis/cannabinoid import/export procedures

TITLE VI– TRANSITION

Specifies the practical steps for implementing the Act, including the issuance of general and specialty licenses, guidelines for distribution, prescription protocols, and forming advisory committees.

TITLE VII - IMPLEMENTATION

Provisions necessary for implementing the Act. It defines key terms, outlines the notification process for affected agencies, describes the reorganization plan, and ensures the continuity of care during the transition period. This title is crucial for the smooth transition of functions and responsibilities to the new regulatory framework established by the Act.

TITLE VIII- ESTABLISH SCHEDULE VI UNDER THE CONTROLLED SUBSTANCE ACT

Amends the Controlled Substances Act to establish Schedule VI and Schedule VI (A), creating a new classification for cannabis and cannabinoid products that acknowledges their medicinal use and regulates them under a framework designed for their unique properties. This section amends the Hemp Authorization Act and transfers functions to align with the new regulations, ensuring a comprehensive approach to the nationwide management and oversight of medical cannabis and cannabinoid products. It also amends the Criminal Code and Sentencing Guidelines to align with these changes, ensuring that the legal framework reflects the updated understanding of cannabis' role in medical treatment.

MEDICAL CANNABIS POLICY TALKING POINTS

NEED FOR LEADERSHIP

The recent recognition of cannabis' medical value by federal health agencies underscores the critical need for Congress to update and harmonize existing laws. While the rescheduling of cannabis marks a significant advance, it does not address all the complexities of its use as a medical treatment.

States have fulfilled their role as laboratories of democracy for medical cannabis policy. It's now our responsibility as lawmakers to ensure that laws keep pace with science and public opinion and pass comprehensive medical cannabis legislation.

NEED FOR FEDERAL MEDICAL CANNABIS POLICY

By integrating medical cannabis into our national healthcare framework, we can offer patients more effective treatment options for chronic and debilitating conditions, potentially reducing reliance on more harmful medications.

Federal reform is necessary to ensure all patients, including veterans, active duty military and federal employees, can benefit from medical cannabis.

State laws are falling short, leaving many patients behind. We need comprehensive federal policies that guarantee access to affordable medical cannabis for everyone.

RESTORING PATIENT RIGHTS

Without comprehensive federal legislation on medical cannabis, millions of patients are stripped of basic rights. This forces many Americans into a difficult position: they must choose between following their healthcare provider's advice and the potentially severe consequences of losing critical federal services and rights, a decision that directly threatens their livelihood and well-being.

The absence of comprehensive medical cannabis legislation leaves millions without essential federal protections, compelling patients to make an impossible choice: their health or their basic rights. For many, prioritizing health could mean risking their housing, education, and financial stability, underlining the urgent need for federal action.

Patients should not have to choose between their rights and their health. It's time to end the federal prohibition on medical cannabis and restore patient freedoms.

MCCA & PRODUCT SAFETY

A regulated cannabis market is a safer market, ensuring that all products meet the highest standards of public health.

The current unregulated markets pose risks due to variability in product quality and safety. A federal program will ensure that all products meet rigorous health and safety standards, protecting consumers from inferior or dangerous products.

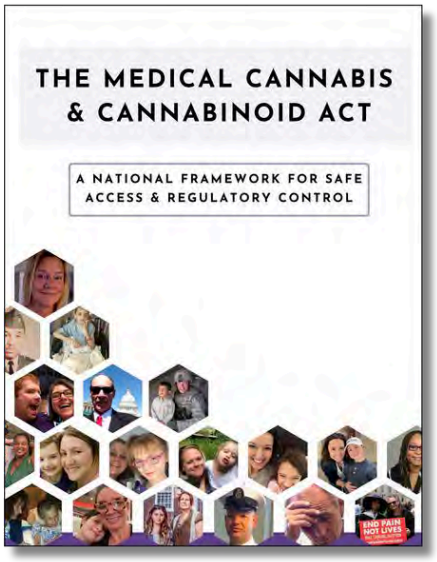
National standards are essential for ensuring patient safety and product consistency, which can actually foster consumer confidence and drive market growth. These standards would level the playing field, encouraging innovation within a safe and regulated environment. Patient health should be our top priority.

CANNABIS MEDICINES & HEALTHCARE SYSTEMS

Medical cannabis presents a cost-effective solution for managing refractory symptoms in chronic conditions, highlighting its potential to enhance patient care while reducing healthcare expenditures.

Embracing medical cannabis as part of our healthcare strategy means embracing innovation and providing hope for millions of patients.

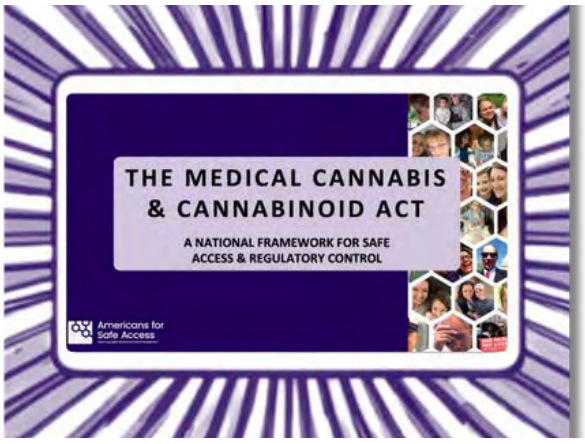
THE MEDICAL CANNABIS & CANNABINOID ACT RESOURCES



THE FULL TEXT OF THE MEDICAL CANNABIS & CANNABINOID ACT

ONE PAGERS & MCCA FACTSHEETS

MCCA FREQUENTLY ASKED QUESTIONS



MCCA PRESENTATION

SAFEACCESS4ALL.ORG

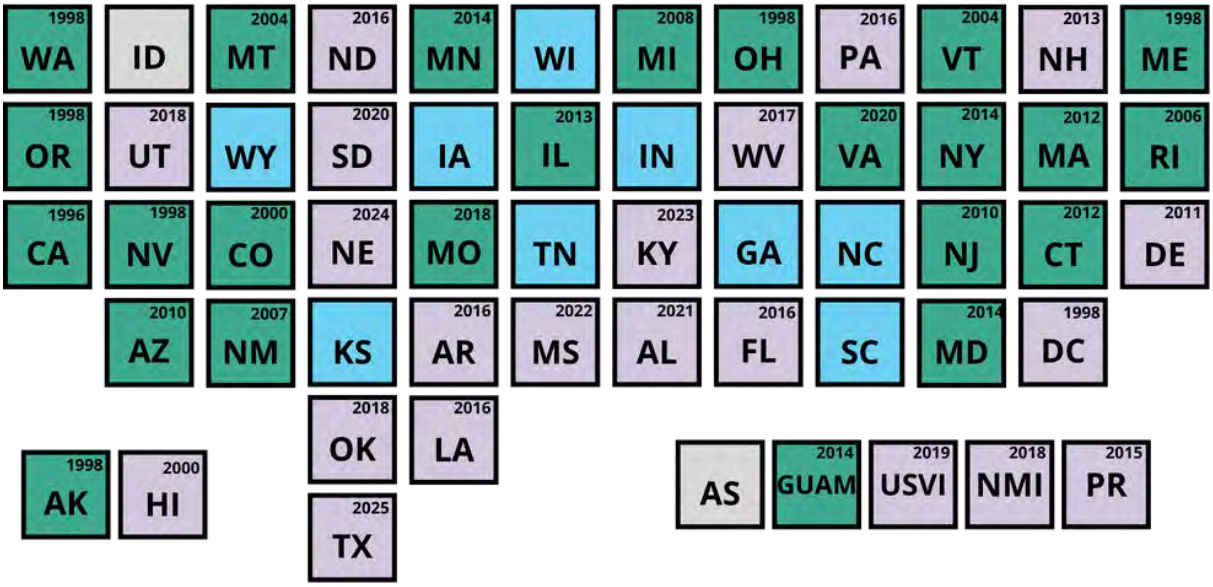
COMING SOON

LABORATORIES OF DEMOCRACY:

THE 30-YEAR STATE MEDICAL CANNABIS EXPERIMENT

An Analysis of Lessons from the State Medical Cannabis Experiment & the Formula for National Access

> A federal medical cannabis program should not start from scratch—it should build upon state progress, restore patients' federal rights, enable interstate commerce, and integrate cannabis into modern healthcare.



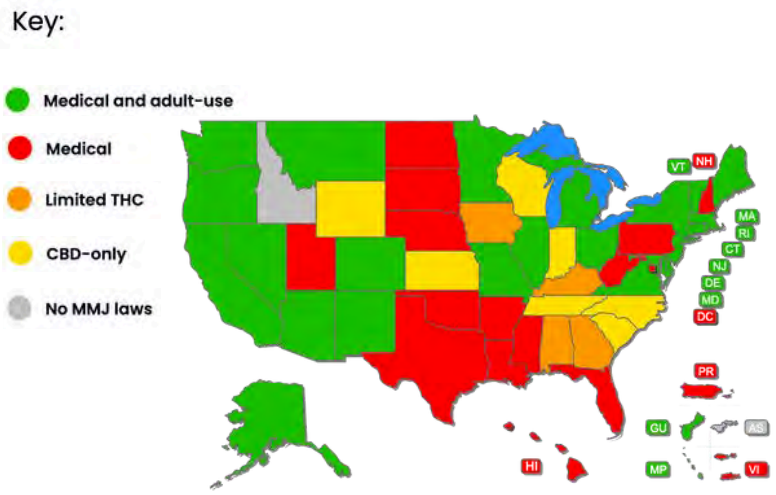
LESSONS FROM THE STATE MEDICAL CANNABIS EXPERIMENT

Lessons learned through real-world implementation, patient advocacy, and regulatory innovation are not theoretical. They are documented, measurable, and transferable. The soon-to-be-released report, Laboratories of Democracy: The 30-Year State Medical Cannabis Experiment, captures this history in full, evaluates where state programs have succeeded and failed patients, and lays out a clear roadmap for aligning state progress with a durable national medical cannabis framework. **As states once again step in to protect patients in the absence of comprehensive federal reform, this report provides the context, evidence, and blueprint needed to ensure that thirty years of hard-won progress are not lost—but finally translated into lasting national access.**

When Americans for Safe Access (ASA) was founded in 2002, only eight states had medical cannabis laws—and those were limited to narrow "criminal exemption" statutes that allowed patients to present a doctor's recommendation as a defense in court. In California, a small network of underground patient collectives emerged to fill the gap in access, but they were met with aggressive federal crackdowns—raids, arrests, and prosecutions that threatened both patients and providers.

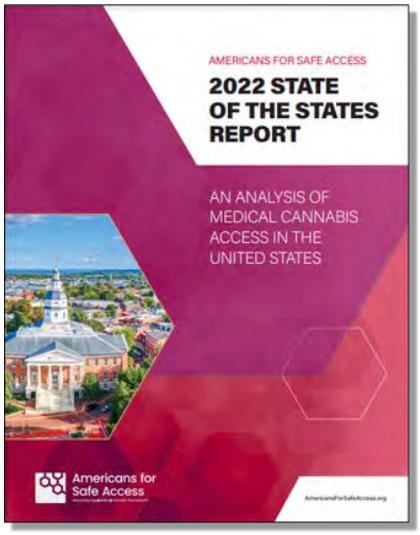
Formed with the goal of integrating medical cannabis into U.S. healthcare systems, ASA launched public awareness campaigns exposing the federal government's response and began passing local access laws in California that would become the foundation for modern state access programs. As a patient advocacy organization, A**SA has always balanced meeting immediate patient needs with driving long-term systemic reform. The state access programs ASA created were never the end goal—they were a form of triage, removing patients from the battlefield of the war on drugs while advocates worked to dismantle federal barriers to access.**

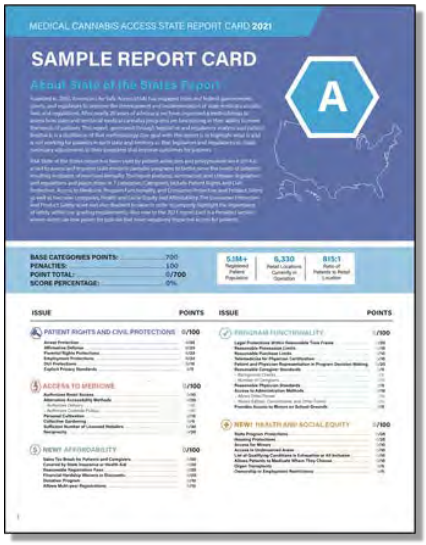
Today, forty states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, the Mariana Islands, and Guam have all passed comprehensive medical cannabis laws and additional nine states have have more restrictive laws, such as those that only allow access to cannabidiol (CBD) oil or products with limited THC. These states and territories cover more than 125 qualifying conditions, with some jurisdictions leaving it to the discretion of physicians to decide when medical cannabis would be an appropriate therapy.



These programs and protections are the direct result of a movement consisting of doctors, scientists, patients, their families, and policymakers working to fill a federal void.

ASA's annual State of the States report series (2014–2023)—the most comprehensive evaluation of how state medical cannabis programs perform for patients—became a cornerstone of ASA's state-level advocacy, providing a consistent framework for assessing progress and driving reform. Each annual report graded every state, territory, and the District of Columbia from "A" to "F" across more than 100 categories, offering lawmakers, regulators, and advocates clear, data-driven policy recommendations. These reports helped catalyze more than 800 legislative and regulatory reforms nationwide by translating patient needs into actionable policy.





A NEW REPORT FOR A NEW ERA

Laboratories of Democracy: The 30-Year State Medical Cannabis Experiment captures a pivotal moment in the evolution of medical cannabis policy. After three decades of state-led innovation, the United States stands at a crossroads. Every state but Idaho has enacted some form of medical cannabis access, yet a growing backlash against adult-use and hemp markets now threatens to undermine patient-focused progress. T**he limitations of many state programs—uneven access, affordability gaps, and the erosion of medical intent—have left patients once again in the crosshairs, caught between competing market forces and outdated federal policies.**

Through detailed grading, expert analysis, and thematic deep dives, the report will illuminate:

- The current state of medical cannabis programs for patients
- How state roles will evolve under a national framework
- State-driven innovations that can redefine medicine in the U.S.
- How a federal program will function—and what it must preserve
- Steps states can take now to prepare for federal alignment

The Laboratories of Democracy report distills 30 years of state experimentation to identify the policies that should inform a federal program, the responsibilities states will retain under a national system, the best practices worth preserving and scaling, and the policies that should stay on the chopping block. More than analysis, it provides a roadmap to expand patient rights, strengthen access, and ensure that the United States leads in the next era of cannabinoid medicine.

ADDITIONS TO GRADING CRITERIA

For 2026, ASA has expanded its grading system to capture the full scope of challenges patients face and the protections they deserve. This year's Laboratories of Democracy report introduces new criteria across multiple categories.

In **Patient Rights and Civil Protections**, states are now evaluated on whether they provide ADA accommodations and guarantee access in hospitals, assisted living facilities, and hospice settings. Access to Medicine now includes requirements for retail staff training on cannabis medicines, ensuring patients receive informed guidance at the point of sale.

Under **Affordability,** the addition of workers' compensation coverage reflects its growing role in expanding insurance reimbursement pathways. Health Equity has been updated to assess how states accommodate juvenile patients in schools, a critical issue for families.

Consumer Protections have been significantly strengthened. New benchmarks include product safety protocols, data transparency, the establishment of reference laboratories, adverse event reporting, and expanded recall systems that ensure effective enforcement, track-and-trace, and timely consumer notification.

Finally, ASA introduces a new evaluative lens on **Regulation Overkill,** highlighting burdensome "plutonium-style" measures that create unnecessary barriers and should be eliminated under federal oversight.

DEEP DIVE TOPICS

The Laboratories of Democracy report will do more than look backward at what states have done; it will examine existing gaps between state programs and health care infrastructure, best practices that should be included in the transition, state-level priorities in the pivot to a national medical cannabis program, and the implications for stakeholders in the absence of a change in federal policies. These deep dives reveal the progress, shortcomings, and limitations of the state-led experiment: providing a blueprint for state and federal policymakers to move to a national framework or for states to develop mitigation strategies to protect patients in the absence of federal progress.

⇒ Integrating into U.S. Healthcare
⇒ Research Priorities & Investments
⇒ Healthcare Coverage & Cost Savings
⇒ Product Safety & Advanced Agriculture
⇒ Patient Access Post-Prohibition
⇒ Parental Rights & Child Protective Services
⇒ Drug Testing & Driving Under the Influence (DUI)
⇒ Home Cultivation
⇒ Medical Professional Education
⇒ Medical Cannabis Market Financial Stress Test
⇒ Global Market

Taken together, these deep dives reinforce the central message of the Laboratories of Democracy Report: thirty years of state-level experimentation have yielded proof of concept: medical cannabis works and can be regulated responsibly. **Yet without a national protocol, the data remains fragmented, and patient protections remain unstable. The next phase of this experiment requires standardization—a federal framework that turns local breakthroughs into lasting, nationwide access.** It is time to ensure those victories are not lost but built upon. The choice before us is stark: let thirty years of patient-led progress wither under neglect or use it as the foundation for a new era in medicine.

Innovative state policies have demonstrated what whole-plant, patient-centered care can achieve—and now provide the foundation for a federal regulatory pathway for complex botanical medicines, the last major barrier to safe access. ASA's proposed Medical Cannabis and Cannabinoid Act (MCCA) provides that pathway. The legislation establishes a new Schedule VI for cannabis, creates a dedicated Office of Medical Cannabis and Cannabinoid Control under the U.S. Department of Health and Human Services, and harmonizes national safety, access, and research standards.

A federal medical cannabis program should not start from scratch—it should build upon state progress, restore patients' federal rights, enable interstate commerce, and integrate cannabis into modern healthcare.

Learn more about the Laboratories of Democracy Report:
www.SafeAccessNow.org/lod_report_teaser

DRAFT EMERGENCY STATE LEGISLATION:

PROTECTING ACCESS TO CANNABINOID MEDICINES ACT OF 2026

The goal of this legislation is to:

- Preserve access to non-intoxicating cannabinoid medicines;
- Ensure products meet medical-grade safety and testing standards and are accurately labeled;
- Stabilize supply before federal changes take effect;
- Give patients, providers, and regulators time to adjust responsibly; and
- Address the systemic barriers that have prevented patients from utilizing state programs.

NOTE: The following draft has been written for a state with a medical cannabis program and can be modified for states with CBD-only, low-THC, and adult-use programs.

DRAFT EMERGENCY STATE LEGISLATION

PROTECTING ACCESS TO CANNABINOID MEDICINES ACT OF 2026

SECTION 1. SHORT TITLE.

This Act shall be known as the Protecting Access to Cannabinoid Medicines Act of 2026.

SECTION 2. LEGISLATIVE FINDINGS AND INTENT.

The Legislature finds that

1. Recent federal amendments to the Agricultural Marketing Act of 1946, enacted through H.R. 5371 (FY2026 Continuing Appropriations Act), redefine hemp and hemp-derived cannabinoid products and will significantly restrict access to full-spectrum cannabinoid products effective November 11, 2026.

2. Millions of patients nationwide—and thousands within this state—depend on full-spectrum, low-THC formulations (such as 16:1 non-intoxicating cannabinoid: THC ratios) to manage chronic illness, neurological disorders, pediatric and adult seizure conditions, cancer-related symptoms, PTSD symptoms, autism, palliative care, sleep disorders, and other medical conditions.

3. The federal changes will eliminate the unregulated interstate market from which many patients currently obtain these products, making state-regulated access urgent and necessary.

4. The State has a compelling interest in ensuring that medical cannabis patients have access to safe, affordable, and medically appropriate cannabinoid products, particularly formulations that are not widely produced in the adult-use marketplace.

5. To achieve this, the State must (a) incentivize licensed manufacturers and cultivators to produce full-spectrum medical formulations and (b) establish a safe, legal in-state supply chain for low-THC, non-intoxicating cannabinoid-biomass that complies with state product-safety standards.

6. It is the intent of the Legislature to maintain patient access to essential cannabinoid medicines while ensuring compliance with federal law, state public-safety standards, and medical best practices.

SECTION 3. DEFINITIONS:

“Department": Designated cannabis regulatory authority.

“Full-spectrum non-intoxicating cannabinoid product": A cannabinoid formulation with a non-intoxicating cannabinoid: THC ratio of 16:1 or greater.

“Non-intoxicating cannabinoid” means a cannabinoid or cannabinoid acid that, based on available scientific evidence, does not produce intoxicating effects at concentrations present in regulated medical formulations, and includes, but is not limited to:

- Cannabidiol (CBD);
- Cannabidivarin (CBDV);
- Cannabichromene (CBC);
- Cannabigerol (CBG); and
- Cannabinoids in acidic form, including but not limited to cannabidiolic acid (CBDA), tetrahydrocannabinolic acid (THCA), and cannabigerolic acid (CBGA).

This definition may be modified by the Department by rule to align with findings, guidance, or determinations published by the U.S. Food and Drug Administration or other federal agencies pursuant to Section 781(3)(A)–(D) of H.R. 5371, or any successor provision.

"Nonresident card" means a card or other identification that:

1. Is issued by a state or jurisdiction other than [State]; and
2. Is the functional equivalent of a registration card.

"Permitted hemp supplier": A USDA-licensed in-state hemp grower authorized to sell biomass for medical extraction.

[INCENTIVES FOR STATE-LICENSED MEDICAL CANNABIS MANUFACTURERS]

SECTION 4. TAX CREDIT FOR NON-INTOXICATING CANNABINOID, LOW-THC MEDICAL PRODUCTS.

a. A licensed medical cannabis manufacturer or cultivator that produces full-spectrum cannabinoid products with a non-intoxicating cannabinoid: THC ratio of 16:1 or greater shall be eligible for a tax credit equal to:

- Up to 15% of the manufacturer's annual costs associated with production, testing, and packaging of qualifying products; or
- A per-unit production credit of up to $1.50 per qualifying unit, whichever is greater.

b. Qualifying units must be:

1. Tested and labeled in accordance with state medical cannabis regulations;
2. Include - total mg, mg/mL, mg/unit (gummy/tablet, etc.), and container volume (mL) or number of units per container on labels;
3. Designated as medical products; and
4. Made available through the state medical cannabis registry or medical dispensary network.

c. The Department shall issue guidance on allowable costs, documentation requirements, and audit procedures within 90 days of enactment.

SECTION 5. NO-INTEREST LOANS OR DIRECT SUBSIDIES.

a. The Department shall issue grants or loans to medical cannabis licensees to:

1. Implement facility upgrades necessary to accommodate the production of non-intoxicating cannabinoid product varieties.
2. Develop or acquire formulations suitable for pediatric-appropriate or for products with a non-intoxicating cannabinoid: THC ratio of 16:1 or greater;
3. Support the development of a statewide "compassion pricing" program.

b. Priority shall be given to manufacturers producing:

1. 16:1 and 20:1 full-spectrum formulations,

2. Pediatric-relevant formulations, including oils, tinctures, nasal sprays, and other formulations deemed appropriate by the state for pediatric use, and products for assisted living, palliative care, and hospice settings.

[AND/OR ALLOW MEDICAL MANUFACTURERS TO PURCHASE NON-INTOXICATING CANNABINOID HEMP BIOMASS FROM USDA-LICENSED IN-STATE FARMERS]

SECTION 6. AUTHORIZED SOURCING OF NON-INTOXICATING CANNABINOID HEMP BIOMASS.

a. A licensed medical cannabis manufacturer may purchase in-state hemp biomass from a USDA-licensed hemp producer for the purpose of manufacturing medical cannabis products, provided that:

1. The hemp producer complies with all state cannabis product-safety regulations applicable to cultivation, including testing, inspections, and contaminant-control rules;

2. The hemp biomass contains THC levels within federal limits (<0.3% total THC on a dry-weight basis) prior to extraction;

3. All intermediate or final cannabinoid products created from hemp biomass shall be regulated as medical cannabis products under state law;

4. Hemp producers operating under this section shall not be deemed medical cannabis licensees solely by virtue of selling biomass to a licensed medical manufacturer.

b. The Department shall create a Hemp-to-Medical-Cannabis Supplier Permit allowing hemp growers to enter the medical supply chain, subject to:

1. USDA license check;

2. Facility inspections; and

3. Product-safety compliance, including staff training.

SECTION 7. STREAMLINED TRANSPORT & TRACK-AND-TRACE INTEGRATION.

a. Hemp biomass and intermediate extracts transferred under this Act must be entered into the state medical cannabis track-and-trace system.

b. Transportation of hemp biomass from a permitted grower to a medical manufacturer is explicitly authorized under state law.

c. The Department shall adopt emergency rules within 60 days to ensure continuity of supply ahead of the federal implementation date of November 11, 2026.

SECTION 8. SALES TAX EXEMPTION FOR QUALIFYING MEDICAL CANNABINOID PRODUCTS.

a. Notwithstanding any other provision of state or local law, qualifying medical cannabinoid products shall be exempt from state and local sales and use taxes.

b. For purposes of this section, qualifying medical cannabinoid products means full-spectrum cannabinoid products that:

1. Are produced by a state-licensed medical cannabis cultivator or manufacturer;
2. Are designated as medical products;

c. The exemption provided under this section shall apply regardless of whether such products are derived from cannabis cultivated under the state medical cannabis program or from in-state hemp biomass lawfully incorporated into the medical cannabis supply chain pursuant to this Act.

d. This exemption shall not apply to adult-use cannabis products or to any cannabinoid products not regulated under state medical cannabis law.

SECTION 9: EXEMPT MEDICAL CANNABIS PRODUCTS FROM SALES AND EXCISE TAXES

a. Medical cannabis businesses shall pay an excise tax of no greater than 7% on the gross receipts of medical cannabis sold to a qualifying patient or to a personal caregiver, but shall not pay a higher tax than businesses of comparable activity and size.

1. Medical facilities that produce cannabis exclusively for medical use shall not be subject to excise tax.

b. Nothing in this chapter shall prevent a locality from implementing a sales tax on medical cannabis; however, this tax rate shall not exceed [insert state's applicable tax rate for over-the-counter medications].

c. If a state has an adult-use medical cannabis program, medical patients shall be exempt from any applicable sales tax.

SECTION 10: EXPAND PROTECTIONS AND DEFINITIONS OF MEDICAL CANNABIS REGISTRATION CARDS FOR QUALIFYING PATIENTS AND DESIGNATED CAREGIVERS

a. A physician may deem a card valid for one year- five years.

b. Until the Department begins to issue registration ID cards, a licensed physician's written recommendation shall provide a qualifying patient the same legal status as a cardholder.

c. Upon receiving a medical cannabis recommendation under this section, a patient shall immediately qualify to begin use of medical cannabis and nothing in this chapter shall prohibit a qualifying patient from obtaining medical cannabis on the same date that a recommendation is issued by a health care provider. A healthcare practitioner's recommendation will remain valid as a method to participate in the medical cannabis program until the application for a registration card is approved or denied by the Department.

d. The Department shall issue any rules necessary for how an employee of a hospice provider, nursing, or medical facility providing care to a qualifying patient may serve as a personal caregiver for the purposes of administering medical cannabis to a qualifying patient.

e. The Department may assess a reasonable fee of no more than twenty-five dollars ($25) to those seeking to obtain a registration card. Notwithstanding, no fee shall be assessed for any patient who is determined by the Department to have a financial hardship.

SECTION 11: HOME DELIVERY

a. The Department shall create rules to facilitate the home delivery of medical cannabis and cannabis-derived products from a dispensing Facility to a qualifying patient or personal caregiver.

SECTION 12: DISCRIMINATION PROHIBITED

a. Unless a failure to do so would cause the employer to lose a monetary or licensing-related benefit under federal law or federal regulations, an employer may not discriminate against a person in hiring, termination, or any term or condition of employment, or otherwise penalize a person, based upon either of the following:

1. The person's status as a qualifying patient, caregiver, or cardholder; or

2. A qualifying patient, caregiver, or cardholder tests positive for cannabis components or metabolites, unless the individual was impaired by cannabis on the premises of the place of employment or during the hours of employment.

b. Unless required by federal law or required to obtain federal funding, no landlord may refuse to rent a dwelling unit to a person or take action against a tenant solely on the basis of an individual's status of a qualifying patient or cardholder under this act.

c. For the purposes of medical care, including organ transplants, a qualifying patient's medical use of cannabis does not constitute the use of an illicit substance or otherwise disqualify a qualifying patient from medical care.

d. Neither the presence of cannabinoid components or metabolites in a person's bodily fluids, nor conduct related to the medical use of cannabis by a custodial or noncustodial parent, grandparent, pregnant woman, legal guardian, or other person charged with the well-being of a child, shall form the sole or primary basis for any action or proceeding by a child welfare agency or a family or juvenile court. This subsection shall apply only to conduct in compliance with this chapter.

e. Health care practitioners shall not disqualify or refuse to provide care for a patient due to positive urinary or blood test results indicating the presence of cannabis or cannabis metabolites, including tetrahydrocannabinol, nor shall the presence of compounds of cannabis or cannabis metabolites be a reason for the cessation of care.

f. Qualifying patient or designated caregivers shall not be subject to any disciplinary action by an occupational or professional licensing board based upon the individual's past or present status as a qualifying patient or designated caregiver.

g. A school shall not deny registration or enrollment or take adverse action based on the student or parents' status as a qualified medical cannabis patient.

h. A school may not limit a registered qualifying patient's access to or medical use of cannabis unless doing so would cause a loss of monetary or licensing-related benefit under federal law.

i. Congregate health facilities such as nursing homes, group homes, adult day programs, and other similar facilities may not limit a registered qualifying patient's access to or medical use of cannabis unless doing so would cause a loss of monetary or licensing-related benefit under federal law.

SECTION 13: RECOGNITION OF NONRESIDENT CARDS

a. The (STATE) and the medical cannabis dispensing facilities in this State which hold valid medical cannabis establishment registration certificates, will recognize a medical cannabis registry identification card issued by another state or the District of Columbia only under the following circumstances:

1. The state or jurisdiction from which the holder or bearer obtained the nonresident card grants an exemption from criminal prosecution for the medical use of cannabis;

2. The nonresident card has an expiration date and has not yet expired;

3. The holder or bearer of the nonresident card signs an affidavit in a form prescribed by the Department, which sets forth that the holder or bearer is entitled to engage in the medical use of cannabis in his or her state or jurisdiction of residence; and

4. The holder or bearer of the nonresident card is in possession of no more than a 90-day supply of cannabis.

b. For the purposes of the reciprocity described in this section:

1. The amount of medical cannabis that the holder or bearer of a nonresident card is entitled to possess in his or her state or jurisdiction of residence is not relevant; and

2. Under no circumstances, while in this State, may the holder or bearer of a nonresident card possess cannabis for medical purposes in excess of a 90-day supply of cannabis.

SECTION 14: HOME CULTIVATION

a. Medical cannabis patients and caregivers may cultivate up to [X] mature plants and [X] immature plants at home, with a maximum cap of [X] plants per household.

SECTION 15: PUBLIC EDUCATION AND PATIENT TRANSITION CAMPAIGN

The Department shall implement a public education campaign to inform patients, caregivers, healthcare providers, and licensees about changes to cannabinoid product access resulting from federal hemp restrictions.

The campaign shall include, at a minimum:

a. Warnings Against Stockpiling Cannabinoid Products, including:

1. Shelf-life limitations of cannabinoid products;
2. Degradation of cannabinoids and terpenes over time; and
3. Risks associated with improper storage.

b. Education on Contaminants Commonly Found in Unregulated or Illicit Cannabinoid Markets, including:

1. Pesticides, heavy metals, residual solvents, and microbial contamination;
2. Risks associated with products lacking verified testing or oversight.

c. Safe Transition Guidance for Patients Currently Using Hemp-Derived Cannabinoid Products, including:

1. Information on legally available medical cannabinoid alternatives within the state;
2. Guidance on transitioning dosages and formulations where clinically appropriate;
3. Clear timelines regarding federal implementation dates and anticipated changes in product availability; and
4. Resources for patients at risk of treatment disruption, including pediatric, chronic illness, and hospice populations.

d. Provider and Dispensary Education, including:

1. Guidance for patient counseling during transition periods;
2. Educational materials to support informed patient decision-making.

SECTION 16: Product Availability Listing and Patient Notification

The Department shall maintain an opt-in, informational listing of licensed medical cannabis dispensaries and manufacturers that make available non-intoxicating cannabinoid products regulated under state medical cannabis law.

- The listing shall be informational in nature only and shall not constitute advertising, endorsement, or preferential treatment of any licensee or product.
- Participation in the listing by dispensaries and manufacturers shall be voluntary and opt-in.
- Patients and caregivers may voluntarily enroll to receive notifications regarding the availability of non-intoxicating cannabinoid products within the state, including general location information and product category updates.

The Department shall ensure that:

- No patient medical information is disclosed;
- Enrollment and notification systems comply with applicable state privacy and data-protection laws; and
- Notifications are limited to availability information and do not include pricing, promotional content, or inducements.

SECTION 17. EMERGENCY RULEMAKING AUTHORITY.

The Department is authorized to implement emergency regulations necessary to ensure uninterrupted patient access to qualifying cannabinoid products. Emergency rules shall remain in effect until permanent rules are adopted.

The Department shall report to the Legislature within 12 months on patient access, product availability, and program utilization under these emergency rules.

SECTION 18. RESOLUTION CALLING FOR NATIONAL MEDICAL CANNABIS PROGRAM.

May it be resolved by the people of [state] that it is the sense of [State] that Congress should immediately pass legislation to establish a national medical cannabis program housed under the Department of Health and Human Services (the Office of Medical Cannabis and Cannabinoid Control) that builds on existing state programs and oversees a new schedule for cannabis and cannabinoids.

SECTION 19. EFFECTIVE DATE.

This Act shall take effect immediately upon enactment.

SECTION 20. SEVERABILITY

The provisions of this law are severable, and if any clause, sentence, paragraph, or section of this measure, or an application thereof, shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, nor invalidate the remainder thereof but shall be confined in its operation to the clause, sentence, paragraph, section, or application adjudged invalid.

TALKING POINTS FOR EMERGENCY LEGISLATION

- I am introducing the Protecting Access to Cannabinoid Medicines Act of 2026 because in **[YEAR MEDICAL CANNABIS LAW PASSED],** our state made a commitment to support patients who need access to cannabis medicines. The change in federal hemp laws puts the entirety of that responsibility back on the states.

- The Protecting Access to Cannabinoid Medicines Act of 2026 is about patients, not the hemp marketplace. Congress already closed the hemp loophole. That decision is final. We're ensuring patients aren't harmed during the cleanup.

- I am calling on my colleagues to pass the Protecting Access to Cannabinoid Medicines Act of 2026 because doing nothing is not neutral—it guarantees disruption.

- President Trump's Executive Order recognizes the problem created by the new hemp laws for patients, but it does not stop cannabinoid products from disappearing in 2026. Recognition is important—but it does not replace access.

- The policies in the Protecting Access to Cannabinoid Medicines Act of 2026 operate entirely within state medical cannabis law and new federal limits. This does not reopen loopholes or create interstate commerce. As with our medical cannabis program, this activity will be protected under the Medical Cannabis Amendment to the Commerce, Justice, Science, and Related Agencies (CJS) appropriations Bill.

- The Protecting Access to Cannabinoid Medicines Act of 2026 recognizes that patients turned to hemp when medical access wasn't working. That didn't happen by accident—it happened because gaps were left unaddressed.

- The Protecting Access to Cannabinoid Medicines Act of 2026 is preventing a collapse in access for patients already using cannabinoid medicines. We're managing a transition, not expanding a market.

- The Protecting Access to Cannabinoid Medicines Act of 2026 does not reopen loopholes or defy federal law. It protects patients by transitioning them into regulated medical systems.

- Congress closed the hemp loophole, and that decision comes with a countdown. If we do nothing, patients will lose access in 2026.

Medical-Only States Specific

- We passed a medical cannabis law—but we did not guarantee access. Patients found another way, and now that pathway is closing.
- We cannot punish patients for navigating barriers that our own laws created.

Adult-Use States

- When adult-use markets expanded, patient access narrowed. Products that patients depended on disappeared.
- We legalized cannabis for adults, but we didn't protect shelf space for patients.
- This bill corrects a market imbalance that left patients behind.

DRAFT EMERGENCY EXECUTIVE ACTION:

PROTECT PATIENT ACCESS TO CANNABINOID MEDICINES

The goal of this executive action is to:

- Preserve access to non-intoxicating cannabinoid medicines;
- Ensure products meet medical-grade safety and testing standards and are accurately labeled;
- Stabilize supply before federal changes take effect;
- Give patients, providers, and regulators time to adjust responsibly; and
- Address the systemic barriers that have prevented patients from utilizing state programs.

NOTE: The following draft executive action is written for a state with a medical cannabis program and can be modified for states with CBD-only, low-THC, and adult-use programs.

DRAFT EXECUTIVE ORDER: EMERGENCY RULE MAKING

PROTECT PATIENT ACCESS TO CANNABINOID MEDICINES

WHEREAS, recent federal amendments to the Agricultural Marketing Act of 1946, enacted through H.R. 5371 (FY2026 Continuing Appropriations Act), redefine hemp and hemp-derived cannabinoid products and will significantly restrict access to full-spectrum cannabinoid products effective November 11, 2026;

WHEREAS, millions of patients nationwide—and thousands within this State—depend on full-spectrum, low-THC, high-non-intoxicating cannabinoid formulations, to manage chronic illness, neurological disorders, pediatric and adult seizure conditions, cancer-related symptoms, PTSD symptoms, autism, palliative care, sleep disorders, and other medical conditions;

WHEREAS, many patients currently rely on hemp-derived full-spectrum cannabinoid products due to gaps, limitations, or affordability challenges within existing state medical cannabis programs;

WHEREAS, the federal amendments will eliminate the unregulated interstate market through which many patients currently access these cannabinoid therapies, creating an imminent risk of treatment disruption;

WHEREAS, the State has a compelling interest in ensuring that medical cannabis patients maintain access to safe, affordable, and medically appropriate cannabinoid products regulated under state law;

WHEREAS, it is necessary to incentivize the in-state production of non-intoxicating and minimally intoxicating cannabinoid medicines while establishing a safe, legal, and transparent in-state supply chain for non-intoxicating cannabinoid biomass that complies with state product-safety standards;

NOW, THEREFORE, under the authority vested in me by the Constitution and laws of the State of **[STATE]**, I hereby order the **[State Cannabis Regulatory Authority]** to implement the following emergency rules to ensure continuity of patient access while maintaining compliance with federal law, state public-safety requirements, and medical best practices.

PURPOSE.

These emergency rules establish a pathway for the continued availability of medically appropriate full-spectrum non-intoxicating cannabinoid formulations following federal restrictions on hemp-derived cannabinoid products, effective November 11, 2026.

DEFINITIONS.

“Department": Designated cannabis regulatory authority.

“Full-spectrum non-intoxicating cannabinoid product": A cannabinoid formulation with a non-intoxicating cannabinoid: THC ratio of 16:1 or greater.

“Non-intoxicating cannabinoid” means a cannabinoid or cannabinoid acid that, based on available scientific evidence, does not produce intoxicating effects at concentrations present in regulated medical formulations, and includes, but is not limited to:

- Cannabidiol (CBD);
- Cannabidivarin (CBDV);
- Cannabichromene (CBC);
- Cannabigerol (CBG); and
- Cannabinoids in acidic form, including but not limited to cannabidiolic acid (CBDA), tetrahydrocannabinolic acid (THCA), and cannabigerolic acid (CBGA).

This definition may be modified by the Department by rule to align with findings, guidance, or determinations published by the U.S. Food and Drug Administration or other federal agencies pursuant to Section 781(3)(A)–(D) of H.R. 5371, or any successor provision.

“Permitted hemp supplier”: A USDA-licensed in-state hemp grower authorized to sell biomass for medical extraction.

THE DEPARTMENT HEREBY ESTABLISHES THE FULL-SPECTRUM CANNABINOID INCENTIVE PROGRAM.

RULE 1. MEDICAL CANNABIS LICENSE INCENTIVE RULE [MANUFACTURER INCENTIVE RULE]

a. Create a tax credit for non-intoxicating cannabinoid, LOW-THC medical products.

Medical cannabis manufacturers and cultivators that produce qualifying products are eligible for reimbursement of up to 15% of production costs or a per-unit incentive, set annually by the Department.

Qualifying products must be tested and labeled in accordance with state medical cannabis regulations, must include total mg/unit, container volume mL/unit or number of units per container on labels, be designated for medical use, and be made available at price caps defined by the Department to ensure affordability.

b. No-Interest Loans or Direct.

No-interest loans or direct subsidies for medical cannabis manufacturers and cultivators to be used for facility upgrades necessary to accommodate space to produce non-intoxicating cannabinoid varieties, develop or acquire formulations, and to offset costs of “compassion pricing” as determined by the Department.

Priority will be given to 16:1 and 20:1 full-spectrum formulations; pediatric-relevant formulations, including oils, tinctures, and other products deemed appropriate by the state for pediatric use; and products for assisted living, palliative care, and hospice settings.

RULE 2. AUTHORIZED IN-STATE HEMP SOURCING. [HEMP BIOMASS INTEGRATION RULE]

Medical cannabis manufacturers may purchase hemp biomass from USDA-licensed in-state producers.

All hemp materials entering the medical cannabis supply chain must undergo the same contaminant and potency testing required for medical cannabis.

All intermediate extracts derived from hemp biomass shall be subject to medical-cannabis manufacturing standards, including track-and-trace, security, and labeling.

RULE 3. PERMITTED SUPPLIER PROGRAM

Hemp producers may obtain a Medical Biomass Supplier Permit

Permit holders shall comply with:

- State cultivation regulations,
- Required inspections, and
- Product-safety standards (microbial, heavy metals, residual solvents, pesticides).

Violations shall be enforced under existing cannabis regulatory penalties.

RULE 4. EMERGENCY CONTINUITY MEASURES.

The Department may waive non-safety-critical requirements to stabilize supply.

The Department shall issue guidance, including allowable costs and compassionate pricing requirements, documentation requirements, and audit procedures, within 90 days of enactment.

RULE 5: EXEMPT MEDICAL CANNABIS PRODUCTS FROM SALES AND EXCISE TAXES

a. Medical cannabis businesses shall pay an excise tax of no greater than 7% on the gross receipts of medical cannabis sold to a qualifying patient or to a personal caregiver, but shall not pay a higher tax than businesses of comparable activity and size.

1. Medical facilities that produce cannabis exclusively for medical use shall not be subject to excise tax.

b. Nothing in this chapter shall prevent a medical cannabis business from implementing a sales tax on medical cannabis; however, this tax rate shall not exceed [insert state's applicable tax rate for over-the-counter medications].

c. If a state has a non-medical cannabis program, medical patients shall be exempt from any applicable sales tax.

RULE 6: EXPAND PROTECTIONS AND DEFINITIONS OF MEDICAL CANNABIS REGISTRATION CARDS FOR QUALIFYING PATIENTS AND DESIGNATED CAREGIVERS

a. A physician may deem a card valid for one year- five years.

b. Until the Department begins to issue registration ID cards, a licensed physician's written recommendation shall provide a qualifying patient the same legal status as a cardholder.

c. Upon receiving a medical cannabis recommendation under this section, a patient shall immediately qualify to begin use of medical cannabis and nothing in this chapter shall prohibit a qualifying patient from obtaining medical cannabis on the same date that a recommendation is issued by a health care provider. A healthcare practitioner's recommendation will remain valid as a method to participate in the medical cannabis program until the application for a registration card is approved or denied by the Department.

d. The Department shall issue any rules necessary for how an employee of a hospice provider, nursing, or medical facility providing care to a qualifying patient may serve as a personal caregiver for the purposes of administering medical cannabis to a qualifying patient.

e. The Department may assess a reasonable fee of no more than twenty-five dollars ($25) to those seeking to obtain a registration card. Notwithstanding, no fee shall be assessed for any patient who is determined by the Department to have a financial hardship.

RULE 7: HOME DELIVERY

a. The Department shall create rules to facilitate the home delivery of medical cannabis and cannabis-derived products from a dispensing Facility to a qualifying patient or personal caregiver.

RULE 8: DISCRIMINATION PROHIBITED

a. Unless a failure to do so would cause the employer to lose a monetary or licensing-related benefit under federal law or federal regulations, an employer may not discriminate against a person in hiring, termination, or any term or condition of employment, or otherwise penalize a person, based upon either of the following:

1. The person's status as a qualifying patient, caregiver, or cardholder; or

2. A qualifying patient, caregiver, or cardholder tests positive for cannabis components or metabolites, unless the individual was impaired by cannabis on the premises of the place of employment or during the hours of employment.

b. Unless required by federal law or required to obtain federal funding, no landlord may refuse to rent a dwelling unit to a person or take action against a tenant solely on the basis of an individual's status of a qualifying patient or cardholder under this act.

c. For the purposes of medical care, including organ transplants, a qualifying patient's medical use of cannabis does not constitute the use of an illicit substance or otherwise disqualify a qualifying patient from medical care.

d. Neither the presence of cannabinoid components or metabolites in a person's bodily fluids, nor conduct related to the medical use of cannabis by a custodial or noncustodial parent, grandparent, pregnant woman, legal guardian, or other person charged with the well-being of a child, shall form the sole or primary basis for any action or proceeding by a child welfare agency or a family or juvenile court. This subsection shall apply only to conduct in compliance with this chapter.

e. Health care practitioners shall not disqualify or refuse to provide care for a patient due to positive urinary or blood test results indicating the presence of cannabis or cannabis metabolites, including tetrahydrocannabinol, nor shall the presence of compounds of cannabis or cannabis metabolites be a reason for the cessation of care.

f. Qualifying patient or designated caregivers shall not be subject to any disciplinary action by an occupational or professional licensing board based upon the individual's past or present status as a qualifying patient or designated caregiver.

g. A school shall not deny registration or enrollment or take adverse action based on the student or parents' status as a qualified medical cannabis patient.

h. A school may not limit a registered qualifying patient's access to or medical use of cannabis unless doing so would cause a loss of monetary or licensing-related benefit under federal law.

i. Congregate health facilities such as nursing homes, group homes, adult day programs, and other similar facilities may not limit a registered qualifying patient's access to or medical use of cannabis unless doing so would cause a loss of monetary or licensing-related benefit under federal law.

RULE 9: RECOGNITION OF NONRESIDENT CARDS

a. The (STATE) and the medical cannabis dispensing facilities in this State which hold valid medical cannabis establishment registration certificates, will recognize a medical cannabis registry identification card issued by another state or the District of Columbia only under the following circumstances:

1. The state or jurisdiction from which the holder or bearer obtained the nonresident card grants an exemption from criminal prosecution for the medical use of cannabis;

2. The nonresident card has an expiration date and has not yet expired;

3. The holder or bearer of the nonresident card signs an affidavit in a form prescribed by the Department, which sets forth that the holder or bearer is entitled to engage in the medical use of cannabis in his or her state or jurisdiction of residence; and

4. The holder or bearer of the nonresident card is in possession of no more than a 90-day supply of cannabis.

b. For the purposes of the reciprocity described in this section:

1. The amount of medical cannabis that the holder or bearer of a nonresident card is entitled to possess in his or her state or jurisdiction of residence is not relevant; and

2. Under no circumstances, while in this State, may the holder or bearer of a nonresident card possess cannabis for medical purposes in excess of a 90-day supply of cannabis.

RULE 10: HOME CULTIVATION

a. Medical cannabis patients and caregivers may cultivate up to [X] mature plants and [X] immature plants at home, with a maximum cap of [X] plants per household.

RULE 11. PUBLIC EDUCATION AND PATIENT TRANSITION CAMPAIGN

The Department shall implement a public education campaign to inform patients, caregivers, healthcare providers, and licensees about changes to cannabinoid product access resulting from federal hemp restrictions.

The campaign shall include, at a minimum:

a. Warnings Against Stockpiling Cannabinoid Products, including:

1. Shelf-life limitations of cannabinoid products;
2. Degradation of cannabinoids and terpenes over time; and
3. Risks associated with improper storage.

b. Education on Contaminants Commonly Found in Unregulated or Illicit Cannabinoid Markets, including:

1. Pesticides, heavy metals, residual solvents, and microbial contamination;
2. Risks associated with products lacking verified testing or oversight.

c. Safe Transition Guidance for Patients Currently Using Hemp-Derived Cannabinoid Products, including:

1. Information on legally available medical cannabinoid alternatives within the state;
2. Guidance on transitioning dosages and formulations where clinically appropriate;
3. Clear timelines regarding federal implementation dates and anticipated changes in product availability; and
4. Resources for patients at risk of treatment disruption, including pediatric, chronic illness, and hospice populations.

d. Provider and Dispensary Education, including:

1. Guidance for patient counseling during transition periods;
2. Educational materials to support informed patient decision-making.

RULE 12: PRODUCT AVAILABILITY LISTING AND PATIENT NOTIFICATION

The Department shall maintain an opt-in, informational listing of licensed medical cannabis dispensaries and manufacturers that make available non-intoxicating cannabinoid products regulated under state medical cannabis law.

- The listing shall be informational in nature only and shall not constitute advertising, endorsement, or preferential treatment of any licensee or product.
- Participation in the listing by dispensaries and manufacturers shall be voluntary and opt-in.
- Patients and caregivers may voluntarily enroll to receive notifications regarding the availability of non-intoxicating cannabinoid products within the state, including general location information and product category updates.

The Department shall ensure that:

- No patient medical information is disclosed;
- Enrollment and notification systems comply with applicable state privacy and data-protection laws; and
- Notifications are limited to availability information and do not include pricing, promotional content, or inducements.

Rule 13: RESOLUTION CALLING FOR NATIONAL MEDICAL CANNABIS PROGRAM.

I call on my distinguished colleagues in [state] legislature to pass a resolution on behalf of the people of [state] that it is the sense of [State] that Congress should immediately pass legislation to establish a national medical cannabis program housed under the Department of Health and Human Services (the Office of Medical Cannabis and Cannabinoid Control) that builds on existing state programs and oversees a new schedule for cannabis and cannabinoids.

TALKING POINTS FOR EMERGENCY RULEMAKING

Emergency Rulemaking to Protect Patient Access Cannabinoid Medicines

- I am issuing emergency rulemaking because in **[YEAR MEDICAL CANNABIS LAW PASSED],** our state made a commitment to support patients who need access to cannabis medicines. The change in federal hemp laws puts the entirety of that responsibility back on the states.

- Today, I am issuing emergency rulemaking to protect patient access to full-spectrum cannabinoid medicines. Emergency authority exists to prevent foreseeable harm. We have a fixed federal deadline and vulnerable patients. Waiting would be irresponsible.

- Congress has closed the hemp loophole, and those changes take effect in 2026. Without state action, patients who rely on cannabinoid medicines will face abrupt loss of access and treatment disruption.

- This action is not about politics or ideology. It is about the continuity of care for patients managing serious medical conditions.

- The goal of this emergency rulemaking is simple: stabilize access, protect public health, and give patients, providers, and regulators time to transition responsibly before federal changes take effect.

- President Trump's Executive Order recognizes the problem created by the new hemp laws, but it does not stop cannabinoid products from disappearing in 2026. Recognition is important—but it does not replace access.

- These emergency rules operate entirely within state medical cannabis law and new federal limits. This does not reopen loopholes or create interstate commerce. As with our medical cannabis program, this activity will be protected under the Medical Cannabis Amendment to the Commerce, Justice, Science, and Related Agencies (CJS) appropriations Bill.

Medical-Only States Specific

- We passed a medical cannabis law—but we did not guarantee access. Patients found another way, and now that pathway is closing.
- We cannot punish patients for navigating barriers that our own laws created.

Adult-Use States

- When adult-use markets expanded, patient access narrowed. Products that patients depended on disappeared.
- We legalized cannabis for adults, but we didn't protect shelf space for patients.
- This bill corrects a market imbalance that left patients behind.

REFERENCES, CITATIONS, & RESOURCES

“In a time of deceit telling the truth is a revolutionary act.”

– George Orwell

NEW HEMP LAWS IMPACT PATIENTS NATIONWIDE

- H.R. 5371—**the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act**, 2026 www.congress.gov/bill/119th-congress/house-bill/5371
- Executive Order "**Increasing Medical Marijuana and Cannabidiol Research**: whitehouse.gov/presidential-actions/2025/12/increasing-medical-marijuana-and-cannabidiol-research/
- "**Understanding Trump's Executive Order on Medical Cannabis & Cannabinoid Research**"-ASA Article: www.safeaccessnow.org/trump_executive_order_rescheduling
- **December 2025 sign on letter from Representatives:** sessions.house.gov/2025/12/congressman-sessions-co-leads-letter-to-president-trump-strongly-urging-him-to-reject-marijuana-rescheduling
- **December 2025 sign on letter from Senate:** https://www.budd.senate.gov/wp-content/uploads/2025/12/12.17.2025-Budd-Letter-on-Marijuana-Rescheduling-1.pdf
- **"What Schedule III Really Means for Medical Cannabis Patients"** -ASA Article: www.safeaccessnow.org/cannabis_rescheduling_progress_validation_and_risk
- **FDA Concludes that Existing Regulatory Frameworks for Foods and Supplements are Not Appropriate for Cannabidiol, Will Work with Congress on a New Way Forward:** https://www.fda.gov/news-events/press-announcements/fda-concludes-existing-regulatory-frameworks-foods-and-supplements-are-not-appropriate-cannabidiol
- **Letter from 39 state AGs to Congress** re: Hemp loophole: www.naag.org/wp-content/uploads/2025/10/NAAG_Hemp-letter-to-Congress-2025.10.24.pdf

WHO IS USING CANNABIS MEDICINE

WHO ARE MEDICAL CANNABIS PATIENTS

- **Medical Cannabis & Cancer:** Ton, M., Newcomb, P.A., Jones, S. et al. Cannabis use after a cancer diagnosis in a population-based sample of cancer survivors. Cancer Causes Control 35, 1033–1042 (2024). https://doi.org/10.1007/s10552-024-01860-w
- **Cancer:** https://seer.cancer.gov/statfacts/html/all.html
- **Older Adults & Cannabis:** www.aarp.org/health/drugs-supplements/rising-marijuana-use-in-older-adults
- **Older Adults population:** www.ncoa.org/article/get-the-facts-on-older-americans
- **Veterans & Cannabis:** The American Legion (2019)
- **Veterans population:** U.S. Census Bureau. (2023). Veteran Status
- **Pediatrics & Cannabis:** Colorado Department of Public Health and Environment (2019). Colorado Medical Marijuana Program Annual Report. California Department of Public Health (2020). Medical Cannabis Program Data Report
- **Cannabis & Pain:** Bicket MC, Stone EM, McGinty EE. Use of Cannabis and Other Pain Treatments Among Adults With Chronic Pain in US States With Medical Cannabis Programs. JAMA Netw Open. 2023;6(1):e2249797. doi:10.1001/jamanetworkopen.2022.49797
- **Pain Population:** Chronic Pain and High-impact Chronic Pain in U.S. Adults, 2023, www.cdc.gov/nchs/products/databriefs/db518.htm
- **Autism & Cannabis:** Lee, D., & Martin, F. (2020). Cannabis Derivatives in the Management of Autism Spectrum Disorders. Autism Research.
- **Autism Population:** Dietz PM, Rose CE, McArthur D, Maenner M. National and State Estimates of Adults with Autism Spectrum Disorder. J Autism Dev Disord. 2020 Dec;50(12):4258-4266. doi: 10.1007/s10803-020-04494-4. PMID: 32390121; PMCID: PMC9128411.

THE CASE FOR A NATIONAL MEDICAL CANNABIS PROGRAM

- **One-third of U.S. adults live with chronic pain:** Chronic Pain and High-impact Chronic Pain in U.S. Adults, 2023, www.cdc.gov/nchs/products/databriefs/db518.htm
- **129 million Americans have at Least One Chronic Disease:** Benavidez GA, Zahnd WE, Hung P, Eberth JM. Chronic Disease Prevalence in the US: Sociodemographic and Geographic Variations by Zip Code Tabulation Area. Prev Chronic Dis. 2024 Feb 29;21:E14. doi: 10.5888/pcd21.230267. PMID: 38426538; PMCID: PMC10944638.
- **Chronic Pain Double Risk of Suicide**: Mélanie Racine (2018) Chronic pain and suicide risk: A comprehensive review, Progress in Neuro-Psychopharmacology and Biological Psychiatry, Volume 87, Part B, 2018, Pages 269-280, https://doi.org/10.1016/j.pnpbp.2017.08.020.
- **½ of Americans 65+ Older take 5-20 Prescriptions Daily:** Medication Overload: https://lowninstitute.org/projects/medication-overload-how-the-drive-to-prescribe-is-harming-older-americans/
- **95% of the 7,000 known Rare Diseases have no FDA-approved Treatment:** National Organization on Rare Disorders (NORD), https://rarediseases.org/
- **$35 Billion Cost of Opioid Misuse & Related Healthcare Issues:** The High Price of the Opioid Crisis, 2021. Increasing access to treatment can reduce cost Pew Charitable Trust, www.pewtrusts.org/en/research-and-analysis/data-visualizations/2021/the-high-price-of-the-opioid-crisis-2021
- **30 million Americans live with A Rare Disease:** National Organization on Rare Disorders (NORD), https://rarediseases.org/
- **Over 50% of Americans 65+ have one or more rheumatic conditions:** www.niams.nih.gov/health-topics/arthritis-and-rheumatic-diseases
- **Chronic Pain Costs Americans $560-635 Billion Annually:** The High Price of the Opioid Crisis, 2021. Increasing access to treatment can reduce cost Pew Charitable Trust, www.pewtrusts.org/en/research-and-analysis/data-visualizations/2021/the-high-price-of-the-opioid-crisis-2021
- **⅓ Veterans have conditions related to Chronic pain: VA research on Pain Management,** www.research.va.gov/pubs/docs/va_factsheets/Pain.pdf
- **1 million Americans are living with MS:** www.nationalmssociety.org/about-the-society/who-we-are/research-we-fund/ms-prevalence
- **10% of Americans have intractable pain:** Chronic Pain and High-impact Chronic Pain in U.S. Adults, 2023, www.cdc.gov/nchs/products/databriefs/db518.htm
- **Chronic & Mental Health Conditions are Responsible for 90% of the $41 Trillion on U.S. Healthcare Spent Annually:** CDC Health and Economic Costs of Chronic Conditions, www.cdc.gov/chronic-disease/data-research/facts-stats/index.html
- **Uncontrollable Epilepsy Effects at Least 1 million people in the U.S.**: www.epilepsy.com/stories/latest-stats-about-epilepsy-cdc-who-has-epilepsy-and-seizure-control
- **Every Day 750 Americans 65+ are hospitalized due to serious side effects from medications**: Medication Overload: https://lowninstitute.org/projects/medication-overload-how-the-drive-to-prescribe-is-harming-older-americans/

MEDICAL CANNABIS & THE U.S. PAIN CRISIS

- **Chronic Pain and High-Impact Chronic Pain in U.S. Adults, 2023**, www.cdc.gov/nchs/products/databriefs/db518.htm
- **The High Price of the Opioid Crisis, 2021. Increasing access to treatment can reduce cost:** Pew Charitable Trust, www.pewtrusts.org/en/research-and-analysis/data-visualizations/2021/the-high-price-of-the-opioid-crisis-2021
- Lopez, Cesar D. BS; Boddapati, Venkat MD; Jobin, Charles M. MD; Hickernell, Thomas R. MD. **State Medical Cannabis Laws Associated With Reduction in Opioid Prescriptions** by Orthopaedic Surgeons in Medicare Part D Cohort. Journal of the American Academy of Orthopaedic Surgeons 29(4):p e188-e197, February 15, 2021. | DOI: 10.5435/JAAOS-D-19-00767
- **Pills to Pot:** Observational Analyses of Cannabis Substitution Among Medical Cannabis Users With Chronic PainKevin F. Boehnke, J. Ryan Scott, Evangelos Litinas, Suzanne Sisley, David A. Williams, Daniel J. Clauw; The Journal of Pain Volume 20 Issue 7 Pages 830-841 (July 2019)

- **CDC Health and Economic Costs of Chronic Conditions,** www.cdc.gov/chronic-disease/data-research/facts-stats/index.html
- Mélanie Racine (2018) **Chronic pain and suicide risk:** A comprehensive review, Progress in Neuro-Psychopharmacology and Biological Psychiatry, Volume 87, Part B, 2018, Pages 269-280, https://doi.org/10.1016/j.pnpbp.2017.08.020.
- Management Science Associates, **"Impact of Cannabis on Opioid Prescriptions in Chronic Pain: Insights from Recent Research in Utah,**" 2024. www.utah.gov/pmn/files/1194859.pdf.
- Nguyen T, Li Y, Greene D, Stancliff S, Quackenbush N. (2023). **Changes in Prescribed Opioid Dosages Among Patients Receiving Medical Cannabis for Chronic Pai**n, New York State, 2017-2019. JAMA Netw Open. 2023;6(1):e2254573.
- Management Science Associates, **"Impact of Cannabis on Opioid Prescriptions in Chronic Pain: Insights from Recent Research in Utah,"** 2024. www.utah.gov/pmn/files/1194859.pdf.
- Nguyen T, Li Y, Greene D, Stancliff S, Quackenbush N. (2023). **Changes in Prescribed Opioid Dosages Among Patients Receiving Medical Cannabis for Chronic Pain,** New York State, 2017-2019. JAMA Netw Open. 2023;6(1):e2254573.
- **68 million Americans are living with chronic pain:** Chronic Pain and High-impact Chronic Pain in U.S. Adults, 2023, www.cdc.gov/nchs/products/databriefs/db518.htm
- **80% of Americans live in a state with a medical cannabis program:** www.pewresearch.org/short-reads/2024/02/29/most-americans-now-live-in-a-legal-marijuana-state-and-most-have-at-least-one-dispensary-in-their-county/
- The National Academies of Medicine found conclusive evidence that cannabis treats pain: National Academies of Sciences, Engineering, and Medicine. (2017). **The health effects of cannabis and cannabinoids.** https://nap.nationalacademies.org
- U.S. Department of Health and Human Services. (2023). **Basis for recommendation to reschedule marijuana.** www.hhs.gov/sites/default/files/marijuana-scheduling-recommendation.pdf
- **Only 2% of Americans are utilizing medical cannabis programs:** U.S. Department of Health and Human Services (2023). Basis for recommendation to reschedule marijuana. https://www.hhs.gov/sites/default/files/marijuana-scheduling-recommendation.pdf

VETERANS, ACTIVE MILITARY, & CANNABIS

- Ilgen MA, Bohnert ASB, Ganoczy D, Bair MJ, McCarthy JF, Blow FC. **Opioid dose and risk of suicide. Pain.** 2016 May;157(5):1079-1084. doi: 10.1097/j.pain.0000000000000484. PMID: 26761386; PMCID: PMC4939394.
- www.hsrd.research.va.gov/for_researchers/cyber_seminars/archives/2351-notes.pdf
- www.mentalhealth.va.gov/docs/data-sheets/2024/2024-Annual-Report-Part-2-of-2_508.pdf
- **Veterans Administration:** www.research.va.gov/topics/pain.cfm
- Lynskey, M. T., Thurgur, H., Athanasiou-Fragkouli, A., Schlag, A. K., & Nutt, D. J. (2024). **Suicidal Ideation in Medicinal Cannabis Patients: A 12-Month Prospective Study. Archives of Suicide Research,** 1–15. doi.org/10.1080/13811118.2024.2356615

AGING POPULATIONS & CANNABIS MEDICINES

- Yang, K.H., Kaufmann, C.N., Nafsu, R., Lifset, E.T., Nguyen, K., Sexton, M., Han, B.H., Kim, A. and Moore, A.A. (2021), **Cannabis: An Emerging Treatment for Common Symptoms in Older Adults.** J Am Geriatr Soc, 69: 91-97. https://doi.org/10.1111/jgs.16833
- **Marijuana Use Among Older Adults Climbs to New High** www.aarp.org/health/drugs-supplements/rising-marijuana-use-in-older-adults
- **Older Adults population**: www.ncoa.org/article/get-the-facts-on-older-americans
- Els C, Jackson TD, Kunyk D, Lappi VG, Sonnenberg B, Hagtvedt R, Sharma S, Kolahdooz F, Straube S. **Adverse events associated with medium- and long-term use of opioids for chronic non-cancer pain**: an overview of Cochrane Reviews. Cochrane Database Syst Rev. 2017 Oct 30;10(10):CD012509.

- Abuhasira R, Schleider LB, Mechoulam R, Novack V. **Epidemiological characteristics, safety and efficacy of medical cannabis in the elderly.** Eur J Intern Med. 2018 Mar;49:44-50. doi: 10.1016/j.ejim.2018.01.019. PMID: 29398248.
- Greis A, Larsen E, Liu C, Renslo B, Radakrishnan A, Wilson-Poe AR. **Perceived Efficacy, Reduced Prescription Drug Use, and Minimal Side Effects of Cannabis in Patients with Chronic Orthopedic Pain. Cannabis Cannabinoid** Res. 2022 Dec;7(6):865-875. doi: 10.1089/can.2021.0088. Epub 2021 Nov 12. PMID: 34767730;
- **National Survey on Drug Use and Health, between 2009-2019**

COMPASSIONATE USE: RARE DISEASES & PEDIATRIC DISORDERS

- **National Organization on Rare Disorders (NORD),** https://rarediseases.org/
- Arkell TR, Downey LA, Hayley AC, Roth S. **Assessment of Medical Cannabis and Health-Related Quality of Life**. JAMA Netw Open. 2023;6(5):e2312522. doi:10.1001/jamanetworkopen.2023.12522
- Aran A, Harel M, Cassuto H, Polyansky L, Schnapp A, Wattad N, Shmueli D, Golan D, Castellanos FX. **Cannabinoid treatment for autism: a proof-of-concept** randomized trial. Mol Autism. 2021 Feb 3;12(1):6. doi: 10.1186/s13229-021-00420-2. PMID: 33536055;
- Hacohen M, Stolar OE, Berkovitch M, Elkana O, Kohn E, Hazan A, Heyman E, Sobol Y, Waissengreen D, Gal E, Dinstein I. **Children and adolescents with ASD treated with CBD-rich cannabis exhibit significant improvements, particularly in social symptoms: an open-**label study. Transl Psychiatry. 2022 Sep 9;12(1):375. doi: 10.1038/s41398-022-02104-8. PMID: 36085294
- Colorado Department of Public Health and Environment (2019). **Colorado Medical Marijuana Program Annual Report.** California Department of Public Health (2020). Medical Cannabis Program Data Report

RHEUMATIC & CHRONIC CONDITIONS & MEDICAL CANNABIS

- CDC Health and Economic Costs of Chronic Conditions, www.cdc.gov/chronic-disease/data-research/facts-stats/index.html
- Benavidez GA, Zahnd WE, Hung P, Eberth JM. **Chronic Disease Prevalence in the US:** Sociodemographic and Geographic Variations by Zip Code Tabulation Area. Prev Chronic Dis. 2024 Feb 29;21:E14. doi: 10.5888/pcd21.230267. PMID: 38426538; PMCID: PMC10944638.
- National Institute of Arthritis and Musculoskeletal and Skin Diseases, **Arthritis and Rheumatic Diseases** www.niams.nih.gov/health-topics/arthritis-and-rheumatic-diseases
- Vecchio D, Varrasi C, Virgilio E, Spagarino A, Naldi P, Cantello R. **Cannabinoids in multiple sclerosis:** A neurophysiological analysis. Acta Neurol Scand. 2020 Oct;142(4):333-338. doi: 10.1111/ane.13313. Epub 2020 Jul 21. PMID: 32632918.
- Boehnke, K.F., Scott, J.R., Martel, M.O., Smith, T., Bergmans, R.S., Kruger, D.J., Williams, D.A. and Fitzcharles, M.-A. (2024), **Substituting Medical Cannabis for Medications Among Patients with Rheumatic Conditions in the United States and Canada.** ACR Open Rheumatology.
- Chaves C, Bittencourt PCT, Pelegrini A. **Ingestion of a THC-Rich Cannabis Oil in People with Fibromyalgia:** A Randomized, Double-Blind, Placebo-Controlled Clinical Trial. Pain Med. 2020 Oct 1;21(10):2212-2218. doi: 10.1093/pm/pnaa303. PMID: 33118602; PMCID: PMC7593796.
- Aychman MM, Goldman DL, Kaplan JS. **Cannabidiol's neuroprotective properties and potential treatment of traumatic brain injuries.** Front Neurol. 2023 Feb 2;14:1087011. doi: 10.3389/fneur.2023.1087011. PMID: 36816569; PMCID: PMC9932048
- **1 million Americans are living with MS:** www.nationalmssociety.org/about-the-society/who-we-are/research-we-fund/ms-prevalence
- Patel AD. **Cannabinoids in Neurologic Illnesses.** Neurol Clin. 2021 Feb;39(1):231-241. doi: 10.1016/j.ncl.2020.09.012. Epub 2020 Nov 7. PMID: 33223086.
- 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"

THE ROLE OF STATES IN PROTECTING PATIENT ACCESS

- **Cannabis laws state-by-state:** www.safeaccessnow.org/states
- **WHAT'S IN YOUR CANNABIS?** A Patient & Consumer Guide to Navigating Cannabis Safety www.SafeAccessNow.org/navigating_cannabis_safety
- **Medical Equity Checklist:** Strategies to Address and Protect Patient Needs in Recreational Market www.safeaccessnow.org/medicalequity
- **Americans for Safe Access Model State Legislation:** www.safeaccessnow.org/model_state_legislation
- **Patient Focused Certification Product Safety Protocols:** www.safeaccessnow.org/pfcstandards

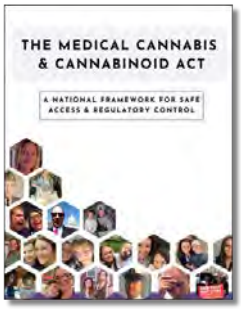
TRANSITIONING TO A NATIONAL PROGRAM: THE MEDICAL CANNABIS & CANNABINOID ACT

- **"Legal Consequences of Rescheduling Marijuana," CRS Report: January 16th, 2024 (updated May 1, 2024)** www.congress.gov/crs-product/LSB11105
- Ahn K. **The worldwide trend of using botanical drugs and strategies for developing global drugs.** BMB Rep. 2017 Mar;50(3):111-116. doi: 10.5483/bmbrep.2017.50.3.221. PMID: 27998396; PMCID: PMC5422022.
- International Narcotics Control Board (2022). **Report of the International Narcotics Control Board for 2022,** https://unis.unvienna.org/unis/uploads/documents/2023-INCB/INCB_annual_report-English.pdf
- FDA, **Botanical Drug Development: Guidance for Industry** www.fda.gov/regulatory-information/search-fda-guidance-documents/botanical-drug-development-guidance-industry
- FDA, **Cannabis and Cannabis-Derived Compounds: Quality Considerations for Clinical Research Guidance for Industry (2023)** www.fda.gov/regulatory-information/search-fda-guidance-documents/cannabis-and-cannabis-derived-compounds-quality-considerations-clinical-research-guidance-industry
- World Health Organization. **"Extract from the Report of the 41st ECDD: Cannabis and Cannabis-Related Substances**." www.who.int/publications/m/item/ecdd-41-cannabis-recommendations
- World Health Organization (2020, December 4). **"UN Commission on Narcotic Drugs Reclassifies Cannabis to Recognize Its Therapeutic Uses,"** www.who.int/news/item/04-12-2020-un-commission-on-narcotic-drugs-reclassifies-cannabis-to-recognize-its-therapeutic-uses
- **"HHS Recommendation to Reschedule Marijuana: Implications for Federal Policy"** *September 13, 2023, CRS Report www.congress.gov/crs-product/IN12240*
- HHS: "**Basis for the Recommendation to Reschedule Marijuana into Schedule III of the Controlled Substances Act"** www.dea.gov/sites/default/files/2024-05/2016-17954-HHS.pdf
- OLC memo: "**Questions Related to the Potential Rescheduling of Marijuana",** www.justice.gov/olc/media/1352141/dl?inline
- DEA, DOJ: "**Notice of proposed rulemaking: Schedules of Controlled Substances: Rescheduling of Marijuana"** May 21, 2024, www.federalregister.gov/documents/2024/05/21/2024-11137/schedules-of-controlled-substances-rescheduling-of-marijuana

LABORATORIES OF DEMOCRACY

- **ASA's State of the States Reports:** www.safeaccessnow.org/sos22
- **Laboratories of Democracy Report Teaser:** www.SafeAccessNow.org/lod_report_teaser

ADDITIONAL RESOURCES

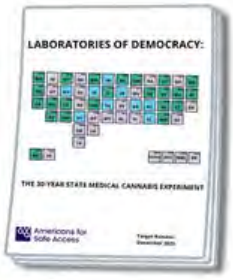


THE FULL TEXT OF THE MEDICAL CANNABIS & CANNABINOID ACT
ASA's Model Federal Legislation
www.SafeAccess4All.org

MEDICAL CANNABIS EQUITY CHECKLIST
Strategies to Address and Protect Patient Needs in Recreational Market
www.SafeAccessNow.org/MedicalEquity

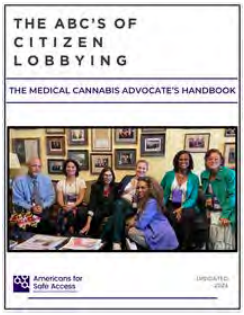
PROTECTING PATIENT ACCESS
Share this report with medical cannabis shareholders
www.safeaccessnow.org/protect_patient_access

Learn more about issues facing medical cannabis in the United States
www.SafeAccessNow.org/patient_bingo



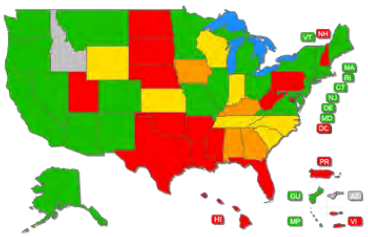
Learn more about ASA's Laboratories of Democracy 2026 Report
www.SafeAccessNow.org/lod_report_teaser

ASA's December 2025 Policy Memo for Congress
www.SafeAccessNow.org/December_2025_Memo

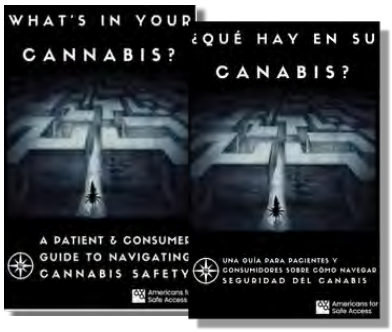


Learn how to use your voice to protect patient access
www.SafeAccessNow.org/Citizen_Lobbying

FREE PATIENT GUIDE TO TRAVEL IN THE U.S.
www.SafeAccessNow.org/Travel



STATE BY STATE RESOURCES FOR PATIENTS, CAREGIVERS, ADVOCATES & MEDICAL PROFESSIONALS
www.SafeAccessNow.org/States



FREE PATIENT GUIDE TO NAVIGATING CANNABIS SAFETY
WhatsInYourCannabis.org

GET UPDATES & ALERTS!
SafeAccessNow.org/email-updates

SUSTAIN ASA'S WORK, BECOME AN ASA MEMBER!
SafeAccessNow.org/membership

Americans for Safe Access

Founded in 2002, Americans for Safe Access (ASA) is the largest national organization of patients, medical professionals, scientists, providers, and concerned citizens promoting safe and legal access to cannabis for therapeutic use and research.

SafeAccessNow.org