DAVID Y. IGE
GOVERNOR

JOSH GREEN
LT. GOVERNOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
335 MERCHANT STREET, ROOM 310
P.O. BOX 541
HONOLULU, HAWAII 96809
Phone Number: 586-2850
Fax Number: 586-2856
cca.hawaii.gov

CATHERINE P. AWAKUNI COLÓN
DIRECTOR

JO ANN M. UCHIDA TAKEUCHI
DEPUTY DIRECTOR

Testimony of the Department of Commerce and Consumer Affairs

Before the
House Committee on Judiciary
Friday, March 22, 2019
2:10 p.m.
State Capitol, Conference Room 325

On the following measure:
H.R. 86, REQUESTING THE UNITED STATES CONGRESS TO ENACT LEGISLATION REMOVING CANNABIS FROM THE FEDERAL CONTROLLED SUBSTANCES ACT AND FACILITATE THE FULL SPECTRUM OF PRIVATE BANKING SERVICES FOR CANABIS-RELATED BUSINESS

Chair Lee and Members of the Committee,

My name is Iris Ikeda, and I am the Commissioner of Financial Institutions for the Department of Commerce and Consumer Affairs' (Department) Division of Financial Institutions (DFI). The Department offers comments on this resolution.

This resolution requests the United States Congress to enact legislation that will remove cannabis from the federal Controlled Substances Act and facilitate the full spectrum of private banking services for cannabis-related business.

The DFI is responsible for ensuring the safety and soundness of state-chartered banks and state-chartered credit unions. The DFI also regulates money transmitters, which have been providing services to cannabis businesses in the absence of traditional financial institutions so doing.

The well-documented conflict between federal and state law on allowing private banks to serve cannabis-related businesses has created barriers for banks desiring to serve businesses involved in state-licensed cannabis activities. This has resulted in regulatory and legal risk at the insured depository level, de-risking in the financial sector to mitigate risks, and the rise of a “cash and carry” industry.

The lack of clarity on how banks can serve the cannabis industry, without the threat of forfeiture of assets or criminal penalties, has led to an increase in cannabis cash transactions. Barriers for financial institutions to serve cannabis and ancillary businesses create a commercial condition devoid of robust regulation and supervision; these barriers also diminish the ability to identify operators who are circumventing federal and state licensing and regulatory frameworks. This raises public safety concerns, increases difficulty in tracking the flow of funds, and contributes to a loss of opportunities for economic activity, workforce development, and community development.

The limited number of U.S. financial institutions serving this industry previously relied on the Department of Justice’s “Cole Memo,” which was rescinded in January 2018. Currently, financial institutions rely on guidance from the Financial Crimes Enforcement Network (FinCEN) relating to Bank Secrecy Act and Anti-Money Laundering Act requirements.

While Congress has taken some action, such as the Rohrbacher amendment prohibiting the use of federal funds to interfere with state medicinal marijuana programs, this is a stopgap approach that requires a permanent resolution. Banking services availability under the SAFE Banking Act, H.R. 1595 has bipartisan support and is agnostic about other issues pertaining to cannabis. The DFI supports legislation that creates a safe harbor for financial institutions to serve a state-compliant business or that entrusts sovereign states with full oversight over and jurisdiction of cannabis-related activity.

Thank you for the opportunity to testify on this bill.

HR-86
Submitted on: 3/20/2019 2:35:12 PM
Testimony for JUD on 3/22/2019 2:10:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Ken Stover	Individual	Support	No

Comments:

HR-86
Submitted on: 3/20/2019 8:40:26 PM
Testimony for JUD on 3/22/2019 2:10:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Patrick Harley Simmons	Individual	Support	No

Comments:

HR-86
Submitted on: 3/21/2019 8:19:46 AM
Testimony for JUD on 3/22/2019 2:10:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Georgina Mckinley	Individual	Support	No

Comments:

I support HR86 ...

TO: House of Representatives, Committee on Judiciary
FROM: Wendy Gibson R.N.
RE: HCR 89 / HR 86 (IN Support)
Hearing March 22 2019 Conference Room #325, 2:10 PM

Dear Chair Lee, Vice Chair San Buenaventura and Committee Members,

I am Wendy Gibson, an R.N, a Cannabis Nurse Educator and member of the American Cannabis Nurses Association. I have worked in health care in the United States for over 34 years, 24 of those in Hawaii (10 of those in pharmacy work).

I strongly support HR86/HCR89. I believe that the botanical medicine, cannabis needs to be **REMOVED** from the Controlled Substance Act entirely. It never belonged in a Schedule I category and still **does not meet <u>any of the criteria listed below</u>**.

In whole plant form, with hundreds of therapeutic chemicals, cannabis cannot meet the FDA's criteria to become an "accepted" medicine. So, whole plant botanical medicine can never be "prescribed". **Nearly every State in the USA** recognizes some type of medicinal use of cannabis. Hawaii and 32 other USA States have medicinal cannabis programs, with another 14 States recognizing the medicinal use of CBD (one of the major components of cannabis). The Federal Government IND program provides medicinal cannabis to patients and has done so since 1978.

These are some of the reasons why I believe cannabis does not meet any of the criteria for the Schedule I category and should be removed:

1. The potential for ABUSE is low, not high
2. It does have "Accepted" medical use in 33 US States and 30 Countries
3. It has been used safely under medical supervision for thousands of years.

1. Potential for **Abuse**—Although cannabis is used very widely globally, it does not have a "high" potential for abuse. Most people who use cannabis do so responsibly, without problems. Rates of cannabis abuse have been greatly exaggerated: the numbers derived from court-mandated treatment (to avoid jail time) or the result of using the DSM-5 manual (a poor tool for measurement of use of an illegal substance). One addiction specialist, Dr. Carl Hart explains that the numbers are much lower than the often-cited "9%", perhaps more like 2.6 percent (and possibly up to 11.5% in those who start using before the age of 14).
http://www.huffingtonpost.com/sunil-kumar-aggarwal/cannabis-depedency-drug-war-bad-science_b_4675961.html

2. **Medical usefulness has been accepted** in the United States--multiple times:
    a. **Between 1850 and 1939** when hundreds of cannabis-based medications were sold in pharmacies and was described in the United States Pharmacopoeia (USP).

b. **From 1978 to the Present** with the Federal Government's **Investigational New Drug program**—of which there are 4 surviving patients who have benefitted from the medicinal properties of cannabis for many years. Monthly, they receive their allotted 300 rolled marijuana cigarettes that the Federal government supplies. [See: http://www.medicalcannabis.com/patients-care-givers/federal-ind-patients/]
c. **In 2017** The National Academy of Sciences, Engineering, and Medicine released a comprehensive report, a review of over 10,000 scientific abstracts, showing conclusive or substantial evidence exists for the **efficacy of whole-plant cannabis** and its derivatives in patients suffering from chronic pain, multiple sclerosis, and other disorders. The report questions the Schedule I status.
d. **In 2019** the **number of US States** that recognize some medicinal usefulness is 49 out of 50. There are medical cannabis programs in 33 States, plus the District of Columbia, Guam and Puerto Rico. 15 additional States recognize the medicinal properties of CBD. The States have removed cannabis from the Schedule I drug category in a de facto fashion. Also, **In 2019** the **number of Countries** with medical cannabis acceptance is more than 30 [https://en.wikipedia.org/wiki/Legality_of_cannabis]

3. A lack of accepted safety for use under medical supervision

e. Millions of patients are currently using cannabis under medical supervision—globally, without incident. We have dosing guidelines for THC and CBD.
f. Prescription drugs with CBD and THC are available in at least in 30 countries **(**Sativex in 28, Marinol, Syndros and Epidiolex in the U.S.)
g. Protocols for use of whole plant medicines, under medical supervision have been developed
h. Whole plant medicine has a better safety profile that over-the-counter or prescription drugs, with a fairly predictable list of side effects that does not include death and no true "Lethal dose".
i. With over 28,000 scientific studies we do know that most of the side effects are **predictable, manageable and tend to dissipate** over time (as the patient develops tolerance).
j. Side effects are **well within the range that is deemed acceptable** for most prescription drugs.
k. Tens of thousands of health care professionals support the removal of cannabis from the Schedule I drug status to remove barriers to research
[See: American Academy of Neurology statement at https://www.aan.com/policy-and-guidelines/policy/position-statements/medical-marijuana/ and

Organizations Supporting Access to Therapeutic Cannabis
http://www.medicalcannabis.com/about/health-care-professionals/supporting-organizations/]

RE: Safety--It has been established by multiple Government Commissioned Studies such as the La Guardia Committee Report (1944), the Shafer Commission report (1972). I would like to remind you of **DEA Judge** Francis L. Young's findings in 1988: In medical treatment "safety" is a relative term. A drug deemed "safe" for use in treating a life-threatening disease might be "unsafe" if prescribed for a patient with a minor ailment. The determination of "safety" is made in terms of whether a drug's benefits outweigh its potential risks and the risks of permitting the disease to progress. Marijuana, **in its natural form**, is **one of the safest therapeutically** active substances known to man. By any measure of rational analysis marijuana can be safely used within a supervised routine of medical care. The Act, at 21 U.S.C. § 812(b)(1)(C), requires that marijuana be retained in Schedule I **IF" there is a lack of accepted safety for use --under medical supervision**." If there is no lack of such safety, if it is accepted that this substance can be used with safety under medical supervision, then it is **unreasonable to keep it in Schedule I**. He also stated that "It would be unreasonable, **arbitrary and capricious** for DEA to continue to stand between those sufferers and the benefits of this substance in light of the evidence in this record."
[http://medicalcannabisreport.com/wpcontent/uploads/2015/05/FLYoungDEARuling1988.pdf]

I agree with the 2018 ECDD recommendation that preparations considered to be **pure cannabidiol should not be scheduled within the International Drug Control Conventions**. Their report says that cannabidiol is found in cannabis and cannabis resin does not have psychoactive properties and has no potential for abuse and no potential to produce dependence. It does not have significant ill-effects. Cannabidiol has been shown to be effective in the management of certain treatment-resistant, childhood-onset epilepsy disorders . . .
[See: https://www.govinfo.gov/content/pkg/FR-2019-03-01/pdf/2019-03662.pdf]

The medical community, patients and problematic drug users have suffered as a result of more than 80 years of cannabis prohibition. Research has been grossly stunted and slanted [See: Pharmacy and Therapeutics. 2017 Mar; 42(3): 180–188. Medicinal Cannabis: History, Pharmacology, And Implications for the Acute Care Setting https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5312634/]

Millions of patients have had to fight for decades to gain access to a comparatively safe medicine, which in many cases is the ONLY medication that works for them and helps them get off of other, more harmful and addictive substances such as opiates and benzodiazepines. Public health has suffered: youth seek more dangerous alternatives to getting high such as synthetic drugs which can be deadly; those who need help with substance use disorders do not seek medical help or end up in

jail/prison where they do not get therapies; patient's do not disclose their cannabis use and may experience drug-drug-interactions; we have an opioid overdose crisis which could be lessened if medical cannabis was an accepted and available option. **Because of Prohibition, Banking has been severely restricted.** Legal cannabis transactions are restricted to cash only transactions and that has been problematic for our dispensary licensees. HCR89 / HR86 will address this.

The biggest tragedy in my mind is that prohibition has led to widespread fear and ignorance in the medical community. **Most health care professionals are unaware** of the endocannabinoid system (ECS), our bodies own THC factory and the master controlling system of our neurologic and immune systems. Most health care professionals are unaware of **the existence and importance of the ECS**, the largest neurotransmitter system in the human body—that responds to cannabinoids.

Please keep in mind that the **placement of cannabis into the schedule I drug** category **was never based upon anything scientific** and was supposed to be temporary (until more science came in). In 1970, President Richard M. Nixon's wish was to disrupt Vietnam war protestors and black communities by placing cannabis and heroin into the Schedule I drug category. He got his wish.

The results of this War on Drugs has been a violent racist-fuelled disaster, deemed to be a FAILED WAR by the **Global Commission on Drug Policy in 2011**. Their report argues that the decades-old "global war on drugs has failed, with devastating consequences for individuals and societies around the world. Instead of punishing users who the report says "do no harm to others," the commission argues that governments should **end criminalization of drug use,** experiment with legal models that would undermine organized crime syndicates and **offer health and treatment services for drug-users in need**.
[https://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Commission_Report_English.pdf]

In Summary: The Scheduling of any "drug" needs to be **based upon the science** of the safety and effectiveness of the drug, not based upon law enforcement's views. Cannabis medicines contain multiple ingredients and cannot meet the FDA's requirements to be "accepted" medicine. It has been approved by most USA States as a medicine and States retain the rights to govern the practice of Medicine. Cannabis does not belong in the Controlled Substance Act. Please remove it.

Thank you for this opportunity to testify.
Wendy Gibson RN/BSN American Cannabis Nurses Association Member
(808) 321-4503

HR-86
Submitted on: 3/20/2019 11:58:26 PM
Testimony for JUD on 3/22/2019 2:10:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Gerard Silva	Individual	Oppose	No

Comments:

This is a Drug that has killed many people that I know in the last 30 years. This should NEVER BE CHANGED to become Legal . The only Reason the DEMOCRAPS want this ledal is to keep the population Dum and Stupied . But the Hawaii people are get Wize to what they are trying to do beware of the Back lash!!