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**WRITTEN TESTIMONY ONLY**

**Testimony COMMENTING on SB2408-SD1**
**RELATING TO COMPASSIONATE ACCESS TO MEDICAL CANNABIS**

SENATOR KARL RHOADS, CHAIR
SENATE COMMITTEE ON JUDICIARY

Hearing Date and Time: 2-27-2026, 10:30AM Room Number: 016

**Fiscal Implications:** Undetermined.

**Department Position:** The Department of Health ("Department") appreciates the intent of this this measure and thanks the previous committee for accepting the Department's offered amendment.

**Department Testimony:** The Office of Medical Cannabis Control and Regulation (OMCCR) provides the following testimony on behalf of the Department. The OMCCR supports the intent of this measure to improve access for terminally ill medical cannabis patients and appreciates the committee's consideration of the Department's prior concerns. We believe the amendments adopted by the previous committee appropriately address potential conflicts with federal law, accreditation requirements, and facility policies while still preserving patient access in a safe and responsible manner.

The Department remains committed to working collaboratively with the Legislature and stakeholders to ensure that terminally ill patients and qualifying older adults can access medical cannabis in a manner that is consistent with state law and compatible with the operational requirements of health care facilities.

**Offered Amendments:** None.

Thank you for the opportunity to testify on this measure.

HAWAII SUBSTANCE ABUSE COALITION

**SB2408 SD1 Cannabis Use for Elderly in Healthcare Facilities**

COMMITTEE ON JUDICIARY
Sen. Karl Rhoads, Chair
Sen. Mike Gabbarrd, Vice Chair
Friday, Feb 27, 2026: 10:30: Room 016 Videoconference

## Hawaii Substance Abuse Coalition Proposes Amendment SB2408 SD1 or else Opposes:

*ALOHA CHAIR, VICE CHAIR, AND DISTINGUISHED COMMITTEE MEMBERS. My name is Alan Johnson. I am the ad hoc leader of the Hawaii Substance Abuse Coalition (HSAC), a statewide organization for substance use disorder and co-occurring mental health disorder prevention and treatment agencies and recovery-oriented services.*

Allowing medical cannabis into a substance abuse residential treatment facility is a serious policy decision, and it is reasonable to oppose it when cannabis is itself a drug of abuse for many patients.

HSAC respectfully requests an amendment to ensure clarity:

§-2 Definitions Section 3 (C.) line 14 (page 4),

"Health care facility" does not include a chemical dependency recovery hospital, a chemical dependency residential treatment center, a state hospital, or an emergency department of a general acute care hospital while the patient is receiving emergency services and care.

# Here's Why

The bill wisely excludes a "chemical dependency recovery hospital." **That should include also a Residential treatment center because such centers are treating addictions that include cannabis use. Most patients have a secondary problem with cannabis while a few patients even have a primary diagnosis of cannabis use disorder. The use of**

# cannabis would be a trigger for relapse in almost every patient.

**Cannabis Use Disorder**
For many clients entering treatment today, **cannabis use is most common**. Cannabis use disorder is either:

- the primary drug of abuse, or a major relapse trigger tied to polysubstance use.
- Permitting cannabis in treatment settings sends a conflicting message: that one intoxicating substance is acceptable while others are not.

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**Treatment Requires Clear Boundaries and Consistency**.
Introducing medical cannabis undermines Structure, accountability by creating ambiguity about sobriety and recovery.

- Clients may reasonably ask: “Why is cannabis allowed but alcohol is not?” “How is this different from my past drug use?” “Does recovery still mean abstinence?”

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**High Risk of Diversion and Misuse**
Residential treatment facilities already face challenges managing contraband and medication misuse. Allowing cannabis creates additional risks:

- diversion to other clients
- trading or selling among residents
- difficulty verifying dosage and form
- inconsistent regulation compared to FDA-approved medications
- Unlike tightly controlled prescriptions, cannabis products vary widely in potency and psychoactive effect.

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**Cannabis Use Can Impair Recovery Progress**
Cannabis use is associated with:

- impaired motivation and cognition, increased anxiety or mood instability
- relapse into other substances

Clients in early recovery need full mental clarity to participate meaningfully in treatment. Introducing THC into the environment may delay or disrupt that process.

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**Federal and Licensing Conflicts Remain**
Many residential treatment facilities rely on federal funding, Medicaid reimbursement, SAMHSA standards, accreditation requirements, Cannabis remains a Schedule I substance under federal law. Allowing it in facilities could jeopardize funding.

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**Recovery Spaces Must Be Safe for All Clients to be free of triggers**
Residential treatment is a shared environment with group activities.

- Allowing cannabis use affects not only the individual patient but everyone around them, including those who are: recovering from cannabis addiction, vulnerable to relapse, or triggered by exposure to drug-related behavior or odor

Treatment facilities must prioritize the collective recovery atmosphere over individual substance access.

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**Appropriate Alternatives Already Exist**
If a patient has legitimate medical needs, there are FDA-approved, non-intoxicating alternatives that can be safely managed in treatment, including:

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**Closing Statement**
In closing, residential substance abuse treatment facilities must remain environments of sobriety, clarity, and consistency. Allowing cannabis—especially when it is a significant drug of abuse—creates contradictions, increases relapse risk, complicates treatment goals, and threatens the integrity of recovery programs.

We appreciate the opportunity to testify and are available for questions**.**

HICIA
Hawai'i Cannabis Industry Association

To: Senator Karl Rhoads, Chair
Senator Mike Gabbard, Vice-Chair
Members of the Committee on Judiciary

Fr: TY Cheng on behalf of Hawaii Cannabis Industry Association

Re: Testimony **In Support on Senate Bill (SB) 2408 SD1**
RELATING TO COMPASSIONATE ACCESS TO MEDICAL CANNABIS.
Allows terminally ill patients and qualifying patients over sixty-five years of age with chronic diseases to use medical cannabis within specified health care facilities under certain conditions. Requires enforcement by the Department of Health. (SD1)

Dear Chair Rhoads, Vice Chair, and Members of the Committee,

My name is TY Cheng, Chairman of the Hawai'i Cannabis Industry Association. I am here today in **support with comments** on SB2408 SD1.

This bill is fundamentally about compassion, access, and legal clarity—especially for terminally ill patients and seniors with chronic conditions. For these patients, medical cannabis is not experimental or recreational. It is a physician-recommended treatment used to manage pain, nausea, appetite loss, anxiety, and other serious symptoms when conventional medications have failed or produced intolerable side effects.

At the federal level, cannabis is currently undergoing rescheduling to Schedule III under the Controlled Substances Act—where medications such as Tylenol with codeine are classified. This proposed reclassification reflects increasing recognition of accepted medical use and an established safety profile under physician supervision.

Yet here in Hawai'i, our most vulnerable patients still face administrative delays before they can legally access their medicine especially in some health care facilities. Even after physician certification, patients may wait two to seven days to receive their 329 registration from the Department of Health before being able to purchase medical cannabis and still be barred from using their medicine in a health care facility.

For a terminally ill patient, days matter. Comfort matters. Dignity matters. SB2408 SD1 moves Hawai'i closer to patient-centered healthcare.

I respectfully urge the Committee to pass SB2408 SD1. Mahalo for your time and consideration.

**February 27, 2026 at 10:30 am**
**Conference Room 016**

**Senate Committee on Judiciary**

To: Chair Karl Rhoads
Vice Chair Mike Gabbard

From: Paige Heckathorn Choy
Vice President, Government Affairs
Healthcare Association of Hawaii

**Re: Submitting Comments**
**SB 2048 SD 1, Relating to Compassionate Access to Medical Cannabis**

The Healthcare Association of Hawaii (HAH), established in 1939, serves as the leading voice of healthcare on behalf of 170 member organizations who represent almost every aspect of the health care continuum in Hawaii. Members include acute care hospitals, skilled nursing facilities, home health agencies, hospices, assisted living facilities and durable medical equipment suppliers. In addition to providing access to appropriate, affordable, high-quality care to all of Hawaii's residents, our members contribute significantly to Hawaii's economy by employing over 30,000 people statewide.

Thank you for the opportunity to **submit comments** on this measure, which would allow—but not require—healthcare organizations to permit the use of an individual's cannabis while admitted for care. We understand that the bill has been amended to clarify that inpatient facilities may, but are not required to, allow the use of medical cannabis by patients. We appreciate that the measure is now permissive in nature and would respectfully oppose any future amendments that would make such allowance mandatory.

Decisions about what substances may be permitted in an inpatient environment must be consistent with federal law and clinical standards. Hospitals, skilled nursing facilities, and hospices that participate in Medicare are required to comply with all applicable federal laws and rules as enforced by the Centers for Medicare and Medicaid Services. Cannabis remains classified as a Schedule I substance under the federal Controlled Substances Act. There is no federal exception that authorizes hospitals or other inpatient providers to prescribe, dispense, store, or administer cannabis, even where state law permits its use in other settings. Facilities must carefully consider the potential risk to their federal certification, reimbursement, and licensure when evaluating whether to allow cannabis use within their walls.

While the bill attempts to create safeguards, practical and regulatory challenges persist. For example, if a patient or caregiver is unable to properly manage or remove a cannabis product,

the facility could be placed in a position of possessing or controlling a federally prohibited substance. In addition, CMS enforcement is retrospective as well as prospective. The ability to suspend or revoke permission after the fact does not eliminate exposure for conduct that occurred during a survey period.

There are also important clinical considerations. Inpatient care is structured around standardized, verified, and actively managed medications. Cannabis products vary widely in potency, formulation, and route of administration. They are not FDA-approved, and there is limited ability to ensure consistency in dosing or to fully assess interactions with other medications being administered during an acute hospitalization. This complicates medication reconciliation, safety monitoring, and coordinated care planning, particularly for medically complex patients.

We respect the intent of providing comfort and dignity to patients. However, decisions about whether to permit cannabis use in an inpatient facility must remain voluntary and grounded in each organization's assessment of regulatory risk, patient safety, and operational feasibility. We would welcome continued dialogue with policymakers to ensure that any approach appropriately balances compassion for patients with the legal and clinical realities faced by licensed facilities.

Thank you for the opportunity to provide our comments on this important matter.

**SB 2408 SD 1**
**Relating to Compassionate Access to Medical Cannabis**
**Oppose Unless Amended**

February 26, 2026

Aloha Chair Rhoads, Vice Chair Gabbard, and honorable members of the Senate Judiciary Committee:

The Hawai'i Alliance for Cannabis Reform strongly supports allowing patients to use medical cannabis preparations in health care facilities. However, we oppose SB 2408 SD 1, and urge you to amend it to expand — instead of restrict — medical cannabis access for people with devastating illnesses.

As amended, SB 2408 SD 1 does not require health facilities to accommodate medical cannabis for terminally ill patients and patients who are 65 and older, as the introduced version of the bill did. Instead, it provides health facilities "may" do so. Meanwhile, it adds burdens and restrictions that facilities *must* abide by should they choose to allow medical cannabis preparations for those patients. SB 2408 SD 1 requires facilities that choose to allow medical cannabis for terminally ill patients to create and disseminate new written guidelines and to document medical cannabis in their medical records. In practice, some facilities are more comfortable simply looking the other way, given cannabis's illegality under federal law. Required documentation could increase their perceived risk.

SB 2408 SD 1 (and SB 2408 as introduced) also forces nursing homes and other health care facilities to ban conduct they can now allow. For example, it provides, "a general acute care hospital *shall not allow* a patient with a chronic disease to use medical cannabis unless the patient is terminally ill." (emphasis added) We understand that some patients with serious but non-terminal conditions who need cannabis to manage their devastating symptoms have been allowed to use medical cannabis in Hawai'i hospitals. This would put a stop to that.

**No health care facility should be prohibited from allowing patients relief. And a bill that is intended to expand access should not have the opposite result.**

Our strong preference is restoring the mandatory nature of the bill, and revising the language to allow medical cannabis at health care facilities for all medical cannabis patients, not just those who are senior citizens or terminally ill. Mississippi, Arizona, and Minnesota have provisions to that effect.[1] However, that seems

[1] Arizona Revised Statutes § 36-2805, Mississippi Code § 41-137-21, Minnesota Statutes, § 342.56, Subd. 2.

extremely unlikely to become law given that both the House and Senate health committees amended Ryan's Law to be permissive instead of mandatory, pursuant to testimony from the attorney general, Department of Health, and the Healthcare Association of Hawaii.

Please see below for a proposed amendment that is consistent with the AG and DOH's input without adding burdens or making matters worse for patients. It specifies that it does not supersede Hawaii's smoke-free law. It would allow health facilities to permit medical cannabis, while giving them the flexibility to develop their own processes and without adding any new burdens. This flexibility is all the more important since federal policy is in flux, given the ongoing process to reschedule cannabis to Schedule III.

We hope you will adopt this amendment. Barring that, we urge you to defer the bill, rather than advancing SB 2408 SD 1.

Mahalo for your time and public service,

The Hawai'i Alliance for Cannabis Reform
info@legalizehawaii.org
LegalizeHawaii.org

**Member Organizations:**

ACLU of Hawai'i ◆ Cannabis Society of Hawai'i ◆ Hawaiian Council
Doctors for Drug Policy Reform ◆ Drug Policy Forum of Hawai'i
Last Prisoner Project ◆ Marijuana Policy Project

# Appendix —Proposed Compromise Amendment

Replace all of Section 1 with:

SECTION 1. Chapter 329, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

§ -1(a) A hospital, clinic, nursing home, home for the aged or infirm, hospice, assisted living facility, residential care institution, adult day health care facility, adult foster care home, or health care facility may allow the medical use of cannabis by qualifying patients, and may allow primary caregivers to assist qualifying patients in administering medical cannabis.

(b) This section does not authorize smoking or vaporizing of cannabis in a location where smoking or vaporization is prohibited by chapter 328J.

**SB2408,SD1 Allows Medical Cannabis in Healthcare Facilities**

COMMITTEE ON JUDICIARY
Sen. Karl Rhoads, Chair
Sen. Mike Gabbard, Vice Chair
Friday, Feb. 27, 2026: 10:30: Room 016 & Videoconference

*ALOHA CHAIR, VICE CHAIR, AND DISTINGUISHED COMMITTEE MEMBERS. My name is Brian Baker. I am the President and CEO for Hina Mauka, a mental health and substance use disorder treatment and prevention agency for thousands of adults and adolescents on Oahu and Kauai, including recovery-oriented services and housing transitional living programs.*

Hina Mauka **OPPOSES SB2408,SD1** and provides this testimony as a major residential treatment and prevention provider, as well as a member of the Hawaii Substance Abuse Coalition (HSAC).

**Hina Mauka requests the following AMENDMENT to SB2408,SD1, as supported by the Hawaii Substance Abuse Coalition (HSAC), documented below.**

*"Allowing medical cannabis into a substance abuse residential treatment facility is a serious policy decision, and it is reasonable to oppose it when cannabis is itself a drug of abuse for many patients.*

*HSAC respectfully requests an amendment to ensure clarity:*

*§-2 Definitions Section 3 (C.) line 14 (page 4),*

*"Health care facility" does not include a chemical dependency recovery hospital, a chemical dependency residential treatment center, a state hospital, or an emergency department of a general acute care hospital while the patient is receiving emergency services and care.*

***Cannabis Use Disorder***
*For many clients entering treatment today, **cannabis is central**. Cannabis use disorder is increasingly common, and for a substantial number of patients, cannabis is either:*

- *the primary drug of abuse, or a major relapse trigger tied to polysubstance use.*
- *Permitting cannabis in treatment settings sends a conflicting message: that one intoxicating substance is acceptable while others are not.*

---

***Treatment Requires Clear Boundaries and Consistency**.*

*Introducing medical cannabis undermines Structure, accountability by creating ambiguity about sobriety and recovery.*

- *Clients may reasonably ask: "Why is cannabis allowed but alcohol is not?" "How is this different from my past drug use?" "Does recovery still mean abstinence?"*

---

***High Risk of Diversion and Misuse***

*Residential treatment facilities already face challenges managing contraband and medication misuse. Allowing cannabis creates additional risks:*

- *diversion to other clients*
- *trading or selling among residents*
- *difficulty verifying dosage and form*
- *inconsistent regulation compared to FDA-approved medications*
- *Unlike tightly controlled prescriptions, cannabis products vary widely in potency and psychoactive effect.*

---

***Cannabis Use Can Impair Recovery Progress***

*Cannabis use is associated with:*

- *impaired motivation and cognition, increased anxiety or mood instability*
- *relapse into other substances*

*Clients in early recovery need full mental clarity to participate meaningfully in treatment. Introducing THC into the environment may delay or disrupt that process.*

---

***Federal and Licensing Conflicts Remain***

*Many residential treatment facilities rely on federal funding, Medicaid reimbursement, SAMHSA standards, accreditation requirements, Cannabis remains a Schedule I substance under federal law. Allowing it in facilities could jeopardize funding.*

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***Recovery Spaces Must Be Safe for All Clients to be free of triggers***

*Residential treatment is a shared environment with group activities.*

- *Allowing cannabis use affects not only the individual patient but everyone around them, including those who are: recovering from cannabis addiction, vulnerable to relapse, or triggered by exposure to drug-related behavior or odor*

*Treatment facilities must prioritize the collective recovery atmosphere over individual substance access.*

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***Appropriate Alternatives Already Exist***

*If a patient has legitimate medical needs, there are FDA-approved, non-intoxicating alternatives that can be safely managed in treatment, including:*

---

***Closing Statement***

*In closing, residential substance abuse treatment facilities must remain environments of sobriety, clarity, and consistency. Allowing cannabis—especially when it is a significant drug of abuse—creates contradictions, increases relapse risk, complicates treatment goals, and threatens the integrity of recovery programs."*

Hina Mauka appreciates the opportunity to provide this opposition testimony and requests the HSAC-supported Amendment.

**SB-2408-SD-1**
Submitted on: 2/23/2026 6:47:44 PM
Testimony for JDC on 2/27/2026 10:30:00 AM

| Submitted By | Organization | Testifier Position | Testify |
|---|---|---|---|
| Courtney Kacir | Individual | Support | Written Testimony Only |

Comments:

Aloha Committee Members,

I am testifying in **SUPPORT** of SB 2408, SD1. Relating to Compassionate Access to Medical Cannabis.

I do not think this law should be limited to the terminally ill or people over age 65. Patients leave AMA(Against Medical Advice) because they are unable to use their medical cannabis medicine. Cannabis allows patients to feel more alert and engage with family, unlike heavy sedation caused by pharmaceuticals traditionally used in healthcare settings. The patients should be allowed to use their own cannabis medication just like we do for the other medications that we do not carry in healthcare facilities.

Mahalo for the opportunity to testify,

Courtney Kacir, RN BSN

Honolulu, Hawaii

**SB-2408-SD-1**
Submitted on: 2/24/2026 9:35:30 AM
Testimony for JDC on 2/27/2026 10:30:00 AM

| Submitted By | Organization | Testifier Position | Testify |
|---|---|---|---|
| Kai Luke | Individual | Support | Written Testimony Only |

Comments:

Aloha Chair, Vice Chair, and Distinguished Committee Members,

As a voting member of the community, I appreciate you hearing this bill.

With the United States Department of Health and Senior Services holding patent 6630507b1 titled “Cannabinoids as Antioxidants and Neuroprotectants” filed in 1999, there is recorded historical evidence of the potential therapeutic benefits of Cannabis.

This may have enormous effects going forward as all humans have an “Endocannabinoid System” or ECS that helps to regulate the body via homeostasis.

While many of the global community moves towards future proofing health initiatives with Cannabis, we lack the cohesiveness to provide a safe and strong foundation to build on the understanding of plant medicine.

Please support the majority of the community’s choice to participate in the growing cannabis sector and let the resources benefit the entire community.

I support this bill with amendments and need to see more inclusion for minorities and the underserved indigenous communities that are most impacted by reefer madness and the war on cannabis.

Thank you for allowing me to testify.

Mahalo,

Kai Luke

TO: JDC Chair Rhodes, Vice Chair Gabbard and Committee Members

From: Robert Lawrence Bence, Disabled 329 patient who needs this bill to survive hospital visits

RE: **Amendments for SB2408 SD1 To add severely disabled to patient definition and change the may language back to shall making the bill worthwhile again**

Date: 2/25/2026

Aloha Senators,

This bill is deeply personal for me as medical cannabis is the only reason I'm still alive according to several doctors. If my 329 use is halted I will die. After brain surgery and learning how to walk and talk again I was the youngest at the rehabilitation hospital this bill currently would not allow severely disabled patients who need it to survive please add us to the patient definition. Please change may back to shall the hospitals already may so for this bill to actually help anyone it needs to be changed back to shall. I and other advocates have shared with OMCCR the several ways that this could comply with federal law, some examples are listed at the end of this testimony. The OMCCR should be working with patients to prepare for schedule 3 with research not opposing this bill as it was originally written as shall to help the patients and the may change made it worthless.

**SECTION 1. – Definition of "Patient" (Section -2)**

Location: Page 6, lines 15–21

**Amend § -2 "Patient" to read:**

"Patient means an individual who meets one or more of the following criteria:
(1) Is terminally ill; or
(2) Is over sixty-five years of age with a chronic disease for which the patient has received a written certification from the patient's physician or advanced practice registered nurse pursuant to part IX of chapter 329; or
**(3) Is severely disabled with a chronic disease for which the patient has received a written certification from the patient's physician or advanced practice registered nurse pursuant to part IX of chapter 329."**

Effect: Adds a third category for severely disabled patients with chronic conditions, aligned structurally with paragraph (2).

**SECTION 2. – Facility Duties (Section -3)**

Locations: Page 7, lines 18–22 (and any similar "may" language in Section -3)

**Amend as follows:**

Wherever the bill currently reads "~~**may**~~ develop, implement, or adopt written guidelines, procedures, or policies,"
**replace with:**
"**shall** develop, implement, and disseminate written guidelines, procedures, and policies"

Effect: Converts permissive language into mandatory duties for all health care facilities under this Act. Makes the law useful as they may already allow so no need for the law the original intent of this bill was Shall because the state should fight to protect the rights of the most vulnerable if it wants to have a medical program or else it's just a worthless bill that changes nothing.

**SECTION 3. – Optional Conforming Edit for Acute Care Hospitals (Section -3(b))**

Location: Page 8, lines 5–10

**Amend §-3(b) to read:**

"Notwithstanding subsection (a), a general acute care hospital shall not permit a patient with a chronic disease to use medical cannabis unless the patient is terminally ill or is severely disabled with a chronic disease as defined in §-2(3)."

Effect: Ensures the new patient category is not inadvertently excluded from access in general acute care hospitals.

**STATEMENT OF INTENT**

The purpose of this amendment is to ensure that severely disabled individuals with chronic diseases have the same access to medical cannabis in health care facilities as other protected patient groups under this Act.

Additionally, converting “may” to “shall” ensures that facility compliance is mandatory, promoting consistent statewide implementation and preventing uneven application of the law.

Continuity of care during rehabilitation and hospitalization for patients can determine whether recovery continues or serious harm occurs. These amendments ensure:

SB2408 aligns with existing Hawai’i medical cannabis law, disability rights principles, and basic standards of medical ethics.

I also strongly agree with MPP amendment to allow inhalation in designated areas as it’s the most effective method of dose titration.

The changes suggested by OMCCR and the AG to change shall to may would eliminate this bill. Hawai’i should work to champion patient rights.

To compromise with the Hospital Industry Associations concerns there are several legal arguments the state could make to say the use is federally legal.

SB2408 is legally defensible and compassionate public policy.

First, under the Tenth Amendment to the United States Constitution, the federal government cannot require Hawai‘i to criminalize conduct under state law. The Supreme Court confirmed in Printz v. United States that states are not obligated to enforce federal drug laws.

Second, Congress has repeatedly restricted federal enforcement against state medical cannabis programs through the Rohrabacher–Blumenauer Amendment, and the Ninth Circuit held in United States v. McIntosh that DOJ cannot prosecute individuals who are in strict compliance with state medical cannabis laws.

Hawai‘i is within the Ninth Circuit.

SB2408 does not require hospitals to distribute cannabis. It simply allows qualified patients, particularly those who are terminally ill to access their already legal, state-authorized medicine while receiving care.

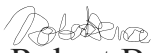
Additionally, Congress passed the Medical Marijuana and Cannabidiol Research Expansion Act, signaling clear federal movement toward medical normalization. We could do research under current Federal law thanks to Senator Schatz and signed by Biden in 2022.

Trump has already moved to start Schedule 3 so by the time this bill is in effect it might be also in effect.

The legislature already passed a bill the governor could enact to protect 329 patients from federal law.

This bill respects state sovereignty over health care, protects vulnerable patients, and aligns with evolving federal policy please amend it back to shall and add disabled patients.

Mahalo



Robert Bence