TESTIMONY OF
THE DEPARTMENT OF THE ATTORNEY GENERAL
KA ʻOIHANA O KA LOIO KUHINA
THIRTY-THIRD LEGISLATURE, 2026

ON THE FOLLOWING MEASURE:
S.B. NO. 2408, RELATING TO COMPASSIONATE ACCESS TO MEDICAL CANNABIS.

BEFORE THE:
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

DATE: Wednesday, February 18, 2026 **TIME:** 1:00 p.m.

LOCATION: State Capitol, Room 225

TESTIFIER(S): Anne E. Lopez, Attorney General, or
Alana L. Bryant, Deputy Attorney General

Chair San Buenaventura and Members of the Committee:

The Department of the Attorney General (Department) offers the following comments.

This bill adds a new chapter to the Hawaii Revised Statutes, the Compassionate Access to Medical Cannabis Act, which would require most licensed health care facilities in the State to allow certain patients to use medical cannabis in compliance with part IX of chapter 329, Hawaii Revised Statutes (HRS). Specifically, the bill applies to terminally ill patients and qualifying patients over sixty-five years of age with chronic disease, and excludes chemical dependency recovery hospitals, state hospitals, and emergency departments of general acute care hospitals.

The Department notes that the bill would mandate accommodation of medical cannabis use by covered health care facilities, notwithstanding the continued prohibition of cannabis under federal law. While the bill attempts to address potential federal conflicts, mandatory accommodation could expose health care facilities to legal uncertainties, including the potential risk to federal funding or other federal enforcement consequences.

The Department further notes that the bill allows a health care facility to suspend compliance if a federal agency initiates an enforcement action or issues guidance expressly prohibiting the use of medical cannabis in health care facilities (page 9, line

20, through page 11, line 2). However, there is no assurance that suspending patient use of medical cannabis would resolve or mitigate any federal enforcement action once initiated.

If the intent of the bill is to clarify that, under state law, a health care facility *may* allow the use of medical cannabis by eligible patients, rather than to require such accommodation, the Department recommends amending § -3(a), on page 6, lines 12-17, to read as follows:

> Except as provided in subsection (b), a health care facility **may** permit patient use of medical cannabis, as authorized by the patient's physician or advanced practice registered nurse pursuant to part IX of chapter 329 and indicated in the patient's medical record, and, **if a health care facility elects to permit patient use of medical cannabis,** shall do all of the following:

In addition, the Department recommends deleting § -7(b), on page 11, lines 3-8, as the provision may create ambiguity regarding the scope of permissible noncompliance with federal law.

Finally, the Department notes that on December 18, 2025, the President issued an Executive Order directing the U.S. Attorney General to "take all necessary steps to complete the rulemaking process related to rescheduling marijuana to Schedule III of the [Controlled Substances Act] in the most expeditious manner in accordance with Federal law . . . ." If marijuana is rescheduled to Schedule III, requiring licensed health care facilities in the State that comply with applicable federal requirements to allow certain patients to use medical cannabis in accordance with part IX of chapter 329, HRS, may present reduced legal risk; however, it is not possible to ascertain this with certainty in the abstract.

Thank you for the opportunity to provide comments on this bill.

JOSH GREEN, M.D.
GOVERNOR OF HAWAII
KE KIA'ĀINA O KA MOKU'ĀINA 'O HAWAI'I

KENNETH S. FINK, MD, MGA, MPH
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KA LUNA HO'OKELE

STATE OF HAWAII
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Testimony COMMENTING on SB2408
RELATING TO COMPASSIONATE ACCESS TO MEDICAL CANNABIS

SENATOR JOY A. SAN BUENAVENTURA, CHAIR
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Hearing Date and Time: 02-18-26, 1:00PM Room Number: 225

Fiscal Implications: Undetermined.

Department Position: The Department of Health ("Department") appreciates the intent of this this measure and offers comments and proposed amendments.

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. However, this measure would require every facility that provides medical services to a terminally ill patient, or to any registered medical cannabis patient over the age of sixty-five, to allow the use of medical cannabis, with limited exceptions for chemical dependency recovery hospitals, State hospitals, and emergency departments of general acute care hospitals.

As drafted, section -3(a) states that a health care facility "shall permit" medical cannabis use. This mandatory language may create unintended conflicts with federal law, Medicare and Medicaid participation, accreditation requirements, patient safety protocols, and institutional or religious policies. To preserve patient access while avoiding these potential conflicts, we respectfully recommend replacing "shall permit" with "may permit" in section -3(a). This

clarifies that state law allows the use of medical cannabis in these facilities, but does not require a facility to violate federal law.

Offered Amendments: page 6, lines 11-17:

§ -3 Health care facilities; duties regarding permitted use of medical cannabis. (a) Except as provided in subsection (b), a health care facility [~~shall~~] may permit patient use of medical cannabis, as authorized by the patient's physician or advanced practice registered nurse pursuant to part IX of chapter 329 and indicated in the patient's medical record, and shall do all of the following:

Thank you for the opportunity to testify on this measure.

SB-2408
Submitted on: 2/16/2026 8:46:38 AM
Testimony for HHS on 2/18/2026 1:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Shelby "Pikachu" Billionaire	Testifying for KIngdom of The Hawaiian Islands & Ohana Unity Party	Support	Remotely Via Zoom

Comments:

Testimony in Strong Support of SB2408 – Compassionate Access to Medical Cannabis Act (Ryan's Law)

Aloha kakou, Chair and Members of the Committee,

I am Master Shelby "Pikachu" Billionaire, HRM, Kingdom of The Hawaiian Islands, H.I., Chairman of the Ohana Unity Party. Aloha nui loa from the heart of our islands, where we live by the spirit of **aloha**—love, compassion, mercy, kindness, and grace—and where **‘ohana** means no one is left behind, for as the ‘ōlelo no‘eau wisely teaches: *‘Ike aku, ‘ike mai. Kōkua aku, kōkua mai. Pēlā ka nohona ‘ohana.* “Observe others, be observed. Help others, be helped. That is the way of family life.”

Today, I stand before you to urge passage of SB2408, embodying this sacred principle by extending true compassion to our kupuna and terminally ill loved ones. This bill, known as the "Compassionate Access to Medical Cannabis Act" or "Ryan's Law," creates a new chapter in our statutes to allow **terminally ill patients** (those with a prognosis of one year or less) and **qualifying patients over sixty-five** with chronic diseases to safely use their doctor-authorized medical cannabis in health care facilities—hospitals, skilled nursing facilities, hospices, congregate living health facilities, and home health agencies—while fully complying with part IX of chapter 329. It is a measured, humane step: no smoking or vaping (with limited exceptions for home health), secure locked storage, patient or caregiver responsibility for handling, staff training, and clear prohibitions on staff administration.

These safeguards honor safety while upholding **mālama**—to care for, nurture, and preserve the well-being of our people. In our Hawaiian way, we know that **ua ola loko i ke aloha**—“love gives life within”—and that true healing begins with compassion for body, mind, and spirit. Yet too many of our kupuna and those facing terminal illness suffer needlessly when admitted to facilities that force them to abandon their effective, certified medical cannabis treatment for pain, nausea, appetite, and quality of life. Hawaii’s medical cannabis program serves thousands responsibly, with zero overdose deaths from medical use and clear benefits for chronic conditions, cancer symptoms, PTSD, and end-of-life care. Denying access in these settings creates cruel barriers—unnecessary pain for patients, heartbreak for families, and a disconnect from our core value of **kuleana** to care for one another. SB2408 aligns perfectly with aloha ‘āina and aloha kekahi i kekahi—“love one another.”

It follows successful models from other states, integrates with our existing registry, and ensures facilities cannot deny admission based on use. This is not expansion for its own sake; it is targeted relief for the most vulnerable, allowing them to face their final days—or manage chronic illness—with dignity, comfort, and the medicine that works for them. **In closing, with deepest aloha and a call to mālama our ‘ohana in their time of greatest need, I respectfully ask the Committee to pass SB2408 swiftly.

Key reasons include:** -

Terminally ill patients (prognosis of one year or less) and **qualifying kupuna over 65 with chronic diseases** deserve uninterrupted, doctor-approved access to medical cannabis in care facilities—honoring their right to relief and quality of life.

- Proven value of medical cannabis for symptom management in chronic and end-of-life care, with **zero overdose deaths** from responsible medical use in Hawaii. - Strong safeguards built in: no staff handling, secure storage, no smoking/vaping in most settings, full compliance with registry cards—protecting patients, staff, and facilities alike.

- True embodiment of Hawaiian values: **aloha**, **‘ohana**, and **mālama**, ensuring no keiki, kupuna, or loved one suffers alone, as we live by *kōkua aku, kōkua mai*—helping and being helped as family. -

A compassionate, limited measure that reduces suffering, supports healing, and shows the world Hawaii leads with heart and wisdom.

Mahalo nui loa for your kuleana in this important work. I am available for any questions and urge you to pass SB2408—let us show the power of aloha in action.

Master Shelby "Pikachu" Billionaire, HRM Kingdom of The Hawaiian Islands, H.I. Ohana Unity Party, Chairman

To: Senator Joy A. Buenaventura, Chair
Senator Angus L.K. McKelvey, Vice-Chair
Members of the Health and Human Services Committee

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

Fr: Karlyn Laulusa on behalf of Manoa Botanicals, LLC.

Re: Testimony In Support on Senate Bill (SB) 2408
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.

Dear Chair Buenaventura, Chair Rhoads, and Members of the Committees:

My name is Karlyn Laulusa and I am the Chief Executive Officer at Manoa Botanicals, and I stand **in strong support** of **SB2408**.

Anti-cannabis policy continues to signal that the Department of Health prioritizes restriction over patient access.

Terminally ill patients and individuals of any age living with chronic disease should have immediate access to treatments that may provide comfort, dignity, and improved quality of life. Medical cannabis is the only physician-authorized therapy that is not made readily available.

No other recommended treatment requires patients in crisis to navigate delays, additional administrative hurdles, or risk legal exposure before obtaining relief.

Criminalizing individuals confronting life-limiting illness is not public health policy. **It is regulatory overreach — and it is inhumane.**

Thank you for the opportunity to provide written testimony.
Karlyn Laulusa
Chief Executive Officer
Noa Botanicals

Marijuana Policy Project
P.O. Box 21824 • Washington, DC 20009
202-462-5747 • www.mpp.org

SB 2408 Relating to Compassionate Access to Medical Cannabis Comments: Strongly Urging Amendments

February 17, 2026

Aloha Chair Buenaventura, Vice Chair McKelvey, and honorable members of the Senate Health and Human Services and Commerce Committee:

I am Karen O'Keefe, an attorney and the director of state policies at the non-profit Marijuana Policy Project (MPP). For more than 30 years, MPP has had the honor of working alongside patients to craft and improve medical cannabis programs.

We strongly support allowing terminally ill patients and kupuna to use medical cannabis preparations in health care facilities, and we commend Chair Buenaventura for proposing this bill. However, we are alarmed that the House companion bill has been amended to be *worse* than the status quo (HB 1542, HD 1). We are concerned that even the introduced bill makes matters worse for some patients, and we urge amendments if it is advanced.

As it is currently drafted, SB 2408 would force nursing homes and other health care facilities to ban conduct they may be allowing now, or may wish to allow in the future. **No health care facility should be prohibited from allowing patients relief.**

We recommend replacing the bill with broader language based on MPP's model medical cannabis bill, to protect all patients, not just senior citizens and the terminally ill. Our model language has been adopted (with a few modifications) in at least two other states — Mississippi and Minnesota. It allows facilities to implement reasonable restrictions and avoids imposing burdens on the health care facilities that SB 2408 mandates. **We have included suggested amendatory language as an Appendix.**

My colleagues and I have worked with hundreds of patients over the years who have found relief from cannabis where other medications have failed them or provided intolerable side effects and risks. This includes patients with paralyzing spasms, merciless pain, appetite loss, intractable seizures, and a host of other devastating conditions. Many of those patients were under 65 and many did not have terminal conditions. They, too, deserve access to the medication they depend on if they are in a nursing home, adult foster home, or hospital.

I. Concerns with SB 2408, as introduced:

A. SB 2408 <u>prohibits</u> hospitals from allowing non-terminal patients from using cannabis in any form.

SB 2408 § -3 (b) provides, "a general acute care hospital ***shall not*** permit a patient with a chronic disease to use medical cannabis unless the patient is terminally ill."

We strongly urge you to strike this provision, which is also in HB 1542, HD 1. A bill intended to improve access for some medical cannabis patients should not deprive others of access they are allowed under current law.

B. SB 2408 *requires* health care facilities, including nursing homes, to ban the vaporization and smoking of cannabis, even if they wish to allow it. It also prohibits cannabis use if a home care aide is anywhere in the residence.

No facility or home aide agency should be required to ban cannabis vaping or smoking where they can allow tobacco smoking and nicotine vaping. Yet, § -3 (a)(1) requires health facilities to "prohibit smoking or vaping as methods to use medical cannabis; provided that a home health agency shall only prohibit smoking or vaping immediately before or while home health agency staff are present in the residence."

Numerous studies have found smoked or vaporized cannabis efficacious with minimal side effects.[1] Inhalation allows near-immediate effect and precise titration of dosage, which are important to providing emergency relief. Cannabis has not been shown to cause lung cancer,[2] in stark contrast to tobacco smoking.

Hawaii's Smoke Free Law, Chapter 328J, prohibits smoking and vaping tobacco and plants in indoor places of employment, and within 20 feet of building entrances, exits, air intake ducts, vents, and windows. Its exceptions include:

> "Private and semiprivate rooms in nursing homes and long-term care facilities that are occupied by one or more persons, all of whom are smokers and have requested in writing to be placed in a room where smoking is permitted; provided that smoke from these places shall not infiltrate into areas where smoking is prohibited under this chapter." HRS § 328J-7 (7)

If a nursing home is allowed to allow tobacco smoking in a private room with smokers only, it still should be allowed to allow medical cannabis smoking and vaporization, too. Tobacco smoking is far more hazardous and has no medical benefit. In addition, home health aides should not have to be outside of an entire *residence* for a patient to smoke or vape cannabis. A different room would suffice.

[1] Several of them are available here: https://www.cmcr.ucsd.edu/index.php/studies/completed-studies
[2] National Academies of Sciences, Engineering, and Medicine (2017).

Please do not enact a version of SB 2408 that includes: "(1) Prohibit smoking or vaping as methods to use medical cannabis; provided that a home health agency shall only prohibit smoking or vaping immediately before or while home health agency staff are present in the residence;"

Language could be added in a different section clarifying, "This chapter does not require a health care facility to allow the smoking or vaping of medical cannabis by any patient."

II. Concerns with HB 1542, HD 1,

Please defeat the bill if you would otherwise change "shall" to "may."

Based on testimony from the Department of Health and others, the House Committee on Health revised the language from being mandatory to permissive — changing it from providing facilities "shall" provide accommodations to terminally ill and those 65 and older (in some case) to providing they "may" do so.

There is nothing in existing law to prevent health facilities from allowing medical cannabis use. Indeed, testimony in the House Health Committee explained that some are already doing so. With a "shall" to "may" change, SB 2408 would make matters worse, adding burdens and restrictions, including:

- Requiring nursing homes to ban cannabis vaping smoking in private rooms.
- Prohibiting acute hospitals from allowing non-terminal patients from using medical cannabis (even if it is essential to managing their symptoms).
- Requiring medical cannabis to be included in a patient's medical records (though facilities may prefer plausible deniability and not to have to reference cannabis or be involved in it at all).
- Requiring a patient to provide a copy of their medical cannabis registry card or certificate (which may significantly slow access).
- Requiring health facilities to develop, disseminate, and train health care facility staff on written guidelines developed by the health care facility for the use and disposal of medical cannabis within the health care facility.

The "shall" to "may" change makes the bill worse than meaningless, by adding hurdles and restrictions.

Concluding Thoughts

We strongly support allowing terminally ill patients and those over 65 to use medical cannabis in health care facilities and we commend the Chair for addressing that need. However, amending the bill from "shall" to "may" would make matters worse than the status quo.

In addition, other states have more compassionate language than SB 2408, as introduced. We urge you to instead adopt language similar to Mississippi and Minnesota's law to include non-terminal patients and patients under the age of 65, who are also deserving of the access to the medication that manages their pain, spasms, seizures, and other symptoms. Their language also avoids burdens that SB 2408 would impose on health care facilities.

Mahalo for your time and consideration,

Karen O'Keefe
Director of State Policies
202-905-2012
kokeefe@mpp.org

Appendix

Suggested Amendment Based on Mississippi and Minnesota

Replace Section 1 with:

(a) Except as provided in (d), any nursing care institution, hospice, hospital, assisted living center, assisted living facility, assisted living home, residential care institution, adult day healthcare facility, or adult foster care home may adopt reasonable restrictions on the use of cannabis by their patients, residents, or persons receiving services, including:

(1) that the facility and its agents are not responsible for providing the cannabis to qualifying patients;

(2) that cannabis be consumed by a method other than smoking; and

(3) that cannabis be consumed only in a place specified by the facility.

(b) Nothing in this section requires a facility listed in subsection (a) to adopt restrictions on the medical use of cannabis, except that cannabis smoking may not be allowed on school grounds.

(c) A facility listed in subsection (a) may not unreasonably limit a registered qualifying patient's access to or use of cannabis authorized under this chapter unless failing to do so would cause the facility to lose a monetary or licensing-related benefit under federal law or regulations.

(d) This section does not apply to a chemical dependency recovery hospital or facility.

February 18, 2026 at 1:00 pm
Conference Room 225

Senate Committee on Health and Human Services

To: Chair Joy A. San Buenaventura
Vice Chair Angus L.K. McKelvey

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

Re: Testimony in Opposition
SB 2048, 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.

We appreciate the opportunity to testify in opposition to this measure. Our members understand and respect the intent behind this measure and strive to ensure that all patients are treated with comfort and dignity during difficult times. However, providers of inpatient care—including hospitals, skilled nursing facilities, and hospices—have an obligation to operate within federal law in order to continue to operate and provide needed care to the community. Ultimately, this measure asks our providers to violate federal law and Medicare Conditions of Participation (CoPs) that would threaten their license and funding sources.

Providers that participate in Medicare are required to comply with all applicable federal laws and CoPs, as enforced by the Centers for Medicare and Medicaid Services (CMS). Because cannabis is still classified as a Schedule I substance under the Controlled Substances Act, it cannot be prescribed, dispensed, stored, or administered in a medical setting or by licensed practitioners. Importantly, there is no federal exception that allows hospitals or other inpatient providers to permit the storage, handling and prescription of cannabis, even when state law authorizes its use for specific populations.

We understand that certain provisions in the bill seek to create safeguards for providers. However, we do not believe that these safeguards are sufficient. Specifically, we would note that hospitals may need to possess a cannabis product if neither a patient nor a caregiver is

able to dispense of the product. Further, allowing a hospital to suspend or revoke permission for cannabis use does not eliminate federal exposure once the practice has occurred. CMS enforcement is retrospective as well as prospective. Survey deficiencies, citations, and enforcement actions can be based on conduct that occurred during a survey period, even if the hospital later discontinues the practice. The ability to suspend permission therefore does not meaningfully protect hospitals from consequences under federal law.

There are also clinical issues regarding the use of cannabis in inpatient settings, particularly for individuals who are hospitalized for an acute condition. In the inpatient hospital environment, care is coordinated around medications that are standardized, verifiable, and actively managed by the clinical team. Cannabis products can vary widely in potency and formulation, making it difficult for clinicians to fully understand how a product may interact with other treatments and complicates medication reconciliation.

While we share the goal of providing comfort and compassion to patients admitted to a hospital, nursing facility, or hospice home, this measure puts organizations and providers in a difficult position. Ultimately, facilities would be required to knowingly allow a federally prohibited substance into the inpatient environment that violates CoPs and threatens funding and licensure. Further, providers would need to clinically manage the use of cannabis that is not standardized or FDA-approved. For these reasons, we ask that this measure be deferred.

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

HAWAII SUBSTANCE ABUSE COALITION

SB2408 Cannabis Use for Elderly in Healthcare Facilities

COMMITTEE ON HEALTH AND HUMAN SERVICES
Sen. Joy San Buenaventura, Chair
Sen. Angus McKelvey, Vice Chair
Friday, Feb 13, 2026: 1:00: Room 225 Videoconference

Hawaii Substance Abuse Coalition Proposes Amendment SB2408 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.

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.

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.

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.

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

HSAC appreciates the opportunity to provide testimony and are available for questions.

SB2408 Allows Medical Cannabis in Healthcare Facilities

COMMITTEE ON HEALTH AND HUMAN SERVICES
Sen. Joy A. San Buenaventura, Chair
Sen. Angus L.K. McKelvey, Vice Chair
Wednesday, Feb. 18, 2026: 1:00: Room 225 & 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** 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, 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.

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.

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 request HSAC-supported Amendment.

Hawai'i Alliance for Cannabis Reform
SB 2408 Comments

February 17, 2026

Aloha Chair San Buenaventura, Vice Chair McKelvey, and members of the Senate Health and Human Services committee:

We strongly support the noble goal of SB 2408, allowing terminally ill patients to access medical cannabis while in health care facilities. However, we have serious concerns that this vehicle may ultimately reduce, instead of increase, patients' ability to use medical cannabis products in nursing homes, hospitals, and other health facilities.

SB 2408, as introduced, requires nursing homes, hospitals, and other health facilities to accommodate terminal patients' — and in some cases patients over 65 with a chronic illness — use of non-smoked, non-vaped medical cannabis. However, SB 2408 also erodes existing freedoms by:

- *prohibiting* acute care hospitals from allowing medical cannabis by non-terminal patients, and
- *prohibiting* facilities from allowing smoked or vaporized cannabis, although existing Hawai'i law allows nursing homes to allow smoking and vaporization in private rooms under certain conditions.

We are even more concerned that the House companion was amended in the Health Committee to change "shall" to "may," meaning no facility would be required to accommodate medical cannabis. Meanwhile, the bill imposes burdens and restrictions that may result in fewer facilities allowing medical cannabis than are currently doing so. And, as noted, it completely bans the use of medical cannabis by non-terminal patients in acute care hospitals.

We would prefer the bill be voted down if it would otherwise be modified as HB 1542 HD 1 was — to change "shall" to "may" — as was requested by the Department of Health.

We urge your committee to instead amend SB 2408 to model it after Mississippi Code 41-137-21, which provides protections for non-terminal as well as terminal patients, and which does not discriminate based on age. Mississippi also avoids the burdens contained in SB 2408, such as requiring facilities to document medical

cannabis in medical records and to train staff on disposing of cannabis. Mississippi's approach allows nursing homes and other medical facilities to essentially just look the other way, in which they may be more comfortable since medical cannabis is not legal under federal law.

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

Mississippi Code § 41-137-21

(1) Any nursing facility, hospital, hospice, assisted living facility, personal care home, adult day care facility, or adult foster care facility may adopt reasonable restrictions on the use of medical cannabis by registered qualifying patients who are receiving health care services, residential care services, or day care services from the facility, including:

(a) That the facility will not store or maintain the patient's supply of medical cannabis;

(b) That the facility, caregivers, or hospice agencies serving the facility's residents are not responsible for providing the medical cannabis for registered qualifying patients; and

(c) That medical cannabis be consumed only in a place specified by the facility.

(2) Nothing in this section requires a facility listed in subsection (1) of this section to adopt restrictions on the medical use of medical cannabis.

(3) A facility listed in subsection (1) of this section may not unreasonably limit a registered qualifying patient's access to or medical use of medical cannabis authorized under this chapter, unless failing to do so would cause the facility to lose a monetary or licensing-related benefit under federal law or regulations.

TO: CPN Chair Keohokalole, Vice Chair Fukunaga and HHS Chair San Buenaventura Vice Chair Aquino and Committee Members

From: Robert Lawrence Bence, Disabled and only alive today because of uninterrupted hospital use, 329 patient

RE: Tentative Support for **SB32408 Begging for Life Saving Amendments**

Aloha Senators,

I was born with a birth defect known as AVM that led to a stroke and brain surgery followed by intensive in patient rehabilitation hospitals and clinics here on Maui and at Stanford where I was sent for radiation and brain surgery. Several doctors and nurses said my constant consistent use of cannabis allowed me to survive the largest intact aneurism they had seen it was the size of a golf ball but did not bleed. Several times including the time of my stroke and seizures I did not use cannabis as would be distracted and not understanding it's true value. I never had any issue as long as can use. I have used it in Maui and both hospitals in California despite the law. If chose life or jail will chose to survive. **Please amend this bill to clarify protection to the third class of patients listed as C. In the beginning of the bill but left out of the further patient definitions.**

Proposed Amendment – Definition of Patient
"Patient" means an individual who:
(1) Is terminally ill;
(2) Is over sixty-five years of age with a chronic disease; or
(3) Persons who are catastrophically and severely disabled, including, for catastrophically disabled persons, speech, physical, and occupational therapy. For the purposes of this definition, "a person who is catastrophically and severely disabled" means a person whose origin of disability was acquired through trauma or nondegenerative neurologic illness, for whom it has been determined that active rehabilitation would be beneficial, and to whom these services are being provided.

Proposed Conforming Amendment – Health Care Facilities
A health care facility shall permit a patient meeting subsection (3) of the definition of "patient" to use medical cannabis in accordance with this chapter when medically necessary to prevent life-threatening complications or severe disability.

Proposed Revision – General Acute Care Hospitals
Notwithstanding any other provision, a general acute care hospital shall permit use of medical cannabis by a patient who meets subsection (3) of the definition of "patient" when supported by written certification from a physician or advanced practice registered nurse that continued access is medically necessary to prevent serious harm or death.

Personal Context and Public Service
I submit this amendment as a person with a lifelong disability who spent significant time in a rehabilitation hospital following brain surgery for a congenital birth defect.

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'imedical 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 to the house version 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 Biden. 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.

Mahalo

Robert Bence

To: The Honorable Members of the Senate Committee on Health and Human Services and Committee on Judiciary

Distinguished Chairs and Committee Members,

My name is **Laverne Moore**. I strongly oppose SB 2408.

While the title "Compassionate Access" sounds noble, as an educator who has spent over half a century witnessing the societal impacts of drug normalization, I am deeply concerned about the broader message this bill sends and the practical safety risks it creates.

Concerns Regarding SB 2408

- **Normalization in Care Settings:** This bill allows for the use of medical cannabis within specific healthcare facilities, including skilled nursing and congregate living facilities. As a member of several community boards, I am concerned about the liability and safety of these environments. When we bring these substances into communal living and care spaces, we increase the risk of diversion and accidental exposure.
- **The "Ryan's Law" Precedent:** While intended for the terminally ill and those over 65, expanding the locations where cannabis can be used is another step toward total normalization. In my 54 years of teaching, I have seen how "policy creep" works. What starts as an exception for one group eventually becomes the standard for all, further eroding the drug-free messaging we work so hard to maintain for our youth.
- **Impact on Healthcare Staff:** The bill prohibits healthcare staff from administering the substance, yet requires the facility to allow its use. This creates a confusing and potentially dangerous regulatory "grey area" for workers. Our focus should be on evidence-based medical care, not forcing facilities to accommodate Schedule I substances that conflict with federal regulations.

A Voice for the Community

Every time we expand the presence of cannabis in our community, we make it harder to protect our children from the perception that these substances are harmless. We need to be strengthening our healthcare and education systems, not complicating them with the logistical and social burdens of expanded cannabis access.

As a lifelong advocate for Hawai‘i’s families and students, I urge you to **vote NO** on SB 2408.

Mahalo for your time and for your continued service to our people.

Sincerely,

Laverne Moore Retired Educator

LATE

the Drug Policy Forum of hawai'i

Dedicated to safe, responsible, humane, and effective drug policies since 1993

TESTIMONY IN SUPPORT OF SB 2408

TO: Chair San Buenaventura, Vice Chair McKelvey, and HHS Committee

FROM: Nikos Leverenz, DPFH Board President

DATE: February 18, 2026 (1:00 P.M.)

Drug Policy Forum of Hawai'i (DPFH) **supports** SB 2408, which 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.

California's Compassionate Access to Medical Cannabis Act, also known as "Ryan's Law," passed the legislature unanimously in 2021 and was signed into law by Governor Gavin Newsom. As a result, terminally ill Californians have had access to medical cannabis in healthcare facilities since January 1, 2022. The law was subsequently expanded to include any patient over 65 years of age with a chronic disease, added home health agencies to covered health care facilities, and prohibited health care facilities from denying a patient's admission based on their use of medical cannabis.

Medical cannabis should not be subject to more severe restrictions than smoked tobacco in health care facilities given the relative lack of therapeutic benefit of smoked tobacco for those who are terminally ill or living with chronic diseases. The significant incidence of preventable illnesses and deaths caused by smoked tobacco each year stands in stark contrast to the relative benefits and harms of cannabis use.

As such, DPFH recommends that the proposed Section -3 (1), which prohibits smoking or vaping of medical cannabis "provided that a home health agency shall only prohibit smoking or vaping immediately before or while home health agency staff are present in the residence," be deleted and replaced with a reference to HRS §328J-7(4), which exempts private and semiprivate rooms in nursing homes and long-term care facilities, with conditions, from the larger prohibition of smoking in enclosed or partially enclosed places open to the public provided by HRS §328J-3.

The proposed Section -3 (1) could instead read: "Allow smoking or vaping of medical cannabis flower and concentrates under conditions set forth in section 328J-7(4)."

Medical cannabis is most commonly used for pain relief, to improve appetite, and reduce nausea. In certain cases, it can be used as an alternative to heavy pain relievers like fentanyl and morphine. Many terminally ill patients choose to use cannabis for treatment or pain relief and wish to continue that use while at the hospital, providing consistency in their individual course of treatment.

To date, the Centers for Medicare and Medicaid Services (CMS) has not been aware of a provider that has specifically lost funding or been penalized for permitting the use of medical cannabis. Furthermore, CMS states that it would not cite healthcare facilities for allowing medical cannabis use unless the federal Department of Justice declares its intent or acts to interfere with state medial cannabis laws.

Americans for Safe Access, a longstanding organization dedicated to ensuring safe and legal access to cannabis for therapeutic use and research, has an online resource guide to assist healthcare facilities with the implementation of Ryan's Law that should also be of value to Hawaiʻi facilities.

Since 1993 DPFH has advanced public discussions and policy changes around the Hawaiʻi's drug polices, which continue to advance severe criminal penalties and extended periods of criminal legal supervision. DPFH also supports policy changes around substance use and behavioral health issues that are anchored in harm reduction, public health, and human rights. These changes include broader access to community-based behavioral health treatment, the repeal of cannabis prohibition in favor of rational regulation, reducing the severity of sentencing laws, prosecutorial practices, penological practices, and criminal legal supervision, and advancing other changes to laws and policies that reduce the impact of the criminal legal system on individuals and families from under-resourced communities.

Mahalo for the opportunity to provide testimony.