TESTIMONY ON H-7454, ARTICLE 14,
RELATING TO CAREGIVERS/COMPASSION CENTERS
March 29, 2016

The ACLU of Rhode Island appreciates the opportunity to testify on this budget Article, which would make significant, and in some instances largely deleterious, changes to the state's medical marijuana program.

The most severe change is the introduction of a "sick tax" on the growing of medical marijuana by patients and caregivers. The proposal also makes some other less dramatic changes to the current law that could have an adverse impact on the program, and we address those issues below. However, before commenting on the specifics of what is in the bill, we begin this written testimony by briefly addressing two matters not tackled by the Article and which we would urge the Committee to consider addressing in passing some version of this proposal.

I. Clarifying Two Ambiguities in Current Law

Ambiguities in the current medical marijuana statute have led the ACLU to file two lawsuits over the statute's meaning. We urge the Committee to formally resolve those ambiguities in passing out an amended version of Article 14.

First, the medical marijuana law bars employers from refusing to employ an individual "solely for his or her status as a cardholder." R.I.G.L. 21-28.6-4(c). In the past few years, we have received a number of complaints from participants in the medical marijuana program who have had to take a drug test for a job. Not surprisingly, the test turns up positive for marijuana,

and these employers have (initially) refused to hire the applicant based on the test results, notwithstanding the state law's protection. They have disingenuously claimed that they were not denying the applicant employment because of his "cardholder status," but rather because he failed a drug test. We have been mostly successful in persuading employers that such an interpretation of the law is improper, but last year we were forced to sue one employer who stuck to that strained interpretation of the statute. The Superior Court has denied a motion to dismiss the case, and the lawsuit remains pending. Rep. Slater has introduced legislation (H-7807) to make as clear as possible Section 28.6-4(c)'s meaning and avoid any further disputes over the current language's clear attempt to protect medical marijuana patients from discrimination. We urge the Committee to incorporate the language in Rep. Slater's bill into this budget Article.

Second, when the state's medical marijuana law was enacted ten years ago, the Department of Health acknowledged that registered nurse practitioners (RNPs) and physician assistants (PAs) could, like physicians themselves, certify that a patient had a debilitating medical condition that qualified him or her for participation in the medical marijuana program. They were able to make such certifications for patients with whom they had a bona fide practitioner-patient relationship and had completed a full assessment of their medical history. This is directly in keeping with the "global signature" law that the General Assembly enacted some years ago. Unfortunately, in 2012, DOH summarily reversed course and directed that only certifications signed by physicians would be accepted. The ACLU filed a lawsuit to challenge this action, and the matter ended up getting resolved informally without a court ruling.

In order to avoid any possible confusion or disputes in the future, we urge that the Article be amended to make clear that PAs and RNPs, in line with their powers to prescribe medicine, similarly retain the authority to issue medical marijuana certifications.

II. The "Sick Tax"

Moving to the Article itself, our biggest concern involves the imposition of what we, and others, have called a "sick tax" on medical marijuana patients.

The "sick tax" would, according to a fact sheet prepared by the Governor's office, impose a $150 per plant charge on patients lawfully growing marijuana for medical purposes, and a $350 per plant charge for caregivers volunteering their time and energy to grow plants for sick patients. The proposal also reduces the number of plants that patients can grow.

This tax, or even one at a slightly reduced level, would be devastating to many patients and caregivers, making it extremely difficult, if not impossible, for them to access the medicine they need to manage their pain and other serious medical symptoms. The proposed tax has generated a palpable fear in the patient community and should be struck from the budget.

While the Governor has been quoted as calling the proposed tax "fairly modest" and "meant to be not onerous," that is simply not so. The Governor's fact sheet claims that each marijuana plant is "estimated to generate an average of $17,280 of annual revenue for a caregiver," and that therefore the tax "amounts to just 2 percent of the value of marijuana produced." But patients and caregivers are growing the plants for medical purposes only. They make no money from the plants; indeed, they face significant costs in growing the marijuana. The street – or compassion center – value of the plans is simply irrelevant.

The effect of this tax would be to force many patients and caregivers out of the program. One cardholder, who participated in a news conference with the ACLU last month denouncing the tax, noted that as both a medical marijuana patient and a caregiver for five other patients, the proposed tax would add more than $8,000 a year to her cost of growing medicine.

Having a medical marijuana program means little if the state makes it impossible for people of lesser means to actually participate in it. The patients and caregivers affected by this proposal grow medical marijuana to ease their symptoms and to help others; they are not running a lucrative drug trade. The state should treat them just as they would any other patient using legal medication. We fervently hope the Committee will take this troubling tax proposal off the table.

III. Additional Concerns and Comments

1. Page 6, lines 31-33. [R.I.G.L. 21-28.6-4(o)] The Article proposes to delete language authorizing cardholders to provide medical marijuana to other cardholders as long as they make no profit from it. In other words, patients or caregivers, when they end up with excess marijuana for their own needs (but within the statutory limits), can now share that excess rather than simply throw it out. The "gifting" provision has helped patients who have no medicine and can afford no medicine to actually get medicine. It is a lifeline for some very sick low income patients who cannot afford to reimburse a caregiver for the costs of growing and who cannot afford, or otherwise grow their own. This is a useful and common sense provision and we are troubled to see it being removed. We urge its reinstatement.

2. Page 9, lines 2-5. [R.I.G.L. 21-28.6-6(d)] We strongly support the bill's proposal to expedite access to the medical marijuana program by persons who are eligible for hospice care.

3. Page 10, lines 13-14. [R.I.G.L. 21-28.6-4(d)] This would delete language requiring issuance of registration cards by the Department of Health within five days of approving an application. We cannot conceive of a compelling rationale for eliminating this timeframe. It is important to emphasize that these are applications that have already been approved. The DOH bureaucracy should not be so slow as to take more than a week to issue a card after it has been

approved. A clear timeframe for agency action is especially important since we are dealing with a patient's access to medicine.

4. Page 13, lines 5-8. [R.I.G.L. 21-28.6-9(b)] The Governor proposes to remove another timeframe from the current law, this one requiring applications to be acted upon within 35 days. Again, particularly (and solely) within the context of patients and caregivers, the presence of a timeframe is essential to make sure that applications are addressed promptly. We would not object to inclusion of a provision allowing for brief extensions of time in individual applications on a case-by-case basis if necessary, but patients should not be forced to wait months for their application to be approved.

5. Page 17, lines 22-23. [R.I.G.L. 21-28.6-12(c)(5). This section revises language relating to criminal records of persons seeking to work or volunteer at compassion centers. A past criminal record involving certain offenses (including drug offenses) definitively bars the person from being employed or volunteering. We believe there should be a safety-valve mechanism so that individuals can be judged on their merits and not be pre-emptively barred from employment based on a record that could be decades old. Particularly in regards to felony drug offenses, we know that enforcement of those laws, and marijuana laws in particular, has fallen disproportionately on the backs of people of color. It is troubling to see that disproportionate enforcement used to further bar them from employment.

6. Page 27, line 4-5. [R.I.G.L. 21-28.6-15] This is the new section of law establishing the "sick tax." While it goes on to *allow* DBR to adopt regulations to make the "medical marijuana tags" available at a reduced price to patients based on their income, the agency is not required to do so. If any tax is imposed, there should be a provision for a means test, mandating a reduced fee for patients who may not be able to afford it.

7. Page 29, lines 15-29. [R.I.G.L. 21-28.6-16(a)(4-6)] This section addresses the disqualification of caregivers from the program based on their criminal records. For the reasons noted in #5 above, we oppose this section's automatic disqualification process. In addition, it is worth noting that this provision is even more restrictive than current law, which authorizes an exception "if the applicant's connected patient is an immediate family member and the card is restricted to that patient only." [R.I.G.L. 21-28.6-6(a)(4)]. That exception has been deleted. This section's automatic disqualification is also in tension with another provision in the Article that does not require automatic disqualification of a caregiver based on a *subsequent* criminal conviction. [Page 30, lines 18-21, R.I.G.L. 21-28.6-16(a)(5)].

8. Page 34, lines 3-14 [R.I.G.L. 21-28.6-20(b)] contains some confusing language, which does not mirror the language currently in the law, concerning the confidentiality of patient and caregiver information. It should be clarified.

9. Page 34, 15-23 [R.I.G.L. 21-28.6-20(c)]. This new section would appear to provide law enforcement officials much greater access to patient and caregiver information than is authorized by the current law. It is unclear if that is its purpose. In either event, we would urge that the current language in the statute be used. The confidentiality of patients and caregivers should be paramount, and law enforcement should not have broad powers to gain access to information about who is in the program.

We appreciate the Committee's consideration of these comments and hope they will be taken into account in analyzing and revising this budget Article. The well-being of thousands of Rhode Islanders is potentially at stake.