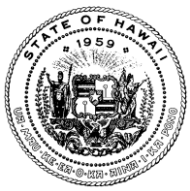
JOSH GREEN, M.D.
GOVERNOR OF HAWAI'I
KE KIA'ĀINA O KA MOKU'ĀINA 'O HAWAI'I

DEPT. COMM. NO. 492

ELIZABETH A. CHAR, M.D.
DIRECTOR OF HEALTH
KA LUNA HO'OKELE



STATE OF HAWAI'I
DEPARTMENT OF HEALTH
KA 'OIHANA OLAKINO
P. O. BOX 3378
HONOLULU, HI 96801-3378

In reply, please refer to:
File:

December 15, 2022

The Honorable Ronald D. Kouchi,
President and Members of the Senate
Thirty-second State Legislature
State Capitol, Room 409
Honolulu, Hawaii 96813

The Honorable Scott K. Saiki, Speaker
and Members of the House of
Representatives
Thirty-second State Legislature
State Capitol, Room 431
Honolulu, Hawaii 96813

Dear President Kouchi, Speaker Saiki, and Members of the Legislature:

For your information and consideration, I am transmitting a copy "Regarding the Final Report of the Task Force Convened to Explore the Development of a Dual Use Program for Cannabis and the Impacts of Cannabis Legalization on Qualifying Patients, including Access to Medical Cannabis by Qualifying Patients;" pursuant to Act 169 Session Laws of Hawaii 2021.

In accordance with Section 93-16, Hawaii Revised Statutes, I am also informing you that the report may be viewed electronically at:

https://health.hawaii.gov/opppd/department-of-health-reports-to-2023-legislature/

Sincerely,

Elizabeth A. Char, M.D.
Director of Health

Enclosures
c: Legislative Reference Bureau
Hawaii State Library System (2)
Hamilton Library

REPORT OF THE DUAL USE CANNABIS TASK FORCE TO THE THIRTY FOURTH LEGISLATURE STATE OF HAWAII 2023

PURSUANT TO ACT 169, SESSION LAWS OF HAWAII 2021, REGARDING THE FINAL REPORT OF THE TASK FORCE CONVENED TO EXPLORE THE DEVELOPMENT OF A DUAL USE PROGRAM FOR CANNABIS AND THE IMPACTS OF CANNABIS LEGALIZATION ON QUALIFYING PATIENTS, INCLUDING ACCESS TO MEDICAL CANNABIS BY QUALIFYING PATIENTS

PREPARED BY:

STATE OF HAWAII
DEPARTMENT OF HEALTH
OFFICE OF MEDICAL CANNABIS CONTROL AND REGULATION
DECEMBER 2022

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I. EXECUTIVE SUMMARY

The Act 169 Dual Use Cannabis Task Force (Task Force) was established by the legislature pursuant to S.B. 1139, H.D. 1, S.D. 2, C.D. 1 (2021), which directed the Department of Health, Office of Medical Cannabis Control and Regulation (DOH OMCCR) to convene a Task Force to explore the development of a dual system program of the legalization for cannabis and the impacts of legalization of cannabis on qualifying patients, including access to medical cannabis by qualifying patients. "Dual Use" means a combined system of legalized medical and non-medical ("adult") cannabis use.

The Task Force was not asked to, and did not, consider whether there should be a dual use system. Rather, as directed by Act 169, the Task Force assumed that there will be a dual use system and then identified and studied the important issues that would be raised by such a system.

DOH OMCCR convened the Task Force by inviting members of industry, regulators, legislators, representatives of county and state leadership, medical providers, and patient advocates, as described below, to participate in monthly meetings from April 2022 through November 2022. The meetings included hearing from the public, subject matter experts, and working groups formed to study important issues pertaining to medical and non-medical cannabis use, and considerations for cannabis legalization.

The Task Force established five working groups that were assigned to study and report on the following topic areas: the types of tax structures and tax rates that would be beneficial for Hawaii; cannabis justice reform, service equity, and market equity policies to reduce and remediate disparities caused by cannabis criminalization in Hawaii; the allowable market structures and restrictions on licenses and home growing; the concerns and priorities of registered medical use patients and certifying providers; and policies to safeguard public and consumer health and safety.

This final report addresses the areas studied by giving a synopsis of the working group findings and the Task Force discussions. While the report does not summarize public input, the written and oral testimony submitted by the public was made available to the Task Force members for each member's consideration. Each section includes final recommendations for the legislature that the Task Force agreed upon, along with any objections or reservations to recommendations by individual members.

The Task Force was able to develop many substantive recommendations which are discussed later in this report. Taxation and market structure recommendations included establishing a framework with key elements that support the development and sustainment of a well-functioning market such as a horizontal license structure and promotion of Hawaii branding and plant genetics, and that builds upon existing regulatory authority, avoids excessive taxation, and minimizes impacts to registered patients. Medical use recommendations included assurances for the continued availability of products for patients, expanding and reinforcing patient protections, and education of patients, providers, and the public. Public health and safety recommendations addressed the protection of vulnerable populations and the need for ongoing surveillance of health

impacts. However, because of the myriad aspects of social equity, including justice reform, service and market equity, the Task Force chose to recommend future study in lieu of specific follow-up actions. It was not possible for the Task Force to address every possible consideration for a legalized dual use system in the time afforded.

It is noted that this Final Report is largely a consensus report of the Task Force members. Not all members attended all Task Force meetings, and members participated as individuals. No endorsement by members individually or by the agencies they represent is implied by the specific recommendations included in the Final Report, or in their participation in the Working Groups, or on the Task Force.

II. INTRODUCTION

The Dual Use Cannabis Task Force (Task Force) was established by the legislature pursuant to Act 169, Session laws of Hawaii 2021, which directed the Department of Health, Office of Medical Cannabis Control and Regulation to convene a Task Force to "explore the development of a dual system program of the legalization for cannabis and the impacts of legalization of cannabis on qualifying patients, including access to medical cannabis by qualifying patients." "Dual Use" means a combined system of legalized medical and non-medical ("adult") cannabis use.

Medical use of cannabis was legalized in Hawaii in 2000. However, because access to cannabis for medical use continued to be a challenge, in 2015, Act 241, establishing the dispensary licensing system, was signed into law, and codified as Chapter 329D, HRS, to ensure patient access. In 2018, Act 159 established the Office of Medical Cannabis Control and Regulation to implement the medical cannabis dispensary system and administer the medical cannabis patient registry.

Hawaii law requires all patients with qualifying debilitating medical conditions to be registered with the Medical Cannabis Patient Registry Section and receive a 329 Registration Card before they begin to use cannabis legally for medicinal purposes. The Department of Health is required to provide law enforcement officials with limited access to the Medical Cannabis Registry Program's database as a tool to safeguard the community against illegal cannabis use and/or illegal cannabis grow sites.

The Dispensary Licensing Section licenses and inspects the state's medical cannabis dispensaries and production/grow sites and certifies the private, independent testing laboratories. The inspections include the monitoring and tracking of cannabis plant material to prevent diversion, reviewing products sold to ensure that they comply, overseeing the manufacturing processes, and observing and monitoring of laboratory testing of cannabis flower and manufactured products for patient and public safety.

III. TASK FORCE MEMBERS

The Task Force was comprised of the following members, representing the specified agencies or subject matter areas:

Act 169 SLH 2021 Dual Use of Cannabis Task Force Members

Name and Title	Agency and/or Role Representing
Dori Palcovich, Economic Development Specialist	Department of Business, Economic Development, and Tourism
Jo Ann Uchida Takeuchi, Deputy Director	Department of Commerce and Consumer Affairs
Michele N. Nakata, Chief Office of Medical Cannabis Control and Regulation	Department of Health
Isaac Choy, Director	Department of Taxation
Jared Redulla, Chief Investigator Narcotics Enforcement Division	Department of Public Safety
Barett Otani, Executive Assistant	County of Hawaii
Dr. James Ireland, Director Honolulu Emergency Services Department	City and County of Honolulu Certifying Medical Provider
Ellen Ching, Administrator Boards and Commissions	County of Kauai
Terilynne Gorman Communications Team Member	County of Maui
Senator Joy A. San Buenaventura	Hawaii State Senate
Representative Ryan I. Yamane	Hawaii House of Representatives
Randy Gonce, Executive Director	Hawaii Cannabis Industry Association
Wendy Gibson-Vivian, RN, BSN	Patient Advocate
Nikos A. Leverenz, Grants and Advancement Manager Hawaii Health and Harm Reduction Center	Patient Advocate
Garrett Halydier, Esq.	Adult Use Legal Scholar and Proponent

IV. PROCESS AND PROCEDURES

The Task Force was chaired by Michele Nakata, Program Manager of the Department of Health Office of Medical Cannabis Control and Regulation. Retired Judge Michael Broderick provided facilitative services. Eleven Task Force meetings were held from April 2022 through November 2022. Meetings were conducted virtually and in-person at:

Hawaii State Art Museum
No. 1 Capitol District Building
250 South Hotel Street
Honolulu, HI 96813
First Floor Multipurpose Room

The Sunshine Law is codified at part I of chapter 92, Hawaii Revised Statutes and was applied to all Task Force meetings. Meeting notices were electronically posted on the State of Hawaii Public Meetings Calendar[1] and filed with the Office of the Lieutenant Governor six calendar days prior to each meeting. In addition, the meeting notices, video recording minutes of the meetings, submitted written public testimony, and meeting materials were publicly posted on the Department of Health Dual Use Cannabis Task Force webpage.[2]

[1] Hawaii Public Meetings Calendar at: https://calendar.ehawaii.gov/calendar/
[2] DOH Dual Use Cannabis Task Force webpage at: https://health.hawaii.gov/medicalcannabis/dual-use/

During the first meeting on April 25, 2022, members of the Task Force discussed the charge of the Task Force and topic areas to be discussed. During the second meeting on May 31, 2022, five Working Groups (Permitted Interaction Groups) were established, and Task Force Members were assigned to the Working Groups. The scope of each Working Group's investigation and each Member's authority was defined. The Members and Chair(s) of each Working Group were:

PERMITTED INTERACTION GROUP	SCOPE OF INVESTIGATION	TASK FORCE MEMBERS	CONTACT
Tax Working Group	To identify and make recommendations on the types of tax structures for medical cannabis and adult-use cannabis programs that would provide benefits to Hawaii, including identification of tax rates for each program.	**Isaac Choy** (Chair) Ellen Ching Randy Gonce Garrett Halydier	Isaac.W.Choy@hawaii.gov
Social Equity Working Group	To identify Hawaii communities and populations disproportionately impacted by cannabis criminalization and make recommendations for social equity and restorative justice policies that would help to reduce and remediate past and ongoing disparities, including equity in the market, community reinvestment, and expungement and resentencing.	**Randy Gonce** (Co-Chair) **Garrett Halydier** (Co-Chair) Nikos Leverenz Sen. Joy San Buenaventura	director@808hicia.org garrett@halydierlaw.com
Market Structure Working Group	To identify and make recommendations on the structure of the market that could be allowed, including restrictions on licenses and home growing.	**Randy Gonce** (Chair) Garrett Halydier Dori Palcovich Jo Ann Takeuchi	director@808hicia.org
Medical Use Working Group	To identify the concerns and priorities of registered medical use patients and certifying medical providers and make recommendations on policies that would help to address these concerns and priorities.	**Terilynne Gorman** (Co-Chair) **Nikos Leverenz** (Co-Chair) Wendy Gibson Randy Gonce Dr. James Ireland Rep. Ryan Yamane	terilynne.f.gorman@co.maui.hi.us nleverenz@hhhrc.org
Public Health & Safety Working Group	To identify and make recommendations on policies to safeguard public and consumer health and safety, including preventing youth access, impaired driving, use disorder, and impacts to mental health.	**Michele Nakata** (Chair) Randy Gonce Dr. James Ireland Barett Otani Sen. Joy San Buenaventura Jared Redulla	OMCCR@doh.hawaii.gov

The Tax and Market Structure Working Groups presented their findings and recommendations on August 29, 2022. The Social Equity and Medical Use Working Groups presented their findings and recommendations on September 19, 2022. The Public Health and Safety Working Group presented its findings and recommendations on October 3, 2022. The Task Force discussed each working group report and a quorum of members voted to determine which working group recommendations would be included as Task Force recommendations in the Dual Use Task Force final report to the Legislature. Members were invited to submit objections and reservations to Task Force recommendations for the record as well as to submit additional recommendations for consideration and a vote by the Task Force for inclusion in the final report. The Task Force voted to adopt the final report on November 28, 2022, at 1:15:44.[3]

V. TASK FORCE FINDINGS AND RECOMENDATIONS

A. Tax

i. Introduction

The potential tax revenue from legalization of adult-use cannabis is a recurring discussion among state regulators and the cannabis industry throughout the nation. The Task Force sought to investigate this issue to ensure that regulatory oversight and social equity

[3] Recording of the November 28, 2022, meeting at: https://www.youtube.com/watch?v=FNgz--WGEtw

programs can be adequately funded, while keeping the burden on cannabis businesses and costs to the consumer as low as practicable.

ii. Investigation

The Tax Working Group was established at the meeting on May 31, 2022, at 2:11:12.[4] The scope of the Working Group's investigation was to "identify and make recommendations on the types of tax structures for medical cannabis and adult-use cannabis programs that would provide benefits to Hawaii, including identification of tax rates for each program." Members comprised: Isaac Choy (Chair), Ellen Ching, Randy Gonce, and Garrett Halydier.

The Working Group requested that Seth Colby, Ph.D., Tax Research and Planning Officer at the Department of Taxation, conduct its research and draft a report. Dr. Colby was selected for his economic expertise and professional experience assessing and forecasting market dynamics. Dr. Colby interviewed the members of the Working Group to understand the principal issues of concern that should be addressed in the report. He then developed and adhered to the following methodology to produce the report:

1. Dr. Colby conducted a comprehensive review of the economic literature regarding recreational cannabis markets, taxation, market structure, and regulation. He also developed a database of different regulatory approaches used by recreational states and their associated outcomes.

2. Dr. Colby interviewed key players in Hawaii's medical cannabis market as well as officials involved in the regulation of cannabis in recreational states. This included several site visits to production facilities on different islands.

3. Using information from the academic literature and data gathered from the interviews, Dr. Colby developed dynamic economic models that estimated the size of the market, identified the key variables that influenced market outcomes, and the effects of different tax regimes.

4. Dr. Colby composed a report that incorporated the key findings of the investigation and the results of the economic models.

Dr. Colby delivered a draft of the report for review by members of the Tax Working Group on July 29, 2022. Member comments were incorporated into the report and the final report was voted on and accepted in the August 15, 2022, meeting.

[4] Recording of the May 31, 2022, meeting at: https://www.youtube.com/watch?v=5ctzh71PjR0

The Tax Working Group reported its investigation findings, summarized below, on August 29, 2022, at 1:02:58.[5] The full Tax Working Group report[6] may be found on the DOH Dual Use Cannabis Task Force webpage.

Tax Working Group Findings:
The 2021 Hawaii cannabis market is estimated to be worth $240 million, of which $50 million derives from the medical cannabis industry and the remaining are in illegal sales. The cannabis market operates in a gray zone due to the federal government's 2013 decision to reduce enforcement efforts, and the State's legalization of medical cannabis sales in 2015 and decriminalization of cannabis possession in 2020. While the non-medical cannabis market is illegal, it is tolerated. Illegal cannabis sold in Hawaii is often produced outside of the State, mostly from California which exports cheap and relatively high-quality products.

Gray market producers do not have to comply with the regulations and taxes imposed on licensed medical cannabis dispensaries. As a result, the price of one ounce of cannabis flower at a medical dispensary is about 40-100% more expensive than its equivalent in the gray market. This two-tiered market where the prices in the legal market are much higher than in the gray market incentivizes users, even those with a medical card, to make their purchase in the illicit gray market. Although the sales at medical cannabis dispensaries have steadily grown from $18.2 million in 2018 to $50 million in 2022, the percentage of card-holding patients that use dispensaries to make purchases has declined. In January 2021, unique patient encounters only represented one-third of total patients.

Hawaii's current law allows cannabis cooperatives to cultivate large quantities of cannabis outside of the licensed dispensary system. Since these entities are not subject to the costly regulations on production, tracking, manufacturing, laboratory testing, and sale of cannabis, their prices are usually significantly less than the dispensaries.

If the large price differential between the gray market and the legal market continues, the gray market is expected to flourish. Tax revenues are a function of legal market operations. If the State legalizes cannabis for adult-use, regulation and market structure should promote conditions that favor a legal price that can compete with gray market prices. Current laws restrict the operational scale of dispensaries, limiting the number of production centers, plant counts, and retail locations. SB 2260 passed in 2022 relaxes production constraints but may be insufficient to support adult-use cannabis. It is usually better for producers who are knowledgeable about the production process, rather than lawmakers, to establish the level of scale that can bring down costs while being profitable. The mandate for vertical integration (requiring each licensee to cultivate, process, manufacture, and dispense) also drives up costs and concentrates industry risks.

The current legal medical market size is small given that dispensaries are limited to medical cannabis card holders and can only engage in retail in the county in which they

[5] Recording of the August 29, 2022, meeting at: https://www.youtube.com/watch?v=hlluRWGSU4Y
[6] Tax Working Group Report at: https://health.hawaii.gov/medicalcannabis/files/2022/08/CANNABIS-TAX-PIG-REPORT-FINAL.pdf

are licensed. Current legislation creates segmented markets for each county, which limits competition and increases the chances of market collusion. Allowing businesses to operate on any island and increasing the number of licenses for producers, manufacturer and retailers can increase the market size and competition. The heavy regulatory burden, although essential for protecting consumers, can be reevaluated given that this creates significant hurdles for small businesses.

Lack of access to banking services and financing due to cannabis classification under Federal law imposes significant cost on businesses. Some states have chartered credit unions to service their cannabis industry. Federal corporate taxes prevent cannabis businesses from deducting normal business expenses, increasing their tax burden. Furthermore, states that have legalized recreational cannabis apply a special excise tax which gray market sellers do not pay. While the corporate tax code must be addressed at the federal level, Hawaii can adopt a taxation regime which is adequately high to produce revenues for social priorities, but low enough to allow legal cannabis to compete with the gray market.

For this investigation, economic models were developed to identify tax rates which would enable a competitive legal market and to estimate potential tax revenues. Results from the cost-production model, which estimates prices for differing levels of cost of production, mark-ups, and tax rates, suggest that legal businesses in Hawaii could effectively compete with the gray market, if the State elects to gradually phase-in the excise tax. As the industry matures and, the cost of production comes down, competitive legal prices could be maintained with an increased excise tax. This cost-production structure reflects other state's experiences. This tiered strategy would encourage the development of a legal market that outcompetes the gray market sales while providing ample tax revenues over the long-term.

A mature cannabis market which includes legal and illegal sales is estimated to be $354 million. This would imply legal sales worth $172-$273 million and tax revenues of $34-$53 million in a year of a mature market (assuming sales prices of $225-$275 per ounce). Other states' experience suggest that it takes about five years for a cannabis market to fully mature, so tax revenues in the initial years following legalization of adult-use cannabis are expected to be lower. However, it is important to note that the dynamics of an adult-use market in Hawaii are unknown, making impossible to predict prevailing price, and tax revenue with certainty.

With respect to tax treatment of medical use cannabis, the most important considerations are reliable legal access and affordability. A functioning adult-use market will provide medical cannabis patients with reliable access at a considerably lower cost than currently exists in the medical dispensary market. After legalization of adult-use, prices would be expected to drop more than 15%, offsetting the suggested excise tax of 15% of a mature market. Medical cannabis is not a prescription drug and therefore not eligible for the GET exemption on prescription drugs. To ensure affordability, medical patients should not be subjected to the cannabis excise tax until the prevailing price of adult-use cannabis declines by more than the size of the excise tax. If the average price decline is greater

than the excise tax, the same tax treatment should be applied for medical cannabis card holders as for adult-use to prevent use of a tax loophole to avoid paying the excise tax.

The Task Force discussed the Tax Working Group report on October 3, 2022, at 1:10:50.[7] The Working Group highlighted three conclusions from the report, that 1) regulating cannabis after legalization will be expensive, 2) there will not be a significant net tax gain, and 3) substantial elimination of the illegal market would have to be achieved to realize any profit.

There were dissenting opinions among the Task Force on the cost-benefits of legalization. Comments were made on potential long-term net gains in a mature market and the public health and social gains of livelihoods no longer being harmed by criminalization. Members expressed the need to consider how cannabis law enforcement has disproportionately penalized Native Hawaiians and other communities of color and resulting costs to the probation system. At the same time, concerns were raised regarding public health and safety consequences The need to substantiate trends with data, rather than anecdotal information, was identified.

Members sought to clarify the level of revenue that legalization could generate for the State. Based on gross earnings of the 4.5% GET alone, the Working Group estimated $2 million in the first 2 years, $5 million in years 3 and 4, and $10 million at year 5 and beyond. A visual graph was presented showing tax revenue earned from the medical cannabis industry, which showed tax revenue collections worth $2.6 million in 2021. As an indication of the costs for enforcement, the Working Group noted that the Department of Taxation spent $30 million to achieve a 98% tax compliance in the State and suggested that the compliance cost of effectively regulating cannabis would be high as well.

Opinions also differed on the extent to which cannabis tourism would contribute to tax revenues. While some members thought that tourism would drive revenue higher, the Working Group opined that tourism might not generate high revenue given the tourist demographics traveling to Hawaii.

The need to regulate the illegal market was underscored. Estimating the market size is challenging given the difficulty of quantifying the illegal market, as such the estimate provided in the report ranging from $279-$429 million and averaging $354 million, may be a conservative estimate. Revenue could be higher if prices are close to illegal market prices and buyers move from the illegal to legal market sources. Lower prices can be achieved by allowing for large farms, which can produce on larger economies of scale. Different scenarios could be generated to examine different levels of revenue increase based on sales on the illegal market and price changes.

The Task Force voted to approve all five of the Tax Working Group recommendations on October 31, 2022, at 2:54:20.[8]

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[7] Recording of the October 3, 2022, meeting at: https://www.youtube.com/watch?v=v1GtYQVVEfc
[8] Recording of the October 31, 2022, meeting at: https://www.youtube.com/watch?v=0uTl31h2DRM

iii. Tax Recommendations

All five of the Tax Working Group's recommendations were voted on as a group with the following votes obtained: 9 Ayes, 0 Noes, and 1 With Reservations.[9]

Task Force Tax Recommendations:

1. Hawaii lawmakers should pursue a legal and regulatory framework that is not subject to burdensome levels of regulation and taxation and promotes the development of a mature well-functioning market that can effectively compete with the gray market.

2. An adult-use cannabis excise tax should be levied on the final sale of cannabis products. The cannabis excise tax should be in addition to the GET of 4.5%, start out low in the initial phases of the market and increase as the market matures to a rate of 15%. The proposed excise tax rate is 5.0% for the first two years that the adult-use market is operational, 10% for years three and four, and 15% in the fifth year of operation and beyond. The State should receive 80% of cannabis excise tax revenues and the counties should receive 20% allocated to the county where the sale is made.

3. Parity in taxation between the medical and adult-use markets should occur only if the price of adult-use cannabis has experienced a percent decline from the price in the medical market prior to recreational legalization that is larger than the cannabis excise tax. If this trigger is not met, medical use patients should not be subject to the cannabis excise tax.

4. The number of licenses issued to producers and manufacturers should be limited and the regulatory agency should have discretion over the number of licenses issued to allow it to respond to market developments. This will encourage smaller players currently operating in the gray market to start operating legally; minimize the price differential between the legal market and the gray market; and promote competitiveness within the industry.

5. Legislation should provide the legal framework for the cannabis market and the regulatory agency should be given powers to develop, modify, and enforce regulations that are more technical in nature. To increase accountability and transparency, major decisions by the regulatory agency should be reviewed by an advisory board whose members include: 2 members from the cannabis industry; 1 member from the Department of Health; 1 member from the Department of Public Safety; and 3 members appointed by the Governor with at least one board member representing an island that is not Oahu.

[9] Reservations of Member Gorman may be found in section V.A.iv.

iv. Objections and Reservations

[**Teri Gorman**] Prior to establishing any excise or sales tax rates for adult-use cannabis products, legislators and taxation professionals must understand and accommodate the "risk premium" inherent in a longstanding underground economy. If the state tries to capture the risk premium through over-taxation of the legal market, it will incentivize growth in the underground economy while retarding the regulated economy. Other states, including California and Oregon, have had this experience.

Prior to establishing tax rates and taxation policy, DOTAX and state legislators should study these research papers:

The Pros and Cons of Cannabis Taxes, by Richard Auxier and Nikhita Airi, published by the Tax Policy Center of the Urban Institute & Brookings Institution, September 28, 2022

The Federal Shake-Up of America's Marijuana Taxes, by Pat Oglesby, published by SSRN, April 4, 2022

B. Social Equity

i. Introduction

Social equity programs to address the disproportionate impact of cannabis criminalization are at the forefront of any state adult-use cannabis plan. These have taken a myriad of forms from expungement of records to technical and financial assistance, to community reinvestment. The Task Force sought to investigate this issue to identify what social equity should mean for Hawaii and its impacted communities.

ii. Investigation

The Social Equity Working Group was established at the meeting on May 31, 2022, at 2:13:55.[10] The scope of the Working Group's investigation was to "identify Hawaii communities and populations disproportionately impacted by cannabis criminalization and make recommendations for social equity and restorative justice policies that would help to reduce and remediate past and ongoing disparities, including equity in the market, community reinvestment, and expungement and resentencing." Members comprised: Randy Gonce (Co-Chair), Garrett Halydier (Co-Chair), Nikos Leverenz, and Sen. Joy San Buenaventura.

The Social Equity Working Group gathered data for its investigation by a variety of outreach activities, reviewing data and analyses previously done by social equity organizations in the cannabis industry around the nation and soliciting what data is collected and available from the judiciary, Department of Corrections, Department of

[10] Recording of the May 31, 2022, meeting at: https://www.youtube.com/watch?v=5ctzh71PjR0

Public Safety, and county police departments, among others. Noting however that this data is limited as indicated by the Hawaii Legislative Research Bureau's 2017 report on decriminalization of cannabis[11]. In addition, the Working Group conducted a series of Social Equity Group Listening Sessions to give local communities an opportunity to share their stories of interactions with cannabis enforcement. These occurred on:

- July 23, 2022, in Hilo at the County Building
- July 23, 2022, in Kona at the West Hawaii Civic Center Building
- August 6, 2022, in Lihue at the Moikeha Meeting Room
- August 7, 2022, in Honolulu at Waku/Work Hawaii
- August 7, 2022, in Waianae at Aloha Subs
- August 14, 2022, in Wailuku at the War Memorial Special Events Arena
- August 14, 2022, in Kaunakakai at the Mitchell Pauole Complex

The Social Equity Working Group reported its investigation findings, summarized below, on September 19, 2022, at 1:22:02.[12] The full Social Equity Working Group report[13] may be found on the DOH Dual Use Cannabis Task Force webpage.

Social Equity Working Group Findings:
The Social Equity Working Group espouses "social equity" as stated by the Minority Cannabis Business Association requiring fairness and impartiality and when addressing equity in the cannabis industry, must also encompass restorative policies addressing the harms of past cannabis prohibition on impacted communities. Hawaii has been affected by the federal Controlled Substances Act establishing cannabis as a Schedule I drug and the war on cannabis enforcement of harsh penalties and targeting of minorities. Significant enforcement in Hawaii includes Operation Green Harvest in the 1970s and Operations Wipe Out in 1990, which destroyed cannabis crops, significantly raising cannabis prices which subsequently drove the use of methamphetamine which was cheaper. Some counties have transitioned away from large scale enforcement operations, but others have doubled down with criminal penalties and jail time. The limited number of medical cannabis licensees allowed to grow and sell cannabis is stark injustice which protects a class of citizens while others suffer irreparable harms for the same behavior.

Cannabis Justice Reform
The Social Equity Working Group finds that full legalization is vital to remediating racial disparities in enforcement. In other states, partial legalization or other half measures have reduced the overall number of drug arrests, but increased the disparity between arrests of majority and minority ethnicities. In Hawaii, Native Hawaiians are disproportionately affected by cannabis enforcement, and partial legalization would likely exacerbate this issue. In reviewing court decisions defining levels of legalization and legal cannabis possession, the Working Group could not craft an intelligible rule or scale for legal vs. criminal cannabis possession that was not purely arbitrary.

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[11] Panacea Or Pipe Dream: Does Portugal's Drug Decriminalization Policy Translate For Hawaii?, Hawaii Legislative Research Bureau, Report. No. 1, 2017.
[12] Recording of the September 19, 2022, meeting at: https://www.youtube.com/watch?v=684DnQKRV_I
[13] Tax Working Group Report at: https://health.hawaii.gov/medicalcannabis/files/2022/09/Social-Equity-Group-Final-Report.pdf

To address the stigma on cannabis cultivation, production, and use that pervades Hawaii's society, penalties for operating an unlicensed cannabis business should be set in a civil framework. In doing so, Hawaii can adopt a model in which the crime is not associated with cannabis possession itself, but rather with evasion of a statutory obligation to obtain a license, and which would apply referral to the attorney general only when the offense reaches a sufficient level of intentional evasion. However, full legalization and de-scheduling of cannabis should not exempt cannabis from penalties under other elements of Hawaii law, including distribution to a minor, impaired driving, growing on state lands, etc. Full legalization and de-scheduling would move the criminal sphere to regulations and enforcement mechanisms applicable to similar activities, such as cultivation regulations, consumer protection laws, workers compensation and labor laws, and tax registration and payment. Enforcement can be placed under non-law-enforcement governance rather than a law enforcement framework, as numerous other states have done with their legal cannabis industries.

With respect to resentencing and record clearance, the Social Equity Working Group recognized many of the logistical hurdles involved in navigating the Hawaii State Judiciary and Department of Corrections record systems. The Social Equity Working Group proposed that funding be set aside for a center at the William S. Richardson School of Law to aid those seeking expungement and to give students practical legal experience. The Social Equity Working group noted that this recommendation accords with President Joe Biden's Executive Order on October 6, 2022, which urges states to decriminalize and expunge the records of all those convicted of mere possession of cannabis. In fact, all current, proposed bills before the federal government relating to cannabis legalization or decriminalization include substantial funding for state organizations implementing resentencing and expungement processes. The Social Equity Working Group references the report "Legalization & Retroactive Relief in Hawaii" prepared for the Dual Use of Cannabis Task Force by the Last Prisoner Project in August 2022, from which the group's recommendations are based. Furthermore, for comprehensively researched statistics concerning arrest and incarceration for cannabis-related offenses in Hawaii, the Social Equity Working Group refers to Chapter 5 of the Report No. 1, 2017 from the Hawaii Legislative Research Bureau, Panacea or Pipe Dream: Does Portugal's Drug Decriminalization Policy Translate for Hawai'i? (Table 5-13 of the report shows arrests for possession of marijuana to be substantially higher than for opium, cocaine, and synthetic narcotic across the years between 2000 to 2014.)

The Working Group found that the most direct method for remediation for Hawaii's prosecution under the War on Drugs with the least possibility of mistake or diversion would be vital assistance payable directly to the survivors and families. One of the most frequent concerns raised at the Social Equity Group Listening Sessions was the devastating ongoing and historic impacts of drug enforcement in Hawaii—specifically, the results of civil asset forfeiture practices in connection with drug enforcement actions. Whole families lost their homes, their familial land, vehicles, and other possessions due to even minor drug charges. Resources will be needed to identify and process applicable records for remediation because under Hawaii's criminal code, cannabis offenses are generally not directly identified or electronically searchable in any current reference

technology. Rather, the police reports and other documents for each criminal case will need to be reviewed to identify cases that involved cannabis offenses for possible resentencing, record clearance, and remediation of civil asset forfeiture consequences.

Service Equity

Due to its Schedule I status at both the federal and state level, cannabis use or proximity can have dramatically negative, life-changing effects not only on those affected by criminal enforcement, but also on legal medical use card holders. Protections can be enhanced for certified medical users, along with adult-users under a dual-use system, with respect to employment, child custody, housing, insurance, real estate, banking, and professional services.

Many employers currently maintain zero-tolerance policies, disciplining or terminating employees for failing a random drug test that detects cannabis components or metabolites although these tests do not accurately measure actual impairment, but could reflect use from as long as 90 days previously.

Current policies of Family Court have seen removal of children from homes and custody decisions against parents in association with cannabis use or possession, or a failed cannabis drug test, even when in possession of a valid medical use certification.

Under federal law, even medical use of cannabis is a violation of housing program rules. The United States Department of Housing and Urban Development (HUD) has stated that Public Housing Agencies and owners of federally assisted housing may not grant tenant requests to use medical cannabis as a reasonable accommodation for their disabilities.

Clarity is needed from past federal court rulings on insurance contracts on how state law would apply to insurance contracts in Hawaii. This is important for consumers, as well as current and future cannabis businesses, especially social equity and small businesses, who already struggle to obtain personal, property, and business insurance.

Current cannabis businesses in Hawaii have found it difficult to obtain affordable rental space due to landlord reticence for multiple reasons including fear of cannabis 'trafficking', business complaints and nuisance lawsuits, claims of aiding and abetting the commission of a felony, etc. These issues will need to be addressed as they will be even more impactful on social equity and small business licensees with landlords asking for higher rents, larger deposits, extensive security and other build-out requirements, insurance requirements, and indemnity provisions.

Likewise, because no banking services of any kind are available to Hawaii's current cannabis industry, the large amounts of cash involved in legal cannabis transactions create a risk of theft or robbery.

Finally, while current Hawaii law permits provision of legal services to the cannabis industry, it does not afford similar access to other necessary professional services, either

at all or without significant cost, creating barriers to small business and social equity licensee participation in the legal industry.

Equity in the Market

Social equity applicants can face high barriers to market entry, given complicated and burdensome regulations, and having no guidance or support to operate in an extremely challenging regulated environment. Most feedback received from the Social Equity Group Listening Sessions was that potential cannabis growers and manufacturers, particularly social equity individuals and businesses, could not meet the high bar to enter the current licensed medical cannabis industry. Approaches other states have taken to address this include setting low barriers for obtaining a license and providing social equity programs such as priority applications for social equity businesses. State support would be needed to even the playing field for social equity applicants and licensees who lack access to start-up capital, information, skills, and training for successful operation of a business in a highly regulated industry, and access to experts in the cannabis industry. Provision of specialized support for social equity applicants during the application process and/or after a license is granted would be necessary to meet the stated goal of equal opportunity.

During the transition period from a medical cannabis program to legalization of adult-use, cannabis enforcement often becomes a low priority as the state establishes new regulatory agencies. As a result, other states have experienced sales of unregulated, untested products on a large and visible scale by unlicensed sources. Given the size of Hawaii's legacy market, the State will need an interim transition plan if it intends to use legalized adult-use to reduce the volume of unlicensed, unregulated operations. To help ensure an adequate and safe supply for the medical cannabis patients, the state can provide licenses to qualifying social equity individuals to produce and manufacture medical cannabis products. As a new workforce builds around the legal cannabis industry, affirmative action aligned with social equity goals would help to ensure equity and support a healthier economy.

Finally, the State will need to define who qualifies as a social equity applicant. Criteria that other states have used include race, arrest data, and areas of greatest impact. Hawaii's criteria may differ based on history and demographics. For example, although Native Hawaiians make up only about 10% of Hawaii's population, data from the PEW Research Crime Data Explorer shows that Native Hawaiians have the highest rate of arrests for cannabis possession, at 40%, and are therefore four times as likely to be arrested for cannabis in the state than any other demographic. This data would suggest that Native Hawaiians qualify as the community most impacted for cannabis arrests.

The Task Force discussed the Social Equity Working Group report on September 26, 2022, at 4:03.[14] The Task Force sought to understand how Hawaii's transformative justice program could differ from Oregon, which has been reported unsuccessful. The Working Group clarified that Oregon had not directed the required resources for the

[14] Recording of the September 26, 2022, meeting at: https://www.youtube.com/watch?v=0TXBH5hK5HY

program and that rather than harm reduction as in Oregon, the Working Group is advocating for criminal justice through resentencing and record clearance. The Group proposed that required resources could be realized through post-legalization cost savings in Judiciary, Department of Corrections, Department of Public Safety, and County Police expenses as observed in other states. Resentencing would require review of individual cannabis-related offenses dating back to 1970, when the Controlled Substances Act was passed, and in accordance with the new legalization scheme. An automatic system could facilitate the identification of social equity cases for resentencing and record clearance; however, a public awareness campaign would also be needed to ensure that individuals can bring their case forward for review.

The Working Group raised the need for the State to pursue all avenues to address the current conflict with federal laws criminalizing cannabis, and that enacting law to protect medical use patients would be more efficient than requesting a DEA exemption. Members discussed the threshold amount of cannabis possession that should be considered as a criminal offense and a 1-ounce minimum limit was suggested. However, the Working Group expressed concern that applying limits has resulted in greater racial disparities in other states and instead recommended that cannabis be generally as legal as possible with enforcement as a civil process.

The Task Force discussed approaches for applying social equity given that residency and race-based requirements may fall under dormant commerce clause and equal protection challenges. Possible solutions identified for community reinvestment not yet challenged include lowering license fees for equity applicants, tying equity licenses to adversely impacted neighborhoods or zip codes, and providing positive support to equity applicants. In discussing allowing communities the option to opt-out, Members expressed reservations that opt-out provisions could lead to greater inequity, particularly the overconcentration of cannabis production and retail in the neighborhoods that had been disparately impacted by cannabis criminalization.

Finally, the Task Force raised the need for proposed language defining “Native Hawaiian,” a demographic with no current federal recognition. Options discussed included a general recommendation for the Legislature to include a definition, identifying appropriate language in consultation with Native Hawaiian organizations such as Kamehameha Schools, or applying a zip-code based approach for addressing disparities resulting from the war on drugs.

At the meeting on November 14, 2022, Chair Nakata expressed her concern that the Task Force had not had adequate time to investigate recommendations for social equity and restorative justice policies. Given the broad scope and complexity of potential considerations and the critical role of social equity in the legalization of cannabis, Chair Nakata proposed that instead of voting on which of the Working Group recommendations to adopt, the Task Force consider recommending further study using the Working Group report as a guideline. At 2:27:18, Members voted to not adopt the working group recommendations and to consider alternate recommendations to be included in the final

report at the next meeting.[15] On November 28, 2022, the Task Force voted to approve the following Social Equity recommendations at 28:46.[16]

iii. Social Equity Recommendations

All three of the Task Force's Social Equity recommendations were voted on as a group with the following votes obtained: 11 Ayes, 0 Noes, and 0 With Reservations.

Task Force Social Equity Recommendations:

1. Legislation should establish a properly resourced Legalized Cannabis Social Equity Task Force to make recommendations for:

    - Cannabis Justice Reform – including consideration of the level of legalization; resentencing and record clearance; remediation; funding the identification and processing of applicable records; removal of law enforcement oversight; and civil asset forfeiture equity.

    - Service Equity – including consideration of equity in employment; custody; housing; insurance; real estate; banking; professional services; and community reinvestment.

    - Equity in the Market – including consideration of social equity licensing; state support for social equity license applications; transition period; social equity licensee product sales during the transition; state support for social equity licensee businesses; affirmative action type protections; and qualifying for social equity designation.

    The Task Force shall at a minimum include leaders from Office Hawaiian Affairs and Dept. of Hawaiian Homelands.

2. The Act 169 Dual Use of Cannabis Task Force is pleased to provide the Hawaii State Legislature with a menu of policy options to investigate in order to best integrate appropriate social equity policies into any future dual use cannabis program in Hawaii. The history of cannabis enforcement in Hawaii has engendered a diverse set of inequities across racial, economic, and geographic spectrums, and as the rest of the country is discovering as well, explicit policies must be put in place to redress these harms. Without integrated social equity policies, the experience of other states, as well as a variety of scholarly research sources, have shown that these inequities only increase in emerging cannabis industries.

[15] Recording of the November 14, 2022, meeting at: https://www.youtube.com/watch?v=gcFK0qAlrMY
[16] Recording of the November 28, 2022, meeting at: https://www.youtube.com/watch?v=FNgz--WGEtw

The attached report from the Social Equity Working Group of the Dual Use Task Force surveys the landscape of potential policies. While the Dual Use Task Force as a whole cannot explicitly recommend any of these policies in particular, the Task Force does recognize that any set of social equity policies meant to effectively redress the historical harms of cannabis enforcement will need to pull something from each of the three "buckets" of policies outlined in the report: Cannabis Justice Reform, Community Reinvestment, and Equity in the Market.

It is the opinion of the Act 169 Dual Use of Cannabis Task Force that the integration of social equity policies into a dual use cannabis program deserves intentional study and incorporation by the Hawaii State Legislature into any future cannabis bills.

3. In lieu of approving specific recommendations made by the Social Equity Working Group, the Dual Use Task Force requests legislators convene a new properly resourced Working Group to research Social Equity while considering a legal adult-use cannabis industry. This Working Group should use the report submitted by the Dual Use Task Force's Social Equity Working Group as a high-quality resource document.

   Social equity as part of a newly legal cannabis program is essential to any future legislation and regulation in Hawaii. Other jurisdictions have included social equity as a vital element of legalizing adult cannabis use programs. While there are differences and similarities among many of these programs, Hawaii's situation is unique because of the effects that cannabis laws have had on Native Hawaiians specifically.

   For this reason, the legislature's Social Equity Working Group should, at minimum, include leader(s) from the Office of Hawaiian Affairs as the state's lead agency for improving the wellbeing of Native Hawaiians. OHA should establish methods for determining Native Hawaiian ancestry to qualify those seeking to participate in a Social Equity Program. OHA should also take the lead on developing a plan for a Native Hawaiian Social Equity Program in conjunction in collaboration with other Hawaiian-serving state agencies and non-governmental organizations.

   Equally important is the inclusion of the Department of Hawaiian Homelands because many of the lands under their jurisdiction are zoned for agricultural use by Native Hawaiians and could be key to strengthening cultivation and processing of locally grown cannabis.

   Finally, because one's racial, ethnic, or cultural background does not predict success or failure in any business enterprise, legislators should include other

Hawaiian-serving organizations to advise on appropriate education and/or professional development programs needed to properly prepare Native Hawaiians who seek to participate in a social equity program.

iv. Objections and Reservations

There were no objections or reservations raised by Task Force members regarding the Task Force Social Equity recommendations.

C. Market Structure Investigation

i. Intro

The cannabis industry is one of the fastest-growing industries in the United States and global sales are estimated to reach $33.6 billion by 2025. Market structure is a critical consideration for adult-use legalization because, as with any other industry, market structure will affect the resulting market outcomes through impact on the motivations, opportunities, and decisions of participants. This is especially important given that a primary motivating factor for legalization is suppression of the illicit market by encouraging entry into the legal market.

ii. Investigation

The Market Structure Working Group was established at the meeting on May 31, 2022, at 2:15:30.[17] The scope of the Working Group's investigation was to "identify and make recommendations on the structure of the market that could be allowed, including restrictions on licenses and home growing." Members comprised: Randy Gonce (Chair), Garrett Halydier, Dori Palcovich, Jo Ann Uchida Takeuchi.

The Market Structure Working Group met on June 22, 28, July 5, 26, and August 2, 9, and 15, 2022 and submitted its report to the Task Force on August 17, 2022.

The Market Structure Working Group reported its investigation findings, summarized below, on August 29, 2022, at 1:51:22.[18] The full Market Structure Working Group report[19] may be found on the DOH Dual Use Cannabis Task Force webpage.

The Market Structure Working Group started off by grounding itself in the current environment around the nation regarding the cannabis market structure. The preliminary investigative review of the pros and cons of horizontal and vertical structures, types of licenses that are available around the country, and states that currently have an adult-use program was divided between the four members of the group. States that were reviewed

[17] Recording of the May 31, 2022, meeting at: https://www.youtube.com/watch?v=5ctzh71PjR0
[18] Recording of the August 29, 2022, meeting at: https://www.youtube.com/watch?v=hlluRWGSU4Y
[19] Market Structure Working Group Report at: https://health.hawaii.gov/medicalcannabis/files/2022/08/2022.08.17-Market-Structure-Group-Report.pdf

included California, Colorado, Illinois, Maine, Michigan, Nevada, New York, and Oregon. The findings were discussed over the course of subsequent meetings with the goal of seeking answers to questions such as:

- What license structure do they use (what activities do they have licenses for, what do the licenses authorize, costs for a license, and anything else you find relevant to the structure of the licensing scheme)
- What licensing process did they use to issue the licenses and what was required to get a license
- Anything interesting about the success or failure of the initial roll-out/implementation of the program
- Anything interesting about the current shape of the industry x number of years after the roll-out
    - Did the industry grow or stagnate, were the licenses used, did the businesses succeed/fail?
- What sort of regulatory agency/framework oversees the industry?
- What sorts of market participation/economic numbers can you find?
    a. Medical patient numbers before/after legalization
    b. Consumer numbers after legalization
    c. Consumer demographics
    d. Price of wholesale/retail cannabis products over time

At the July 26th meeting the Market Structure Working Group was introduced to Mark Richie, Branch Chief for DBEDT's Business Support Division to discuss the Made in Hawaii products versus Hawaii Seals of Quality program. Over the course of the next few meetings, the Market Structure Working Group began structuring the report. Garrett Halydier graciously drafted and submitted the report based on our investigations and discussion.

Market Structure Working Group Findings:

The Market Structure Group found that in implementing adult-use cannabis programs, other states have endeavored to develop a healthy market ecosystem grounded on balanced supply and demand; an equitable, policy-driven distribution of market share; effective tools to ameliorate the public health impact of increased cannabis consumption; targeted strategies to transition the legacy market to the regulated market; and the application of tax revenue to designated public purposes. Due to a variety of factors, states have had mixed success in achieving these goals, and Hawaii can benefit from the lessons learned in other states to develop Hawaii-specific policies that will better achieve these goals.

An important consideration for a healthy cannabis market is creating a licensing structure that will limit the legacy and the gray markets by offering effective on-ramps into the regulated and licensed adult-use program. This would mean transitioning from Hawaii's current "vertical integration" structure, in which all elements of production, manufacturing, and sale are handled by a single entity under a single license, to a "horizontal licensing" structure, which provides for a variety of cannabis business licenses. Vertical integration requires significant capital investment and presents a great

challenge for small businesses to enter the industry or to compete with large enterprises. Vertical integration makes it nearly impossible for equity applicants to succeed and creates obstacles to allowing the market to find the optimal pricing to compete with the legacy or gray markets. Benefits of maintaining a vertical structure include less resources required to manage an industry comprised of fewer market participants, greater control and reliability of the supply chain, greater economies of scale, faster adjustment of product offerings based on demand, and ability to attract big investors. On the other hand, the horizontal licensing structure is less expensive, and allows for more market participants and trade specialization, leading to greater product diversity. Retailers would be able to buy from multiple growers and provide both medical and adult-use with access to a wider product range, including unique cannabis strains. Furthermore, the horizontal structure allows the regulating authority to ensure that all elements of the industry are regulated, effectively respond to aggregate demand and supply issues, and increase revenue through licensing fees and taxes. All adult-use markets in the U.S. apply horizontal licensing structures, and some states ban vertically integrated businesses.

The licensing system should be structured to allow approval of applicants who meet licensure requirements. The Market Structure Working Group recognizes concerns about oversaturation or undersupply of cannabis and that limiting the number of available licenses is a means of controlling supply and demand. However, prices will naturally fall as industry adjusts to influx of customers and supplies, and artificially prolonging the process by restricting licenses would incentivize overinvestment in business infrastructure reliant on current prices, inhibiting Hawaii's cannabis industry from competing in a national market. License restrictions may also negatively impact social equity. As Hawaii shifts to a horizontal model and diversifies the licensee population, the setting of license caps at the start of the program may be premature. An alternative method of managing the number of market participants and supply of cannabis is to authorize the governing body to adjust license requirements, such as fees, to discourage new entrants when the market becomes saturated. Another issue observed in other states after adult-use implementation is the influx of foreign and interstate investors who may introduce questionable fiscal resources and control sufficient capital to create significant market inefficiencies. Other states have seen a rash of businesses started then quickly abandoned to take advantage of the initial price bump. These abandoned properties drive up home prices, are a blight on neighborhoods, and distort the local markets by keeping local growers and operators out of the industry. Current Hawaii rules do not preclude participation by foreign or interstate investors provided the criteria for minimum Hawaii ownership is met.

A comprehensive adult-use licensing scheme should include licenses for cultivation, manufacturing/processing, distribution, delivery, testing, transportation, retail, and on-site consumption. These licenses should be "stackable" as long as the requirements for a particular license type are met, and there should be no limit on how many different types of licenses a licensee can acquire. However, there should be a limit on how many of a particular type of license a licensee can acquire to prevent monopolization of the market. Furthermore, limited, lawful home grow is an important element of legalized cannabis,

particularly for Hawaii given its extensive history with medical cannabis and affordability for medical patients on fixed incomes.

The system for cultivation licenses needs to: (1) provide for the continuation of small individual grows; (2) allow for the easy transition of the legacy market into the new, legal licensee structure; (3) encourage small, artisanal farmers to take advantage of Hawaii's unique micro-climates and cannabis genetics; (4) create sufficient supply for both the local and tourism markets; (5) prioritize local ownership of cannabis businesses; (6) forestall industry domination by large, multi-state operations; (7) continue to protect the safety of industry participants and consumers alike; and (8) prepare Hawaii to compete as an exporter on the national and international stage over the next ten to twenty years.

The Market Structure Working Group's proposed licensing structure would allow cultivation licenses to sell seeds/clones, grow products indoor or outdoor, sell directly or consign their cannabis to retail licenses and only licensed cannabis businesses, require product testing to meet state health standards, and submit an audit with every license renewal. The detailed Market Structure Working Group report specifies how these, and other requirements and licensing pricing can be applied to various licenses, including home grow (up to 20 plants), cooperatives, and commercial grow from 20 plants to over 10,000 square feet of cultivation.

A licensing structure will also be needed for plant-touching businesses, i.e., manufacturing/processing, distribution, delivery, testing, transportation, retail dispensary, and on-site consumption. Business licenses regulations and proposed requirements for each of these business specializations are detailed in the Market Structure Working Group report. All consumer sales must be tested and packaged appropriately, although testing would not be required for licensee-to-licensee sales. The regulating authority should investigate the feasibility of requiring a seed-to-sale tracking system. Other considerations include minimum financial standards to qualify, but which would accommodate small businesses, pre-licensing inspection with technical assistance for social equity applicants, and labeling requirements, including "Made in Hawaii" branding to protect Hawaii's unique cannabis genetics. Facilitating the growth of plant-touching businesses will lay the groundwork for a flourishing Hawaii industry that will be ready to expand into additional markets in the future.

The Task Force discussed the Market Structure Working Group report on September 19, 2022, at 2:03:43.[20] The Working Group clarified that the report recommendations were not meant to be prescriptive, but to provide suggestions on how the market could be structured. The Working Group addressed comments from public testimony, agreeing with a recommendation to include incentives for local farms and to have a flexible regulatory authority with independent decision-making powers and the ability to change licensing fees. No additional comments were provided by other Task Force Members.

[20] Recording of the September 19, 2022, meeting at: https://www.youtube.com/watch?v=684DnQKRV_I

The Task Force voted to approve five of six of the Market Structure Working Group recommendations on November 14, 2022, at 2:09:05.[21]

iii. Market Structure Recommendations

Task Force Market Structure Recommendations:

1. The market structure should not create a stand-alone industry that requires a large amount of individual oversight by the regulatory authority and regulatory overlap with current agencies and rules. Most of the rules applicable to the cannabis market: consumer protection, common law nuisance, county building safety/building codes, AOAO covenants, tax compliance, business registration requirements, labor laws, insurance requirements, etc., already exist and do not need to be created sui generis. Thus, restrictions should not be stronger than the laws and restrictions that currently govern alcohol breweries, distilleries, distributors, and retail locations. [10 Ayes, 0 Noes, 1 With Reservations[22]]

2. The licensing structure should be horizontal, with a variety of licenses for all plant-touching elements of the supply chain, and no limits on how many different types of licenses a licensee may acquire (i.e., voluntary vertical integration). [7 Ayes, 1 No, 3 With Reservations[23]]

3. The regulatory agency should be given authority to establish license fees, the number of licenses, and other licensing requirements to prevent the oversupply and undersupply of cannabis in the market. [9 Ayes, 0 Noes, 1 With Reservations[24]]

4. The State should establish geographic indicators, appellations, or other forms of intellectual property or branding protection, like the Department of Agriculture's "Seals of Quality" program, and potentially in partnership with the Hawaii Tourism Authority, to protect and promote Hawaii's unique genetics and world-renown brand. [7 Ayes, 3 Noes, 1 With Reservations[25]]

5. There should be an independent regulatory body that consists of a smaller oversight board supported by a larger advisory board yielding the powers and

[21] Recording of the November 14, 2022, meeting at: https://www.youtube.com/watch?v=gcFK0qAlrMY

[22] Member Gonce voted with reservations but did not submit a written statement for inclusion in the final report.
[23] Members Gonce and Gorman and Chair Nakata voted with reservations but did not submit a written statement for inclusion in the final report.
[24] Member Gorman voted with reservations but did not submit a written statement for inclusion in the final report.
[25] Chair Nakata voted with reservations but did not submit a written statement for inclusion in the final report.

duties to regulate and control the adult-use and medical use cannabis licensing and registration programs. [5 Ayes, 3 Noes, 3 With Reservations[26]]

iv. Objections and Reservations

[**Wendy Gibson**] My reservations regarding the Market Structure Working Group recommendation #3 on home grown cannabis plants for personal use are that I believe that 20 plants per person (for adult-use) is too many, especially if no limits per household are established. A household with 5 adults would be allowed to grow 100 plants. I believe that allowing 20 per person can lead to many problems, including:

- Encouragement of heavy use
- Risk of diversion to youth
- Theft/robbery
- Public nuisance from odor and noisy equipment (such as fans)
- Law enforcement dealing with difficult to enforce laws/rules.

Medical cannabis patients are allowed to grow up to 10 plants. I think that the number of plants for adult-users should be less than 10 and they should not be allowed to sell their product unless they have a license to do so.

D. Medical Use Working Group

i. Intro

Act 169 SLH 2021 specified consideration of the impacts of adult-use legalization on qualifying patients, including access to medical cannabis by qualifying patients as a primary purpose of the Dual Use Cannabis Task Force. While legalization reduces the stigma surrounding cannabis use and barriers faced by patients, not all medical use patients unilaterally support adult-use. One identified unintended consequence is that the market no longer caters to medical patients with medical users finding that they can no longer find the products that they want and need.

ii. Investigation

The Medical Use Working Group was established at the meeting on May 31, 2022, at 2:21:11.[27] The scope of the Working Group's investigation was to "identify the concerns and priorities of registered medical use patients and certifying medical providers and make recommendations on policies that would help to address these concerns and priorities." Members comprised: Terilynne Gorman (Co-Chair), Nikos Leverenz (Co-Chair), Wendy Gibson, Randy Gonce, Dr. James Ireland, and Rep. Ryan Yamane.

[26] Members Randy Gonce, Teri Gorman and Nikos Leverenz voted with reservations but did not submit a written statement for inclusion in the final report.
[27] Recording of the May 31, 2022, meeting at: https://www.youtube.com/watch?v=5ctzh71PjR0

The Medical Use Working Group relied primarily on the results of a confidential online, rapid survey deployed to the Hawaii DOH Medical Cannabis Patient Registry and medical providers. The Working Group received responses from 3,237 patients, 62 caretakers for an adult, and three caretakers for a minor participated in the patient survey. The survey, results, interpretation of results, open responses and comments from patients are appended to this report.

In addition, Working Group members spoke with Arizona-based physician, Sue Sisley, M.D., via Zoom for nearly an hour. Dr. Sisley shared her experiences in other states that have enacted dual use programs following medical programs. Working Group members also discussed anecdotal stories about the struggles and problems shared by anonymous Hawaii medical cannabis patients.

The Medical Use Working Group reported its investigation findings, summarized below, on September 19, 2022, at 2:39:15.[28] The full Medical Use Working Group report[29] and the Patient and Provider Rapid Survey report may be found on the DOH Dual Use Cannabis Task Force webpage.[30]

Medical Use Working Group Findings:
In July 2022, at the request of the Medical Use Working Group, the Hawaii Department of Health Office of Medical Cannabis Control and Regulation deployed a voluntary and anonymous online survey in collaboration with the Medical Use Working Group to collect input from patients, their caregivers, and certifying medical providers in the state medical cannabis program on their perceptions and concerns around the legalization of adult-use and patients' current experiences in accessing medical cannabis and issues in relation to their medical use. Survey findings showed that most patient respondents believed that the legalization of adult-use would have a positive effect on medical use of cannabis, while certifying medical providers varied in their opinions. Both patients and providers commented that legalization would facilitate access to those needing cannabis for medical use who were not enrolled in the medical use program and reduce stigma and discrimination against medical cannabis users.

Almost 90% of respondents hoped that legalization would lead to more product variety and reduced costs, although 44% were concerned that prices would rise, for example from overregulation and higher taxes. Other concerns included supply shortages, longer purchase wait times, and deteriorating product quality, although two-thirds of patients and one-half of providers were not concerned that product quality would decline. Nearly one-third of patients and providers were concerned that patients would lose the right to grow their own cannabis. Another shared concern was that there would be less focus on

[28] Recording of the September 19, 2022, meeting at: https://www.youtube.com/watch?v=684DnQKRV_I
[29] Medical Use Working Group Report at: https://health.hawaii.gov/medicalcannabis/files/2022/08/Medical-Use-PIG-Recommendations.pdf
[30] Patient and Provider Rapid Survey Report at: https://health.hawaii.gov/medicalcannabis/files/2022/08/Medical-Cannabis-Patient-and-Provider-Survey-July-2022.pdf

patient care and that fewer patients would seek medical consultation for their treatment needs.

Most patients stated an intent to remain registered with the medical cannabis program should Hawaii legalize adult-use. Reasons for remaining a registered patient were for legal protections (e.g., employment, interisland and interstate travel, housing, etc.), to continue receiving medical consultation with providers and caregiver support, to be recognized as a medical patient and have patient needs met, and because the medical program ensures quality control and testing of products. The 12% of patients who reported that they would exit the medical cannabis program cited registration and provider fees as the main reason for leaving. Some stated that they will no longer need medical cannabis for their condition, or that medical cannabis did not help with their condition. The leading consideration for the one-third of respondents who were unsure whether they would remain a registered patient was cost. These respondents commented that they would remain registered if there were special benefits (e.g., tax breaks, dispensary discounts, priority access for purchasing products, etc.) for registered patients.

The survey also gathered information on the types of products patients needed and the extent to which they were able to access these. Patients grew or shopped for a variety of products, with the most sought-after being specific THC/CBD ratios, edibles, and flower material. Specific strains and THC/CBD ratios were needed for relieving specific syndromes. A high proportion of patients (86%) sourced some of their products from dispensaries, and 55% used dispensaries only. The next most common way patients obtained products was by growing their own (32%) with 9% exclusively growing their own. Few patients (3%) grew in a collective (group of patients sharing a common grow area) or sourced online (2%). Over 87% of patients reported always or often being able to obtain the products they needed, but of those who were not always able to source needed products, reasons included that these products were not available at dispensaries (56%), not affordable (48%), or inability to travel interisland (19%).

Distance from dispensaries and lack of delivery or curbside services presented an access challenge for many patients with one-fourth reporting no transportation or having debilitating conditions. The survey also collected data on the medical information sources patients rely on. Two-thirds consulted with healthcare professionals, but a large proportion (56%) also obtained information from licensed dispensary employees.

Patients were asked about socioeconomic and legal issues related to their medical use so that recommendations could be made to address the stigma and discrimination surrounding cannabis use and issues related to cannabis' federal classification as a Schedule I drug. Three-fourths of patients reported no issues with employment, traffic violations, housing, medical benefits, insurance, child custody, or purchasing firearms related to their medical use or inability to use medical cannabis in public. Some patients (14%) reported not being able to obtain a gun or permit or not being able to use medical cannabis in public places (9%). For some, the Schedule 1 classification was a barrier to housing access and government assistance. Patients also commented that federal law places financial burden on patients since health insurance does not cover cannabis

treatment. Most providers (69%) reported that their medical practice had not been negatively impacted by federal law. Those who had been impacted clarified that the law interfered with their ability to provide patient care or that it caused them to be hesitant to enroll in the medical cannabis program.

The Task Force discussed the Medical Use Working Group report on September 26, 2022, at 1:08:41.[31] The Working Group clarified that the laboratory testing requirement recommendation was intended to apply only to entities growing medical cannabis for sale and for multiple users. Private citizens growing their own medical cannabis could choose to test their products but would not be subject to required testing. The Working Group emphasized that testing by independent third-party laboratories of all commercial products was essential because underlying health issues could be exacerbated by product contamination. Support was expressed for aligning testing requirements for commercial products with those for medical use products, which are rigorous and evidence-based to limit risks associated with cannabis. Clarification of the testing process was discussed.

The Task Force discussed whether there should be mechanisms to prevent individuals at risk for suicide and other mental health consequences of cannabis use from qualifying for medical use of cannabis. The Working Group recommended that this decision be left to the certifying medical provider given they have the required skills and knowledge and familiarity with the patient. Trained dispensary workers could also potentially help to identify concerning psychological conditions and refer the patients back to their certifying providers as needed. Given the limited research on cannabis in the United States, annual updates and continuing education is needed to ensure that patients and dispensary personnel, as well as certifying providers remain informed on developments in medical cannabis research. Generally, all medical professionals will need to be educated, especially given the potential drug-drug interactions with cannabis, including CBD products which are widely available and have more drug interactions than THC. Certifying providers may not be the same as the treating clinician, so the latter may have limited or no knowledge of the patient's use of medical cannabis. Health information systems linking prescription drug monitoring to the medical patient registry would allow the treating provider to discuss potential drug interactions with their patients.

The Working Group stated its position that it was incumbent upon the State to facilitate a broad range of products for medical patients and not place restrictions on modes of delivery needed by patients. However, there was concern raised that smoked and vaped forms may pose similar risks as tobacco smoke, and that long-term effects remain unknown. The Force Members underscored the need for more robust research on cannabis, which has been hampered by the federal Controlled Substances Act.

Finally, Task Force Members discussed the adverse legal experiences of medical patients, particularly those resulting from firearm restrictions and employment drug testing. While the recommendation to change the firearm prohibition will conflict with federal law, in advocating for medical use patients, the Working Group asked that to the extent possible, local State and law enforcement implement policies to enable medical user ownership of

[31]Recording of the September 26, 2022, meeting at: https://www.youtube.com/watch?v=0TXBH5hK5HY

firearms, and to not take actions such as in 2017 directing medical use patients to surrender their firearms. A public safety concern was raised regarding limitation of cannabis testing for employment. The Working Group agreed that ensuring public safety was important but clarified that the presence of THC metabolites in urine did not mean that a person is impaired.

The Task Force voted to approve all but one of the Medical Use Working Group recommendations on November 14, 2022, at 1:38:02.[32]

iii. Medical Use Recommendations

Task Force Medical Use Recommendations:

Medical Considerations

1. Legislation should require healthcare facilities to allow the use of medical cannabis on their premises for terminally ill patients with a valid medical cannabis card or/ recommendation from their physician. [9 Ayes; 1 No; 1 With Reservations[33]]

2. Higher THC content per serving and per package should be allowed in medical-use products than for adult-use, due to the special needs of medical use patients, especially those in palliative care. [8 Ayes; 1 No; 2 With Reservations[34]]

3. Medical dispensaries should be authorized to provide delivery services and curbside pick-up to protect patient health and privacy and to ensure access by homebound patients, those in palliative care, and those with compromised immunity due to pre-existing health conditions. [8 Ayes; 2 Noes; 1 With Reservations[35]]

4. The State should eliminate the list of qualifying conditions as a requirement for registration in the medical cannabis registry and respect the doctor-patient relationship by allowing qualifying physicians and/or APRNs to decide for medical use of cannabis. [9 Ayes; 2 Noes; 0 With Reservations]

[32] Recording of the November 14, 2022, meeting at: https://www.youtube.com/watch?v=gcFK0qAlrMY

[33] Chair Michele Nakata voted with reservations but did not submit a written statement for inclusion in the final report.
[34] Member Gonce voted with reservations but did not submit a written statement for inclusion in the final report.
[35] Reservations of Member Halydier may be found in section V.D.iv.

5. Registered medical use patients should retain their right to grow their own cannabis plants and/or designate a caregiver as currently provided by law. [9 Ayes; 1 No; 1 With Reservations[36]]

6. Registered medical use patients should remain exempt from any new taxes that may be levied on the sale of cannabis or cannabis products under an adult-use program. [8 Ayes; 3 Noes; 0 With Reservations]

7. All cannabis and manufactured cannabis products, intended for sale or distribution, should be subject to the same testing standards currently provided by law, to ensure safety and quality of all commercial cannabis statewide for medical use. [11 Ayes; 0 Noes; 0 With Reservations]

8. Medical cannabis retail locations should be required to maintain a dedicated inventory for medical use patients and offer a private meeting space for patient consultation with staff members. [9 Ayes; 0 Noes; 2 With Reservations[37]]

9. All existing medical cannabis licensees should be allowed to continue to operate without disruption as the adult-use program is operationalized. [7 Ayes; 2 Noes; 2 With Reservations[38]]

10. Current legislation and regulations should be reviewed and amended to allow for expanded production and wholesale limits in anticipation of increased demand. [5 Ayes; 3 Noes; 3 With Reservations[39]]

Patient Protections

1. Legislation should provide employment protections for registered medical use patients covering hiring, discipline, and termination. A positive test for cannabis metabolites shall not be proof of impairment on the job, and employers and insurance companies must be prohibited from medical discrimination. [7 Ayes; 3 Noes; 1 With Reservations[40]]

2. Legislation should prohibit law enforcement agencies from denying or revoking the right to own permitted firearms, solely due to a person's status as a registered medical use patient. [9 Ayes; 2 Noes; 0 With Reservations]

[36] Member Gonce voted with reservations but did not submit a written statement for inclusion in the final report.
[37] Members Halydier and Gonce voted with reservations but did not submit a written statement for inclusion in the final report.
[38] Members Gonce and Uchida Takeuchi voted with reservations but did not submit a written statement for inclusion in the final report.
[39] Members Halydier, Gorman, and Uchida Takeuchi voted with reservations but did not submit a written statement for inclusion in the final report.
[40] Member Ireland voted with reservations but did not submit a written statement for inclusion in the final report.

3. Legislation should permit registered medical use patients to possess medical cannabis and cannabis products for personal use when traveling between counties within the State. [9 Ayes; 2 Noes; 0 With Reservations]

4. Legislation should permit patient reimbursement for approved medical cannabis products by state-regulated insurers. [8 Ayes; 3 Noes; 0 With Reservations]

Patient and Public Health Education

1. The Department of Health should develop a robust education campaign aimed at reducing ignorance and stigma surrounding the medical use of cannabis for medical professionals, healthcare administrators, and insurance providers. [9 Ayes; 1 No; 1 With Reservations[41]]

2. The Department of Health should develop and deploy a public health education campaign about medical cannabis use, safety considerations, and how to identify signs of psychological dependence. [10 Ayes; 1 No; 0 With Reservations]

iv. Objections and Reservations

[**Garrett Halydier**] There should be no distinction between medical and adult-use markets products. Labeling requirements should solve any potential negative impacts.

Third parties, in addition to medical dispensaries, should also be allowed to provide delivery services for medical patients.

Any decision to exempt medical use patients from any new taxes should be placed in the hands of an independent regulatory body, or otherwise made consistent with the recommendations of the Tax Working Group.

Medical cannabis dispensaries should not be required to offer patient consultations. Dispensaries should only be allowed to offer private patient consultations under specific guidance for such consultations to avoid any misconception that such consultations are providing medical advice.

Amendments to legislation and regulations to allow for expanded production and wholesale limits should be consistent with the recommendations of the Market Structure Working Group, and not exceed the relevant restrictions, as provided by any Dual-Use or Adult-Use cannabis industry authorizing legislation.

E. Public Health and Safety Working Group

[41] Member Gibson-Viviani voted with reservations but did not submit a written statement for inclusion in the final report.

i. Intro

Cannabis is an inherently complex plant with known health benefits while also being potentially intoxicating and addictive. This binary raises concerns about health and safety consequences that may be amplified by expansion to adult-use, including the long-term impacts of use, heavy use, and second-hand exposure.

ii. Investigation

The Public Health and Safety Working Group was established at the meeting on May 31, 2022, at 2:25:52.[42] The scope of the Working Group's investigation was to "identify and make recommendations on policies to safeguard public and consumer health and safety, including preventing youth access, impaired driving, use disorder, and impacts to mental health." Members comprised: Michele Nakata (Chair), Randy Gonce, Dr. James Ireland, Barett Otani, Sen. Joy San Buenaventura, and Jared Redulla.

Due to the competing priorities of its members, the Public Health and Safety Working Group met only once, on June 27, 2022, and only four of six members were able to attend. As such, the investigation was undertaken primarily by the Chair and drew heavily from the 2017 National Academies of Science, Engineering, and Medicine report and Evidence Statements of the Colorado Department of Health and the Environment, Retail Marijuana Public Health Advisory Committee. Investigation findings and recommendations were reviewed and endorsed by all six Working Group members on September 26, 2022.

The Public Health and Safety Working Group reported its investigation findings, summarized below, on October 3, 2022, at 22:45.[43] The full Public Health and Safety Working Group report[44] may be found on the DOH Dual Use Cannabis Task Force webpage.

Public Health and Safety Working Group Findings:
A wide range of public health and safety harms associated with cannabis use were identified. A major concern identified by the Substance Use and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health (NSDUH) are developmental impacts on adolescents and young adults, for which substantial or moderate evidence show cognitive and academic impairment; increased risk of developing psychotic and other mental health disorders, including schizophrenia and more suicidal thoughts or attempts; and greater likelihood of progression to substance use disorders for cannabis, alcohol, tobacco, and other drugs in adulthood. Equally concerning are adverse fetal development outcomes resulting from cannabis consumption during pregnancy and breastfeeding. Biological evidence shows passage of THC through the placenta and breastmilk, and studies have shown resulting low birthweight, reduced

[42] Recording of the May 31, 2022, meeting at: https://www.youtube.com/watch?v=5ctzh71PjR0
[43] Recording of the October 3, 2022, meeting at: https://www.youtube.com/watch?v=v1GtYQVVEfc
[44] Public Health and Safety Working Group Report at: https://health.hawaii.gov/medicalcannabis/files/2022/09/Dual-Use-of-Cannabis-Public-Health-Safety-Working-Group-Report_FINAL_2022-9-26-1.pdf

cognitive function, decreased IQ and academic ability and attention problems among exposed offspring.

NSDUH research, as well as that of numerous other mental health specialists, has established association of cannabis use with neurological, cognitive, and mental health disorders among adults as well. Use of cannabis has been associated with increased impairment of memory, learning, and attention; psychotic disorders and symptoms; and higher risk of depressive disorders, PTSD, and suicide. Cannabis use disorder can develop, particularly with increasing frequency of use. Prolonged use can lead to cyclic vomiting (i.e., cannabinoid hyperemesis syndrome), and heavy cannabis smoking to chronic bronchitis. Other adverse effects include increased risk of ischemic stroke among individuals under 55 years of age, and increased risk of cancer. Furthermore, clinically important drug-drug interactions between cannabis and multiple medications pose health complications for children and adults.

The National Institute on Drug Abuse (NIDA) continues to emphasize the traffic safety concerns that increased access to cannabis following legalization of adult-use presents. After alcohol, cannabis is the substance most often associated with impaired driving, and combined use of cannabis and alcohol increases impairment and risk of motor vehicle crash than use of either substance alone. Studies examining the duration of THC-induced driving impairment, found evidence of impairment up to 8 hours after oral ingestion and 6 hours after smoking. In addition, blood THC levels among cannabis-impaired drivers are now higher than in the past.

The American Lung Association and U.S. Centers for Disease Control and Prevention (CDC) emphasize that cannabis smoke shares the same carcinogenic chemicals as tobacco smoke. Like tobacco smoke, cannabis smoke can cause a range of illnesses to the individual who smokes as well as others exposed to secondhand smoke in the same household and multi-unit residences. Detectable THC concentrations have been found in children living in households with a parent, relative or caretaker who uses cannabis. A study on tobacco smoke reported that half of residents in multi-unit buildings experienced smoke entering their units despite smoke-free policies.

Children, youth, pregnant women, and elderly are among the populations most vulnerable to health effects of legalized adult-use. The American Academy of Pediatrics (AAP) highlights the significant clinical effects requiring medical attention resulting from unintended exposure in children. States with increased legal access have seen increases in unintentional pediatric poisoning despite the use of child resistant packaging. Among U.S. adolescents, cannabis is the most widely used illicit drug, with over one in five reporting current use in 2019. Policies implemented to reduce youth access include restricting sales to licensed dispensaries; limiting retailer hours; extensive advertising restrictions; prohibiting retail near schools, youth centers, parks, and playgrounds; and controlling products forms and packaging so that they are not attractive to children and youth. Cannabis is also the most used illicit drug among pregnant women, with between 3-7% reporting use. Studies show increasing acceptance of use during pregnancy despite American College of Obstetricians and Gynecologists (ACOG) recommendations

discouraging use by pregnant women due to potential impacts on the developing fetus. Increasing cannabis use has also been documented among adults ages 65 and above, whose chronic medical conditions and general decline in functioning increases their vulnerability for potential adverse effects. Product safety guidelines and policies established early and prior to adult-use access can ensure public safety and consumer protections. In addition to child-resistant packaging, labeling requirements are needed to prohibit unsubstantiated health claims. Laboratory testing requirements for contaminants currently in place for medical use products are applicable to adult-use retail products. Also, because greater THC concentrations increase the likelihood of adverse health outcomes, consumer protection can be further achieved through THC concentration limits and/or taxation of sales based on THC concentration.

Management of environmental impacts are important considerations for expansion of the legal market to include adult-use. Cannabis cultivation and product manufacturing requires intensive energy use, especially if cultivated in a controlled indoor environment, requiring intense artificial lighting, ventilation, cooling, dehumidification, etc. As with any agricultural-based industry, there will be substantial water and land use demands. Effective management of water resources includes automated watering systems that produce less than 20% runoff, with filtration and reuse of wastewater. Proper land use management is needed to ensure the long-term health of land and soil. Specific attention to pesticides and heavy metals is critical because these are stored in cannabis plant material and concentrated in manufactured products. Waste management best practices include on-site composting and fermentation, minimizing universal and hazardous waste through source-reduction and substitution (e.g., using LEDs instead of mercury-containing fixtures), and use of recyclable or biodegradable packaging materials. Air quality control options include carbon filtration for indoor cultivation facilities that are sealed and applying mass balance calculations to estimate and limit volatile organic compound (VOC) emissions from product manufacturing. The strong odors from cannabis odor emissions are already a significant community concern that impacts quality of life for those living near cultivation sites.

Additional important health, social and environmental impacts not yet known are likely given that research on the effects of cannabis have been limited globally.

The Task Force opened discussions on the Public Health and Safety Working Group report on October 31, 2022, at 1:19:32,[45] but no Task Force Members had any comments.

The Task Force voted to approve all three of the Public Health and Safety Working Group recommendations on November 14, 2022, at 1:27:55.[46]

iii. Public Health and Safety Recommendations

[45] Recording of the October 31, 2022, meeting at: https://www.youtube.com/watch?v=0uTl31h2DRM
[46] Recording of the November 14, 2022, meeting at: https://www.youtube.com/watch?v=gcFK0qAlrMY

Task Force Public Health and Safety Recommendations:

1. The State should adopt the recommendations of the 2020 American Public Health Association Policy Statement, "A Public Health Approach to Regulating Commercially Legalized Cannabis" (Policy Number 20206) to: provide protection to children and youth and other vulnerable and marginalized populations; minimize harm to the public; and monitor patterns of cannabis use and related public health and safety outcomes. [11 Ayes; 0 Noes; 0 With Reservations]

2. The Department of Health should establish a comprehensive surveillance program that: monitors cannabis use and exposure trends and risk associations among Hawaii's population; quantifies adverse events, including, but not limited to hospitalizations and emergency department visits, impaired driving and traffic-related fatalities; and cannabis dependence or addiction treatment rates; and monitors adverse effects from prolonged cannabis use, particularly cannabinoid hyperemesis syndrome and outcomes among medical use patients, such as drug interactions. [8 Ayes; 0 Noes; 3 With Reservations[47]]

3. The Department of Health should convene a Public Health Advisory Committee analogous to the Colorado Department of Public Health and Environment Retail Marijuana Public Health Advisory Committee comprised of health care professionals who have expertise in fields that intersect with cannabis use including poison control, neuropsychology, laboratory sciences, pharmacology, medical toxicology, emergency medicine, psychiatry, pediatric emergency medicine, neonatology, addiction medicine, and public health.

   Duties of the advisory committee should include: a review of current scientific literature on the health effects of cannabis use to come to consensus on population health effects; translation into public health messages; recommendation of public health policies; and identification and prioritization of gaps in the science important to public health. [9 Ayes; 0 Noes; 2 With Reservations[48]]

iv. Objections and Reservations

[**Garrett Halydier**] The recommended Public Health Advisory Committee should be subordinate to the independent regulatory body established to oversee the Dual-Use Cannabis Industry as a whole.

[47] Members Ireland and Uchida Takeuchi voted with reservations but did not submit a written statement for inclusion in the final report. Reservations of Member Gibson-Viviani may be found in section V.E.iv. Member Halydier voted Aye and submitted a written statement found in section V.E.iv.

[48] Member Uchida Takeuchi voted with reservations but did not submit a written statement for inclusion in the final report. Reservations of Member Gibson-Viviani may be found in section V.E.iv.

[**Wendy Gibson-Viviani**] My reservations about recommendation #2 from the Public Health and Safety Working Group regarding DOH establishing a comprehensive surveillance program is that, although I agree that a surveillance program is needed, I have reservations regarding the following suggested data:

- In the Colorado Monitoring Health Concerns related to Marijuana, the data suggested to be collected when tracking Dose and Drug-Drug Interactions is the method, the amount, the THC content, and frequency of use.

  I suggest collecting more data than that. CBD and possibly some of the terpenes in cannabis can also lead to drug-drug-interactions. So, data collection should also include lab test results or information from product labels when available. Patients may be able to describe the "flavor" (such as skunky or lemony) which may give important clues to which terpenes may be in the product.

- Addiction treatment rates may be based on "court-mandated" treatment and may not reflect actual need for treatment. Users may be faced with the choice of going to rehab or jail, leading to skewed statistics.

  I urge tracking which cases are court-mandated.

My reservations about recommendation #3 from the Public Health and Safety Permitted Interaction Group, RE: DOH convening a Public Health Advisory Committee are that, although I agree that reviews of current scientific literature on the health effects of cannabis use are important. However, if we are asking lawmakers to base policy on studies that are focused only on negative health effects, then it is also important that we include acknowledgment that:

- Associations and correlations do not equate to causation. While cannabis use is associated with mental health issues, causation cannot be established. As rates of cannabis use go up, rates of schizophrenia do not follow the upward trends.

- When all that you monitor are adverse events, this leads to incomplete and biased samples, resulting in skewed data and a research gap.

- While the Public Health and Safety working group gathered the best reviews of literature we have, we also need to acknowledge the limitations of the studies. Some examples:
  - These studies were not randomized, placebo-controlled, human studies using lab-tested products of known chemovars.
  - We don't know the method of delivery.
  - It is unknown if the products used had contaminants: The government used to spray paraquat on crops; the government-provided materials given to researchers may contain lead and mold (as Dr. Sue Sisley experienced); cannabis users and the plants may have been exposed to fumes from leaded gasoline or wildfires.

I strongly urge inclusion of a health care professional with expertise in the use of medical cannabis on the Advisory Committee, such as a medical cannabis researcher or a certifying provider or a cannabinoid specialist.

I suggest that once a Public Health Advisory Committee is created, they attempt to identify research gaps and include studies that may show potential benefits to public health and safety. A growing body of studies suggest that cannabis may be used as a harm reduction tool. For example, cannabis has been used to reduce the intake of opioids, benzodiazepines, and alcohol, possibly averting overdoses. Estimations of savings from reductions in prescription drug use for Medicaid are in the billions of dollars. We have some indications that cannabis improves socialization and may reduce domestic violence (in couples that use cannabis). And some studies show that CBD can be used to reduce cravings for heroin, reduce damage from methamphetamine use and hemorrhagic strokes.

Please note these statements from National Academies of Sciences, Engineering, and Medicine's 2017 *The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research*[49]:

- Chapter 12, Mental Health, Box 12-1. Comorbidity in Substance Abuse and Mental Illness (page 296): "…it is important to note that the issue of co-morbidity directly affects the ability to determine causality and/or directionality in associations between substance use and mental health outcomes."

- Chapter 15, Challenges and Barriers in Conducting Cannabis Research (page 378): "This lack of evidence-based information on the health effects of cannabis and cannabinoids poses a public health risk."

- Chapter 15, Challenges and Barriers in Conducting Cannabis Research, Box 15-2. Summary of Chapter Conclusions (page 389): Barriers include: "the classification of cannabis as a Schedule I substance"; researchers' limited access to "quantity, quality, and type of cannabis product necessary to address specific research questions"; funders needed to support "research that explores the harmful and beneficial health effects"; need to develop conclusive evidence for the effects of cannabis use and improve research methodology.

- Chapter 16, Recommendations to Support and Improve the Cannabis Research Agenda (page 397): "Ensuring that cannabis research is of uniformly high quality will require the development of guidelines for data collection, standards for research design and reporting, standardized terminology, and a minimum dataset for clinical and epidemiological studies."

[49] Recording of the November 14, 2022, meeting at: National Academies of Sciences, Engineering, and Medicine. 2017. *The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research*. Washington, DC: The National Academies Press. https://doi.org/10.17226/24625

F. Additional Task Force Recommendations

i. Intro

Task Force members were invited to suggest additional recommendations to be included as Task Force recommendations in the final report. The additional recommendations were discussed at the meeting on November 28, 2022, and members voted to include the following additional recommendations at 58:00.[50]

ii. Recommendations

All four of the Task Force's additional recommendations were voted on as a group with the following votes obtained: 11 Ayes, 0 Noes, and 2 With Reservations. [51]

Additional Task Force Recommendations:

1. Recommend the State of Hawaii take direct action to stop Federal Schedule 1 classification of cannabis from being applied to Hawaii's registered medical cannabis patients, certifying medical professionals and state licensees.

   Rationale: US Federal Government states that Schedule I drugs are deemed as high-risk substances that are easily abused and are highly addictive. According to the DEA, the drugs in this schedule currently hold no accepted medical benefit, and therefore, no prescriptions may be written for Schedule 1 substances.

   Explanation: The Federal Government's stance on medical use of cannabis is in direct opposition to Hawaii State Law that acknowledges the medical benefits of cannabis. There is an abundance of evidence-based, peer-reviewed studies that have concluded that cannabis is not highly addictive, and there is emerging evidence that the relative safety profile of cannabis warrants further exploration of cannabis as an adjunct or alternative treatment for Opioid Use Disorder.[52]

2. The University of Hawai'i John A. Burns School of Medicine should investigate offering medical cannabis education as part of its curriculum.

3. The Department of Health (DOH) Office of Medical Cannabis Control & Regulation should include medical cannabis education for healthcare professionals, as part of the certifying provider application process.

[50]Recording of the November 28, 2022, meeting at: https://www.youtube.com/watch?v=FNgz--WGEtw
[51] Reservations of Chair Nakata and Member Leverenz may be found in section V.F.iii.
[52] Wiese B, Wilson-Poe AR. Emerging Evidence for Cannabis' Role in Opioid Use Disorder. Cannabis Cannabinoid Res. 2018 Sept 1;3 (1): 179-189. Doi 10.1089/can.2-18.0022. PMID:30221197; PMCID:PMC6135562

To complete the application process, applicants must complete a minimum of 2 hours of an evidence-based, medical cannabis educational activity.

They may do this by either:

- Viewing a medical cannabis training video (or series of videos) which the DOH has created or approved of; or

- Purchasing and completing a medical cannabis education course from a DOH-approved list, preferably a course that provides contact hours (such as CMEs or CEUs).

For APRNs, the content should be similar to the July 2018, National Council State Boards of Nursing – National Guidelines for Medical Marijuana: APRN's Certifying a Medical Marijuana Qualifying Condition. This can be found at https://www.journalofnursingregulation.com/article/S2155-8256(18)30097-8/pdf.

For MDs, Dos, and APRNs, the content should be similar to the State of New York's Office of Cannabis Management requirements which can be viewed at https://cannabis.ny.gov/practitioners.

4. The following should be a priority to allow Hawaii to act before the federal government imposes its own system of legalization upon us:

    - A working group should be formed to look at potential solutions to resolving the DEA Schedule I and state conflicts.

    - Attempts should be made to get an exemption from the DEA as doing so could potentially reduce some of the harms currently being inflicted upon medical cannabis patients (and their providers) and may help open research in Hawaii.

iii. Objections and Reservations

[**Michele Nakata**] Reservation on additional recommendation #1 to "take direct action to stop Federal Schedule 1 classification of cannabis…" as it is unclear what action should be taken. Recommend instead that the State study this issue further.

[**Nikos Leverenz**] Object to the need for a working group to be formed under additional recommendation #4 because it is incumbent upon the federal government to de-schedule cannabis.

VI. SUBJECT MATTER RESOURCE INDIVIDUALS

Michael Backes, Author of *Cannabis Pharmacy: The Practical Guide to Medical Marijuana*, and cannabis expert

Amanda Borup, Policy Analyst, Oregon Liquor and Cannabis Commission

Andrew Brisbo, Executive Director, Michigan Cannabis Regulatory Agency

Steve Gilbert, Chief of Administration, Nevada Cannabis Compliance Board

Iris Ikeda, Commissioner of Financial Institutions, Hawaii Department of Commerce and Consumer Affairs

Dominique Mendiola, Senior Director Colorado Marijuana Enforcement Division, Colorado Department of Revenue

Justin Nordhorn, Director of Policy and External Affairs, Washington State Liquor and Cannabis Board

Gillian Schauer, Executive Director, Cannabis Regulators Association (CANNRA)

DeVaughn Ward, Senior Legislative Counsel, Marijuana Policy Project