HOUSE BILL REPORT
E2SHB 2149

As Passed House:
February 17, 2014

Title: An act relating to medical marijuana.

Brief Description: Concerning medical marijuana.

Sponsors: House Committee on Appropriations (originally sponsored by Representatives Cody, Carlyle, Johnson, Jinkins, Morrell and Santos).

Brief History:
Committee Activity:
Health Care & Wellness: 1/15/14, 1/23/14 [DPS];
Appropriations: 2/7/14, 2/10/14 [DP2S(w/o sub HCW)].
Floor Activity:
Passed House: 2/17/14, 67-29.

Brief Summary of Engrossed Second Substitute Bill

- Reduces the amount of useable marijuana that a qualifying patient or designated provider may possess from 24 ounces to three ounces or, if authorized by the qualifying patient's health care professional, a specified amount over three ounces.
- Reduces the number of marijuana plants that a qualifying patient or designated provider may possess from up to 15 plants to a maximum of three flowering and three non-flowering plants or, if authorized by the qualifying patient's health care professional, a specified number over six plants.
- Eliminates the authority to establish collective gardens to produce marijuana for medical use.
- Requires qualifying patients and designated providers to obtain a qualifying patient recognition card or designated provider recognition card from the Department of Health.
- Establishes a medical marijuana endorsement that licensed marijuana retailers may obtain to sell marijuana to qualifying patients and designated providers in amounts greater than those available to non-medical customers.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 11 members: Representatives Cody, Chair; Riccelli, Vice Chair; Clibborn, Green, Jinkins, Moeller, Morrell, Rodne, Ross, Tharinger and Van De Wege.

Minority Report: Without recommendation. Signed by 6 members: Representatives Schmick, Ranking Minority Member; Harris, Assistant Ranking Minority Member; DeBolt, G. Hunt, Manweller and Short.

Staff: Christopher Blake (786-7392).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass and do not pass the substitute bill by Committee on Health Care & Wellness. Signed by 26 members: Representatives Hunter, Chair; Ormsby, Vice Chair; Ross, Assistant Ranking Minority Member; Buys, Carlyle, Christian, Cody, Dunshee, Fagan, Green, Haigh, Haler, Harris, Hudgins, S. Hunt, Jinkins, Kagi, Lytton, Morrell, Parker, Pettigrew, Schmick, Seaquist, Springer, Sullivan and Tharinger.

Minority Report: Do not pass. Signed by 4 members: Representatives Chandler, Ranking Minority Member; Wilcox, Assistant Ranking Minority Member; G. Hunt and Taylor.

Staff: Charlie Gavigan (786-7340).

Background:

Regulation of Marijuana.
Marijuana is classified as a Schedule I substance under the Controlled Substances Act (CSA). Under the CSA, Schedule I substances are characterized as having a high potential for abuse, no currently accepted medical use, and no accepted safe means for using the drug under medical supervision. The manufacture, possession, or distribution of Schedule I substances is a criminal offense under federal law.

In 1998 Washington voters approved Initiative 692 to allow qualifying patients to use limited amounts of marijuana for medicinal purposes. To become a qualifying patient, a person must be: (1) diagnosed with a terminal or debilitating condition; (2) advised by a health care professional about the risks and benefits of the medical use of marijuana; and (3) advised by a health care professional that he or she may benefit from the medical use of marijuana. A qualifying patient may authorize a designated provider to obtain medical marijuana and perform other responsibilities on behalf of the qualifying patient.

Qualifying patients and designated providers are protected from arrest or prosecution under state laws relating to marijuana if the individual uses and possesses it for medicinal purposes, does not exceed specified amounts, and meets other criteria. Qualifying patients may grow marijuana themselves or have a designated provider grow on their behalf. They may also

obtain marijuana through collective gardens which consist of up to 10 qualifying patients who share in the responsibilities of producing and processing marijuana for medical use.

In 2012 Washington voters approved Initiative 502 which established a regulatory system for the production, processing, and distribution of limited amounts of marijuana for non-medical purposes. Under this system, the Liquor Control Board (Board) issues licenses to marijuana producers, processors, and retailers and adopts standards for the regulation of these operations. Persons over 21 years old may purchase up to one ounce of useable marijuana, 16 ounces of solid marijuana-infused product, and 72 ounces of liquid marijuana-infused product at a licensed retailer.

Liquor Control Board Work Group.
In 2013 the Legislature directed the Board to work with the Department of Health (Department) and the Department of Revenue to develop recommendations related to the interaction between the regulation of recreational marijuana compared to medical marijuana. The recommendations must address age limits; authorization requirements for medical marijuana; health care professional regulations; collective gardens; possession amounts; location requirements; licensing requirements for medical marijuana production, processing, and retailing; taxation of medical marijuana; and a designated agency as the appropriate regulatory entity.

The Board submitted its recommendations to the Legislature in December 2013. The recommendations relate to:

- allowing 18- to 20-year-olds to have access to medical marijuana;
- allowing access to medical marijuana for children under 18 years old with parent or guardian consent;
- establishing a mandatory registry for qualifying patients and designated providers and issuing cards to persons on the registry;
- requiring registry information to be entered by the authorizing health care professional;
- allowing access to the registry for law enforcement, the Department of Revenue, and health professions disciplining authorities;
- requiring the Department to define "debilitating" and "intractable pain";
- eliminating collective gardens;
- reducing possession amounts from 24 ounces of useable marijuana to three ounces;
- allowing qualifying patients and designated providers to possess up to six marijuana plants;
- integrating medical and recreational marijuana producers, processors, and retailers into a single licensing system; and
- exempting purchases for qualifying patients from sales and use taxes.

Federal Response to State Marijuana Regulations.
Washington is one of 20 states that have passed legislation allowing the use of marijuana for medicinal purposes and one of two states that allow its recreational use. These activities, however, remain illegal under federal law. Absent of congressional action, state laws permitting the use of marijuana will not protect a person from legal action by the federal government.

In recent years, the United States Department of Justice (DOJ) has issued several policy statements regarding state regulation of marijuana. The latest of these was issued in August 2013. In this memorandum, federal prosecutors were instructed to focus investigative and prosecutorial resources related to marijuana on specific enforcement priorities to prevent:

- the distribution of marijuana to minors;
- marijuana sales revenue from being directed to criminal enterprises;
- marijuana from being diverted from states where it is legal to states in which it is illegal;
- state-authorized marijuana activity from being used as a cover for trafficking other illegal drugs or other illegal activity;
- violence and the use of firearms in the production and distribution of marijuana;
- drugged driving and other marijuana-related public health consequences;
- the growth of marijuana on public lands; and
- marijuana possession or use on federal property.

The memorandum maintains that the DOJ has not historically prosecuted individuals in cases that pertain to the possession of small amounts of marijuana for personal use on private property. With respect to state laws that authorize marijuana production, distribution, and possession, the memorandum asserts that when these activities are conducted in compliance with strong and effective regulatory and enforcement systems, there is a reduced threat to federal priorities. In those instances, the memorandum provides that state and local law enforcement should be the primary means of regulation. The memorandum, however, continues to affirm its authority to challenge the regulatory system and to bring individual enforcement actions in cases in which state enforcement efforts are inadequate.

Summary of Engrossed Second Substitute Bill:

Possession Amounts of Marijuana.
The holder of a qualifying patient recognition card or designated provider recognition card may assert protections from arrest and prosecution under state marijuana laws if:

- he or she is in compliance with possession amount limitations;
- he or she presents the recognition card to any peace officer upon request;
- he or she maintains a copy of the recognition card by marijuana plants, marijuana products, and useable marijuana at his or her residence;
- the peace officer does not have evidence that marijuana has been converted to the qualifying patient's or designated provider's own personal, non-medical use; and
- the peace officer does not have evidence that the designated provider has been a designated provider to more than one qualifying patient within a 15-day period.

The amount of marijuana that qualifying patients and designated providers may possess is reduced from a combination of useable marijuana and marijuana product that does not exceed 24 ounces to a combination of useable marijuana and marijuana product that does not exceed three ounces.

A health care professional may approve an extraordinary amount of marijuana for a qualifying patient for more than three ounces of useable marijuana and more than six plants. If approved for this extraordinary amount, the health care professional must specify the

amount of useable marijuana and the number of marijuana plants that are authorized. The extraordinary amount is available if the qualifying patient's health care professional attests that: (1) he or she is the principle health care provider treating the qualifying patient's terminal or debilitating condition, or has examined the patient upon direct referral from the principle health care professional treating the patient's terminal or debilitating medical condition; (2) he or she has an ongoing relationship with the patient that includes regular visits; (3) alternatives to marijuana and marijuana in amounts less than three ounces have been attempted and have been unsuccessful; and (4) efforts to use alternatives to marijuana and marijuana in amounts less than three ounces are documented by the health care professional.

The number of marijuana plants that a qualifying patient or designated provider may possess is reduced from 15 plants to three flowering plants and three non-flowering plants. The Department of Health (Department) must adopt rules to define the maximum size of marijuana plants. By November 15, 2019, the Department, in collaboration with the State Liquor Control Board (Board), must report to the Governor and the Legislature regarding the need for qualifying patients and designated providers to possess marijuana plants. Using information maintained by the Department, the report shall determine the adequacy of the commercial marijuana supply as it pertains to patient distance to retailers, patient hardships regarding accessing a safe and adequate supply of marijuana, and cost as a barrier to access. The report must also include information from law enforcement about the extent to which the possession of marijuana plants by qualifying patients and designated providers has been associated with the conversion of marijuana for non-medical use.

The authority for a person who is both a qualifying patient and a designated provider to possess twice the amounts of authorized marijuana plants, useable marijuana, and marijuana product is eliminated to limit the person to the amounts for a single qualifying patient or designated provider.

Qualifying Patient and Designated Provider Recognition Cards.
After May 1, 2015, qualifying patients and designated providers may apply to the Department for a recognition card. To obtain a qualifying patient recognition card, an applicant must submit: (1) an application that is signed by the qualifying patient, or his or her parent or guardian if the qualifying patient is less than 18 years old, and the health care professional who signed the qualifying patient's valid documentation, and (2) a copy of his or her valid documentation. To obtain a designated provider recognition card, an applicant must submit: (1) an application signed by the designated provider and the qualifying patient making the designation, and (2) a copy of the qualifying patient recognition card or application for a recognition card for the qualifying patient making the designation.

The recognition card must at least contain the person's name, the person's birth date, the expiration date of the recognition card, and any extraordinary amounts approved by the qualifying patient's health care professional. Designated provider recognition cards must also include the name of the qualifying patient being represented. Recognition cards expire on the date identified by the health care professional, which may not exceed one year.

If the qualifying patient is less than 18 years old, a parent or guardian must be named as the minor qualifying patient's designated provider. The parent or guardian also must have sole

control over the minor qualifying patient's marijuana, except that the minor qualifying patient may possess enough marijuana to fulfill the next dose.

The Department shall safeguard the records of applicants for qualifying patient recognition cards and designated provider recognition cards. The information must remain confidential and may only be disclosed:

- to peace officers to verify whether or not a person is lawfully in possession of a qualifying patient recognition card or designated provider recognition card;
- to law enforcement and prosecutorial officials engaged in a specific investigation involving a designated person;
- to a health care professional licensing, certification, or regulatory agency or entity;
- in an aggregated form that does not allow for individual card holders to be identified;
- to prescribers or dispensers of controlled substances for purposes of caring for their patients;
- to Department of Revenue employees to determine tax exemptions; and
- to Board employees as necessary to determine compliance with medical marijuana endorsement standards.

Medical Marijuana Endorsement.
As of May 1, 2015, the authority for qualifying patients to establish and operate collective gardens is eliminated.

After May 1, 2015, licensed marijuana retailers may apply to the Board for a medical marijuana endorsement. An endorsement allows the marijuana retailer to sell useable marijuana and marijuana-infused products to qualifying patients and designated providers who have recognition cards in amounts up to three ounces, or, if specifically approved by a health care professional, up to eight ounces. To obtain an endorsement, a marijuana retailer must hold a license that is in good standing with the Board and pay a fee of $200. Marijuana retailers with a medical marijuana endorsement must notify the Board if they intend to serve only medical marijuana customers or both medical and non-medical marijuana customers. Up to five percent of medical marijuana endorsements may serve only medical marijuana customers.

The Board must adopt rules for the operation of marijuana retailers that hold a medical marijuana endorsement. The rules must address the verification of the identity of qualifying patients and designated providers, the labeling of tetrahydrocannabinol concentrations and cannabinoids in marijuana being sold at the marijuana retailer, and the recording of sales to qualifying patients and designated providers to determine tax exemptions and compliance with purchasing amount limitations. The Board must conduct periodic reassessments of the maximum number of retail outlet licenses and make adjustments to assure an adequate supply for medical marijuana customers. The first reassessment must be completed by March 1, 2015.

Requirements for Health Care Professionals.
Prior to renewing a qualifying patient's valid documentation, a health care professional must complete the same physical examination and advising procedures required for an initial valid documentation. In addition to existing physical examination and advising procedures, if a patient is less than 18 years old, the health care professional must reexamine the minor

qualifying patient annually, or more frequently if medically indicated, and consult with the minor qualifying patient's parent or guardian as medically indicated. The health care professional must also consult with other health care providers treating the minor qualifying patient before providing the minor qualifying patient with valid documentation authorizing the medical use of marijuana.

Health care professionals may not provide services related to authorizing the medical use of marijuana in any place other than the health care professional's permanent physical location of business. Health care professionals may not charge different rates for services depending upon the amount of marijuana authorized or the duration of the authorization.

The Department must convene a work group of members of the Medical Quality Assurance Commission, the Board of Osteopathic Medicine and Surgery, the Nursing Care Quality Assurance Commission, the Board of Naturopathy, and an association representing physicians. The work group must develop practice guidelines for health care professionals to consider when authorizing the medical use of marijuana for patients. The practice guidelines must address patient assessments, patient examinations, dosing criteria, treatment plans, patient communications, record maintenance, and other patient care issues identified by the work group. The work group must also consider training and practice standards for employees of marijuana retailers that hold a medical marijuana endorsement. The standards must identify practices for advising qualifying patients and designated providers in selection of a type of marijuana, product use, order fulfillment, and safe handling of products. In addition, the work group must adopt a definition of "medical-grade marijuana."

The authority for the Medical Quality Assurance Commission and Board of Osteopathic Medicine and Surgery to approve additional terminal or debilitating conditions that apply to the determination of a person as a qualifying patient is repealed.

Referential Changes.
References to "cannabis" are changed to "marijuana." References to previously vetoed provisions are eliminated.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after the adjournment of the session in which the bill is passed, except for section 12, relating to possession amounts and exclusions from penalties for qualifying patients and designated providers, and section 24, relating to the repeal of sections, which take effect May 1, 2015.

Staff Summary of Public Testimony (Health Care & Wellness):

(In support) The medical marijuana system needs to mirror the recreational marijuana system as much as possible and this bill addresses the differences responsibly. This bill treats marijuana like other drugs, particularly with respect to the prescription monitoring program. While many patients rely on marijuana and their needs vary tremendously, other patients may be better served by the recreational market.

This bill adopts many of the Liquor Control Board's recommendations. The need to reconcile medical and recreational marijuana this session is paramount because of the impending start of the recreational system. Federal guidance suggests that a highly regulated system is required. This balances the intent of Initiative 502 (I-502) and federal requirements. Counties need clarity from the state in how to implement the law.

The registry gets law enforcement out of the business of asking people about their medical condition by having a simple card that they can easily verify. The qualifying patient recognition card is the most important part of the bill because people will be under different rules for carrying the same substance, and law enforcement needs to know which rules apply. This bill establishes a clear set of rules to minimize conflict with citizens.

Having an online system of health care professionals entering information for issuing recognition cards would be more efficient, faster, and cheaper. There should be a short amount of time between the issuance of recognition cards and the sunset of existing authorizations. There should be an amendment to reference that arrest and prosecution protections do not apply to pre-trial release by courts in DUI cases. There needs to be an amendment to have the repeal of land use authority under the medical system coincide with the recreational system coming into place. The Medical Association should be on the work group. There should be more clarity about how frequently reexaminations for minors should occur and which other health care providers should be consulted.

(With concerns) The current system is not working and there are members of the medical marijuana community who would like to have legislation this year. House Bill 2233 is a sensible middle ground, which was drafted by the patient community. Cannabis is a recognized herbal medicine.

(Opposed) Patients want access to a safe alternative to pharmaceuticals that they can grow at home. The medical marijuana community is able to regulate itself and it works well for patients. The collective garden system as a "pea patch" model works as it was envisioned. Physicians should regulate through their relationships with their patients. Patients want to work with physicians and the Department of Health, but not the Board. There should not be any limits on the possession amounts because it is different for every person. Marijuana helps real people stay functional.

The Board is not qualified to establish the patients' needs. Registries have been abused in other states. The patient registry represents agency mission creep. If there is going to be a registry, it should not contain personal addresses. A secure registry cannot be established to guarantee privacy. A medical marijuana market cannot continue when law enforcement still considers marijuana to be its primary threat.

This bill is premature until the recreational marijuana market has had time to develop. Endorsements are not necessary because much of what will be sold at retailers is also used for medicine. The state should work to maintain access in case I-502 stores do not have the diverse strains that are needed for patients. The bill will not change home grow practices.

The bill should cover all forms of irretractable pain. This bill makes it harder for poor and disabled patients to get health care.

This is a bad public policy because it is a regressive tax on a medicine and it will harm the poor. None of the I-502 models talk about the federal tax and this does not work mathematically; this will destroy the medical marijuana system.

The use of the term "marijuana" is offensive. This hearing is trying to circumvent the right against self-incrimination. The Medical Marijuana Work Group violated the Open Public Meetings Act. This bill is a violation of the Privileges and Immunities clause and creates special legislation. This bill incorporates the recommendations of an illegal secret work group.

Staff Summary of Public Testimony (Appropriations):

(In support) None.

(With concerns) As part of the rule-making process, the Liquor Control Board (LCB) was required to complete a small business impact statement. The LCB did not assess the impact on small business in Washington. It is appalling to see this work coming from a state agency. The information is invalid and as a result, people are misinformed. Work has been done to gather 300 pages of data from various small businesses from across the state. The recommendations are going to hurt people and there will be jobs lost as a result.

Initiative-502 (I-502) being combined with medical cannabis is like going to the proctologist for brain surgery. The retailers under I-502 do not understand medical cannabis patients' needs. The collectives provide medicine to patients for free. Ending collectives would cause patients to lose access.

The current limits came from a working group that looked at a 60-day supply. Under this proposal, medical patients would lose access to medicine. Patients want to talk to a person who understands the medicinal value of cannabis. While the system may need some modifications, patients need protection.

People have conditions that are terminal or incurable. In these cases, doctors have already confirmed the person will not get better, yet this bill would require additional office visits to maintain one's status as a qualified patient. Additionally, going to a retail store for medicine could expose people with weakened immune systems to sickness and further jeopardize their health.

(Opposed) There are people who have few alternatives when it comes to their medical treatment. In some cases, it takes years to get a diagnosis and the choices are surgery, which may not address the medical condition, or cannabis. This bill takes away people's right to access medicine and the doctors that are needed. It also requires a person who has a permanent diagnosis to continue to go to the doctor and incur costs to remain an eligible patient, even though their condition is not anticipated to change.

Possession of marijuana is still a crime at the federal level. Requiring patients to submit their information to a registry would put patients at risk of federal prosecution. The registry would be in conflict with the Health Insurance Portability and Accountability Act (HIPAA) regulations. Patient registries have been compromised.

There are two choices, the I-502 tax structure can be amended or there needs to be efforts to increase arrests to drive up black market costs. These alternatives do not require that medical patients be forced into the recreational system. The federal tax is not included in any of the estimates regarding the cost of marijuana through I-502 stores. This would show that the economic model is not viable because the federal tax would make it cost more than $60 a gram. The I-502 system is not currently working. Medical cannabis users are law-abiding citizens and the provisions in this proposal would turn them into lawbreakers.

Any changes to medical marijuana laws should be to provide protection to patients and doctors. In 2008 the Department of Health and doctors developed plant limits for medical marijuana patients and these limits have worked well. The limits under this proposal would only offer a week's supply, which is not enough. Patients need an organically grown supply. Currently, it is possible to work with collectives to process extracts at a low cost. Under the I-502 model, there is not the ability to work with patients to provide access to a secure, low-cost source of cannabis extracts. In the retail market, it will cost $60 per gram for cannabis extract.

Medical cannabis has helped with Dravet Syndrome (Syndrome). The cannabis that is used has high cannibidiol (CBD) and low tetrahydrocannabinol (THC) levels. The cannabis that is needed to treat this Syndrome has zero recreational value. It is important to allow for a longer sunset on collective gardens. Medical cannabis is going through a renaissance and moving to dosing by the milligram. Medical patients want dose consistency; they want to feel well, not high. Many patients are referred to cannabis by main stream physicians.

On May 7, 2009, the Washington State Board of Pharmacy ruled that cannabis is an herbal medication and under RCW 82.08.0283, herbal medicines are tax exempt in Washington. There are 80 cities and counties with moratoriums or bans in Washington with more cities and counties implementing restrictions. If recreation marijuana stores were open today, more than 95 percent of the state's residents would not have local access. Patients cannot be thrown into a system that is not up and working. This would require patients to enter a registry but makes no such requirement on recreational user's—this flies in the face of logic and violates a patient's right to privacy.

It is unlikely that patients would go into a shop licensed under I-502 to access their medicine. The economic impacts of the bill should be reviewed, as thousands of people will lose jobs. This is not revenue that is being sent out-of-state and these are commodities that are being produced in state. Local government will use the funding for law enforcement and more people will be prosecuted, which is not what the voters supported when they passed I-502. This would increase costs to the state.

Cannabis is the official terminology and Washington should use the correct language, not the derogative term.

Persons Testifying (Health Care & Wellness): (In support) Kristi Weeks, Department of Health; Rick Garza, Liquor Control Board; Tom McBride, Washington Association of Prosecuting Attorneys; Don Pierce, Sheriffs and Police Chiefs; Josh Weiss, Washington State Association of Counties; Sean Graham, Washington State Medical Association; Candice Bock, Association of Washington Cities; and Sharon Whitson.

(With concerns) Kari Boiter, Health Before Happy Hour; Ryan Day; and Michael West, Association of Cannabis Growers and Breeders.

(Opposed) John Worthington, American Alliance for Medical Cannabis; Cat Jeter, Independent Cannabis Producers Cooperative; Ryan Agnew, C Squared Public Affairs; Jerry Dierker; Stephanie Viskovich, Gina Garcia and Sandra Garcia, Cannabis Action Coalition; Arthur West; Steve Fager; Tim Fager; Shawn DeNae, Washington Bud Company; Kirk Ludden; Adam Assenberg; Steve Sarich; Esther Winterson; Lydia Ensley and Jeremy Kaufman, Center for Palliative Care, Coalition for Cannabis Standards and Ethics; and Dr. Gil Mobley.

Persons Testifying (Appropriations): (With concerns) Alicia LeDuc; Debbie Hansen; Dawn Darington, Choice Wellness; and Tawnee Couan.

(Opposed) John Novak, 420 Leaks; John Worthington; Scott Meyer; Steve Crites; Lucy Luddington; Jeff Wilhoit, Health Before Happy Hour; Ryan Day; Allan Frankel, Green Bridge Medical; Steve Sarich and Arthur West, Cannabis Action Coalition; Nightmare Alabama; Jeff Eidsness; Allison Bigelow, Cannabis Research Collective; Stephanie Quane; and Micah Anderson.

Persons Signed In To Testify But Not Testifying (Health Care & Wellness): Kathleen Bohnsack and Alan Brownser, Disabled Veterans; John Novak; Dr. James R. Lathrop, Advanced Holistic Health; Jessica McPhail, Medical Herb Providers; Sean McAllister; Don Skakie, Real Legalization; Alex Cooley, Solstice CCSE; Brian Stone; Will Laudanski; Seth Dawson, Washington Association for Substance Abuse Prevention; Julie Caynor, THC Foundation; Dawn Darington, Choice Wellness Center; Brad Ecklund, Cannabis Action Coalition; Terry Kohl, Washington Association of Naturopathic Physicians; David Mesford; Ammie Audal, Seattle Hempfest; Nightmare Alabama, KIEF Radio; Karma Hodges; Harrison McCauley-Hill; Stuart Guss, Weed Experts LLC; Hank Chiappetta; James Davies; Dr. Katie Baker; Tawnee Cowan; David McNeil; Steve Bogart; Allison Bigelow, Cannabis Research Collective; Sarena Haskins, Sonshine Organics; and Steve Elliott, Seattle Weekly.

Persons Signed In To Testify But Not Testifying (Appropriations): None.