Attachment A

House Finance

HB21-1317 Regulating Marijuana Concentrates

Typed Text of Testimony Submitted

Name, Position, Representing	**Typed Text of Testimony**
Dawn Blackman Against Self	Dear Committee, I am writing to you all to implore you to reject HB21-1317 and HB21-1058. . Both of these bills are an absolute assault on the Colorado medical cannabis program and its patients for access and affordability, on doctors who aren't prepared or even willing or able to follow the parameters set out, on the concentrate manufacturers and medical and retail dispensaries that will have to revamp their manufacturing and sales models, and even on the environment itself for all the extra, unnecessary packaging waste that will be created by requiring grams of concentrate be divided into doses. .While no system is perfect, restricting access to many legitimately ill patients because unfortunate things may happen in other families is unconscionable. If that's the logic to follow, why is it an issue to defund the police? The same young people could have chosen alcohol as their substance, but no one's sponsoring a bill demanding that alcohol be sold divided into shots and limiting how many can be purchased. In fact, we look at people sideways if they buy just one shooter, and by the way, the waste from those winds up all over the place, too. I spent my entire day, from 12:30pm to nearly 8pm out in the halls of the Capitol on the 18th, listening to the live audio of absolutely heartbreaking stories from clearly hurting families. I submitted written testimony the night before. But I also listened to the stories of people and children who absolutely need high potency THC for their medicine, literally, to live. Some patients require it all the time. Period. It's what works for them, "research" or not. So many people who testified are living proof of the efficaciousness. I saw my friends come in wheelchairs and walkers, with conditions both visible and invisible, leaving their disabled children at home to come and fight to keep themselves and their kids alive. We just want to stay alive, too. These two bills make it that much harder for everyone involved, and

	doesn't stop teens and young adults from doing what they do. Otherwise there wouldn't have been a vaping bill and law passed. Thank you for your consideration, Dawn Blackman Aurora .
Crystal Beattie Against Self	Hello My name is Crystal Beattie. I am a Veteran/Medical Refugee that moved here to Colorado and saved my own life with Cannabis Concentrates when all the Pharmaceuticals failed me.. I ingest High Potency THC Cannabis Oil to control my Hemiplegic Migraines amongst my other diagnosis. The Medical language in HB21-1317 is all wrong for Patients that need access to this medicine, especially patients ages 17 to 21 but essentially all of us. It will ultimately end Medical Access and Quantities needed the way it is currently written. This will cause harm to myself as well as the rest of the Americans with disabilities that live in this community such as Cancer Patients, Epilepsy Patients, Autism Patients * ESPECIALLY THE CHILDREN*, Chronic Pain Patients, Traumatic Brain Injury Patients... Virtually ALL PATIENTS will be harmed by this Bill as it stands. Please vote NO!!!!! Thank you for your time..
Autumn Brooks Amend Clear Creek School District Re-1	I was unanble to upload my testimony. Please see my emails sent to the committee members. CCSD is in a amend position to HB21-1317

5/20/2020

Dear Madam chair, Representative Herod, Madam Vice chair Bird ,and all the other members of the house finance committee,

My Name is Dr. Peter Pryor MD MPH, although many people know me by my business name Doc Morrison.
I have been a Medical Marijuana Doctor for 7 years now. This makes me an expert in Medical Marijuana. Before this I was a successful Emergency Medicine Doctor at Denver Health. The hospital considered me to be an expert in Emergency Medicine.

Ever since I graduated from Tulane Medical School back in 2000 I have enjoyed every second that I have been a physician. During my career I have met amazing patients along the way and been able to help an extremely large amount of sick patients.

In my current position focusing on deciding whether or not a patient will benefit from the use of Cannabis. I have developed a "bonafide patient doctor relationship' better than I was ever able to do being an Emergency Medicine doctor. While I did see many more patients in the ER, I have thousands of patients that I've developed a personal relationship with. Once I left Emergency Medicine and began my private practice I focused intensely on staying up to date on regulations and making sure that I always abide by the rules and regulations set forth by the state legislators as well as the MED. To have been left out of any type of stakeholder process prior to the introduction of HB 21-1317 was not only disappointing to me as a medical marijuana expert who follows all the statutes and guidelines, despite the difficulty of keeping up with the ever changing regulations set forth in this state. I love what I do though so I have no complaints if that's just one hurdle I have to deal with to continue providing the highest quality of care to my patients while making sure to stay compliant.

I meet with all of my patients for up to 20 minutes. HB 21-1317 would make that impossible as well as burden my practice in a number of ways. I am unaware of any evidence that shows that as recommending physicians, many who have been following basically the same protocol for over twenty years, need to drastically change how we practice medicine.

In order to stay compliant with the changes as written in the current draft of HB 21-1317 I would have to either charge my patients a significantly higher rate, we all ready know insurance does not cover or reimburse visits to a marijuana recommending physician.This bill would also keep records of the medical records brought to me by the patient and my written SOAP note.

I currently document why the individuals who visit my office would benefit from using Medical Marijuana MMJ and I ask them how they get it in their system. I encourage everyone suffering from a condition who can benefit from mmj to use edibles, topicals,

or other consumption methods that do not affect the lungs. I make sure that nobody leaves my office before I discourage vaping,dabbing, and smoking flower. I discuss how smoking gave me a cough that sounded like COPD. I decided to quit smoking MMJ 3 years ago and feel better in my 50s than I did in my 40s. I have found that I can still receive the same benefits through other routes of administration as previously mentioned without putting my lungs in jeopardy.
I spend as much time as necessary educating patients who have limited or no experience and how they can start dosing comfortably.

I give all my patients my cell phone number. Imagine that 3,000+ patients all get my cell number. My phone stays busy with interesting questions, observations and discussions surrounding illness and how MMJ might be helpful (risks & benefits). pre pandemic and now by video conference. Everyone has the option for video conference but many of my returning patients prefer the simplicity of the phone interview. I fill out the State Physician Certification for them.

I believe I was one of the first MMJ doctors to ask for implementation of Telemedicine when the pandemic began last year. Beginning February 2020 I was seeing patients in their cars in my parking lot. On 2/27/2020 I wrote a letter to Governor Polis and CDPHE to beg for permission to see patients by telephone and video. It was my first of a series of letters. Despite the panic due to the pandemic I have had wonderful experience conducting recommendations via telemedicine. There are many benefits and very few downsides. The benefits are conveyed to me through my patients who I ask for their feedback on telemedicine. Not everyone likes it but it is my impression that if you took the politics out of it that very few people would prefer to drive across town or the state to get to my office where you may be in the waiting room with 6 other people and their families. Taking a day off of work to get to see me. Driving from Sedgwick CO. Getting yourself out of your death bed to come for a 20minute visit. What are the downsides? None that I see as truly negative and I am still developing bonafide patient doctor relationships and encouraging people to change their lives for the better and to live healthier lifestyles however that may be as every patient is unique.

We hope COVID19 is going away for good and we have everything under control. I say stay tuned. COVID19 will not go away easily. In the not too distant future we may have further reasons we will not all want to be face to face, in the same small waiting room, maskless with strangers. Especially when there are safe alternatives to face to face with no downsides. I believe that our world climate is changing and we are living it. Car emissions contribute to global warming. Keeping this as an option cuts down on the driving by 15 patients daily. I see patients from everywhere in the state. Think about all of the other physicians recommending cannabis. This could easily add up.

5/20/2020

In reading the language for HB 21-1058 regarding the additional requirements for patient's between 18 & 20 years old and the idea that 2 physicians must be involved to diagnose the patient. I don't feel I need another doctor to agree with me for evaluation of chronic pain nor do I think that would help the patient. I believe I satisfy this by reviewing medical records which I require for all patients under the age of 30. If a patient has never been to see a physician but has obvious deformity due to trauma I do not think it is beneficial for that patient to see another doctor who may unnecessarily X-rays or perform bloodwork and then prescribe medications such as Hydrocodone, Oxycodone, any of the other over-prescribed opioids, Gabapentin, Carisoprodol,, sleeping meds, anxiety meds, tranquilizers such as benzodiazepines, or antidepressants. Gabapentin may be the next opioid epidemic. The idea that you have to have two physicians from different medical practices diagnose the patient and have an in person medical consultation makes no sense on a Telemedicine bill. That is a barrier to treatment. I don't think it works well with patients under the age of 18 where this is already in place. I am a doctor. Let me be a doctor.

Regarding the idea that 18 to 20 year olds are getting more MMJ licenses since the pandemic lets review the CDPHE statistics regarding number of patients in that group in Jan Feb 2020 vs Jan Feb 2021 which are the most current stats available at the time of writing this. Jan 2020: 3,483 patients which is 4.25 % of all patient on registry in terms of age, Feb 2020: 3,563 patients 4.32%. Now in Jan 2021: 3,935 patients 4.53% and Feb 2021: 3,979 patients 4.56%. This does not seem like a race to the doctors office by patients under the age of 21.

Although I recommend that my patients use edibles and topicals and avoid smoking flower, and vaping or dabbing. If you spend too much effort establishing so many barriers to treatment these children you are trying to protect will likely continue to use Marijuana either legally or illegally pushing them away. I don't have the chance to tell them about how smoking negatively will affect their lungs. This is a population who struggles for their money. I consider it an honor to get to them when they are so young. They hear me when I tell them not to smoke. No one ever argues with "our lungs were not meant to smoke" and many tell me thank you for telling them not to smoke.

Every one of my patients gets my cell phone number. I see the follow up every 3 months as another barrier to treatment. I believe an annual update is adequate and should not be changed. This would cause 4x as much work for myself, and 4x as much effort on the patients part.

Regarding the prohibition of charging additional fees for plant counts I don't believe the State can tell me what to charge for my services. It has taken me years to develop my strategy for plant counts and how to keep within the CO State regulations which I believed were later deemed unconstitutional. I have kept those numbers down and to

my knowledge I have never had a plant count issue with any of my patients. In all types of medicine the billing varies by the risk of the procedure or evaluation. Because arm stitches are on the low end as far as risk goes there is not a high charge. On the other hand brain surgery is extremely high risk which is why neurosurgeons charge more.

Everyone who expresses a desire to have a plant count is required to have medical records which I review with them to determine if they have documented support of a required condition. There is a lengthy discussion of how they use their plants and why they would use or process their desired amount of plants. I have used this risk evaluation to price the plant counts I am willing to provide in accordance with the requested number of plants along with the evaluation of the medical records provided.

Doing all of this to limit the amount of extended plant counts as a part of my total patient population. The risk is both to my personal and professional reputation as well as my ability to practice medicine. Many doctors including one I know personally have had their medical licenses suspended by the board of health here in Colorado because they were writing too many higher plant counts per their patient population. My patients return to me because I take the plant counts seriously. They pay for those licenses because they know that after I have established their need for a higher plant count and have been paid by them that I am willing to personally show up in person for their court appearance. If they end up with a criminal charge and unfortunately end up going to court for doing nothing other than legally growing their allotted plant count then I will defend their state constitutional right to grow Medical Marijuana.

Thank you for your consideration regarding these topics. I am willing to free my time to testify at any point or schedule a meeting to discuss my professional opinion and thoughts to anyone about how our state should not have the ability to limit my ability to act in the best interest of the patient. especially when I was not given any say in the drafting of the language or invited as a stakeholder to any meetings prior to introduction. This is important. Telemedicine is a great thing. I don't think you should hurt Medical Marijuana by giving us the goodness of Telemedicine and the badness of the attempt to mandate pricing and pushing people away from what is now a legitimate medical practice. Medical Marijuana is struggling. Taking away the plant counts will change Medical Marijuana and I don't believe the change will favor Medical Marijuana.

Putting more barriers to alternative treatments mandating evaluation by the very doctors many of my patients are trying to avoid going to in the first place is ironic and insulting. As is the every 3 month follow up. While HB 21-1058 has a lot of good points, HB 21-1317 on the other hand is overreaching and overregulating. I just mentioned that medical marijuana is struggling, this bill could potentially kill the entire industry and put cannabis back onto the black market. That means no third party testing, no regulatory oversight, no limits. This bill is allegedly attempting to prevent looping, but if

it just leads people to purchase their cannabis from an unregulated source not only is the state losing out on tax money, but people who are looking to get around the purchasing limits will just go elsewhere.

Thank you for your consideration,

Sincerely

Peter Pryor II MD MPH
720-272-2897 cell
www.DocMorrison.com

Cannabis Clinicians Colorado
5101 E Colfax Ave
Denver CO 80220

May 20, 2021

Dear Friends –

On behalf of Cannabis Clinicians Colorado, a non-profit professional society dedicated to good clinical practice, research, and education for physicians, clinicians, caregivers, and other persons working directly with Colorado medical marijuana patients, I ask for a temporary delay in this bill so we can help advise and or amend certain sections to both comply with state and national laws and to make it more workable. While we are 100% in favor of helping stop diversion of cannabis to minors and unauthorized persons, and 100% in favor of research on cannabis products and potencies, if HB21-1317 passes as currently written it will violate both the Colorado constitution's medical marijuana amendment and inadvertently end medical marijuana for 87,000+ sick people in one fell swoop.

Why? 1) It puts cannabis recommending physicians/providers in the untenable position of violating their DEA licenses by writing a de facto prescription for medical marijuana. In 1996, the 9th circuit court of appeals ruling Conant vs Walters paved the way for the Colorado medical marijuana amendment by highlighting the distinction between "recommending" and "prescribing". The court held that the federal government could not punish or threaten to punish a physician for "recommending" marijuana to a patient.

For that reason, the medical marijuana amendment to the Colorado constitution allows a doctor to recommend cannabis but not prescribe it. HB21-1317 forces doctors into prescription territory by requiring inclusion of dosages, potencies, routes of administration, and purchase limits. In states that have tried this, such as Massachusetts, the DEA has literally gone door to door to the homes of cannabis physicians and told them to stop writing cannabis "prescriptions" or lose their DEA license.

2) It requires doctors to do what none of the 38,000+ studies on PubMed.gov can do, which is find a correlation between any given dose of cannabis and blood levels and/or effects in patients. How can we recommend a potency level, dosage form, and daily quantity when we have no scientific means of determining this? Numerous meta-analysis of PubMed.gov cannabis study data repeatedly come to the same conclusion: there is NO known correlation between dose and effect with cannabis. It varies widely by individual. That is why we give our patients starting doses and instructions for safe titration only, rather than explicit doses and cannabinoid ratios.

Here's a link to the 2018 version of our New Patient Success Guide. (The 2021 version will be published after the end of the legislative session)

3) It creates an undue burden on the patient by requiring adult patients to have either a primary care physician or records from a previous diagnosis. If passed as written, the bill effectively forces patients to pay for 2 medical visits: one to diagnose a chronic debilitating condition, and one to recommend medical

marijuana. This is NOT the intention of the Colorado constitution, and the one-visit-only cannabis recommendation for adults has been repeatedly upheld by CPDHE for over 20 years. If the bill adds this requirement for 18-20 year olds, fine. If it adds it for 65 year olds, that's a problem. When I first began helping patients join the medical marijuana registry in 2010, fully half of our patients used medical marijuana instead of conventional allopathic medicine because they had no access to health insurance and/or health care. Because we always want our patients to do more for their health than just smoke pot, we had resource sheets for helping people join Medicaid, giving numbers for county health programs, and for clinics that did not require insurance. After Obamacare, the number of patients with no access to health insurance and/or health care has fallen by half. And some patients are actually put in danger of losing health insurance or federal housing assistance if a known "pot doc" requests records.

The burden is further aggravated as providers who write medical marijuana evaluations cannot belong to insurance networks. Providers writing cannabis recommendations are also denied hospital privileges at over 80% of Colorado hospitals. Medical malpractice insurance companies set pricing based on the number of medical marijuana recommendations a provider writes per month. Discrimination like this is why only 438 (1.6%!) of the 27,000+ active physicians listed in DORA in Colorado are registered to write medical marijuana recommendations. And it's why 90% of medical marijuana patients use a cannabis specialist clinic and not a PCP for recommendations. Yes, the patient has to pay out of pocket for the cannabis evaluation, but the appeal of getting a provider with actual cannabis experience is generally considered worth the cost.

4) The bill fails to make a distinction between types of cannabis concentrates. Concentrates manufactured for inhaled use by dabbing such as wax, shatter, and rosin carry a higher risk for misuse in our clinical experience. Concentrates designed for ingestion such as honeyed oils, RSO/"Phoenix Tears", and infused cooking oils have lower probability for misuse. The 40 gram limit was set with good intention that a rural cancer patient wanting to try a traditional RSO aka Rick Simpson Oil treatment of 60 grams THC taken over orally over 90 days could get the first 45 days worth of meds in one drive. How often does this happen? Very rarely, as 40 grams of RSO generally costs almost $5,000. Vape pens do not give the same super-high potency hit as dabbing because of their significantly lower temperature point, and so are often used as a rescue for acute episodic conditions. We believe the bill can be strengthened without having a provider write a prescription by distinguishing between concentrate types. We are in favor of limiting purchases of inhaled concentrates intended for dabbing more strictly, while setting limits for concentrates intended for oral use and pre-packaged vape pen cartridges higher.

We have other suggestions / tweaks for the bill, such as adding lists of over-the-count products and supplements that help make people less high following overuse of cannabis to both the bill's proposed pamphlets and provider training. We would like to eliminate the restriction on patients applying for renewals by mail shopping with paperwork as it almost exclusively punishes older, rural patients for being too sick to renew their cards in a timely fashion. We applaud the CME/CNE/Continuing Education requirement for recommending providers; interestingly, it would make cannabis specialists the only providers in Colorado required to get continuing education to renew their licenses.

Please feel free to contact me directly. I am with patients both Thursday May 20th and Friday May 21st, but will make time for this important issue.

Best regards,

Martha Montemayor CNC
Director, Cannabis Clinicians Colorado

Cell 303-618-1774

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Our tax ID number is 47-2008663

Colorado Coroners Association
7390 Julynn Road
Colorado Springs, Colorado 80919

May 20, 2021

House Finance Committee Members
Colorado State Capitol
200 East Colfax
Denver, CO 80203

RE: HB21-1317

Dear Committee Member:
The Colorado Coroner's Association (CCA) has reviewed HB21-1317, Concerning the Regulation of Marijuana for Safe Consumption, and, specifically, Section 4, page 12, Required toxicology screening for a suicide, overdose death, or accidental death. We respect the sponsors' intent and want this legislation to work in the most efficient manner for coroners in all counties, regardless of size, and for the research to be based on sound science. Therefore, we have requested several amendments, and the Speaker has assured us that we can work together on these amendments for second reading. We appreciate his gesture and look forward to making Section 6 workable for all parties involved without changing the intent of the legislation.

For the Committee's edification, CCA would like to briefly mention the major issues needing attention. HB21-1317 requires that every non-natural death of an individual (i.e., Accidental, Suicide, Homicide, and Undetermined manners of death) under the age of 25 years of age to be subject to a toxicology screen.

Our first issue is the cost of such screens, and that this legislation does not become an unfunded mandate on local governments. Already, County Coroner budgets have been exhausted by the COVID-19 pandemic. We request that the

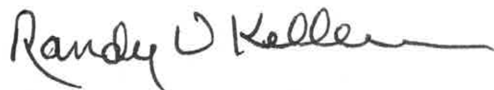
legislation will provide funding for private lab work or be a free of cost screening by the Colorado Bureau of Investigation (CBI).

Our second concern is related to making sure the collected data reflects the intent of the bill. When individuals are admitted to a hospital, admission blood work is undertaken, but is routinely disposed of after a period of three to seven days. If the person dies after this period, the coroner's postmortem toxicology screen won't reveal exact toxin levels at the time of the incident that sent the individual to the hospital.

Several remaining issues are worth mentioning. There may be a need for training in smaller county coroner offices concerning the procedures for withdrawing bodily fluids and for related supplies. Also, some reporting language to the Colorado Violent Death Reporting System should be modified to be consistent with current statutes. In addition, we have some questions about the type and specifics of the toxicology screen required. Again, we believe these issues can be addressed through technical amendments.

CCA looks forward to continuing a dialogue on this important public policy issue and amendments that would make it work for the coroner community.

Sincerely,



Randy Keller
Fremont County Coroner
President, Colorado County Coroner's Association

Cc: Speaker of the House Alec Garnett
Representative Yadira Caraveo