To the Senate Law and Justice Committee:

My name is Sara Payne. I am the Vice President for Government Affairs and Policy Counsel at Jushi, Inc, the parent company of medical marijuana permit holders in Pennsylvania. In addition to my law degree, I also hold a Master of Public Administration in Healthcare Policy and Management, a Master of Business Administration and a Bachelor's degree in Environmental Science.

I spent the last 15 years working in highly regulated and emerging industries in a number of different roles, including in business development, advanced R&D, government affairs, public policy, and most recently, 3 years in-house with Jushi following 8 years in the private practice of law.

While in private practice, I started working on cannabis law and policy matters in 2012. During my nearly ten years of experience in this field, I managed the cannabis practice group at a 350+ attorney law firm and represented companies operating in, or seeking to operate in, medical cannabis programs, adult use cannabis programs and industrial hemp programs across the country, and have provided cannabis policy guidance to decisionmakers in more than 25 jurisdictions.

At the outset, I would like to commend the Commonwealth of Pennsylvania, and particularly the legislature, for the long and careful work involved in making medical cannabis available to Pennsylvanians coping with serious medical conditions. Through Jushi's permit-holding subsidiaries, we interact with Pennsylvanians who benefit from the program every day and I can tell you with certainty that your work has improved the quality of life for hundreds of thousands of your constituents.

Today, I am here to offer some operational-based perspective on the Commonwealth's Medical Marijuana Program now that interested stakeholders have observed its effectiveness for a few years and offer some suggestions about how policy and governance tools could be used going forward to further improve one of the most successful medical cannabis programs in the U.S.

In this respect, most people here today likely have the benefit of directly or indirectly interacting with some aspect of regulated medical marijuana in Pennsylvania, so I will limit my comments to two broad topics. First, I would like to share some feedback about the Program as a permit holder representative that is responsible to: (i) dispense medical cannabis products to certified patients; and (ii) cultivate medical cannabis and manufacture medical cannabis products. Second, I would like to provide the Committee with information respecting a few relevant industry trends and related points of comparison with other states based on my multi-jurisdictional experience.

Today, 37 sates, D.C., Guam, Puerto Rico and the U.S. Virgin Islands regulate cannabis for medical use, while 18 of those states, D.C. and Guam have also legalized cannabis for adult use. Though some of these programs are very new, some have been in operation for several years – and in both cases, cannabis policy in Pennsylvania should benefit from the experience of other states as its Medical Marijuana Program continues to mature and the Commonwealth considers a future adult use policy.

In short, whether avoiding recreating the wheel as to policies and laws that work or avoiding those that do not, Pennsylvania is positioned to leverage actual outcomes and data in a way many other states could not. This advantage should result in a faster concept-to-legislation timeline, a higher confidence level in what constitutes sound public policy simultaneously with developing legislation, and a successful implementation process for future policy initiatives.

Now, with categorical respect for a Program that has certified more than 600,000 patients and maintained stringent safety and security standards from seed to sale across multiple different types of licensed operators, I would like to take this opportunity to address a handful of weaknesses in the Program.

Despite the Program's many successes, the weaknesses are significant and should be addressed if the goal of the legislative and executive branches is to ensure a patient-centric, public health and safety-based program. Fortunately, in my professional opinion, the weaknesses I am going to describe can be remedied in a reasonably simple and expeditious manner.

From my perspective, I see the principle existing weaknesses in Pennsylvania's Medical Marijuana Program as based in: (i) communications issues between the Department of Health (DOH) and other medical cannabis stakeholders; and (ii) a governance structure that limits the efficient and consistent regulation of cannabis in a comprehensive manner.

I. Communications; Formality and Consistency

In the short-term, program weaknesses largely stem from a fundamental breakdown in communication between the DOH as the regulator and the regulated community (*i.e.*, permitholders), and an apparent lack of communication (or inconsistent communication) within DOH between program leadership and employees on the ground responsible for working with patients and permitholders.

a. Communications Between the Regulator and Regulated Community

Any well managed regulatory relationship involves an open line of communication between the regulator and the regulated community. Unfortunately, that hasn't happened in Pennsylvania, and the breakdown has effectively been categorical. Over the course of years, the Department was unavailable for meetings to discuss policy or practice – something of critical importance as

grower/processor and dispensary permitholders built the supply chain and distribution infrastructure from necessary to support the Program the ground up. In this respect, there were and are countless areas of developing law that impacted the regulated community daily without guidance from DOH. And, that lack of that kind of regulator-stakeholder engagement carried over into product approvals and patient communications, making it difficult to know what was and was not allowed given the entirely novel nature of the Program.

The Department's lack of engagement – and this extended to all forms of communication, including calls and emails – made it very difficult to decipher inconsistent decisions or policy positions. To this end, there have been several instances, particularly over the past two years, where DOH would provide permitholders different information or an inconsistent decision on a question or application for some type of approval. The Department's unwillingness to explain what made the two situations or permitholders different or to rectify apparent inconsistencies is why so many permitholders and other stakeholders have raised the communications concern.

I would like to stress that lack of communication is not just a concern among permitholders, as illustrated through confusion over the patient assistance fund. Specifically, for the last four years, money has been accruing in a patient assistance account – $20M of it was borrowed during the pandemic for general fund needs – while patients who qualify and need those funds to make access to medical cannabis a financial possibility have been waiting. The Department has yet to release any of these funds under the premise that the law doesn't allow for the distribution prior to the adoption of the permanent regulations, a process DOH extended several times. For at least a full year, multiple stakeholder groups have been trying to engage with DOH on this issue in hopes of finding a solution.

The examples identified above are only a few illustrations of emerging issues in this rapidly developing field where the regulator and the regulated community need to engage so the Pennsylvania's successful Medical Marijuana Program remain patient-centric.

b. <u>Formality of Communications from Regulator/ "Regulations by Email"</u>

Another area of concern is the use of electronic communications to promulgate – what are by any measure – new regulations. Over the past few years several major policy and regulatory changes have been announced to permitholders *via* email without any type of other communication, engagement, notice, opportunity to be heard, or detail respecting the practical impact of the policy or regulatory changes before implementation. Examples include interpretations (and reinterpretations) of statutory authority and regulations, as well as entirely novel policy positions – all of which were communicated informally by email and were not subject to rulemaking but were enforced as if binding regulation. Of even greater concern is that these email rules and policy positions were never not posted publicly and were not communicated to every permitholder.

c. Internal Communications

An apparent lack or breakdown of communication within DOH has led to confusion among the regulated community and an uneven application of the temporary regulations. This commonly results in different decisions or outcomes in connection with applications or requests for approvals based on effectively the same facts and under effectively the same circumstances.

Especially over the past two years, the regulated community has experienced different decisions on essentially the same facts in several contexts – including in connection with requests for approval for store opening events, patient loyalty program communications, product approvals, real estate-related approvals, and manufacturing operations-type matters. Consistent internal communication and regulator engagement with the regulated community would improve decision consistency – or at least ensure equivalent standards are applied in equivalent situations. Such communication appears to be lacking.

II. Governance Structure

Many of the communications concerns, as well as other weakness in the Program, stem from a governance structure that no longer works for the Medical Marijuana Program, the Industrial Hemp program, or a future cannabis regulatory structure.

Like in many other states, Pennsylvania's Medical Marijuana Program was developed close in time to its Industrial Hemp Program when the Commonwealth had little to no experience or expertise in legal cannabis or hemp production, manufacturing, retail sales or other critical areas requiring cannabis-related governance. Thus, as in many other states, regulatory responsibility for the Medical Marijuana Program was appended to a public health-focused body, in this case, DOH, and regulatory responsibility for the Industrial Hemp Program was appended to an agriculture-focused body, in this case, the Department of Agriculture (DOA).

In many respects, this decision was logical, and the respective Programs seemed to fit naturally in the agencies to which they were assigned. In practice however, a clean separation becomes blurred almost immediately. For example, DOH in Pennsylvania and public health-focused agencies elsewhere may have a great deal of expertise regulating epidemiological issues, conventional pharmaceuticals, medical professionals, retail pharmacies and the like, but have no expertise in agriculture, horticulture, manufacturing (as opposed to narrower production activities, like compounding pharmacy) and a number of other key aspects across the cannabis product supply chain.

In contrast, DOA in Pennsylvania and agriculturally-focused agencies elsewhere may have the expertise necessary to regulate cultivation-type activities, but in addition to lacking in retail expertise, they have been largely unprepared to address rapid changes in the cannabis industry,

such as introduction of delta-8 products, and have largely lacked the enforcement focus and capabilities to ensure proper cultivation compliance.[1]

In some jurisdictions, states have assigned regulation of cultivation activities to an agriculturally-focused body and subsequent activities, including manufacturing and retail sales, to another one or more regulating bodies. This method has also been ineffective – but for different reasons.

As you may expect, when two or more agencies are responsible to regulate, the government is often required to purchase and maintain duplicative facilities and equipment, and can suffer staffing inefficiencies. The relevant agencies may also both try to regulate the same thing – or each assume the other body is responsible to regulate a specific matter. This has been especially true in the cannabis industry, where we have seen the foregoing scenario playout in two primary ways: (i) where duplicative but inconsistent regulations among agencies create separate and distinct rules governing the same conduct but are in conflict; and (ii) where each agency with potential jurisdiction fails to regulate and thereby a gap in regulation that leaves conduct that should be regulated subject to no oversight. These situations routinely occur where a cannabis program is regulated by more than one body – but we also see it play out where cannabis and hemp are regulated by different agencies.

This is why a comprehensive approach to cannabis regulation starts with a standalone umbrella agency like a Cannabis Control Board. A Cannabis Control Board could be the lead on all cannabis issues with several programs housed underneath it that focus on different aspects of the industry. In effect, a body like a Cannabis Control Board would set cannabis policy and promulgate regulations as directed by the legislature. It would have regulatory responsibility for industrial hemp intended for human consumption,[2] the Medical Marijuana Program, and a future adult use cannabis program. Each of these lanes should be staffed by individuals with specific expertise to improve the quality, effectiveness and efficiency of regulation, the regulatory process and the program for all stakeholders, and each of these individuals should report to a singular executive accountable to a board of directors, the legislature and governor.

This model has the added benefit of being adaptable – as the industry evolves, new types of products or activities can either be assigned within the existing structure, as would be the case for an adult use program should this type of umbrella regulator be created expeditiously, or the executive director, with the approval of the board of directors, could a new lane to address the regulatory requirements and challenges that arise in connection with a rapidly evolving industry.

[1] Especially in the context of industrial hemp programs, Agriculture Departments have not been effective at ensuring hemp crops are actually hemp as opposed to high THC marijuana, and due to the cultivation conditions Agriculture Department are accustomed to, bad actors have successfully used hemp licenses to conceal unlicensed outdoor grow marijuana operations.

[2] As opposed to industrial and agricultural applications, and hemp cultivation and manufacturing for these purposes should remain in an agriculturally-focused agency to prevent farmers not intending to cultivate and manufacture hemp for human consumption and use are not unduly overregulated.

This flexibility is critical as conditions impacting cannabis policy change federally and on the state level in neighboring states and across the U.S.

The above-described structure may sound complicated, but in practice it is the most effective and efficient way to regulate cannabis equitably while ensuring public health and safety priorities remain at the forefront of policy decisions. Further, and assuming appropriate staffing decisions, such a structure would address the weakness we see in the Commonwealth's Medical Marijuana Program in a way that preserves all of its strengths while making the few improvements necessary to best serve patients and ensure proper health and safety controls are effective and in place.

I would like to thank the Committee for the opportunity to testify today. Let me close with this thought – both the industry and the Department share the same mission – serving the patient community safely. The more we engage with each other, the better we serve that mission. I, on behalf of Jushi Inc, look forward to the opportunity to so engage and stand ready to cooperate and collaborate with DOH in all respects.

I am happy to take any questions about my testimony or my experience in other jurisdictions.