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July 22, 2024

The Honorable Anne Milgram
Administrator
U.S. Drug Enforcement Administration
U.S. Department of Justice
8701 Morrissette Drive
Springfield, VA 22152

RE: Docket No. DEA-1362; A.G. Order No. 5931-2024 Schedules of Controlled Substances: Rescheduling of Marijuana; Notice of Proposed Rulemaking

Dear Administrator Milgram:

On behalf of the physician and medical student members of the American Medical Association (AMA), I offer the following comments regarding the proposed rule to reschedule marijuana to a Schedule III Controlled Substance. AMA policy, which is set by the AMA House of Delegates—representing state medical associations and national medical specialty societies across the United States—provides the foundation for our comments on the proposed rule and frames several key considerations, as discussed below:

1. While AMA policy has adapted to the changing landscape of state and federal law governing cannabis use, possession, distribution, and related matters, the AMA maintains that there are significant public health and other concerns regarding cannabis use—particularly for vulnerable populations, youth and adolescents, and people who are pregnant or breastfeeding.

2. The AMA also has long-standing policy stating that "scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use."

3. There is a clear need for more effective regulatory boundaries and guidelines concerning cannabis marketing, promotion, limiting the potency of cannabis extracts and concentrates, as well as packaging to protect children and youth.

4. To emphasize a point made throughout the proposed rule, cannabis is not a benign substance and, should it be rescheduled, the federal government and states must do a far more effective job with education and prevention efforts for cannabis-related use, education, and prevention.

The Need to Ensure Public Health and Safety

The AMA greatly appreciates that the U.S. Department of Health and Human Services (HHS) in its recommendations, and the U.S. Drug Enforcement Administration (DEA) in its proposed rule, each detail the significant and broad public health and safety concerns regarding cannabis use. The AMA further appreciates that HHS and DEA also highlight multiple harmful physical and psychological effects regarding cannabis use. The AMA agrees that the multiple and varied considerations surrounding the potential rescheduling of cannabis must be given thoughtful consideration before determining whether such a step is warranted. AMA policy provides that "cannabis is a dangerous drug and as such is a serious public health concern; [and] believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older)." The AMA also "discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding."

While rescheduling cannabis from a Schedule I Controlled Substance to a Schedule III Controlled Substance is not the same thing as approving cannabis for non-medical use (or medical use for that matter), the AMA is concerned that rescheduling may send a mixed message to consumers that cannabis use is safe. Even though HHS may have concluded that cannabis has a currently accepted medical use (CAMU), the AMA believes that there is a difference between a CAMU for an FDA-approved medication that has been subject to robust clinical trials, as opposed to the use of a botanical in various forms (edibles, oils, smoked, etc.) that do not have the benefit of robust clinical data. Further, some ambiguity arises from the various terms employed—per the HHS National Institutes of Health, National Center for Complementary and Integrative Health, "The word 'cannabis' refers to all products derived from the plant Cannabis sativa. The cannabis plant contains about 540 chemical substances. The word 'marijuana' refers to parts of or products from the plant Cannabis sativa that contain substantial amounts of tetrahydrocannabinol (THC)." The DEA distinguished the relative CAMU for certain conditions, including where cannabis has no real benefit. The AMA is concerned that rescheduling will cause individuals to believe that cannabis has an accepted CAMU for any marketed use. The AMA urges the DEA to take this into consideration.

The Need for Additional Research and Data

We appreciate that HHS' recommendation to reschedule cannabis was based, in part, on its view that cannabis-related harms may be less than the comparable harms associated with the use of heroin, cocaine and certain Schedule II Controlled Substances. It is unclear how HHS determined that these are the most effective comparators and the AMA notes that less harm does not mean the absence of harm. The HHS recommendation and DEA analysis provide multiple data points indicating a wide variety of harms, including increased prevalence of emergency department visits and hospital admissions; increased calls to poison control centers; increased prevalence of cannabis use disorder; continued use by youth and adolescents; and discussion of the harmful physical and psychological effects of cannabis use. As such, the AMA strongly agrees with DEA that for each of the eight factors cited in the proposed rule, additional data and other information are necessary to help DEA make an informed final determination.

The increased need for research, data, and other information to assess the safety and efficacy of cannabis and cannabis-derived products also persists. The DEA points out throughout the proposed rule that, although there are multiple different federal databases that capture elements of cannabis-related harms, there is a glaring lack of data to fully evaluate harms—or safety—of existing cannabis policies across the country. The AMA agrees with DEA that additional information is necessary for these evaluations. The AMA further encourages local, state, and federal public health agencies to improve surveillance efforts to

ensure data is available on the short- and long-term health effects of cannabis, especially emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder. Accomplishing these goals of compiling and maintaining the requisite data will require scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications—and if cannabis is rescheduled—on the botanical itself in all of the different forms, potencies, and routes of administration that cannabis products provide. To be clear, the AMA does not support the legalization of cannabis, but we recognize the vast research gaps and needs that exist to fully inform public health officials, physicians, and patients. The AMA agrees with DEA that additional data and research on cannabis' pharmacological effects are appropriate for consideration.

The Need for Consistent Regulatory Oversight

If cannabis is rescheduled, there is a significant need for consistent, robust regulation. There are 39 different state regulatory schemes in effect in 38 states and the District of Columbia that have authorized the medical and/or adult use of cannabis. Every state takes a different approach to manufacturing quality, consistency, marketing, packaging, enforcement of consumer protections and other essential elements of a functional regulatory framework. The AMA is deeply concerned by DEA's observation that "there is a lack of unified controls on cultivation and manufacturing, which raises concerns related to the safety, quality, the impact of Δ9-THC potency, and consistency of botanical substances (e.g., botanical raw materials, extracts, and intermediates) and final product formulations that are currently accessed for medical and nonmedical use. Products sourced from State-authorized adult-use and medical-use programs are subject to a patchwork of inconsistent product standards and safety requirements."

If the cannabis botanical is rescheduled, the AMA urges several actions, including having the federal government provide clear guidance—and enforcement of that guidance—to develop and provide for uniform regulatory oversight to help assure patient safety. The AMA also has policy recommending that all cannabis products not approved by the FDA include the following warning: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process." While we understand rescheduling may not affect non- Δ9-THC products, the AMA recommends that the federal government also consider the public health and safety concerns surrounding cannabidiol and cannabis-derived products—vital issues for which reliable clinical data and research do not exist.

The Need to Protect America's Youth and Adolescents

The AMA continues to be alarmed by increases in overall use and harm associated with cannabis use. It bears repeating that rescheduling cannabis to a Schedule III Controlled Substance will give cannabis a veneer of acceptability and safety that is not warranted for all patient populations or medical conditions. This is particularly true given that there are only a handful of FDA-approved cannabis/cannabidiol products, yet there are tens of millions of current and recent cannabis users, including millions of youth and adolescents. HHS and DEA each cite multiple databases and surveillance surveys, and while the results are slightly different, the consistent findings among them show that cannabis use generally continues to increase, and cannabis is used more frequently than the comparator drugs (heroin, cocaine, Schedule II substances) but less than alcohol. Furthermore, as reported by NSDUH in 2022, 3.7 million people initiated cannabis use in the past year, with more than half (53 percent or 2.0 million people) initiating cannabis use before the age of 21. HHS and DEA also found that the harms associated with alcohol were greater than cannabis use, but cannabis-related harms were more common than comparator drugs. The AMA is greatly concerned that without further data to help inform education and prevention

strategies, these trends will continue and lead to additional harm. Therefore, the AMA strongly supports the DEA's call for additional information with respect to the harms associated with cannabis use, particularly for youth and adolescents, as part of its deliberations.

The Need to Address Other Public Health and Practical Concerns

The AMA discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding. The U.S. Substance Abuse and Mental Health Services Administration makes clear that "No amount of marijuana has been proven safe to use during pregnancy or while breastfeeding." The AMA and the nation's leading medical societies all advise against cannabis use during pregnancy and while breastfeeding because of research, data and clinical experience demonstrating the harms to the mother, fetus, and child. Yet, cannabis use during pregnancy continues to increase—likely in part due to the false perception of cannabis' safety. Growing acceptance and use is not a clinical marker to justify increased use when there is demonstrated harm. The AMA agrees with the proposed rule's call for additional information on the abuse potential and other consequences of rescheduling cannabis.

At the same time, the AMA also continues to urge that the federal government pursue public health-based strategies, rather than incarceration, in the handling of individuals who possess cannabis for personal use. Similarly, the AMA recognizes that cannabis policy in the United States has had a disproportionate, negative effect on Black and Brown Americans with respect to criminalization, incarceration, and subsequent inequities. This is why, in part, the AMA supports expungement of cannabis-related crimes when a state has subsequently made the prior illegal activity legal. The AMA commends HHS and DEA for recognizing the inequitable effects of cannabis-related criminalization, but we also urge continued vigilance and nuance in the rulemaking process.

Another issue is that not all states have authorized cannabis for medical or adult use, and the effects of rescheduling cannabis at the federal level may lead to inappropriate state-federal conflicts and confusion. For example, it is not at all clear how the federal government expects physicians to prescribe cannabis or pharmacists to dispense it. Given that the proposed rule potentially reschedules the botanical product, would the Controlled Substances Act (CSA) then authorize a physician to prescribe the botanical as long as the prescription met all of the other elements of the CSA? For example, what specific elements would need to be included on the prescription? Are physicians expected to recommend specific types of cannabis, forms of cannabis and route(s) of administration? Would the botanical then be authorized to be dispensed in pharmacies registered by the DEA? Would patients then be able to have their prescriptions covered by their health insurance plan, including Medicaid, Medicare, and other federally regulated payors? Does the DEA expect states to modify state laws requiring authorized dispensaries to enter cannabis-related information into state prescription drug monitoring programs? These are considerations that should be addressed in any final rule.

In conclusion, the AMA has multiple concerns with cannabis being rescheduled as a Schedule III Controlled Substance. There are clear harms to individuals, including youth, adolescents, and pregnant and breastfeeding individuals. Harms are not limited to these vulnerable populations, however. In addition, while HHS has identified several, limited CAMU for cannabis, DEA also raises the fact of the extremely limited research to help inform public health strategies to mitigate harms or support additional CAMU. The AMA strongly supports additional research and urges DEA to take the limited, available research into consideration in deciding whether to reschedule cannabis. Finally, the AMA has significant concerns about the practical implications of rescheduling—many of which were not raised in the proposed rule. While the AMA strongly supports efforts to end longstanding inequities suffered because

of criminal penalties, we also strongly support regulatory clarity to provide guidance to physicians and patients. Given the extreme patchwork of state cannabis laws, the AMA sees this as an incredibly daunting challenge, but one that must be fully addressed if cannabis is to be rescheduled.

Thank you for your consideration. If you have any questions, please contact Margaret Garikes, AMA Vice President for Federal Affairs, at Margaret.Garikes@ama-assn.org or 202-789-7409.

Sincerely,

James L. Madara, MD