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Dr. Forsyth and other members of the Commission,

I sent this letter to JLARC staff with the hope that they will forward it to you and to the other members of the Citizen Commission for the Performance Measurement of Tax Preferences.

I appreciate the opportunity I had to speak with members of the Commission on Thursday regarding medical cannabis tax preferences. Dr. Forsyth, after reviewing my testimony, I was left with the sense that I had not answered two of your questions directly enough.
One question asked whether other states have done a better job at medical cannabis than has Washington State. The other question concerned information about product hygiene that is available to patients in the unregulated market versus the regulated market. They were both important questions and I wanted to circle back around to them with the hope that I provide you with the answers you were seeking.

Product hygiene.
In my testimony I described the lack of product testing in the recreational cannabis market – which is the "medical" market in Washington State for all practical purposes. I asserted that patients are seeking "cleaner and more appropriate access in the unregulated market." Your question seemed to be: In the absence of testing in the unregulated market, how do patients know the product is cleaner? It is an obvious question. And the answer is: objectively, other than the testing that myself and others sometimes do, patients do not objectively know.

I believe a core to the answer, though, goes to educated confidence. There is enough information out there that patients understand that Washington's regulated product is not clean.
When patients go to unregulated sources, they have three tools beyond testing. One, of course, is referrals, i.e. asking other patients who they trust. Like the way you find a car mechanic. Another way is through their senses. An educated patient can smell the product. Through smell, I can tell if cannabis flower has had pyrethrin or neem oil applied to it, or if it has been properly flushed before harvest, or properly cured after harvest.
But the third and key way is by talking to the farmer. The unregulated market usually has more of a farm to table dynamic, where patients can ask questions about how crops are grown. I would say this is the single most important feature of the unregulated market that provides patients information about product hygiene. However, in order for this to work, patients need to have some education and know what to ask.

During the hearing, my response was that testing reveals that unregulated flower seems to objectively be cleaner. Though the process patients use to vet unregulated product is not ideal, it does seem to work. There are contaminants that consistently appear in tests of regulated product that almost never appear in unregulated product, and I suspect that is because the farmers are often face to face with the patients they serve, and may feel more accountable because of it.

Clearly, not all patients want to be weed sommeliers, nor should it be required of them. When I fill a prescription, my doctor dispenses some information, then my pharmacist dispenses some information, and that is easy and safer. Cannabis patients need access to a system that is more like that. The state tests milk and wheat and water, and all sorts of other things. Especially if cannabis is being sold as medicine, then that product should be tested for things that could pose a risk to their health. Patients should be able to go into a store and buy a product with a reasonable confidence that it has been tested for safety.
<u>And if that product has not be subject to reasonable testing, then that product certainly should not qualify for a medically-premised tax preference.</u>

Forgetting about patient issues for a moment, Washington State, specifically LCB, may decide to persist with the notion that selling partially-tested Taco Bell weed is all that consumers are entitled to. But Washington State is alone in that notion and, when the state barriers come down, the state cannabis industry will get its cans handed to it because nobody outside of the state will want to touch our product. I live here, and I infrequently buy regulated product, and then, only from farmers that I know well.

The example of Colorado, trust, and the economics of the excise tax.

You asked which states do a better job. The answer is Colorado. There are two aspects to that. (Maybe more than two, but I will mention two.)
But before I do that, let me mention that I am ignoring the other states not only because Colorado is more successful, but also because the other state schemes are so different from Washington as to not be comparable. California is in its own universe, so there is no easy, rational way to make a comparison. Oregon less so, but still quite different.

Then there is the example of Colorado. During testimony I mentioned that patients in other states seem enthusiastic about their medical programs, as indicated by their participation rates. I mentioned Colorado's high patient registration rate (90,000 or so, with 2 million fewer citizens than Washington State). This is particularly notable because Colorado's market has several features that might suppress the participation rate.
First, Colorado begins with an excise tax rate of 15% for all adult consumers –which makes it more price attractive than Washington State's 37% excise tax rate, even with a 10% patient

sales tax discount. Colorado allows for six-plant adult recreational home growing that does not require registration. Even with all of these features, Colorado has a very high patient registration rate.

I suspect that there are two features that make Colorado's patients engage so much more than Washington patients: their excise tax reduction and trust.

Excise tax.

At the beginning, Colorado made the decision that is was preferable to lure patients out of the black market than it was to make every nickel off of each patient. Their public policy decision was to charge every registered patient 3% excise tax -enough, by their calculation, to administer the program, but not enough to realize any excess revenue from them.
Colorado made an initial mistake of allowing 99-plant patient limits, which left open a door for diversion, but they later reduced that limit to twelve plants, which seems to have addressed that issue. Even after they reduced the allowed plant counts, patient registration only fell by 10% or so over time.

it is interesting to note that, even with a recreational home growing allowance, in addition to a medical growing program, Colorado has consistently experienced higher per capita cannabis sales than Washington State from the beginning, which certainly benefits licensees, ancillary businesses and employees.
This is due to a higher participation rate in the regulated system. It has also been suggested that Colorado benefits from cannabis tourism, but I have never seen any numbers to support that. I suspect measuring the per capita revenues from before and after Utah legalization might lend evidence to that.

Trust

In contrast, Washington State began on the opposite end of the spectrum.
From the beginning, Washington policy began with the prejudice that 90% of all cannabis patients are fake and our doctors are lying. Washington's public policy emphasis then was built on the priority that any "medical benefits" given to patients prioritize first minimum loss of revenue and suppressing first the potential for diversion. Patients were, and still are, first seen as potential criminals and as potential threats to maximizing state revenue. rather than as vulnerable citizens with unique needs. In contrast to Colorado, the focus on patients in Washington State has never been on serving us, but in suppressing us as potential criminals and coercing us into the recreational weed market. Therein lies the roots of patient mistrust and avoidance of the regulated market, and unfortunately recriminalization of patients –the most well-vetted and in-need consumers of cannabis in the state.

The numbers suggest that Washington's approach has spectacularly back-fired.

Can a sales tax exemption matter? And what might be a better solution.

But I digress from the issue of taxes, so let me return there.

As the Colorado experiment seems to have succeeded, I have concerns about whether a sales tax exemption alone on DOH Compliant product will remedy the inability of patients to participate in the regulated market.

As I stated in testimony, the cheapest recreational product in Washington is far less expensive than the least expensive product in the unregulated market. Forgetting the quality and medical appropriateness issue for a moment, at $3 to $7 per gram for cheap recreational 502 products, that 10% sales tax exemption does not make much of a difference for even poor patients. I calculate $17 per month savings. It is something, but clearly not that meaningful given the hoops patients are required to jump through to receive it.

On the other end, with DOH Compliant product, if patients, who tend to be poor as a result of our infirmities, are given a sales tax exemption on DOH-quality product, which tends to be in the $17 per gram range, does that bring that product in reach of patients. And I am not confident that it does.

I feel there is a good case to be made that if an excise tax exemption on $17/gram, medical-quality product could bring the cost down to $11/gram, then that is definitely more within reach of patients, at the quality they require, and the incentive required to lure patients out of the black market and into the regulated market, where they can request testing results; where they can be putting money into the pockets of licensees and their employees, where they could be acting legally instead of criminally. It would also be at a price that does not compete with the cheap recreational product (meaning no patient would tax advantage of that excise tax exemption to receive a 'best price'.) I feel this approach would solve that adequate-quality at an attainable-price puzzle that patients require and that is completely absent currently. I feel a far better idea would be to replace a sales tax exemption with an excise tax exemption on DOH Compliant product only for patients in the registry.

So at 1,700 words, that is my pitch.

Thank you for your work. I feel it matters. Thank you for the opportunity to express my views. If I can be of help, please reach out.

Sincerely,
John Kingsbury

cc:
Dr. Grant Forsyth
Ronald L. Bueing
Diane Lourdes Dick
Andi Nofziger-Meadows
Dr. Sharon Kioko
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