

SPOKEN REMARKS: KEVIN A. SABET, PH.D.

South Dakota Medical Marijuana Oversight Committee | Tuesday, October 13, 2026

Time allotted: 30-minute block (about 20 minutes of remarks, about 10 minutes of member questions).

OPENING

Chair Garcia, Vice Chair Carley, members of the committee, thank you for having me, and thank you to your staff for making the remote connection work.

I'm Dr. Kevin Sabet. I lead Smart Approaches to Marijuana, a national organization I co-founded with former Congressman Patrick J. Kennedy in 2013. SAM is the leading non-profit fighting against the commercialization of marijuana, which we view as a detrimental public health and safety threat. We have a science advisory board with researchers from esteemed institutions across the world who inform the work we do every day. I've worked on drug policy for three decades, including as an advisor in three presidential administrations.

I'll cover three things here today. First, where federal rescheduling actually stands and what it means for South Dakota. Second, how medical programs drift into de facto recreational markets. And third, specific options for this committee, the Legislature, and the Department. You also have my written testimony, which includes the citations.

PART ONE: WHERE FEDERAL RESCHEDULING STANDS

Let me start with rescheduling, because I know you heard in August that it's still under review. For the broad question, that's right. But for medical marijuana in South Dakota, the change has already happened.

There are two separate federal tracks.

First, track one. On April 28th, a Justice Department order took effect moving two categories of marijuana to Schedule Three: marijuana in FDA-approved drugs, and marijuana held under a state medical license. So the product in South Dakota's licensed medical system is now, federally, Schedule Three. That order is being challenged in the federal appeals court in Washington. On September 9th, the court declined to put the order on hold while the case goes forward. That was not a ruling on the merits. The order rests on a treaty provision that lets the Attorney General act by order instead of going through normal rulemaking, and whether that was lawful is the question the court will decide. So the order is in effect today, and it could still be struck down.

Track two is the broader question: should all marijuana, including recreational, move to Schedule Three? DEA held a hearing on that this summer. Now we wait for the judge's recommendation, then a final decision from the DEA Administrator, and then, almost certainly, more litigation. There is no deadline.

So what does track one mean for you? It makes South Dakota's own decisions more important, not less. Here's what changes.

First, your state license is now the federal on-off switch. The order sets up a fast-track DEA registration for businesses that hold a state medical license. The state license is treated as conclusive proof of state authorization. And if South Dakota suspends, revokes, or doesn't renew a license, the federal

registration is automatically suspended too. Every licensing and enforcement decision your Department makes now has federal consequences.

Second, a South Dakota certification now does the job of a prescription. For a registered dispensary, the federal government accepts whatever certification your state law accepts, as long as it's dated, signed, and identifies the patient and the practitioner. But a certification isn't a prescription. It doesn't name a product. It doesn't set a dose. It doesn't limit quantity. Whatever standard you set for certifications is the only standard there is.

Third, federal rules step aside for state rules. Registered businesses can follow state law, not DEA's rules, on labeling, packaging, security, and disposal. And rescheduling brings no federal potency limit, no product restriction, and no advertising rule. If South Dakota doesn't set a standard, nobody does.

Fourth, the industry will have more money. Businesses under a state medical license are no longer hit by the federal tax provision, known as 280E, that blocked normal business deductions. That means more capital for marketing and expansion.

The Department told you in August it had more questions than answers, including whether businesses have to register with DEA. The short answer is this: under federal law, handling a Schedule Three drug requires a DEA registration. Businesses that applied by late June can keep operating while DEA reviews their applications. I'd encourage the committee to simply ask each licensed establishment where it stands.

Now, what the order does not do. Four things.

It is not FDA approval. Nothing on a dispensary shelf in South Dakota has been reviewed by the FDA for safety, effectiveness, or dose.

It is not a verdict on South Dakota's program. I want to be precise here. The order does recognize state licensing. But it makes no judgment about whether any state's qualifying conditions, practitioners, or products are appropriate. It limits registrations to medical purposes and to the scope of the state license.

It does not limit your authority. Federal drug law doesn't preempt state law unless there's a direct conflict, and running a stricter program than Washington would tolerate is not a conflict. You remain free to narrow conditions, cap potency, restrict products, and tighten certification.

And it does not cover recreational or unlicensed marijuana, which stays in Schedule One.

And if track two is finalized and all marijuana moves to Schedule Three, the federal line between medical and recreational goes away. That would not legalize recreational marijuana, and it would not change South Dakota law. But it would make the design of your medical program the main thing standing between medical access and the commercial market your voters have rejected twice.

PART TWO: HOW MEDICAL BECOMES DE FACTO RECREATIONAL

Which brings me to my second topic. How does a medical program become a recreational one without anyone voting for it?

Oklahoma is the cautionary tale. Its program has no list of qualifying conditions at all; a physician's recommendation for any reason will do. It grew into thousands of dispensaries, and the state eventually had to freeze new

business licenses. South Dakota is nowhere near that. But the same forces are at work in every program, and the design choices are what hold them back.

I've watched this happen elsewhere across the country. Some medical programs stay small and clinical. Others become markets you can't tell apart from recreational. The difference usually isn't the ballot language. It comes down to four design choices.

One: how broad the qualifying conditions are. Programs built around specific diagnoses stay medical. Programs built around symptoms, especially pain, grow fast, because pain is common, it's self-reported, and it can't be objectively verified.

Look at your own data. In August, seventy percent of South Dakota patients qualified under severe, debilitating pain, and almost fourteen percent under PTSD. That's about eighty-four percent of the program. Cancer is about four percent. MS is about one percent. And the program grew by about a third in a single year, to nearly twenty thousand patients.

I'm not saying those patients aren't hurting. Many are. But the evidence matters. A randomized trial published in 2022 found that adults who got a card for pain, anxiety, depression, or insomnia developed cannabis use disorder at about twice the rate of those who waited, with no significant improvement in pain, anxiety, or depression.

Two: how easy it is to get certified. The warning signs are clinics that exist to sell certifications, one-time visits, and a handful of practitioners certifying a large share of patients. South Dakota has done a lot right here: in-person exams, a real practitioner-patient relationship, no certifications during

pregnancy, notice to the patient's regular doctor, and anti-kickback rules. But certifications can last a year, the statute still allows a certification-only relationship on referral, and you have about 211 practitioners for nearly 20,000 patients.

What you don't have yet is a public picture of how those certifications are spread across practitioners. That one number would tell you more than almost anything else. And ask yourselves: when a card says severe pain, does anyone know what product the patient should use, at what dose, or whether anything else was tried first? Under the current system, usually not.

Three: potency and product. Marijuana today is not the marijuana of the 1990s. Average THC in federal testing roughly quadrupled between 1995 and 2022, and many concentrates and vapes sold today exceed 99 percent THC. Heavy use of high-potency products is linked to psychosis, to cannabis hyperemesis syndrome, and to addiction. One large study found that daily users of high-potency cannabis had about five times the odds of a psychotic disorder. South Dakota's statute has no potency limit. And your purchase limit, three ounces every fourteen days, works out to about six grams a day, every day. That's far beyond what therapeutic use requires, and it leaves real room for diversion.

Four: supply oversight. Can the state see where product goes? Your Department has worked hard to rebuild its inspection program this past year, and that deserves credit. But home cultivation has grown from 61 patients to 715 in four years, and it sits outside seed-to-sale tracking, outside testing, and likely outside the new federal framework.

PART THREE: WHAT YOU CAN DO

So what can you do?

The Legislature can do several things. First, tie pain and PTSD to documentation. A certification for severe pain should name the underlying diagnosis and show that conventional treatments were tried. A PTSD certification should rest on a diagnosis from a qualified mental health professional. For a patient with a real diagnosis, that isn't a burden. It's routine medicine.

Second, give the Department clear authority over potency and product form: THC limits no greater than 10-15 percent potency, and ideally restrictions on product types. The legislature should prohibit inhalable products like joints or vapes due to the additional health risks. It should also limit edibles, which often are appealing to kids. Legal product forms should be limited to pills and capsules.

Third, if you do keep other product forms, right-size the purchase limit, either below three ounces every two weeks, or as a monthly THC limit that accounts for concentrates.

Fourth, make certifications clinical. Have the practitioner state a product form and a maximum daily amount, and let the tracking system enforce it. Consider a shorter first certification with an in-person follow-up before renewal, and require a check of the prescription monitoring program.

Fifth, tighten home cultivation, for example by limiting it to patients who don't have reasonable access to a dispensary, and requiring periodic re-verification.

Sixth, update the advertising provision in your statute so the Department can prohibit health claims and youth-appealing marketing, especially now that the tax change will free up marketing dollars.

And require an annual public report: certifications by practitioner, qualifying conditions, sales by potency and product type, home grows, enforcement actions, and health and traffic safety data.

For the Department, it can do many things within existing law. It can adopt the standardized certification form your statute already allows. Use the tracking data to flag outliers, like patients buying the maximum every period and practitioners with unusual volumes, and refer concerns to the licensing board, which the statute permits. Put clear warnings on labels and at the counter about psychosis, hyperemesis, addiction, driving, and pregnancy. And set up a line of communication with DEA, since your enforcement actions now suspend federal registrations automatically.

And for this committee: ask for the data. Federal registration status for every establishment, certifications by practitioner, and sales by potency.

CLOSE

Let me close with this. Whatever happens in court, the federal government has now put South Dakota's own rules in the driver's seat. If you have to keep a medical marijuana program, patients with serious illness are best served by a program that looks like medicine: specific diagnoses, real relationships with clinicians, known doses, and honest labels.

My organization is glad to be a resource to the committee and the Department as you work through this. Thank you. I'm happy to take your questions.

ANTICIPATED QUESTIONS (PREP NOTES, NOT FOR READING ALOUD)

The audience includes two senators, two representatives, a physician, a PA, a nurse practitioner, a police chief, a sheriff, a counselor, and a patient member, plus 30 to 40 members of the public, including growers, dispensary owners, patients, and lobbyists. Expect at least one question framing SAM as trying to end the program.

"Isn't SAM really trying to repeal the medical program?"

No. Point back to the two votes. Nothing proposed repeals access; every option keeps a path for patients with serious conditions. A tighter program protects the legitimacy of the patients who most need it.

"Can doctors prescribe marijuana now that it's Schedule III?"

No. A certification is not a prescription and names no product or dose. No dispensary product is FDA-approved. Physicians could already prescribe the FDA-approved cannabinoid drugs (dronabinol, nabilone, Epidiolex), and that is unchanged.

"Do our businesses have to register with DEA, and what if they didn't?"

Federal law requires registration to handle a Schedule III substance. Filers within 60 days of April 28 (about June 27) may operate while DEA reviews, and DEA is to make every effort to decide those within six months. Non-filers do not get that safe harbor. How DEA enforces is DEA's call; the committee can simply ask establishments for their status.

"Would stricter state rules conflict with the new federal order?"

No. 21 U.S.C. 903 preserves state law absent a positive conflict, and the order itself caps federal registrations at the scope of the state license. Stricter is fully compatible.

"What if the D.C. Circuit strikes down the April order?"

Covered marijuana would return to Schedule I, and 280E would apply again. South Dakota's program runs under state law and existed before April, so it would continue either way. That is exactly why state standards should not depend on federal status. Keep answers on the litigation factual; SAM is a party (check with counsel beforehand on how much to say).

"What does this mean for patients who own firearms?"

Not settled. Rescheduling did not remove marijuana from the controlled substances list, and the Supreme Court's June 2026 decision in *United States v. Hemani* narrowed the federal gun prohibition as applied without striking it down. Suggest legislative counsel review the notice required by SDCL 34-20G-28.1. Do not give individual legal advice.

"Isn't marijuana safer than opioids for pain patients?"

Defer clinical detail to Dr. Madras and Dr. Finn. Note that early studies linking medical marijuana laws to fewer opioid deaths reversed when the data were extended (Shover et al., PNAS 2019).

"What about intoxicating hemp THC products in gas stations?"

Agree they are a serious problem and a de facto recreational market of their own. The federal hemp redefinition was set for Nov. 12, 2026; the continuing resolution signed Sept. 2 delayed most of it to Dec. 11. South Dakota can act on its own regardless, and should, so that tightening the medical program doesn't push people to unregulated hemp products.

"Can the state regulate home grows further?"

Yes. Options include access-based eligibility, better site documentation, re-verification, and compliance checks. Home grows sit outside seed-to-sale, testing, and, in SAM's reading, the federal registration framework.

"What would you say to a patient with MS or cancer?"

These reforms are designed to protect you. A program where 84 percent of cards are for pain and PTSD, with no dose guidance, is the program most at risk of losing public trust.