

WRITTEN TESTIMONY OF KEVIN A. SABET, PH.D.

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*Submitted to the South Dakota Legislature
Medical Marijuana Oversight Committee
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SUMMARY OF TESTIMONY

1. **Federal rescheduling is running on two tracks.** Since April 28, 2026, marijuana held under a state medical license and FDA-approved marijuana products have been in Schedule III. A separate proceeding on all marijuana awaits an administrative law judge's recommendation. The April order faces a pending challenge in the D.C. Circuit, which on September 9 declined to pause it while the case proceeds.
2. **The April order makes South Dakota's own decisions more important, not less.** Federal registration for South Dakota businesses rests on the state license and lapses automatically when that license is suspended, revoked, or expires. A state certification now stands in for a prescription. Federal packaging, labeling, security, and disposal rules defer to state law. Whatever standard South Dakota sets is, in practice, the only standard.
3. **Rescheduling is not FDA approval.** It creates no federal floor for potency or product safety, does not reach recreational or unlicensed marijuana, and does not limit South Dakota's authority to run a stricter program.
4. **Medical programs become de facto recreational through four design features:** broad symptom-based qualifying conditions, weak certification practices, unlimited potency and product forms, and thin supply oversight. South Dakota's own data show pressure on several of these fronts.
5. **The Legislature, the Department of Health, and this committee have concrete options** to keep the program medical without repealing what voters approved. They are listed in Part III.

Chair Garcia, Vice Chair Carley, and members of the committee, thank you for the invitation to submit this testimony and to appear on October 13. I lead Smart Approaches to Marijuana, a nonpartisan organization that works on evidence-based marijuana policy, and I have served as a drug policy advisor in three presidential administrations.

This testimony addresses the three areas: where federal rescheduling stands and what it means for a state like South Dakota; how medical programs drift toward de facto recreational access; and concrete options for keeping South Dakota's program as strict as possible within what voters approved.

South Dakotans approved Initiated Measure 26 by about 70 percent in 2020, and they rejected recreational legalization in 2022 and again in 2024. Voters wisely rejected the full commercialization of marijuana, but South Dakota still needs to ensure that its medical program stays truly medical.

Disclosure. SAM is among the petitioners challenging the April 2026 federal order in the D.C. Circuit and was a designated participant in the DEA rescheduling hearing. I describe both proceedings factually below and note where SAM has taken a position.

I. Where Federal Rescheduling Stands, and What It Does and Does Not Change for South Dakota

A. Two separate federal tracks

Track one: the April 2026 order. On April 22, 2026, the Acting Attorney General signed an order, published and effective April 28, placing two categories of marijuana in Schedule III: marijuana contained in an FDA-approved drug product, and marijuana subject to a state medical marijuana license.¹ The order relied on a provision of the Controlled Substances Act (CSA), 21 U.S.C. 811(d)(1), that allows scheduling actions required by treaty obligations to be taken by order, without the findings and notice-and-comment rulemaking that ordinarily apply.² It also created an expedited DEA registration pathway for state medical licensees, discussed below.

Three sets of petitioners, including SAM, have challenged the order in consolidated cases in the U.S. Court of Appeals for the D.C. Circuit, arguing among other things that the treaty provision does not authorize this kind of action.³ On September 9, 2026, a three-judge panel denied a motion to stay the order while the litigation proceeds, concluding that the petitioners had not met the demanding standard for a stay, and directed the parties to propose a briefing format.⁴ That ruling did not decide the merits. The order remains in effect today, and it could still be vacated.

Track two: broader rescheduling. Separately, DEA ended the stalled hearing on the rule first proposed in May 2024 to move all marijuana, including marijuana sold in recreational markets, to Schedule III, and started a new one. That hearing ran from June 29 to July 15, 2026, and post-hearing briefs were due August 17.⁵ The remaining steps are a recommended decision from the

¹Schedules of Controlled Substances: Rescheduling of Food and Drug Administration Approved Products Containing Marijuana From Schedule I to Schedule III; Corresponding Change to Permit Requirements, 91 Fed. Reg. 22714 (Apr. 28, 2026) (AG Order No. 6754-2026) (the "April 2026 Order").

²21 U.S.C. 811(d)(1); April 2026 Order, 91 Fed. Reg. 22714 (discussion of treaty authority and the Administrative Procedure Act).

³SAM Inc. v. U.S. Department of Justice, No. 26-1106 (D.C. Cir. filed May 4, 2026), consolidated with Nos. 26-1130 and 26-1136. The petitioners are Smart Approaches to Marijuana and the National Drug and Alcohol Screening Association; the attorneys general of Indiana and Nebraska (Louisiana has withdrawn); and a coalition including an addiction recovery provider, physicians, a victims' advocacy organization, and a pharmaceutical developer.

⁴Order, SAM Inc. v. U.S. Department of Justice, No. 26-1106 et al. (D.C. Cir. Sept. 9, 2026) (denying the joint motion of the National Drug and Alcohol Screening Association and MMJ International Holdings for a stay pending review).

⁵Schedules of Controlled Substances: Rescheduling of Marijuana, notice of proposed rulemaking, 89 Fed. Reg. 44597 (May 21, 2024); Schedules of Controlled Substances: Rescheduling of Marijuana, notice of hearing, 91 Fed. Reg. 22777 (Apr. 28, 2026);

presiding administrative law judge, an opportunity for objections, and a final decision by the DEA Administrator, which will likely be challenged in court.⁶ No deadline has been announced for the recommendation or the final decision.

Broader rescheduling remains under review. For medical marijuana in South Dakota, however, the federal change has already taken effect, and it has concrete consequences.

B. What the April order changes for South Dakota

1. The state license is now the federal on-off switch. The order directs DEA to establish an expedited registration process for businesses holding state medical licenses, provides that the state license is "conclusive evidence" of state authorization, and requires DEA to grant registration unless doing so would be inconsistent with the public interest or treaty obligations.⁷ A federal registration may not exceed the scope of the state license, and it is automatically suspended if the state license is suspended, revoked, or expires.⁸ In practical terms, every licensing and enforcement decision the Department of Health makes now carries federal consequences.

2. Businesses need a DEA registration to operate lawfully under federal law. Under the CSA, anyone who manufactures, distributes, or dispenses a Schedule III substance must be registered with DEA. The order allows applicants who filed within 60 days of publication, a window that closed in late June, to continue operating under their state licenses while DEA reviews their applications, and it directs DEA to make every effort to decide those applications within six months. Registered cultivators must also take part in a nominal-price purchase-and-resale arrangement with DEA and store harvested crops in a facility DEA can access until that transaction is complete.⁹ When the Department briefed this committee in August, it did not say whether South Dakota businesses would need to register, and the program administrator said the state had "more questions than answers"; an industry representative reported that many establishments were already in the DEA process.¹⁰ The committee may wish to ask each licensed establishment to report its federal registration status.

3. A South Dakota certification now does the work of a prescription. For dispensing by a registered business, the order accepts any certification that state law deems sufficient, provided it is dated and signed on the day it is issued and lists the patient's name and address and the

U.S. Department of Justice, press release no. 26-392 (Apr. 23, 2026); Order for Transcript Corrections and Post-Hearing Briefs, *In re Proposed Rescheduling of Marijuana* (DEA July 16, 2026) (Chief ALJ Derek C. Julius) (setting an August 17, 2026 deadline).

⁶21 C.F.R. 1308.41 to 1308.45 and 21 C.F.R. part 1316, subpart D (hearing procedures, recommended decision, and exceptions).

⁷April 2026 Order, adding 21 C.F.R. 1301.13(k) and (k)(2).

⁸21 C.F.R. 1301.13(k)(3), as added by the April 2026 Order.

⁹21 U.S.C. 822; 21 C.F.R. 1301.13(k)(6) and (k)(7), as added by the April 2026 Order.

¹⁰Makenzie Huber, "Reclassification eases taxes and banking for medical cannabis, but leaves state with questions," *South Dakota Searchlight* (Aug. 17, 2026).

practitioner's name, address, and state license number.¹¹ The federal government has, in effect, handed the prescriber's gatekeeping role to South Dakota's written certification. Unlike a prescription, however, a certification specifies no product, no dose, and no quantity.

4. Federal safety rules defer to state rules. Registered licensees may follow state law, rather than DEA's regulations, for labeling, packaging, sealing, disposal, and physical security, subject to a federal warning label, and DEA must accept state-required records and reports "to the maximum extent permissible."¹² Rescheduling brings no federal potency limit, product-form restriction, or advertising rule with it. If South Dakota does not set a standard, there is no standard.

5. More money flows to the industry. Section 280E of the Internal Revenue Code disallows ordinary business deductions only for trafficking in Schedule I or II substances. The order states that state medical licensees are no longer subject to it and encourages the Treasury Department to consider retroactive relief.¹³ Lower effective tax rates and easier banking, both discussed at your August meeting, mean more capital for marketing and expansion. South Dakota's statute currently limits how far the Department may restrict advertising.¹⁴

C. What the April order does not change

It is not FDA approval. No product on a South Dakota dispensary shelf has been reviewed by the FDA for safety, effectiveness, purity, or dose. The FDA-approved cannabinoid medicines that exist, such as dronabinol, nabilone, and the purified CBD medicine Epidiolex, went through that process. Dispensary products did not, and rescheduling does not change that.

It is not a verdict on any state's program design. The order goes further than any prior federal action in recognizing state licensing as the gateway to federal registration. But the order makes no finding that any state's qualifying conditions, certification practices, or products are appropriate. It limits registrations to medical purposes and ties them to the scope of the state license.¹⁵ How strict or permissive South Dakota's program is remains South Dakota's decision, and South Dakota's responsibility.

It does not limit South Dakota's authority. The CSA does not preempt state law unless there is a "positive conflict" between the two so that they cannot consistently stand together.¹⁶ A state that runs a narrower or stricter program than federal law would tolerate is not in conflict with federal law. South Dakota remains free to narrow qualifying conditions, cap potency, restrict product forms, and tighten certification standards.

¹¹21 C.F.R. 1301.13(k)(5), as added by the April 2026 Order.

¹²21 C.F.R. 1301.13(k)(4), (k)(8), (k)(9), and (k)(10), as added by the April 2026 Order; 21 U.S.C. 825(c).

¹³26 U.S.C. 280E; April 2026 Order, 91 Fed. Reg. 22714 (discussion of tax implications).

¹⁴SDCL 34-20G-72(4)(i).

¹⁵21 C.F.R. 1301.13(k)(1)(D) and (k)(3), as added by the April 2026 Order.

¹⁶21 U.S.C. 903.

It does not reach recreational or unlicensed marijuana, which remain in Schedule I.¹⁷ The order's registration pathway is built for licensed businesses. It is unclear whether a registry card counts as a "state medical marijuana license" at all, and home cultivators are in any event not positioned to obtain DEA registration. In practice, home-grown marijuana sits outside the new federal registration framework, which is relevant to the committee's interest in home cultivation.

D. If broader rescheduling is finalized

If DEA ultimately moves all marijuana to Schedule III, the federal distinction between medical and recreational marijuana would disappear, and the Section 280E benefit would extend to recreational businesses nationwide. It would not legalize recreational marijuana, and it would not change South Dakota law, under which recreational marijuana remains illegal. It would, however, make the design of South Dakota's medical program the principal line between medical access and a commercial market voters have twice rejected.

II. How Medical Programs Drift Toward De Facto Recreational Access

Across the country, medical programs tend to follow one of two paths. Some remain relatively small and tied to specific diagnoses and to clinicians who treat those conditions. Others grow into markets that are difficult to distinguish from recreational ones, where the card is a formality and sales are dominated by high-potency flower, vapes, concentrates, and edibles. The difference is rarely the text of the original ballot measure. It usually comes down to four design features.

1. Qualifying condition breadth. Programs that list specific diagnoses tend to stay smaller. Programs that include symptom-based categories, especially pain, grow quickly, because pain is common, self-reported, and cannot be objectively verified. South Dakota's statute covers any chronic or debilitating condition that produces "severe, debilitating pain," along with post-traumatic stress disorder.¹⁸ In the Department's August 2026 data, 70 percent of South Dakota medical users qualified under severe, debilitating pain and nearly 14 percent under PTSD, together about 84 percent of the program. Cancer accounted for about 4 percent, multiple sclerosis for about 1 percent, and ALS for a small fraction of 1 percent.¹⁹ The program has grown from 14,843 cardholders at the end of fiscal year 2025 to 19,821 patients in August 2026.²⁰

The evidence base matters. A 2022 randomized clinical trial assigned adults seeking a medical marijuana card for pain, insomnia, anxiety, or depression either to obtain a card immediately or to wait 12 weeks. Those who obtained a card immediately developed cannabis use disorder at roughly twice the rate of the comparison group (17.1 percent versus 8.6 percent) and showed no significant

¹⁷April 2026 Order, 91 Fed. Reg. 22714 (marijuana outside the two covered categories remains in schedule I).

¹⁸SDCL 34-20G-1(8).

¹⁹South Dakota Department of Health, August 2026 Medical Cannabis Data (Sept. 1, 2026).

²⁰Id.; Makenzie Huber, "Medical marijuana home cultivation licenses surge in South Dakota," South Dakota Searchlight (Aug. 17, 2026) (reporting 14,843 cardholders at the end of fiscal year 2025).

improvement in pain, anxiety, or depression.²¹ That is the population a pain-dominated program largely serves.

2. Certification standards. The second driver is how easy it is to obtain a certification. The familiar warning signs are clinics whose business is certifications rather than ongoing care, one-time visits without follow-up, and a small number of practitioners certifying a large share of patients. South Dakota has taken real steps here: an in-person examination at the initial visit, a bona fide practitioner-patient relationship, a prohibition on certifying pregnant or breastfeeding patients, notice to a patient's primary care provider when the certifying practitioner is not the patient's regular clinician, bans on referral kickbacks and on discounts tied to certification, and reporting of cardholders to the prescription drug monitoring program.²² Those are sound provisions. But the statute still permits a relationship whose sole purpose is certification when the patient has been referred, certifications may last up to one year, and the Department reports 211 practitioners for nearly 20,000 patients.²³ The committee does not yet have a public picture of how certifications are distributed among those practitioners, which is the best indicator of whether certification has become a formality.

3. Potency and product form. The third driver is what is actually sold. Average THC content in federally monitored cannabis samples more than quadrupled between 1995 and 2022, from below 4 percent to over 16 percent,²⁴ and commercial markets now sell far stronger products: a 2025 study of Colorado dispensary products found flower averaging about 21 percent THC and concentrates about 71 percent.²⁵ Frequent use of high-potency products is associated with psychosis, cannabis hyperemesis syndrome, and cannabis use disorder. A 2019 multisite study in *The Lancet Psychiatry* found that daily use of high-potency cannabis was associated with roughly five times the odds of a psychotic disorder compared with never using cannabis.²⁶ South Dakota's statute contains no THC potency limit. The Department's current rules cap edibles at 50 milligrams of THC per serving and bar products shaped to appeal to minors, but they place no potency limit on flower, concentrates, or vape products, and they count concentrates toward the purchase limit by weight alone.²⁷ When the Department proposed potency-based limits in its original 2021 rules, industry argued that the statute did not authorize them.²⁸ Separately, the dispensing limit of three

²¹Jodi M. Gilman et al., Effect of Medical Marijuana Card Ownership on Pain, Insomnia, and Affective Disorder Symptoms in Adults: A Randomized Clinical Trial, *JAMA Network Open* 5(3):e222106 (2022).

²²SDCL 34-20G-1(2), 34-20G-5.1, 34-20G-5.2, 34-20G-78, 34-20G-78.1, 34-20G-78.2, and 34-20G-88.1.

²³SDCL 34-20G-1(2)(d) and 34-20G-43; South Dakota Department of Health, August 2026 Medical Cannabis Data.

²⁴<https://nida.nih.gov/research/research-data-measures-resources/cannabis-potency-data>

²⁵Accuracy of labeled THC potency across flower and concentrate cannabis products, *Scientific Reports* 15 (2025) (Colorado dispensary products; mean observed THC of 20.8 percent for flower and 70.7 percent for concentrates).

²⁶Marta Di Forti et al., The contribution of cannabis use to variation in the incidence of psychotic disorder across Europe (EU-GEI): a multicentre case-control study, *The Lancet Psychiatry* 6(5):427-436 (2019).

²⁷ARSD 44:90:07:04(1), (3), and (4); ARSD 44:90:02:16. Citations are to the most recently published rules; a Department rules package is pending.

²⁸South Dakota Department of Health, minutes of public hearing on proposed ARSD article 44:90 (2021) (industry testimony that proposed potency limits in 44:90:02:10 exceeded the Department's statutory authority).

ounces per 14 days allows a patient to purchase roughly six grams of flower per day, every day, or up to 24 grams of concentrate every two weeks at any potency. That is far above what supposed therapeutic use would require and leaves room for diversion.²⁹

4. Supply oversight. The fourth driver is whether the state can see where product goes: seed-to-sale tracking, inspections, and enforcement against sales to people outside the program. The Department told this committee in August that it has overhauled its inspection program over the past year, which is to its credit. Home cultivation, however, is a growing gap. The number of patients authorized to grow at home rose from 61 in fiscal year 2022 to 715 in fiscal year 2026, and the Department described the limited regulation of home grows as a concern.³⁰ Home-grown marijuana is outside seed-to-sale tracking, outside mandatory testing, and, as noted above, likely outside the new federal registration framework.

III. Concrete Options to Keep South Dakota's Program Truly Medical

Each of the following recommendations is designed to ensure real medical oversight. Some are within the Department's existing authority; others would require legislation.

For the Legislature

1. **Tie symptom-based conditions to documentation.** Require that a certification based on severe, debilitating pain identify the underlying diagnosis and document that conventional treatments have been tried or are contraindicated. Require that a PTSD certification rest on a diagnosis by a psychiatrist, psychologist, or other qualified licensed mental health professional.
2. **Give the Department clear authority over potency and product form.** Authorize, in statute, THC limits not exceeding 10-15%. Do not permit products to be combustible or inhalable (such as joints or vapes) due to the added health risks. Only permit pill or capsule form products. If edible products remain on the market, codify the Department's existing per-serving and per-package THC limits for edibles and its prohibition on products that appeal to minors, so they cannot be loosened by rule.
3. **Right-size purchase limits.** Replace the three-ounce, 14-day limit with a lower limit, or with a monthly THC limit measured in milligrams that accounts for concentrates and edibles.
4. **Make certifications clinical rather than transactional.** Require each certification to state a recommended product form and a maximum daily THC amount that dispensaries must honor and the tracking system can enforce. Consider a shorter initial certification with an in-

²⁹SDCL 34-20G-70; ARSD 44:90:02:16 (eight grams of concentrate or vaporizer product counts as one ounce). Three ounces is approximately 85 grams.

³⁰Huber, "Reclassification eases taxes and banking," *supra* note 10; Huber, "Medical marijuana home cultivation licenses surge," *supra* note 22.

person follow-up before renewal, a required check of the prescription drug monitoring program before certifying, and continuing education for certifying practitioners.

5. **Tighten home cultivation.** Options include limiting home cultivation to patients without reasonable access to a dispensary, requiring more detailed site documentation and periodic re-verification, and authorizing compliance checks.
6. **Update advertising authority.** SDCL 34-20G-72(4)(i) currently bars the Department from restricting on-site signs, business directory listings, listings in marijuana-related publications, and sponsorship of events. Amend it so the Department has full authority over marketing, including outdoor advertising and event sponsorships, particularly near schools, parks, and other places frequented by minors.
7. **Require annual public reporting.** Direct the Department to publish each year the de-identified distribution of certifications by practitioner, qualifying conditions, sales by product category and THC potency, home cultivation authorizations, enforcement actions, and available data on cannabis-related emergency visits, poison center calls, and impaired driving.

For the Department of Health, within existing authority

8. **Adopt a standardized certification form,** which the statute already authorizes, capturing the diagnosis, prior treatments, and recommended product form.³¹
9. **Use tracking data to flag outliers:** patients who purchase at or near the maximum every period, practitioners with unusually high certification volumes, and dispensaries with anomalous sales. Refer practitioner concerns to the licensing board, as the statute already permits.³²
10. **Strengthen warnings** on labels and at the point of sale regarding psychosis, cannabis hyperemesis syndrome, cannabis use disorder, impaired driving, and use during pregnancy.
11. **Coordinate with DEA.** Because a state suspension or revocation now automatically suspends a federal registration, establish a channel to notify DEA of enforcement actions and to track the federal registration status of South Dakota licensees.

For the Committee

12. **Request the data that shows whether the program is drifting:** the federal registration status of each establishment, the distribution of certifications by practitioner, and sales by potency and product type.
13. **Encourage in-state research** using the new federal research pathway, so that South Dakota institutions can study outcomes among South Dakota patients directly. As one example of

³¹SDCL 34-20G-72(3).

³²SDCL 34-20G-88(4).

why this matters, early studies suggesting that medical marijuana laws reduced opioid overdose deaths did not hold up when researchers extended the data.³³

Conclusion

South Dakotans voted for a medical program and against a recreational one. Whatever its ultimate fate in court, the April federal order has put South Dakota's own rules in the driver's seat. 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. Thank you for the opportunity to testify. I look forward to the committee's questions on October 13, and SAM would be glad to serve as a resource to the committee and the Department going forward.

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³³Chelsea L. Shover et al., Association between medical cannabis laws and opioid overdose mortality has reversed over time, *Proceedings of the National Academy of Sciences* 116(26):12624-12626 (2019).