FIEC

Adult Personal Use of Marijuana

22-05

2023

Financial Impact Estimating Conference

ADULT PERSONAL USE OF MARIJUANA
Serial Number 22-05

Table of Contents

Authorization .... Tab 1

- Letter of Request for Financial Impact Estimating Conference (FIEC)

Current Law .... Tab 2

- Article X, Section 29, Florida Constitution - Medical marijuana production, possession and use
- Section 212.08, F.S. –
  Sales, rental, use, consumption, distribution, and storage tax; specified exemptions
- Section 381.986, F.S. – Medical use of marijuana
- Section 581.217, F.S. – State hemp program
- Chapter 2023-71, Laws of Florida
- Chapter 2023-299, Laws of Florida

Federal Guidance .... Tab 3

- United States Government Accountability Office Report to Congressional Requesters – State Marijuana Legalization: DOJ Should Document Its Approach to Monitoring the Effects of Legalization, 12/15
- Office of the Attorney General – Memorandum: Marijuana Enforcement, January 4, 2018
- Executive Office of the President – Statement from President Biden on Marijuana Reform, October 6, 2022
- Executive Office of the President – A Proclamation on Granting Pardon for the Offense of Simple Possession of Marijuana, October 6, 2022
- United States Department of Justice – Justice Department Statement of President's Announcements Regarding Simple Possession of Marijuana, October 6, 2022

State Reports .... Tab 4

- FIEC for Amendment 15-01: Use of Marijuana for Debilitating Medical Conditions
- FIEC for Amendment 16-02: Regulate Marijuana in a Manner Similar to Alcohol to Establish Age, Licensing, and Other Restrictions
- Florida Department of Health (DOH) – Annual Update on the Statewide Cannabis and Medical Marijuana Education and Illicit Use Prevention Campaign, January 31, 2023
- DOH – Office of Medical Marijuana Use Weekly Update, May 12, 2023

- Florida Department of Highway Safety and Motor Vehicles – Impaired Driving Annual Report, January 31, 2023

Reports .... Tab 5

- National Conference of State Legislatures (NCSL) – State Medical Cannabis Laws, June 22, 2023
- NCSL – State Cannabis Taxation, January 7, 2021
- Federation of Tax Administrators - Status of State Taxation/ Sales of Marijuana, November 17, 2022
- RAND Publications – After the Grand Opening: Assessing Cannabis Supply and Demand in Washington State, 2019
- National Survey on Drug Use and Health (NSDUH) – Substance Use in Florida by Age Group 2021 Tables
- NSDUH – 2021 National Survey on Drug Use and Health – National Maps of Prevalence Estimates, by State (Marijuana Related Maps)
- Arcview Market Research – The State of Legal Cannabis Markets, 8th Edition – Executive Summary
- HHS Public Access – Impacts of Changing Marijuana Policies on Alcohol Use in the United States, 2017
- Boston University Law Review – Marijuana Taxation: Theory and Practice, 2021
- California Reports:
  - California Cannabis Advisory Committee – 2021 Annual Report
  - California Department of Tax and Fee Administration – Cannabis Tax Revenues
- Colorado Reports:
  - Colorado Department of Revenue – Marijuana Sales
  - Colorado Department of Revenue – Marijuana Tax Revenue
  - Colorado Department of Revenue – Current & Prior Retail Marijuana Average Market Rates
  - Colorado Department of Revenue – Marijuana Sales Report, January 2014 to Date
  - Colorado Department of Revenue – Marijuana Tax and Fee Revenue Report, February 2014 to Date
- Trulieve Cannabis Corp. – Form 10-K Items 7 and 7A for Fiscal Year Ended December 31, 2022

Media Sources .... Tab 6

- None Provided

EDR Supporting Materials .... Tab 7

- Criminal Justice System, June 12, 2023
- Capacity for Legalizing Recreational Marijuana, June 12, 2023
- Overview of the Current Medical Marijuana Market in Florida, June 12, 2023
- Health and Human Services, June 26, 2023
- Local Water Utilities, June 26, 2023
- Summary of Impact on Alcohol and Tobacco Use, June 26, 2023
- Black Market for Marijuana, 2023 Update

- Analysis of the Potential Impact on Sales Tax of the Proposed Constitutional Amendment (Revised), July 12, 2023

Materials from the Sponsor .... Tab 8

- Smart & Safe Florida – Sponsor's Submission to the Financial Impact Estimating Conference, June 9, 2023

Materials from Proponents .... Tab 9

- None Provided

Materials from Opponents .... Tab 10

- Drug Free America Foundation – Email to FIEC – Fiscal Costs of Legalization, July 6, 2023

Materials from Interested Parties .... Tab 11

- None Provided

Requested Agency Material .... Tab 12

- Florida Department of Revenue (DOR) – State Taxation of Adult Use Marijuana, June 12, 2023
- DOR – Memorandum: Adult Personal Use of Marijuana (Constitutional Amendment 22-05), June 21, 2023
- DOR – Medical Marijuana Parcel Summary Estimate, June 26, 2023
- Florida Department of Health (DOH) – Office of Medical Marijuana Use – Petition Initiative 22-05 FIEC Presentation, June 26, 2023
- DOH – Impact Analysis of Petition Initiative 22-05, July 7, 2023
- Florida Sheriffs Association and Florida Police Chiefs Association – Response to FIEC Request, June 23, 2023
- Florida Association of Counties – Letter to FIEC – Adult Personal Use of Marijuana, July 7, 2023

Impact .... Tab 13

- Pending Conference Decision

Tab 1

Authorization

RON DESANTIS
Governor

CORD BYRD
Secretary of State

April 6, 2023

Financial Impact Estimating Conference
c/o Amy Baker
Office of Economic and Demographic Research
111 West Madison Street, Ste. 574
Tallahassee, Florida 32399-6588

Dear Ms. Baker:

Section 100.371(13), Florida Statutes, provides that at the same time the Secretary of State submits an initiative petition to the Attorney General pursuant to section 15.21, the Secretary shall also submit a copy of the petition to the Financial Impact Estimating Conference.

The criteria in section 15.21, Florida Statutes, has been met for the initiative petition titled **Adult Personal Use of Marijuana**, Serial Number 22-05 and I have submitted the petition to the Attorney General. Therefore, I am also submitting a copy of the initiative petition to you.

Sincerely,

Cord Byrd
Secretary of State

CB/am

pc: Smart & Safe Florida

Enclosures

CONSTITUTIONAL AMENDMENT FULL TEXT

Ballot Title: Adult Personal Use of Marijuana

Ballot Summary: Allows adults 21 years or older to possess, purchase, or use marijuana products and marijuana accessories for non-medical personal consumption by smoking, ingestion, or otherwise; allows Medical Marijuana Treatment Centers, and other state licensed entities, to acquire, cultivate, process, manufacture, sell, and distribute such products and accessories. Applies to Florida law; does not change, or immunize violations of, federal law. Establishes possession limits for personal use. Allows consistent legislation. Defines terms. Provides effective date.

Article and Section Being Created or Amended: Article X, Section 29

Full Text of the Proposed Amendment: SECTION 29. ~~Medical m~~Marijuana production, possession and use.—

(a) PUBLIC POLICY.

(1) The medical use of marijuana by a qualifying patient or caregiver in compliance with this section is not subject to criminal or civil liability or sanctions under Florida law.

(2) A physician shall not be subject to criminal or civil liability or sanctions under Florida law solely for issuing a physician certification with reasonable care to a person diagnosed with a debilitating medical condition in compliance with this section.

(3) Actions and conduct by a Medical Marijuana Treatment Center registered with the Department, or its agents or employees, and in compliance with this section and Department regulations, shall not be subject to criminal or civil liability or sanctions under Florida law.

(4) The non-medical personal use of marijuana products and marijuana accessories by an adult, as defined below, in compliance with this section is not subject to any criminal or civil liability or sanctions under Florida Law.

(5) Medical Marijuana Treatment Centers, and other entities licensed as provided below, are allowed to acquire, cultivate, process, manufacture, sell, and distribute marijuana products and marijuana accessories to adults for personal use upon the Effective Date provided below. A Medical Marijuana Treatment Center, or other state licensed entity, including its agents and employees, acting in accordance with this section as it relates to acquiring, cultivating, processing, manufacturing, selling, and distributing marijuana products and marijuana accessories to adults for personal use shall not be subject to criminal or civil liability or sanctions under Florida law.

(b) DEFINITIONS. For purposes of this section, the following words and terms shall have the following meanings:

(1) "Debilitating Medical Condition" means cancer, epilepsy, glaucoma, positive status for human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), post-traumatic stress disorder

Initiative Information

Date Approved 8/23/2022 **Serial Number** 22-05
Sponsor Name: Smart & Safe Florida
Sponsor Address: 1400 Village Square Boulevard, Suite 3-321, Tallahassee, FL 32312

(PTSD), amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, multiple sclerosis, or other debilitating medical conditions of the same kind or class as or comparable to those enumerated, and for which a physician believes that the medical use of marijuana would likely outweigh the potential health risks for a patient.

(2) "Department" means the Department of Health or its successor agency.

(3) "Identification card" means a document issued by the Department that identifies a qualifying patient or a caregiver.

(4) "Marijuana" has the meaning given cannabis in Section 893.02(3), Florida Statutes (2014), and, in addition, "Low-THC cannabis" as defined in Section 381.986(1)(b), Florida Statutes (2014), shall also be included in the meaning of the term "marijuana."

(5) "Medical Marijuana Treatment Center" (MMTC) means an entity that acquires, cultivates, possesses, processes (including development of related products such as food, tinctures, aerosols, oils, or ointments), transfers, transports, sells, distributes, dispenses, or administers marijuana, products containing marijuana, related supplies, or educational materials to qualifying patients or their caregivers and is registered by the Department.

(6) "Medical use" means the acquisition, possession, use, delivery, transfer, or administration of an amount of marijuana not in conflict with Department rules, or of related supplies by a qualifying patient or caregiver for use by the caregiver's designated qualifying patient for the treatment of a debilitating medical condition.

(7) "Caregiver" means a person who is at least twenty-one (21) years old who has agreed to assist with a qualifying patient's medical use of marijuana and has qualified for and obtained a caregiver identification card issued by the Department. The Department may limit the number of qualifying patients a caregiver may assist at one time and the number of caregivers that a qualifying patient may have at one time. Caregivers are prohibited from consuming marijuana obtained for medical use by the qualifying patient.

(8) "Physician" means a person who is licensed to practice medicine in Florida.

(9) "Physician certification" means a written document signed by a physician, stating that in the physician's professional opinion, the patient suffers from a debilitating medical condition, that the medical use of marijuana would likely outweigh the potential health risks for the patient, and for how long the physician recommends the medical use of marijuana for the patient. A physician certification may only be provided after the physician has conducted a physical examination and a full assessment of the medical history of the patient. In order for a physician certification to be issued to a minor, a parent or legal guardian of the minor must consent in writing.

(10) "Qualifying patient" means a person who has been diagnosed to have a debilitating medical condition, who has a physician certification and a valid qualifying patient identification card. If the Department does not begin issuing identification cards within nine (9) months after the effective date of this section, then a valid physician certification will serve as a patient identification card in order to allow a person to become a "qualifying patient" until the Department begins issuing identification cards.

CONSTITUTIONAL AMENDMENT FULL TEXT

(11) "Marijuana accessories" means any equipment, product, or material of any kind that are used for inhaling, ingesting, topically applying, or otherwise introducing marijuana products into the human body for personal use.

(12) "Marijuana products" means marijuana or goods containing marijuana.

(13) "Personal use" means the possession, purchase, or use of marijuana products or marijuana accessories by an adult 21 years of age or older for non-medical personal consumption by smoking, ingestion, or otherwise. An adult need not be a qualifying patient in order to purchase marijuana products or marijuana accessories for personal use from a Medical Marijuana Treatment Center. An individual's possession of marijuana for personal use shall not exceed 3.0 ounces of marijuana except that not more than five grams of marijuana may be in the form of concentrate.

(c) LIMITATIONS.

(1) Nothing in this section allows for a violation of any law other than for conduct in compliance with the provisions of this section.

~~(2) Nothing in this section shall affect or repeal laws relating to non-medical use, possession, production, or sale of marijuana.~~

(2) Nothing in this amendment prohibits the Legislature from enacting laws that are consistent with this amendment.

(3) Nothing in this section authorizes the use of medical marijuana by anyone other than a qualifying patient.

(4) Nothing in this section shall permit the operation of any vehicle, aircraft, train or boat while under the influence of marijuana.

(5) Nothing in this section changes federal law or requires the violation of federal law or purports to give immunity under federal law.

(6) Nothing in this section shall require any accommodation of any on-site medical use of marijuana in any correctional institution or detention facility or place of education or employment, or of smoking medical marijuana in any public place.

(7) Nothing in this section shall require any health insurance provider or any government agency or authority to reimburse any person for expenses related to the medical use of marijuana.

(8) Nothing in this section shall affect or repeal laws relating to negligence or professional malpractice on the part of a qualified patient, caregiver, physician, MMTC, or its agents or employees.

(d) DUTIES OF THE DEPARTMENT. The Department shall issue reasonable regulations necessary for the implementation and enforcement of this section. The purpose of the regulations is to ensure the availability and safe use of medical marijuana by qualifying patients. It is the duty of the Department to promulgate regulations in a timely fashion.

Initiative Information

Date Approved 8/23/2022 **Serial Number** 22-05
Sponsor Name: Smart & Safe Florida
Sponsor Address: 1400 Village Square Boulevard, Suite 3-321, Tallahassee, FL 32312

CONSTITUTIONAL AMENDMENT FULL TEXT

(1) Implementing Regulations. In order to allow the Department sufficient time after passage of this section, the following regulations shall be promulgated no later than six (6) months after the effective date of this section:

a. Procedures for the issuance and annual renewal of qualifying patient identification cards to people with physician certifications and standards for renewal of such identification cards. Before issuing an identification card to a minor, the Department must receive written consent from the minor's parent or legal guardian, in addition to the physician certification.

b. Procedures establishing qualifications and standards for caregivers, including conducting appropriate background checks, and procedures for the issuance and annual renewal of caregiver identification cards.

c. Procedures for the registration of MMTCs that include procedures for the issuance, renewal, suspension and revocation of registration, and standards to ensure proper security, record keeping, testing, labeling, inspection, and safety.

d. A regulation that defines the amount of marijuana that could reasonably be presumed to be an adequate supply for qualifying patients' medical use, based on the best available evidence. This presumption as to quantity may be overcome with evidence of a particular qualifying patient's appropriate medical use.

(2) Identification cards and registrations. The Department shall begin issuing qualifying patient and caregiver identification cards, and registering MMTCs no later than nine (9) months after the effective date of this section.

(3) If the Department does not issue regulations, or if the Department does not begin issuing identification cards and registering MMTCs within the time limits set in this section, any Florida citizen shall have standing to seek judicial relief to compel compliance with the Department's constitutional duties.

(4) The Department shall protect the confidentiality of all qualifying patients. All records containing the identity of qualifying patients shall be confidential and kept from public disclosure other than for valid medical or law enforcement purposes.

(e) LEGISLATION. Nothing in this section shall limit the legislature from enacting laws consistent with this section. The legislature may provide for the licensure of entities that are not Medical Marijuana Treatment Centers to acquire, cultivate, possess, process, transfer, transport, sell, and distribute marijuana products and marijuana accessories for personal use by adults.

(f) SEVERABILITY. The provisions of this section are severable and if any clause, sentence, paragraph or section of this measure, or an application thereof, is adjudged invalid by a court of competent jurisdiction other provisions shall continue to be in effect to the fullest extent possible.

(g) EFFECTIVE DATE. This amendment shall become effective six (6) months after approval by the voters.

Initiative Information

Date Approved 8/23/2022 **Serial Number** 22-05

Sponsor Name: Smart & Safe Florida

Sponsor Address: 1400 Village Square Boulevard, Suite 3-321, Tallahassee, FL 32312

FLORIDA DEPARTMENT OF STATE
DIVISION OF ELECTIONS
R.A. Gray Building
500 South Bronough Street, Rm 316
Tallahassee, Florida 32399

quadient
FIRST-CLASS MAIL
AUTO
04/12/2023
US POSTAGE $000.53
ZIP 32399
041M12254179

Financial Impact Estimating Conference
c/o Amy Baker
Office of Economic and Demographic Research
111 West Madison Street, Suite 574
Tallahassee, Florida 32399

081 CAF8AMB 32399

Tab 2

Current Law

ARTICLE X - SECTION 29. Medical marijuana production, possession and use.—

(a) PUBLIC POLICY.

(1) The medical use of marijuana by a qualifying patient or caregiver in compliance with this section is not subject to criminal or civil liability or sanctions under Florida law.

(2) A physician shall not be subject to criminal or civil liability or sanctions under Florida law solely for issuing a physician certification with reasonable care to a person diagnosed with a debilitating medical condition in compliance with this section.

(3) Actions and conduct by a Medical Marijuana Treatment Center registered with the Department, or its agents or employees, and in compliance with this section and Department regulations, shall not be subject to criminal or civil liability or sanctions under Florida law.

(b) DEFINITIONS. For purposes of this section, the following words and terms shall have the following meanings:

(1) "Debilitating Medical Condition" means cancer, epilepsy, glaucoma, positive status for human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), post-traumatic stress disorder (PTSD), amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, multiple sclerosis, or other debilitating medical conditions of the same kind or class as or comparable to those enumerated, and for which a physician believes that the medical use of marijuana would likely outweigh the potential health risks for a patient.

(2) "Department" means the Department of Health or its successor agency.

(3) "Identification card" means a document issued by the Department that identifies a qualifying patient or a caregiver.

(4) "Marijuana" has the meaning given cannabis in Section 893.02(3), Florida Statutes (2014), and, in addition, "Low-THC cannabis" as defined in Section 381.986(1)(b), Florida Statutes (2014), shall also be included in the meaning of the term "marijuana."

(5) "Medical Marijuana Treatment Center" (MMTC) means an entity that acquires, cultivates, possesses, processes (including development of related products such as food, tinctures, aerosols, oils, or ointments), transfers, transports, sells, distributes, dispenses, or administers marijuana, products containing marijuana, related supplies, or educational materials to qualifying patients or their caregivers and is registered by the Department.

(6) "Medical use" means the acquisition, possession, use, delivery, transfer, or administration of an amount of marijuana not in conflict with Department rules, or of related supplies by a qualifying patient or caregiver for use by the caregiver's designated qualifying patient for the treatment of a debilitating medical condition.

(7) "Caregiver" means a person who is at least twenty-one (21) years old who has agreed to assist with a qualifying patient's medical use of marijuana and has qualified for and obtained a caregiver identification card issued by the Department. The Department may limit the number of qualifying patients a caregiver may assist at one time and the number of caregivers that a qualifying patient may have at one time. Caregivers are prohibited from consuming marijuana obtained for medical use by the qualifying patient.

(8) "Physician" means a person who is licensed to practice medicine in Florida.

(9) "Physician certification" means a written document signed by a physician, stating that in the physician's professional opinion, the patient suffers from a debilitating medical condition, that the medical use of marijuana would likely outweigh the potential health risks for the patient, and for how long the physician recommends the medical use of marijuana for the patient. A physician certification may only be provided after the physician has conducted a physical examination and a full assessment of the medical history of the patient. In order for a physician certification to be issued to a minor, a parent or legal guardian of the minor must consent in writing.

(10) "Qualifying patient" means a person who has been diagnosed to have a debilitating medical condition, who has a physician certification and a valid qualifying patient identification card. If the Department does not begin issuing identification cards within nine (9) months after the effective date of this section, then a valid physician certification will serve as a patient identification card in order to allow a person to become a "qualifying patient" until the Department begins issuing identification cards.

(c) LIMITATIONS.

(1) Nothing in this section allows for a violation of any law other than for conduct in compliance with the provisions of this section.

(2) Nothing in this section shall affect or repeal laws relating to non-medical use, possession, production, or sale of marijuana.

(3) Nothing in this section authorizes the use of medical marijuana by anyone other than a qualifying patient.

(4) Nothing in this section shall permit the operation of any vehicle, aircraft, train or boat while under the influence of marijuana.

(5) Nothing in this section requires the violation of federal law or purports to give immunity under federal law.

(6) Nothing in this section shall require any accommodation of any on-site medical use of marijuana in any correctional institution or detention facility or place of education or employment, or of smoking medical marijuana in any public place.

(7) Nothing in this section shall require any health insurance provider or any government agency or authority to reimburse any person for expenses related to the medical use of marijuana.

(8) Nothing in this section shall affect or repeal laws relating to negligence or professional malpractice on the part of a qualified patient, caregiver, physician, MMTC, or its agents or employees.

(d) DUTIES OF THE DEPARTMENT. The Department shall issue reasonable regulations necessary for the implementation and enforcement of this section. The purpose of the regulations is to ensure the availability and safe use of medical marijuana by qualifying patients. It is the duty of the Department to promulgate regulations in a timely fashion.

(1) Implementing Regulations. In order to allow the Department sufficient time after passage of this section, the following regulations shall be promulgated no later than six (6) months after the effective date of this section:

a. Procedures for the issuance and annual renewal of qualifying patient identification cards to people with physician certifications and standards for renewal of such identification cards. Before issuing an identification card to a minor, the Department must receive written consent from the minor’s parent or legal guardian, in addition to the physician certification.

b. Procedures establishing qualifications and standards for caregivers, including conducting appropriate background checks, and procedures for the issuance and annual renewal of caregiver identification cards.

c. Procedures for the registration of MMTCs that include procedures for the issuance, renewal, suspension and revocation of registration, and standards to ensure proper security, record keeping, testing, labeling, inspection, and safety.

d. A regulation that defines the amount of marijuana that could reasonably be presumed to be an adequate supply for qualifying patients’ medical use, based on the best available evidence. This presumption as to quantity may be overcome with evidence of a particular qualifying patient’s appropriate medical use.

(2) Identification cards and registrations. The Department shall begin issuing qualifying patient and caregiver identification cards, and registering MMTCs no later than nine (9) months after the effective date of this section.

(3) If the Department does not issue regulations, or if the Department does not begin issuing identification cards and registering MMTCs within the time limits set in this section, any Florida citizen shall have standing to seek judicial relief to compel compliance with the Department’s constitutional duties.

(4) The Department shall protect the confidentiality of all qualifying patients. All records containing the identity of qualifying patients shall be confidential and kept from public disclosure other than for valid medical or law enforcement purposes.

(e) LEGISLATION. Nothing in this section shall limit the legislature from enacting laws consistent with this section.

(f) SEVERABILITY. The provisions of this section are severable and if any clause, sentence, paragraph or section of this measure, or an application thereof, is adjudged invalid by a court of competent jurisdiction other provisions shall continue to be in effect to the fullest extent possible.

History.—Proposed by Initiative Petition filed with the Secretary of State January 9, 2015; adopted 2016.

212.08 Sales, rental, use, consumption, distribution, and storage tax; specified exemptions.—The sale at retail, the rental, the use, the consumption, the distribution, and the storage to be used or consumed in this state of the following are hereby specifically exempt from the tax imposed by this chapter.

(2) EXEMPTIONS; MEDICAL.—

[1](l) Marijuana and marijuana delivery devices, as defined in s. 381.986, are exempt from the taxes imposed under this chapter.

[1]Note.—Section 1, ch. 2017-232, provides that "[i]t is the intent of the Legislature to implement s. 29, Article X of the State Constitution by creating a unified regulatory structure. If s. 29, Article X of the State Constitution is amended or a constitutional amendment related to cannabis or marijuana is adopted, this act shall expire 6 months after the effective date of such amendment." If such amendment or adoption takes place, paragraph (2)(l), as created by s. 2, ch. 2017-232, is repealed, and paragraph (2)(m) will be redesignated as paragraph (2)(l)."

Select Year: 2022 Go

The 2022 Florida Statutes (including 2022 Special Session A and 2023 Special Session B)

Title XXIX PUBLIC HEALTH | Chapter 381 PUBLIC HEALTH: GENERAL PROVISIONS | View Entire Chapter

[1]**381.986 Medical use of marijuana.—**

(1) DEFINITIONS.—As used in this section, the term:

(a) "Caregiver" means a resident of this state who has agreed to assist with a qualified patient's medical use of marijuana, has a caregiver identification card, and meets the requirements of subsection (6).

(b) "Chronic nonmalignant pain" means pain that is caused by a qualifying medical condition or that originates from a qualifying medical condition and persists beyond the usual course of that qualifying medical condition.

(c) "Close relative" means a spouse, parent, sibling, grandparent, child, or grandchild, whether related by whole or half blood, by marriage, or by adoption.

(d) "Edibles" means commercially produced food items made with marijuana oil, but no other form of marijuana, that are produced and dispensed by a medical marijuana treatment center.

(e) "Low-THC cannabis" means a plant of the genus *Cannabis*, the dried flowers of which contain 0.8 percent or less of tetrahydrocannabinol and more than 10 percent of cannabidiol weight for weight; the seeds thereof; the resin extracted from any part of such plant; or any compound, manufacture, salt, derivative, mixture, or preparation of such plant or its seeds or resin that is dispensed from a medical marijuana treatment center.

(f) "Marijuana" means all parts of any plant of the genus *Cannabis*, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant or its seeds or resin, including low-THC cannabis, which are dispensed from a medical marijuana treatment center for medical use by a qualified patient.

(g) "Marijuana delivery device" means an object used, intended for use, or designed for use in preparing, storing, ingesting, inhaling, or otherwise introducing marijuana into the human body, and which is dispensed from a medical marijuana treatment center for medical use by a qualified patient, except that delivery devices intended for the medical use of marijuana by smoking need not be dispensed from a medical marijuana treatment center in order to qualify as marijuana delivery devices.

(h) "Marijuana testing laboratory" means a facility that collects and analyzes marijuana samples from a medical marijuana treatment center and has been certified by the department pursuant to s. 381.988.

(i) "Medical director" means a person who holds an active, unrestricted license as an allopathic physician under chapter 458 or osteopathic physician under chapter 459 and is in compliance with the requirements of paragraph (3)(c).

(j) "Medical use" means the acquisition, possession, use, delivery, transfer, or administration of marijuana authorized by a physician certification. The term does not include:

1. Possession, use, or administration of marijuana that was not purchased or acquired from a medical marijuana treatment center.

2. Possession, use, or administration of marijuana in the form of commercially produced food items other than edibles or of marijuana seeds.

3. Use or administration of any form or amount of marijuana in a manner that is inconsistent with the qualified physician's directions or physician certification.

4. Transfer of marijuana to a person other than the qualified patient for whom it was authorized or the qualified patient's caregiver on behalf of the qualified patient.

5. Use or administration of marijuana in the following locations:

a. On any form of public transportation, except for low-THC cannabis not in a form for smoking.

b. In any public place, except for low-THC cannabis not in a form for smoking.

c. In a qualified patient's place of employment, except when permitted by his or her employer.

d. In a state correctional institution, as defined in s. 944.02, or a correctional institution, as defined in s. 944.241.

e. On the grounds of a preschool, primary school, or secondary school, except as provided in s. 1006.062.

f. In a school bus, a vehicle, an aircraft, or a motorboat, except for low-THC cannabis not in a form for smoking.

6. The smoking of marijuana in an enclosed indoor workplace as defined in s. 386.203(5).

(k) "Physician certification" means a qualified physician's authorization for a qualified patient to receive marijuana and a marijuana delivery device from a medical marijuana treatment center.

(l) "Qualified patient" means a resident of this state who has been added to the medical marijuana use registry by a qualified physician to receive marijuana or a marijuana delivery device for a medical use and who has a qualified patient identification card.

(m) "Qualified physician" means a person who holds an active, unrestricted license as an allopathic physician under chapter 458 or as an osteopathic physician under chapter 459 and is in compliance with the physician education requirements of subsection (3).

(n) "Smoking" means burning or igniting a substance and inhaling the smoke.

(o) "Terminal condition" means a progressive disease or medical or surgical condition that causes significant functional impairment, is not considered by a treating physician to be reversible without the administration of life-sustaining procedures, and will result in death within 1 year after diagnosis if the condition runs its normal course.

(2) QUALIFYING MEDICAL CONDITIONS.—A patient must be diagnosed with at least one of the following conditions to qualify to receive marijuana or a marijuana delivery device:

(a) Cancer.

(b) Epilepsy.

(c) Glaucoma.

(d) Positive status for human immunodeficiency virus.

(e) Acquired immune deficiency syndrome.

(f) Posttraumatic stress disorder.

(g) Amyotrophic lateral sclerosis.

(h) Crohn's disease.

(i) Parkinson's disease.

(j) Multiple sclerosis.

(k) Medical conditions of the same kind or class as or comparable to those enumerated in paragraphs (a)-(j).

(l) A terminal condition diagnosed by a physician other than the qualified physician issuing the physician certification.

(m) Chronic nonmalignant pain.

(3) QUALIFIED PHYSICIANS AND MEDICAL DIRECTORS.—

(a) Before being approved as a qualified physician, as defined in paragraph (1)(m), and before each license renewal, a physician must successfully complete a 2-hour course and subsequent examination offered by the Florida Medical Association or the Florida Osteopathic Medical Association which encompass the requirements of this section and any rules adopted hereunder. The course and examination shall be administered at least annually and may be offered in a distance learning format, including an electronic, online format that is available upon request. The price of the course may not exceed $500. A physician who has met the physician education requirements of former s. 381.986(4), Florida Statutes 2016, before June 23, 2017, shall be deemed to be in

compliance with this paragraph from June 23, 2017, until 90 days after the course and examination required by this paragraph become available.

(b) A qualified physician may not be employed by, or have any direct or indirect economic interest in, a medical marijuana treatment center or marijuana testing laboratory.

(c) Before being employed as a medical director, as defined in paragraph (1)(i), and before each license renewal, a medical director must successfully complete a 2-hour course and subsequent examination offered by the Florida Medical Association or the Florida Osteopathic Medical Association which encompass the requirements of this section and any rules adopted hereunder. The course and examination shall be administered at least annually and may be offered in a distance learning format, including an electronic, online format that is available upon request. The price of the course may not exceed $500.

(4) PHYSICIAN CERTIFICATION.—

(a) A qualified physician may issue a physician certification only if the qualified physician:

1. Conducted a physical examination while physically present in the same room as the patient and a full assessment of the medical history of the patient.

2. Diagnosed the patient with at least one qualifying medical condition.

3. Determined that the medical use of marijuana would likely outweigh the potential health risks for the patient, and such determination must be documented in the patient's medical record. If a patient is younger than 18 years of age, a second physician must concur with this determination, and such concurrence must be documented in the patient's medical record.

4. Determined whether the patient is pregnant and documented such determination in the patient's medical record. A physician may not issue a physician certification, except for low-THC cannabis, to a patient who is pregnant.

5. Reviewed the patient's controlled drug prescription history in the prescription drug monitoring program database established pursuant to s. 893.055.

6. Reviews the medical marijuana use registry and confirmed that the patient does not have an active physician certification from another qualified physician.

7. Registers as the issuer of the physician certification for the named qualified patient on the medical marijuana use registry in an electronic manner determined by the department, and:

a. Enters into the registry the contents of the physician certification, including the patient's qualifying condition and the dosage not to exceed the daily dose amount determined by the department, the amount and forms of marijuana authorized for the patient, and any types of marijuana delivery devices needed by the patient for the medical use of marijuana.

b. Updates the registry within 7 days after any change is made to the original physician certification to reflect such change.

c. Deactivates the registration of the qualified patient and the patient's caregiver when the physician no longer recommends the medical use of marijuana for the patient.

8. Obtains the voluntary and informed written consent of the patient for medical use of marijuana each time the qualified physician issues a physician certification for the patient, which shall be maintained in the patient's medical record. The patient, or the patient's parent or legal guardian if the patient is a minor, must sign the informed consent acknowledging that the qualified physician has sufficiently explained its content. The qualified physician must use a standardized informed consent form adopted in rule by the Board of Medicine and the Board of Osteopathic Medicine, which must include, at a minimum, information related to:

a. The Federal Government's classification of marijuana as a Schedule I controlled substance.

b. The approval and oversight status of marijuana by the Food and Drug Administration.

c. The current state of research on the efficacy of marijuana to treat the qualifying conditions set forth in this section.

d. The potential for addiction.

e. The potential effect that marijuana may have on a patient's coordination, motor skills, and cognition, including a warning against operating heavy machinery, operating a motor vehicle, or engaging in activities that

require a person to be alert or respond quickly.

f. The potential side effects of marijuana use, including the negative health risks associated with smoking marijuana.

g. The risks, benefits, and drug interactions of marijuana.

h. That the patient's deidentified health information contained in the physician certification and medical marijuana use registry may be used for research purposes.

(b) If a qualified physician issues a physician certification for a qualified patient diagnosed with a qualifying medical condition pursuant to paragraph (2)(k), the physician must submit the following to the applicable board within 14 days after issuing the physician certification:

1. Documentation supporting the qualified physician's opinion that the medical condition is of the same kind or class as the conditions in paragraphs (2)(a)-(j).

2. Documentation that establishes the efficacy of marijuana as treatment for the condition.

3. Documentation supporting the qualified physician's opinion that the benefits of medical use of marijuana would likely outweigh the potential health risks for the patient.

4. Any other documentation as required by board rule.

The department must submit such documentation to the Consortium for Medical Marijuana Clinical Outcomes Research established pursuant to s. 1004.4351.

(c) If a qualified physician determines that smoking is an appropriate route of administration for a qualified patient, other than a patient diagnosed with a terminal condition, the qualified physician must submit the following documentation to the applicable board:

1. A list of other routes of administration, if any, certified by a qualified physician that the patient has tried, the length of time the patient used such routes of administration, and an assessment of the effectiveness of those routes of administration in treating the qualified patient's qualifying condition.

2. Research documenting the effectiveness of smoking as a route of administration to treat similarly situated patients with the same qualifying condition as the qualified patient.

3. A statement signed by the qualified physician documenting the qualified physician's opinion that the benefits of smoking marijuana for medical use outweigh the risks for the qualified patient.

(d) A qualified physician may not issue a physician certification for marijuana in a form for smoking to a patient under 18 years of age unless the patient is diagnosed with a terminal condition, the qualified physician determines that smoking is the most effective route of administration for the patient, and a second physician who is a board-certified pediatrician concurs with such determination. Such determination and concurrence must be documented in the patient's medical record and in the medical marijuana use registry. The certifying physician must obtain the written informed consent of such patient's parent or legal guardian before issuing a physician certification to the patient for marijuana in a form for smoking. The qualified physician must use a standardized informed consent form adopted in rule by the Board of Medicine and the Board of Osteopathic Medicine which must include information concerning the negative health effects of smoking marijuana on persons under 18 years of age and an acknowledgment that the qualified physician has sufficiently explained the contents of the form.

(e) The Board of Medicine and the Board of Osteopathic Medicine shall review the documentation submitted pursuant to paragraph (c) and shall each, by July 1, 2021, adopt by rule practice standards for the certification of smoking as a route of administration.

(f) A qualified physician may not issue a physician certification for more than three 70-day supply limits of marijuana or more than six 35-day supply limits of marijuana in a form for smoking. The department shall quantify by rule a daily dose amount with equivalent dose amounts for each allowable form of marijuana dispensed by a medical marijuana treatment center. The department shall use the daily dose amount to calculate a 70-day supply.

1. A qualified physician may request an exception to the daily dose amount limit, the 35-day supply limit of marijuana in a form for smoking, and the 4-ounce possession limit of marijuana in a form for smoking established in paragraph (14)(a). The request shall be made electronically on a form adopted by the department in rule and must include, at a minimum:

a. The qualified patient's qualifying medical condition.

b. The dosage and route of administration that was insufficient to provide relief to the qualified patient.

c. A description of how the patient will benefit from an increased amount.

d. The minimum daily dose amount of marijuana that would be sufficient for the treatment of the qualified patient's qualifying medical condition.

2. A qualified physician must provide the qualified patient's records upon the request of the department.

3. The department shall approve or disapprove the request within 14 days after receipt of the complete documentation required by this paragraph. The request shall be deemed approved if the department fails to act within this time period.

(g) A qualified physician must evaluate an existing qualified patient at least once every 30 weeks before issuing a new physician certification. A physician must:

1. Determine if the patient still meets the requirements to be issued a physician certification under paragraph (a).

2. Identify and document in the qualified patient's medical records whether the qualified patient experienced either of the following related to the medical use of marijuana:

a. An adverse drug interaction with any prescription or nonprescription medication; or

b. A reduction in the use of, or dependence on, other types of controlled substances as defined in s. 893.02.

3. Submit a report with the findings required pursuant to subparagraph 2. to the department. The department shall submit such reports to the Consortium for Medical Marijuana Clinical Outcomes Research established pursuant to s. 1004.4351.

(h) An active order for low-THC cannabis or medical cannabis issued pursuant to former s. 381.986, Florida Statutes 2016, and registered with the compassionate use registry before June 23, 2017, is deemed a physician certification, and all patients possessing such orders are deemed qualified patients until the department begins issuing medical marijuana use registry identification cards.

(i) The department shall monitor physician registration in the medical marijuana use registry and the issuance of physician certifications for practices that could facilitate unlawful diversion or misuse of marijuana or a marijuana delivery device and shall take disciplinary action as appropriate.

(j) The Board of Medicine and the Board of Osteopathic Medicine shall jointly create a physician certification pattern review panel that shall review all physician certifications submitted to the medical marijuana use registry. The panel shall track and report the number of physician certifications and the qualifying medical conditions, dosage, supply amount, and form of marijuana certified. The panel shall report the data both by individual qualified physician and in the aggregate, by county, and statewide. The physician certification pattern review panel shall, beginning January 1, 2018, submit an annual report of its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(k) The department, the Board of Medicine, and the Board of Osteopathic Medicine may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this subsection.

(5) MEDICAL MARIJUANA USE REGISTRY.—

(a) The department shall create and maintain a secure, electronic, and online medical marijuana use registry for physicians, patients, and caregivers as provided under this section. The medical marijuana use registry must be accessible to law enforcement agencies, qualified physicians, and medical marijuana treatment centers to verify the authorization of a qualified patient or a caregiver to possess marijuana or a marijuana delivery device and record the marijuana or marijuana delivery device dispensed. The medical marijuana use registry must also be accessible to practitioners licensed to prescribe prescription drugs to ensure proper care for patients before medications that may interact with the medical use of marijuana are prescribed. The medical marijuana use registry must prevent an active registration of a qualified patient by multiple physicians.

(b) The department shall determine whether an individual is a resident of this state for the purpose of registration of qualified patients and caregivers in the medical marijuana use registry. To prove residency:

1. An adult resident must provide the department with a copy of his or her valid Florida driver license issued under s. 322.18 or a copy of a valid Florida identification card issued under s. 322.051.

2. An adult seasonal resident who cannot meet the requirements of subparagraph 1. may provide the department with a copy of two of the following that show proof of residential address:

a. A deed, mortgage, monthly mortgage statement, mortgage payment booklet or residential rental or lease agreement.

b. One proof of residential address from the seasonal resident's parent, step-parent, legal guardian or other person with whom the seasonal resident resides and a statement from the person with whom the seasonal resident resides stating that the seasonal resident does reside with him or her.

c. A utility hookup or work order dated within 60 days before registration in the medical use registry.

d. A utility bill, not more than 2 months old.

e. Mail from a financial institution, including checking, savings, or investment account statements, not more than 2 months old.

f. Mail from a federal, state, county, or municipal government agency, not more than 2 months old.

g. Any other documentation that provides proof of residential address as determined by department rule.

3. A minor must provide the department with a certified copy of a birth certificate or a current record of registration from a Florida K-12 school and must have a parent or legal guardian who meets the requirements of subparagraph 1.

For the purposes of this paragraph, the term "seasonal resident" means any person who temporarily resides in this state for a period of at least 31 consecutive days in each calendar year, maintains a temporary residence in this state, returns to the state or jurisdiction of his or her residence at least one time during each calendar year, and is registered to vote or pays income tax in another state or jurisdiction.

(c) The department may suspend or revoke the registration of a qualified patient or caregiver if the qualified patient or caregiver:

1. Provides misleading, incorrect, false, or fraudulent information to the department;

2. Obtains a supply of marijuana in an amount greater than the amount authorized by the physician certification;

3. Falsifies, alters, or otherwise modifies an identification card;

4. Fails to timely notify the department of any changes to his or her qualified patient status; or

5. Violates the requirements of this section or any rule adopted under this section.

(d) The department shall immediately suspend the registration of a qualified patient charged with a violation of chapter 893 until final disposition of any alleged offense. Thereafter, the department may extend the suspension, revoke the registration, or reinstate the registration.

(e) The department shall immediately suspend the registration of any caregiver charged with a violation of chapter 893 until final disposition of any alleged offense. The department shall revoke a caregiver registration if the caregiver does not meet the requirements of subparagraph (6)(b)6.

(f) The department may revoke the registration of a qualified patient or caregiver who cultivates marijuana or who acquires, possesses, or delivers marijuana from any person or entity other than a medical marijuana treatment center.

(g) The department shall revoke the registration of a qualified patient, and the patient's associated caregiver, upon notification that the patient no longer meets the criteria of a qualified patient.

(h) The department may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this subsection.

(6) CAREGIVERS.—

(a) The department must register an individual as a caregiver on the medical marijuana use registry and issue a caregiver identification card if an individual designated by a qualified patient meets all of the requirements of this subsection and department rule.

(b) A caregiver must:

1. Not be a qualified physician and not be employed by or have an economic interest in a medical marijuana treatment center or a marijuana testing laboratory.

2. Be 21 years of age or older and a resident of this state.

3. Agree in writing to assist with the qualified patient's medical use of marijuana.

4. Be registered in the medical marijuana use registry as a caregiver for no more than one qualified patient, except as provided in this paragraph.

5. Successfully complete a caregiver certification course developed and administered by the department or its designee, which must be renewed biennially. The price of the course may not exceed $100.

6. Pass a background screening pursuant to subsection (9), unless the patient is a close relative of the caregiver.

(c) A qualified patient may designate no more than one caregiver to assist with the qualified patient's medical use of marijuana, unless:

1. The qualified patient is a minor and the designated caregivers are parents or legal guardians of the qualified patient;

2. The qualified patient is an adult who has an intellectual or developmental disability that prevents the patient from being able to protect or care for himself or herself without assistance or supervision and the designated caregivers are the parents or legal guardians of the qualified patient;

3. The qualified patient is admitted to a hospice program; or

4. The qualified patient is participating in a research program in a teaching nursing home pursuant to s. 1004.4351.

(d) A caregiver may be registered in the medical marijuana use registry as a designated caregiver for no more than one qualified patient, unless:

1. The caregiver is a parent or legal guardian of more than one minor who is a qualified patient;

2. The caregiver is a parent or legal guardian of more than one adult who is a qualified patient and who has an intellectual or developmental disability that prevents the patient from being able to protect or care for himself or herself without assistance or supervision;

3. All qualified patients the caregiver has agreed to assist are admitted to a hospice program and have requested the assistance of that caregiver with the medical use of marijuana; the caregiver is an employee of the hospice; and the caregiver provides personal care or other services directly to clients of the hospice in the scope of that employment; or

4. All qualified patients the caregiver has agreed to assist are participating in a research program in a teaching nursing home pursuant to s. 1004.4351.

(e) A caregiver may not receive compensation, other than actual expenses incurred, for any services provided to the qualified patient.

(f) If a qualified patient is younger than 18 years of age, only a caregiver may purchase or administer marijuana for medical use by the qualified patient. The qualified patient may not purchase marijuana.

(g) A caregiver must be in immediate possession of his or her medical marijuana use registry identification card at all times when in possession of marijuana or a marijuana delivery device and must present his or her medical marijuana use registry identification card upon the request of a law enforcement officer.

(h) The department may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this subsection.

(7) IDENTIFICATION CARDS.—

(a) The department shall issue medical marijuana use registry identification cards for qualified patients and caregivers who are residents of this state, which must be renewed annually. The identification cards must be resistant to counterfeiting and tampering and must include, at a minimum, the following:

1. The name, address, and date of birth of the qualified patient or caregiver.

2. A full-face, passport-type, color photograph of the qualified patient or caregiver taken within the 90 days immediately preceding registration or the Florida driver license or Florida identification card photograph of the qualified patient or caregiver obtained directly from the Department of Highway Safety and Motor Vehicles.

3. Identification as a qualified patient or a caregiver.

4. The unique numeric identifier used for the qualified patient in the medical marijuana use registry.

5. For a caregiver, the name and unique numeric identifier of the caregiver and the qualified patient or patients that the caregiver is assisting.

6. The expiration date of the identification card.

(b) The department must receive written consent from a qualified patient's parent or legal guardian before it may issue an identification card to a qualified patient who is a minor.

(c) The department shall adopt rules pursuant to ss. 120.536(1) and 120.54 establishing procedures for the issuance, renewal, suspension, replacement, surrender, and revocation of medical marijuana use registry identification cards pursuant to this section and shall begin issuing qualified patient identification cards by October 3, 2017.

(d) Applications for identification cards must be submitted on a form prescribed by the department. The department may charge a reasonable fee associated with the issuance, replacement, and renewal of identification cards. The department shall allocate $10 of the identification card fee to the Division of Research at Florida Agricultural and Mechanical University for the purpose of educating minorities about marijuana for medical use and the impact of the unlawful use of marijuana on minority communities. The department shall contract with a third-party vendor to issue identification cards. The vendor selected by the department must have experience performing similar functions for other state agencies.

(e) A qualified patient or caregiver shall return his or her identification card to the department within 5 business days after revocation.

(8) MEDICAL MARIJUANA TREATMENT CENTERS.—

(a) The department shall license medical marijuana treatment centers to ensure reasonable statewide accessibility and availability as necessary for qualified patients registered in the medical marijuana use registry and who are issued a physician certification under this section.

1. As soon as practicable, but no later than July 3, 2017, the department shall license as a medical marijuana treatment center any entity that holds an active, unrestricted license to cultivate, process, transport, and dispense low-THC cannabis, medical cannabis, and cannabis delivery devices, under former s. 381.986, Florida Statutes 2016, before July 1, 2017, and which meets the requirements of this section. In addition to the authority granted under this section, these entities are authorized to dispense low-THC cannabis, medical cannabis, and cannabis delivery devices ordered pursuant to former s. 381.986, Florida Statutes 2016, which were entered into the compassionate use registry before July 1, 2017, and are authorized to begin dispensing marijuana under this section on July 3, 2017. The department may grant variances from the representations made in such an entity's original application for approval under former s. 381.986, Florida Statutes 2014, pursuant to paragraph (e).

2. The department shall license as medical marijuana treatment centers 10 applicants that meet the requirements of this section, under the following parameters:

a. As soon as practicable, but no later than August 1, 2017, the department shall license any applicant whose application was reviewed, evaluated, and scored by the department and which was denied a dispensing organization license by the department under former s. 381.986, Florida Statutes 2014; which had one or more administrative or judicial challenges pending as of January 1, 2017, or had a final ranking within one point of the highest final ranking in its region under former s. 381.986, Florida Statutes 2014; which meets the requirements of this section; and which provides documentation to the department that it has the existing infrastructure and technical and technological ability to begin cultivating marijuana within 30 days after registration as a medical marijuana treatment center.

b. As soon as practicable, the department shall license one applicant that is a recognized class member of *Pigford v. Glickman*, 185 F.R.D. 82 (D.D.C. 1999), or *In Re Black Farmers Litig.*, 856 F. Supp. 2d 1 (D.D.C. 2011). An applicant licensed under this sub-subparagraph is exempt from the requirement of subparagraph (b)2. An applicant that applies for licensure under this sub-subparagraph, pays its initial application fee, is determined by the department through the application process to qualify as a recognized class member, and is not awarded a license under this sub-subparagraph may transfer its initial application fee to one subsequent opportunity to apply for licensure under subparagraph 4.

c. As soon as practicable, but no later than October 3, 2017, the department shall license applicants that meet the requirements of this section in sufficient numbers to result in 10 total licenses issued under this subparagraph, while accounting for the number of licenses issued under sub-subparagraphs a. and b.

3. For up to two of the licenses issued under subparagraph 2., the department shall give preference to applicants that demonstrate in their applications that they own one or more facilities that are, or were, used for the canning, concentrating, or otherwise processing of citrus fruit or citrus molasses and will use or convert the facility or facilities for the processing of marijuana.

4. Within 6 months after the registration of 100,000 active qualified patients in the medical marijuana use registry, the department shall license four additional medical marijuana treatment centers that meet the requirements of this section. Thereafter, the department shall license four medical marijuana treatment centers within 6 months after the registration of each additional 100,000 active qualified patients in the medical marijuana use registry that meet the requirements of this section.

(b) An applicant for licensure as a medical marijuana treatment center shall apply to the department on a form prescribed by the department and adopted in rule. The department shall adopt rules pursuant to ss. 120.536(1) and 120.54 establishing a procedure for the issuance and biennial renewal of licenses, including initial application and biennial renewal fees sufficient to cover the costs of implementing and administering this section, and establishing supplemental licensure fees for payment beginning May 1, 2018, sufficient to cover the costs of administering ss. 381.989 and 1004.4351. The department shall identify applicants with strong diversity plans reflecting this state's commitment to diversity and implement training programs and other educational programs to enable minority persons and minority business enterprises, as defined in s. 288.703, and veteran business enterprises, as defined in s. 295.187, to compete for medical marijuana treatment center licensure and contracts. Subject to the requirements in subparagraphs (a)2.-4., the department shall issue a license to an applicant if the applicant meets the requirements of this section and pays the initial application fee. The department shall renew the licensure of a medical marijuana treatment center biennially if the licensee meets the requirements of this section and pays the biennial renewal fee. However, the department may not renew the license of a medical marijuana treatment center that has not begun to cultivate, process, and dispense marijuana by the date that the medical marijuana treatment center is required to renew its license. An individual may not be an applicant, owner, officer, board member, or manager on more than one application for licensure as a medical marijuana treatment center. An individual or entity may not be awarded more than one license as a medical marijuana treatment center. An applicant for licensure as a medical marijuana treatment center must demonstrate:

1. That, for the 5 consecutive years before submitting the application, the applicant has been registered to do business in the state.

2. Possession of a valid certificate of registration issued by the Department of Agriculture and Consumer Services pursuant to s. 581.131.

3. The technical and technological ability to cultivate and produce marijuana, including, but not limited to, low-THC cannabis.

4. The ability to secure the premises, resources, and personnel necessary to operate as a medical marijuana treatment center.

5. The ability to maintain accountability of all raw materials, finished products, and any byproducts to prevent diversion or unlawful access to or possession of these substances.

6. An infrastructure reasonably located to dispense marijuana to registered qualified patients statewide or regionally as determined by the department.

7. The financial ability to maintain operations for the duration of the 2-year approval cycle, including the provision of certified financial statements to the department.

a. Upon approval, the applicant must post a $5 million performance bond issued by an authorized surety insurance company rated in one of the three highest rating categories by a nationally recognized rating service. However, a medical marijuana treatment center serving at least 1,000 qualified patients is only required to maintain a $2 million performance bond.

b. In lieu of the performance bond required under sub-subparagraph a., the applicant may provide an irrevocable letter of credit payable to the department or provide cash to the department. If provided with cash under this sub-subparagraph, the department shall deposit the cash in the Grants and Donations Trust Fund within the Department of Health, subject to the same conditions as the bond regarding requirements for the applicant to

forfeit ownership of the funds. If the funds deposited under this sub-subparagraph generate interest, the amount of that interest shall be used by the department for the administration of this section.

8. That all owners, officers, board members, and managers have passed a background screening pursuant to subsection (9).

9. The employment of a medical director to supervise the activities of the medical marijuana treatment center.

10. A diversity plan that promotes and ensures the involvement of minority persons and minority business enterprises, as defined in s. 288.703, or veteran business enterprises, as defined in s. 295.187, in ownership, management, and employment. An applicant for licensure renewal must show the effectiveness of the diversity plan by including the following with his or her application for renewal:

a. Representation of minority persons and veterans in the medical marijuana treatment center's workforce;

b. Efforts to recruit minority persons and veterans for employment; and

c. A record of contracts for services with minority business enterprises and veteran business enterprises.

(c) A medical marijuana treatment center may not make a wholesale purchase of marijuana from, or a distribution of marijuana to, another medical marijuana treatment center, unless the medical marijuana treatment center seeking to make a wholesale purchase of marijuana submits proof of harvest failure to the department.

(d) The department shall establish, maintain, and control a computer software tracking system that traces marijuana from seed to sale and allows real-time, 24-hour access by the department to data from all medical marijuana treatment centers and marijuana testing laboratories. The tracking system must allow for integration of other seed-to-sale systems and, at a minimum, include notification of when marijuana seeds are planted, when marijuana plants are harvested and destroyed, and when marijuana is transported, sold, stolen, diverted, or lost. Each medical marijuana treatment center shall use the seed-to-sale tracking system established by the department or integrate its own seed-to-sale tracking system with the seed-to-sale tracking system established by the department. Each medical marijuana treatment center may use its own seed-to-sale system until the department establishes a seed-to-sale tracking system. The department may contract with a vendor to establish the seed-to-sale tracking system. The vendor selected by the department may not have a contractual relationship with the department to perform any services pursuant to this section other than the seed-to-sale tracking system. The vendor may not have a direct or indirect financial interest in a medical marijuana treatment center or a marijuana testing laboratory.

(e) A licensed medical marijuana treatment center shall cultivate, process, transport, and dispense marijuana for medical use. A licensed medical marijuana treatment center may not contract for services directly related to the cultivation, processing, and dispensing of marijuana or marijuana delivery devices, except that a medical marijuana treatment center licensed pursuant to subparagraph (a)1. may contract with a single entity for the cultivation, processing, transporting, and dispensing of marijuana and marijuana delivery devices. A licensed medical marijuana treatment center must, at all times, maintain compliance with the criteria demonstrated and representations made in the initial application and the criteria established in this subsection. Upon request, the department may grant a medical marijuana treatment center a variance from the representations made in the initial application. Consideration of such a request shall be based upon the individual facts and circumstances surrounding the request. A variance may not be granted unless the requesting medical marijuana treatment center can demonstrate to the department that it has a proposed alternative to the specific representation made in its application which fulfills the same or a similar purpose as the specific representation in a way that the department can reasonably determine will not be a lower standard than the specific representation in the application. A variance may not be granted from the requirements in subparagraph 2. and subparagraphs (b)1. and 2.

1. A licensed medical marijuana treatment center may transfer ownership to an individual or entity who meets the requirements of this section. A publicly traded corporation or publicly traded company that meets the requirements of this section is not precluded from ownership of a medical marijuana treatment center. To accommodate a change in ownership:

a. The licensed medical marijuana treatment center shall notify the department in writing at least 60 days before the anticipated date of the change of ownership.

b. The individual or entity applying for initial licensure due to a change of ownership must submit an application that must be received by the department at least 60 days before the date of change of ownership.

c. Upon receipt of an application for a license, the department shall examine the application and, within 30 days after receipt, notify the applicant in writing of any apparent errors or omissions and request any additional information required.

d. Requested information omitted from an application for licensure must be filed with the department within 21 days after the department's request for omitted information or the application shall be deemed incomplete and shall be withdrawn from further consideration and the fees shall be forfeited.

e. Within 30 days after the receipt of a complete application, the department shall approve or deny the application.

2. A medical marijuana treatment center, and any individual or entity who directly or indirectly owns, controls, or holds with power to vote 5 percent or more of the voting shares of a medical marijuana treatment center, may not acquire direct or indirect ownership or control of any voting shares or other form of ownership of any other medical marijuana treatment center.

3. A medical marijuana treatment center may not enter into any form of profit-sharing arrangement with the property owner or lessor of any of its facilities where cultivation, processing, storing, or dispensing of marijuana and marijuana delivery devices occurs.

4. All employees of a medical marijuana treatment center must be 21 years of age or older and have passed a background screening pursuant to subsection (9).

5. Each medical marijuana treatment center must adopt and enforce policies and procedures to ensure employees and volunteers receive training on the legal requirements to dispense marijuana to qualified patients.

6. When growing marijuana, a medical marijuana treatment center:

a. May use pesticides determined by the department, after consultation with the Department of Agriculture and Consumer Services, to be safely applied to plants intended for human consumption, but may not use pesticides designated as restricted-use pesticides pursuant to s. 487.042.

b. Must grow marijuana within an enclosed structure and in a room separate from any other plant.

c. Must inspect seeds and growing plants for plant pests that endanger or threaten the horticultural and agricultural interests of the state in accordance with chapter 581 and any rules adopted thereunder.

d. Must perform fumigation or treatment of plants, or remove and destroy infested or infected plants, in accordance with chapter 581 and any rules adopted thereunder.

7. Each medical marijuana treatment center must produce and make available for purchase at least one low-THC cannabis product.

8. A medical marijuana treatment center that produces edibles must hold a permit to operate as a food establishment pursuant to chapter 500, the Florida Food Safety Act, and must comply with all the requirements for food establishments pursuant to chapter 500 and any rules adopted thereunder. Edibles may not contain more than 200 milligrams of tetrahydrocannabinol, and a single serving portion of an edible may not exceed 10 milligrams of tetrahydrocannabinol. Edibles may have a potency variance of no greater than 15 percent. Edibles may not be attractive to children; be manufactured in the shape of humans, cartoons, or animals; be manufactured in a form that bears any reasonable resemblance to products available for consumption as commercially available candy; or contain any color additives. To discourage consumption of edibles by children, the department shall determine by rule any shapes, forms, and ingredients allowed and prohibited for edibles. Medical marijuana treatment centers may not begin processing or dispensing edibles until after the effective date of the rule. The department shall also adopt sanitation rules providing the standards and requirements for the storage, display, or dispensing of edibles.

9. Within 12 months after licensure, a medical marijuana treatment center must demonstrate to the department that all of its processing facilities have passed a Food Safety Good Manufacturing Practices, such as Global Food Safety Initiative or equivalent, inspection by a nationally accredited certifying body. A medical marijuana treatment center must immediately stop processing at any facility which fails to pass this inspection until it demonstrates to the department that such facility has met this requirement.

10. A medical marijuana treatment center that produces prerolled marijuana cigarettes may not use wrapping paper made with tobacco or hemp.

11. When processing marijuana, a medical marijuana treatment center must:

a. Process the marijuana within an enclosed structure and in a room separate from other plants or products.

b. Comply with department rules when processing marijuana with hydrocarbon solvents or other solvents or gases exhibiting potential toxicity to humans. The department shall determine by rule the requirements for medical marijuana treatment centers to use such solvents or gases exhibiting potential toxicity to humans.

c. Comply with federal and state laws and regulations and department rules for solid and liquid wastes. The department shall determine by rule procedures for the storage, handling, transportation, management, and disposal of solid and liquid waste generated during marijuana production and processing. The Department of Environmental Protection shall assist the department in developing such rules.

d. Test the processed marijuana using a medical marijuana testing laboratory before it is dispensed. Results must be verified and signed by two medical marijuana treatment center employees. Before dispensing, the medical marijuana treatment center must determine that the test results indicate that low-THC cannabis meets the definition of low-THC cannabis, the concentration of tetrahydrocannabinol meets the potency requirements of this section, the labeling of the concentration of tetrahydrocannabinol and cannabidiol is accurate, and all marijuana is safe for human consumption and free from contaminants that are unsafe for human consumption. The department shall determine by rule which contaminants must be tested for and the maximum levels of each contaminant which are safe for human consumption. The Department of Agriculture and Consumer Services shall assist the department in developing the testing requirements for contaminants that are unsafe for human consumption in edibles. The department shall also determine by rule the procedures for the treatment of marijuana that fails to meet the testing requirements of this section, s. 381.988, or department rule. The department may select samples of marijuana from a medical marijuana treatment center facility which shall be tested by the department to determine whether the marijuana meets the potency requirements of this section, is safe for human consumption, and is accurately labeled with the tetrahydrocannabinol and cannabidiol concentration or to verify the result of marijuana testing conducted by a marijuana testing laboratory. The department may also select samples of marijuana delivery devices from a medical marijuana treatment center to determine whether the marijuana delivery device is safe for use by qualified patients. A medical marijuana treatment center may not require payment from the department for the sample. A medical marijuana treatment center must recall marijuana, including all marijuana and marijuana products made from the same batch of marijuana, that fails to meet the potency requirements of this section, that is unsafe for human consumption, or for which the labeling of the tetrahydrocannabinol and cannabidiol concentration is inaccurate. The department shall adopt rules to establish marijuana potency variations of no greater than 15 percent using negotiated rulemaking pursuant to s. 120.54(2)(d) which accounts for, but is not limited to, time lapses between testing, testing methods, testing instruments, and types of marijuana sampled for testing. The department may not issue any recalls for product potency as it relates to product labeling before issuing a rule relating to potency variation standards. A medical marijuana treatment center must also recall all marijuana delivery devices determined to be unsafe for use by qualified patients. The medical marijuana treatment center must retain records of all testing and samples of each homogenous batch of marijuana for at least 9 months. The medical marijuana treatment center must contract with a marijuana testing laboratory to perform audits on the medical marijuana treatment center's standard operating procedures, testing records, and samples and provide the results to the department to confirm that the marijuana or low-THC cannabis meets the requirements of this section and that the marijuana or low-THC cannabis is safe for human consumption. A medical marijuana treatment center shall reserve two processed samples from each batch and retain such samples for at least 9 months for the purpose of such audits. A medical marijuana treatment center may use a laboratory that has not been certified by the department under s. 381.988 until such time as at least one laboratory holds the required certification, but in no event later than July 1, 2018.

e. Package the marijuana in compliance with the United States Poison Prevention Packaging Act of 1970, 15 U.S.C. ss. 1471 et seq.

f. Package the marijuana in a receptacle that has a firmly affixed and legible label stating the following information:

(I) The marijuana or low-THC cannabis meets the requirements of sub-subparagraph d.

(II) The name of the medical marijuana treatment center from which the marijuana originates.

(III) The batch number and harvest number from which the marijuana originates and the date dispensed.

(IV) The name of the physician who issued the physician certification.

(V) The name of the patient.

(VI) The product name, if applicable, and dosage form, including concentration of tetrahydrocannabinol and cannabidiol. The product name may not contain wording commonly associated with products marketed by or to children.

(VII) The recommended dose.

(VIII) A warning that it is illegal to transfer medical marijuana to another person.

(IX) A marijuana universal symbol developed by the department.

12. The medical marijuana treatment center shall include in each package a patient package insert with information on the specific product dispensed related to:

a. Clinical pharmacology.

b. Indications and use.

c. Dosage and administration.

d. Dosage forms and strengths.

e. Contraindications.

f. Warnings and precautions.

g. Adverse reactions.

13. In addition to the packaging and labeling requirements specified in subparagraphs 11. and 12., marijuana in a form for smoking must be packaged in a sealed receptacle with a legible and prominent warning to keep away from children and a warning that states marijuana smoke contains carcinogens and may negatively affect health. Such receptacles for marijuana in a form for smoking must be plain, opaque, and white without depictions of the product or images other than the medical marijuana treatment center's department-approved logo and the marijuana universal symbol.

14. The department shall adopt rules to regulate the types, appearance, and labeling of marijuana delivery devices dispensed from a medical marijuana treatment center. The rules must require marijuana delivery devices to have an appearance consistent with medical use.

15. Each edible shall be individually sealed in plain, opaque wrapping marked only with the marijuana universal symbol. Where practical, each edible shall be marked with the marijuana universal symbol. In addition to the packaging and labeling requirements in subparagraphs 11. and 12., edible receptacles must be plain, opaque, and white without depictions of the product or images other than the medical marijuana treatment center's department-approved logo and the marijuana universal symbol. The receptacle must also include a list of all the edible's ingredients, storage instructions, an expiration date, a legible and prominent warning to keep away from children and pets, and a warning that the edible has not been produced or inspected pursuant to federal food safety laws.

16. When dispensing marijuana or a marijuana delivery device, a medical marijuana treatment center:

a. May dispense any active, valid order for low-THC cannabis, medical cannabis and cannabis delivery devices issued pursuant to former s. 381.986, Florida Statutes 2016, which was entered into the medical marijuana use registry before July 1, 2017.

b. May not dispense more than a 70-day supply of marijuana within any 70-day period to a qualified patient or caregiver. May not dispense more than one 35-day supply of marijuana in a form for smoking within any 35-day period to a qualified patient or caregiver. A 35-day supply of marijuana in a form for smoking may not exceed 2.5 ounces unless an exception to this amount is approved by the department pursuant to paragraph (4)(f).

c. Must have the medical marijuana treatment center's employee who dispenses the marijuana or a marijuana delivery device enter into the medical marijuana use registry his or her name or unique employee identifier.

d. Must verify that the qualified patient and the caregiver, if applicable, each have an active registration in the medical marijuana use registry and an active and valid medical marijuana use registry identification card, the amount and type of marijuana dispensed matches the physician certification in the medical marijuana use registry for that qualified patient, and the physician certification has not already been filled.

e. May not dispense marijuana to a qualified patient who is younger than 18 years of age. If the qualified patient is younger than 18 years of age, marijuana may only be dispensed to the qualified patient's caregiver.

f. May not dispense or sell any other type of cannabis, alcohol, or illicit drug-related product, including pipes or wrapping papers made with tobacco or hemp, other than a marijuana delivery device required for the medical use of marijuana and which is specified in a physician certification.

g. Must, upon dispensing the marijuana or marijuana delivery device, record in the registry the date, time, quantity, and form of marijuana dispensed; the type of marijuana delivery device dispensed; and the name and medical marijuana use registry identification number of the qualified patient or caregiver to whom the marijuana delivery device was dispensed.

h. Must ensure that patient records are not visible to anyone other than the qualified patient, his or her caregiver, and authorized medical marijuana treatment center employees.

(f) To ensure the safety and security of premises where the cultivation, processing, storing, or dispensing of marijuana occurs, and to maintain adequate controls against the diversion, theft, and loss of marijuana or marijuana delivery devices, a medical marijuana treatment center shall:

1.a. Maintain a fully operational security alarm system that secures all entry points and perimeter windows and is equipped with motion detectors; pressure switches; and duress, panic, and hold-up alarms; and

b. Maintain a video surveillance system that records continuously 24 hours a day and meets the following criteria:

(I) Cameras are fixed in a place that allows for the clear identification of persons and activities in controlled areas of the premises. Controlled areas include grow rooms, processing rooms, storage rooms, disposal rooms or areas, and point-of-sale rooms.

(II) Cameras are fixed in entrances and exits to the premises, which shall record from both indoor and outdoor, or ingress and egress, vantage points.

(III) Recorded images must clearly and accurately display the time and date.

(IV) Retain video surveillance recordings for at least 45 days or longer upon the request of a law enforcement agency.

2. Ensure that the medical marijuana treatment center's outdoor premises have sufficient lighting from dusk until dawn.

3. Ensure that the indoor premises where dispensing occurs includes a waiting area with sufficient space and seating to accommodate qualified patients and caregivers and at least one private consultation area that is isolated from the waiting area and area where dispensing occurs. A medical marijuana treatment center may not display products or dispense marijuana or marijuana delivery devices in the waiting area.

4. Not dispense from its premises marijuana or a marijuana delivery device between the hours of 9 p.m. and 7 a.m., but may perform all other operations and deliver marijuana to qualified patients 24 hours a day.

5. Store marijuana in a secured, locked room or a vault.

6. Require at least two of its employees, or two employees of a security agency with whom it contracts, to be on the premises at all times where cultivation, processing, or storing of marijuana occurs.

7. Require each employee or contractor to wear a photo identification badge at all times while on the premises.

8. Require each visitor to wear a visitor pass at all times while on the premises.

9. Implement an alcohol and drug-free workplace policy.

10. Report to local law enforcement within 24 hours after the medical marijuana treatment center is notified or becomes aware of the theft, diversion, or loss of marijuana.

(g) To ensure the safe transport of marijuana and marijuana delivery devices to medical marijuana treatment centers, marijuana testing laboratories, or qualified patients, a medical marijuana treatment center must:

1. Maintain a marijuana transportation manifest in any vehicle transporting marijuana. The marijuana transportation manifest must be generated from a medical marijuana treatment center's seed-to-sale tracking system and include the:

a. Departure date and approximate time of departure.

b. Name, location address, and license number of the originating medical marijuana treatment center.

c. Name and address of the recipient of the delivery.

d. Quantity and form of any marijuana or marijuana delivery device being transported.

e. Arrival date and estimated time of arrival.

f. Delivery vehicle make and model and license plate number.

g. Name and signature of the medical marijuana treatment center employees delivering the product.

(I) A copy of the marijuana transportation manifest must be provided to each individual, medical marijuana treatment center, or marijuana testing laboratory that receives a delivery. The individual, or a representative of the center or laboratory, must sign a copy of the marijuana transportation manifest acknowledging receipt.

(II) An individual transporting marijuana or a marijuana delivery device must present a copy of the relevant marijuana transportation manifest and his or her employee identification card to a law enforcement officer upon request.

(III) Medical marijuana treatment centers and marijuana testing laboratories must retain copies of all marijuana transportation manifests for at least 3 years.

2. Ensure only vehicles in good working order are used to transport marijuana.

3. Lock marijuana and marijuana delivery devices in a separate compartment or container within the vehicle.

4. Require employees to have possession of their employee identification card at all times when transporting marijuana or marijuana delivery devices.

5. Require at least two persons to be in a vehicle transporting marijuana or marijuana delivery devices, and require at least one person to remain in the vehicle while the marijuana or marijuana delivery device is being delivered.

6. Provide specific safety and security training to employees transporting or delivering marijuana and marijuana delivery devices.

(h) A medical marijuana treatment center may not engage in advertising that is visible to members of the public from any street, sidewalk, park, or other public place, except:

1. The dispensing location of a medical marijuana treatment center may have a sign that is affixed to the outside or hanging in the window of the premises which identifies the dispensary by the licensee's business name, a department-approved trade name, or a department-approved logo. A medical marijuana treatment center's trade name and logo may not contain wording or images commonly associated with marketing targeted toward children or which promote recreational use of marijuana.

2. A medical marijuana treatment center may engage in Internet advertising and marketing under the following conditions:

a. All advertisements must be approved by the department.

b. An advertisement may not have any content that specifically targets individuals under the age of 18, including cartoon characters or similar images.

c. An advertisement may not be an unsolicited pop-up advertisement.

d. Opt-in marketing must include an easy and permanent opt-out feature.

(i) Each medical marijuana treatment center that dispenses marijuana and marijuana delivery devices shall make available to the public on its website:

1. Each marijuana and low-THC product available for purchase, including the form, strain of marijuana from which it was extracted, cannabidiol content, tetrahydrocannabinol content, dose unit, total number of doses available, and the ratio of cannabidiol to tetrahydrocannabinol for each product.

2. The price for a 30-day, 50-day, and 70-day supply at a standard dose for each marijuana and low-THC product available for purchase.

3. The price for each marijuana delivery device available for purchase.

4. If applicable, any discount policies and eligibility criteria for such discounts.

(j) Medical marijuana treatment centers are the sole source from which a qualified patient may legally obtain marijuana.

(k) The department may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this subsection.

(9) BACKGROUND SCREENING.—An individual required to undergo a background screening pursuant to this section must pass a level 2 background screening as provided under chapter 435, which, in addition to the disqualifying offenses provided in s. 435.04, shall exclude an individual who has an arrest awaiting final disposition for, has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to an offense under chapter 837, chapter 895, or chapter 896 or similar law of another jurisdiction.

(a) Such individual must submit a full set of fingerprints to the department or to a vendor, entity, or agency authorized by s. 943.053(13). The department, vendor, entity, or agency shall forward the fingerprints to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for national processing.

(b) Fees for state and federal fingerprint processing and retention shall be borne by the individual. The state cost for fingerprint processing shall be as provided in s. 943.053(3)(e) for records provided to persons or entities other than those specified as exceptions therein.

(c) Fingerprints submitted to the Department of Law Enforcement pursuant to this subsection shall be retained by the Department of Law Enforcement as provided in s. 943.05(2)(g) and (h) and, when the Department of Law Enforcement begins participation in the program, enrolled in the Federal Bureau of Investigation's national retained print arrest notification program. Any arrest record identified shall be reported to the department.

(10) MEDICAL MARIJUANA TREATMENT CENTER INSPECTIONS; ADMINISTRATIVE ACTIONS.—

(a) The department shall conduct announced or unannounced inspections of medical marijuana treatment centers to determine compliance with this section or rules adopted pursuant to this section.

(b) The department shall inspect a medical marijuana treatment center upon receiving a complaint or notice that the medical marijuana treatment center has dispensed marijuana containing mold, bacteria, or other contaminant that may cause or has caused an adverse effect to human health or the environment.

(c) The department shall conduct at least a biennial inspection of each medical marijuana treatment center to evaluate the medical marijuana treatment center's records, personnel, equipment, processes, security measures, sanitation practices, and quality assurance practices.

(d) The Department of Agriculture and Consumer Services and the department shall enter into an interagency agreement to ensure cooperation and coordination in the performance of their obligations under this section and their respective regulatory and authorizing laws. The department, the Department of Highway Safety and Motor Vehicles, and the Department of Law Enforcement may enter into interagency agreements for the purposes specified in this subsection or subsection (7).

(e) The department shall publish a list of all approved medical marijuana treatment centers, medical directors, and qualified physicians on its website.

(f) The department may impose reasonable fines not to exceed $10,000 on a medical marijuana treatment center for any of the following violations:

1. Violating this section or department rule.
2. Failing to maintain qualifications for approval.
3. Endangering the health, safety, or security of a qualified patient.
4. Improperly disclosing personal and confidential information of the qualified patient.
5. Attempting to procure medical marijuana treatment center approval by bribery, fraudulent misrepresentation, or extortion.
6. Being convicted or found guilty of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which directly relates to the business of a medical marijuana treatment center.
7. Making or filing a report or record that the medical marijuana treatment center knows to be false.
8. Willfully failing to maintain a record required by this section or department rule.

9. Willfully impeding or obstructing an employee or agent of the department in the furtherance of his or her official duties.

10. Engaging in fraud or deceit, negligence, incompetence, or misconduct in the business practices of a medical marijuana treatment center.

11. Making misleading, deceptive, or fraudulent representations in or related to the business practices of a medical marijuana treatment center.

12. Having a license or the authority to engage in any regulated profession, occupation, or business that is related to the business practices of a medical marijuana treatment center suspended, revoked, or otherwise acted against by the licensing authority of any jurisdiction, including its agencies or subdivisions, for a violation that would constitute a violation under Florida law.

13. Violating a lawful order of the department or an agency of the state, or failing to comply with a lawfully issued subpoena of the department or an agency of the state.

(g) The department may suspend, revoke, or refuse to renew a medical marijuana treatment center license if the medical marijuana treatment center commits any of the violations in paragraph (f).

(h) The department may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this subsection.

(11) PREEMPTION.—Regulation of cultivation, processing, and delivery of marijuana by medical marijuana treatment centers is preempted to the state except as provided in this subsection.

(a) A medical marijuana treatment center cultivating or processing facility may not be located within 500 feet of the real property that comprises a public or private elementary school, middle school, or secondary school.

(b)1. A county or municipality may, by ordinance, ban medical marijuana treatment center dispensing facilities from being located within the boundaries of that county or municipality. A county or municipality that does not ban dispensing facilities under this subparagraph may not place specific limits, by ordinance, on the number of dispensing facilities that may locate within that county or municipality.

2. A municipality may determine by ordinance the criteria for the location of, and other permitting requirements that do not conflict with state law or department rule for, medical marijuana treatment center dispensing facilities located within the boundaries of that municipality. A county may determine by ordinance the criteria for the location of, and other permitting requirements that do not conflict with state law or department rule for, all such dispensing facilities located within the unincorporated areas of that county. Except as provided in paragraph (c), a county or municipality may not enact ordinances for permitting or for determining the location of dispensing facilities which are more restrictive than its ordinances permitting or determining the locations for pharmacies licensed under chapter 465. A municipality or county may not charge a medical marijuana treatment center a license or permit fee in an amount greater than the fee charged by such municipality or county to pharmacies. A dispensing facility location approved by a municipality or county pursuant to former s. 381.986(8)(b), Florida Statutes 2016, is not subject to the location requirements of this subsection.

(c) A medical marijuana treatment center dispensing facility may not be located within 500 feet of the real property that comprises a public or private elementary school, middle school, or secondary school unless the county or municipality approves the location through a formal proceeding open to the public at which the county or municipality determines that the location promotes the public health, safety, and general welfare of the community.

(d) This subsection does not prohibit any local jurisdiction from ensuring medical marijuana treatment center facilities comply with the Florida Building Code, the Florida Fire Prevention Code, or any local amendments to the Florida Building Code or the Florida Fire Prevention Code.

(12) PENALTIES.—

(a) A qualified physician commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, if the qualified physician issues a physician certification for the medical use of marijuana for a patient without a reasonable belief that the patient is suffering from a qualifying medical condition.

(b) A person who fraudulently represents that he or she has a qualifying medical condition to a qualified physician for the purpose of being issued a physician certification commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(c) A qualified patient who uses marijuana, not including low-THC cannabis, or a caregiver who administers marijuana, not including low-THC cannabis, in plain view of or in a place open to the general public; in a school bus, a vehicle, an aircraft, or a boat; or on the grounds of a school except as provided in s. 1006.062, commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(d) A qualified patient or caregiver who cultivates marijuana or who purchases or acquires marijuana from any person or entity other than a medical marijuana treatment center violates s. 893.13 and is subject to the penalties provided therein.

(e)1. A qualified patient or caregiver in possession of marijuana or a marijuana delivery device who fails or refuses to present his or her marijuana use registry identification card upon the request of a law enforcement officer commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083, unless it can be determined through the medical marijuana use registry that the person is authorized to be in possession of that marijuana or marijuana delivery device.

2. A person charged with a violation of this paragraph may not be convicted if, before or at the time of his or her court or hearing appearance, the person produces in court or to the clerk of the court in which the charge is pending a medical marijuana use registry identification card issued to him or her which is valid at the time of his or her arrest. The clerk of the court is authorized to dismiss such case at any time before the defendant's appearance in court. The clerk of the court may assess a fee of $5 for dismissing the case under this paragraph.

(f) A caregiver who violates any of the applicable provisions of this section or applicable department rules, for the first offense, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083 and, for a second or subsequent offense, commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(g) A qualified physician who issues a physician certification for marijuana or a marijuana delivery device and receives compensation from a medical marijuana treatment center related to the issuance of a physician certification for marijuana or a marijuana delivery device is subject to disciplinary action under the applicable practice act and s. 456.072(1)(n).

(h) A person transporting marijuana or marijuana delivery devices on behalf of a medical marijuana treatment center or marijuana testing laboratory who fails or refuses to present a transportation manifest upon the request of a law enforcement officer commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(i) Persons and entities conducting activities authorized and governed by this section and s. 381.988 are subject to ss. 456.053, 456.054, and 817.505, as applicable.

(j) A person or entity that cultivates, processes, distributes, sells, or dispenses marijuana, as defined in s. 29(b)(4), Art. X of the State Constitution, and is not licensed as a medical marijuana treatment center violates s. 893.13 and is subject to the penalties provided therein.

(k) A person who manufactures, distributes, sells, gives, or possesses with the intent to manufacture, distribute, sell, or give marijuana or a marijuana delivery device that he or she holds out to have originated from a licensed medical marijuana treatment center but that is counterfeit commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. For the purposes of this paragraph, the term "counterfeit" means marijuana; a marijuana delivery device; or a marijuana or marijuana delivery device container, seal, or label which, without authorization, bears the trademark, trade name, or other identifying mark, imprint, or device, or any likeness thereof, of a licensed medical marijuana treatment center and which thereby falsely purports or is represented to be the product of, or to have been distributed by, that licensed medical marijuana treatment facility.

(l) Any person who possesses or manufactures a blank, forged, stolen, fictitious, fraudulent, counterfeit, or otherwise unlawfully issued medical marijuana use registry identification card commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(13) UNLICENSED ACTIVITY.—

(a) If the department has probable cause to believe that a person or entity that is not registered or licensed with the department has violated this section, s. 381.988, or any rule adopted pursuant to this section, the

department may issue and deliver to such person or entity a notice to cease and desist from such violation. The department also may issue and deliver a notice to cease and desist to any person or entity who aids and abets such unlicensed activity. The issuance of a notice to cease and desist does not constitute agency action for which a hearing under s. 120.569 or s. 120.57 may be sought. For the purpose of enforcing a cease and desist order, the department may file a proceeding in the name of the state seeking issuance of an injunction or a writ of mandamus against any person or entity who violates any provisions of such order.

(b) In addition to the remedies under paragraph (a), the department may impose by citation an administrative penalty not to exceed $5,000 per incident. The citation shall be issued to the subject and must contain the subject's name and any other information the department determines to be necessary to identify the subject, a brief factual statement, the sections of the law allegedly violated, and the penalty imposed. If the subject does not dispute the matter in the citation with the department within 30 days after the citation is served, the citation shall become a final order of the department. The department may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section. Each day that the unlicensed activity continues after issuance of a notice to cease and desist constitutes a separate violation. The department shall be entitled to recover the costs of investigation and prosecution in addition to the fine levied pursuant to the citation. Service of a citation may be made by personal service or by mail to the subject at the subject's last known address or place of practice. If the department is required to seek enforcement of the cease and desist or agency order, it shall be entitled to collect attorney fees and costs.

(c) In addition to or in lieu of any other administrative remedy, the department may seek the imposition of a civil penalty through the circuit court for any violation for which the department may issue a notice to cease and desist. The civil penalty shall be no less than $5,000 and no more than $10,000 for each offense. The court may also award to the prevailing party court costs and reasonable attorney fees and, in the event the department prevails, may also award reasonable costs of investigation and prosecution.

(d) In addition to the other remedies provided in this section, the department or any state attorney may bring an action for an injunction to restrain any unlicensed activity or to enjoin the future operation or maintenance of the unlicensed activity or the performance of any service in violation of this section.

(e) The department must notify local law enforcement of such unlicensed activity for a determination of any criminal violation of chapter 893.

(14) EXCEPTIONS TO OTHER LAWS.—

(a) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other provision of law, but subject to the requirements of this section, a qualified patient and the qualified patient's caregiver may purchase from a medical marijuana treatment center for the patient's medical use a marijuana delivery device and up to the amount of marijuana authorized in the physician certification, but may not possess more than a 70-day supply of marijuana, or the greater of 4 ounces of marijuana in a form for smoking or an amount of marijuana in a form for smoking approved by the department pursuant to paragraph (4)(f), at any given time and all marijuana purchased must remain in its original packaging.

(b) Notwithstanding paragraph (a), s. 893.13, s. 893.135, s. 893.147, or any other provision of law, a qualified patient and the qualified patient's caregiver may purchase and possess a marijuana delivery device intended for the medical use of marijuana by smoking from a vendor other than a medical marijuana treatment center.

(c) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other provision of law, but subject to the requirements of this section, an approved medical marijuana treatment center and its owners, managers, and employees may manufacture, possess, sell, deliver, distribute, dispense, and lawfully dispose of marijuana or a marijuana delivery device as provided in this section, s. 381.988, and by department rule. For the purposes of this subsection, the terms "manufacture," "possession," "deliver," "distribute," and "dispense" have the same meanings as provided in s. 893.02.

(d) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other provision of law, but subject to the requirements of this section, a certified marijuana testing laboratory, including an employee of a certified marijuana testing laboratory acting within the scope of his or her employment, may acquire, possess, test, transport, and lawfully dispose of marijuana as provided in this section, in s. 381.988, and by department rule.

(e) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other law, but subject to the requirements of this section, the department, including an employee of the department acting within the scope of his or her employment, may acquire, possess, test, transport, and lawfully dispose of marijuana and marijuana delivery devices as provided in this section, in s. 381.988, and by department rule.

(f) A licensed medical marijuana treatment center and its owners, managers, and employees are not subject to licensure or regulation under chapter 465 or chapter 499 for manufacturing, possessing, selling, delivering, distributing, dispensing, or lawfully disposing of marijuana or a marijuana delivery device, as provided in this section, in s. 381.988, and by department rule.

(g) This subsection does not exempt a person from prosecution for a criminal offense related to impairment or intoxication resulting from the medical use of marijuana or relieve a person from any requirement under law to submit to a breath, blood, urine, or other test to detect the presence of a controlled substance.

(h) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other provision of law, but subject to the requirements of this section and pursuant to policies and procedures established pursuant to s. 1006.062(8), school personnel may possess marijuana that is obtained for medical use pursuant to this section by a student who is a qualified patient.

(i) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other provision of law, but subject to the requirements of this section, a research institute established by a public postsecondary educational institution, such as the H. Lee Moffitt Cancer Center and Research Institute, Inc., established under s. 1004.43, or a state university that has achieved the preeminent state research university designation under s. 1001.7065 may possess, test, transport, and lawfully dispose of marijuana for research purposes as provided by this section.

(15) APPLICABILITY.—

(a) This section does not limit the ability of an employer to establish, continue, or enforce a drug-free workplace program or policy.

(b) This section does not require an employer to accommodate the medical use of marijuana in any workplace or any employee working while under the influence of marijuana.

(c) This section does not create a cause of action against an employer for wrongful discharge or discrimination.

(d) This section does not impair the ability of any party to restrict or limit smoking or vaping marijuana on his or her private property.

(e) This section does not prohibit the medical use of marijuana or a caregiver assisting with the medical use of marijuana in a nursing home facility licensed under part II of chapter 400, a hospice facility licensed under part IV of chapter 400, or an assisted living facility licensed under part I of chapter 429, if the medical use of marijuana is not prohibited in the facility's policies.

(f) Marijuana, as defined in this section, is not reimbursable under chapter 440.

(16) FINES AND FEES.—Fines and fees collected by the department under this section shall be deposited in the Grants and Donations Trust Fund within the Department of Health.

[2](17) Rules adopted pursuant to this section before July 1, 2023, are not subject to ss. 120.54(3)(b) and 120.541. This subsection expires July 1, 2023.

History.—s. 2, ch. 2014-157; s. 1, ch. 2016-123; s. 24, ch. 2016-145; ss. 1, 3, 18, ch. 2017-232; s. 29, ch. 2018-10; s. 43, ch. 2018-110; s. 1, ch. 2018-142; s. 1, ch. 2019-1; s. 39, ch. 2019-116; s. 85, ch. 2020-2; s. 31, ch. 2020-114; s. 13, ch. 2021-37; s. 7, ch. 2021-52; ss. 3, 4, ch. 2022-71; s. 17, ch. 2022-157.

[1]**Note.**—

A. Section 1, ch. 2017-232, provides that "[i]t is the intent of the Legislature to implement s. 29, Article X of the State Constitution by creating a unified regulatory structure. If s. 29, Article X of the State Constitution is amended or a constitutional amendment related to cannabis or marijuana is adopted, this act shall expire 6 months after the effective date of such amendment." If such amendment or adoption takes place, s. 381.986, as amended by s. 1, ch. 2017-232, will read:

381.986 Compassionate use of low-THC and medical cannabis.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Cannabis delivery device" means an object used, intended for use, or designed for use in preparing, storing, ingesting, inhaling, or otherwise introducing low-THC cannabis or medical cannabis into the human body.

(b) "Dispensing organization" means an organization approved by the department to cultivate, process, transport, and dispense low-THC cannabis or medical cannabis pursuant to this section.

(c) "Independent testing laboratory" means a laboratory, including the managers, employees, or contractors of the laboratory, which has no direct or indirect interest in a dispensing organization.

(d) "Legal representative" means the qualified patient's parent, legal guardian acting pursuant to a court's authorization as required under s. 744.3215(4), health care surrogate acting pursuant to the qualified patient's written consent or a court's authorization as required under s. 765.113, or an individual who is authorized under a power of attorney to make health care decisions on behalf of the qualified patient.

(e) "Low-THC cannabis" means a plant of the genus *Cannabis*, the dried flowers of which contain 0.8 percent or less of tetrahydrocannabinol and more than 10 percent of cannabidiol weight for weight; the seeds thereof; the resin extracted from any part of such plant; or any compound, manufacture, salt, derivative, mixture, or preparation of such plant or its seeds or resin that is dispensed only from a dispensing organization.

(f) "Medical cannabis" means all parts of any plant of the genus *Cannabis*, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, sale, derivative, mixture, or preparation of the plant or its seeds or resin that is dispensed only from a dispensing organization for medical use by an eligible patient as defined in s. 499.0295.

(g) "Medical use" means administration of the ordered amount of low-THC cannabis or medical cannabis. The term does not include the:

1. Possession, use, or administration of low-THC cannabis or medical cannabis by smoking.

2. Transfer of low-THC cannabis or medical cannabis to a person other than the qualified patient for whom it was ordered or the qualified patient's legal representative on behalf of the qualified patient.

3. Use or administration of low-THC cannabis or medical cannabis:

a. On any form of public transportation.

b. In any public place.

c. In a qualified patient's place of employment, if restricted by his or her employer.

d. In a state correctional institution as defined in s. 944.02 or a correctional institution as defined in s. 944.241.

e. On the grounds of a preschool, primary school, or secondary school.

f. On a school bus or in a vehicle, aircraft, or motorboat.

(h) "Qualified patient" means a resident of this state who has been added to the compassionate use registry by a physician licensed under chapter 458 or chapter 459 to receive low-THC cannabis or medical cannabis from a dispensing organization.

(i) "Smoking" means burning or igniting a substance and inhaling the smoke. Smoking does not include the use of a vaporizer.

(2) PHYSICIAN ORDERING.—A physician is authorized to order low-THC cannabis to treat a qualified patient suffering from cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms; order low-THC cannabis to alleviate symptoms of such disease, disorder, or condition, if no other satisfactory alternative treatment options exist for the qualified patient; order medical cannabis to treat an eligible patient as defined in s. 499.0295; or order a cannabis delivery device for the medical use of low-THC cannabis or medical cannabis, only if the physician:

(a) Holds an active, unrestricted license as a physician under chapter 458 or an osteopathic physician under chapter 459;

(b) Has treated the patient for at least 3 months immediately preceding the patient's registration in the compassionate use registry;

(c) Has successfully completed the course and examination required under paragraph (4)(a);

(d) Has determined that the risks of treating the patient with low-THC cannabis or medical cannabis are reasonable in light of the potential benefit to the patient. If a patient is younger than 18 years of age, a second physician must concur with this determination, and such determination must be documented in the patient's medical record;

(e) Registers as the orderer of low-THC cannabis or medical cannabis for the named patient on the compassionate use registry maintained by the department and updates the registry to reflect the contents of the order, including the amount of low-THC cannabis or medical cannabis that will provide the patient with not more than a 45-day supply and a cannabis delivery device needed by the patient for the medical use of low-THC cannabis or medical cannabis. The physician must also update the registry within 7 days after any change is made to the original order to reflect the change. The physician shall deactivate the registration of the patient and the patient's legal representative when treatment is discontinued;

(f) Maintains a patient treatment plan that includes the dose, route of administration, planned duration, and monitoring of the patient's symptoms and other indicators of tolerance or reaction to the low-THC cannabis or medical cannabis;

(g) Submits the patient treatment plan quarterly to the University of Florida College of Pharmacy for research on the safety and efficacy of low-THC cannabis and medical cannabis on patients;

(h) Obtains the voluntary written informed consent of the patient or the patient's legal representative to treatment with low-THC cannabis after sufficiently explaining the current state of knowledge in the medical community of the effectiveness of treatment of the patient's condition with low-THC cannabis, the medically acceptable alternatives, and the potential risks and side effects;

(i) Obtains written informed consent as defined in and required under s. 499.0295, if the physician is ordering medical cannabis for an eligible patient pursuant to that section; and

(j) Is not a medical director employed by a dispensing organization.

(3) PENALTIES.—

(a) A physician commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, if the physician orders low-THC cannabis for a patient without a reasonable belief that the patient is suffering from:

1. Cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms that can be treated with low-THC cannabis; or

2. Symptoms of cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms that can be alleviated with low-THC cannabis.

(b) A physician commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, if the physician orders medical cannabis for a patient without a reasonable belief that the patient has a terminal condition as defined in s. 499.0295.

(c) A person who fraudulently represents that he or she has cancer, a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms, or a terminal condition to a physician for the purpose of being ordered low-THC cannabis, medical cannabis, or a cannabis delivery device by such physician commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(d) An eligible patient as defined in s. 499.0295 who uses medical cannabis, and such patient's legal representative who administers medical cannabis, in plain view of or in a place open to the general public, on the grounds of a school, or in a school bus, vehicle, aircraft, or motorboat, commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(e) A physician who orders low-THC cannabis, medical cannabis, or a cannabis delivery device and receives compensation from a dispensing organization related to the ordering of low-THC cannabis, medical cannabis, or a cannabis delivery device is subject to disciplinary action under the applicable practice act and s. 456.072(1)(n).

(4) PHYSICIAN EDUCATION.—

(a) Before ordering low-THC cannabis, medical cannabis, or a cannabis delivery device for medical use by a patient in this state, the appropriate board shall require the ordering physician to successfully complete an 8-hour course and subsequent examination offered by the Florida Medical Association or the Florida Osteopathic Medical Association that encompasses the clinical indications for the appropriate use of low-THC cannabis and medical cannabis, the appropriate cannabis delivery devices, the contraindications for such use, and the relevant state and federal laws governing the ordering, dispensing, and possessing of these substances and devices. The course and examination shall be administered at least annually. Successful completion of the course may be used by a physician to satisfy 8 hours of the continuing medical education requirements required by his or her respective board for licensure renewal. This course may be offered in a distance learning format.

(b) The appropriate board shall require the medical director of each dispensing organization to hold an active, unrestricted license as a physician under chapter 458 or as an osteopathic physician under chapter 459 and successfully complete a 2-hour course and subsequent examination offered by the Florida Medical Association or the Florida Osteopathic Medical Association that encompasses appropriate safety procedures and knowledge of low-THC cannabis, medical cannabis, and cannabis delivery devices.

(c) Successful completion of the course and examination specified in paragraph (a) is required for every physician who orders low-THC cannabis, medical cannabis, or a cannabis delivery device each time such physician renews his or her license. In addition, successful completion of the course and examination specified in paragraph (b) is required for the medical director of each dispensing organization each time such physician renews his or her license.

(d) A physician who fails to comply with this subsection and who orders low-THC cannabis, medical cannabis, or a cannabis delivery device may be subject to disciplinary action under the applicable practice act and under s. 456.072(1)(k).

(5) DUTIES OF THE DEPARTMENT.—The department shall:

(a) Create and maintain a secure, electronic, and online compassionate use registry for the registration of physicians, patients, and the legal representatives of patients as provided under this section. The registry must be accessible to law enforcement agencies and to a dispensing organization to verify the authorization of a patient or a patient's legal representative to possess low-THC cannabis, medical cannabis, or a cannabis delivery device and record the low-THC cannabis, medical cannabis, or cannabis delivery device dispensed. The registry must prevent an active registration of a patient by multiple physicians.

(b) Authorize the establishment of five dispensing organizations to ensure reasonable statewide accessibility and availability as necessary for patients registered in the compassionate use registry and who are ordered low-THC cannabis, medical cannabis, or a cannabis delivery device under this section, one in each of the following regions: northwest Florida, northeast Florida, central Florida, southeast Florida, and southwest Florida. The department shall develop an application form and impose an initial application and biennial renewal fee that is sufficient to cover the costs of administering this section. An applicant for approval as a dispensing organization must be able to demonstrate:

1. The technical and technological ability to cultivate and produce low-THC cannabis. The applicant must possess a valid certificate of registration issued by the Department of Agriculture and Consumer Services pursuant to s. 581.131 that is issued for the cultivation of more than 400,000 plants, be operated by a nurseryman as defined in s. 581.011, and have been operated as a registered nursery in this state for at least 30 continuous years.

2. The ability to secure the premises, resources, and personnel necessary to operate as a dispensing organization.

3. The ability to maintain accountability of all raw materials, finished products, and any byproducts to prevent diversion or unlawful access to or possession of these substances.

4. An infrastructure reasonably located to dispense low-THC cannabis to registered patients statewide or regionally as determined by the department.

5. The financial ability to maintain operations for the duration of the 2-year approval cycle, including the provision of certified financials to the department. Upon approval, the applicant must post a $5 million performance bond. However, upon a dispensing

organization's serving at least 1,000 qualified patients, the dispensing organization is only required to maintain a $2 million performance bond.

6. That all owners and managers have been fingerprinted and have successfully passed a level 2 background screening pursuant to s. 435.04.

7. The employment of a medical director to supervise the activities of the dispensing organization.

(c) Upon the registration of 250,000 active qualified patients in the compassionate use registry, approve three dispensing organizations, including, but not limited to, an applicant that is a recognized class member of *Pigford v. Glickman*, 185 F.R.D. 82 (D.D.C. 1999), or *In Re Black Farmers Litig.*, 856 F. Supp. 2d 1 (D.D.C. 2011), and a member of the Black Farmers and Agriculturalists Association, which must meet the requirements of subparagraphs (b)2.-7. and demonstrate the technical and technological ability to cultivate and produce low-THC cannabis.

(d) Allow a dispensing organization to make a wholesale purchase of low-THC cannabis or medical cannabis from, or a distribution of low-THC cannabis or medical cannabis to, another dispensing organization.

(e) Monitor physician registration and ordering of low-THC cannabis, medical cannabis, or a cannabis delivery device for ordering practices that could facilitate unlawful diversion or misuse of low-THC cannabis, medical cannabis, or a cannabis delivery device and take disciplinary action as indicated.

(6) DISPENSING ORGANIZATION.—An approved dispensing organization must, at all times, maintain compliance with the criteria demonstrated for selection and approval as a dispensing organization under subsection (5) and the criteria required in this subsection.

(a) When growing low-THC cannabis or medical cannabis, a dispensing organization:

1. May use pesticides determined by the department, after consultation with the Department of Agriculture and Consumer Services, to be safely applied to plants intended for human consumption, but may not use pesticides designated as restricted-use pesticides pursuant to s. 487.042.

2. Must grow low-THC cannabis or medical cannabis within an enclosed structure and in a room separate from any other plant.

3. Must inspect seeds and growing plants for plant pests that endanger or threaten the horticultural and agricultural interests of the state, notify the Department of Agriculture and Consumer Services within 10 calendar days after a determination that a plant is infested or infected by such plant pest, and implement and maintain phytosanitary policies and procedures.

4. Must perform fumigation or treatment of plants, or the removal and destruction of infested or infected plants, in accordance with chapter 581 and any rules adopted thereunder.

(b) When processing low-THC cannabis or medical cannabis, a dispensing organization must:

1. Process the low-THC cannabis or medical cannabis within an enclosed structure and in a room separate from other plants or products.

2. Test the processed low-THC cannabis and medical cannabis before they are dispensed. Results must be verified and signed by two dispensing organization employees. Before dispensing low-THC cannabis, the dispensing organization must determine that the test results indicate that the low-THC cannabis meets the definition of low-THC cannabis and, for medical cannabis and low-THC cannabis, that all medical cannabis and low-THC cannabis is safe for human consumption and free from contaminants that are unsafe for human consumption. The dispensing organization must retain records of all testing and samples of each homogenous batch of cannabis and low-THC cannabis for at least 9 months. The dispensing organization must contract with an independent testing laboratory to perform audits on the dispensing organization's standard operating procedures, testing records, and samples and provide the results to the department to confirm that the low-THC cannabis or medical cannabis meets the requirements of this section and that the medical cannabis and low-THC cannabis is safe for human consumption.

3. Package the low-THC cannabis or medical cannabis in compliance with the United States Poison Prevention Packaging Act of 1970, 15 U.S.C. ss. 1471 et seq.

4. Package the low-THC cannabis or medical cannabis in a receptacle that has a firmly affixed and legible label stating the following information:

a. A statement that the low-THC cannabis or medical cannabis meets the requirements of subparagraph 2.;

b. The name of the dispensing organization from which the medical cannabis or low-THC cannabis originates; and

c. The batch number and harvest number from which the medical cannabis or low-THC cannabis originates.

5. Reserve two processed samples from each batch and retain such samples for at least 9 months for the purpose of testing pursuant to the audit required under subparagraph 2.

(c) When dispensing low-THC cannabis, medical cannabis, or a cannabis delivery device, a dispensing organization:

1. May not dispense more than a 45-day supply of low-THC cannabis or medical cannabis to a patient or the patient's legal representative.

2. Must have the dispensing organization's employee who dispenses the low-THC cannabis, medical cannabis, or a cannabis delivery device enter into the compassionate use registry his or her name or unique employee identifier.

3. Must verify in the compassionate use registry that a physician has ordered the low-THC cannabis, medical cannabis, or a specific type of a cannabis delivery device for the patient.

4. May not dispense or sell any other type of cannabis, alcohol, or illicit drug-related product, including pipes, bongs, or wrapping papers, other than a physician-ordered cannabis delivery device required for the medical use of low-THC cannabis or medical cannabis, while dispensing low-THC cannabis or medical cannabis.

5. Must verify that the patient has an active registration in the compassionate use registry, the patient or patient's legal representative holds a valid and active registration card, the order presented matches the order contents as recorded in the registry, and the order has not already been filled.

6. Must, upon dispensing the low-THC cannabis, medical cannabis, or cannabis delivery device, record in the registry the date, time, quantity, and form of low-THC cannabis or medical cannabis dispensed and the type of cannabis delivery device dispensed.

(d) To ensure the safety and security of its premises and any off-site storage facilities, and to maintain adequate controls against the diversion, theft, and loss of low-THC cannabis, medical cannabis, or cannabis delivery devices, a dispensing organization shall:

1.a. Maintain a fully operational security alarm system that secures all entry points and perimeter windows and is equipped with motion detectors; pressure switches; and duress, panic, and hold-up alarms; or

b. Maintain a video surveillance system that records continuously 24 hours each day and meets at least one of the following criteria:

(I) Cameras are fixed in a place that allows for the clear identification of persons and activities in controlled areas of the premises. Controlled areas include grow rooms, processing rooms, storage rooms, disposal rooms or areas, and point-of-sale rooms;

(II) Cameras are fixed in entrances and exits to the premises, which shall record from both indoor and outdoor, or ingress and egress, vantage points;

(III) Recorded images must clearly and accurately display the time and date; or

(IV) Retain video surveillance recordings for a minimum of 45 days or longer upon the request of a law enforcement agency.

2. Ensure that the organization's outdoor premises have sufficient lighting from dusk until dawn.

3. Establish and maintain a tracking system approved by the department that traces the low-THC cannabis or medical cannabis from seed to sale. The tracking system shall include notification of key events as determined by the department, including when cannabis seeds are planted, when cannabis plants are harvested and destroyed, and when low-THC cannabis or medical cannabis is transported, sold, stolen, diverted, or lost.

4. Not dispense from its premises low-THC cannabis, medical cannabis, or a cannabis delivery device between the hours of 9 p.m. and 7 a.m., but may perform all other operations and deliver low-THC cannabis and medical cannabis to qualified patients 24 hours each day.

5. Store low-THC cannabis or medical cannabis in a secured, locked room or a vault.

6. Require at least two of its employees, or two employees of a security agency with whom it contracts, to be on the premises at all times.

7. Require each employee to wear a photo identification badge at all times while on the premises.

8. Require each visitor to wear a visitor's pass at all times while on the premises.

9. Implement an alcohol and drug-free workplace policy.

10. Report to local law enforcement within 24 hours after it is notified or becomes aware of the theft, diversion, or loss of low-THC cannabis or medical cannabis.

(e) To ensure the safe transport of low-THC cannabis or medical cannabis to dispensing organization facilities, independent testing laboratories, or patients, the dispensing organization must:

1. Maintain a transportation manifest, which must be retained for at least 1 year.

2. Ensure only vehicles in good working order are used to transport low-THC cannabis or medical cannabis.

3. Lock low-THC cannabis or medical cannabis in a separate compartment or container within the vehicle.

4. Require at least two persons to be in a vehicle transporting low-THC cannabis or medical cannabis, and require at least one person to remain in the vehicle while the low-THC cannabis or medical cannabis is being delivered.

5. Provide specific safety and security training to employees transporting or delivering low-THC cannabis or medical cannabis.

(7) DEPARTMENT AUTHORITY AND RESPONSIBILITIES.—

(a) The department may conduct announced or unannounced inspections of dispensing organizations to determine compliance with this section or rules adopted pursuant to this section.

(b) The department shall inspect a dispensing organization upon complaint or notice provided to the department that the dispensing organization has dispensed low-THC cannabis or medical cannabis containing any mold, bacteria, or other contaminant that may cause or has caused an adverse effect to human health or the environment.

(c) The department shall conduct at least a biennial inspection of each dispensing organization to evaluate the dispensing organization's records, personnel, equipment, processes, security measures, sanitation practices, and quality assurance practices.

(d) The department may enter into interagency agreements with the Department of Agriculture and Consumer Services, the Department of Business and Professional Regulation, the Department of Transportation, the Department of Highway Safety and Motor Vehicles, and the Agency for Health Care Administration, and such agencies are authorized to enter into an interagency agreement with the department, to conduct inspections or perform other responsibilities assigned to the department under this section.

(e) The department must make a list of all approved dispensing organizations and qualified ordering physicians and medical directors publicly available on its website.

(f) The department may establish a system for issuing and renewing registration cards for patients and their legal representatives, establish the circumstances under which the cards may be revoked by or must be returned to the department, and establish fees to implement such system. The department must require, at a minimum, the registration cards to:

1. Provide the name, address, and date of birth of the patient or legal representative.

2. Have a full-face, passport-type, color photograph of the patient or legal representative taken within the 90 days immediately preceding registration.

3. Identify whether the cardholder is a patient or legal representative.

4. List a unique numeric identifier for the patient or legal representative that is matched to the identifier used for such person in the department's compassionate use registry.

5. Provide the expiration date, which shall be 1 year after the date of the physician's initial order of low-THC cannabis or medical cannabis.

6. For the legal representative, provide the name and unique numeric identifier of the patient that the legal representative is assisting.

7. Be resistant to counterfeiting or tampering.

(g) The department may impose reasonable fines not to exceed $10,000 on a dispensing organization for any of the following violations:

1. Violating this section, s. 499.0295, or department rule.

2. Failing to maintain qualifications for approval.

3. Endangering the health, safety, or security of a qualified patient.

4. Improperly disclosing personal and confidential information of the qualified patient.

5. Attempting to procure dispensing organization approval by bribery, fraudulent misrepresentation, or extortion.

6. Being convicted or found guilty of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which directly relates to the business of a dispensing organization.

7. Making or filing a report or record that the dispensing organization knows to be false.

8. Willfully failing to maintain a record required by this section or department rule.

9. Willfully impeding or obstructing an employee or agent of the department in the furtherance of his or her official duties.

10. Engaging in fraud or deceit, negligence, incompetence, or misconduct in the business practices of a dispensing organization.

11. Making misleading, deceptive, or fraudulent representations in or related to the business practices of a dispensing organization.

12. Having a license or the authority to engage in any regulated profession, occupation, or business that is related to the business practices of a dispensing organization suspended, revoked, or otherwise acted against by the licensing authority of any jurisdiction, including its agencies or subdivisions, for a violation that would constitute a violation under Florida law.

13. Violating a lawful order of the department or an agency of the state, or failing to comply with a lawfully issued subpoena of the department or an agency of the state.

(h) The department may suspend, revoke, or refuse to renew a dispensing organization's approval if a dispensing organization commits any of the violations in paragraph (g).

(i) The department shall renew the approval of a dispensing organization biennially if the dispensing organization meets the requirements of this section and pays the biennial renewal fee.

(j) The department may adopt rules necessary to implement this section.

(8) PREEMPTION.—

(a) All matters regarding the regulation of the cultivation and processing of medical cannabis or low-THC cannabis by dispensing organizations are preempted to the state.

(b) A municipality may determine by ordinance the criteria for the number and location of, and other permitting requirements that do not conflict with state law or department rule for, dispensing facilities of dispensing organizations located within its municipal boundaries. A county may determine by ordinance the criteria for the number, location, and other permitting requirements that do not conflict with state law or department rule for all dispensing facilities of dispensing organizations located within the unincorporated areas of that county.

(9) EXCEPTIONS TO OTHER LAWS.—

(a) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other provision of law, but subject to the requirements of this section, a qualified patient and the qualified patient's legal representative may purchase and possess for the patient's medical use up to the amount of low-THC cannabis or medical cannabis ordered for the patient, but not more than a 45-day supply, and a cannabis delivery device ordered for the patient.

(b) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other provision of law, but subject to the requirements of this section, an approved dispensing organization and its owners, managers, and employees may manufacture, possess, sell, deliver, distribute, dispense, and lawfully dispose of reasonable quantities, as established by department rule, of low-THC cannabis, medical cannabis, or a cannabis delivery device. For purposes of this subsection, the terms "manufacture," "possession," "deliver," "distribute," and "dispense" have the same meanings as provided in s. 893.02.

(c) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other provision of law, but subject to the requirements of this section, an approved independent testing laboratory may possess, test, transport, and lawfully dispose of low-THC cannabis or medical cannabis as provided by department rule.

(d) An approved dispensing organization and its owners, managers, and employees are not subject to licensure or regulation under chapter 465 or chapter 499 for manufacturing, possessing, selling, delivering, distributing, dispensing, or lawfully disposing of reasonable quantities, as established by department rule, of low-THC cannabis, medical cannabis, or a cannabis delivery device.

(e) An approved dispensing organization that continues to meet the requirements for approval is presumed to be registered with the department and to meet the regulations adopted by the department or its successor agency for the purpose of dispensing medical cannabis or low-THC cannabis under Florida law. Additionally, the authority provided to a dispensing organization in s. 499.0295 does not impair the approval of a dispensing organization.

(f) This subsection does not exempt a person from prosecution for a criminal offense related to impairment or intoxication resulting from the medical use of low-THC cannabis or medical cannabis or relieve a person from any requirement under law to submit to a breath, blood, urine, or other test to detect the presence of a controlled substance.

B. Section 14(1), ch. 2017-232, as amended by s. 15, ch. 2021-37, and as reenacted and amended by s. 18, ch. 2022-157, "in order to implement Specific Appropriations 467 through 469, 473, 475, and 478 of the 2022-2023 General Appropriations Act," provides that:

"(1) EMERGENCY RULEMAKING.—

"(a) The Department of Health and the applicable boards shall adopt emergency rules pursuant to s. 120.54(4), Florida Statutes, and this section necessary to implement s. 381.986, Florida Statutes. If an emergency rule adopted under this section is held to be unconstitutional or an invalid exercise of delegated legislative authority, and becomes void, the department or the applicable boards may adopt an emergency rule pursuant to this section to replace the rule that has become void. If the emergency rule adopted to replace the void emergency rule is also held to be unconstitutional or an invalid exercise of delegated legislative authority and becomes void, the department and the applicable boards must follow the nonemergency rulemaking procedures of the Administrative Procedures Act to replace the rule that has become void.

"(b) For emergency rules adopted under this section, the department and the applicable boards need not make the findings required by s. 120.54(4)(a), Florida Statutes. Emergency rules adopted under this section are exempt from ss. 120.54(3)(b) and 120.541, Florida Statutes. The department and the applicable boards shall meet the procedural requirements in s. 120.54(4)(a), Florida Statutes, if the department or the applicable boards have, before July 1, 2019, held any public workshops or hearings on the subject matter of the emergency rules adopted under this subsection. Challenges to emergency rules adopted under this subsection are subject to the time schedules provided in s. 120.56(5), Florida Statutes.

"(c) Emergency rules adopted under this section are exempt from s. 120.54(4)(c), Florida Statutes, and shall remain in effect until replaced by rules adopted under the nonemergency rulemaking procedures of the Administrative Procedures Act. Rules adopted under the nonemergency rulemaking procedures of the Administrative Procedures Act to replace emergency rules adopted under this section are exempt from ss. 120.54(3)(b) and 120.541, Florida Statutes. By July 1, 2023, the department and the applicable boards shall initiate nonemergency rulemaking pursuant to the Administrative Procedures Act to replace all emergency rules adopted under this section by publishing a notice of rule development in the Florida Administrative Register. Except as provided in paragraph (a), after July 1, 2023, the department and applicable boards may not adopt rules pursuant to the emergency rulemaking procedures provided in this section."

C. Section 19, ch. 2022-157, provides that "[t]he amendments to section 14(1) of chapter 2017-232, Laws of Florida, as amended by section 15 of chapter 2021-37, Laws of Florida, and as amended by this act expire July 1, 2023, and the text of that subsection shall revert to that in existence on June 30, 2019, except that any amendments to such text enacted other than by this act shall be preserved and continue to operate to the extent that such amendments are not dependent upon the portions of text which expire pursuant to this section." Effective July 1, 2023, s. 14(1), ch. 2017-232, as amended by s. 19, ch. 2022-157, will read:

"(1) EMERGENCY RULEMAKING.—

"(a) The Department of Health and the applicable boards shall adopt emergency rules pursuant to s. 120.54(4), Florida Statutes, and this section necessary to implement ss. 381.986 and 381.988, Florida Statutes. If an emergency rule adopted under this section is held to be unconstitutional or an invalid exercise of delegated legislative authority, and becomes void, the department or the applicable boards may adopt an emergency rule pursuant to this section to replace the rule that has become void. If the emergency rule adopted to replace the void emergency rule is also held to be unconstitutional or an invalid exercise of delegated legislative authority and becomes void, the department and the applicable boards must follow the nonemergency rulemaking procedures of the Administrative Procedures Act to replace the rule that has become void.

"(b) For emergency rules adopted under this section, the department and the applicable boards need not make the findings required by s. 120.54(4)(a), Florida Statutes. Emergency rules adopted under this section are exempt from ss. 120.54(3)(b) and 120.541, Florida Statutes. The department and the applicable boards shall meet the procedural requirements in s. 120.54(a), Florida Statutes, if the department or the applicable boards have, before [June 23, 2017], held any public workshops or hearings on the subject matter of the emergency rules adopted under this subsection. Challenges to emergency rules adopted under this subsection are subject to the time schedules provided in s. 120.56(5), Florida Statutes.

"(c) Emergency rules adopted under this section are exempt from s. 120.54(4)(c), Florida Statutes, and shall remain in effect until replaced by rules adopted under the nonemergency rulemaking procedures of the Administrative Procedures Act. By January 1, 2018, the department and the applicable boards shall initiate nonemergency rulemaking pursuant to the Administrative Procedures Act to replace all emergency rules adopted under this section by publishing a notice of rule development in the Florida Administrative Register. Except as provided in paragraph (a), after January 1, 2018, the department and applicable boards may not adopt rules pursuant to the emergency rulemaking procedures provided in this section."

[2]**Note.**—Section 17, ch. 2022-157, amended subsection (17) "[i]n order to implement Specific Appropriations 467 through 469, 473, 475, and 478 of the 2022-2023 General Appropriations Act."

Copyright © 1995-2023 The Florida Legislature • Privacy Statement • Contact Us

Select Year: 2022 Go

The 2022 Florida Statutes (including 2022 Special Session A and 2023 Special Session B)

Title XXXV AGRICULTURE, HORTICULTURE, AND ANIMAL INDUSTRY | Chapter 581 PLANT INDUSTRY | View Entire Chapter

581.217 State hemp program.—

(1) CREATION AND PURPOSE.—The state hemp program is created within the department to regulate the cultivation of hemp in the state. This section constitutes the state plan for the regulation of the cultivation of hemp for purposes of 7 U.S.C. s. 1639p.

(2) LEGISLATIVE FINDINGS.—The Legislature finds that:

(a) Hemp is an agricultural commodity.

(b) Hemp-derived cannabinoids, including, but not limited to, cannabidiol, are not controlled substances or adulterants.

(3) DEFINITIONS.—As used in this section, the term:

(a) "Certifying agency" has the same meaning as in s. 578.011(8).

(b) "Contaminants unsafe for human consumption" includes, but is not limited to, any microbe, fungus, yeast, mildew, herbicide, pesticide, fungicide, residual solvent, metal, or other contaminant found in any amount that exceeds any of the accepted limitations as determined by rules adopted by the Department of Health in accordance with s. 381.986, or other limitation pursuant to the laws of this state, whichever amount is less.

(c) "Cultivate" means planting, watering, growing, or harvesting hemp.

(d) "Hemp" means the plant *Cannabis sativa* L. and any part of that plant, including the seeds thereof, and all derivatives, extracts, cannabinoids, isomers, acids, salts, and salts of isomers thereof, whether growing or not, that has a total delta-9-tetrahydrocannabinol concentration that does not exceed 0.3 percent on a dry-weight basis.

(e) "Hemp extract" means a substance or compound intended for ingestion, containing more than trace amounts of cannabinoid, or for inhalation which is derived from or contains hemp and which does not contain other controlled substances. The term does not include synthetic CBD or seeds or seed-derived ingredients that are generally recognized as safe by the United States Food and Drug Administration.

(f) "Independent testing laboratory" means a laboratory that:

1. Does not have a direct or indirect interest in the entity whose product is being tested;

2. Does not have a direct or indirect interest in a facility that cultivates, processes, distributes, dispenses, or sells hemp or hemp extract in the state or in another jurisdiction or cultivates, processes, distributes, dispenses, or sells marijuana, as defined in s. 381.986; and

3. Is accredited by a third-party accrediting body as a competent testing laboratory pursuant to ISO/IEC 17025 of the International Organization for Standardization.

(4) FEDERAL APPROVAL.—The department shall seek approval of the state plan for the regulation of the cultivation of hemp with the United States Secretary of Agriculture in accordance with 7 U.S.C. s. 1639p within 30 days after adopting rules. If the state plan is not approved by the United States Secretary of Agriculture, the Commissioner of Agriculture, in consultation with and with final approval from the Administration Commission, shall develop a recommendation to amend the state plan and submit the recommendation to the Legislature.

(5) LICENSURE.—

(a) It is unlawful for a person to cultivate hemp in this state without a license issued by the department.

(b) A person seeking to cultivate hemp must apply to the department for a license on a form prescribed by the department and must submit a full set of fingerprints to the department along with the application.

1. The department shall forward the fingerprints to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for national processing.

2. Fingerprints submitted to the Department of Law Enforcement pursuant to this paragraph must be retained by the Department of Law Enforcement as provided in s. 943.05(2)(g) and (h) and must be retained as provided in s. 943.05(4) when the Department of Law Enforcement begins participation in the Federal Bureau of Investigation's national retained fingerprint arrest notification program.

3. Any arrest record identified shall be reported to the department.

(c) The department shall adopt rules establishing procedures for the issuance and annual renewal of a hemp license.

(d) A person seeking to cultivate hemp must provide to the department the legal land description and global positioning coordinates of the area where hemp will be cultivated.

(e) The department shall deny the issuance of a hemp license to an applicant, or refuse to renew the hemp license of a licensee, if the department finds that the applicant or licensee:

1. Has falsified any information contained in an application for a hemp license or hemp license renewal; or

2. Has been convicted of a felony relating to a controlled substance under state or federal law. A hemp license may not be issued for 10 years following the date of the conviction.

(6) HEMP SEED.—A licensee may only use hemp seeds and cultivars certified by a certifying agency or a university conducting an industrial hemp pilot project pursuant to s. 1004.4473.

(7) DISTRIBUTION AND RETAIL SALE OF HEMP EXTRACT.—

(a) Hemp extract may only be distributed and sold in the state if the product:

1. Has a certificate of analysis prepared by an independent testing laboratory that states:

a. The hemp extract is the product of a batch tested by the independent testing laboratory;

b. The batch contained a total delta-9-tetrahydrocannabinol concentration that did not exceed 0.3 percent pursuant to the testing of a random sample of the batch; and

c. The batch does not contain contaminants unsafe for human consumption.

2. Is distributed or sold in a container that includes:

a. A scannable barcode or quick response code linked to the certificate of analysis of the hemp extract batch by an independent testing laboratory;

b. The batch number;

c. The Internet address of a website where batch information may be obtained;

d. The expiration date; and

e. The number of milligrams of each marketed cannabinoid per serving.

(b) Hemp extract distributed or sold in violation of this section shall be considered adulterated or misbranded pursuant to chapter 500, chapter 502, or chapter 580.

(c) Products that are intended for inhalation and contain hemp extract may not be sold in this state to a person who is under 21 years of age.

(8) LAND REGISTRY.—The department shall maintain a registry of land on which hemp is cultivated or has been cultivated within the past 3 calendar years, including the global positioning coordinates and legal land description for each location.

(9) DEPARTMENT REPORTING.—The department shall submit monthly to the United States Secretary of Agriculture a report of the locations in the state where hemp is cultivated or has been cultivated within the past 3 calendar years. The report must include the contact information for each licensee.

(10) VIOLATIONS.—

(a) A licensee must complete a corrective action plan if the department determines that the licensee has negligently violated this section or department rules, including negligently:

1. Failing to provide the legal land description and global positioning coordinates pursuant to subsection (5);

2. Failing to obtain a proper license or other required authorization from the department; or

3. Producing *Cannabis sativa* L. that has a total delta-9-tetrahydrocannabinol concentration that exceeds 0.3 percent on a dry-weight basis.

(b) The corrective action plan must include:

1. A reasonable date by which the licensee must correct the negligent violation; and

2. A requirement that the licensee periodically report to the department on compliance with this section and department rules for a period of at least 2 calendar years after the date of the violation.

(c) A licensee who negligently violates the corrective action plan under this subsection three times within 5 years is ineligible to cultivate hemp for 5 years following the date of the third violation.

(d) If the department determines that a licensee has violated this section or department rules with a culpable mental state greater than negligence, the department shall immediately report the licensee to the Attorney General and the United States Attorney General.

(11) ENFORCEMENT.—

(a) The department shall enforce this section.

(b) Every state attorney, sheriff, police officer, and other appropriate county or municipal officer shall enforce, or assist any agent of the department in enforcing, this section and rules adopted by the department.

(c) The department, or its agent, is authorized to enter any public or private premises during regular business hours in the performance of its duties relating to hemp cultivation.

(d) The department shall conduct random inspections, at least annually, of each licensee to ensure that only certified hemp seeds are being used and that hemp is being cultivated in compliance with this section.

(12) RULES.—By August 1, 2019, the department, in consultation with the Department of Health and the Department of Business and Professional Regulation, shall initiate rulemaking to administer the state hemp program. The rules must provide for:

(a) A procedure that uses post-decarboxylation or other similarly reliable methods for testing the delta-9-tetrahydrocannabinol concentration of cultivated hemp.

(b) A procedure for the effective disposal of plants, whether growing or not, that are cultivated in violation of this section or department rules, and products derived from those plants.

(13) APPLICABILITY.—Notwithstanding any other law:

(a) This section does not authorize a licensee to violate any federal or state law or regulation.

(b) This section does not apply to a pilot project developed in accordance with 7 U.S.C. 5940 and s. 1004.4473.

(c) A licensee who negligently violates this section or department rules is not subject to any criminal or civil enforcement action by the state or a local government other than the enforcement of violations of this section as authorized under subsection (10).

(14) INDUSTRIAL HEMP ADVISORY COUNCIL.—An Industrial Hemp Advisory Council, an advisory council as defined in s. 20.03, is established to provide advice and expertise to the department with respect to plans, policies, and procedures applicable to the administration of the state hemp program.

(a) The advisory council is adjunct to the department for administrative purposes.

(b) The advisory council shall be composed of all of the following members:

1. Two members appointed by the Commissioner of Agriculture.

2. Two members appointed by the Governor.

3. Two members appointed by the President of the Senate.

4. Two members appointed by the Speaker of the House of Representatives.

5. The dean for research of the Institute of Food and Agricultural Sciences of the University of Florida or his or her designee.

6. The president of Florida Agricultural and Mechanical University or his or her designee.

7. The executive director of the Department of Law Enforcement or his or her designee.

8. The president of the Florida Sheriffs Association or his or her designee.

9. The president of the Florida Police Chiefs Association or his or her designee.

10. The president of the Florida Farm Bureau Federation or his or her designee.

11. The president of the Florida Fruit and Vegetable Association or his or her designee.

(c) The advisory council shall elect by a two-thirds vote of the members one member to serve as chair of the council.

(d) A majority of the members of the advisory council constitutes a quorum.

(e) The advisory council shall meet at least once annually at the call of the chair.

(f) Advisory council members shall serve without compensation and are not entitled to reimbursement for per diem or travel expenses.

History.—s. 1, ch. 2019-132; s. 5, ch. 2020-135.

Copyright © 1995-2023 The Florida Legislature • Privacy Statement • Contact Us

CHAPTER 2023-71

Committee Substitute for
Committee Substitute for House Bill No. 1387

An act relating to the Department of Health; creating s. 381.875, F.S.; defining terms; prohibiting certain research in this state relating to enhanced potential pandemic pathogens; requiring researchers applying for state or local funding to disclose certain information; requiring the Department of Health to enjoin violations of specified provisions; providing construction; amending s. 381.986, F.S.; defining the term "attractive to children"; prohibiting medical marijuana treatment centers from producing marijuana products that are attractive to children or manufactured in specified manners; prohibiting marijuana packaging and labeling from including specified wording; prohibiting medical marijuana treatment centers from using certain content in their advertising which is attractive to children or promotes the recreational use of marijuana; revising background screening requirements for certain individuals; amending s. 381.988, F.S.; requiring medical marijuana testing laboratories to subject their employees to background screenings; revising background screening requirements for certain individuals; amending s. 382.005, F.S.; requiring local registrars to electronically file all live birth, death, and fetal death records in their respective jurisdictions in the department's electronic registration system; requiring the local registrars to file a paper record with the department if the electronic system is unavailable; requiring local registrars to make blank paper forms available in such instances; providing requirements for such paper records; amending s. 382.008, F.S.; conforming provisions to changes made by the act; amending s. 382.009, F.S.; revising the types of health care practitioners who may make certain determinations of death; amending ss. 382.013 and 382.015, F.S.; conforming provisions to changes made by the act; amending ss. 382.021 and 382.023, F.S.; revising the reporting requirements and the frequency with which circuit courts must transmit marriage licenses and certain dissolution-of-marriage records to the department; requiring that such records be transmitted electronically; amending s. 382.025, F.S.; extending the timeframe for the confidentiality of certain birth records; authorizing persons appointed by the department to issue certified copies of live birth, death, and fetal death certificates; amending s. 401.27, F.S.; revising requirements for applicants for certification or recertification as emergency medical technicians or paramedics; deleting a requirement that a certain certification examination be offered monthly; deleting related duties of the department; deleting a temporary certificate and related provisions; amending s. 401.2701, F.S.; exempting certain emergency medical services training program applicants from the requirement to have a certain affiliation agreement; amending s. 401.272, F.S.; revising the purpose of certain provisions; specifying requirements for the provision of specified services by paramedics and emergency medical technicians under certain

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

circumstances; revising the department's rulemaking authority; amending s. 401.34, F.S.; deleting certain provisions and fees related to the department's grading of a certain certification examination; amending s. 401.435, F.S.; revising provisions related to minimum standards for emergency medical responder training; amending s. 464.203, F.S.; exempting certain applicants for certification as a certified nursing assistant from the skills-demonstration portion of a certain competency examination; amending ss. 468.1225 and 468.1245, F.S.; revising the scope of practice for audiologists, as it relates to hearing aids to apply to prescription hearing aids only; amending s. 468.1246, F.S.; conforming provisions to changes made by the act; deleting obsolete language; amending ss. 468.1255, 468.1265, and 468.1275, F.S.; conforming provisions to changes made by the act; amending s. 484.0401, F.S.; revising legislative findings and intent to conform to changes made by the act; reordering and amending s. 484.041, F.S.; providing and revising definitions; amending s. 484.042, F.S.; revising membership requirements for members of the Board of Hearing Aid Specialists; amending s. 484.044, F.S.; revising the board's rulemaking authority; deleting obsolete language; amending ss. 484.0445, 484.045, 484.0501, and 484.051, F.S.; revising the scope of practice for hearing aid specialists and making conforming changes to licensure and practice requirements; amending s. 484.0512, F.S.; conforming provisions to changes made by the act; deleting obsolete language; amending ss. 484.0513, 484.053, and 484.054, F.S.; conforming provisions to changes made by the act; amending s. 484.059, F.S.; conforming provisions to changes made by the act; providing applicability; providing a directive to the Division of Law Revision; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Effective upon this act becoming law, section 381.875, Florida Statutes, is created to read:

381.875 Enhanced potential pandemic pathogen research prohibited.—

(1) As used in this section, the term:

(a) "Enhanced potential pandemic pathogen" means a potential pandemic pathogen that results from enhancing the transmissibility or virulence of a pathogen. The term does not include naturally occurring pathogens circulating in or recovered from nature, regardless of their pandemic potential.

(b) "Enhanced potential pandemic pathogen research" means research that may be reasonably anticipated to create, transfer, or use potential pandemic pathogens that result from enhancing a pathogen's transmissibility or virulence in humans.

(c) "Potential pandemic pathogen" means a bacterium, virus, or other microorganism that is likely to be both:

1. Highly transmissible and capable of wide, uncontrollable spread in human populations; and

2. Highly virulent, making it likely to cause significant morbidity or mortality in humans.

(2) Any research that is reasonably likely to create an enhanced potential pandemic pathogen or that has been determined by the United States Department of Health and Human Services, another federal agency, or a state agency as defined in s. 11.45 to create such a pathogen is prohibited in this state.

(3) Any researcher applying for state or local funding to conduct research in this state must disclose in the application to the funding source whether the research meets the definition of enhanced potential pandemic pathogen research.

(4) The Department of Health shall exercise its authority under s. 381.0012 to enjoin violations of this section.

(5) This section does not affect research funded or conducted before the effective date of this act.

Section 2. Present paragraphs (a) through (o) of subsection (1) of section 381.986, Florida Statutes, are redesignated as paragraphs (b) through (p), respectively, a new paragraph (a) is added to that subsection, and paragraphs (a) and (c) of subsection (3), paragraphs (e) and (h) of subsection (8), and subsection (9) of that section are amended, to read:

381.986 Medical use of marijuana.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Attractive to children" means the use of any image or words designed or likely to appeal to persons younger than 18 years of age, including, but not limited to, cartoons, toys, animals, food, or depictions of persons younger than 18 years of age; any other likeness to images, characters, or phrases that are popularly used to advertise to persons younger than 18 years of age; or any reasonable likeness to commercially available candy.

(3) QUALIFIED PHYSICIANS AND MEDICAL DIRECTORS.—

(a) Before being approved as a qualified physician~~, as defined in paragraph (1)(m),~~ and before each license renewal, a physician must successfully complete a 2-hour course and subsequent examination offered by the Florida Medical Association or the Florida Osteopathic Medical Association which encompass the requirements of this section and any rules adopted hereunder. The course and examination must ~~shall~~ be administered at least annually and may be offered in a distance learning format, including an electronic, online format that is available upon request. The price of the course may not exceed $500. A physician who has met the physician

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

education requirements of former s. 381.986(4), Florida Statutes 2016, before June 23, 2017, shall be deemed to be in compliance with this paragraph from June 23, 2017, until 90 days after the course and examination required by this paragraph become available.

(c) Before being employed as a medical director~~, as defined in paragraph (1)(i),~~ and before each license renewal, a medical director must successfully complete a 2-hour course and subsequent examination offered by the Florida Medical Association or the Florida Osteopathic Medical Association which encompass the requirements of this section and any rules adopted hereunder. The course and examination must ~~shall~~ be administered at least annually and may be offered in a distance learning format, including an electronic, online format that is available upon request. The price of the course may not exceed $500.

(8) MEDICAL MARIJUANA TREATMENT CENTERS.—

(e) A licensed medical marijuana treatment center shall cultivate, process, transport, and dispense marijuana for medical use. A licensed medical marijuana treatment center may not contract for services directly related to the cultivation, processing, and dispensing of marijuana or marijuana delivery devices, except that a medical marijuana treatment center licensed pursuant to subparagraph (a)1. may contract with a single entity for the cultivation, processing, transporting, and dispensing of marijuana and marijuana delivery devices. A licensed medical marijuana treatment center must, at all times, maintain compliance with the criteria demonstrated and representations made in the initial application and the criteria established in this subsection. Upon request, the department may grant a medical marijuana treatment center a variance from the representations made in the initial application. Consideration of such a request shall be based upon the individual facts and circumstances surrounding the request. A variance may not be granted unless the requesting medical marijuana treatment center can demonstrate to the department that it has a proposed alternative to the specific representation made in its application which fulfills the same or a similar purpose as the specific representation in a way that the department can reasonably determine will not be a lower standard than the specific representation in the application. A variance may not be granted from the requirements in subparagraph 2. and subparagraphs (b)1. and 2.

1. A licensed medical marijuana treatment center may transfer ownership to an individual or entity who meets the requirements of this section. A publicly traded corporation or publicly traded company that meets the requirements of this section is not precluded from ownership of a medical marijuana treatment center. To accommodate a change in ownership:

a. The licensed medical marijuana treatment center shall notify the department in writing at least 60 days before the anticipated date of the change of ownership.

b. The individual or entity applying for initial licensure due to a change of ownership must submit an application that must be received by the department at least 60 days before the date of change of ownership.

c. Upon receipt of an application for a license, the department shall examine the application and, within 30 days after receipt, notify the applicant in writing of any apparent errors or omissions and request any additional information required.

d. Requested information omitted from an application for licensure must be filed with the department within 21 days after the department's request for omitted information or the application shall be deemed incomplete and shall be withdrawn from further consideration and the fees shall be forfeited.

e. Within 30 days after the receipt of a complete application, the department shall approve or deny the application.

2. A medical marijuana treatment center, and any individual or entity who directly or indirectly owns, controls, or holds with power to vote 5 percent or more of the voting shares of a medical marijuana treatment center, may not acquire direct or indirect ownership or control of any voting shares or other form of ownership of any other medical marijuana treatment center.

3. A medical marijuana treatment center may not enter into any form of profit-sharing arrangement with the property owner or lessor of any of its facilities where cultivation, processing, storing, or dispensing of marijuana and marijuana delivery devices occurs.

4. All employees of a medical marijuana treatment center must be 21 years of age or older and have passed a background screening pursuant to subsection (9).

5. Each medical marijuana treatment center must adopt and enforce policies and procedures to ensure employees and volunteers receive training on the legal requirements to dispense marijuana to qualified patients.

6. When growing marijuana, a medical marijuana treatment center:

a. May use pesticides determined by the department, after consultation with the Department of Agriculture and Consumer Services, to be safely applied to plants intended for human consumption, but may not use pesticides designated as restricted-use pesticides pursuant to s. 487.042.

b. Must grow marijuana within an enclosed structure and in a room separate from any other plant.

c. Must inspect seeds and growing plants for plant pests that endanger or threaten the horticultural and agricultural interests of the state in accordance with chapter 581 and any rules adopted thereunder.

d. Must perform fumigation or treatment of plants, or remove and destroy infested or infected plants, in accordance with chapter 581 and any rules adopted thereunder.

7. Each medical marijuana treatment center must produce and make available for purchase at least one low-THC cannabis product.

8. A medical marijuana treatment center that produces edibles must hold a permit to operate as a food establishment pursuant to chapter 500, the Florida Food Safety Act, and must comply with all the requirements for food establishments pursuant to chapter 500 and any rules adopted thereunder. Edibles may not contain more than 200 milligrams of tetrahydrocannabinol, and a single serving portion of an edible may not exceed 10 milligrams of tetrahydrocannabinol. Edibles may have a potency variance of no greater than 15 percent. Marijuana products, including edibles~~,~~ may not be attractive to children; be manufactured in the shape of humans, cartoons, or animals; be manufactured in a form that bears any reasonable resemblance to products available for consumption as commercially available candy; or contain any color additives. To discourage consumption of edibles by children, the department shall determine by rule any shapes, forms, and ingredients allowed and prohibited for edibles. Medical marijuana treatment centers may not begin processing or dispensing edibles until after the effective date of the rule. The department shall also adopt sanitation rules providing the standards and requirements for the storage, display, or dispensing of edibles.

9. Within 12 months after licensure, a medical marijuana treatment center must demonstrate to the department that all of its processing facilities have passed a Food Safety Good Manufacturing Practices, such as Global Food Safety Initiative or equivalent, inspection by a nationally accredited certifying body. A medical marijuana treatment center must immediately stop processing at any facility which fails to pass this inspection until it demonstrates to the department that such facility has met this requirement.

10. A medical marijuana treatment center that produces prerolled marijuana cigarettes may not use wrapping paper made with tobacco or hemp.

11. When processing marijuana, a medical marijuana treatment center must:

a. Process the marijuana within an enclosed structure and in a room separate from other plants or products.

b. Comply with department rules when processing marijuana with hydrocarbon solvents or other solvents or gases exhibiting potential toxicity to humans. The department shall determine by rule the requirements for medical marijuana treatment centers to use such solvents or gases exhibiting potential toxicity to humans.

c. Comply with federal and state laws and regulations and department rules for solid and liquid wastes. The department shall determine by rule procedures for the storage, handling, transportation, management, and disposal of solid and liquid waste generated during marijuana production and processing. The Department of Environmental Protection shall assist the department in developing such rules.

d. Test the processed marijuana using a medical marijuana testing laboratory before it is dispensed. Results must be verified and signed by two medical marijuana treatment center employees. Before dispensing, the medical marijuana treatment center must determine that the test results indicate that low-THC cannabis meets the definition of low-THC cannabis, the concentration of tetrahydrocannabinol meets the potency requirements of this section, the labeling of the concentration of tetrahydrocannabinol and cannabidiol is accurate, and all marijuana is safe for human consumption and free from contaminants that are unsafe for human consumption. The department shall determine by rule which contaminants must be tested for and the maximum levels of each contaminant which are safe for human consumption. The Department of Agriculture and Consumer Services shall assist the department in developing the testing requirements for contaminants that are unsafe for human consumption in edibles. The department shall also determine by rule the procedures for the treatment of marijuana that fails to meet the testing requirements of this section, s. 381.988, or department rule. The department may select samples of marijuana from a medical marijuana treatment center facility which shall be tested by the department to determine whether the marijuana meets the potency requirements of this section, is safe for human consumption, and is accurately labeled with the tetrahydrocannabinol and cannabidiol concentration or to verify the result of marijuana testing conducted by a marijuana testing laboratory. The department may also select samples of marijuana delivery devices from a medical marijuana treatment center to determine whether the marijuana delivery device is safe for use by qualified patients. A medical marijuana treatment center may not require payment from the department for the sample. A medical marijuana treatment center must recall marijuana, including all marijuana and marijuana products made from the same batch of marijuana, that fails to meet the potency requirements of this section, that is unsafe for human consumption, or for which the labeling of the tetrahydrocannabinol and cannabidiol concentration is inaccurate. The department shall adopt rules to establish marijuana potency variations of no greater than 15 percent using negotiated rulemaking pursuant to s. 120.54(2)(d) which accounts for, but is not limited to, time lapses between testing, testing methods, testing instruments, and types of marijuana sampled for testing. The department may not issue any recalls for product potency as it relates to product labeling before issuing a rule relating to potency variation standards. A medical marijuana treatment center must also recall all marijuana delivery devices determined to be unsafe for use by qualified patients. The medical marijuana treatment center must retain records of all testing and samples of each homogenous batch of marijuana for at least 9 months. The medical marijuana treatment center must contract

with a marijuana testing laboratory to perform audits on the medical marijuana treatment center's standard operating procedures, testing records, and samples and provide the results to the department to confirm that the marijuana or low-THC cannabis meets the requirements of this section and that the marijuana or low-THC cannabis is safe for human consumption. A medical marijuana treatment center shall reserve two processed samples from each batch and retain such samples for at least 9 months for the purpose of such audits. A medical marijuana treatment center may use a laboratory that has not been certified by the department under s. 381.988 until such time as at least one laboratory holds the required certification, but in no event later than July 1, 2018.

e. Package the marijuana in compliance with the United States Poison Prevention Packaging Act of 1970, 15 U.S.C. ss. 1471 et seq.

f. Package the marijuana in a receptacle that has a firmly affixed and legible label stating the following information:

(I) The marijuana or low-THC cannabis meets the requirements of sub-subparagraph d.

(II) The name of the medical marijuana treatment center from which the marijuana originates.

(III) The batch number and harvest number from which the marijuana originates and the date dispensed.

(IV) The name of the physician who issued the physician certification.

(V) The name of the patient.

(VI) The product name, if applicable, and dosage form, including concentration of tetrahydrocannabinol and cannabidiol. The product name may not contain wording commonly associated with products that are attractive to children or which promote the recreational use of marijuana ~~marketed by or to children~~.

(VII) The recommended dose.

(VIII) A warning that it is illegal to transfer medical marijuana to another person.

(IX) A marijuana universal symbol developed by the department.

12. The medical marijuana treatment center shall include in each package a patient package insert with information on the specific product dispensed related to:

a. Clinical pharmacology.

b. Indications and use.

c. Dosage and administration.

d. Dosage forms and strengths.

e. Contraindications.

f. Warnings and precautions.

g. Adverse reactions.

13. In addition to the packaging and labeling requirements specified in subparagraphs 11. and 12., marijuana in a form for smoking must be packaged in a sealed receptacle with a legible and prominent warning to keep away from children and a warning that states marijuana smoke contains carcinogens and may negatively affect health. Such receptacles for marijuana in a form for smoking must be plain, opaque, and white without depictions of the product or images other than the medical marijuana treatment center's department-approved logo and the marijuana universal symbol.

14. The department shall adopt rules to regulate the types, appearance, and labeling of marijuana delivery devices dispensed from a medical marijuana treatment center. The rules must require marijuana delivery devices to have an appearance consistent with medical use.

15. Each edible must ~~shall~~ be individually sealed in plain, opaque wrapping marked only with the marijuana universal symbol. Where practical, each edible must ~~shall~~ be marked with the marijuana universal symbol. In addition to the packaging and labeling requirements in subparagraphs 11. and 12., edible receptacles must be plain, opaque, and white without depictions of the product or images other than the medical marijuana treatment center's department-approved logo and the marijuana universal symbol. The receptacle must also include a list of all the edible's ingredients, storage instructions, an expiration date, a legible and prominent warning to keep away from children and pets, and a warning that the edible has not been produced or inspected pursuant to federal food safety laws.

16. When dispensing marijuana or a marijuana delivery device, a medical marijuana treatment center:

a. May dispense any active, valid order for low-THC cannabis, medical cannabis and cannabis delivery devices issued pursuant to former s. 381.986, Florida Statutes 2016, which was entered into the medical marijuana use registry before July 1, 2017.

b. May not dispense more than a 70-day supply of marijuana within any 70-day period to a qualified patient or caregiver. May not dispense more than one 35-day supply of marijuana in a form for smoking within any 35-day period to a qualified patient or caregiver. A 35-day supply of marijuana

in a form for smoking may not exceed 2.5 ounces unless an exception to this amount is approved by the department pursuant to paragraph (4)(f).

c. Must have the medical marijuana treatment center's employee who dispenses the marijuana or a marijuana delivery device enter into the medical marijuana use registry his or her name or unique employee identifier.

d. Must verify that the qualified patient and the caregiver, if applicable, each have an active registration in the medical marijuana use registry and an active and valid medical marijuana use registry identification card, the amount and type of marijuana dispensed matches the physician certification in the medical marijuana use registry for that qualified patient, and the physician certification has not already been filled.

e. May not dispense marijuana to a qualified patient who is younger than 18 years of age. If the qualified patient is younger than 18 years of age, marijuana may only be dispensed to the qualified patient's caregiver.

f. May not dispense or sell any other type of cannabis, alcohol, or illicit drug-related product, including pipes or wrapping papers made with tobacco or hemp, other than a marijuana delivery device required for the medical use of marijuana and which is specified in a physician certification.

g. Must, upon dispensing the marijuana or marijuana delivery device, record in the registry the date, time, quantity, and form of marijuana dispensed; the type of marijuana delivery device dispensed; and the name and medical marijuana use registry identification number of the qualified patient or caregiver to whom the marijuana delivery device was dispensed.

h. Must ensure that patient records are not visible to anyone other than the qualified patient, his or her caregiver, and authorized medical marijuana treatment center employees.

(h) A medical marijuana treatment center may not engage in advertising that is visible to members of the public from any street, sidewalk, park, or other public place, except:

1. The dispensing location of a medical marijuana treatment center may have a sign that is affixed to the outside or hanging in the window of the premises which identifies the dispensary by the licensee's business name, a department-approved trade name, or a department-approved logo. A medical marijuana treatment center's trade name and logo may not contain wording or images that are attractive to children ~~commonly associated with marketing targeted toward children~~ or which promote recreational use of marijuana.

2. A medical marijuana treatment center may engage in Internet advertising and marketing under the following conditions:

a. All advertisements must be approved by the department.

b. An advertisement may not have any content that is attractive to children or which promotes the recreational use of marijuana ~~specifically targets individuals under the age of 18, including cartoon characters or similar images~~.

c. An advertisement may not be an unsolicited pop-up advertisement.

d. Opt-in marketing must include an easy and permanent opt-out feature.

(9) BACKGROUND SCREENING.—An individual required to undergo a background screening pursuant to this section must pass a level 2 background screening as provided under chapter 435, which, in addition to the disqualifying offenses provided in s. 435.04, shall exclude an individual who has an arrest awaiting final disposition for, has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to an offense under chapter 837, chapter 895, or chapter 896 or similar law of another jurisdiction. Exemptions from disqualification as provided under s. 435.07 do not apply to this subsection.

(a) Such individual must submit a full set of fingerprints to the department or to a vendor, entity, or agency authorized by s. 943.053(13). The department, vendor, entity, or agency shall forward the fingerprints to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for national processing.

(b) Fees for state and federal fingerprint processing and retention shall be borne by the medical marijuana treatment center or caregiver, as applicable ~~individual~~. The state cost for fingerprint processing shall be as provided in s. 943.053(3)(e) for records provided to persons or entities other than those specified as exceptions therein.

(c) Fingerprints submitted to the Department of Law Enforcement pursuant to this subsection shall be retained by the Department of Law Enforcement as provided in s. 943.05(2)(g) and (h) and, when the Department of Law Enforcement begins participation in the program, enrolled in the Federal Bureau of Investigation's national retained print arrest notification program. Any arrest record identified shall be reported to the department.

Section 3. Paragraph (d) of subsection (1) of section 381.988, Florida Statutes, is amended to read:

381.988 Medical marijuana testing laboratories; marijuana tests conducted by a certified laboratory.—

(1) A person or entity seeking to be a certified marijuana testing laboratory must:

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

(d) Require all employees, owners, and managers to submit to and pass a level 2 background screening pursuant to chapter 435. The department ~~s. 435.04 and~~ shall deny certification if the person or entity seeking certification has a disqualifying offense as provided in s. 435.04 or has an arrest awaiting final disposition for, has been found guilty of, or has entered a plea of guilty or nolo contendere to, regardless of adjudication, any offense listed in chapter 837, chapter 895, or chapter 896 or similar law of another jurisdiction. Exemptions from disqualification as provided under s. 435.07 do not apply to this paragraph.

1. Such employees, owners, and managers must submit a full set of fingerprints to the department or to a vendor, entity, or agency authorized by s. 943.053(13). The department, vendor, entity, or agency shall forward the fingerprints to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for national processing.

2. Fees for state and federal fingerprint processing and retention shall be borne by the certified marijuana testing laboratory ~~such owners or managers~~. The state cost for fingerprint processing shall be as provided in s. 943.053(3)(e) for records provided to persons or entities other than those specified as exceptions therein.

3. Fingerprints submitted to the Department of Law Enforcement pursuant to this paragraph shall be retained by the Department of Law Enforcement as provided in s. 943.05(2)(g) and (h) and, when the Department of Law Enforcement begins participation in the program, enrolled in the Federal Bureau of Investigation's national retained print arrest notification program. Any arrest record identified shall be reported to the department.

Section 4. Section 382.005, Florida Statutes, is amended to read:

382.005 Duties of local registrars.—

(1) Each local registrar is charged with the strict and thorough enforcement of the provisions of this chapter and rules adopted hereunder in his or her registration district, and shall make an immediate report to the department of any violation or apparent violation of this law or rules adopted hereunder.

(2) Each local registrar must electronically file all live birth, death, and fetal death records within their respective jurisdictions in the department's electronic registration system. If the department's electronic registration system is unavailable, the local registrar must file a paper record with the department.

(3) Each local registrar must ~~shall~~ make ~~available~~ blank forms available if the department's electronic registration system is unavailable, ~~as necessary~~ and must ~~shall~~ examine each paper certificate of live birth,

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

death, or fetal death when presented for registration in order to ascertain whether ~~or not~~ it has been completed in accordance with ~~the provisions of~~ this chapter and adopted rules. All <u>paper</u> birth, death, and fetal death certificates <u>must</u> ~~shall~~ be typewritten in permanent black ink, and a <u>paper</u> certificate is not complete and correct if it does not supply each item of information called for or satisfactorily account for its omission.

<u>(4)</u>~~(3)~~ The local registrar or his or her deputy, if authorized by the department, shall sign as registrar in attestation of the date of registration <u>of any paper records filed,</u> and may also make and preserve a local <u>paper</u> record of each birth, death, and fetal death certificate registered by him or her, in such manner as directed by the department. The local registrar shall transmit daily to the department all original <u>paper</u> certificates registered. If no births, deaths, or fetal deaths occurred in any month, the local registrar or deputy shall, on the 7th day of the following month, report that fact to the department on a form provided for such purpose.

<u>(5)</u>~~(4)~~ Each local registrar, immediately upon appointment, shall designate one or more deputy registrars to act on behalf of the local registrar.

Section 5. Subsection (2) of section 382.008, Florida Statutes, is amended to read:

382.008 Death, fetal death, and nonviable birth registration.—

(2)(a) The funeral director who first assumes custody of a dead body or fetus shall <u>electronically</u> file the certificate of death or fetal death. In the absence of the funeral director, the physician, physician assistant, advanced practice registered nurse registered under s. 464.0123, or other person in attendance at or after the death or the district medical examiner of the county in which the death occurred or the body was found shall <u>electronically</u> file the certificate of death or fetal death. The person who files the certificate shall obtain personal data from a legally authorized person as described in s. 497.005 or the best qualified person or source available. The medical certification of cause of death <u>must</u> ~~shall~~ be furnished to the funeral director, either in person or via certified mail or electronic transfer, by the physician, physician assistant, advanced practice registered nurse registered under s. 464.0123, or medical examiner responsible for furnishing such information. For fetal deaths, the physician, physician assistant, advanced practice registered nurse registered under s. 464.0123, midwife, or hospital administrator shall provide any medical or health information to the funeral director within 72 hours after expulsion or extraction.

(b) The State Registrar <u>shall</u> ~~may~~ receive electronically a certificate of death, fetal death, or nonviable birth which is required to be filed with the registrar under this chapter through facsimile or other electronic transfer for the purpose of filing the certificate. The receipt of a certificate of death, fetal death, or nonviable birth by electronic transfer constitutes delivery to the State Registrar as required by law.

Section 6. Subsection (2) of section 382.009, Florida Statutes, is amended to read:

382.009 Recognition of brain death under certain circumstances.—

(2) Determination of death pursuant to this section must ~~shall~~ be made in accordance with currently accepted reasonable medical standards.

(a) If the patient's treating health care practitioner is a physician licensed under chapter 458 or chapter 459, the determination must be made by that physician and a second physician ~~two physicians~~ licensed under chapter 458 or chapter 459 who is~~. One physician shall be the treating physician, and the other physician shall be~~ a board-eligible or board-certified neurologist, neurosurgeon, internist, family medicine physician, pediatrician, surgeon, or anesthesiologist.

(b) If the patient's treating health care practitioner is an autonomous advanced practice registered nurse registered under s. 464.0123, the determination must be made by that practitioner and two physicians licensed under chapter 458 or chapter 459. Each physician must be a board-eligible or board-certified neurologist, neurosurgeon, internist, family medicine physician, pediatrician, surgeon, or anesthesiologist.

Section 7. Section 382.013, Florida Statutes, is amended to read:

382.013 Birth registration.—A certificate for each live birth that occurs in this state shall be filed within 5 days after such birth in the department's electronic registration system with the local registrar of the district in which the birth occurred and shall be registered by the local registrar if the certificate has been completed and filed in accordance with this chapter and adopted rules. The information regarding registered births shall be used for comparison with information in the state case registry, as defined in chapter 61.

(1) FILING.—

(a) If a birth occurs in a hospital, birth center, or other health care facility, or en route thereto, the person in charge of the facility is ~~shall be~~ responsible for preparing the certificate, certifying the facts of the birth, and filing the certificate in the department's electronic registration system with the local registrar. Within 48 hours after the birth, the physician, midwife, or person in attendance during or immediately after the delivery shall provide the facility with the medical information required by the birth certificate.

(b) If a birth occurs outside a facility and a physician licensed in this state, a certified nurse midwife, a midwife licensed in this state, or a public health nurse employed by the department was in attendance during or immediately after the delivery, that person shall prepare and file the certificate.

(c) If a birth occurs outside a facility and the delivery is not attended by one of the persons described in paragraph (b), the person in attendance, the mother, or the father shall report the birth to the registrar and provide proof of the facts of birth. The department may require such documents to be presented and such proof to be filed as it deems necessary and sufficient to establish the truth of the facts to be recorded by the certificate and may withhold registering the birth until its requirements are met.

(d) If a birth occurs in a moving conveyance and the child is first removed from the conveyance in this state, the birth shall be filed and registered in this state and the place to which the child is first removed shall be considered the place of birth.

(e) The mother or the father of the child shall attest to the accuracy of the personal data entered on the certificate in time to permit the timely registration of the certificate.

(f) If a certificate of live birth is incomplete, the local registrar shall immediately notify the health care facility or person filing the certificate and shall require the completion of the missing items of information if they can be obtained before ~~prior to~~ issuing certified copies of the birth certificate.

(g) Regardless of any plan to place a child for adoption after birth, the information on the birth certificate as required by this section must be as to the child's birth parents unless and until an application for a new birth record is made under s. 63.152.

(h) The State Registrar may receive electronically a birth certificate for each live birth which is required to be filed with the registrar under this chapter through facsimile or other electronic transfer for the purpose of filing the birth certificate. The receipt of a birth certificate by electronic transfer constitutes delivery to the State Registrar as required by law.

(2) PATERNITY.—

(a) If the mother is married at the time of birth, the name of the husband shall be entered on the birth certificate as the father of the child, unless paternity has been determined otherwise by a court of competent jurisdiction.

(b) Notwithstanding paragraph (a), if the husband of the mother dies while the mother is pregnant but before the birth of the child, the name of the deceased husband shall be entered on the birth certificate as the father of the child, unless paternity has been determined otherwise by a court of competent jurisdiction.

(c) If the mother is not married at the time of the birth, the name of the father may not be entered on the birth certificate without the execution of an affidavit signed by both the mother and the person to be named as the father. The facility shall give notice orally or through the use of video or audio equipment, and in writing, of the alternatives to, the legal consequences of,

and the rights, including, if one parent is a minor, any rights afforded due to minority status, and responsibilities that arise from signing an acknowledgment of paternity, as well as information provided by the Title IV-D agency established pursuant to s. 409.2557, regarding the benefits of voluntary establishment of paternity. Upon request of the mother and the person to be named as the father, the facility shall assist in the execution of the affidavit, a notarized voluntary acknowledgment of paternity, or a voluntary acknowledgment of paternity that is witnessed by two individuals and signed under penalty of perjury as specified by s. 92.525(2).

(d) If the paternity of the child is determined by a court of competent jurisdiction as provided under s. 382.015 or there is a final judgment of dissolution of marriage which requires the former husband to pay child support for the child, the name of the father and the surname of the child shall be entered on the certificate in accordance with the finding and order of the court. If the court fails to specify a surname for the child, the surname shall be entered in accordance with subsection (3).

(e) If the paternity of the child is determined pursuant to s. 409.256, the name of the father and the surname of the child shall be entered on the certificate in accordance with the finding and order of the Department of Revenue.

(f) If the mother and father marry each other at any time after the child's birth, upon receipt of a marriage license that identifies any such child, the department shall amend the certificate with regard to the parents' marital status as though the parents were married at the time of birth.

(g) If the father is not named on the certificate, no other information about the father shall be entered on the certificate.

(3) NAME OF CHILD.—

(a) If the mother is married at the time of birth, the mother and father whose names are entered on the birth certificate shall select the given names and surname of the child if both parents have custody of the child, otherwise the parent who has custody shall select the child's name.

(b) If the mother and father whose names are entered on the birth certificate disagree on the surname of the child and both parents have custody of the child, the surname selected by the father and the surname selected by the mother shall both be entered on the birth certificate, separated by a hyphen, with the selected names entered in alphabetical order. If the parents disagree on the selection of a given name, the given name may not be entered on the certificate until a joint agreement that lists the agreed upon given name and is notarized by both parents is submitted to the department, or until a given name is selected by a court.

(c) If the mother is not married at the time of birth, the parent who will have custody of the child shall select the child's given name and surname.

(d) If multiple names of the child exceed the space provided on the face of the birth certificate they shall be listed on the back of the certificate. Names listed on the back of the certificate shall be part of the official record.

(4) UNDETERMINED PARENTAGE.—The person having custody of a child of undetermined parentage shall register a birth certificate showing all known or approximate facts relating to the birth. To assist in later determination, information concerning the place and circumstances under which the child was found shall be included on the portion of the birth certificate relating to marital status and medical details. In the event the child is later identified, a new birth certificate shall be prepared which shall bear the same number as the original birth certificate, and the original certificate shall be sealed and filed, shall be confidential and exempt from the provisions of s. 119.07(1), and shall not be opened to inspection by, nor shall certified copies of the same be issued except by court order to, any person other than the registrant if of legal age.

(5) DISCLOSURE.—The original certificate of live birth shall contain all the information required by the department for legal, social, and health research purposes. However, all information concerning parentage, marital status, and medical details shall be confidential and exempt from the provisions of s. 119.07(1), except for health research purposes as approved by the department, nor shall copies of the same be issued except as provided in s. 382.025.

Section 8. Section 382.015, Florida Statutes, is amended to read:

382.015 New certificates of live birth; duty of clerks of court and department.—The clerk of the court in which any proceeding for adoption, annulment of an adoption, affirmation of parental status, or determination of paternity is to be registered, shall within 30 days after the final disposition, forward electronically to the department a certified copy of the court order, or a report of the proceedings upon a form to be furnished by the department, together with sufficient information to identify the original birth certificate and to enable the preparation of a new birth certificate. The clerk of the court shall implement a monitoring and quality control plan to ensure that all judicial determinations of paternity are reported to the department in compliance with this section. The department shall track paternity determinations reported monthly by county, monitor compliance with the 30-day timeframe, and report the data to the clerks of the court quarterly.

(1) ADOPTION AND ANNULMENT OF ADOPTION.—

(a) Upon receipt of the report or certified copy of an adoption decree, together with the information necessary to identify the original certificate of live birth, and establish a new certificate, the department shall prepare and file a new birth certificate, absent objection by the court decreeing the adoption, the adoptive parents, or the adoptee if of legal age. The certificate shall bear the same file number as the original birth certificate. All names

and identifying information relating to the adoptive parents entered on the new certificate shall refer to the adoptive parents, but nothing in the certificate shall refer to or designate the parents as being adoptive. All other items not affected by adoption shall be copied as on the original certificate, including the date of registration and filing.

(b) Upon receipt of the report or certified copy of an annulment-of-adoption decree, together with the sufficient information to identify the original certificate of live birth, the department shall, if a new certificate of birth was filed following an adoption report or decree, remove the new certificate and restore the original certificate to its original place in the files, and the certificate so removed shall be sealed by the department.

(c) Upon receipt of a report or certified copy of an adoption decree or annulment-of-adoption decree for a person born in another state, the department shall forward the report or decree to the state of the registrant's birth. If the adoptee was born in Canada, the department shall send a copy of the report or decree to the appropriate birth registration authority in Canada.

(2) DETERMINATION OF PATERNITY.—Upon receipt of the report, a certified copy of a final decree of determination of paternity, or a certified copy of a final judgment of dissolution of marriage which requires the former husband to pay child support for the child, together with sufficient information to identify the original certificate of live birth, the department shall prepare and file a new birth certificate, which shall bear the same file number as the original birth certificate. The registrant's name shall be entered as decreed by the court or as reflected in the final judgment or support order. The names and identifying information of the parents shall be entered as of the date of the registrant's birth.

(3) AFFIRMATION OF PARENTAL STATUS.—Upon receipt of an order of affirmation of parental status issued pursuant to s. 742.16, together with sufficient information to identify the original certificate of live birth, the department shall prepare and file a new birth certificate which shall bear the same file number as the original birth certificate. The names and identifying information of the registrant's parents entered on the new certificate shall be the commissioning couple, but the new certificate may not make reference to or designate the parents as the commissioning couple.

(4) SUBSTITUTION OF NEW CERTIFICATE OF BIRTH FOR ORIGINAL.—When a new certificate of birth is prepared, the department shall substitute the new certificate of birth for the original certificate on file. All copies of the original certificate of live birth in the custody of a local registrar or other state custodian of vital records shall be forwarded to the State Registrar. Thereafter, when a certified copy of the certificate of birth or portion thereof is issued, it shall be a copy of the new certificate of birth or portion thereof, except when a court order requires issuance of a certified copy of the original certificate of birth. In an adoption, change in paternity, affirmation of parental status, undetermined parentage, or court-ordered

substitution, the department shall place the original certificate of birth and all papers pertaining thereto under seal, not to be broken except by order of a court of competent jurisdiction or as otherwise provided by law.

(5) FORM.—Except for certificates of foreign birth which are registered as provided in s. 382.017, and delayed certificates of birth which are registered as provided in ss. 382.019 and 382.0195, all original, new, or amended certificates of live birth shall be identical in form, regardless of the marital status of the parents or the fact that the registrant is adopted or of undetermined parentage.

(6) RULES.—The department shall adopt and enforce all rules necessary for carrying out the provisions of this section.

Section 9. Section 382.021, Florida Statutes, is amended to read:

382.021 Department to receive marriage licenses.~~—On or before the 5th day of each month,~~

(1) The county court judge or clerk of the circuit court shall electronically transmit all original marriage licenses, with endorsements, received ~~during the preceding calendar month,~~ to the department on one of the following reporting schedules:

(a) Weekly, on or before each Friday, all original marriage licenses, with endorsements, received during the preceding calendar week.

(b) Monthly, on or before the 5th day of each month, all original marriage licenses, with endorsements, received during the preceding calendar month.

(2) Any marriage licenses issued and not returned or any marriage licenses returned but not recorded must ~~shall~~ be reported by the issuing county court judge or clerk of the circuit court to the department at the time of transmitting the recorded licenses on the forms to be prescribed and furnished by the department. If~~,~~ during any reporting schedule, the county court judge or clerk of the circuit court does not issue or does not receive a returned marriage license ~~month no marriage licenses are issued or returned~~, the county court judge or clerk of the circuit court must ~~shall~~ report such fact to the department upon forms prescribed and furnished by the department in accordance with the selected reporting schedule.

Section 10. Section 382.023, Florida Statutes, is amended to read:

382.023 Department to receive dissolution-of-marriage records; fees.—

(1) Clerks of the circuit courts shall collect for their services at the time of the filing of a final judgment of dissolution of marriage a fee of up to $10.50, of which 43 percent shall be retained by the clerk of the circuit court as a part of the cost in the cause in which the judgment is granted. The remaining 57 percent shall be remitted to the Department of Revenue for deposit to the

Department of Health to defray part of the cost of maintaining the dissolution-of-marriage records.

<u>(2) The clerk of the circuit court shall electronically transmit to the department</u> a record of each ~~and every~~ judgment of dissolution of marriage granted by the court<u>, including the names of the parties and such other data as required by forms prescribed by the department, on one of the following reporting schedules:</u>

<u>(a) Weekly, on or before each Friday, all final judgments of dissolution of marriage granted during the preceding calendar week, along with an accounting of the funds remitted to the Department of Revenue pursuant to this section.</u>

<u>(b) Monthly, on or before the 10th day of each month, all final judgments of dissolution of marriage granted</u> during the preceding calendar month, ~~giving names of parties and such other data as required by forms prescribed by the department, shall be transmitted to the department, on or before the 10th day of each month,~~ along with an accounting of the funds remitted to the Department of Revenue pursuant to this section.

<u>(3) If, during any reporting schedule, there are no final judgments of dissolution of marriage granted, the clerk of the circuit court must report such fact to the department upon forms prescribed and furnished by the department in accordance with the selected reporting schedule.</u>

Section 11. Subsections (1) and (4) of section 382.025, Florida Statutes, are amended to read:

382.025 Certified copies of vital records; confidentiality; research.—

(1) BIRTH RECORDS.—Except for birth records over <u>125</u> ~~100~~ years old which are not under seal pursuant to court order, all birth records of this state shall be confidential and are exempt from the provisions of s. 119.07(1).

(a) Certified copies of the original birth certificate or a new or amended certificate, or affidavits thereof, are confidential and exempt from the provisions of s. 119.07(1) and, upon receipt of a request and payment of the fee prescribed in s. 382.0255, shall be issued only as authorized by the department and in the form prescribed by the department, and only:

1. To the registrant, if the registrant is of legal age, is a certified homeless youth, or is a minor who has had the disabilities of nonage removed under s. 743.01 or s. 743.015;

2. To the registrant's parent or guardian or other legal representative;

3. Upon receipt of the registrant's death certificate, to the registrant's spouse or to the registrant's child, grandchild, or sibling, if of legal age, or to the legal representative of any ~~of~~ such <u>person</u> ~~persons~~;

4. To any person if the birth record is more than 125 ~~over 100~~ years old and not under seal pursuant to court order;

5. To a law enforcement agency for official purposes;

6. To any agency of the state or the United States for official purposes upon approval of the department; or

7. Upon order of any court of competent jurisdiction.

(b) To protect the integrity of vital records and prevent the fraudulent use of the birth certificates of deceased persons, the department shall match birth and death certificates and post the fact of death to the appropriate birth certificate. Except for a commemorative birth certificate, any certification of a birth certificate of a deceased registrant shall be marked "deceased." In the case of a commemorative birth certificate, such indication of death shall be made on the back of the certificate.

(c) The department shall issue, upon request and upon payment of an additional fee as prescribed under s. 382.0255, a commemorative birth certificate representing that the birth of the person named thereon is recorded in the office of the registrar. The certificate issued under this paragraph shall be in a form consistent with the need to protect the integrity of vital records but shall be suitable for display. It may bear the seal of the state printed thereon and may be signed by the Governor.

(4) CERTIFIED COPIES OF ORIGINAL CERTIFICATES.—Only the state registrar, ~~and~~ local registrars, and those persons appointed by the department are authorized to issue any certificate which purports to be a certified copy of an original certificate of live birth, death, or fetal death. Except as provided in this section, preparing or issuing certificates is exempt from the provisions of s. 119.07(1).

Section 12. Subsections (3), (4), and (5) of section 401.27, Florida Statutes, are amended to read:

401.27 Personnel; standards and certification.—

(3) Any person who desires to be certified or recertified as an emergency medical technician or paramedic must apply to the department ~~under oath~~ on forms provided by the department which shall contain such information as the department reasonably requires, which may include affirmative evidence of ability to comply with applicable laws and rules. The department shall determine whether the applicant meets the requirements specified in this section and in rules of the department and shall issue a certificate to any person who meets such requirements.

(4) An applicant for certification or recertification as an emergency medical technician or paramedic must:

(a) Have completed an appropriate training program as follows:

1. For an emergency medical technician, an emergency medical technician training program approved by the department as equivalent to the most recent EMT-Basic National Standard Curriculum or the National EMS Education Standards of the United States Department of Transportation;

2. For a paramedic, a paramedic training program approved by the department as equivalent to the most recent EMT-Paramedic National Standard Curriculum or the National EMS Education Standards of the United States Department of Transportation;

(b) <u>Attest</u> ~~Certify under oath~~ that he or she is not addicted to alcohol or any controlled substance;

(c) <u>Attest</u> ~~Certify under oath~~ that he or she is free from any physical or mental defect or disease that might impair the applicant's ability to perform his or her duties;

(d) Within 2 years after program completion have passed an examination developed or required by the department;

(e)1. For an emergency medical technician, hold a current American Heart Association cardiopulmonary resuscitation course card or an American Red Cross cardiopulmonary resuscitation course card or its equivalent as defined by department rule;

2. For a paramedic, hold a certificate of successful course completion in advanced cardiac life support from the American Heart Association or its equivalent as defined by department rule;

(f) Submit the certification fee and the nonrefundable examination fee prescribed in s. 401.34, which examination fee will be required for each examination administered to an applicant; and

(g) Submit a completed application to the department, which application documents compliance with paragraphs (a), (b), (c), (e), (f), and this paragraph, and, if applicable, paragraph (d). ~~The application must be submitted so as to be received by the department at least 30 calendar days before the next regularly scheduled examination for which the applicant desires to be scheduled.~~

~~(5) The certification examination must be offered monthly. The department shall issue an examination admission notice to the applicant advising him or her of the time and place of the examination for which he or she is scheduled. Individuals achieving a passing score on the certification examination may be issued a temporary certificate with their examination grade report. The department must issue an original certification within 45 days after the examination. Examination questions and answers are not subject to discovery but may be introduced into evidence and considered only in camera in any administrative proceeding under chapter 120. If an administrative hearing is held, the department shall provide challenged examination questions and answers to the administrative law judge. The~~

~~department shall establish by rule the procedure by which an applicant, and the applicant's attorney, may review examination questions and answers in accordance with s. 119.071(1)(a).~~

Section 13. Paragraph (a) of subsection (1) of section 401.2701, Florida Statutes, is amended to read:

401.2701 Emergency medical services training programs.—

(1) Any private or public institution in Florida desiring to conduct an approved program for the education of emergency medical technicians and paramedics shall:

(a) Submit a completed application on a form provided by the department, which must include:

1. Evidence that the institution is in compliance with all applicable requirements of the Department of Education.

2. Evidence of an affiliation agreement with a hospital that has an emergency department staffed by at least one physician and one registered nurse.

3. Evidence of an affiliation agreement with a current emergency medical services provider that is licensed in this state. Such agreement shall include, at a minimum, a commitment by the provider to conduct the field experience portion of the education program. An applicant licensed as an advanced life support service under s. 401.25 with permitted transport vehicles pursuant to s. 401.26 is exempt from the requirements of this subparagraph and need not submit evidence of an affiliation agreement with a current emergency medical services provider.

4. Documentation verifying faculty, including:

a. A medical director who is a licensed physician meeting the applicable requirements for emergency medical services medical directors as outlined in this chapter and rules of the department. The medical director shall have the duty and responsibility of certifying that graduates have successfully completed all phases of the education program and are proficient in basic or advanced life support techniques, as applicable.

b. A program director responsible for the operation, organization, periodic review, administration, development, and approval of the program.

5. Documentation verifying that the curriculum:

a. Meets the most recent Emergency Medical Technician-Basic National Standard Curriculum or the National EMS Education Standards approved by the department for emergency medical technician programs and Emergency Medical Technician-Paramedic National Standard Curriculum

or the National EMS Education Standards approved by the department for paramedic programs.

b. Includes 2 hours of instruction on the trauma scorecard methodologies for assessment of adult trauma patients and pediatric trauma patients as specified by the department by rule.

6. Evidence of sufficient medical and educational equipment to meet emergency medical services training program needs.

Section 14. Section 401.272, Florida Statutes, is amended to read:

401.272 Emergency medical services community health care.—

(1) The purpose of this section is to encourage more effective utilization of the skills of emergency medical technicians and paramedics by enabling them to perform~~, in partnership with local county health departments,~~ specific additional health care tasks that are consistent with the public health and welfare.

(2) Notwithstanding any other provision of law to the contrary:

(a) Paramedics or emergency medical technicians shall operate under the medical direction of a physician through two-way voice communication or pursuant to established standing orders or protocols and within the scope of their training when providing basic life support, advanced life support, and ~~may perform~~ health promotion and wellness activities ~~and blood pressure screenings~~ in a nonemergency environment~~, within the scope of their training, and under the direction of a medical director~~. As used in this paragraph, the term "health promotion and wellness" means the provision of public health programs pertaining to the prevention of illness and injury.

(b) Paramedics and emergency medical technicians shall operate under the medical direction of a physician through two-way communication or pursuant to established standing orders or protocols and within the scope of their training when a patient is not transported to an emergency department or is transported to a facility other than a hospital as defined in s. 395.002(12).

(c) Paramedics may administer immunizations in a nonemergency environment, within the scope of their training, and under the medical direction of a physician through two-way communication or pursuant to established standing orders or protocols ~~medical director~~. There must be a written agreement between the physician providing medical direction ~~paramedic's medical director~~ and the department or the county health department located in each county in which the paramedic administers immunizations. This agreement must establish the protocols, policies, and procedures under which the paramedic must operate.

(d)~~(c)~~ Paramedics may provide basic life support services and advanced life support services to patients receiving acute and postacute hospital care

at home as specified in the paramedic's supervisory relationship with a physician or standing orders as described in s. 401.265, s. 458.348, or s. 459.025. A physician who supervises or provides medical direction to a paramedic who provides basic life support services or advanced life support services to patients receiving acute and postacute hospital care at home pursuant to a formal supervisory relationship or standing orders is liable for any act or omission of the paramedic acting under the physician's supervision or medical direction when providing such services. The department may adopt and enforce rules necessary to implement this paragraph.

(3) Each physician providing medical direction to ~~medical director under whose direction~~ a paramedic who administers immunizations must verify and document that the paramedic has received sufficient training and experience to administer immunizations. The verification must be documented on forms developed by the department, and the completed forms must be maintained at the service location of the licensee and made available to the department upon request.

(4) The department may adopt and enforce all rules necessary to enforce the provisions relating to a paramedic's administration of immunizations and the performance of health promotion and wellness activities ~~and blood pressure screenings~~ by a paramedic or emergency medical technician in a nonemergency environment.

Section 15. Subsections (5), (6), and (7) of section 401.34, Florida Statutes, are amended to read:

401.34 Fees.—

~~(5) The department may provide same-day grading of the examination for an applicant for emergency medical technician or paramedic certification.~~

~~(6) The department may offer walk-in eligibility determination and examination to applicants for emergency medical technician or paramedic certification who pay to the department a nonrefundable fee to be set by the department not to exceed $65. The fee is in addition to the certification fee and examination fee. The department must establish locations and times for eligibility determination and examination.~~

~~(7) The cost of emergency medical technician or paramedic certification examination review may not exceed $50.~~

Section 16. Section 401.435, Florida Statutes, is amended to read:

401.435 Emergency medical ~~First~~ responder agencies and training.—

(1) The department must adopt by rule the United States Department of Transportation National Emergency Medical Services Education Standards for the Emergency Medical ~~Services: First~~ Responder level ~~Training Course~~ as the minimum standard for emergency medical ~~first~~ responder training. In

addition, the department must adopt rules establishing minimum emergency medical ~~first~~ responder instructor qualifications. For purposes of this section, an emergency medical ~~a first~~ responder includes any individual who receives training to render initial care to an ill or injured person, other than an individual trained and certified pursuant to s. 943.1395(1), but who does not have the primary responsibility of treating and transporting ill or injured persons.

(2) Each emergency medical ~~first~~ responder agency must take all reasonable efforts to enter into a memorandum of understanding with the emergency medical services licensee within whose territory the agency operates in order to coordinate emergency services at an emergency scene. The department must provide a model memorandum of understanding for this purpose. The memorandum of understanding should include dispatch protocols, the roles and responsibilities of emergency medical ~~first~~ responder personnel at an emergency scene, and the documentation required for patient care rendered. For purposes of this section, the term "emergency medical ~~first~~ responder agency" includes a law enforcement agency, a fire service agency not licensed under this part, a lifeguard agency, and a volunteer organization that renders, as part of its routine functions, on-scene patient care before emergency medical technicians or paramedics arrive.

Section 17. Paragraph (a) of subsection (1) of section 464.203, Florida Statutes, is amended to read:

464.203 Certified nursing assistants; certification requirement.—

(1) The board shall issue a certificate to practice as a certified nursing assistant to any person who demonstrates a minimum competency to read and write and successfully passes the required background screening pursuant to s. 400.215. If the person has successfully passed the required background screening pursuant to s. 400.215 or s. 408.809 within 90 days before applying for a certificate to practice and the person's background screening results are not retained in the clearinghouse created under s. 435.12, the board shall waive the requirement that the applicant successfully pass an additional background screening pursuant to s. 400.215. The person must also meet one of the following requirements:

(a) Has successfully completed an approved training program and achieved a minimum score, established by rule of the board, on the nursing assistant competency examination, which consists of a written portion and skills-demonstration portion approved by the board and administered at a site and by personnel approved by the department. Any person who has successfully completed an approved training program within 6 months before filing an application for certification is not required to take the skills-demonstration portion of the competency examination.

Section 18. Section 468.1225, Florida Statutes, is amended to read:

468.1225 Procedures, equipment, and protocols.—

(1) The following minimal procedures shall be used when a licensed audiologist fits and sells a prescription hearing aid:

(a) Pure tone audiometric testing by air and bone to determine the type and degree of hearing deficiency when indicated.

(b) Effective masking when indicated.

(c) Appropriate testing to determine speech reception thresholds, speech discrimination scores, the most comfortable listening levels, uncomfortable loudness levels, and the selection of the best fitting arrangement for maximum hearing aid benefit when indicated.

(2) The following equipment shall be used:

(a) A wide range audiometer that ~~which~~ meets the specifications of the American National Standards Institute for diagnostic audiometers when indicated.

(b) A speech audiometer or a master hearing aid in order to determine the most comfortable listening level and speech discrimination when indicated.

(3) A final fitting ensuring physical and operational comfort of the prescription hearing aid shall be made when indicated.

(4) A licensed audiologist who fits and sells prescription hearing aids shall obtain the following medical clearance: If, upon inspection of the ear canal with an otoscope in the common procedure of fitting a prescription hearing aid and upon interrogation of the client, there is any recent history of infection or any observable anomaly, the client shall be instructed to see a physician, and a prescription hearing aid may ~~shall~~ not be fitted until medical clearance is obtained for the condition noted. If, upon return, the condition noted is no longer observable and the client signs a medical waiver, a prescription hearing aid may be fitted. Any person with a significant difference between bone conduction hearing and air conduction hearing must be informed of the possibility of medical or surgical correction.

(5)(a) A licensed audiologist's office must have available, or have access to, a selection of prescription hearing aid models, hearing aid supplies, and services complete enough to accommodate the various needs of the hearing aid wearers.

(b) At the time of the initial examination for fitting and sale of a prescription hearing aid, the attending audiologist must notify the prospective purchaser of the benefits of telecoil, also known as "t" coil or "t" switch, technology, including increased access to telephones and noninvasive access to assistive listening systems required under the Americans with Disabilities Act of 1990.

(6) Unless otherwise indicated, each audiometric test conducted by a licensee or a certified audiology assistant in the fitting and selling of prescription hearing aids must ~~shall~~ be made in a testing room that has been certified by the department, or by an agent approved by the department, not to exceed the following sound pressure levels at the specified frequencies: 250Hz-40dB, 500Hz-40dB, 750Hz-40dB, 1000Hz-40dB, 1500Hz-42dB, 2000Hz-47dB, 3000Hz-52dB, 4000Hz-57dB, 6000Hz-62dB, and 8000Hz-67dB. An exception to this requirement shall be made in the case of a client who, after being provided written notice of the benefits and advantages of having the test conducted in a certified testing room, requests that the test be conducted in a place other than the licensee's certified testing room. Such request must ~~shall~~ be documented by a waiver that ~~which~~ includes the written notice and is signed by the licensee and the client before ~~prior to~~ the testing. The waiver must ~~shall~~ be executed on a form provided by the department. The executed waiver must ~~shall~~ be attached to the client's copy of the contract, and a copy of the executed waiver must ~~shall~~ be retained in the licensee's file.

(7) The board may ~~shall have the power to~~ prescribe the minimum procedures and equipment used in the conducting of hearing assessments and for the fitting and selling of prescription hearing aids. The board shall adopt and enforce rules necessary to implement ~~carry out the provisions of~~ this subsection and subsection (6).

(8) Any duly authorized officer or employee of the department may ~~shall have the right to~~ make such inspections and investigations as ~~are~~ necessary ~~in order~~ to determine the state of compliance with ~~the provisions of~~ this section and the applicable rules and may enter the premises of a licensee and inspect the records of same upon reasonable belief that a violation of this law is being or has been committed or that the licensee has failed or is failing to comply with ~~the provisions of~~ this part.

Section 19. Section 468.1245, Florida Statutes, is amended to read:

468.1245 Itemized listing of prices; delivery of prescription hearing aid; receipt; guarantee; packaging; disclaimer.—

(1) Before ~~Prior to~~ delivery of services or products to a prospective purchaser, a licensee must ~~shall~~ disclose, upon request by the prospective purchaser, an itemized listing of prices, which must ~~listing shall~~ include separate price estimates for each service component and each product. Provision of such itemized listing of prices may ~~shall~~ not be predicated on the prospective purchaser's payment of any charge or agreement to purchase any service or product.

(2) Any licensee who fits and sells a prescription hearing aid shall, at the time of delivery, provide the purchaser with a receipt containing the seller's signature, the address of his or her regular place of business, and his or her license or certification number, if applicable, together with the brand, model, manufacturer or manufacturer's identification code, and serial number of

the prescription hearing aid furnished and the amount charged for the prescription hearing aid. The receipt must also ~~shall~~ specify whether the prescription hearing aid is new, used, or rebuilt, ~~and shall specify~~ the length of time and other terms of the guarantee, and by whom the prescription hearing aid is guaranteed. When the client has requested an itemized list of prices, the receipt must ~~shall~~ also provide an itemization of the total purchase price, including, but not limited to, the cost of the aid, ear mold, batteries, and other accessories, and the cost of any services. Notice of the availability of this service must be displayed in a conspicuous manner in the office. The receipt must also ~~shall~~ state that any complaint concerning the prescription hearing aid and its guarantee, if not reconciled with the licensee from whom the prescription hearing aid was purchased, should be directed by the purchaser to the department. The address and telephone number of such office must ~~shall~~ be stated on the receipt.

(3) A prescription ~~No~~ hearing aid may not be sold to any person unless both the packaging containing the prescription hearing aid and the contract provided pursuant to subsection (2) carry the following disclaimer in 10-point or larger type: “A hearing aid will not restore normal hearing, nor will it prevent further hearing loss.”

Section 20. Section 468.1246, Florida Statutes, is amended to read:

468.1246 Thirty-day trial period; purchaser’s right to cancel; notice; refund; cancellation fee.—

(1) A person selling a prescription hearing aid in this state must provide the buyer with written notice of a 30-day trial period and money-back guarantee. The guarantee must permit the purchaser to cancel the purchase for a valid reason as defined by rule of the board within 30 days after receiving the prescription hearing aid, by returning the prescription hearing aid or mailing written notice of cancellation to the seller. If the prescription hearing aid must be repaired, remade, or adjusted during the 30-day trial period, the running of the 30-day trial period is suspended 1 day for each 24-hour period that the prescription hearing aid is not in the purchaser’s possession. A repaired, remade, or adjusted prescription hearing aid must be claimed by the purchaser within 3 working days after notification of availability. The running of the 30-day trial period resumes on the day the purchaser reclaims a repaired, remade, or adjusted prescription hearing aid or on the 4th day after notification of availability.

(2) The board, in consultation with the Board of Hearing Aid Specialists, shall prescribe by rule the terms and conditions to be contained in the money-back guarantee and any exceptions thereto. Such rule must ~~shall~~ provide, at a minimum, that the charges for earmolds and service provided to fit the prescription hearing aid may be retained by the licensee. The rules must ~~shall~~ also set forth any reasonable charges to be held by the licensee as a cancellation fee. ~~Such rule shall be effective on or before December 1, 1994. Should the board fail to adopt such rule, a licensee may not charge a cancellation fee which exceeds 5 percent of the total charge for a hearing aid~~

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

~~alone.~~ The terms and conditions of the guarantee, including the total amount available for refund, must ~~shall~~ be provided in writing to the purchaser before ~~prior to~~ the signing of the contract.

Section 21. Section 468.1255, Florida Statutes, is amended to read:

468.1255 Cancellation by medical authorization; purchaser's right to return.—

(1) In addition to any other rights and remedies the purchaser of a prescription hearing aid may have, the purchaser has ~~shall have~~ the right to rescind the transaction if the purchaser for whatever reason consults a licensed physician with specialty board certification in otolaryngology or internal medicine or a licensed family practice physician, subsequent to purchasing a prescription hearing aid, and the physician certifies in writing that the purchaser has a hearing impairment for which a prescription hearing aid will not provide a benefit or that the purchaser has a medical condition which contraindicates the use of a prescription hearing aid.

(2) The purchaser of a prescription hearing aid has ~~shall have~~ the right to rescind as provided in subsection (1) only if the purchaser gives a written notice of the intent to rescind the transaction to the seller at the seller's place of business by certified mail, return receipt requested, which notice shall be posted not later than 60 days following the date of delivery of the prescription hearing aid to the purchaser, and the purchaser returns the prescription hearing aid to the seller in the original condition less normal wear and tear.

(3) If the conditions of subsections (1) and (2) are met, the seller must ~~shall~~, without request, refund to the purchaser, within 10 days after ~~of~~ the receipt of notice to rescind, a full and complete refund of all moneys received, less 5 percent. The purchaser does not ~~shall~~ incur any ~~no~~ additional liability for rescinding the transaction.

Section 22. Section 468.1265, Florida Statutes, is amended to read:

468.1265 Sale or distribution of prescription hearing aids through mail; penalty.—It is unlawful for any person to sell or distribute prescription hearing aids through the mail to the ultimate consumer. Any person who violates this section commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 23. Section 468.1275, Florida Statutes, is amended to read:

468.1275 Place of business; display of license.—Each licensee who fits and sells a prescription hearing aid shall declare and establish a regular place of business, at which his or her license shall be conspicuously displayed.

Section 24. Section 484.0401, Florida Statutes, is amended to read:

484.0401 Purpose.—The Legislature recognizes that the dispensing of prescription hearing aids requires particularized knowledge and skill to ensure that the interests of the hearing-impaired public will be adequately served and safely protected. It recognizes that a poorly selected or fitted prescription hearing aid not only will give little satisfaction but may interfere with hearing ability and, therefore, deems it necessary in the interest of the public health, safety, and welfare to regulate the dispensing of prescription hearing aids in this state. Restrictions on the fitting and selling of prescription hearing aids shall be imposed only to the extent necessary to protect the public from physical and economic harm, and restrictions shall not be imposed in a manner which will unreasonably affect the competitive market.

Section 25. Section 484.041, Florida Statutes, is reordered and amended to read:

484.041 Definitions.—As used in this part, the term:

(1) "Board" means the Board of Hearing Aid Specialists.

(2) "Department" means the Department of Health.

(3) "Dispensing prescription hearing aids" means and includes:

(a) Conducting and interpreting hearing tests for purposes of selecting suitable prescription hearing aids, making earmolds or ear impressions, and providing appropriate counseling.

(b) All acts pertaining to the selling, renting, leasing, pricing, delivery, and warranty of prescription hearing aids.

(6)~~(4)~~ "Hearing aid specialist" means a person duly licensed in this state to practice the dispensing of prescription hearing aids.

(4)~~(5)~~ "Hearing aid" means any wearable ~~an amplifying~~ device designed for, offered for the purpose of, or represented as aiding persons with, or compensating for, impaired hearing ~~to be worn by a hearing-impaired person to improve hearing~~.

(10)~~(6)~~ "Trainee" means a person studying prescription hearing aid dispensing under the direct supervision of an active licensed hearing aid specialist for the purpose of qualifying for certification to sit for the licensure examination.

(5)~~(7)~~ "Hearing aid establishment" means any establishment in this ~~the~~ state which employs a licensed hearing aid specialist who offers, advertises, and performs hearing aid services for the general public.

(7) "Over-the-counter hearing aid" means an air-conduction hearing aid that does not require implantation or other surgical intervention and is

intended for use by a person 18 years of age or older to compensate for perceived mild to moderate hearing impairment.

(8) "Prescription hearing aid" means a hearing aid that satisfies the requirements of this part and is not an over-the-counter hearing aid.

(9)~~(8)~~ "Sponsor" means an active, licensed hearing aid specialist under whose direct supervision one or more trainees are studying prescription hearing aid dispensing for the purpose of qualifying for certification to sit for the licensure examination.

Section 26. Subsection (2) of section 484.042, Florida Statutes, is amended to read:

484.042 Board of Hearing Aid Specialists; membership, appointment, terms.—

(2) Five members of the board shall be hearing aid specialists who have been licensed and practicing the dispensing of prescription hearing aids in this state for at least the preceding 4 years. The remaining four members, none of whom shall derive economic benefit from the fitting or dispensing of hearing aids, shall be appointed from the resident lay public of this state. One of the lay members shall be a prescription hearing aid user but may not ~~neither~~ be nor have been a hearing aid specialist or a licensee of a closely related profession. One lay member shall be an individual age 65 or over. One lay member shall be an otolaryngologist licensed pursuant to chapter 458 or chapter 459.

Section 27. Subsection (2) of section 484.044, Florida Statutes, is amended to read:

484.044 Authority to make rules.—

(2) The board shall adopt rules requiring that each prospective purchaser of a prescription hearing aid be notified by the attending hearing aid specialist, at the time of the initial examination for fitting and sale of a hearing aid, of telecoil, "t" coil, or "t" switch technology. The rules shall further require that hearing aid specialists make available to prospective purchasers or clients information regarding telecoils, "t" coils, or "t" switches. ~~These rules shall be effective on or before October 1, 1994.~~

Section 28. Subsection (2) of section 484.0445, Florida Statutes, is amended to read:

484.0445 Training program.—

(2) A trainee shall perform the functions of a hearing aid specialist in accordance with board rules only under the direct supervision of a licensed hearing aid specialist. The term "direct supervision" means that the sponsor is responsible for all work being performed by the trainee. The sponsor or a hearing aid specialist designated by the sponsor shall give final approval to

work performed by the trainee and shall be physically present at the time the prescription hearing aid is delivered to the client.

Section 29. Subsection (2) of section 484.045, Florida Statutes, is amended to read:

484.045 Licensure by examination.—

(2) The department shall license each applicant who the board certifies meets all of the following criteria:

(a) Has completed the application form and remitted the required fees.~~;~~

(b) Is of good moral character.~~;~~

(c) Is 18 years of age or older.~~;~~

(d) Is a graduate of an accredited high school or its equivalent.~~;~~

(e)1. Has met the requirements of the training program; or

2.a. Has a valid, current license as a hearing aid specialist or its equivalent from another state and has been actively practicing in such capacity for at least 12 months; or

b. Is currently certified by the National Board for Certification in Hearing Instrument Sciences and has been actively practicing for at least 12 months.~~;~~

(f) Has passed an examination, as prescribed by board rule.~~; and~~

(g) Has demonstrated, in a manner designated by rule of the board, knowledge of state laws and rules relating to the fitting and dispensing of prescription hearing aids.

Section 30. Section 484.0501, Florida Statutes, is amended to read:

484.0501 Minimal procedures and equipment.—

(1) The following minimal procedures shall be used in the fitting and selling of prescription hearing aids:

(a) Pure tone audiometric testing by air and bone to determine the type and degree of hearing deficiency.

(b) Effective masking when indicated.

(c) Appropriate testing to determine speech reception thresholds, speech discrimination scores, the most comfortable listening levels, uncomfortable loudness levels, and the selection of the best fitting arrangement for maximum hearing aid benefit.

(2) The following equipment shall be used:

(a) A wide range audiometer that ~~which~~ meets the specifications of the American National Standards Institute for diagnostic audiometers.

(b) A speech audiometer or a master hearing aid in order to determine the most comfortable listening level and speech discrimination.

(3) A final fitting ensuring physical and operational comfort of the prescription hearing aid shall be made.

(4) The following medical clearance shall be obtained: If, upon inspection of the ear canal with an otoscope in the common procedure of a prescription hearing aid fitter and upon interrogation of the client, there is any recent history of infection or any observable anomaly, the client must ~~shall~~ be instructed to see a physician, and a prescription hearing aid may ~~shall~~ not be fitted until medical clearance is obtained for the condition noted. If, upon return, the condition noted is no longer observable and the client signs a medical waiver, a prescription hearing aid may be fitted. Any person with a significant difference between bone conduction hearing and air conduction hearing must be informed of the possibility of medical correction.

(5)(a) A prescription hearing aid establishment ~~office~~ must have available, or have access to, a selection of prescription hearing aid models, hearing aid supplies, and services complete enough to accommodate the various needs of the prescription hearing aid wearers.

(b) At the time of the initial examination for fitting and sale of a prescription hearing aid, the attending hearing aid specialist shall ~~must~~ notify the prospective purchaser or client of the benefits of telecoil, “t” coil, or “t” switch technology, including increased access to telephones and noninvasive access to assistive listening systems required under the Americans with Disabilities Act of 1990.

(6) Each audiometric test conducted by a licensee or authorized trainee in the fitting and selling of prescription hearing aids must ~~shall~~ be made in a testing room that has been certified by the department, or by an agent approved by the department, not to exceed the following sound pressure levels at the specified frequencies: 250Hz-40dB, 500Hz-40dB, 750Hz-40dB, 1000Hz-40dB, 1500Hz-42dB, 2000Hz-47dB, 3000Hz-52dB, 4000Hz-57dB, 6000Hz-62dB, and 8000Hz-67dB. An exception to this requirement shall be made in the case of a client who, after being provided written notice of the benefits and advantages of having the test conducted in a certified testing room, requests that the test be conducted in a place other than the licensee’s certified testing room. Such request must ~~shall~~ be documented by a waiver which includes the written notice and is signed by the licensee and the client before ~~prior to~~ the testing. The waiver must ~~shall~~ be executed on a form provided by the department. The executed waiver must ~~shall~~ be attached to the client’s copy of the contract, and a copy of the executed waiver must ~~shall~~ be retained in the licensee’s file.

(7) The board may ~~shall have the power to~~ prescribe the minimum procedures and equipment which must ~~shall~~ be used in the conducting of hearing assessments, and for the fitting and selling of prescription hearing aids, including equipment that will measure the prescription hearing aid's response curves to ensure that they meet the manufacturer's specifications. These procedures and equipment may differ from those provided in this section in order to take full advantage of devices and equipment which may hereafter become available and which are demonstrated to be of greater efficiency and accuracy. The board shall adopt and enforce rules necessary to implement ~~carry out the provisions of~~ this subsection and subsection (6).

(8) Any duly authorized officer or employee of the department may ~~shall have the right to~~ make such inspections and investigations as ~~are~~ necessary ~~in order~~ to determine the state of compliance with ~~the provisions of~~ this section and the applicable rules and may enter the premises of a licensee and inspect the records of same upon reasonable belief that a violation of this law is being or has been committed or that the licensee has failed or is failing to comply with ~~the provisions of~~ this part ~~act~~.

(9) A licensed hearing aid specialist may service, market, sell, dispense, provide customer support for, and distribute prescription and over-the-counter hearing aids.

Section 31. Section 484.051, Florida Statutes, is amended to read:

484.051 Itemization of prices; delivery of prescription hearing aid; receipt, packaging, disclaimer, guarantee.—

(1) Before ~~Prior to~~ delivery of services or products to a prospective purchaser, any person who fits and sells prescription hearing aids must ~~shall~~ disclose on request by the prospective purchaser an itemized listing of prices, which must ~~listing shall~~ include separate price estimates for each service component and each product. Provision of such itemized listing of prices may ~~shall~~ not be predicated on the prospective purchaser's payment of any charge or agreement to purchase any service or product.

(2) Any person who fits and sells a prescription hearing aid must ~~shall~~, at the time of delivery, provide the purchaser with a receipt containing the seller's signature, the address of her or his regular place of business, and her or his license or trainee registration number, if applicable, together with the brand, model, manufacturer or manufacturer's identification code, and serial number of the prescription hearing aid furnished and the amount charged for the prescription hearing aid. The receipt must also ~~shall~~ specify whether the prescription hearing aid is new, used, or rebuilt~~,~~ ~~and shall specify~~ the length of time and other terms of the guarantee~~,~~ and by whom the prescription hearing aid is guaranteed. If ~~When~~ the client has requested an itemized list of prices, the receipt must ~~shall~~ also provide an itemization of the total purchase price, including, but not limited to, the cost of the aid, earmold, batteries and other accessories, and any services. Notice of the availability of this service shall be displayed in a conspicuous manner in the

office. The receipt must also ~~shall~~ state that any complaint concerning the prescription hearing aid and guarantee therefor, if not reconciled with the licensee from whom the prescription hearing aid was purchased, should be directed by the purchaser to the Department of Health. The address and telephone number of such office must ~~shall~~ be stated on the receipt.

(3) A prescription ~~No~~ hearing aid may not be sold to any person unless both the packaging containing the prescription hearing aid and the itemized receipt provided pursuant to subsection (2) carry the following disclaimer in 10-point or larger type: “A hearing aid will not restore normal hearing, nor will it prevent further hearing loss.”

Section 32. Section 484.0512, Florida Statutes, is amended to read:

484.0512 Thirty-day trial period; purchaser’s right to cancel; notice; refund; cancellation fee; criminal penalty.—

(1) A person selling a prescription hearing aid in this state must provide the buyer with written notice of a 30-day trial period and money-back guarantee. The guarantee must permit the purchaser to cancel the purchase for a valid reason~~,~~ as defined by ~~rule of the~~ board rule, within 30 days after receiving the prescription hearing aid, by returning the prescription hearing aid or mailing written notice of cancellation to the seller. If the prescription hearing aid must be repaired, remade, or adjusted during the 30-day trial period, the running of the 30-day trial period is suspended 1 day for each 24-hour period that the prescription hearing aid is not in the purchaser’s possession. A repaired, remade, or adjusted prescription hearing aid must be claimed by the purchaser within 3 working days after notification of availability. The running of the 30-day trial period resumes on the day the purchaser reclaims the repaired, remade, or adjusted prescription hearing aid or on the fourth day after notification of availability, whichever occurs earlier.

(2) The board, in consultation with the Board of Speech-Language Pathology and Audiology, shall prescribe by rule the terms and conditions to be contained in the money-back guarantee and any exceptions thereto. Such rules must ~~rule shall~~ provide, at a minimum, that the charges for earmolds and service provided to fit the prescription hearing aid may be retained by the licensee. The rules must ~~shall~~ also set forth any reasonable charges to be held by the licensee as a cancellation fee. ~~Such rule shall be effective on or before December 1, 1994. Should the board fail to adopt such rule, a licensee may not charge a cancellation fee which exceeds 5 percent of the total charge for a hearing aid alone.~~ The terms and conditions of the guarantee, including the total amount available for refund, must ~~shall~~ be provided in writing to the purchaser before ~~prior to~~ the signing of the contract.

(3) Within 30 days after the return or attempted return of the prescription hearing aid, the seller shall refund all moneys that must be refunded to a purchaser pursuant to this section. A violation of this

subsection is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(4) For purposes of this section, the term “seller” or “person selling a prescription hearing aid” includes:

(a) Any ~~natural~~ person licensed under this part or any other ~~natural~~ person who signs a sales receipt required by s. 484.051(2) or s. 468.1245(2) or ~~who~~ otherwise fits, delivers, or dispenses a prescription hearing aid.

(b) Any business organization, whether a sole proprietorship, partnership, corporation, professional association, joint venture, business trust, or other legal entity, that ~~which~~ dispenses a prescription hearing aid or enters into an agreement to dispense a prescription hearing aid.

(c) Any person who controls, manages, or operates an establishment or business that dispenses a prescription hearing aid or enters into an agreement to dispense a prescription hearing aid.

Section 33. Section 484.0513, Florida Statutes, is amended to read:

484.0513 Cancellation by medical authorization; purchaser’s right to return.—

(1) In addition to any other rights and remedies the purchaser of a prescription hearing aid may have, the purchaser has ~~shall have~~ the right to rescind the transaction if the purchaser for whatever reason consults a licensed physician with specialty board certification in otolaryngology or internal medicine or a licensed family practice physician, subsequent to purchasing a prescription hearing aid, and the physician certifies in writing that the purchaser has a hearing impairment for which a prescription hearing aid will not provide a benefit or that the purchaser has a medical condition which contraindicates the use of a prescription hearing aid.

(2) The purchaser of a prescription hearing aid has ~~shall have~~ the right to rescind as provided in subsection (1) only if the purchaser gives a written notice of the intent to rescind the transaction to the seller at the seller’s place of business by certified mail, return receipt requested, which must ~~notice shall~~ be posted within ~~not later than~~ 60 days after ~~following~~ the date of delivery of the prescription hearing aid to the purchaser, and the purchaser returns the prescription hearing aid to the seller in the original condition less normal wear and tear.

(3) If the conditions of subsections (1) and (2) are met, the seller must ~~shall~~, without request, refund to the purchaser, within 10 days after ~~of the~~ receipt of the notice to rescind, a full and complete refund of all moneys received, less 5 percent. The purchaser does not ~~shall~~ incur any ~~no~~ additional liability for rescinding the transaction.

Section 34. Section 484.053, Florida Statutes, is amended to read:

484.053 Prohibitions; penalties.—

(1) A person may not:

(a) Practice dispensing prescription hearing aids unless the person is a licensed hearing aid specialist;

(b) Use the name or title “hearing aid specialist” when the person has not been licensed under this part;

(c) Present as her or his own the license of another;

(d) Give false, incomplete, or forged evidence to the board or a member thereof for the purposes of obtaining a license;

(e) Use or attempt to use a hearing aid specialist license that is delinquent or has been suspended, revoked, or placed on inactive status;

(f) Knowingly employ unlicensed persons in the practice of dispensing prescription hearing aids; or

(g) Knowingly conceal information relative to violations of this part.

(2) Any person who violates any provision ~~of the provisions~~ of this section is guilty of a felony of the third degree, punishable as provided in s. 775.082 or s. 775.083.

(3) If a person licensed under this part allows the sale of a prescription hearing aid by an unlicensed person not registered as a trainee or fails to comply with the requirements of s. 484.0445(2) relating to supervision of trainees, the board must ~~shall~~, upon determination of that violation, order the full refund of moneys paid by the purchaser upon return of the prescription hearing aid to the seller’s place of business.

Section 35. Section 484.054, Florida Statutes, is amended to read:

484.054 Sale or distribution of prescription hearing aids through mail; penalty.—It is unlawful for any person to sell or distribute prescription hearing aids through the mail to the ultimate consumer. Any violation of this section constitutes a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 36. Section 484.059, Florida Statutes, is amended to read:

484.059 Exemptions.—

(1) The licensure requirements of this part do not apply to any person engaged in recommending prescription hearing aids as part of the academic curriculum of an accredited institution of higher education, or as part of a program conducted by a public charitable institution supported primarily by voluntary contribution, provided this organization does not dispense or sell prescription hearing aids or accessories.

(2) The licensure requirements of this part do not apply to any person licensed to practice medicine in this ~~the~~ state, except that such physician must ~~shall~~ comply with the requirement of periodic filing of the certificate of testing and calibration of audiometric equipment as provided in this part. A ~~No~~ person employed by or working under the supervision of a person licensed to practice medicine may not ~~shall~~ perform any services or acts which would constitute the dispensing of prescription hearing aids as defined in s. 484.041 ~~s. 484.041(3)~~, unless such person is a licensed hearing aid specialist.

(3) The licensure requirements of this part do not apply to an audiologist licensed under ~~pursuant to~~ part I of chapter 468.

(4) Section ~~The provisions of s.~~ 484.053(1)(a) does ~~shall~~ not apply to registered trainees operating in compliance with this part and board rules ~~of the board~~.

(5) The licensure requirements of this part do not apply to a person who services, markets, sells, dispenses, provides customer support for, or distributes exclusively over-the-counter hearing aids, whether through in-person transactions, by mail, or online. For purposes of this subsection, over-the-counter hearing aids are those that are available without the supervision, prescription, or other order, involvement, or intervention of a licensed person to consumers through in-person transactions, by mail, or online. These devices allow the user to control the device and customize it to the user's hearing needs through the use of tools, tests, or software, including, but not limited to, wireless technology or tests for self-assessment of hearing loss.

Section 37. The Division of Law Revision is directed to replace the phrase "the effective date of this act" wherever it occurs in this act with the date the act becomes a law.

Section 38. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect July 1, 2023.

Approved by the Governor May 11, 2023.

Filed in Office Secretary of State May 11, 2023.

CHAPTER 2023-299

Committee Substitute for
Committee Substitute for Senate Bill No. 1676

An act relating to hemp; amending s. 500.03, F.S.; revising the definition of the term “food”; providing that hemp extract is considered a food subject to certain requirements; amending s. 581.217, F.S.; revising legislative findings regarding the state hemp program; defining the term “attractive to children”; revising definitions; revising the requirements that hemp extract must meet before being distributed and sold in this state; providing that hemp extract may only be sold to businesses in this state which meet certain permitting requirements; providing that hemp extract distributed or sold in this state must meet certain requirements; prohibiting products intended for human ingestion which contain hemp extract from being sold to persons under a specified age; providing civil and criminal penalties; providing enhanced criminal penalties for second or subsequent violations within a specified timeframe; providing that certain products are subject to an immediate stop-sale order; requiring the Department of Agriculture and Consumer Services to adopt specified rules; removing obsolete provisions; reenacting s. 893.02(3), F.S., relating to the definition of the term “cannabis,” to incorporate the amendments made to s. 581.217, F.S., in a reference thereto; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (n) of subsection (1) of section 500.03, Florida Statutes, is amended, and subsection (4) is added to that section, to read:

500.03 Definitions; construction; applicability.—

(1) For the purpose of this chapter, the term:

(n) “Food” includes:

1. Articles used for food or drink for human consumption;

2. Chewing gum;

3. Articles used for components of any such article;

4. Articles for which health claims are made, which claims are approved by the Secretary of the United States Department of Health and Human Services and which claims are made in accordance with s. 343(r) of the federal act, and which are not considered drugs solely because their labels or labeling contain health claims; ~~and~~

5. Dietary supplements as defined in 21 U.S.C. s. 321(ff)(1) and (2); and

6. Hemp extract as defined in s. 581.217.

The term includes any raw, cooked, or processed edible substance; ice; any beverage; or any ingredient used, intended for use, or sold for human consumption.

(4) For the purposes of this chapter, hemp extract is considered a food that requires time and temperature control for the safety and integrity of product.

Section 2. Paragraph (b) of subsection (2) and subsections (3), (7), and (12) of section 581.217, Florida Statutes, are amended to read:

581.217 State hemp program.—

(2) LEGISLATIVE FINDINGS.—The Legislature finds that:

(b) Hemp-derived cannabinoids, including, but not limited to, cannabidiol, are not controlled substances or adulterants if they are in compliance with this section.

(3) DEFINITIONS.—As used in this section, the term:

(a) "Attractive to children" means manufactured in the shape of humans, cartoons, or animals; manufactured in a form that bears any reasonable resemblance to an existing candy product that is familiar to the public as a widely distributed, branded food product such that a product could be mistaken for the branded product, especially by children; or containing any color additives.

(b)~~(a)~~ "Certifying agency" has the same meaning as in s. 578.011(8).

(c)~~(b)~~ "Contaminants unsafe for human consumption" includes, but is not limited to, any microbe, fungus, yeast, mildew, herbicide, pesticide, fungicide, residual solvent, metal, or other contaminant found in any amount that exceeds any of the accepted limitations as determined by rules adopted by the Department of Health in accordance with s. 381.986, or other limitation pursuant to the laws of this state, whichever amount is less.

(d)~~(c)~~ "Cultivate" means planting, watering, growing, or harvesting hemp.

(e)~~(d)~~ "Hemp" means the plant *Cannabis sativa* L. and any part of that plant, including the seeds thereof, and all derivatives, extracts, cannabinoids, isomers, acids, salts, and salts of isomers thereof, whether growing or not, that has a total delta-9-tetrahydrocannabinol concentration that does not exceed 0.3 percent on a dry-weight basis, with the exception of hemp extract, which may not exceed 0.3 percent total delta-9-tetrahydrocannabinol on a wet-weight basis.

(f)~~(e)~~ "Hemp extract" means a substance or compound intended for ingestion, containing more than trace amounts of a cannabinoid, or for inhalation which is derived from or contains hemp and which does not

contain ~~other~~ controlled substances. The term does not include synthetic cannabidiol ~~CBD~~ or seeds or seed-derived ingredients that are generally recognized as safe by the United States Food and Drug Administration.

(g)~~(f)~~ “Independent testing laboratory” means a laboratory that:

1. Does not have a direct or indirect interest in the entity whose product is being tested;

2. Does not have a direct or indirect interest in a facility that cultivates, processes, distributes, dispenses, or sells hemp or hemp extract in the state or in another jurisdiction or cultivates, processes, distributes, dispenses, or sells marijuana, as defined in s. 381.986; and

3. Is accredited by a third-party accrediting body as a competent testing laboratory pursuant to ISO/IEC 17025 of the International Organization for Standardization.

(7) DISTRIBUTION AND RETAIL SALE OF HEMP EXTRACT.—

(a) Hemp extract may only be distributed and sold in the state if the product:

1. Has a certificate of analysis prepared by an independent testing laboratory that states:

a. The hemp extract is the product of a batch tested by the independent testing laboratory;

b. The batch contained a total delta-9-tetrahydrocannabinol concentration that did not exceed 0.3 percent pursuant to the testing of a random sample of the batch; ~~and~~

c. The batch does not contain contaminants unsafe for human consumption; and

d. The batch was processed in a facility that holds a current and valid permit issued by a human health or food safety regulatory entity with authority over the facility, and that facility meets the human health or food safety sanitization requirements of the regulatory entity. Such compliance must be documented by a report from the regulatory entity confirming that the facility meets such requirements.

2. Is distributed or sold in a container that includes:

a. A scannable barcode or quick response code linked to the certificate of analysis of the hemp extract batch by an independent testing laboratory;

b. The batch number;

c. The Internet address of a website where batch information may be obtained;

d. The expiration date; and

e. The number of milligrams of each marketed cannabinoid per serving.

3. Is distributed or sold in a container that:

a. Is suitable to contain products for human consumption;

b. Is composed of materials designed to minimize exposure to light;

c. Mitigates exposure to high temperatures;

d. Is not attractive to children; and

e. Is compliant with the United States Poison Prevention Packaging Act of 1970, 15 U.S.C. ss. 1471 et seq., without regard to provided exemptions.

(b) Hemp extract may only be sold to a business in this state if that business is properly permitted as required by this section.

(c) Hemp extract distributed or sold in this state is subject to the applicable requirements of ~~violation of this section shall be considered adulterated or misbranded pursuant to~~ chapter 500, chapter 502, or chapter 580.

(d)~~(c)~~ Products that are intended for human ingestion or inhalation and that contain hemp extract, including, but not limited to, snuff, chewing gum, and other smokeless products, may not be sold in this state to a person who is under 21 years of age. A person who violates this paragraph commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. A person who commits a second or subsequent violation of this paragraph within 1 year after the initial violation commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(e) Hemp extract distributed or sold in violation of this subsection is subject to s. 500.172 and penalties as provided in s. 500.121. Hemp extract products found to be mislabeled or attractive to children are subject to an immediate stop-sale order.

(12) RULES.—~~By August 1, 2019,~~ The department shall adopt rules~~, in consultation with the Department of Health and the Department of Business and Professional Regulation, shall initiate rulemaking~~ to administer the state hemp program. The rules must provide for:

(a) A procedure that uses post-decarboxylation or other similarly reliable methods for testing the delta-9-tetrahydrocannabinol concentration of cultivated hemp.

(b) A procedure for the effective disposal of plants, whether growing or not, that are cultivated in violation of this section or department rules, and products derived from those plants.

CODING: Language ~~stricken~~ has been vetoed by the Governor

(c) Packaging and labeling requirements that ensure that hemp extract intended for human ingestion or inhalation is not attractive to children.

(d) Advertising regulations that ensure that hemp extract intended for human ingestion or inhalation is not marketed or advertised in a manner that specifically targets or is attractive to children.

Section 3. For the purpose of incorporating the amendments made by this act to section 581.217, Florida Statutes, in a reference thereto, subsection (3) of section 893.02, Florida Statutes, is reenacted to read:

893.02 Definitions.—The following words and phrases as used in this chapter shall have the following meanings, unless the context otherwise requires:

(3) "Cannabis" means all parts of any plant of the genus *Cannabis*, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant or its seeds or resin. The term does not include "marijuana," as defined in s. 381.986, if manufactured, possessed, sold, purchased, delivered, distributed, or dispensed, in conformance with s. 381.986. The term does not include hemp as defined in s. 581.217 or industrial hemp as defined in s. 1004.4473.

Section 4. This act shall take effect July 1, 2023.

Approved by the Governor June 27, 2023.

Filed in Office Secretary of State June 27, 2023.

Tab 3

Federal Guidance

United States Government Accountability Office

Report to Congressional Requesters

December 2015

STATE MARIJUANA LEGALIZATION

DOJ Should Document Its Approach to Monitoring the Effects of Legalization

GAO-16-1

GAO Highlights

Highlights of GAO-16-1, a report to congressional requesters

December 2015

STATE MARIJUANA LEGALIZATION

DOJ Should Document Its Approach to Monitoring the Effects of Legalization

Why GAO Did This Study

An increasing number of states have adopted laws that legalize marijuana for medical or recreational purposes under state law, yet federal penalties remain. In 2012, Colorado and Washington became the first states to legalize marijuana for recreational purposes. In 2013, DOJ updated its marijuana enforcement policy by issuing guidance clarifying federal marijuana enforcement priorities and stating that DOJ may challenge those state marijuana legalization systems that threaten these priorities. GAO was asked to review issues related to Colorado's and Washington's actions to regulate recreational marijuana and DOJ's mechanisms to monitor the effects of state legalization.

This report examines, among other issues, (1) DOJ's efforts to monitor the effects of state marijuana legalization relative to DOJ's 2013 guidance and (2) factors DOJ field officials reported affecting their marijuana enforcement in selected states with medical marijuana laws. GAO analyzed DOJ marijuana enforcement guidance and drug threat assessments, and evaluated DOJ's monitoring efforts against internal control standards. GAO also interviewed cognizant DOJ officials, including U.S. Attorneys and DEA officials in six states.

What GAO Recommends

GAO recommends that DOJ document a plan specifying its process for monitoring the effects of state marijuana legalization, and share the plan with DOJ components. DOJ concurred with GAO's recommendations.

View GAO-16-1. For more information, contact Jennifer Grover at (202) 512-7141 or groverj@gao.gov.

What GAO Found

Officials from the Department of Justice's (DOJ) Office of the Deputy Attorney General (ODAG) reported monitoring the effects of state marijuana legalization relative to DOJ policy, generally in two ways. First, officials reported that U.S. Attorneys prosecute cases that threaten federal marijuana enforcement priorities (see fig. below) and consult with state officials about areas of federal concern, such as the potential impact on enforcement priorities of edible marijuana products. Second, officials reported they collaborate with DOJ components, including the Drug Enforcement Administration (DEA) and other federal agencies, including the Office of National Drug Control Policy, and assess various marijuana enforcement-related data these agencies provide. However, DOJ has not documented its monitoring process, as called for in *Standards for Internal Control in the Federal Government*. Documenting a plan specifying its monitoring process would provide DOJ with greater assurance that its monitoring activities relative to DOJ marijuana enforcement guidance are occurring as intended. Further, making this plan available to appropriate DOJ components can provide ODAG with an opportunity to gain institutional knowledge with respect to its monitoring plan, including the utility of the data ODAG is using. This can better position ODAG to identify state systems that are not effectively protecting federal enforcement priorities and, if necessary, take steps to challenge these systems in accordance with DOJ marijuana enforcement guidance.

DOJ Marijuana Enforcement Priorities

Preventing the distribution of marijuana to minors

Preventing violence and the use of firearms in the cultivation and distribution of marijuana

Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs, and cartels

Preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use

Preventing the diversion of marijuana from states where it is legal under state law in some form to other states

Preventing the growing of marijuana on public lands and the attendant public safety and environmental dangers posed by marijuana production on public lands

Preventing state-authorized marijuana activity from being used as a cover or pretext for the trafficking of other illegal drugs or other illegal activity

Preventing marijuana possession or use on federal property

Source: Department of Justice; Department of the Interior (logo). | GAO-16-1

U.S. Attorneys and DEA officials in six states with medical marijuana laws reported their perspectives on various factors that had affected their marijuana enforcement actions. These include

- applying resources to target the most significant public health and safety threats, such as violence associated with drug-trafficking organizations;
- addressing local concerns regarding the growth of the commercial medical marijuana industry; and
- implementing DOJ's updated marijuana enforcement policy guidance.

Contents

Letter		1
	Background	5
	Features of Colorado's and Washington's Regulatory Systems for Recreational Marijuana	13
	DOJ Reports Actions to Monitor the Effects of State Legalization of Marijuana, but Has Not Documented a Plan for Doing So	25
	DOJ Field Officials Reported That Various Factors Have Affected Their Marijuana Enforcement Actions in Selected States That Have Legalized Marijuana for Medical Purposes	32
	Conclusions	38
	Recommendations for Executive Action	39
	Agency Comments and Our Evaluation	39
Appendix I	DOJ Field Components Contacted in Selected States	41
Appendix II	Comments from the Department of Justice	43
Appendix III	GAO Contact and Staff Acknowledgments	44
Tables		
	Table 1: Reported Number of Recreational Marijuana Licenses Issued by Colorado and Washington, as of August 2015	15
	Table 2: Selected Features of Colorado's and Washington's Recreational Marijuana Systems, as of July 2015	23
	Table 3: Summary of Actions ODAG Officials Reported DOJ was Taking to Monitor the Effects of State Marijuana Legalization Relative to DOJ's August 2013 Marijuana Enforcement Policy Guidance	29
Figures		
	Figure 1: Cannabis Plants	6
	Figure 2: DOJ's Marijuana Enforcement Priorities as Outlined in the August 2013 Marijuana Enforcement Guidance	11

Figure 3: Timeline Showing the Years States and the District of Columbia Passed Measures Legalizing Medical and Recreational Marijuana under State Law and the Years DOJ Issued Marijuana Enforcement Policy Guidance 12
Figure 4: Colorado and Washington Recreational Marijuana License Types 14
Figure 5: Marijuana Plants with Inventory-Tracking System Tags at Colorado and Washington Recreational Marijuana Facilities 18
Figure 6: Marijuana-Infused Products Reviewed by the Washington State Liquor and Cannabis Board 21
Figure 7: DOJ Field Components Contacted in Selected States 42

Abbreviations

CBD	cannabidiol
CSA	Controlled Substances Act of 1970
DEA	Drug Enforcement Administration
DOJ	Department of Justice
EOUSA	Executive Office for United States Attorneys
FBI	Federal Bureau of Investigation
HIDTA	High Intensity Drug Trafficking Area
LIONS	Legal Information Online Network System
Colorado MED	Colorado Marijuana Enforcement Division
OCDETF	Organized Crime Drug Enforcement Task Forces Program
ODAG	Office of the Deputy Attorney General
ONDCP	Office of National Drug Control Policy
RFID	radio frequency identification
THC	delta-9-tetrahydrocannabinol
USAO	United States Attorney's Office
Washington State LCB	Washington State Liquor and Cannabis Board

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.

GAO U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

December 30, 2015

The Honorable Charles E. Grassley
Chairman
Committee on the Judiciary
United States Senate

The Honorable Dianne Feinstein
United States Senate

Under the Controlled Substances Act of 1970 (CSA), generally it is a federal crime for any person to knowingly or intentionally manufacture, distribute, dispense, or possess marijuana.[1] For many years, all 50 states had uniform drug control laws or similar provisions that mirrored the CSA with respect to their treatment of marijuana, making their violation a state criminal offense. However, as of June 2015, 24 states and the District of Columbia have passed laws legalizing marijuana for medical purposes under certain circumstances—yet federal penalties remain under the CSA with regard to marijuana.[2] In November 2012, 2 of these states—Colorado and Washington—became the first states to pass ballot initiatives to legalize the possession of marijuana for recreational use under state law. The ballot initiatives in Colorado and Washington generally were to allow for personal possession of up to an ounce of marijuana for those at least 21 years of age and required the states to establish regulatory and enforcement systems to control the production, processing, and sale of marijuana.[3] More recently, in November 2014, voters in Alaska, Oregon, and the District of Columbia approved ballot measures legalizing marijuana for recreational use.

[1] 21 U.S.C. §§ 841, 844.

[2] In addition to the 24 states and the District of Columbia, that have passed laws legalizing marijuana for medical purposes, 15 states have laws pertaining to only the use of products containing cannabidiol (CBD), one of the active ingredients in marijuana plants. We provide more details later in this report.

[3] For Colorado's regulatory framework regarding the production, processing, and sale of recreational marijuana, see 1 Colo. Code Regs. 212-2, Retail Marijuana Code. For Washington's regulatory framework regarding the production, processing, and sale of recreational marijuana, see Wash. Admin. Code ch. 314-55, Marijuana Licenses, Application Process, Requirements, and Reporting.

The Department of Justice (DOJ) is responsible for enforcing the CSA and developing policies and strategies to do so. In 2009 and 2011, DOJ issued guidance to prosecutors concerning marijuana enforcement under the CSA. On August 29, 2013, DOJ updated that marijuana enforcement guidance following the passage of Colorado's and Washington's state ballot initiatives legalizing recreational marijuana under state law. The guidance described examples of circumstances where the federal government may seek to challenge the regulatory system implemented by a state to control the production, processing, and sale of marijuana because it was likely to threaten federal enforcement priorities. In particular, the guidance instructed DOJ's prosecutorial and law enforcement components to focus marijuana enforcement efforts on priorities that it stated were particularly important to the federal government, such as preventing revenue from the sale of marijuana from going to criminal enterprises, preventing violence and the use of firearms in the cultivation and distribution of marijuana, and preventing the distribution of marijuana to minors. DOJ indicated that the guidance rests on its expectation that states and local governments that have legalized marijuana will implement strong and effective regulatory and enforcement systems that will address the threat that those state laws could pose to these priorities.

You requested that we review the actions Colorado and Washington had taken to implement their recreational marijuana laws, the mechanisms DOJ and its components have established to monitor their effects, and the lessons learned from DOJ's enforcement efforts in response to states' medical marijuana laws. This report examines the following questions:

- What are the features of Colorado's and Washington's systems to regulate the production, processing, and sale of recreational marijuana?
- To what extent is DOJ monitoring the effects of state marijuana legalization relative to DOJ's 2013 marijuana enforcement policy guidance?
- What factors have DOJ field officials reported affecting their marijuana enforcement actions in selected states that have legalized marijuana for medical purposes?

To determine how Colorado and Washington regulate the production, processing, and sale of recreational marijuana, we reviewed laws and regulations governing recreational marijuana in Colorado and Washington

as well as reports describing the development and implementation of these laws and regulations, such as the state of Colorado task force report providing recommendations for implementing Colorado's recreational marijuana legalization law.[4] To obtain additional perspectives on these regulations, we interviewed officials from the state regulatory agencies responsible for developing, implementing, and enforcing the regulations, including the Colorado Department of Revenue's Marijuana Enforcement Division (MED) and the Washington State Liquor and Cannabis Board (Washington State LCB). In addition, we observed Washington State LCB officials conduct inspections at three recreational marijuana facilities. We also interviewed officials from each of the states' state patrols and offices of the attorney general, to obtain their perspectives on implementation and enforcement of the regulations.

To determine how DOJ is monitoring the effects of state marijuana legalization laws relative to DOJ's 2013 marijuana enforcement policy, we reviewed DOJ documentation related to its marijuana enforcement and monitoring efforts, including marijuana enforcement guidance memorandums the Office of the Deputy Attorney General (ODAG) issued to federal prosecutors beginning in 2009, and information DOJ provided to the Senate Judiciary Committee regarding its marijuana enforcement policy. We also reviewed DOJ component agency documentation including Drug Enforcement Administration (DEA) reports describing national drug threat and enforcement trends and guidance describing DOJ investigative and prosecutorial case management systems used by DEA and United States Attorneys' offices (USAO). We interviewed DOJ headquarters officials from ODAG, DEA, the Executive Office for United States Attorneys (EOUSA), and other DOJ components including the Criminal Division and the Office of Justice Programs.[5] We also interviewed officials from the Office of National Drug Control Policy

[4]State of Colorado, *Task Force Report on the Implementation of Amendment 64* (Denver, CO: March 13, 2013).

[5]DOJ's Criminal Division develops, enforces, and supervises the application of all federal criminal laws except those specifically assigned to other divisions. The division and the 93 U.S. Attorneys have the responsibility for overseeing criminal matters as well as certain civil litigation. EOUSA, among other things, facilitates coordination between the Offices of the United States Attorneys and other organizational units of DOJ. The Office of Justice Programs works in partnership with the justice community to identify the most pressing crime-related challenges confronting the justice system and to provide information, training, coordination, and innovative strategies and approaches for addressing these challenges. We discuss DEA and the USAOs later in this report.

(ONDCP), with which DOJ reported coordinating as part of its efforts to monitor the effects of state marijuana legalization.[6] We then evaluated DOJ's reported efforts to monitor the effects of state legalization of marijuana against standards in *Standards for Internal Control in the Federal Government*.[7]

To determine the factors DOJ field officials reported affecting their marijuana enforcement actions in selected states that have legalized marijuana for medical purposes, we selected 6 states for our review, to include (1) Colorado and Washington because, in addition to their recreational marijuana laws, they have long-standing medical marijuana legalization laws in place, and (2) 4 additional states—Alaska, California, Maine, and Oregon—that were the earliest states to pass laws legalizing marijuana for medical purposes. We interviewed officials from the six DEA field divisions and 10 USAOs with jurisdiction for these selected states.[8] The information we obtained from DOJ field officials in these selected states is not generalizable to DOJ field officials in all states with medical marijuana legalization laws, but these interviews provided valuable information and perspectives about the experiences of DOJ field offices in the states. We also interviewed and obtained information from officials from federal agencies that DOJ reported partnering with in its marijuana enforcement actions, including the U.S. Postal Inspection Service, U.S. Forest Service, Bureau of Land Management, National Park Service, and ONDCP High Intensity Drug Trafficking Area (HIDTA) Program offices in selected states.[9] Furthermore, we reviewed

[6]ONDCP is a component of the Executive Office of the President that advises the President on drug control issues, coordinates drug-control activities and related funding across the federal government, and produces the annual *National Drug Control Strategy*, which outlines administration efforts to reduce illicit drug use, manufacturing and trafficking, drug-related crime and violence, and drug-related health consequences.

[7]GAO*, Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: Nov. 1, 1999).

[8]See app. I for a list of the DEA and USAO field offices whose officials we interviewed.

[9]The HIDTA Program, a federal grant program administered by ONDCP, provides resources to assist federal, state, local, and tribal agencies to coordinate activities in areas determined to be critical drug-trafficking regions of the United States. There are currently 28 HIDTAs, which include approximately 17 percent of all counties in the United States and approximately 60 percent of the U.S. population. HIDTA-designated counties are located in 48 states, as well as in Puerto Rico, the U.S. Virgin Islands, and the District of Columbia.

information provided by DEA field divisions and USAOs in the selected states regarding their marijuana enforcement actions from fiscal years 2007 through 2014, including correspondence sent to medical marijuana dispensaries and case information reported in these field divisions' publicly available press releases.[10] We selected this time period to include information on DOJ marijuana enforcement 2 years before DOJ issued its first public marijuana enforcement guidance in 2009 and after its August 2013 guidance.[11]

We conducted this performance audit from July 2014 to November 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Marijuana refers to the dried leaves, flowers, stems, and seeds from the cannabis plant (shown in fig. 1), which contains the psychoactive or mind-altering chemical delta-9-tetrahydrocannabinol (THC), as well as other related compounds. Marijuana can be smoked or consumed in food or drinks, such as marijuana-infused brownies, cookies, peanut butter, candy, and soda. According to the Substance Abuse and Mental Health Services Administration, marijuana is the most widely used illicit drug in the United States. For example, according to the 2013 National Survey on Drug Use and Health, an estimated 44 percent of Americans aged 12 and older reported they had tried marijuana, and an estimated 7.6 percent of

[10]Although the specifics vary by state, medical marijuana dispensaries generally provide for the transfer or sale of medical marijuana products.

[11]It is important to note that during the course of our review, the Department of Justice's appropriations act was passed and section 538 of the Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, 128 Stat. 2130, 2217 (Dec. 16, 2014) stated that "[n]one of the funds made available in this Act to the Department of Justice may be used, with respect to the States of Alabama, Alaska, Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Illinois, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Washington, and Wisconsin, to prevent such States from implementing their own State laws that authorize the use, distribution, possession or cultivation of medical marijuana."

Americans aged 12 and older reported having used marijuana in the past month.[12]

Figure 1: Cannabis Plants

Source: Colorado Marijuana Enforcement Division. | GAO-16-1

[12]Funded by the Substance Abuse and Mental Health Services Administration, the National Survey on Drug Use and Health provides information on the use of illicit drugs, alcohol, and tobacco among noninstitutionalized Americans aged 12 and older. See United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, distributed by Inter-university Consortium for Political and Social Research, *National Survey on Drug Use and Health, 2013*, ICPSR35509-v1 (Ann Arbor, MI: Nov. 18, 2014).

Marijuana is a controlled substance under federal law and is classified in the most restrictive of categories of controlled substances by the federal government. The CSA places all federally controlled substances in one of five “schedules,” depending, among other things, on the drug’s likelihood for abuse or dependence, and whether the drug has an accepted medical use. Marijuana is classified under Schedule I,[13] the classification reserved for drugs that have been found by the federal government to have a high potential for abuse, no currently accepted medical use in treatment in the United States, and a lack of accepted safety for use under medical supervision.[14] In contrast, the other schedules are for drugs of varying addictive properties, but found by the federal government to have a currently accepted medical use. The CSA does not allow Schedule I drugs to be dispensed with a prescription, unlike drugs in the other schedules.[15] Furthermore, the CSA provides federal sanctions for possession, manufacture, distribution, dispensing, or use of Schedule I substances, including marijuana, except in the context of a government-approved research project.[16]

Within DOJ, two components have primary responsibility for enforcing the CSA. DEA is the primary federal law enforcement agency responsible for conducting criminal investigations of potential violations of the CSA. U.S. Attorneys are the chief federal law enforcement officers in federal judicial districts responsible for, among other things, prosecution of criminal cases brought by the federal government and prosecution of civil cases in which the United States is a party.[17] As part of their marijuana enforcement efforts, DEA and the U.S. Attorneys collaborate, often with state and local law enforcement, to conduct criminal investigations and

[13]21 U.S.C. § 812(c), Schedule I (c)(10).

[14]21 U.S.C. § 812(b)(1).

[15]21 U.S.C. § 829.

[16]21 U.S.C. §§ 823(f), 841, 844.

[17]There are 93 U.S. Attorneys stationed throughout the United States, Puerto Rico, the Virgin Islands, Guam, and the Northern Mariana Islands. U.S. Attorneys are appointed by, and serve at the discretion of, the President of the United States, with the advice and consent of the United States Senate. One U.S. Attorney is assigned to each of the 94 judicial districts, with the exception of Guam and the Northern Mariana Islands, where a single U.S. Attorney serves in both districts. Each U.S. Attorney is the chief federal law enforcement officer of the United States within his or her particular jurisdiction.

prosecutions, civil and criminal forfeiture, seizures, and eradications of cannabis plants.[18]

An increasing number of states have adopted laws that legalize the use of marijuana under state law. As of June 2015, 24 states and the District of Columbia had passed legislation or voter initiatives legalizing the possession and distribution of marijuana for medical purposes under state or territorial law.[19] In 1996, California became the first state to do so with its passage of the Compassionate Use Act,[20] and an increasing number of states have passed ballot initiatives, propositions, or legislation under state law to legalize medical marijuana in recent years. For example, from 2007 through June 2015, 13 states and the District of Columbia passed some type of measure to legalize marijuana for medical purposes under state law. The laws these states have passed legalizing medical marijuana vary, as does the extent to which the states have established regulatory and enforcement systems to implement them.

As of June 2015, 4 states and the District of Columbia had passed ballot initiatives legalizing marijuana for recreational purposes under state law. In 2012, Colorado and Washington became the first states to pass ballot initiatives legalizing the production, processing, and sale of marijuana for

[18]For example, DEA's Domestic Cannabis Eradication/Suppression Program is a nationwide law enforcement program that exclusively targets drug-trafficking organizations involved in cannabis cultivation. According to DEA, in 2014, the program was responsible for the eradication of 3,904,213 cultivated outdoor cannabis plants and 396,620 indoor plants. In addition, the program accounted for 6,310 arrests and the seizure of more than $27.3 million of cultivator assets.

[19]In addition to the 24 states, and the District of Columbia, which have passed laws legalizing marijuana for medical purposes, 15 states have laws pertaining to only the use of products containing CBD, one of the active ingredients in marijuana plants. These states have varying statutory provisions that allow the use of low-THC and high-CBD variants of marijuana to treat certain medical conditions.

[20]Compassionate Use Act of 1996, Proposition 215, Cal. Health & Safety Code § 11362.5.

recreational use. In 2014, Alaska, Oregon, and the District of Columbia passed ballot initiatives legalizing marijuana for recreational use.[21]

DOJ's Marijuana Enforcement Policy

DOJ has updated its marijuana enforcement policy in recent years in response to the rising number of states that have legalized marijuana under state law. According to a series of memorandums ODAG issued to U.S. Attorneys beginning in 2009, DOJ is committed to enforcing the CSA for marijuana regardless of state law. However, DOJ has directed its field components to focus on the efficient and rational use of its investigative and prosecutorial resources to address the most significant threats to public health and safety. According to one of the memorandums, DOJ has not historically devoted resources to prosecuting individuals whose conduct is limited to possession of small amounts of marijuana for personal use on private property. Rather, DOJ has left such lower-level or localized marijuana activity to state and local law enforcement authorities through enforcement of their own drug laws.

While reiterating the department's approach to enforcing the CSA and focusing its resources to address the greatest public health and safety threats, each of the ODAG's memorandums provided additional clarification with respect to the conditions that may trigger federal action, including criminal investigation and prosecution. For example, in October 2009, ODAG issued guidance stating that DOJ's investigative and prosecutorial resources should be directed towards the prosecution of significant traffickers of illegal drugs, including marijuana, and the disruption of illegal drug manufacturing and trafficking networks. Moreover, the guidance stated as a general matter, pursuing those priorities should not result in a focus of federal resources on individuals whose actions were in clear and unambiguous compliance with state laws providing for the medical use of marijuana, including individuals with cancer or other serious illnesses who use marijuana as part of a recommended treatment regimen consistent with applicable state law or caregivers who provide such individuals with marijuana in compliance

[21]In November 2014, voters in the District of Columbia approved a ballot initiative legalizing recreational marijuana possession and use, but this law does not allow for the sale of recreational marijuana. Legalization of Possession of Minimal Amounts of Marijuana for Personal Use Act of 2014, Ballot Initiative 71, D.C. Law 20-153, D.C. Code § 48-904.01. Similarly, in November 2014, voters in Alaska and Oregon voted for Measure 2, an act to tax and regulate the production, sale, and use of marijuana, and Measure 91, the Control, Regulation, and Taxation of Marijuana and Industrial Hemp Act, respectively.

with existing state law.[22] The memorandum identified various conduct that may indicate illegal drug-trafficking activity of federal interest,[23] while reiterating that U.S. Attorneys maintained prosecutorial discretion in addressing criminal matters within their districts.[24]

In June 2011, ODAG issued guidance stating that the 2009 memorandum was not intended to shield commercial marijuana operations from federal enforcement actions. Among other things, the guidance also stated that while DOJ's efficient use of limited federal resources had not changed, there had been an increase in the scope of commercial cultivation, sale, distribution, and use of marijuana for purported medical purposes, and that this activity remained of federal concern. Furthermore, the guidance stated that the term medical marijuana "caregiver" referred to individuals providing care to individuals with cancer or other serious illnesses, not commercial operations cultivating, selling, or distributing marijuana.

In August 2013, ODAG issued its first public guidance on marijuana enforcement since Colorado and Washington passed state ballot initiatives legalizing marijuana for recreational purposes. The guidance provided additional clarification of DOJ's priorities and certain circumstances that may warrant DOJ to challenge a state's implementation of its marijuana legalization program. The guidance outlined eight enforcement priorities that were particularly important to the federal government. These priorities generally focused on preventing the conduct ODAG outlined in its 2009 guidance, but with some additional activities specified. For example, the guidance included preventing the

[22]The specific requirements for medical marijuana caregivers vary by state, but in general caregivers are persons permitted under state law to provide medical marijuana to certain medical marijuana patients.

[23]This memorandum identified characteristics of conduct that may indicate illegal drug trafficking of federal interest. These include unlawful possession or unlawful use of firearms; violence; sales to minors; financial and marketing activities inconsistent with the terms, conditions, or purposes of state law, including evidence of money laundering activity or financial gains or excessive amounts of cash inconsistent with purported compliance with state or local law; amounts of marijuana inconsistent with purported compliance with state or local law; illegal possession or sale of other controlled substances; or ties to other criminal enterprises.

[24]According to the *United States Attorneys' Manual*, prosecutorial discretion provides U.S. Attorneys with wide latitude in determining when, whom, how, and whether to prosecute for apparent violations of federal criminal law. See *United States Attorneys' Manual*, Chapter 9-27.000, Principles of Federal Prosecution.

diversion of marijuana from states where it is legal under state law in some form to other states, preventing the growing of marijuana on public lands, and preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use. Figure 2 lists the eight marijuana enforcement priorities outlined in the August 2013 DOJ guidance.

Figure 2: DOJ's Marijuana Enforcement Priorities as Outlined in the August 2013 Marijuana Enforcement Guidance

Preventing the distribution of marijuana to minors

Preventing violence and the use of firearms in the cultivation and distribution of marijuana

Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs, and cartels

Preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use

Preventing the diversion of marijuana from states where it is legal under state law in some form to other states

Preventing the growing of marijuana on public lands and the attendant public safety and environmental dangers posed by marijuana production on public lands

Preventing state-authorized marijuana activity from being used as a cover or pretext for the trafficking of other illegal drugs or other illegal activity

Preventing marijuana possession or use on federal property

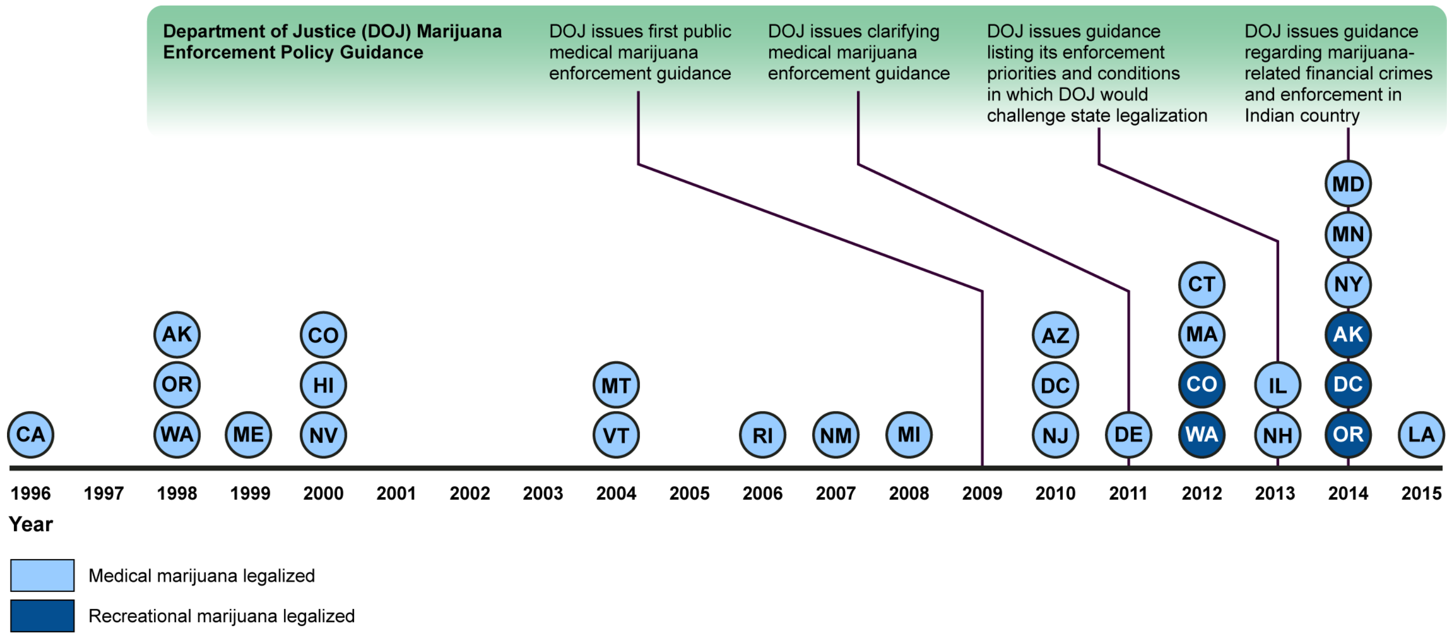
Source: Department of Justice; Department of the Interior (logo). | GAO-16-1

The guidance also stated that outside of these priorities, the enforcement of state law by state and local law enforcement and regulatory bodies should remain the primary means of addressing marijuana-related activity. The guidance stated that in jurisdictions that have enacted laws legalizing marijuana in some form and that have implemented strong and effective regulatory and enforcement systems to control the cultivation, distribution, sale, and possession of marijuana, conduct in compliance with those laws and regulations is less likely to threaten the federal marijuana enforcement priorities. The guidance indicated DOJ's expectation that state systems must not only contain robust controls and procedures on paper, but must also be effective in practice, with jurisdictions providing the necessary resources and demonstrating the willingness to enforce their laws and regulations in a manner that does not undermine federal enforcement priorities. The guidance further stated that if state enforcement efforts are not sufficiently robust to protect

against certain harms outlined in the guidance, the federal government may seek to challenge the state regulatory structures themselves, in addition to continuing to bring individual enforcement actions, including criminal prosecutions, focused on the enforcement priorities.

Figure 3 shows a timeline with the years in which states and the District of Columbia legalized medical and recreational marijuana and the years in which DOJ issued public guidance clarifying its marijuana enforcement policy.[25]

Figure 3: Timeline Showing the Years States and the District of Columbia Passed Measures Legalizing Medical and Recreational Marijuana under State Law and the Years DOJ Issued Marijuana Enforcement Policy Guidance



Source: GAO analysis of state laws and regulations; Department of Justice. | GAO-16-1

[25]In 2014, DOJ issued two additional guidance memorandums addressing financial crimes related to commercial marijuana activities and DOJ's marijuana enforcement on tribal lands. Specifically, in February 2014, ODAG issued a memorandum stating that investigations and prosecutions of certain financial crimes based upon marijuana-related activity should be subject to the same consideration and priorities listed in the August 2013 memorandum. The financial crimes listed in this memorandum include violations of money-laundering statutes, the unlicensed money remitter statute, and the Bank Secrecy Act. In October 2014, EOUSA issued a memorandum stating that the eight priorities listed in the August 2013 memorandum will guide USAOs' marijuana enforcement efforts in Indian country.

Features of Colorado's and Washington's Regulatory Systems for Recreational Marijuana

In November 2012, Colorado and Washington passed state ballot measures that legalized recreational marijuana production, processing, sales, and possession and designated regulatory agencies to develop, implement, and enforce regulations governing the recreational marijuana industry. In 2014, these recreational marijuana regulatory agencies—the Colorado MED and the Washington State LCB—began to implement the new regulations. In general, the two state regulatory systems share similar features, including requirements for licensing, licensee and employee background checks, facility security measures, and product labeling and packaging.[26] The following describes some of the features of the 2 states' regulatory systems.

Licensing. The Colorado MED and the Washington State LCB have established four types of recreational marijuana licenses that allow licensees (or accredited testing facilities) to conduct specific tasks, including producing, processing, or selling marijuana products, or testing marijuana products for potency and potential contaminants.[27] Figure 4 shows the types of recreational marijuana licenses issued in Colorado and Washington.

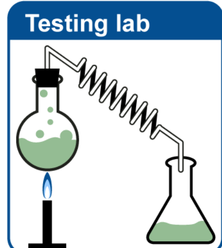
---

[26]For Colorado's regulatory framework regarding the production, processing, and sale of recreational marijuana, see 1 Colo. Code Regs. 212-2, Retail Marijuana Code. See also Colo. Rev. Stat. tit. 12, art. 43.4. For Washington's regulatory framework regarding the production, processing, and sale of recreational marijuana, see Wash. Admin. Code ch. 314-55, Marijuana Licenses, Application Process, Requirements, and Reporting. See also Wash. Rev. Code tit. 69, ch. 69.50.

[27]Colorado and Washington use different terminology for each type of license. For example, in Colorado's regulations a "retail marijuana products manufacturing facility" license allows the licensee to manufacture, prepare, package, store, and label retail marijuana product, whether in concentrated form or comprised of marijuana and other ingredients intended for use or consumption, such as edible products, ointments, or tinctures. Under Washington's regulations, a "marijuana processor" license allows the licensee to process, dry, cure, package, and label usable marijuana, marijuana concentrates, and marijuana-infused products for sale at wholesale to marijuana retailers. We use the Washington terminology in this report.

Figure 4: Colorado and Washington Recreational Marijuana License Types

License type

Producer	Processor	Retailer	Testing lab
			
Marijuana producer licensees can grow, harvest, cure, and package marijuana for sale to other marijuana producers or processors.[a]	Marijuana processor licensees can process, manufacture, package, and label marijuana, marijuana concentrates, and marijuana-infused products for sale to other marijuana processors or retailers.	Marijuana retailer licensees can sell marijuana, marijuana concentrates, and marijuana-infused products to customers who are 21 or older.	Testing lab licensees can conduct state-mandated product quality assurance testing.[b]

Source: GAO analysis of Colorado and Washington recreational marijuana regulations. | GAO-16-1

Notes: Both states require licenses to be renewed annually.

Colorado allows an individual to concurrently hold marijuana producer, processor, and retailer licenses. In contrast, Washington allows individuals to concurrently hold both a marijuana producer and a marijuana processor license, but prohibits producers and processors from having a direct or indirect financial interest in a licensed marijuana retailer. Further, in Colorado, a person who is an owner of a retail marijuana producer, processor, or retailer may not be an owner of a retail marijuana testing facility. In Washington, a person with a financial interest in an accredited testing lab may not have a direct or indirect financial interest in a licensed marijuana producer or processor for whom he or she is conducting required quality assurance testing.

[a]In Colorado, marijuana producer licensees can also sell directly to marijuana retailers.

[b]Washington does not issue testing lab licenses, but has implemented a required accreditation process in order for labs to conduct quality assurance tests.

Table 1 shows the number of active recreational marijuana licenses by type as of August 2015, as reported by each of the 2 states' recreational marijuana regulatory agencies.

Table 1: Reported Number of Recreational Marijuana Licenses Issued by Colorado and Washington, as of August 2015

License type	Licenses issued in Colorado[a]	Licenses issued in Washington[b]
Marijuana producer	480	636
Marijuana processor	134	533
Marijuana retailer	380	191
Testing lab[c]	16	14
Total	**1,010**	**1,374**

Source: Colorado Marijuana Enforcement Division and Washington State Liquor and Cannabis Board | GAO-16-1

[a]Data as of August 3, 2015.

[b]Data as of August 25, 2015. License counts do not include pending issuances or closed facilities.

[c]In Washington, the testing lab count is the number of accredited facilities.

Background checks. Both Colorado and Washington conduct background checks to determine if applicants are eligible to obtain a license to operate a recreational marijuana facility. As part of the licensing process, both states' regulations require applicants to submit documentation that may include biographical information, fingerprints, financial information and funding sources, and facility floor plans. The regulatory agencies review this documentation to determine whether applicants meet eligibility requirements including state residency, age, and criminal history requirements. In order to own, manage, or invest in a marijuana facility, both states' regulations require applicants to be 21 or older and a state resident for at least 2 years in Colorado and 6 months in Washington.[28]

[28]In addition, Colorado regulations state that applicants for employment at recreational marijuana facilities must apply for an occupational license that requires them to be 21 or older and undergo a criminal history record check. In contrast, Washington regulations do not include an occupational license: Nonmanagement employees must be 21 or older, but they are not required to undergo criminal history record checks. The Washington State LCB adopted emergency rules, effective June 20, 2015, which changed the residency requirement from 3 to 6 months.

According to state officials, the states' regulatory agencies are to conduct fingerprint-based criminal history record checks against the Federal Bureau of Investigation's (FBI) criminal history records. State regulatory agency officials are to examine the criminal history record check results and compare that information against the list of potentially disqualifying criminal offenses identified in the regulations to determine if an applicant is eligible for a license. According to Colorado and Washington regulations, generally, applicants who have received a felony conviction for controlled substances within the past 10 years of their application are disqualified; however, the 2 states' methods for making this determination differ. For example, in Colorado an applicant with a felony conviction during the past 5 years or a felony conviction for controlled substances during the past 10 years is disqualified.[29] In contrast, Washington uses a point system for different types of convictions to consider an applicant's eligibility, whereby an applicant with 8 or more points is normally disqualified. Under this system, a felony conviction during the past 10 years is worth 12 points, a gross misdemeanor or a misdemeanor conviction during the past 3 years is worth 5 or 4 points, respectively, and each failure to report a conviction is worth 4 points. Both states require licensees to inform the regulatory agency of new criminal convictions.[30]

Facility security measures. Colorado and Washington regulations require that recreational marijuana facilities have physical security measures installed to combat theft and diversion of marijuana. These generally include perimeter fencing at outdoor marijuana producer facilities; a security alarm system on all perimeter entry points and perimeter windows; as well as a video surveillance system with camera coverage of all points of entry and exit to the exterior of the licensed premises, point-of-sale areas, and other areas such as areas where marijuana is grown or manufactured. The regulations specify that licensees must store recordings with the time and date available for a

[29]The Colorado MED may grant a license to a person if the person has a state felony conviction based on possession or use of marijuana or marijuana concentrate that would not be a felony if the person were convicted of the offense on the date of the application for a license.

[30]According to state regulations, both the Colorado MED and the Washington State LCB have the option during the license renewal process to fingerprint current licensees and conduct a follow-up criminal history record check. According to state regulations, this is done at the Director's discretion in Colorado and randomly in Washington. Washington State LCB officials reported that they had conducted follow-up criminal history checks for all first-time licensee renewals, and they will do so randomly in the future.

minimum of 40 days in Colorado and 45 days in Washington. According to officials, the stored video records are used to verify information agency officials obtain from inspections as well as actions reported by licensees such as the destruction of a plant or shipping marijuana products to another marijuana licensee. For example, we observed an unannounced premises check of a Washington marijuana producer where there was a delay of approximately 10 minutes before the Washington State LCB officers were able to access the facility. The officers stated that in that type of situation they might examine the last 10 minutes of a facility's recorded video to check for suspicious activity.

Inventory-tracking systems. Both states' regulations require licensees to use inventory-tracking systems that the regulatory agencies operate and monitor. According to state officials, the regulatory agencies have implemented electronic systems for inventory tracking and require that unique identifier tags be attached to marijuana plants and marijuana-infused products. For example, according to state officials, the Colorado MED uses radio frequency identification (RFID) tags, while the Washington State LCB uses tags with a 16-digit number and an optional bar code. Licensees must enter each identifier tag number and information about the marijuana plant or product into the electronic inventory-tracking systems.[31] Licensees must document all inventory changes in the system, such as harvesting existing plants, transporting plants or products once they are sold to another licensee, destroying plant waste or unused plants and products, thefts, and sales to retail customers.

Colorado MED and Washington State LCB officials stated that they are able to use the inventory-tracking systems to trace specific marijuana plants and products through each stage of the supply chain, including production, processing, delivery to a retail store, and sale to a consumer. For example, Colorado MED officials reported an instance where the agency used the state inventory-tracking system to identify the lot numbers of marijuana-infused products made with potentially mold-contaminated marijuana and the retail stores that received those products in order to prevent them from being sold to consumers. Colorado MED and Washington State LCB officials reported that inventory-tracking

[31]The states' inventory-tracking systems are the Colorado Marijuana Enforcement Tracking Reporting and Compliance system and the Washington Marijuana Traceability System.

system data are actively monitored to identify possible irregularities and verify information from inspections. For example, Washington State LCB officials reported that their agency audited a retail licensee that reported significant sales in 1 month and zero sales in the subsequent month. Figure 5 shows a photo of marijuana plants with RFID and bar code tags at Colorado and Washington recreational marijuana facilities, respectively.

Figure 5: Marijuana Plants with Inventory-Tracking System Tags at Colorado and Washington Recreational Marijuana Facilities

Source: Colorado Marijuana Enforcement Division (left photograph) and Washington State Liquor and Cannabis Board (right photograph). | GAO-16-1

Both states' regulations require licensees to notify the Colorado MED or Washington State LCB about the transport of marijuana or marijuana-infused products to other licensed facilities. Licensees must generate a transport manifest from information entered into the inventory-tracking system, such as the type of product, amount or weight, destination, the driver, and the transport vehicle, as well as the departure time and expected delivery time. Colorado MED and Washington State LCB officials reported that transport manifests can be verified by state and local police if a marijuana delivery driver is stopped for traffic violations to confirm that drivers are legally transporting marijuana or marijuana products.

Product quality assurance testing. The Colorado MED and Washington State LCB have established regulatory provisions for licensees to submit marijuana and marijuana-infused product samples to state-approved testing labs for quality assurance testing. According to the regulations, testing labs are to perform a number of tests on samples, including potency testing to determine the percentage of THC in the sample; screening for harmful microorganisms such as bacteria or fungus; and may include tests for certain contaminants.[32] Colorado and Washington regulations state that if a sample fails quality assurance tests, the batch of marijuana or marijuana-infused products it was taken from cannot be sold and must either be destroyed or retested.[33]

Labeling and packaging. Both states' regulations include labeling and packaging standards for recreational marijuana products. Marijuana product labels are required to state that the product contains marijuana and include warnings about the potential health impacts of consuming the product.[34] In addition, for edible marijuana-infused products, labels must also include an ingredients list, serving size statement and the number of

[32]For example, Colorado MED officials reported that contaminant testing was not yet mandatory as of March 2015 and that the processes were being tested before full implementation. According to regulations, contaminant tests may include but are not limited to screening for pesticide, harmful chemicals, adulterants or other types of microbials, molds, metals, filth, or residual solvents. Washington State LCB officials reported that Washington does not currently require testing for pesticides, but they are working on the issue. According to regulations, additional testing includes screening for residual solvent levels in certain products and may include screening for unsafe levels of metals.

[33]Washington regulations permit a sample that fails a quality assurance test and the associated trim, leaf, and other usable material to be used to create extracts using hydrocarbon or carbon dioxide closed loop system upon approval of the board. After processing, the extract must still pass all required quality assurance tests.

[34]For example, Washington's regulations require all usable marijuana sold at retail stores to include the following warnings: "Warning: This product has intoxicating effects and may be habit forming. Smoking is hazardous to your health"; "There may be health risks associated with consumption of this product; Should not be used by women that are pregnant or breast feeding"; "For use only by adults twenty-one and older. Keep out of reach of children"; "Marijuana can impair concentration, coordination, and judgment. Do not operate a vehicle or machinery under the influence of this drug"; and a statement that discloses all pesticides applied to the marijuana plants and growing medium during production and processing. There are similar but separate warning requirements for retail marijuana-infused products.

servings of marijuana in the product, among other things.[35] The states' regulations also prohibit the packaging and labeling of a marijuana product from being designed in ways that are appealing to children or other persons under 21 years of age. For example, Colorado requires that multiple-serving edible marijuana product packaging maintain its child-resistant effectiveness for repeated openings or that single-serving edible marijuana products bundled into a larger package contain individually wrapped servings in child-resistant packaging.

Generally, Colorado regulations also require that multiple-serving edible retail marijuana products have single-serving amounts that are physically demarked and easily separated, while liquid edible multiple-serving retail marijuana products can either be marked on the container to show individual servings or include a measuring device. For example, a marijuana-infused chocolate bar may have scored pieces that each contain 10 milligrams of THC.[36] Washington regulations require that marijuana-infused edible products in solid form that contain more than one serving in the package must be packaged individually in single servings in childproof packaging and marijuana-infused edible products in liquid form that contain more than one serving in the package must include a measuring device with the product.

According to officials, the Washington State LCB has implemented a process for reviewing marijuana-infused products to determine if they may be sold by licensed retail facilities.[37] For example, Washington marijuana processor licensees must obtain approval from the Washington LCB for all marijuana-infused edible products, labeling, and packaging prior to offering these items for sale to a marijuana retailer. The processor licensee must submit a photo of the product, label, and package to the Washington State LCB for approval. According to Washington State LCB officials, a four-person working group meets on a weekly basis to review

[35]Both states' regulations define a single serving as an amount of marijuana-infused product that contains 10 milligrams of THC and each sale unit of a marijuana-infused product such as a cookie or soda is limited to a maximum of 100 milligrams of THC.

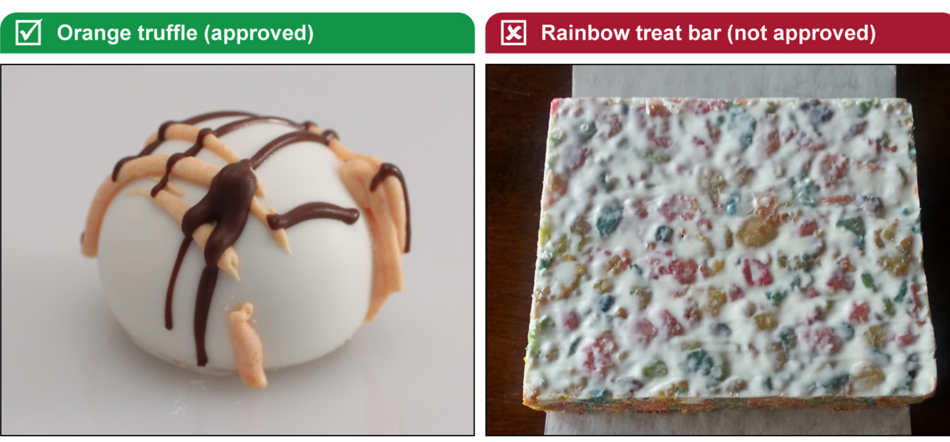
[36]By regulation, the size of a standard serving of marijuana shall be no more than 10 milligrams of active THC and no individual edible retail marijuana product unit for sale shall contain more than 100 milligrams of active THC.

[37]Colorado does not currently have a comparable approval process for marijuana-infused products.

submitted products and determine if they are appealing to children. For example, the officials reported that the working group had previously approved marijuana-infused peanut brittle for sale, but did not approve hot chocolate mix, animal cookies, or gummy bears because these products were deemed to be appealing to children.

Figure 6 shows examples of marijuana-infused products that the Washington State LCB reviewed—one that was approved for sale and another that was not.

Figure 6: Marijuana-Infused Products Reviewed by the Washington State Liquor and Cannabis Board



Source: Washington State Liquor and Cannabis Board. | GAO-16-1

Consumer restrictions. Both Colorado's and Washington's recreational marijuana regulations include restrictions on consumer use of marijuana, including limits on who may possess marijuana, how much may be possessed, and where it may be used. For example, both states prohibit marijuana retailers from selling to anyone under age 21. In addition, the 2 states restrict the amount of marijuana that a marijuana retailer is permitted to sell to an individual. For example, Colorado prohibits retail marijuana stores from selling more than 1 ounce of retail marijuana or its equivalent in retail marijuana product during a single transaction to a Colorado resident and more than a quarter ounce of retail marijuana or its equivalent in retail marijuana product during a single sales transaction to

a nonresident.[38] In Washington, a single transaction is limited to 1 ounce of usable marijuana, 16 ounces of solid marijuana-infused products meant to be eaten or swallowed, 7 grams of marijuana-infused extract or concentrates for inhalation, or 72 ounces of marijuana-infused products in liquid form meant to be eaten or swallowed. Neither state allows marijuana consumption in public or at marijuana retailer facilities.

To address the risk of drugged driving, both states have established THC blood level limits that are similar to the blood alcohol limits used for determining alcohol impairment.[39] Law enforcement can use roadside breath tests to test for alcohol impairment, but Colorado and Washington currently test for THC only using blood draws. According to state laws, generally, drivers suspected of being impaired by law enforcement officers can be required to undergo blood testing to determine if they are under the influence of drugs and if their blood contains 5 nanograms or more of THC per milliliter.

Facility inspections. Both Colorado's and Washington's regulations generally require marijuana licensees to grant regulatory agencies access to their facilities to carry out inspections. Colorado MED and Washington State LCB officials stated that they conduct scheduled and unscheduled inspections to verify regulatory compliance by licensees, including final inspections of new facilities and inspections of existing facilities. Colorado MED and Washington State LCB officials stated that they planned to conduct ongoing facility compliance checks modeled on their agencies' liquor enforcement procedures. For example, Colorado MED and Washington State LCB officials reported performing underage compliance checks at retail stores.

Violations and penalties. In both states, regulatory violations are addressed through penalties that can include monetary fines, suspension or cancellation of a license, and criminal charges. The Colorado MED and Washington State LCB report using a system of progressive discipline

[38]Colorado allows any person 21 or older to grow up to six marijuana plants, three of which can be mature plants. Up to 1 ounce of marijuana can be given to a person 21 or older so long as there is no payment involved. Washington does not allow individuals to grow recreational marijuana.

[39]For more information on drug-impaired driving, see GAO, *Drug-Impaired Driving: Additional Support Needed for Public Awareness Initiatives*, GAO-15-293 (Washington, D.C.: Feb. 24, 2015).

with escalating penalties for repeated infractions. For example, in Colorado, the penalty for selling marijuana to a minor could include "license suspension, a fine per individual violation, a fine in lieu of suspension up to $100,000, and/or license revocation depending on the mitigating and aggravating circumstances."[40] Washington regulations state that the sale of marijuana to a minor by a licensed marijuana business will result in a 10-day suspension or $2,500 fine for the first offense, a 30-day license suspension on the second offense, and cancellation of the license on the third offense. Table 2 shows selected features of Colorado's and Washington's recreational marijuana regulations, as of July 2015.

Table 2: Selected Features of Colorado's and Washington's Recreational Marijuana Systems, as of July 2015

Selected features	Colorado	Washington
Licensee eligibility requirements		
State residency	At least 2 years[a]	At least 6 months
Age	At least 21 years old	At least 21 years old
Criminal history	Fingerprint-based check against Federal Bureau of Investigation (FBI) records to determine eligibility based on disqualifying offenses	Fingerprint-based check against FBI records to determine eligibility based on disqualifying offenses
Facility location restrictions		
Local approval	Local jurisdictions may prohibit recreational marijuana facilities	Local jurisdictions may raise objections, and prospective facilities must comply with local ordinances
Near areas where minors gather	Not specifically prohibited in state regulations. Local jurisdictions may impose time, place, manner, and location requirements	Not within 1,000 feet of a school, playground, recreation center, childcare center, public park, public transit center, library, or game arcade. Local jurisdictions may further reduce this distance to a minimum of 100 feet for every location except schools and playgrounds.
Facility security measures		
Monitored alarm system	Yes	Yes
Video surveillance system	Yes	Yes
Video recording storage	At least 40 days	At least 45 days

[40]Applicants and licensees can request an administrative hearing to appeal decisions by the Colorado MED and Washington State LCB, including an initial denial of a license and suspension or revocation of an existing license.

Selected features	Colorado	Washington
Perimeter fencing	No specific height, must prevent public from entering secure areas at outdoor marijuana producers	At least 8 feet high at outdoor marijuana producers
Inventory tracking		
Electronic inventory tracking system	Yes	Yes
Shipments and transport manifests	Shipments are entered into inventory tracking system. Transport manifests include product information, driver, vehicle, destination, departure time, and expected delivery time	Shipments are entered into inventory tracking system and quarantined for 24 hours. Transport manifests include product information, driver, vehicle, destination, departure time, and expected delivery time
Labeling and packaging		
Single serving definition	10 milligrams of THC delta-9-tetrahydrocannabinol (THC)	10 milligrams of THC
Maximum servings per sale unit	100 milligrams of THC	100 milligrams of THC
Child-resistant or childproof packaging required	Yes. Packaging and label design cannot be appealing to children.	Yes. Packaging and label design cannot be appealing to children.
Label statements	Serving size, ingredients, usage instructions, expiration date, health warnings, marijuana symbol, chemicals used in production	Serving size, ingredients, usage instructions, expiration date, health warnings, chemicals used in production
Consumer restrictions		
Marijuana possession limit	Up to 1 ounce of marijuana or equivalent amount of marijuana-infused product	Up to 1 ounce of marijuana, 16 ounces of solid marijuana-infused products, 7 grams of marijuana-infused extract for inhalation, or 72 ounces of liquid marijuana-infused products
Public consumption	No	No
Blood level for drugged driving	5 nanograms of THC per milliliter of blood	5 nanograms of THC per milliliter of blood

Source: GAO analysis of Colorado and Washington recreational marijuana laws and regulations | GAO 16-1

[a]Non-owner employees of recreational marijuana facilities are required to obtain an occupational license and be current residents.

Regulatory development and revision. Officials from both states reported using information from commissioned studies and working groups, as well as DOJ's marijuana enforcement guidance, to inform their recreational marijuana regulations and have continued to do so as they have adopted regulatory changes. For example, in Colorado, a state-commissioned task force developed recommendations for implementing

Colorado's recreational marijuana law,[41] while Washington used a crime and drug policy consultant to inform its regulatory development.[42] Moreover, since recreational marijuana sales began in Colorado in January 2014 and in Washington in July 2014, both states have made revisions to their regulations. For example, in June 2015, the Washington State LCB adopted rules relating to marijuana-infused edible products, while in May 2015, the Colorado MED adopted changes regarding the packaging of marijuana products.

DOJ Reports Actions to Monitor the Effects of State Legalization of Marijuana, but Has Not Documented a Plan for Doing So

DOJ Reports Taking Actions to Monitor Effects of State Marijuana Legalization

As noted earlier, in August 2013, DOJ's ODAG issued guidance stating DOJ's expectation that state and local governments that have enacted laws authorizing marijuana-related conduct will implement strong and effective regulatory and enforcement systems to ensure that the laws do not undermine federal enforcement priorities. However, the guidance noted that if state enforcement efforts are not sufficiently robust to protect against threats to federal enforcement priorities, the federal government may seek to challenge the state regulatory structures themselves, in

[41]State of Colorado, *Task Force Report on the Implementation of Amendment 64* (Denver, CO: March 13, 2013).

[42]For example, see Mark A. R. Kleiman, BOTEC Analysis Corporation, UCLA, *Alternative Bases for Limiting Cannabis Production*, (Los Angeles, CA: June 28, 2013).

addition to conducting individual enforcement actions, including criminal prosecutions, focused on the priorities.[43]

According to ODAG officials and information DOJ has provided to Congress since issuing the August 2013 guidance, DOJ is taking actions to monitor the effects of state legalization of marijuana relative to DOJ's marijuana enforcement policy generally in two ways. First, DOJ continues to enforce the CSA by conducting individual law enforcement actions targeting those marijuana cases that threaten any of the eight enforcement priorities outlined in the August 2013 ODAG guidance. ODAG officials reported that U.S. Attorneys, as the senior federal law enforcement officials in the states, were effectively monitoring whether cases were implicating DOJ's marijuana enforcement priorities and prosecuting those cases that did. In addition to conducting federal prosecutions, officials from ODAG and the U.S. Attorneys for Colorado and Washington reported that U.S. Attorneys were actively engaged in consultation and discussion with state and local regulatory and law enforcement officials. Through these interactions, officials reported that U.S. Attorneys have been able to communicate federal enforcement priorities, assess the implications of legalization relative to the priorities, and identify specific areas of federal concern as state laws have been implemented. For example, officials reported that as state recreational marijuana legalization was being implemented in Colorado, the U.S. Attorney had consulted with state and local officials to identify concerns about edible marijuana products and the potential that their sale and use could threaten federal enforcement priorities.

Second, ODAG officials reported that DOJ was using various sources of information to monitor the effects of marijuana legalization under state laws. ODAG officials stressed that DOJ's focus was on monitoring the effects that legalization has had relative to DOJ's enforcement priorities,

[43]It is important to note that during the course of our review, the Department of Justice's appropriations act was passed and section 538 of the Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, 128 Stat. 2130, 2217 (Dec. 16, 2014) stated that "[n]one of the funds made available in this Act to the Department of Justice may be used, with respect to the States of Alabama, Alaska, Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Illinois, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Washington, and Wisconsin, to prevent such States from implementing their own State laws that authorize the use, distribution, possession or cultivation of medical marijuana."

rather than evaluating specific requirements within states' legalization laws or regulatory systems. ODAG officials reported that DOJ as a whole shared responsibility for collecting information to inform DOJ's monitoring of the effects of state marijuana legalization, while ODAG was responsible for assessing this information to guide DOJ's response to state marijuana legalization—including whether DOJ might challenge the state laws or regulatory systems.

ODAG officials reported that their most detailed description of the data sources DOJ used in its monitoring efforts could be found in information DOJ sent to Congress in early 2015 as part of testimony for confirmation hearings for the Attorney General and Deputy Attorney General. According to this information, DOJ possessed quantitative and qualitative data and used these data to inform its marijuana enforcement efforts. ODAG reported that, as it carried out its monitoring efforts, DOJ would continue to consider all types of data on the degree to which state systems regulating marijuana-related activity protect federal enforcement priorities and public safety and health, including existing federal surveys on drug use; state and local research; and feedback from federal, state, and local law enforcement. To this end, the ODAG officials said that they were reviewing information developed by DOJ components such as DEA and USAOs, and other relevant information developed or published by other federal agencies. From within DOJ, ODAG officials cited DEA, EOUSA, and the Organized Crime Drug Enforcement Task Forces Program (OCDETF) as their primary data sources for monitoring the effects of state marijuana legalization.[44] In particular, ODAG officials reported that DEA's *National Drug Threat Assessments* were a source for identifying the effects of marijuana legalization. The *National Drug Threat Assessment*, prepared annually by DEA, assesses the threat posed to the United States by the trafficking and abuse of illicit drugs based upon law enforcement, intelligence, and public health data available for the review period. For example, DEA's 2014 *National Drug Threat Assessment* summarizes emerging developments related to drug trafficking and the use of illicit substances of abuse, including marijuana, and highlights

[44]According to DOJ, the OCDETF Program, directed by ODAG, is the centerpiece of the Attorney General's drug strategy to reduce the availability of drugs by disrupting and dismantling major drug trafficking organizations and money laundering organizations and related criminal enterprises. The program operates nationwide and combines the resources and unique expertise of numerous federal, state, and local agencies in a coordinated effort against major drug trafficking and money-laundering organizations.

concerns associated with the legalization of marijuana. Among other things, the report includes information regarding ingestion of marijuana edibles by children in states with medical marijuana availability, marijuana-related emergency department visits, and the increasing use of marijuana concentrates and the public safety threat posed by the process used to make these concentrates—noting that butane extraction has resulted in numerous explosions and injuries.[45] ODAG officials also cited information that they were considering from DOJ components' case management systems, including EOUSA's Legal Information Online Network System (LIONS) and OCDETF's Management Information System. According to DOJ, these systems include, among other things, information on cases opened or declined by the USAO, cases prosecuted, and their disposition.

ODAG officials also reported relying on information from other federal agencies that conduct public health and safety studies, such as ONDCP's HIDTA program and the National Institute on Drug Abuse.[46] For example, ODAG officials stated that they had reviewed reports that the Rocky Mountain HIDTA had issued describing the impacts of marijuana legalization in Colorado. These reports included information from various sources regarding impaired driving, youth marijuana use, emergency room and hospital marijuana-related admissions, and the diversion of marijuana from Colorado to other states.[47]

Furthermore, ODAG officials reported that ODAG and other DOJ components were sharing information regarding federal marijuana enforcement efforts in states that have legalized marijuana. In particular, ODAG officials cited the USAOs' establishment of a Marijuana

[45]According to the DEA's 2014 *National Drug Threat Assessment*, marijuana concentrates are extracted from the leafy material of the marijuana plant in many ways, but the most common and potentially most dangerous method is butane extraction, which uses highly flammable butane gas to extract THC from the marijuana plant material.

[46]An institute of the National Institutes of Health, the National Institute on Drug Abuse reports that its mission is to lead the nation in bringing the power of science to bear on drug abuse and addiction. In this role, it reports that it provides strategic support and research across a broad range of disciplines while ensuring the rapid and effective dissemination and use of the results of that research to significantly improve prevention and treatment and to inform policy as it relates to drug abuse and addiction.

[47]Rocky Mountain High Intensity Drug Trafficking Area, Investigative Support Center, *The Legalization of Marijuana in Colorado: The Impact. Volume 3 Preview 2015*. (Denver, CO: 2015)

Enforcement Working Group, composed of U.S. Attorneys with jurisdiction for states that have legalized some form of marijuana who meet on a monthly basis to share information and perspectives regarding marijuana enforcement. ODAG officials reported participating in these meetings to discuss issues associated with DOJ's enforcement efforts. Officials also reported that DOJ is working with ONDCP to identify other mechanisms by which to collect and assess data on the effects of state marijuana legalization. For example, ODAG officials reported participating in ONDCP-led interagency working groups that have met periodically since August 2014 to discuss data collection and evaluation regarding the effects of state marijuana legalization. ODAG officials reported that, as part of their own monitoring efforts, they would consider any information regarding the effects of marijuana legalization on public health and safety that ONDCP developed and shared with them.

Table 3 identifies and summarizes the various actions ODAG officials reported that DOJ was taking to monitor the effects of state legalization of marijuana on its federal enforcement priorities.

Table 3: Summary of Actions ODAG Officials Reported DOJ was Taking to Monitor the Effects of State Marijuana Legalization Relative to DOJ's August 2013 Marijuana Enforcement Policy Guidance

Reported action	How reportedly used to monitor effects of state marijuana legalization
U.S. Attorneys conduct individual enforcement actions in states that have legalized marijuana and consult with state and local agencies in these states to address concerns regarding effects of marijuana legalization efforts.	• Office of the Deputy Attorney General (ODAG) officials reported that U.S. Attorneys, as the senior federal law enforcement officials in the states, were monitoring whether cases involve Department of Justice (DOJ) marijuana enforcement priorities and prosecuting those cases that do. • U.S. Attorneys in Colorado and Washington reported working with state and local agencies to address federal concerns regarding the effects of state marijuana legalization systems relative to DOJ's marijuana enforcement priorities.
ODAG officials collaborate with and assess information from DOJ components and other federal agencies.	• ODAG officials reported that they were assessing various data sources with information about the effects of state marijuana legalization, including the Drug Enforcement Administration's *National Drug Threat Assessments*, data from the U.S. Attorneys' case management system, and various data collected by federal agencies regarding public health and public safety. • ODAG officials reported participating in the monthly meetings of U.S. Attorneys from states that have legalized some form of marijuana. These meetings were designed to share information on marijuana enforcement cases. • ODAG officials reported that they participate in periodic Office of National Drug Control Policy-led interagency meetings to discuss the effects of state marijuana legalization.

Source: GAO analysis of DOJ provided information. |GAO 16-1

DOJ Has Not Documented Its Plan for Monitoring the Effects of State Marijuana Legalization

Notwithstanding these efforts, DOJ has provided limited specificity with respect to aspects of its plan for monitoring the effect of state marijuana legalization relative to ODAG's August 2013 marijuana enforcement policy guidance. As we noted earlier, ODAG officials reported that they were considering various qualitative and quantitative data sources and identified some of the sources they were using, such as DEA's *National Drug Threat Assessments*. However, ODAG officials did not state how they would make use of the various information from the sources they cited to monitor the effects of state marijuana legalization. For example, ODAG officials reported that the most detailed description of DOJ's monitoring efforts is contained in responses to questions for the record that DOJ sent to Congress in early 2015. According to this information, DOJ identified LIONS and OCDETF data as information sources for its monitoring efforts, noting that these case management systems provided statistical information reflecting the efforts of DOJ in prosecuting violations of federal law. DOJ reported that these data collections systems collectively assist in informing the department's counterdrug policy, establishing law enforcement priorities, and making resource allocations. However, ODAG officials did not make clear how ODAG would be using these data in its efforts to monitor the effects of state marijuana legalization. For example, officials from EOUSA—which maintains LIONS—reported that USAOs do not consistently enter information in LIONS specifying the primary drug type involved in a case. Thus, officials said that LIONS would not provide reliable information regarding the extent of marijuana-related cases in a USAO district.[48]

Similarly, while officials identified DEA and HIDTA reports and various public health studies as sources of data for their monitoring efforts, they did not identify how they would use the data from these various reports and studies to monitor the effects of marijuana legalization relative to each of the eight marijuana enforcement priorities. ODAG officials also did not state how DOJ would use the information to determine whether

[48]The DOJ Office of the Inspector General has previously examined limitations with LIONS, noting that it was not designed as a statistical system, and therefore can be an imperfect tool for responding to specific, detailed inquiries seeking comprehensive, uniform nationwide data sought for purposes other than case management. For example, see U.S. Department of Justice, Office of the Inspector General, *Audit of the Department of Justice's Efforts to Address Mortgage Fraud*, Audit Report 14-12, (Washington, D.C.: March 2014). Also see U.S. Department of Justice, Office of the Inspector General, *Resource Management of United States Attorneys' Offices*, Audit Report 09-03, (Washington, D.C.: November 2008).

the effects of state marijuana legalization necessitated federal action to challenge a state's regulatory system.

Further, ODAG officials reported that they had not documented their monitoring process. These officials reported that they did not see a benefit in DOJ documenting how it would monitor the effects of state marijuana legalization relative to the August 2013 ODAG guidance. Rather, ODAG officials reported that they would continue to consider all sources of available data as part of their ongoing responsibilities and would be using these data to inform DOJ's efforts to protect its marijuana enforcement priorities. ODAG officials said they would consider documenting their monitoring plan in the future if they determined the need; however, they did not identify the conditions that might lead them to do so.

Standards for Internal Control in the Federal Government provides the overall framework for establishing and maintaining an effective internal control system.[49] The standards specify the need for internal controls to be clearly documented, and the documentation to be readily available for review. Moreover, information should be recorded and communicated to management and others within the entity who need it and in a form and within a timeframe that enables them to carry out their internal control and other responsibilities. Documentation also provides a means to retain organizational knowledge and mitigate the risk of having that knowledge limited to a few personnel, as well as a means to communicate that knowledge as needed to external parties.[50]

[49]GAO/AIMD-00-21.3.1. Internal control is an integral component of an organization's management that provides reasonable assurance that the following objectives are being achieved: effectiveness and efficiency of operations, reliability of financial reporting, and compliance with applicable laws and regulations. These standards, issued pursuant to the requirements of the Federal Managers' Financial Integrity Act of 1982, provide the overall framework for establishing and maintaining internal control in the federal government. Also pursuant to the Federal Managers' Financial Integrity Act of 1982, the Office of Management and Budget issued *Circular A-123*, revised December 21, 2004, to provide the specific requirements for assessing the reporting on internal controls. Internal control standards and the definition of internal control in *Circular A-123* are based on GAO's *Standards for Internal Control in the Federal Government*.

[50]See GAO, *Standards for Internal Control in the Federal Government,* GAO-14-704G (Washington, D.C.: Sept. 10, 2014). GAO recently revised and reissued its *Standards for Internal Control in the Federal Government*. These new standards became effective October 1, 2015.

Documenting a plan specifying its monitoring process would provide DOJ with greater assurance that control activities—such as the ways DOJ is monitoring the effect of state marijuana legalization relative to federal enforcement priorities—are occurring as intended. Moreover, leveraging existing mechanisms to make this plan available to appropriate officials from DOJ components that are providing the various data can provide ODAG with an opportunity to gain institutional knowledge with respect to its monitoring plan, including the utility of the data ODAG is using. For example, ODAG cited LIONS as a key source of information for monitoring, yet EOUSA reported limitations with LIONS in tracking marijuana enforcement cases, and there may be limitations with other sources of information that ODAG officials are using, or planning to use, to monitor the effects of marijuana legalization. Incorporating the feedback into its monitoring plan can help ODAG ensure it is using the most appropriate data and thus better position it to identify those state systems that are not effectively protecting federal enforcement priorities—so that DOJ can work with states to address concerns and, if necessary, take steps to challenge those systems, in accordance with its 2013 marijuana enforcement guidance.

DOJ Field Officials Reported That Various Factors Have Affected Their Marijuana Enforcement Actions in Selected States That Have Legalized Marijuana for Medical Purposes

We interviewed officials from six DEA field divisions and 10 USAOs with jurisdictions for 6 states that have legalized marijuana for medical purposes: Alaska, California, Colorado, Maine, Oregon, and Washington. Overall, officials from these DEA field divisions and USAOs reported that their marijuana enforcement efforts were focused on addressing DOJ's marijuana enforcement priorities while ensuring they were effectively applying their limited resources. Officials reported their perspectives on factors that had affected their marijuana enforcement actions, including key public health and safety threats, local concerns regarding the commercial medical marijuana industry, and DOJ's updated marijuana enforcement policy.

Applying resources to target most significant public health and safety threats. Officials from all of the DEA divisions and USAOs we spoke with reported that they continued to apply their limited resources to address the most significant threats in their jurisdictions. In this way, officials generally reported that marijuana enforcement, while important, was nonetheless one of many competing priorities, along with investigating and prosecuting other types of drug crimes and, for USAOs, all federal crimes in their districts. For example:

- Officials from the USAO for the Northern District of California reported dealing with a wide variety of federal crimes, including non-drug crimes, such as health care fraud, investment fraud, and computer hacking. Officials reported that they needed to be selective in how they directed their resources—and that those resources they directed toward marijuana enforcement generally involved gangs and violent crime, which pose significant threats to public safety.

- Officials from the USAO for the Eastern District of California reported that their district is one of the largest sources of marijuana production in the country, and many of the district's cases involve marijuana grown on public lands or interstate trafficking involving drug-trafficking organizations; however, the largest portion of the district's drug cases involve methamphetamine cases. Officials attributed this to the district historically being one of the main domestic sources of methamphetamine production and transport, which officials said poses a more significant threat to public health and safety in the district than marijuana, including a high number of hospitalizations and involvement of violent Mexican drug-trafficking organizations. As a result, the USAO has used its prosecutorial discretion to direct greater resources to methamphetamine prosecutions rather than those for marijuana. Similarly, a senior official from the DEA Seattle Division reported that the division's priorities are the investigation of crimes involving heroin, methamphetamine, and Mexican drug cartels.

- Officials from the DEA San Diego Division and the USAO for the Southern District of California reported that within their jurisdictions, large quantities of drugs are trafficked from Mexico through U.S. maritime and land borders. Accordingly, their top priority is addressing the major poly-drug-trafficking organizations involved in these drug operations and the violent crime that is typically associated with them.[51]

- A senior official from the DEA Anchorage, Alaska, District office reported that the district has generally focused its investigative resources on drugs other than marijuana, including cocaine, heroin, and methamphetamine. This official reported that because most drug-trafficking organizations traffic more than one type of drug, marijuana is often a part of but not the focus of the district's investigations.

[51]Poly-drug organizations manufacture or distribute more than one type of drug, such as cocaine, heroin, marijuana, and methamphetamine.

- Officials from DEA field divisions and USAOs in 4 of 6 states—California, Colorado, Oregon, and Washington—reported taking actions to target individuals associated with the rising number of butane hash oil explosions in their jurisdictions. For example, according to the DEA San Diego Division, the presence of butane hash oil laboratories at indoor marijuana growing operations was a growing concern and resulted in approximately 20 explosions and fires in the San Diego County area during fiscal year 2014.

Addressing concerns regarding the commercial medical marijuana industry. Officials from DEA field divisions and USAOs reported targeting commercial marijuana operations having the most significant impacts on local communities in their jurisdictions. For example, officials from DEA field divisions and USAOs in 4 of 6 selected states—California, Colorado, Oregon, and Washington—reported sending warning letters to about 1,900 owners and lien holders of medical marijuana dispensaries during fiscal years 2007 through 2013. Officials reported taking this action partly in response to requests from civic leaders, municipalities, and law enforcement officials concerned about the growth in the commercial medical marijuana industry.

In general, the letters emphasized that DOJ has the authority to enforce the CSA even when certain activities may be permitted under state law. The letters also notified the recipients that they could be subject to federal civil and criminal penalties and advised them to discontinue the distribution of marijuana. Some letters, from officials in California, Oregon, and Washington, stated that while the dispensaries they targeted were illegal under the CSA, they were generally also illegal under the states' own medical marijuana programs. Furthermore, some officials in California reported that the dispensaries they targeted were also illegal under local ordinances. DEA and USAO officials reported that sending warning letters was an efficient and effective way to close dispensaries and support local community concerns. For example, officials from the USAO for the Central District of California reported that most of the nearly 700 dispensaries to which they sent letters closed. In addition, the U.S. Attorney for the District of Colorado reported sending letters in fiscal year 2012 to dozens of medical marijuana dispensaries operating within 1,000 feet of schools to protect the health, safety, and welfare of Colorado youth—and that all of the dispensaries that received letters closed or moved.

Officials in 3 states—California, Oregon, and Washington—also reported conducting criminal investigations and prosecutions or civil forfeiture suits

in conjunction with their letter campaigns. For example, the four U.S. Attorneys in California reported that in October 2011, they began coordinated enforcement actions targeting the for-profit medical marijuana industry in California. According to officials from the USAOs, these actions included sending warning letters to owners and lien holders of medical marijuana dispensaries, conducting criminal investigations and prosecutions, and initiating civil forfeiture lawsuits.[52] Officials from the USAOs in California reported that they initiated these efforts in part to address concerns raised by civic leaders, municipalities, and law enforcement officials regarding the growing numbers of marijuana dispensaries in their districts. Officials reported that the number of dispensaries in their districts rose considerably beginning in 2009, and through discussions with state and local law enforcement, they began efforts to reduce the numbers of these dispensaries.[53]

DOJ's updated marijuana enforcement policy. Officials from DEA field locations and USAOs we spoke with reported that their implementation of the marijuana enforcement guidance ODAG has issued since 2009 had affected their marijuana enforcement actions to varying degrees.

- Officials from all DEA and USAO locations we spoke with reported that the series of marijuana enforcement guidance ODAG issued had not changed their enforcement focus, which continues to emphasize the most significant threats in their jurisdiction, and that they maintained active partnerships with state and local law enforcement officials. For example, the U.S. Attorney for the District of Colorado reported working closely with the state's Attorney General and the state's marijuana regulatory agency on various issues related to

[52]For example, officials from the USAO for the Central District of California reported that these actions included a number of federal and state criminal prosecutions, more than 26 federal forfeiture actions, and the execution of more than 55 search warrants at over 100 locations.

[53]Officials from the USAOs responsible for the Districts of Alaska and Maine reported that they were not aware of any criminal prosecutions in their respective districts associated with the medical marijuana industry in recent years, nor had they sent letters to owners and lien holders of medical marijuana dispensaries. The U.S. Attorney for the District of Alaska attributed this, in part, to the fact that there were no operational dispensaries in Alaska, while officials from the USAO in Maine reported that Maine's eight state-registered dispensaries have generally caused limited problems that have been addressed through state enforcement efforts, but nothing that had risen to the level of federal interest.

marijuana enforcement, including the sale of marijuana edibles and butane hash oil explosions.

- Some DEA and USAO field officials reported examining their existing caseloads following DOJ's August 2013 marijuana enforcement guidance to determine whether the cases were implicating DOJ's marijuana enforcement priorities, and some field officials reported closing a limited number of cases that did not threaten the priorities. For example:
  - Officials from the USAO for the District of Oregon reported that shortly after the August 2013 guidance was issued, they reviewed their open marijuana cases from 2011 to 2013 and determined that all of the cases were in compliance with the updated guidance. Similarly, the U.S. Attorney for the Eastern District of Washington reported that he was not aware of any cases that the USAO prosecuted prior to the August 2013 guidance that the USAO would no longer consider for prosecution.
  - Elsewhere, officials from the DEA Seattle Division and the USAO for the Central District of California reported reviewing their caseloads and closing a limited number of cases that did not threaten one of the eight marijuana enforcement priorities. For example, a senior official from the DEA Seattle Division reported closing seven investigations that did not threaten the priorities in the first several months after the guidance was issued, whereas officials from the USAO for the Central District of California reported closing some forfeiture cases.
- Officials from some DEA and USAO locations reported that the August 2013 DOJ guidance had led them to change their marijuana enforcement tactics, including scaling back their roles in targeting the commercial medical marijuana industry. For example:
  - Officials from USAOs in Alaska, California, and Oregon, and from one DEA field division in California, reported that, in accordance with the 2013 guidance, they would decline to consider for investigation and prosecution some marijuana-growing cases that they may have investigated and prosecuted prior to the 2013

guidance because these cases did not threaten DOJ's marijuana enforcement priorities.[54]

- Officials from two DEA field divisions—Los Angeles and Seattle—reported that because they were now required to demonstrate that at least one marijuana enforcement priority was threatened in an investigation before the USAO would grant them a search warrant, it had become more difficult to gather the additional evidence that may have helped them do so. These officials expressed concern that the August 2013 marijuana enforcement policy guidance had made it more challenging for them to identify crimes that potentially affected DOJ's enforcement priorities.

- Officials from DEA and USAOs in the 4 states that had reported sending warning letters to owners and lien holders of medical marijuana dispensaries—California, Colorado, Oregon, and Washington—reported that they had not sent warning letters since the August 2013 guidance was issued. Officials attributed this change in part to the fact that the guidance requires that they no longer consider the size or commercial nature of a dispensary alone in taking marijuana enforcement actions, but rather whether a dispensary is implicating one or more of the enforcement priorities listed in the August 2013 guidance. For example, officials from one DEA field division reported that they were not directing resources to investigate dispensaries unless there was clear evidence that these priorities were being threatened.

- Officials from the USAO for the District of Alaska reported that while they continued their strong partnerships with state and local law enforcement, they had reduced some marijuana enforcement support to the state. Specifically, officials reported that prior to the issuance of the August 2013 guidance, they had a general understanding with Alaska state and local law enforcement that the USAO would accept for federal prosecution marijuana cases involving recidivists that the state had prosecuted at least twice before. Officials said the USAO had since moved away from supporting the state in this way unless the suspects in the case

[54]According to the August 2013 guidance, in exercising prosecutorial discretion, prosecutors should no longer consider the size or commercial nature of a marijuana operation alone as a proxy for assessing whether marijuana trafficking threatens DOJ's enforcement priorities.

were involved in activities that threatened DOJ’s marijuana enforcement priorities.

Conclusions

It has been over 2 years since DOJ’s ODAG issued guidance in August 2013 stating that in jurisdictions that have enacted laws legalizing marijuana in some form, if state enforcement efforts are not sufficiently robust to protect against threats to federal enforcement priorities, the federal government may seek to challenge the state regulatory structures themselves, in addition to continuing to bring individual enforcement actions, including criminal prosecutions. ODAG officials reported relying on U.S. Attorneys to monitor the effects of marijuana enforcement priorities through their individual enforcement actions and communication with state agencies about how state legalization may threaten these priorities. ODAG officials also reported using various information sources provided by DOJ components and other federal agencies to monitor the effects of marijuana legalization and the degree to which existing state systems regulating marijuana-related activity protect federal enforcement priorities and public health and safety. However, ODAG officials have not documented their monitoring process or provided specificity about key aspects of it, including potential limitations of the data they report using and how they will use the data to identify states that are not effectively protecting federal enforcement priorities. Given the growing number of states legalizing marijuana, it is important for DOJ to have a clear plan for how it will be monitoring the effects of state marijuana legalization relative to DOJ marijuana enforcement guidance. Documenting a plan that specifies its monitoring process, such as the various data ODAG is using for monitoring along with their potential limitations, the roles of U.S. Attorneys in the monitoring process, and how ODAG is using all these inputs to monitor the effects of state legalization can provide DOJ with greater assurance that its monitoring activities are occurring as intended. Sharing the plan with DOJ components responsible for providing information to ODAG can help ensure that ODAG has an opportunity to gain institutional knowledge with respect to whether its monitoring plan includes the most appropriate information. This will help place DOJ in the best position to identify state systems that are not effectively protecting federal enforcement priorities, and take steps to challenge those systems if necessary in accordance with its 2013 marijuana enforcement guidance.

Recommendations for Executive Action

We recommend that the Attorney General take the following actions:

- direct ODAG to document a plan specifying DOJ's process for monitoring the effects of marijuana legalization under state law, in accordance with DOJ's 2013 marijuana enforcement policy guidance, to include the identification of the various data ODAG will use and their potential limitations for monitoring the effects of state marijuana legalization, and how ODAG will use the information sources in its monitoring efforts to help inform decisions on whether state systems are effectively protecting federal marijuana enforcement priorities, and

- direct ODAG to use existing mechanisms to share DOJ's monitoring plan with appropriate officials from DOJ components responsible for providing information DOJ reports using regarding the effects of state legalization to ODAG, obtain feedback, and incorporate the feedback into its plan.

Agency Comments and Our Evaluation

On September 28, 2015, we provided a draft of this report to DOJ and ONDCP for their review and comment. We also provided excerpts of the draft report for review and comment to the Colorado MED, Colorado Attorney General's office, Washington State LCB, and Washington State Attorney General's office. ONDCP, the Colorado MED, Colorado Attorney General's office, Washington State LCB, and Washington State Attorney General's office provided technical comments, which we incorporated as appropriate.

In its written comments, reproduced in appendix II, DOJ concurred with both of our recommendations. DOJ stated that ODAG will document a plan to identify the various data sources that will assist DOJ and USAO's in making enforcement decisions, including decisions in individual criminal prosecutions or civil enforcement actions, regarding marijuana-related crimes. DOJ stated that it will also monitor these data, as well as other sources of information, to determine whether states that have legalized recreational marijuana are effectively protecting DOJ's federal enforcement priorities as articulated in DOJ's guidance memorandum dated August 28, 2013. Lastly, DOJ stated that to the greatest extent possible DOJ will seek to publicly share the data it receives pursuant to this plan. DOJ also provided technical comments, which we have incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Attorney General, the Director of National Drug Control Policy, the Director of the Colorado MED, the Director of the Washington State LCB, the attorney generals of Colorado and Washington, appropriate congressional committees and members, and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions, please contact me at (202) 512-7141 or groverj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.

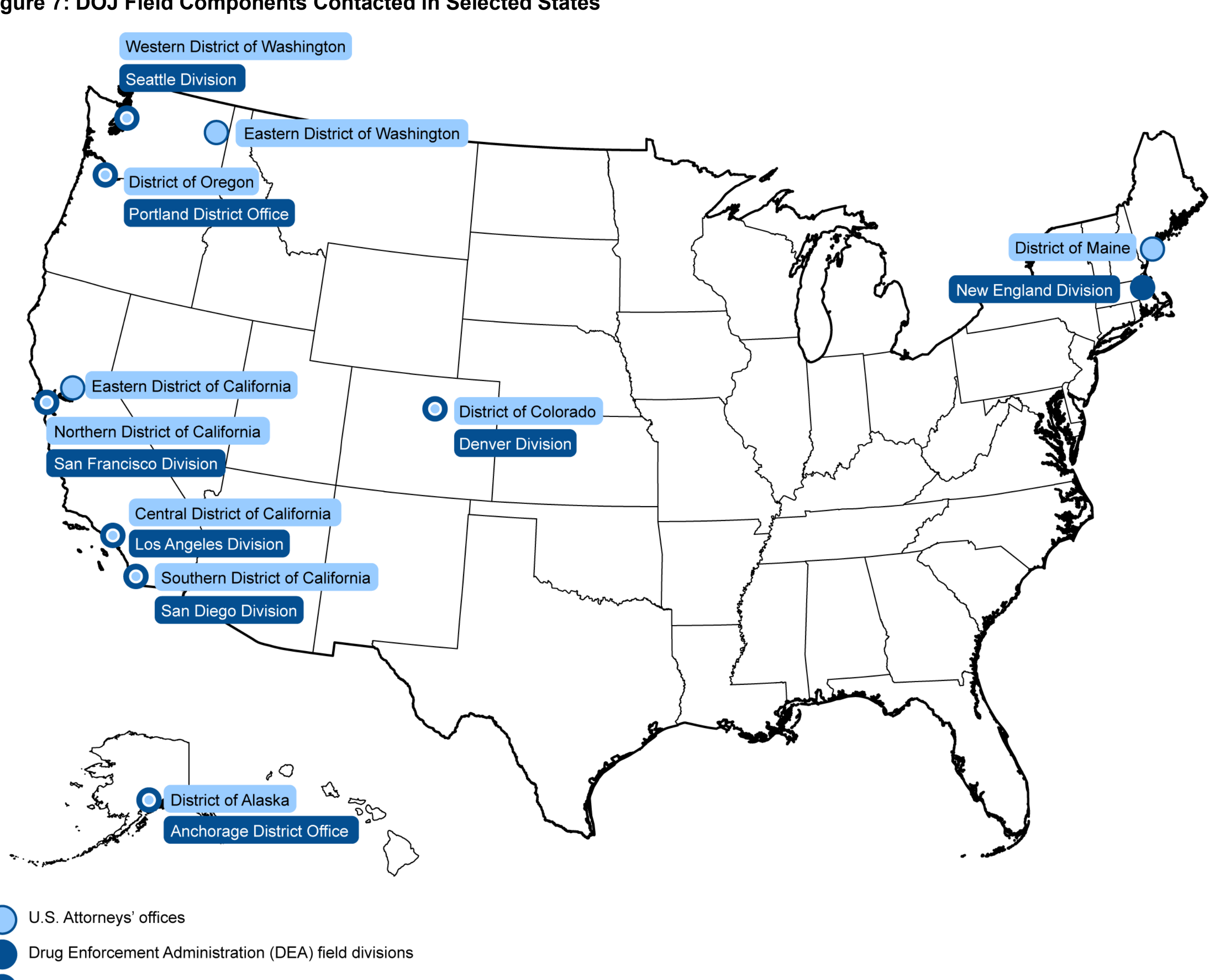
Sincerely yours,

Jennifer Grover
Director, Homeland Security and Justice

Appendix I: DOJ Field Components Contacted in Selected States

To determine the factors Department of Justice (DOJ) field officials reported affecting their marijuana enforcement actions in selected states that have legalized marijuana for medical purposes, we selected 6 states for our review, to include (1) Colorado and Washington because, in addition to their recreational marijuana laws, they have long-standing medical marijuana legalization laws in place, and (2) 4 additional states—Alaska, California, Maine, and Oregon—that were the earliest states to pass laws legalizing marijuana for medical purposes. We interviewed officials from the six Drug Enforcement Administration (DEA) field divisions and 10 U.S. Attorneys' offices (USAO) with jurisdiction for these selected states. These DEA field divisions and USAOs include the following.

Figure 7: DOJ Field Components Contacted in Selected States



Source: GAO review of Department of Justice information; Map Resources (map). | GAO-16-1

Note: The DEA New England Division has jurisdiction for Maine. The DEA Seattle Division includes the Anchorage District Office and Portland District Office.

Appendix II: Comments from the Department of Justice

U.S. Department of Justice

Washington, D.C. 20530

November 13, 2015

Jenny Grover
Acting Director
Homeland Security and Justice
U.S. Government Accountability Office
441 G Street, NW
Rm. 6H19
Washington, DC 20548

Re: Draft Report GAO-16-1, STATE MARIJUANA LEGALIZATION: DOJ Should Document Its Approach to Monitoring the Effects of Legalization

Dear Ms. Grover:

Thank you for providing the Department of Justice (Department) with the opportunity to review and comment on the draft Government Accountability Office (GAO) Report referenced above. The Department appreciates the work of the GAO team that prepared the report and the amount of data collected.

The Department concurs with both action items in the recommendation. The Department, through the Office of the Deputy Attorney General (ODAG) will document a plan to identify the various data sources that will assist the Department and the United States Attorneys' Offices in making enforcement decisions, including decisions in individual criminal prosecutions or civil enforcement actions, regarding marijuana-related crimes. The Department will also monitor this data, as well as other sources of information, to determine whether states that have legalized recreational marijuana are effectively protecting the Department's federal enforcement priorities as articulated in the Department's guidance memorandum dated August 28, 2013. To the greatest extent possible, the Department will seek to publicly share the data it receives pursuant to this plan.

Again, thank you for the opportunity to review and comment on this draft Report. Technical comments were previously provided under separate cover. Please feel free to contact me if you have any questions. We look forward to working with the GAO as we strive to improve our programs and further our commitment to make continuous improvements to the management of the Department.

Sincerely,

Michael H. Allen
for Lee J. Lofthus
Assistant Attorney General
for Administration

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Jennifer Grover, (202) 512-7141 or groverj@gao.gov

Staff Acknowledgments

In addition to the contact named above, Tom Jessor (Assistant Director) and Jason Berman (Analyst-in-Charge) managed this assignment. David Alexander, David Bieler, Billy Commons, Dominick Dale, Alexandra Gonzalez, Eric Hauswirth, Susan Hsu, Stephen Komadina, Jan Montgomery, and Alexandra Rouse made key contributions to this report.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's website (http://www.gao.gov). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to http://www.gao.gov and select "E-mail Updates."

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, http://www.gao.gov/ordering.htm.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on Facebook, Flickr, Twitter, and YouTube.
Subscribe to our RSS Feeds or E-mail Updates.
Listen to our Podcasts and read The Watchblog.
Visit GAO on the web at www.gao.gov.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

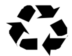
Website: http://www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Katherine Siggerud, Managing Director, siggerudk@gao.gov, (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548



Please Print on Recycled Paper.

Office of the Attorney General
Washington, D.C. 20530

January 4, 2018

MEMORANDUM FOR ALL UNITED STATES ATTORNEYS

FROM: Jefferson B. Sessions, III
Attorney General

SUBJECT: Marijuana Enforcement

In the Controlled Substances Act, Congress has generally prohibited the cultivation, distribution, and possession of marijuana. 21 U.S.C. § 801 *et seq.* It has established significant penalties for these crimes. 21 U.S.C. § 841 *et seq.* These activities also may serve as the basis for the prosecution of other crimes, such as those prohibited by the money laundering statutes, the unlicensed money transmitter statute, and the Bank Secrecy Act. 18 U.S.C. §§ 1956-57, 1960; 31 U.S.C. § 5318. These statutes reflect Congress's determination that marijuana is a dangerous drug and that marijuana activity is a serious crime.

In deciding which marijuana activities to prosecute under these laws with the Department's finite resources, prosecutors should follow the well-established principles that govern all federal prosecutions. Attorney General Benjamin Civiletti originally set forth these principles in 1980, and they have been refined over time, as reflected in chapter 9-27.000 of the U.S. Attorneys' Manual. These principles require federal prosecutors deciding which cases to prosecute to weigh all relevant considerations, including federal law enforcement priorities set by the Attorney General, the seriousness of the crime, the deterrent effect of criminal prosecution, and the cumulative impact of particular crimes on the community.

Given the Department's well-established general principles, previous nationwide guidance specific to marijuana enforcement is unnecessary and is rescinded, effective immediately.[1] This memorandum is intended solely as a guide to the exercise of investigative and prosecutorial discretion in accordance with all applicable laws, regulations, and appropriations. It is not intended to, does not, and may not be relied upon to create any rights, substantive or procedural, enforceable at law by any party in any matter civil or criminal.

---

[1] Previous guidance includes: David W. Ogden, Deputy Att'y Gen., Memorandum for Selected United States Attorneys: Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana (Oct. 19, 2009); James M. Cole, Deputy Att'y Gen., Memorandum for United States Attorneys: Guidance Regarding the Ogden Memo in Jurisdictions Seeking to Authorize Marijuana for Medical Use (June 29, 2011); James M. Cole, Deputy Att'y Gen., Memorandum for All United States Attorneys: Guidance Regarding Marijuana Enforcement (Aug. 29, 2013); James M. Cole, Deputy Att'y Gen., Memorandum for All United States Attorneys: Guidance Regarding Marijuana Related Financial Crimes (Feb. 14, 2014); and Monty Wilkinson, Director of the Executive Office for U.S. Att'ys, Policy Statement Regarding Marijuana Issues in Indian Country (Oct. 28, 2014).

OCTOBER 06, 2022

Statement from President Biden on Marijuana Reform

As I often said during my campaign for President, no one should be in jail just for using or possessing marijuana. Sending people to prison for possessing marijuana has upended too many lives and incarcerated people for conduct that many states no longer prohibit. Criminal records for marijuana possession have also imposed needless barriers to employment, housing, and educational opportunities. And while white and Black and brown people use marijuana at similar rates, Black and brown people have been arrested, prosecuted, and convicted at disproportionate rates.

Today, I am announcing three steps that I am taking to end this failed approach.

First, I am announcing a pardon of all prior Federal offenses of simple possession of marijuana. I have directed the Attorney General to develop an administrative process for the issuance of certificates of pardon to eligible individuals. There are thousands of people who have prior Federal convictions for marijuana possession, who may be denied employment, housing, or educational opportunities as a result. My action will help relieve the collateral consequences arising from these convictions.

Second, I am urging all Governors to do the same with regard to state offenses. Just as no one should be in a Federal prison solely due to the possession of marijuana, no one should be in a local jail or state prison for that reason, either.

Third, I am asking the Secretary of Health and Human Services and the Attorney General to initiate the administrative process to review expeditiously how marijuana is scheduled under federal law. Federal law currently classifies marijuana in Schedule I of the Controlled Substances Act, the classification meant for the most dangerous substances. This is the same schedule as for heroin and LSD, and even higher than the classification of fentanyl and methamphetamine – the drugs that are driving our overdose epidemic.

Finally, even as federal and state regulation of marijuana changes, important limitations on trafficking, marketing, and under-age sales should stay in place.

Too many lives have been upended because of our failed approach to marijuana. It's time that we right these wrongs.

###

OCTOBER 06, 2022

A Proclamation on Granting Pardon for the Offense of Simple Possession of Marijuana

Acting pursuant to the grant of authority in Article II, Section 2, of the Constitution of the United States, I, Joseph R. Biden Jr., do hereby grant a full, complete, and unconditional pardon to (1) all current United States citizens and lawful permanent residents who committed the offense of simple possession of marijuana in violation of the Controlled Substances Act, as currently codified at 21 U.S.C. 844 and as previously codified elsewhere in the United States Code, or in violation of D.C. Code 48–904.01(d)(1), on or before the date of this proclamation, regardless of whether they have been charged with or prosecuted for this offense on or before the date of this proclamation; and (2) all current United States citizens and lawful permanent residents who have been convicted of the offense of simple possession of marijuana in violation of the Controlled Substances Act, as currently codified at 21 U.S.C. 844 and as previously codified elsewhere in the United States Code, or in violation of D.C. Code 48–904.01(d)(1); which pardon shall restore to them full political, civil, and other rights.

My intent by this proclamation is to pardon only the offense of simple possession of marijuana in violation of Federal law or in violation of D.C. Code 48–904.01(d)(1), and not any other offenses related to marijuana or other controlled substances. No language herein shall be construed to pardon any person for any other offense, including possession of other controlled substances, whether committed prior, subsequent, or contemporaneous to the pardoned offense of simple possession of marijuana. This pardon does not apply to individuals who were non-citizens not lawfully present in the United States at the time of their offense.

Pursuant to this proclamation, the Attorney General, acting through the Pardon Attorney, shall administer and effectuate the issuance of certificates of pardon to eligible applicants who have been charged or convicted for the offense of simple possession of marijuana in violation of the Controlled Substances Act, as currently codified at 21 U.S.C. 844 and as previously codified elsewhere in the United States Code, or in violation of D.C. Code 48–904.01(d)(1). The Attorney General, acting through the Pardon Attorney, is directed to develop and announce application procedures for certificates of pardon and to begin accepting applications in accordance with such procedures as soon as reasonably practicable. The Attorney General,

acting through the Pardon Attorney, shall review all properly submitted applications and shall issue certificates of pardon to eligible applicants in due course.

IN WITNESS WHEREOF, I have hereunto set my hand this sixth day of October, in the year of our Lord two thousand twenty-two, and of the Independence of the United States of America the two hundred and forty-seventh.

JOSEPH R. BIDEN JR.

An official website of the United States government
Here’s how you know

STICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE Thursday, October 6, 2022

Justice Department Statement on President’s Announcements Regarding Simple Possession of Marijuana

The Justice Department today released the following statement from spokesman Anthony Coley

The Justice Department today released the following statement from spokesman Anthony Coley regarding the President’s proclamation granting a full, complete, and unconditional pardon to U.S. citizens and lawful permanent residents who have committed, or been convicted of, the offense of simple possession of marijuana in violation of the Controlled Substances Act, as currently codified at 21 U.S.C. 844 and as previously codified elsewhere in the U.S. Code, or in violation of D.C. Code 48–904.01(d)(1):

“The Justice Department will expeditiously administer the President’s proclamation, which pardons individuals who engaged in simple possession of marijuana, restoring political, civil, and other rights to those convicted of that offense. In coming days, the Office of the Pardon Attorney will begin implementing a process to provide impacted individuals with certificates of pardon.

“Also, in accordance with the President’s directive, Justice Department officials will work with our colleagues at the Department of Health and Human Services as they launch a scientific review of how marijuana is scheduled under federal law.”

Topic(s):
Civil Rights

Component(s):
Office of Public Affairs
Office of the Pardon Attorney

Press Release Number:
22-1075

Updated October 6, 2022

Tab 4

State Reports

FINANCIAL IMPACT ESTIMATING CONFERENCE

COMPLETE INITIATIVE FINANCIAL INFORMATION STATEMENT: USE OF MARIJUANA FOR DEBILITATING MEDICAL CONDITIONS (15-01)

SUMMARY OF INITIATIVE FINANCIAL INFORMATION STATEMENT

The amendment allows the use of medical marijuana for certain specified debilitating medical conditions, and other debilitating medical conditions of the same kind or class as or comparable to the specified conditions, for which a physician believes that the medical use of marijuana would likely outweigh the potential health risks for the patient. The amendment also establishes a process for the sale of medical marijuana to qualifying patients and designated caregivers. Based on information provided through public workshops and staff research, the Financial Impact Estimating Conference expects the amendment to have the following financial effects:

- Based on Colorado's experience, the Department of Health estimates that it will incur $2.7 million in annual costs for its regulatory responsibilities, upon full implementation. These costs may be offset by fees charged to the medical marijuana industry and users. However, the imposition of fees may require further action by the Legislature.
- The Department of Business and Professional Regulation, the Agency for Health Care Administration, the Department of Children and Families and the Department of Agriculture and Consumer Services do not expect the amendment to significantly affect their regulatory functions. Any regulatory impacts that occur will likely be offset by fees charged to the affected industries.
- The Department of Highway Safety and Motor Vehicles, the Department of Law Enforcement, the Police Chiefs Association, and the Sheriffs Association expect additional law enforcement costs based on the experience of other states with similar laws. The magnitude of such costs cannot be determined.
- Local governments were unable to quantify the amendment's impact, if any, on the services they provide.
- The Conference determined that medical marijuana is tangible personal property. Therefore, its purchase is subject to sales and use tax, unless a specific exemption exists.
- Based on the testimony from affected state agencies, the Conference determined that medical marijuana is currently not classified and likely will not be classified as a common household remedy entitled to a sales tax exemption.
- Based on information provided by the Department of Revenue and the Department of Agriculture and Consumer Services, the Conference determined that the applicability of agricultural-related exemptions to the sale or production of medical marijuana is uncertain. Should the exemptions apply, the direct sale or dispensation of medical marijuana in its raw form by the grower or cultivator to an end-user or designated caregiver would be exempt. This uncertainty also applies to exemptions for items used in the production of medical marijuana such as power farm equipment, fertilizer and pesticides.
- The increase in sales tax revenues to state and local governments cannot be determined precisely because too many unknowns affect the amount of taxable sales, but the increase will be substantial. For example, assuming Florida's medical marijuana consumption mirrors Colorado's experience, annual state and local government sales tax revenues could increase by an estimated $67 million after taking into account lawful consumption of medical marijuana currently authorized in Florida.
- The impact on property taxes, either positive or negative, cannot be determined.

FINANCIAL IMPACT STATEMENT

Increased costs from this amendment to state and local governments cannot be determined. There will be additional regulatory costs and enforcement activities associated with the production, sale, use and possession of medical marijuana. Fees may offset some of the regulatory costs. Sales tax will likely apply to most purchases, resulting in a substantial increase in state and local government revenues that cannot be determined precisely. The impact on property tax revenues cannot be determined.

SUBSTANTIVE ANALYSIS

A. Proposed Amendment
Ballot Title:

Use of Marijuana for Debilitating Medical Conditions.

Ballot Summary:

Allows medical use of marijuana for individuals with debilitating medical conditions as determined by a licensed Florida physician. Allows caregivers to assist patients' medical use of marijuana. The Department of Health shall register and regulate centers that produce and distribute marijuana for medical purposes and shall issue identification cards to patients and caregivers. Applies only to Florida law. Does not immunize violations of federal law or any non-medical use, possession or production of marijuana.

Proposed Amendment to the Florida Constitution:

ARTICLE X, SECTION 29. - Medical marijuana production, possession and use.

(a) PUBLIC POLICY.

(1) The medical use of marijuana by a qualifying patient or caregiver in compliance with this section is not subject to criminal or civil liability or sanctions under Florida law.
(2) A physician shall not be subject to criminal or civil liability or sanctions under Florida law solely for issuing a physician certification with reasonable care to a person diagnosed with a debilitating medical condition in compliance with this section.
(3) Actions and conduct by a Medical Marijuana Treatment Center registered with the Department, or its agents or employees, and in compliance with this section and Department regulations, shall not be subject to criminal or civil liability or sanctions under Florida law.

(b) DEFINITIONS. For purposes of this section, the following words and terms shall have the following meanings:

(1) "Debilitating Medical Condition" means cancer, epilepsy, glaucoma, positive status for human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), post-traumatic stress disorder (PTSD), amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, multiple sclerosis, or other debilitating medical conditions of the same kind or class as or comparable to those enumerated, and for which a physician believes that the medical use of marijuana would likely outweigh the potential health risks for a patient.
(2) "Department" means the Department of Health or its successor agency.
(3) "Identification card" means a document issued by the Department that identifies a qualifying patient or a caregiver.

(4) "Marijuana" has the meaning given cannabis in Section 893.02(3), Florida Statutes (2014), and, in addition, "Low-THC cannabis" as defined in Section 381.986(1)(b), Florida Statutes (2014), shall also be included in the meaning of the term "marijuana."

(5) "Medical Marijuana Treatment Center" (MMTC) means an entity that acquires, cultivates, possesses, processes (including development of related products such as food, tinctures, aerosols, oils, or ointments), transfers, transports, sells, distributes, dispenses, or administers marijuana, products containing marijuana, related supplies, or educational materials to qualifying patients or their caregivers and is registered by the Department.

(6) "Medical use" means the acquisition, possession, use, delivery, transfer, or administration of an amount of marijuana not in conflict with Department rules, or of related supplies by a qualifying patient or caregiver for use by the caregiver's designated qualifying patient for the treatment of a debilitating medical condition.

(7) "Caregiver" means a person who is at least twenty-one (21) years old who has agreed to assist with a qualifying patient's medical use of marijuana and has qualified for and obtained a caregiver identification card issued by the Department. The Department may limit the number of qualifying patients a caregiver may assist at one time and the number of caregivers that a qualifying patient may have at one time. Caregivers are prohibited from consuming marijuana obtained for medical use by the qualifying patient.

(8) "Physician" means a person who is licensed to practice medicine in Florida.

(9) "Physician certification" means a written document signed by a physician, stating that in the physician's professional opinion, the patient suffers from a debilitating medical condition, that the medical use of marijuana would likely outweigh the potential health risks for the patient, and for how long the physician recommends the medical use of marijuana for the patient. A physician certification may only be provided after the physician has conducted a physical examination and a full assessment of the medical history of the patient. In order for a physician certification to be issued to a minor, a parent or legal guardian of the minor must consent in writing.

(10) "Qualifying patient" means a person who has been diagnosed to have a debilitating medical condition, who has a physician certification and a valid qualifying patient identification card. If the Department does not begin issuing identification cards within nine (9) months after the effective date of this section, then a valid physician certification will serve as a patient identification card in order to allow a person to become a "qualifying patient" until the Department begins issuing identification cards.

(c) LIMITATIONS.

(1) Nothing in this section allows for a violation of any law other than for conduct in compliance with the provisions of this section.

(2) Nothing in this section shall affect or repeal laws relating to non-medical use, possession, production, or sale of marijuana.

(3) Nothing in this section authorizes the use of medical marijuana by anyone other than a qualifying patient.

(4) Nothing in this section shall permit the operation of any vehicle, aircraft, train or boat while under the influence of marijuana.

(5) Nothing in this section requires the violation of federal law or purports to give immunity under federal law.

(6) Nothing in this section shall require any accommodation of any on-site medical use of marijuana in any correctional institution or detention facility or place of education or employment, or of smoking medical marijuana in any public place.

(7) Nothing in this section shall require any health insurance provider or any government agency or authority to reimburse any person for expenses related to the medical use of marijuana.

(8) Nothing in this section shall affect or repeal laws relating to negligence or professional malpractice on the part of a qualified patient, caregiver, physician, MMTC, or its agents or employees.

(d) DUTIES OF THE DEPARTMENT. The Department shall issue reasonable regulations necessary for the implementation and enforcement of this section. The purpose of the regulations is to ensure the availability and safe use of medical marijuana by qualifying patients. It is the duty of the Department to promulgate regulations in a timely fashion.

(1) Implementing Regulations. In order to allow the Department sufficient time after passage of this section, the following regulations shall be promulgated no later than six (6) months after the effective date of this section:

a. Procedures for the issuance and annual renewal of qualifying patient identification cards to people with physician certifications and standards for renewal of such identification cards. Before issuing an identification card to a minor, the Department must receive written consent from the minor's parent or legal guardian, in addition to the physician certification.

b. Procedures establishing qualifications and standards for caregivers, including conducting appropriate background checks, and procedures for the issuance and annual renewal of caregiver identification cards.

c. Procedures for the registration of MMTCs that include procedures for the issuance, renewal, suspension and revocation of registration, and standards to ensure proper security, record keeping, testing, labeling, inspection, and safety.

d. A regulation that defines the amount of marijuana that could reasonably be presumed to be an adequate supply for qualifying patients' medical use, based on the best available evidence. This presumption as to quantity may be overcome with evidence of a particular qualifying patient's appropriate medical use.

(2) Identification cards and registrations. The Department shall begin issuing qualifying patient and caregiver identification cards, and registering MMTCs no later than nine (9) months after the effective date of this section.

(3) If the Department does not issue regulations, or if the Department does not begin issuing identification cards and registering MMTCs within the time limits set in this section, any Florida citizen shall have standing to seek judicial relief to compel compliance with the Department's constitutional duties.

(4) The Department shall protect the confidentiality of all qualifying patients. All records containing the identity of qualifying patients shall be confidential and kept from public disclosure other than for valid medical or law enforcement purposes.

(e) LEGISLATION. Nothing in this section shall limit the legislature from enacting laws consistent with this section.

(f) SEVERABILITY. The provisions of this section are severable and if any clause, sentence, paragraph or section of this measure, or an application thereof, is adjudged invalid by a court of competent jurisdiction other provisions shall continue to be in effect to the fullest extent possible.

Effective Date

Article XI, Section 5(e), of the Florida Constitution states that, unless otherwise specified in the Florida Constitution or the proposed constitutional amendment, the proposed amendment will become effective on the first Tuesday after the first Monday in January following the election. Assuming the amendment passes in 2016, the effective date is January 3, 2017. However, the amendment allows the Department of Health six months after the effective date to promulgate regulations and nine months after the effective date to begin registering medical marijuana treatment facilities and begin issuing identification cards.

B. Substantive Effect of Proposed Amendment

Input Received from Proponents and Opponents

The Conference sought input from those groups who were on record as supporting or opposing the petition initiative. The sponsor chose not to provide a response to a request for overall input on the initiative. However, a representative of the Medical Marijuana Business Association of Florida attended the meetings and expressed support for the amendment.

An opponent group, Drug Free America/Save Our Society from Drugs (S.O.S.), a non-profit drug policy organization based in St. Petersburg, submitted written testimony specific to the petition initiative. The testimony focused on the potential costs to the state if the proposed constitutional amendment passes. The testimony noted that administrative costs for licensing and regulating the marijuana industry in Florida would be close to the $9.5 million spent by Colorado in Fiscal Year 2013-14 for 35 full-time positions and other expenses associated with developing regulations, training, websites, materials, and labeling requirements, even though these costs were for medical and recreational marijuana enforcement. The testimony also enumerates costs to other state agencies. The full written testimony can be found on the Office of Economic and Demographic Research's website at: http://edr.state.fl.us/Content/constitutional-amendments/2016Ballot/DrugFreeAmericaMemo_9-30-15.pdf.

Background

Current Legal Status of Marijuana in Florida

Florida law defines cannabis as "all parts of any plant of the genus *Cannabis*, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant or its seeds or resin"[1] and places it, along with other sources of tetrahydrocannabinol (THC), on the list of Schedule I drugs.[2] Schedule I drugs are substances that have a high potential for abuse and no currently accepted medical use in treatment in the United States. As a Schedule I drug, possession and trafficking in cannabis carry criminal penalties that vary from a misdemeanor of the first degree[3] up to a felony of the first degree with a possible minimum sentence of 15 years in prison and a $200,000 fine.[4] Paraphernalia[5] that is sold, manufactured, used, or possessed with the intent to be used to plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, inject, ingest, inhale, or otherwise introduce into the human body a controlled substance is also prohibited and carries criminal penalties ranging from a misdemeanor of the first degree to felony of the third degree.[6]

[1] S. 893.02(c), F.S.
[2] S. 893.03(c)7. and 37., F.S.
[3] For possessing or delivering less than 20 grams. See s. 893.13(3) and (6)(b), F.S.
[4] Trafficking in more than 25 pounds, or 300 plants, of cannabis is a felony of the first degree with a minimum sentence that varies from 3 to 15 years in prison depending on the amount of cannabis. See s. 893.135(1)(a), F.S.
[5] As defined in s. 893.145, F.S.
[6] S. 893.147, F.S.

Notwithstanding the above, the Florida Legislature passed the Compassionate Medical Cannabis Act of 2014[7] (act), which legalized a low tetrahydrocannabinol (THC) and high cannabidiol (CBD) form of cannabis (low-THC cannabis)[8] for the medical use[9] by patients suffering from cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms.

Compassionate Medical Cannabis Act of 2014

Patient Treatment with Low-THC Cannabis

The Compassionate Medical Cannabis Act of 2014 provides that a Florida licensed allopathic or osteopathic physician who has completed the required training[10] and has examined and is treating such a patient may order low-THC cannabis for that patient to treat a disease, disorder, or condition or to alleviate its symptoms, if no other satisfactory alternative treatment options exist for that patient. In order to meet the requirements of the act all of the following conditions must apply:

- The patient is a permanent resident of Florida;
- The physician determines that the risks of ordering low-THC cannabis are reasonable in light of the potential benefit for that patient;[11]
- The physician registers as the orderer of low-THC cannabis for the patient on the compassionate use registry (registry) maintained by the Department of Health (DOH) and updates the registry to reflect the contents of the order;
- The physician maintains a patient treatment plan that includes the dose, route of administration, planned duration, and monitoring of the patient's symptoms and other indicators of tolerance or reaction to the low-THC cannabis;
- The physician submits the patient treatment plan quarterly to the UF College of Pharmacy for research on the safety and efficacy of low-THC cannabis on patients; and
- The physician obtains the voluntary informed consent of the patient or the patient's legal guardian to treatment with low-THC cannabis after sufficiently explaining the current state of knowledge in the medical community of the effectiveness of treatment of the patient's condition with low-THC cannabis, the medically acceptable alternatives, and the potential risks and side effects.

---

[7] *See* ch. 2014-157, L.O.F., and s. 381.986, F.S.

[8] The act defined "low-THC cannabis," as the dried flowers of the plant *Cannabis* which contain 0.8 percent or less of tetrahydrocannabinol and more than 10 percent of cannabidiol weight for weight, or the seeds, resin, or any compound, manufacture, salt, derivative, mixture, or preparation of the plant or its seeds or resin. *See* s. 381.986(1)(b), F.S. Eleven states allow limited access to marijuana products (low-THC and/or high CBD-cannabidiol): Alabama, Florida, Iowa, Kentucky, Mississippi, Missouri, North Carolina, South Carolina, Tennessee, Utah, and Wisconsin. Twenty-three states, the District of Columbia, and Guam have laws that permit the use of marijuana for medicinal purposes. See infra note 28. *See* http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx (Tables 1 and 2), (last visited on Sep. 28, 2015).

[9] Pursuant to s. 381.986(1)(c), F.S., "medical use" means administration of the ordered amount of low-THC cannabis; and the term does not include the possession, use, or administration by smoking, or the transfer of low-THC cannabis to a person other than the qualified patient for whom it was ordered or the qualified patient's legal representative. Section 381.986(1)(e), F.S., defines "smoking" as burning or igniting a substance and inhaling the smoke; smoking does not include the use of a vaporizer.

[10] Section 381.986(4), F.S., requires such physicians to successfully complete an 8-hour course and examination offered by the Florida Medical Association or the Florida Osteopathic Medical Association that encompasses the clinical indications for the appropriate use of low-THC cannabis, appropriate delivery mechanisms, contraindications for such use, and the state and federal laws governing its ordering, dispensing, and processing.

[11] If a patient is younger than 18 years of age, a second physician must concur with this determination, and such determination must be documented in the patient's medical record.

A physician who orders low-THC cannabis for a patient without a reasonable belief that the patient is suffering from a required condition and any person who fraudulently represents that he or she has a required condition to a physician for the purpose of being ordered low-THC cannabis commits a misdemeanor of the first degree. The DOH is required to monitor physician registration and ordering of low-THC cannabis in order to take disciplinary action as needed.

The act creates exceptions to existing law to allow qualified patients[12] and their legal representatives to purchase, acquire, and possess low-THC cannabis (up to the amount ordered) for that patient's medical use, and to allow dispensing organizations (DO), and their owners, managers, and employees, to acquire, possess, cultivate, and dispose of excess product in reasonable quantities to produce low-THC cannabis and to possess, process, and dispense low-THC cannabis. DOs and their owners, managers, and employees are not subject to licensure and regulation under ch. 465, F.S., relating to pharmacies.[13]

Dispensing Organizations

The act requires the DOH to approve five DOs with one in each of the following regions: northwest Florida, northeast Florida, central Florida, southeast Florida and southwest Florida.[14] In order to be approved as a DO, an applicant must possess a certificate of registration issued by the Department of Agriculture and Consumer Services for the cultivation of more than 400,000 plants, be operated by a nurseryman, and have been operating as a registered nursery in this state for at least 30 continuous years. Applicants are also required to demonstrate:

- The technical and technological ability to cultivate and produce low-THC cannabis.
- The ability to secure the premises, resources, and personnel necessary to operate as a DO.
- The ability to maintain accountability of all raw materials, finished products, and any byproducts to prevent diversion or unlawful access to or possession of these substances.
- An infrastructure reasonably located to dispense low-THC cannabis to registered patients statewide or regionally as determined by the department.
- The financial ability to maintain operations for the duration of the 2-year approval cycle, including the provision of certified financials to the department;
- That all owners and managers have been fingerprinted and have successfully passed a level 2 background screening pursuant to s. 435.04, F.S.; and
- The employment of a medical director, who must be a physician and have successfully completed a course and examination that encompasses appropriate safety procedures and knowledge of low-THC cannabis.[15]

Upon approval, a DO must post a $5 million performance bond. The DOH is authorized to charge an initial application few and a licensure renewal fee, but is not authorized to charge an initial licensure fee.[16] An approved DO must also maintain all approval criteria at all times.

Beginning on July 7, 2014, the DOH held several rule workshops intended to write and adopt rules implementing the provisions of s. 381.986, F.S., and the DOH put forward a proposed rule on September 9, 2014. This proposed rule was challenged by multiple organizations involved in the rulemaking workshops and was found to be an invalid exercise of delegated legislative

---

[12] *See* s. 381.986(1)(d), F.S., which provides that a "qualified patient" is a Florida resident who has been added by a physician licensed under ch. 458, F.S., or ch. 459, F.S., to the compassionate use registry to receive low-THC cannabis from a DO.
[13] *See* s. 381.986(7)(c), F.S.
[14] *See* s. 381.986(5)(b), F.S.
[15] Id.
[16] Id.

authority by the Administrative Law Judge on November 14, 2014.[17] Afterward, the DOH held a negotiated rulemaking workshop in February of 2015, which resulted in a new proposed rule being published on February 6, 2015.[18] The new proposed rule was also challenged on, among other things, the DOH's statement of estimated regulatory costs (SERC) and the DOH's conclusion that the rule will not require legislative ratification. Hearings were held on April 23 and 24, 2015, and a final order was issued on May 27, 2015, which found the rule to be valid.[19] Currently, the rules have taken effect as of June 17, 2015, and the DOH held an application period for DO approval which ended on July 8, 2015. The DOH received 28 applications for DO approval but has not approved any DOs at present.[20]

The Compassionate Use Registry

The act requires the DOH to create a secure, electronic, and online registry for the registration of physicians and patients and for the verification of patient orders by DOs, which is accessible to law enforcement. The registry must allow DOs to record the dispensation of low-THC cannabis, and must prevent an active registration of a patient by multiple physicians. Physicians must register qualified patients with the registry and DOs are required to verify that the patient has an active registration in the registry, that the order presented matches the order contents as recorded in the registry, and that the order has not already been filled before dispensing any low-THC cannabis. DOs are also required to record in the registry the date, time, quantity, and form of low-THC cannabis dispensed. The DOH has indicated that the registry is built and ready to move to the operational phase.[21]

The Office of Compassionate Use and Research on Low-THC Cannabis

The act requires the DOH to establish the Office of Compassionate Use under the direction of the deputy state health officer to administer the act. The Office of Compassionate Use is authorized to enhance access to investigational new drugs for Florida patients through approved clinical treatment plans or studies, by:

- Creating a network of state universities and medical centers recognized for demonstrating excellence in patient-centered coordinated care for persons undergoing cancer treatment and therapy in this state.[22]
- Making any necessary application to the United States Food and Drug Administration or a pharmaceutical manufacturer to facilitate enhanced access to compassionate use for Florida patients; and
- Entering into agreements necessary to facilitate enhanced access to compassionate use for Florida patients.[23]

The act includes several provisions related to research on low-THC cannabis and cannabidiol including:

- Requiring physicians to submit quarterly patient treatment plans to the UFCP for research on the safety and efficacy of low-THC cannabis;

[17] *See* https://www.doah.state.fl.us/ROS/2014/14004296.pdf (last accessed March 27, 2015).
[18] The rule is available at http://www.floridahealth.gov/programs-and-services/office-of-compassionate-use/_documents/64-4-rule-text.pdf, (last visited on Sep. 28, 2015).
[19] The final order is available at http://www.floridahealth.gov/programs-and-services/office-of-compassionate-use/_documents/final-order-15-1694rp.pdf (last visited on Sep. 28, 2015).
[20] Phone conversation with Marco Paredes, Legislative Planning Director for the DOH, on Sep. 23, 2015.
[21] Conversation with Jennifer Tschetter, Chief of Staff (DOH) (March 20, 2015).
[22] *See* s. 381.925, F.S.
[23] *See* s. 385.212, F.S.

- Authorizing state universities to perform research on cannabidiol and low-THC cannabis and exempting them from the provisions in ch. 893, F.S., for the purposes of such research; and
- Appropriating $1 million to the James and Esther King Biomedical Research Program for research on cannabidiol and its effects on intractable childhood epilepsy.

The Necessity Defense in Florida

Despite the fact that the use, possession, and sale of marijuana is prohibited by state law, other than what is allowed under the Compassionate Medical Cannabis Act of 2014, Florida courts have found that circumstances can necessitate medical use of marijuana and circumvent the application of any criminal penalties. The necessity defense was successfully applied in a marijuana possession case in Jenks v. State[24] where the First District Court of Appeal found that "section 893.03 does not preclude the defense of medical necessity" for the use of marijuana if the defendant:

- Did not intentionally bring about the circumstance which precipitated the unlawful act;
- Could not accomplish the same objective using a less offensive alternative available; and
- The evil sought to be avoided was more heinous than the unlawful act.

In the cited case the defendants, a married couple, were suffering from uncontrollable nausea due to AIDS treatment and had testimony from their physician that he could find no effective alternative treatment. Under these facts, the First District found that the Jenks met the criteria for the necessity defense and ordered an acquittal of the charges of cultivating cannabis and possession of drug paraphernalia.

Medical Marijuana Laws and Practices in Other States

Currently, 23 states and the District of Columbia[25] have some form of law that permits the use of marijuana for medicinal purposes. Recently approved laws in 15 additional states and Florida allow use of "low THC, high cannabidiol (CBD)" products for medical reasons in limited situations or as a legal defense. These states' laws were not considered in this analysis since the proposed constitutional amendment does not limit the type of marijuana that can be sold.[26]

Medical marijuana laws vary widely in detail but most are similar in that they touch on several recurring themes. Most state laws include the following in some form:

- A list of medical conditions for which a practitioner can recommend the use of medical marijuana to a patient.

---

[24] 582 So. 2d 676

[25] These states include Alaska, Arizona, California, Colorado, Connecticut, Delaware, Hawaii, Illinois (effective 2014), Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, and Washington. California was the first to establish a medical marijuana program in 1996 and Minnesota and New York were the most recent states to pass medical marijuana legislation in 2014. Source: http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx, accessed 9/8/2015.

26 These states include Alabama, Georgia, Iowa, Kentucky, Louisiana, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming. Source: http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx, accessed 9/8/2015.

- Nearly every state has a list of medical conditions though the particular conditions vary from state to state. Most states also include a way to expand the list either by allowing a state agency or board to add medical conditions to the list or by including a "catch-all" phrase.[27] Most states require that the patient receive certification from at least one, but sometimes two, physicians designating that they have a qualifying condition before they can be issued an ID card.

- Provisions for the patient to designate one or more caregivers who can possess the medical marijuana and assist the patient in preparing and using the medical marijuana.
  - The number of caregivers allowed and the qualifications to become a caregiver vary from state to state. Most states allow 1 or 2 caregivers and require that they be at least 21 years of age and, typically, cannot be the patient's physician. Caregivers are generally allowed to purchase or grow marijuana for the patient, be in possession of the allowed quantity of marijuana, and aid the patient in using the marijuana, but are prohibited from using the marijuana themselves.
- A required identification card for the patient, caregiver, or both that is typically issued by a state agency.
- A registry of people who have been issued an ID card.
- A method for registered patients and caregivers to obtain medical marijuana.
- General restrictions on where medical marijuana may be used.

Different states have varying provisions on who is allowed to grow medical marijuana: patients, caregivers, cultivation centers, or dispensaries or a combination thereof. Most states that currently have medical marijuana allow dispensaries for the purchase of the product. In addition, caregivers or cultivation centers may be allowed to sell in some states. Caregivers are sometimes not explicitly allowed to sell and in some cases prohibited from receiving compensation. They may only be allowed to recoup costs of materials and supplies but not labor (see table below).

[27] Such as in California's law that includes "any other chronic or persistent medical symptom that either: Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990, or If not alleviated, may cause serious harm to the patient's safety or physical or mental health."

Cultivation and Sales of Medical Marijuana by State

State	Grow Own	Who Can Grow	Purchase	Who Can Sell
Alaska	Yes	Patients, caregivers	No	No one
Arizona	Yes, in some cases	Patients, caregivers, dispensaries	Yes	Dispensaries (dispensaries can acquire product) *Caregivers (reimbursement for expenses but not compensation for services)*
California	Yes	Patients, caregivers, dispensaries	Yes	Dispensaries (collectives & cooperatives), (dispensaries can acquire product) Caregivers (not clear what limitations apply)
Colorado	Yes	Patients, caregivers, dispensaries	Yes	Dispensaries (dispensaries must grow 70% of product sold, can acquire the rest from other dispensaries) Caregivers (not clear what limitations apply)
Connecticut	No	Dispensaries	Yes	Dispensaries
Delaware	No	Dispensaries	Yes	Dispensaries
District of Columbia	Yes	Patients, cultivation centers, dispensaries	Yes	Dispensaries (dispensaries may acquire from cultivation centers)
Hawaii	Yes	Patient, dispensaries	Yes	Dispensaries, caregivers
Illinois	No	Cultivation centers, dispensaries	Yes	Dispensaries
Maine	Yes	Patients, caregivers, dispensaries	Yes	Dispensaries, caregivers
Maryland	No	Cultivation centers, dispensaries	Yes	Cultivation centers, caregivers, dispensaries
Massachusetts	Yes, in some cases	Patients, caregivers, dispensaries	Yes	Dispensaries, caregivers
Michigan	Yes	Patients, caregivers, dispensaries	Yes	Caregivers, dispensaries (dispensaries not in state law but in some local ordinances)
Minnesota	No	Dispensaries	Yes	Dispensaries
Montana	Yes	Patient OR caregiver, but not both	Yes	Caregivers (conflicting laws regarding compensation ofcaregivers or limits on number of patients per caregiver, litigation still ongoing), may be regulated as dispensaries locally
Nevada	Yes, in some cases	Patients, caregivers, dispensaries	Yes	Dispensaries
New Hampshire	No	Dispensaries	Yes	Dispensaries
New Jersey	No	Cultivation centers, dispensaries	Yes	Cultivation centers, dispensaries
New Mexico	Yes, in some cases	Cultivation centers	Yes	Cultivation centers with own dispensing locations
New York	No	Cultivation centers	Yes	Cultivation centers with own dispensing locations
Oregon	Yes, at registered sites	Patients, caregivers	Yes	Dispensaries (dispensaries cannot grow, they must acquire from patients or caregivers) caregivers (reimburse for cost of supplies and utilities but not labor)
Rhode Island	Yes	Patients, caregivers, dispensaries	Yes	Caregivers, dispensaries (dispensaries can grow at cultivation sites or acquire from patients or caregivers)
Vermont	Yes	Patients, caregivers, dispensaries	Yes	Caregivers, dispensaries (dispensaries must grow their own at cultivation sites)
Washington	Yes	Patients, caregivers	No	Collective gardens

NOTE: Additional detail and sources can be found at EDR's website: http://edr.state.fl.us/Content/constitutional-amendments/2016Ballot/MedMSummary_Table_10-21-15.pdf

Medical Marijuana Laws and the Federal Government

Regardless of whether an individual state has allowed the use of marijuana for medicinal purposes, or otherwise, the Federal Controlled Substances Act lists it as a Schedule I drug with no accepted medical uses. Under federal law possession, manufacturing, and distribution of marijuana is a crime.[28] Although state medical marijuana laws protect patients from prosecution for the legitimate use of marijuana under the guidelines established in that state, such laws do not protect individuals from prosecution under federal law should the federal government choose to act on those laws.

In August of 2013, the United States Justice Department issued a publication entitled "Smart on Crime: Reforming the Criminal Justice System for the 21st Century."[29] This document details the federal government's changing stance on low-level drug crimes announcing a "change in Department of Justice charging policies so that certain people who have committed low-level, nonviolent drug offenses, who have no ties to large-scale organizations, gangs, or cartels will no longer be charged with offenses that impose draconian mandatory minimum sentences. Under the revised policy, these people would instead receive sentences better suited to their individual conduct rather than excessive prison terms more appropriate for violent criminals or drug kingpins." This announcement indicates the justice department's relative unwillingness to prosecute low-level drug cases leaving such prosecutions largely up to state authorities.

In February 2014, the U.S. Department of Justice Deputy Attorney General Cole issued a "Memorandum for All United States Attorneys: Guidance Regarding Marijuana Related Financial Crimes."[30] The memorandum's purpose was to clarify Bank Secrecy Act ("BSA") expectations for financial institutions seeking to provide services to marijuana-related businesses. The Cole Memo reiterates Congress's determination that marijuana is a dangerous drug and that the illegal distribution and sale of marijuana is a serious crime that provides a significant source of revenue to large-scale criminal enterprises, gangs, and cartels. A concurrent guidance, issued by The Department of the Treasury Financial Crimes Enforcement Network, clarifies how financial institutions can provide services to marijuana-related businesses consistent with their BSA obligations.[31]

Potential Users of Medical Marijuana

The Office of Economic and Demographic Research (EDR) developed six approaches that estimate the potential number of medical marijuana users in Florida as of April 1, 2017. Approach I draws on the experience of other states. Approaches II – V attempt to estimate the pool of eligible users with the specified medical conditions in the proposed ballot initiative, but not the "other debilitating conditions of the same kind or class as or comparable to those enumerated". It is not possible to precisely estimate the number of users that would qualify

[28] The punishments vary depending on the amount of marijuana and the intent with which the marijuana is possessed. See http://www.fda.gov/regulatoryinformation/legislation/ucm148726.htm#cntlsbd. Last visited Oct. 21, 2015.
[29] See http://www.justice.gov/ag/smart-on-crime.pdf. Last accessed on Oct. 17, 2013.
[30] James M. Cole, Deputy Attorney General, U.S. Department of Justice, Memorandum for All United States Attorneys: Guidance Regarding Marijuana Related Financial Crimes (February 14, 2014), http://www.justice.gov/sites/default/files/usao-wdwa/legacy/2014/02/14/DAG%20Memo%20-%20Guidance%20Regarding%20Marijuana%20Related%20Financial%20Crimes%202%2014%2014%20(2).pdf, accessed 9/29/2015.
[31] The Department of the Treasury Financial Crimes Enforcement Network Guidance, BSA Expectations Regarding Marijuana-Related Businesses, February 14, 2014, http://www.fincen.gov/statutes_regs/guidance/pdf/FIN-2014-G001.pdf, accessed 9/29/2015.

under “other debilitating medical conditions of the same kind or class as or comparable to those enumerated” as these conditions are currently unknown and are to be determined by the physician when he or she believes that the medical use of marijuana would likely outweigh the potential health risks for a patient. Approach VI uses the number of illicit recreational marijuana users as a guide.

Estimates of Potential Florida Medical Marijuana Users

Estimation Approach	April 1, 2017
I. States with medical marijuana laws	1,586 to 440,552
II. Disease prevalence	2,038,131
III. Disease incidence	130,237
IV. Use by cancer patients	247,689
V. Deaths	47,805
VI. Self-reported marijuana use	1,168,775 to 1,752,277
Range	**1,586 to 1,752,277**

The following is a summary of each of these approaches.

Approach I. States with Medical Marijuana Laws
Approach I applies rates of medical marijuana use from other states to Florida’s 2017 projected population. Data from the medical marijuana patient registries for 2014 and in a few cases, 2012, 2013 or 2015 from 19 other states and the District of Columbia were used. Using the current experience of these states and the District of Columbia, there may be an estimated 1,586 to 440,552 Floridians using marijuana for debilitating medical conditions in 2017. The lower range of the estimate is more likely if the medical marijuana program is rolled out slowly, such as in New Jersey, or faces implementation, administrative, and/or legal challenges that will limit the number of registrants in the first year. The higher range of the estimate may be more likely at full implementation of a more mature program, such as in Colorado.

Approach II. Disease Prevalence
Approach II uses disease prevalence rates (proportion of people alive diagnosed with a certain disease) for cancer, epilepsy, HIV, multiple sclerosis, Parkinson’s disease, and Posttraumatic Stress Disorder (single year prevalence) to determine the number of eligible patients with the conditions specified in the proposed ballot initiative. There will be an estimated 2,038,131 patients alive in 2017 that, during their lifetime, have been diagnosed with cancer, epilepsy, HIV, multiple sclerosis, Parkinson’s disease, and Posttraumatic Stress Disorder (single year prevalence). These patients represent the pool of eligible patients for use of marijuana. This approach does not make assumptions about the percentage of eligible patients who will avail themselves of the opportunity to use marijuana. Analysis of data from states that have medical marijuana shows that a relatively small percentage of all patients with a certain disease use marijuana. Prevalence data for the remaining conditions specified in the proposed ballot initiative were not available. In addition, there are unspecified “other debilitating medical conditions of the same kind or class as or comparable to those enumerated” in the proposed ballot initiative which cannot be estimated under this approach.

Approach III. Disease Incidence

Approach III uses disease incidence rates (proportion of people newly diagnosed with a certain disease per year) for amyotrophic lateral sclerosis (ALS), cancer, epilepsy, and HIV to determine the number of eligible patients with the conditions specified in the proposed ballot initiative. Disease incidence cases are a subset of disease prevalence cases, so Approach III has a smaller estimate than Approach II. There will be an estimated 130,237 patients newly diagnosed with ALS, cancer, epilepsy, and HIV in 2017 in Florida. These patients represent the pool of eligible patients for medical use of marijuana. This approach does not make assumptions about the percentage of eligible patients who will avail themselves of the opportunity to use marijuana. Incidence data for the remaining conditions specified in the proposed ballot initiative were not available. In addition, there are unspecified “other debilitating medical conditions of the same kind or class as or comparable to those enumerated” in the proposed ballot initiative which cannot be estimated under this approach.

Approach IV. Use by Cancer Patients

Approach IV uses medical marijuana penetration rates (usage rates) among cancer patients and/or survivors, to estimate (1) medical marijuana users among cancer patients in Florida and (2) total potential marijuana users under the proposed amendment. The number of Florida cancer patients that are likely to use medical marijuana is calculated by applying the average penetration rate (usage rate of medical marijuana) among cancer patients from ten other states to the estimated number of cancer patients in Florida in 2017. Assuming Florida will have the same average proportion of cancer patients in the total medical marijuana users as these ten states, the number of medical marijuana users with cancer is grown to represent total medical marijuana users with all conditions. This approach produces 247,689 medical marijuana users with all conditions in Florida in 2017.

Approach V. Deaths

Approach V assumes that mostly terminally ill patients will use medical marijuana. Thus, it uses 2014 death rates by disease for the specified diseases, excluding ALS, glaucoma, and Posttraumatic Stress Disorder, for which no data were available, in the proposed ballot initiative to estimate the number of users. Assuming Florida will have the same proportion of deaths from these diseases, applying these rates to 2017 population projections produces a pool of 47,805 potential eligible medical marijuana patients with the specified conditions. This approach does not make assumptions about the percentage of eligible patients who will avail themselves of the opportunity to use marijuana. In addition, there are unspecified “other debilitating medical conditions of the same kind or class as or comparable to those enumerated” in the proposed ballot initiative which cannot be estimated under this approach.

Approach VI. Self-Reported Marijuana Use (Illicit Recreational Use)

Approach VI presents self-reported illicit marijuana use from the 2013 National Survey on Drug Use and Health. Assuming that marijuana use rates will remain the same and adjusting 2013 survey results to the 2017 Florida population projections shows that there may be an estimated 1,752,277 self-reported recreational users of marijuana 18 years of age or older in Florida. If we exclude the population 18 to 24 from this estimate since they would not be as likely to suffer from the debilitating conditions envisioned in the ballot initiative as their older counterparts, it is estimated that there may be 1,168,775 self-reported recreational users of marijuana in Florida. Approach VI was

included because some of the current illicit use may be for medical purposes. This estimation approach has been used by other states to estimate recreational marijuana use. Also, this approach was included to give an upper bound to the estimates that captures the intent of "other debilitating medical conditions of the same kind or class as or comparable to those enumerated." Since it is not clear how this language will be implemented, approach VI assumes that all illicit drug users would be able to obtain physician certifications for debilitating medical conditions.

EDR also estimated the extent to which a pill mill scenario and medical marijuana tourism may affect the potential number of users of medical marijuana.

- *Pill Mills:* The potential medical marijuana population was compared to the estimates of the population illicitly using pain relievers for nonmedical reasons to examine whether "pill mills" can develop for medical marijuana. Applying use rates from the 2013 National Survey on Drug Use and Health, it is estimated that there will be 622,398 pain reliever users for nonmedical reasons in 2017, with higher rates among the 12 to 17 and 18 to 24 age groups compared to the 25 and over age group. The multi-step process consisting of (1) an examination and assessment by a physician in order for a patient to receive a physician certification and (2) the application process through the Department of Health for an identification card may dissuade a pill mill scenario. Further, the amendment allows the Department of Health to issue implementing regulations, and allows the Legislature to enact laws consistent with the amendment that may provide additional regulatory protection.
- *Medical Marijuana Tourism:* The multi-step process described above would discourage shorter-duration visitors from participating in Florida's medical marijuana program. Snowbirds (visitors staying one month or longer) were used as a potential universe for medical marijuana tourists. An estimated 24,307 to 43,233 snowbirds may apply for ID cards.

After careful consideration and review of all methods, the Conference estimated that the number of potential users of medical marijuana upon full implementation of the amendment would be approximately 450,000 persons per year.

C. Fiscal Impact of Proposed Amendment

Summary of the Department of Health's Analysis

The Department's Planning Assumptions

The analysis from the Department of Health assumes the proposed Constitutional Amendment entitled "Use of Marijuana for Certain Medical Conditions" will be approved by the Florida voters and will have an effective date of January 3, 2017. The analysis further assumes the Department of Health will: (1) promulgate rules by June 30, 2017, (2) issue qualified patient and caregiver identification cards prior to October 1, 2017, and (3) register Medical Marijuana Treatment Centers prior to October 1, 2017.

The department analysis provides general planning assumptions, as well as a series of assumptions specific to marijuana, physician authority under state and federal law and regulations, qualifying patient and caregiver identification cards, qualifications and standards for caregivers, medical marijuana treatment centers licensure and regulation, and the department's responsibilities.

The department estimates the following numbers of annual program participants: (1) 440,552 qualified patients, (2) 130,844 caregivers and (3) 1,993 registered Medical Marijuana Treatment Centers. These estimates were derived based on experience data for the state of Colorado.

The department states that it may need additional legislative authority to levy fees for the purpose of implementing this constitutional amendment.

Program Components

The Department of Health will establish a Florida Medical Marijuana Program which supports: (1) acceptance of physician certifications, (2) patient and caregiver identification cards, (3) qualifications and standards for caregivers, (4) medical marijuana treatment center registration and regulation, and (5) regulation of the adequate supply of marijuana for a qualifying patient's medical use. For each of these components, the department's analysis cited relevant definitions as provided in the petition initiative language and indicates the department's responsibilities relative to each component.

Program Costs

According to the analysis provided by the Department of Health, the department will incur an estimated $2.9 million in costs in Year 1 (2017) and $2.7 million in costs in Year 2 (2018) to comply with the regulatory responsibilities assigned to it by the constitutional amendment. Details regarding these costs are in the following table.

Cost Analysis, 2017 and 2018

Cost of Program Implementation	Year 1 2017	Year 2 2018	Description
Program Staff – State Health Office Year 1 – Program Administrator, Environmental Consultant, Gov't Operations Consultant II and Senior Clerk Year 2 – Program Administrator, Environmental Consultant, Gov't Operations Consultant II and Senior Clerk	$264,686	$299,950	Year 1 Total Salary, Fringe, Expense & HR 25% Lapse Factor Program Administrator ($78,393) Environmental Consultant ($71,733) Gov't Operations Consultant II ($79,578) Senior Clerk ($34,982) Year 2 Total Salary, Fringe, Expense & HR Program Administrator ($95,322) Environmental Consultant ($85,096) Gov't Operations Consultant II ($79,578) Senior Clerk ($39,954)
Support for rule development	$59,406	$0	Contracted operations management consultant $20 hr. /2080 hours plus fringe (35%) and contract overhead (4%). One-time contractual.
Develop & disseminate educational materials	$49,120	$21,060	Contracted educator $20.00 hr. /1500 hours plus fringe (35%) and contract overhead (4%). One-time contractual. Costs to disseminate materials to physician = $7,000 Year 2 includes 750 hours of contracted time to refresh training materials.
Business Analyst for data system	$88,400	$0	$85 per hours for 1040 hours. One-time contractual.
Data system for patient/caregiver registration & medical treatment center management	$255,000	$0	Cost to design, develop, test and data system based on business requirements. One-time contractual cost based on Five Points purchase order for the implementation of SB 1030.
Annual data system user support and maintenance	$0	$129,600	Annual cost of help desk and software maintenance based on Five Points agreement for the implementation of SB 1030.
Field Staff (30 FTEs)– Treatment facility inspections, reinspections, and complaint investigations Year 1 – 3 months Year 2 – 12 months	$1,121,156	$2,216,804	Funds 30 Environmental Specialist II's to conduct inspections & investigations. Environmental Specialist II ($404,036) + non-recurring standard package ($116,460) + recurring expense package ($184,980) + maximum travel ($405,360) + HR Costs ($10,320) for a total of $1,121,156. (Salary $ Fringe $53,871, Travel $9,606, Expense $6,166 Recurring $3,882 Nonrecurring and HR $344) for a total of $2,216,804.
Regional Inspector Transportation, Computers and Connectivity	$1,099,320	$17,280	One-time cost for 30 state vehicles @ $35,000 each and 30 pen tablets @ $1,500 each for regional inspectors. Routine repair and maintenance in Year 2 included in cost per service. VPN connectivity service $48 per month per inspector for 3 months in year 1 – $4,320. Year 2 costs included in cost per service.
Total Estimated Costs	**$2,937,088**	**$2,684,694**	

NOTE: Based on the limited information regarding how the program would be implemented these cost estimates could change when more information becomes available.

Requested Information from State Agencies

The following table reflects a summary of information received from several agencies that were asked to provide comments to the Conference. Note the information specific to the Department of Revenue is addressed separately under tax discussions that appear subsequently in this document.

State / Local Agency	Date Info Provided	Result
Florida Department of Health	10/16/2015	Written preliminary and final analyses and testimony showing $2.9 million in costs in Year 1 (2017) and $2.7 million in costs in Year 2 (2018), at least a portion of which is likely to be offset by regulatory fees (see preceding section).
Florida Department of Children and Families Substance Abuse and Mental Health Program	10/19/2015	The department's position remains the same as regarding the proposed constitutional amendment 13-02. The department indicated that the budget impact cannot be determined. The budget for these services is set in the General Appropriations Act which is controlled by the Legislature and Governor. These services are not an entitlement.
Florida Agency for Health Care Administration	10/19/2015	Discussed the possible impact regarding "caregivers". The activity would fall into current regulatory oversight and would not significantly change regulatory duties. Health care clinics would only be impacted if the clinics accept 3rd party reimbursement.
Florida Board of Pharmacy	10/19/2015	The Medical Marijuana Treatment Center would be a separate facility or entity and the certificate is not a prescription, so there would be no additional costs.
Florida Department of Business and Professional Regulation (DBPR) Division of Drugs, Devices and Cosmetics	10/18/2015	Whether medical marijuana is a "common household remedy" is currently unknown. "Common household remedy" is not defined in statute and DBPR has no authority to further define the term. Making the determination involves the forming of a technical assistance advisory committee which is outside of DBPR's purview. At this time marijuana is a schedule I controlled substance under both state and federal law, having no currently accepted medical use in treatment in the United States. DBPR has not been petitioned to include medical marijuana on the list of common household remedies. Additionally, no schedule I controlled substance is currently listed as a common household remedy. The form of the substance does not greatly matter, unless it is a food or has been processed. DOH is the agency delegated responsibility with implementing the proposed constitutional amendment. DBPR is not delegated any authority or responsibility regarding the implementation of the proposed constitutional amendment, but would serve as a resource to DOR and DOH as necessary.
Florida Department of Agriculture and Consumer Services	10/16/2015	The department's position remains the same as regarding the proposed constitutional amendment 13-02. Would not result in a significant regulatory impact to the agency: oversight of the plants; nursery stock dealers' license; commercial weights; agricultural inspection stations, etc. Fees would cover any additional costs.

State / Local Agency	Date Info Provided	Result
Florida Department of Law Enforcement	10/19/2015	The Florida Department of Law Enforcement does not anticipate a fiscal impact as long as the criminal justice community does not have an expectation FDLE labs would determine whether cannabis found by officers is medical cannabis < 0.8 % THC and >10% CBD or recreational grade. Currently the laboratories identify the plant and whether THC is present. Current laboratory testing cannot determine the difference between medical grade and recreational cannabis. The implementation of a quantification procedure for THC and CBD based on previous workload for cannabis, could require more than 30 additional FTE chemistry positions statewide and appropriate space to house them. The estimated fiscal impact to fund 30 crime laboratory analyst positions is more than $2.2 million. In addition, the department anticipates the increased availability of cannabis with higher THC concentrations would increase driving under the influence laboratory evidence submissions by law enforcement agencies. This would have a fiscal impact on the toxicology sections of the department's crime laboratories, in terms of additional staffing and instrumentation. However, this impact is undetermined at this time.
Florida Office of the Attorney General	10/19/2015	Referred the Conference to a letter that was submitted to the Chief Justice and Justices of the Florida Supreme Court.
Florida Department of Highway Safety and Motor Vehicles	10/20/2015	The department's position remains the same as regarding the proposed constitutional amendment 13-02. Indicated that there may be some additional costs, but cannot quantify them at this time. The costs may be due to law enforcement training needs and public education and outreach.
Florida Association of Counties	10/15/2015	The association's position remains the same as regarding the proposed constitutional amendment 13-02. The Florida Association of Counties is unable to make a determination about the financial impact of the proposed amendment on local governments as per email.
Florida League of Cities	10/19/2015	Phone conversation indicating that the League of Cities is unable to quantify any potential impact to costs at this time.
Florida Police Chiefs Association	10/20/2015	Email indicating additional enforcement and training costs based on the experience from other states that have similar amendments, but they were unable to quantify these costs at this time.
Florida Sheriffs Association	10/20/2015	The association's position remains the same as regarding the proposed constitutional amendment 13-02. At that time, their presentation and email indicated additional enforcement costs based on the experience from other states that have similar amendments, but they were unable to quantify these costs at this time.

Florida Sales Tax Treatment of Medical Marijuana

Since medical marijuana is tangible personal property for the purposes of Chapter 212, Florida Statutes, its purchase is subject to Florida sales and use tax unless a specific exemption exists. In this regard, there were three possible areas of current law exemptions considered by the Conference: prescription-based exemptions, the common household remedy exemption, and agricultural-related exemptions.

The Conference has determined that the prescription-based exemptions do not apply to medical marijuana purchases due to technical constraints that include the interaction of state and federal law. The Florida Statutes define a prescription as "any order for drugs or medicinal supplies written or transmitted by any means of communication by a duly licensed practitioner authorized by the laws of the state to prescribe such drugs or medicinal supplies and intended to be dispensed by a pharmacist." Current federal law prohibits a physician from writing prescriptions for Schedule I controlled substances, which would include marijuana. In addition, the proposed amendment establishes a certification process that allows the end-user to control both the product type and dosage frequency without the need for an authorizing prescription, making the certification process fundamentally different from the typical prescription purchase. Moreover, the proposed amendment requires medical marijuana to be dispensed by a Medical Marijuana Treatment Center that is not required to be a pharmacy. Similarly, the exemption for medical products requires a prescription and would not be applicable to the sales of supplies related to medical marijuana.

The exemption for common household remedies does not require the presence of a prescription. Pursuant to Florida Statutes, the Department of Business and Professional Regulation (DBPR) must approve a list of these items, and that list is then certified to and adopted by the Department of Revenue through the rule-making process. There is also a process for inclusion of additional items. The existing list contains a mixture of specifically named remedies and broad classes of remedies. Both departments have identified reasons why the exemption may not apply, emphasizing the restrictive nature of the dispensing process. DBPR stated that medical marijuana does not fit under any category on the currently adopted Common Household Remedies list (DR-46NT, R. 07/10), nor does DBPR expect to modify the "Common Household Remedies" listing to add medical marijuana in the foreseeable future. The department cites federal regulations which continue to designate any form of marijuana as a Schedule I drug with no current authorized use and no treatment value.

Based on information provided by the Department of Revenue and the Department of Agriculture and Consumer Services, the Conference determined that the applicability of agricultural-related exemptions to the sale or production of medical marijuana is uncertain because medical marijuana may not be considered an agricultural product. Should the exemptions apply, the direct sale or dispensation of medical marijuana in its raw form by the grower or cultivator to an end-user or designated caregiver would be exempt. Also exempt would be items used in the production of medical marijuana such as power farm equipment, fertilizer and pesticides.

Potential Sales Tax Impact

In an attempt to quantify the potential magnitude of the sales tax impact, the Conference looked to other states to analyze their results. Of the *18 states and the District of Columbia* that have approved the use of medical marijuana *and levy a sales tax*, at least 12 states and the District of Columbia have a sales tax structure that encompasses medical marijuana transactions.[32] In New Jersey and Illinois, legislation explicitly made the sale of medical marijuana subject to tax. In the District of Columbia, marijuana's status as a Schedule I drug appears to disqualify it from an exemption.

The Office of Economic and Demographic Research used the information from other states to analyze the potential range of state sales tax revenues. The number of users, the consumption per user and the cost of the product are all critical assumptions and cause the projections to change dramatically as they are varied. Using price data from Vermont, allowable usage from Connecticut, survey data on the illegal use of marijuana for recreational purposes, and two of the estimates of projected Florida users discussed earlier, the estimated sales tax collections range from a low of $11.8 million to a maximum of $356.8 million.

Potential Range of State Sales Tax Revenues from Medical Marijuana End-Users Assuming No Sales Tax Exemptions Apply

The Following Examples Demonstrate a Range that is Generated by Varying Assumptions

Quantity Consumed/ Estimation Approach	UPDATED April 1, 2017 Users	Sales ($)		State Sales Tax Revenues ($)	
		$225/ oz	$450/ oz	$225/ oz	$450/ oz
Annual use of 3.53 oz (100 g)[1] (Illicit Drug Use Pattern, 1.5 gram, 5-6 times/month)					
I. States with medical marijuana laws	440,552	349,908,426	699,816,852	20,994,506	41,989,011
IV. Use by cancer patients	247,689	196,726,988	393,453,977	11,803,619	23,607,239
Annual use of 30 oz (850 g)[2] (1.5 g 1.6 times per day, all year round)					
I. States with medical marijuana laws	440,552	2,973,726,000	5,947,452,000	178,423,560	356,847,120
IV. Use by cancer patients	247,689	1,671,900,750	3,343,801,500	100,314,045	200,628,090

NOTE: Additional detail can be found at EDR's website:
http://edr.state.fl.us/Content/constitutional-amendments/2016Ballot/MedMTab28.pdf

Another approach to estimate potential sales tax revenues uses sales tax collections, number of registrants, and amount of medical marijuana sold in Colorado for 2014. Assuming Florida will have a medical marijuana consumption pattern similar to Colorado, annual sales tax collections are estimated to be close to $84.9 million. After deducting the updated estimated sales tax collections for the low-THC cannabis authorized by CS/CS/SB1030 of $17.6 million, the net sales tax collections under the proposed constitutional amendment are estimated at $67.3 million.

[32] Arizona, California, Colorado, Connecticut, Illinois, Maine, Nevada, New Jersey, New Mexico, New York, Rhode Island, Washington, and the District of Columbia have sales taxes.

Florida 2017 Sales Tax Collection Estimates
Based on Colorado's 2014 Experience

	Colorado	Florida
Patients	115,115	440,552
Amount per patient (oz)	16.14	16.14
Pretax price per oz	199	199
Sales	334,751,145	1,414,675,735
Sales tax collections	**9,997,717**	**84,880,544**
Sales tax collections from updated impact of CS/CS/SB1030		**17,579,912**
NET impact of proposed amendment		**67,300,632**

NOTE: Additional detail can be found at EDR's website:http://edr.state.fl.us/Content/constitutional-amendments/2016Ballot/MedMTab28_update%202.pdf

In conclusion, the increase in sales tax revenues to state and local governments cannot be determined precisely because too many unknowns affect the amount of taxable sales, but the increase will be substantial. As shown above, the estimates vary from a low of $11.8 million to a high of $356.8 million. Assuming Florida's medical marijuana consumption mirrors Colorado's experience, annual state and local government sales tax revenues could increase by an estimated $67 million after taking into account lawful consumption of medical marijuana in Florida.

Florida Property Tax Treatment of Medical Marijuana

It is unclear whether land used for growing medical marijuana will be considered agricultural property for property tax purposes. If the land is considered agricultural property, it will receive a classified use agricultural assessment. Regardless of whether the land is considered agricultural property, taxable value may increase or decrease relative to its current value. Therefore, the impact on property taxes is indeterminate—both in terms of magnitude and direction.

FLORIDA FINANCIAL IMPACT ESTIMATING CONFERENCE

Regulate Marijuana in a Manner Similar to Alcohol
to Establish Age, Licensing, and Other Restrictions
Serial Number 16-02
October 25, 2019

FINANCIAL IMPACT STATEMENT

The amendment permits legal sales of recreational marijuana which will be subject to sales tax. As a result of those sales and an accompanying increase in tourism, sales tax collections increase by at least $190 million per year once the legal retail market is fully operational. The estimated impacts increase the state's overall budget by less than 0.1%. At a minimum, the required state regulatory structure will cost $1.5 million for startup and $9.1 million annually to operate; however, it is probable that this cost will be offset by fees. Local governments' regulatory costs are unknown. The net impact of additional costs and savings associated with the criminal justice system cannot be determined. As a result of the identified impacts, the amendment has slightly positive effects on the economy. Florida's GDP is higher each year by an average of $3.8 billion. This represents 0.32% of the annual total.

SUMMARY OF INITIATIVE FINANCIAL INFORMATION STATEMENT

The Financial Impact Estimating Conference identified the following revenue, budgetary and economic impacts to Florida:

- *Increased state and local governments' sales tax revenue associated with transactions in the legal retail market, whether by former black market participants, tourists, new users, expanded use, or the conversion of medical marijuana participants*—This increase reflects current law making non-medical marijuana subject to sales tax. Assuming Florida's legal retail market is fully operational by the beginning of FY 2021-22 and supply is sufficient to meet demand, the minimum increase in government revenues is $146.4 million per year.
- *Increased sales tax revenues associated with additional expenditures by new tourists induced to come to Florida by the legalization of marijuana*—The minimum increase in government revenues is $43.6 million per year and occurs under existing law.
- *Added costs to create and maintain the regulatory structure at the Department of Business and Professional Regulation*—The total cost is projected to be $9.1 million annually, with an additional $1.5 million needed for startup. It is probable new license fees will completely offset these costs.
- *Savings generated by a reduction in some marijuana-related crimes which are offset by costs related to an increase in the number of persons arrested and convicted of DUIs or other similar offenses*—These impacts affect the bottom-line cost of the shared state and local criminal justice system. Overall, the net impact in any given year is indeterminate.
- *Increased potential for marijuana-related health issues*—The discrete impact caused by the proposed amendment cannot be isolated from the effects associated with current illegal usage or other addictive behaviors. Further, the research is still evolving, but suggestive that these effects would typically occur over long-periods of heavy usage and may be mitigated by a switch from more dangerous substances to the regulated marijuana market. Given the countervailing effects, the impact on Florida's public health care costs is indeterminate and may evolve over many years. In part, this is because the vast majority of the new legal market participants are already using and purchasing the product on the black market.

- *New costs for law enforcement agencies during the startup and implementation phases*—The increased training costs are indeterminate but short-lived, as these costs ultimately revert to pre-legalization levels.
- *Economic impact from the increase in revenue, income and jobs associated with the production and sale of recreational marijuana, including the impact associated with additional tourism expenditures*—The analysis shows slightly positive effects on the state's economy. Relative to the baseline, Real Gross Domestic Product (GDP) is higher each year by an average of $3.8 billion. This represents 0.32% of the annual total.

The impact on collections from the existing Gross Receipts Tax on utilities will be positive, but cannot be quantified in advance of the proposed amendment's implementation by state and local governments since utility use varies under different scenarios. In addition, the imposition of an excise tax on legal marijuana products is subject to legislative enactment and cannot be assumed in advance of that action.

SUBSTANTIVE ANALYSIS

A. Proposed Amendment

Ballot Title:

Regulate Marijuana in a Manner Similar to Alcohol to Establish Age, Licensing, and Other Restrictions

Ballot Summary:

Regulates marijuana (hereinafter "cannabis") for limited use and growing by persons twenty-one years of age or older. State shall adopt regulations to issue, renew, suspend, and revoke licenses for cannabis cultivation, product manufacturing, testing and retail facilities. Local governments may regulate facilities' time, place and manner and, if state fails to timely act, may license facilities. Does not affect compassionate use of low-THC cannabis, nor immunize federal law violations.

Article and Section Being Created or Amended:
Article X, Section 29

Full Text of the Proposed Amendment:
ARTICLE X
SECTION 29. Florida Cannabis Act —

(a) PURPOSE AND FINDINGS.

(1) Short title. On the effective date of this amendment, it shall be known as the "Florida Cannabis Act."

(2) In the interest of the efficient use of law enforcement resources, enhancing revenue for public purposes, and individual freedom, the people of the State of Florida find and declare that the use of cannabis should be legal for persons twenty-one years of age or older.

(3) In the interest of the health and public safety of our citizenry, the people of the State of Florida further find and declare cannabis should be regulated in a manner similar to alcohol so that:

a. Consumers will have to show proof of age before purchasing cannabis;

b. Selling, distributing, or transferring cannabis to minors under the age of twenty-one shall remain illegal;

c. Driving while impaired under the influence of cannabis shall remain illegal;

d. Only legitimate, taxpaying business people will conduct sales of cannabis; and

e. Cannabis sold in this state will be labeled and subject to additional regulations to ensure consumers are informed and protected.

(4) The people of the State of Florida further find and declare it is necessary to ensure consistency and fairness in the application of this section throughout the state and that, therefore, the matters addressed by this section are, except as specified herein, matters of statewide concern.

(b) DEFINITIONS. As used in this section, unless the context otherwise requires:

(1) "Applicant" means an individual person or any form of business that applies for a license to operate a cannabis establishment. Any person or business entity may hold multiple licenses, providing each license be applied for and renewed individually and independently of any other license.

(2) "Business entity" means any form of business operation recognized under Florida law, including partnership that is registered to do business in Florida prior to filing for a license to operate a cannabis establishment.

(3) "Cannabis" means all parts of the plant of the genus Cannabis, as defined in s. 893.02(3), Florida Statutes (2016). Nothing in this definition or this section shall be deemed to permit or prohibit the cultivation of the plant of the genus Cannabis as a raw material for use of its fiber or pectin, or its structural polymers (the polysaccharides cellulose and hemicelluloses and the aromatic polymer lignin) for any industrial purpose, including the preparation of functionalized textiles, or for any purpose other than human consumption.

(4) "Cannabis cultivation facility" means an entity licensed to cultivate, prepare, and package cannabis and sell cannabis to ret ail cannabis stores, to cannabis product manufacturing facilities, and to other cannabis cultivation facilities, but not to consumers.

(5) "Cannabis establishment" means a cannabis cultivation facility, a cannabis testing facility, a cannabis product manufacturing facility, or a retail cannabis store.

(6) "Cannabis plant" means a plant, including, but not limited to, a seedling or cutting. To determine if a piece or part of a cannabis plant severed from the cannabis plant is itself a cannabis plant, the severed piece or part must have some readily observable evidence of root formation, such as root hairs. Callous tissue is not readily observable evidence of root formation. The viability and sex of a plant and the fact that the plant may or may not be a dead harvested plant are not relevant in determining if the plant is a cannabis plant.

(7) "Cannabis product manufacturing facility" means an entity licensed to purchase cannabis; manufacture, prepare, and package cannabis products; and sell cannabis and cannabis products to other cannabis product manufacturing facilities and to retail cannabis stores, but not to consumers.

(8) "Cannabis products" means concentrated cannabis products and cannabis products that are comprised of cannabis and other ingredients intended for human consumption or human topical application, including but not limited to, edible products, infused products, ointments, and tinctures.

(9) "Cannabis testing facility" means an entity licensed to analyze and certify the safety and potency of cannabis.

(10) "Consumer" means a person twenty-one years of age or older who purchases cannabis or cannabis products for personal use by persons twenty-one years of age or older, but not for resale to others. Consumer does not include any form of business entity, partnership, or incorporation.

(11) "Corporation" means any form of business entity, partnership, joint venture, limited liability company, cooperative, or other manner of incorporation.

(12) "County" means a political subdivision of the state established pursuant to s. 1, Art. VIII of the State Constitution.

(13) "Department" means the Florida Department of Business & Professional Regulation or its successor agency.

(14) "Florida Cannabis Act" means this section of the Florida Constitution, and as may be codified.

(15) "Municipality" means a municipality created under general or special law or recognized pursuant to s. 2 or s. 6, Art. VIII of the State Constitution.

(16) "Retail cannabis store" means an entity licensed to purchase cannabis from cannabis cultivation facilities and cannabis products from cannabis product manufacturing facilities and to sell cannabis and cannabis products to consumers.

(c) PERSONAL USE OF CANNABIS. Notwithstanding any other provision of law, the following acts are not unlawful and shall not be an offense under Florida law or the law of any county or municipality within Florida or be a basis for seizure or forfeiture of assets under Florida law for persons twenty-one years of age or older. These are minimum quantities, subject to increase by state, county, or municipal legislation, but not subject to decrease:

(1) Possessing, using, displaying, purchasing, or transporting cannabis, and cannabis products in quantities reasonably indicative of personal use or for use by household members;

(2) Growing six mature flowering cannabis plants per household member twenty-one years of age or older and possessing the harvest therefrom, provided the growing takes place indoors or in a locked greenhouse and the cannabis grown is not made available for sale; outdoor growing for personal consumption is not herein permitted statewide, but may be permitted locally if approved by legislation created at the county or municipal level; nothing in this subsection shall prevent the state legislature from creating laws that permit outdoor growing for personal consumption;

(3) Transfer of one ounce or less of cannabis without remuneration to a person who is twenty-one years of age or older;

(4) Allowing or restricting consumption of cannabis within a private business establishment or on its premises consistent with this section; or

(5) Assisting another person who is twenty-one years of age or older in any of the acts described in paragraphs (1) through (5) of this subsection.

(d) LAWFUL OPERATION OF CANNABIS ESTABLISHMENT. Notwithstanding any other provision of law, the following acts are not unlawful and shall not be an offense under Florida law or be a basis for seizure or forfeiture of assets under Florida law for persons twenty-one years of age or older:

(1) Possessing, displaying, or transporting cannabis or cannabis products; purchase of cannabis from a cannabis cultivation facility; purchase of cannabis or cannabis products from a cannabis product manufacturing facility; or sale of cannabis or cannabis product to consumers, if the person conducting the activities described in this subsection has obtained a current, valid license to operate a retail cannabis store or is acting in his or her capacity as an owner, employee or agent of a licensed retail cannabis store;

(2) Cultivating, harvesting, processing, packaging, transporting, displaying, or possessing cannabis; delivery or transfer of cannabis t o a cannabis testing facility; selling cannabis to a cannabis cultivation facility, a cannabis product manufacturing facility, or a retail cannabis store; or the purchase of cannabis from a cannabis cultivation facility, if the person conducting the activities described in this subsection has obtained a current, valid license to operate a cannabis cultivation facility or is acting in his or her capacity as an owner, employee, or agent of a licensed cannabis cultivation facility;

(3) Packaging, processing, transporting, manufacturing, displaying, or possessing cannabis or cannabis products; delivery or transfer of cannabis or cannabis products to a cannabis testing facility; selling cannabis or cannabis products to a retail cannabis store or a cannabis product manufacturing facility; the purchase of cannabis from a cannabis cultivation facility; or the purchase of cannabis or cannabis products from a cannabis product manufacturing facility, if the person conducting the activities described in this subsection has a current, valid license to operate a cannabis product manufacturing facility or is acting in his or her capacity as an owner, employee, or agent of a licensed cannabis product manufacturing facility;

(4) Possessing, cultivating, processing, repackaging, storing, transporting, displaying, transferring or delivering cannabis or cannabis products in connection with testing activities, if the person has obtained a current, valid license to operate a cannabis testing facility or is acting in his or her capacity as an owner, employee, or agent of a licensed cannabis testing facility; or

(5) Leasing or otherwise allowing the use of property owned, occupied or controlled by any person, corporation or other entity for any of the activities conducted lawfully in accordance with paragraphs (1) through (5) of this subsection.

(e) REGULATION OF CANNABIS.

(1) No later than 6 months from the effective date, the department shall adopt regulations necessary for implementation of this section to include:

a. Procedures for the issuance, renewal, suspension, and revocation of a license to operate a cannabis establishment, with such procedures subject to all requirements of s. 120.54, Florida Statutes (2016) or as amended;

b. Any license issued to an individual person shall only be issued to a person of good moral character who is not less than twenty-one years of age and who has resided in the United States for the preceding five years and who has been a U.S. citizen for the preceding five years or has established lawful permanent residence in the United States for the preceding five years as evidenced by a "Green Card" and has resided in the United States for the preceding five years.

c. Any license issued to a business entity shall only be issued to a business entity of which all directors of a corporate applicant, members of a limited liability applicant, partners of a partnership applicant, or joint venturors of a joint venture applicant are of good moral character, are not less than twenty-one years of age, and at least 75% thereof have resided in the United States for the preceding five years and have been a U.S. citizen for the preceding five years or have established lawful permanent residence in the United States for the preceding five years as evidenced by a "Green Card" and have resided in the United States for the preceding five years;

d. That in the case of an individual applicant, any license shall be issued only to a person who has been domiciled in the State of Florida for at least 6 months immediately prior to applying;

e. That in the case of a business entity applicant, any license shall be issued only to business entities that can show at least 25% of the directors, members, partners, or joint venturor applicants have been domiciled in the State of Florida for at least 6 months immediately prior to applying;

f. That no license under this section shall be issued to any person, director, member, partner, or joint venturor who has been convicted of a felony offense, except that if the licensing authority determines that the applicant or licensee is otherwise suitable to be issued a license and granting the license would not compromise public safety. In making this determination the licensing authority shall conduct a thorough review of the nature of the crime, conviction, circumstances, and evidence of rehabilitation of the applicant, and shall evaluate the suitability of the applicant or licensee to be issued a license based on the evidence found through the review. In determining which offenses are substantially related to the qualifications, functions, or duties of the business or profession for which the application is made, the licensing authority shall include any felony conviction.

g. In the case of a business entity applicant, the requirements stated in this subsection shall apply to each and every director, member, partner, or joint venturor in a business entity, but not to persons that are solely investors or owners; and

h. The department may suspend or revoke a license under this section, or may refuse to issue a license under this section to:

1. Any person, firm, or corporation the license of which under this section has been revoked or has been abandoned after written notice that revocation or suspension proceedings had been or would be brought against the license;

2. Any corporation if an officer or director of the corporation has had her or his license under this section revoked or has abandoned her or his license after written notice that revocation or suspension proceedings had been or would be brought against her or his license; or

3. Any person who is or has been an officer or director of a corporation, or who directly or indirectly closely held an ownership interest in a corporation, the license of which has been revoked or abandoned after written notice that revocation or suspension proceedings had been or would be brought against the license.

i. Security requirements for cannabis establishments;

j. Requirements to prevent the sale or diversion of cannabis and cannabis products to persons under the age of twenty-one;

k. Labeling and packaging requirements for cannabis and cannabis products sold or distributed by a cannabis establishment;

l. Health and safety regulations and standards for the manufacture and testing of cannabis products and the cultivation of cannabis;

m. Guidelines on the advertising and display of cannabis and cannabis products; and

n. Civil penalties for the failure to comply with regulations made pursuant to this section.

(2) In order to protect consumer privacy, the department shall not require a consumer to provide a retail cannabis store with person al information other than government-issued identification to determine the consumer's age, and a retail cannabis store shall not be required to acquire and record personal information about consumers other than information typically acquired in a financial transaction conducted at a retail liquor store.

(3) Nothing contained in this section shall be construed to create nor in any way limit any taxing authority to make, collect, administer, enforce or distribute any tax levy relating to this section under any taxing authority's power to tax authorized by the constitution or the laws of this state.

(4) No later than 6 months from the effective date, each county or municipality shall enact an ordinance or regulation specifying the entity within the county or municipality responsible for processing applications submitted for a license to operate a cannabis establishment within the boundaries of the county or municipality and for the issuance of any such license should the issuance by the county or municipality become necessary because of a failure by the department to adopt regulations pursuant to subsection (e)(1) or failure by the department to process a license application in accordance with subsection (e)(6).

(5) A county or municipality may enact ordinances or regulations not in conflict with this section or state regulations or legislation.

a. Governing the time, place, manner, and number of cannabis establishment operations;

b. Establishing procedures for the issuance, suspension, and revocation of a license issued by the county or municipality in accordance with subsections (e)(7) or (e)(8), such procedures to be subject to all requirements of s. 120.54, Florida Statutes (2016) or as amended; and

c. Establishing civil penalties for violation of an ordinance or regulation governing the time, place, and manner of a cannabis establishment that may operate in such county or municipality, whether licensed by the state, a county or municipality.

(6) Each application for an annual license to operate a cannabis establishment shall be submitted to the department. The department shall:

a. Begin accepting and processing applications 6 months from the effective date;

b. Upon request by the county or municipality, immediately forward a copy of each application to the county in which the applicant desires to operate;

c. Issue an annual license to the applicant between forty-five and ninety days after receipt of an application unless the department finds the applicant is not in compliance with regulations enacted pursuant to subsection (e)(1) or the department is notified by the relevant county or municipality that the applicant is not in compliance with subsection (e)(5) in effect at the time of application, provided, where a county or municipality has enacted a numerical limit on the number of cannabis establishments and a greater number of applicants seek licensing, the department shall solicit and consider input from the county or municipality as to the county or municipality's preference for licensure; and

d. Upon denial of an application, notify the applicant in writing of the specific reason for its denial.

(7) If the department does not issue a license to an applicant within ninety days of receipt of the application filed in accordance with subsection (e)(6) and does not notify the applicant of the specific reason for its denial, or the specific reason as to why the applicant is not in compliance with regulations enacted pursuant to subsection (e)(1), in writing, within such time period, the applicant may resubmit the application directly to the county or municipality, pursuant to subsection (e)(5), and the county or municipality may issue an annual license to the applicant. A county or municipality issuing a license to an applicant shall do so within ninety days of receipt of the resubmitted application unless the county or municipality finds and notifies the applicant that the applicant is not in compliance with ordinances and regulations made pursuant to subsection (e)(5) in effect at the time the application is resubmitted. The county or municipality shall notify the department if an annual license has been issued to the applicant. A license issued by a county or municipality in accordance with this subsection shall have the same force and effect as a license issued by the department in accordance with subsection (e)(6). A subsequent or renewed license may be

issued under this subsection on an annual basis only upon resubmission to the county or municipality of a new application submitted to the department pursuant to subsection(e)(6), if the department does not issue a license to an applicant within ninety days of receipt of the application for a subsequent or renewed annual license filed in accordance with subsection (e)(6) and does not notify the applicant of the specific reason for its denial, or the specific reason as to why the applicant is not in compliance with regulations enacted pursuant to subsection (e)(1), in writing, within such time period. Nothing in this subsection shall limit such relief as may be available to an aggrieved party under ss. 120.56, 120.565, 120.569, 120.57, 120.573, or 120.574, Florida Statutes (2016) or as amended.

(8) If the department does not adopt regulations in accordance with subsection (e)(1), an applicant may submit an application directly to a county or municipality after 6 months from the effective date, and the county or municipality may issue an annual license to the applicant. A county or municipality issuing a license to an applicant shall do so within ninety days of receipt of the application, unless it finds and notifies the applicant that the applicant is not in compliance with ordinances and regulations made pursuant to subsection (e)(5) in effect at the time of application, and shall notify the department if an annual license has been issued to the applicant. A license issued by a county or municipality in accordance with this subsection shall have the same force and effect as a license issued by the department in accordance with subsection (e)(6). A subsequent or renewed license may be issued under this subsection on an annual basis if the department has not adopted regulations in accordance with subsection (e)(1) at least ninety days prior to the date upon which such subsequent or renewed license would be effective or if the department has adopted regulations pursuant to subsection (e)(1) but has not, at least ninety days after the adoption of such regulations, issued the license pursuant to subsection (e)(6) and has not notified the applicant, in writing, of the specific reason for its denial.

(9) A county or municipality may prohibit the licensing of a cannabis establishment whether licensed by the department, county or municipality, providing the prohibition is approved by a vote of the electorate in a general election during an even numbered year. Grandfather clause. —If any county or municipality prohibits the licensing of any cannabis establishment under this subsection, any license issued prior to the effective date of any such county or municipal prohibition shall continue in full force, be subject to renewal, and in no way be affected by any post-licensing prohibition enacted under this subsection.

(f) EMPLOYERS, DRIVING, MINORS, CONTROL OF PROPERTY, AND FEDERAL LAW.

(1) Nothing in this section is intended to require an employer to permit or accommodate the use, consumption, possession, transfer, display, transportation, sale, or growing of cannabis in the workplace or to affect or repeal the ability of employers to have policies restricting the use of cannabis by employees during work hours.

(2) Nothing in this section is intended to allow driving while impaired by cannabis, nor shall this section prevent the state from criminal penalties pursuant to s. 316.193, Florida Statutes (2016) or as amended.

(3) Nothing in this section is intended to permit the transfer of cannabis, with or without remuneration, to a person under the age of twenty-one or to allow a person under the age of twenty-one to purchase, possess, use, transport, grow, or consume cannabis, except as otherwise permitted under state law or the Florida Constitution.

(4) Nothing in this section shall prohibit a person, employer, corporation or any other entity who occupies, owns or controls a residency or detention facility, whether public or private, when residence or detention is incidental to the provision of medical, geriatric, educational, counseling, rehabilitation, correctional, or similar services; transient occupancy in a hotel, condominium, motel, rooming house, or similar public lodging, or transient occupancy in a mobile home park; occupancy by a holder of a proprietary lease in a cooperative apartment; or occupancy by an owner of a condominium unit from prohibiting or otherwise regulating the possession, consumption, use, display, transfer, distribution, sale, transportation, or growing of cannabis on or in that property.

(5) Nothing in this section purports to give immunity under federal law for possession, consumption, use, display, transfer, distribution, sale, transportation, or growing of cannabis.

(g) THE FLORIDA CANNABIS ACT'S EFFECT ON OTHER FLORIDA LAWS RELATING TO CANNABIS OR MARIJUANA.

(1) Nothing in this section shall be construed to affect or repeal s. 112.0455, Florida Statutes (2016) (Drug-Free Workplace Act) except as stated herein.

(2) Nothing in this section shall be construed to affect or repeal s. 327.38, Florida Statutes (2016) (use of water skis, aquaplane, or similar device from a vessel while under the influence of marijuana).

(3) Nothing in this section shall be construed to limit or extend any privilege, right, or duty on the part of medical cannabis dispensing organizations, qualified patients, physicians, caregivers or any other persons, entities, or activities governed by Florida's Compassionate Use of low-THC Cannabis Act, s. 381.986 et seq., Florida Statutes (2016) or as amended.

(4) The Florida Legislature shall, no later than 6 months from the effective date, revise s. 775.087(2)(a)1(q), Florida Statutes (2016) (actual possession of a firearm or destructive device) to qualify the word "cannabis" to accommodate possession consistent with this section.

(5) The Florida Legislature shall, no later than 6 months from the effective date, revise s. 775.087(3)(a)1(r), Florida Statutes (2016) or as amended (actual possession of a semiautomatic firearm and its high capacity detachable box magazine, or a machine gun) to qualify the word "cannabis" to accommodate possession consistent with this section.

(6) The Florida Legislature shall, no later than 6 months from the effective date, revise s. 812.14(6)(b), Florida Statutes (2016) or as amended (use of utility services to grow marijuana indoors) to accommodate use of utility services consistent with this section.

(7) The Florida Legislature shall, no later than 6 months from the effective date, revise ss. 893.145 - 893.147, Florida Statutes (2016) or as amended, to qualify the definition of "drug paraphernalia," the determination of paraphernalia, and the use, possession, manufacture, delivery, transportation, advertisement, or retail sale of drug paraphernalia consistent with this section, and shall otherwise revise, Chapter 893, Florida Statutes (2016) (drug abuse prevention and control) as needed to qualify and quantify cannabis possession and use consistent with this section.

(h) SELF-EXECUTING, SEVERABILITY, CONFLICTING PROVISIONS. All provisions of this section are self-executing except as specified herein. All provisions of this section are severable, and, except where otherwise indicated in the text, shall supersede conflicting state statutory, local charter, ordinance, or resolution, and other state and local provisions.

(i) EFFECTIVE DATE. Except as otherwise provided herein, all provisions of this proposed amendment shall be effective as an amendment to the Constitution of the State of Florida on the first Tuesday after the first Monday in January following the election.

B. Effective Date

Article XI, Section 5(e), Florida Constitution, states: "Unless otherwise specifically provided for elsewhere in this constitution, if the proposed amendment or revision is approved by vote of at least sixty percent of the electors voting on the measure, it shall be effective as an amendment to or revision of the constitution of the state on the first Tuesday after the first Monday in January following the election, or on such other date as may be specified in the amendment or revision."

Assuming the initiative is on the ballot in 2020, the effective date would be January 5, 2021.

C. Formal Communications to and from the Sponsor, Proponents, and Opponents

The Sponsor, Sensible Florida, Inc., did not appoint a representative to present on its behalf and did not attend the meetings held by the Financial Impact Estimating Conference (FIEC). The FIEC sought to identify any groups that were on record as supporting or opposing the petition initiative; however, none were identified.

D. Input Received from the Sponsor, Proponents, Opponents, and Interested Parties

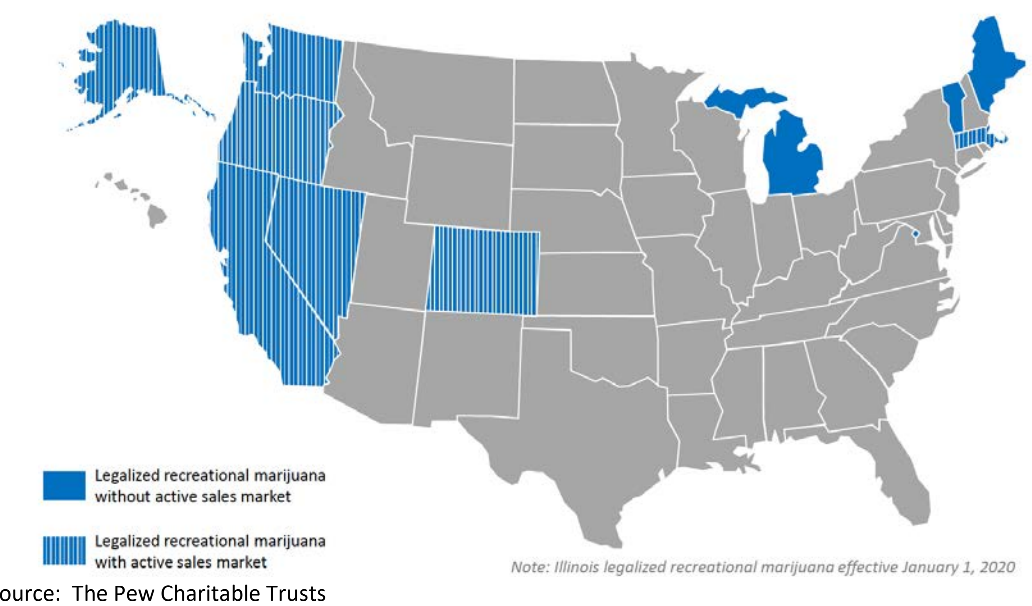
The FIEC directly requested information from the Florida Department of Business and Professional Regulation, Florida Department of Corrections, Florida Department of Health, Florida Department of Highway Safety and Motor Vehicles, Florida Police Chiefs Association, Florida Sheriffs Association, Florida League of Cities and the Florida Association of Counties. In addition, the FIEC allows any proponent, opponent, or interested party to present or provide the FIEC with materials to consider. Documentation of any materials received by the FIEC can be found in the EDR Notebook on the website at: http://edr.state.fl.us/Content/constitutional-amendments/2020Ballot/MarijuanaRegulationAdditionalInformation.cfm

E. Background

Federal marijuana laws still exist. According to a January 4, 2018, memorandum from the Attorney General of the United States:

> *In the Controlled Substances Act, Congress has generally prohibited the cultivation, distribution, and possession of marijuana. 21 U.S.C. § 801 et seq. It has established significant penalties for these crimes. 21 U.S.C. § 841 el seq. These activities also may serve as the basis for the prosecution of other crimes, such as those prohibited by the money laundering statutes, the unlicensed money transmitter statute, and the Bank Secrecy Act. 18 U.S.C. §§ 1956-57, 1960; 31 U.S.C. § 5318. These statutes reflect Congress's determination that marijuana is a dangerous drug and that marijuana activity is a serious crime.*

Currently, a total of 33 states, the District of Columbia, Guam, Puerto Rico and the US Virgin Islands have authorized the use of medical marijuana.[1] Of these, 11 states and the District of Columbia have further legalized recreational marijuana. The graphic below does not show Illinois, because its legalized recreational program will not be operational until January 1, 2020.



Source: The Pew Charitable Trusts

[1] See http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx; retrieved October 24, 2019, but dated October 16, 2019.

Both Colorado and Washington legalized recreational marijuana in November 2012; however, Colorado was the first state to actually begin sales (January 2014). The table below details the year when legalization of recreational marijuana occurred.[2]

Area	Year of Legalization
Colorado	2012
Washington	2012
Alaska	2014
District of Columbia	2014
Oregon	2014
California	2016
Maine	2016
Massachusetts	2016
Nevada	2016
Michigan	2018
Vermont	2018
Illinois	2019

Source: http://www.ncsl.org/research/civil-and-criminal-justice/marijuana-overview.aspx

The first action in Florida occurred in 2014 when the Legislature passed the Compassionate Medical Cannabis Act of 2014.[3] This act legalized a non-euphoric low tetrahydrocannabinol (THC) and high cannabidiol (CBD) form of cannabis (low-THC cannabis)[4] for medical use[5] by patients suffering from cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms. The law was amended during the 2016 Session to expand the regulatory structure relating to dispensing low-THC cannabis and authorize approved dispensing organizations to cultivate and dispense high-THC cannabis to eligible patients as defined under the Right to Try Act (RTTA).[6]

As part of the 2016 General Election, Floridians passed a constitutional amendment (Use of Marijuana for Debilitating Medical Conditions 15-01) that had the following ballot summary:

> *"Allows medical use of marijuana for individuals with debilitating medical conditions as determined by a licensed Florida physician. Allows caregivers to assist patients' medical use of marijuana. The Department of Health shall register and regulate centers that produce and distribute marijuana for medical purposes and shall issue identification cards to patients and caregivers. Applies only to Florida law. Does not immunize violations of federal law or any non-medical use, possession or production of marijuana."*[7]

---

[2] Forecasts Hazy for State Marijuana Revenue, Unknown price and demand, lack of historical data leave planners with limited information, August 2019, https://www.pewtrusts.org/-/media/assets/2019/08/marijuana-brief_v2.pdf

[3] Chapter 2014-157, Laws of Fla., codified in s. 381.986, F.S.

[4] Section 381.986(1)(b), F.S. (2014), defines "low-THC cannabis," as the dried flowers of the plant *Cannabis* which contain 0.8 percent or less of tetrahydrocannabinol and more than 10 percent of cannabidiol weight for weight, or the seeds, resin, or any compound, manufacture, salt, derivative, mixture, or preparation of the plant or its seeds or resin.

[5] Section 381.986(1)(c), F.S. (2014), defines "medical use" as administration of the ordered amount of low-THC cannabis; and the term does not include the possession, use, or administration by smoking, or the transfer of low-THC cannabis to a person other than the qualified patient for whom it was ordered or the qualified patient's legal representative. Section 381.986(1)(e), F.S. (2014), defines "smoking" as burning or igniting a substance and inhaling the smoke; smoking does not include the use of a vaporizer.

[6] Section 499.0295, F.S.

[7] https://dos.elections.myflorida.com/initiatives/fulltext/pdf/50438-3.pdf

This constitutional amendment created s. 29, Article X of the Florida Constitution. During Special Session 2017A, the Legislature passed Senate Bill 8A to implement these provisions. In 2019, the Legislature passed Senate Bill 182, authorizing qualified physicians to recommend medical marijuana in a form for smoking.

The Florida Department of Health, Office of Medical Marijuana Use, regulates Florida's medical marijuana program. As of September 30, 2019, the program's use registry had 270,574 active qualified patients (valid identification cards).[8] The current qualifying conditions for use of medical marijuana in Florida are:

- Cancer
- Epilepsy
- Glaucoma
- Positive status for human immunodeficiency virus (HIV)
- Acquired immunodeficiency syndrome (AIDS)
- Post-traumatic stress disorder (PTSD)
- Amyotrophic lateral sclerosis (ALS)
- Crohn's disease
- Parkinson's disease
- Multiple sclerosis (MS)
- Medical conditions of the same kind or class as or comparable to those above
- A terminal condition diagnosed by a physician other than the qualified physician issuing the physician certification
- Chronic nonmalignant pain caused by a qualifying medical condition or that originates from a qualifying medical condition and persists beyond the usual course of that qualifying medical condition

There are no age restrictions on the use of medical marijuana; however, "[i]f a patient is younger than 18 years of age, a second physician must concur with this determination, and such concurrence must be documented in the patient's medical record."[9] The statutes also require that the patient, or the patient's parent or legal guardian if the patient is a minor, sign the informed consent acknowledging that the qualified physician has sufficiently explained its content.[10]

In addition:

> *"A qualified physician may not issue a physician certification for marijuana in a form for smoking to a patient under 18 years of age unless the patient is diagnosed with a terminal condition, the qualified physician determines that smoking is the most effective route of administration for the patient, and a second physician who is a board-certified pediatrician concurs with such determination. Such determination and concurrence must be documented in the patient's medical record and in the medical marijuana use registry. The certifying physician must obtain the written informed consent of such patient's parent or legal guardian before issuing a physician certification to the patient for marijuana in a form for smoking. The qualified physician must use a standardized informed consent form adopted in rule by the Board of Medicine and the Board of Osteopathic Medicine which must include information concerning the negative health effects of smoking marijuana on persons under 18 years of age and an acknowledgment that the qualified physician has sufficiently explained the contents of the form."*[11]

---

[8] Tabulations by the Office of Economic and Demographic Research of data provided by the Department of Health, Office of Medical Marijuana Use, October 2019.

[9] Section 381.986(4)(a)3, Florida Statutes.

[10] Section 381.986(4)(a)8, Florida Statutes.

[11] Section 381.986(4)(d), Florida Statutes.

F. Discussion of Impact of Proposed Amendment

Summary of the Proposed Amendment

The proposed amendment:

- Allows persons 21 years of age or older to possess, use, display, purchase, or transport cannabis and cannabis products in quantities reasonably indicative of personal use or for use by household members.
- Allows for growing six mature flowering cannabis plants per adult household member and possessing the harvest therefrom which may not be sold.
- Establishes a regulatory framework for issuing licenses and regulating the activities of persons and businesses operating a cultivation facility, a testing facility, a product manufacturing facility, or a retail cannabis store. Licenses are to be issued by the state and, under certain circumstances, may be issued by a county or municipality.
- Allows counties and municipalities to establish regulations governing the time, place, and number of cannabis establishment operations.
- Allows a county or municipality to prohibit the future licensing of cannabis establishments if the prohibition is approved by vote of the electorate in a general election. Licenses issued prior to the prohibition remain valid.
- Contains a number of other provisions that address the effects of the amendment on current Florida law.

Summary of Financial Impact

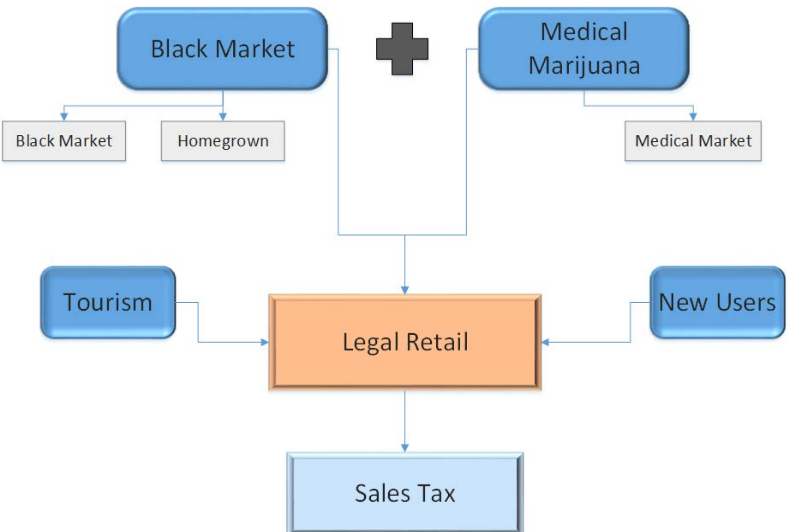
The proposed amendment will have a number of fiscal and economic impacts specific to Florida. A summary is provided below and a more detailed discussion follows:

- Increase in sales tax revenues associated with transactions occurring in the legal retail market, whether by former black market participants, the conversion of medical marijuana participants, tourists or new and expanding users. This increase reflects current law which would make non-medical marijuana subject to sales tax.
- Increase in sales tax revenues associated with additional expenditures by new tourists induced to come to Florida only because of the existence of legal marijuana. This increase occurs under existing law.
- Costs to create and maintain the regulatory structure at the Department of Business and Professional Regulation. This agency is specified in the amendment.
- Reduction in some marijuana-related crimes due to the legalization of its use which is offset by a probable increase in persons arrested and convicted of DUI-related or other similar offenses. These impacts affect the bottom-line cost of the shared state and local criminal justice system, inclusive of any savings.
- Increased potential for marijuana-related health issues. The discrete impact caused by the proposed amendment cannot be isolated from the effects associated with current illegal usage or other addictive behaviors. Further, the research is still evolving, but suggestive that these effects would typically occur over long-periods of heavy usage and may be mitigated by a switch from more dangerous substances to the regulated marijuana market.
- New costs for state and local law enforcement agencies for startup and implementation.
- Economic impact from the increase in revenue, income and jobs associated with the production and sale of legal marijuana.
- Economic impact from the increase in revenue, income and jobs associated with additional tourism expenditures.

The impact on collections from the existing Gross Receipts Tax on utilities will be positive, but cannot be quantified in advance of the proposed amendment's implementation by state and local governments since utility use varies under different scenarios. In addition, the imposition of an excise tax on legal marijuana products is subject to legislative enactment and cannot be assumed in advance of that action.

Overview of Legal Retail Market

An increase in state and local sales taxes will be an immediate effect of the proposed amendment. The amount of the sales tax increase depends on a number of assumptions primarily related to the market participants. In this regard, the future consumers will come from various segments of Florida's resident population, as well as tourists. For example, a significant number of Floridians and visitors to the state already purchase marijuana from the black market. Some of these users are expected to convert to the legal retail market. In addition, as discussed above, Florida already has a medical marijuana market which may contribute to the non-medical pool of legal retail participants. Other participants will come from additional tourists deciding to visit Florida solely due to the availability of legal marijuana. In addition, new consumers who have either never tried marijuana or tried it in the past, but have not used it in the past 12 months, may enter the legal retail market. All of these consumer groups are shown on the flowchart immediately below. The first part of the following discussion addresses the general economic framework.



a. *Black Market*

Florida has a black market for marijuana today. A "black market" is defined as an underground economy where the transactions involve the exchange of illegal goods or services. The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that there were 2,425,000[12] Floridians 12 years and over who had used marijuana one or more times during a recent 12-month timespan.[13] Of those, 1,929,000 were aged 21 years and over.[14] Some of these users are currently authorized under the Florida constitution to use marijuana for medical purposes and would not be involved in black market or illegal activities.

---

[12] Substance Abuse and Mental Health Services Administration, Table 2. Marijuana Use in the Past Year, by Age Group and State: Estimated Numbers (in Thousands), Annual Averages Based on 2016 and 2017 NSDUHs.

[13] This analysis uses the SAMHSA definition of "past year users" to denote persons who have used marijuana once or more times in the past 12 months. The "past year" definition in this analysis includes those who have used marijuana within the past month.

[14] Substance Abuse and Mental Health Services Administration, The 2016-2017 National Surveys on Drug Use and Health, special tabulation provided to the FIEC, October 2019.

The new legal retail market will be directly competing with the existing black market. Ultimately, the number of people who convert will be a function of both the price difference (if any) and the elimination of risk. In addition, the proposed amendment allows for Floridians aged 21 or older to possess and harvest six mature flowering cannabis plants for non-retail use, provided the growing takes place indoors or in a locked greenhouse. A share of the black market consumers will choose this option once the amendment becomes law. Today, the product for Florida's black market comes from both locally grown and imported sources.

b. Medical Marijuana

Floridians participating in Florida's existing medical marijuana market currently incur costs that would not be necessary in the legal retail market. These expenses include the cost of the identification card (ID) and the cost of the physician's visit, both of which are required in order to receive an order for medical marijuana. The annual cost for the ID card is currently $75 per year; while the cost for the doctor's visit is reported to range between $160 and $300,[15] with an evaluation conducted at least once every 30 weeks. Both the cost avoidance and the amendment's requirement to protect consumer privacy will induce some of these participants to switch to the legal retail market.

c. Tourism

The availability of recreational marijuana is likely to impact Florida's tourism industry. The FIEC expects an increase in the number of adult tourists due to marijuana legalization. These adult tourists would visit Florida primarily for marijuana consumption. New tourists expand Florida's tourism industry and increase sales tax collections through added expenditures. An additional economic impact will come from existing tourists who are currently consuming black market marijuana, but who will switch to the new legal market in Florida. These tourists are not anticipated to spend additional money in the state, but their marijuana purchases will now be taxable.

d. New Users and Expanded Use

There will be new Florida users who purchase in the legal retail market. These users represent consumers that (1) never tried marijuana before, or (2) tried marijuana before, but not within the past year. In addition, some existing users will choose more potent products or increase their current frequency of use. The FIEC was unable to quantify the number of first-time users, and developed a combined proxy for the remaining two groups.

Costs and Revenues

The FIEC anticipates that the proposed amendment allowing expanded legal use of marijuana will result in various costs and revenues affecting the state of Florida and local governments. Not all of these costs and revenues are quantifiable.

Regulation

The proposed amendment identifies the Department of Business and Professional Regulation (DBPR) or its successor as the state entity responsible for adoption of any regulations that are necessary for implementation. The department prepared a detailed analysis which is summarized in the table below and can be found in Appendix A. The total cost is projected to be $9.1 million on a recurring basis, with an additional $1.5 million needed for start-up. The DBPR analysis made no assumption as to whether new license fees would offset all, none or a portion of these costs; however, the FIEC assumes they will.

[15] Testimony by a proponent from NORML at the FIEC workshop on September 20, 2019.

	Positions (FTEs)	Recurring	Non-Recurring
Core Program and Support Staffing Projections	83		
Salaries and Benefits		$ 5,178,581	
Expenses		$ 497,502	$ 342,458
Equipment, Facilities and Resources			
Facility Leasing Average		$ 3,332,815	
Fleet Acquisition and Management		$ 90,000	$ 540,000
Supplemental Technology Equipment			$ 134,670
Ongoing Maintenance and Data Services		$ 42,644	
Litigation (two years of non-recurring)			$ 500,000
Start-Up (with Litigation occurring two years)			$ 1,517,128
Ongoing Costs (recurring)		$ 9,141,542	

In addition, the proposed amendment specifies that:

"(4) No later than 6 months from the effective date, each county or municipality shall enact an ordinance or regulation specifying the entity within the county or municipality responsible for processing applications submitted for a license to operate a cannabis establishment within the boundaries of the county or municipality and for the issuance of any such license should the issuance by the county or municipality become necessary because of a failure by the department to adopt regulations pursuant to subsection (e)(1) or failure by the department to process a license application in accordance with subsection (e)(6). (5) A county or municipality may enact ordinances or regulations not in conflict with this section or state regulations or legislation."

Through this mechanism, the proposed amendment envisions that regulation would occur on both the state and local levels. Local governments were unable to estimate their regulatory costs because of uncertainty regarding the amendment's specific requirements. The FIEC assumed that the state's regulatory structure would be in place sometime within the 2021-22 fiscal year.

Criminal Justice System

The legalization of recreational marijuana has the potential to affect the criminal justice system, and much of the research is mixed as to the direction of the impact. Research on the relationship between recreational marijuana legalization and crime at the state level has found no significant impact,[16, 17] while a study at the county level found a reduction in certain types of crime when comparing Washington and Oregon, which legalized at different times.[18] However, research at the neighborhood level has yielded conflicting results regarding the extent or direction of an impact.[19, 20, 21, 22]

Marijuana-specific crime is one area where a reduction might be expected, since much of the current law will no longer apply for people 21 years of age or older. However, an annual report published by the Colorado Division of Criminal Justice has indicated that while they saw significant decreases in

[16] Maier, S, Mannes, S, Koppenhofer, E. 2017. "The Implications of Marijuana Decriminalization and Legalization on Crime in the United States." *Contemporary Drug Problems*, 44(2):125-146.

[17] Ruibin L, Willits, D, Stohr, M., Makin, D, Snyder, J, Lovrich, N, Meize, M, Stanton, D, Wu, G, Hemmens, C. 2019. "The Cannabis Effect on Crime: Time-Series Analysis of Crime in Colorado and Washington State." *Justice Quarterly*.

[18] Dragone, D, Prarolo, G, Vanin, P, Zanella, G. 2019. "Crime and the legalization of recreational marijuana. Journal of Economic Behavior & Organization." *Journal of Economic Behavior & Organization*, 159: 488-501.

[19] Freisthler, B, Gaidus, A, Tam, C, Ponicki, W, Gruenewald, p. 2017 "From Medical to Recreational Marijuana Sales: Marijuana Outlets and Crime in an Era of Changing Marijuana Legislation." *The Journal of Primary Prevention*, 38(3):249-263.

[20] Hughes, L, Schaible, L, Jimmerson, K. 2019. "Marijuana Dispensaries and Neighborhood Crime and Disorder in Denver, Colorado." *Justice Quarterly*.

[21] Burkhardt, J, Goemans, C. 2019. "The short-run effects of marijuana dispensary openings on local crime." *The Annals of Regional Science*, 63(1): 163-189.

[22] Brinkman, J, Mok-Lamme, D. 2019. "Not in my backyard? Not so fast. The effect of marijuana legalization on neighborhood crime." *Regional Science and Urban Economics*, 78.

marijuana possession arrests (-51 percent) and sales arrests (-17 percent) between 2012 and 2017, production arrests saw a significant increase (+51 percent).[23] Additionally, marijuana-related felony court filings, while seeing an initial decline between 2012 and 2014, had returned to near pre-legalization levels in 2017. This is likely due to the pervasiveness of the developing black market used to supply other states where marijuana is still illegal. At the same time, police clearance rates have been shown to improve under legalization,[24] which could be an indicator of a redirection of resources previously dedicated to marijuana arrests to other offenses. While current research has not examined such an argument, an increase in clearance rates could lead to new arrests—either increasing criminal justice system costs or offsetting the savings associated with the reduction in arrests for marijuana possession.

According to the Florida Department of Corrections, in FY 2018-19, the majority of marijuana-related new commitments were for "sale/manufacture/delivery" (112) and "possession of marijuana over 20 grams" (69). Two other offenses resulted in a notable number of new commitments: "trafficking in cannabis between 25 pounds and 2,000 pounds" (36), and the "sale of marijuana and other drugs within 1,000 feet of a church or business" (38). Although detailed sentencing data is not currently available for FY 2018-19, in FY 2017-18 roughly 3.0 percent of offenders were sentenced to prison for possession, while 10.2 percent were sentenced to prison for sale/manufacture/delivery. Given the information available from Colorado, it is not known how sale/manufacture/delivery might be affected, since a similar black market for sale to other states may develop in Florida. Furthermore, with low incarceration rates for possession, it is entirely possible that those receiving prison for these offenses did so because they committed other offenses or pled down from sale/manufacture/delivery. Therefore, it is not known if an actual reduction in overall admissions would occur at the state level. For the vast majority of offenders receiving a sentence other than prison, the Florida Department of Corrections has indicated that there will not be a significant impact on their operations, even with a reduction in the population under supervision for marijuana crimes.

Government costs for the criminal justice system would also be impacted if there is an increase in offenses relating to driving under the influence (DUI). The Colorado Division of Criminal Justice found that while the number of DUI citations issued decreased between 2014 and 2017, the prevalence of marijuana or marijuana-in-combination identified as the impairing substance increased from 12 percent of all DUIs in 2014 to 15 percent in 2017.[25] However, a further review of the data indicates that the number of marijuana citations were relatively stable during this time period (i.e., the percentage increased simply because the universe itself was smaller). Furthermore, the number of fatalities in which a driver tested positive for Delta-9 THC, a possible indicator of impairment, saw a decrease from 13 percent of all fatalities in 2016 to 8 percent of all fatalities in 2017. Other research has suggested that incidents of impaired driving in states where recreational marijuana was legalized have increased; however, testing of the relationship between legalization and traumatic injuries or fatalities has provided mixed results.[26, 27, 28] Further blurring definitive conclusions, California saw an increase in fatal

---

[23] Reed, J. "Impacts of Marijuana Legalization in Colorado: A Report Pursuant to Senate Bill 13–283." Report, Colorado Division of Criminal Justice, October 2018.

[24] Makin, D, Willits, D, Wu, G, DuBois, K, Lu, R, Stohr, M, Koslicki, W, Stanton, D, Hemmens, C, Snyder, J, Lovrich, N. 2019. "Marijuana Legalization and Crime Clearance Rates: Testing Proponent Assertions in Colorado and Washington State." *Police Quarterly*, 22(1), 31–55.

[25] Reed, J. "Impacts of Marijuana Legalization in Colorado: A Report Pursuant to Senate Bill 13–283." Report, Colorado Division of Criminal Justice, October 2018.

[26] Chung, C, Salottolo, K, Tanner II, A, Carrick, M, Madayag, R, Berg, G, Lieser, M, Bar-Or, D. "The impact of recreational marijuana commercialization on traumatic injury." *Injury Epidemiology*, 6.

[27] Lynch, J, McMahon, Lucian. 2019. "A Rocky Road So Far: Recreational Marijuana and Impaired Driving." Report, Insurance Information Institute, March 2019.

[28] Leyton M. 2019. "Cannabis legalization: Did we make a mistake? Update 2019." *Journal of Psychiatry & Neuroscience*, 44(5): 291–293.

accidents involving drivers who tested positive for marijuana during the decade prior to legalization.[29] Of overall note, testing THC levels has proven to be challenging for states. In Florida, the current use of blood tests is only required in cases of death or serious bodily injury.[30]

With respect to the juvenile portion of the criminal justice system, whether legalized recreational marijuana for adults leads to increased underage marijuana use is an important question. According to the Colorado Division of Criminal Justice, arrests for marijuana offenses declined for both the 10 to 17 age group and the 18 to 20 age group. Additional studies of marijuana use among adolescents yielded mixed results. For the periods 2010-2012 and 2013-2015, one study indicated that there was increased use among eighth graders (+2.0 percent) and tenth graders (+4.1 percent) in Washington, but no significant differences in Colorado. In both instances, the comparison group is states that did not legalize recreational marijuana use.[31] However, more recent studies using different data sets have shown small declines in use among Washington's 8th and 10th graders following legalization[32], as well as a decrease in overall teenage use relative to other states.[33] To add to the differing results, a special SAMHSA tabulation for the FIEC indicated that after an initial surge in the first year of legalization in Colorado, usage among the population aged 12 to 17 fell below prior annual levels (see Appendix B).

Lastly, based on the presentation by the Florida Sheriffs Association, front-end costs related to implementation (i.e. training drug sniffing dogs to no longer detect marijuana, training officers, etc.) are likely. Colorado estimated that they went from training 80 percent of their dogs to detect marijuana to training only 20 percent.[34] According to David Ferland, executive director of the United States Police Canine Association, a few departments in legalized states have decided to take their chances in court, but the overwhelming majority of states are preparing specialized training to respond to the legalized setting.[35] While the proposed constitutional amendment could lead to an initial increase in costs, future training costs should revert back to the pre-legalization levels.

Overall, the net impact on the criminal justice system in any given year is indeterminate. Largely, this is due to three factors: (1) the mixed results found in the available studies on implementing states; (2) the coexisting potential for cost savings and cost increases within the same year; and (3) the continuing black market, post-legalization.

Health Effects

Legalizing recreational marijuana and making it widely available to the public may have a variety of impacts on health. The scientific literature related to the health effects of marijuana shows an association between marijuana use and potential negative health outcomes. While there are many factors precluding proof of causality, the correlations between negative health outcomes and marijuana use exist. Current research into the association between marijuana use and potential adverse health outcomes is limited by the changes in legality, potency, consumption methods, and many other factors. However, high frequency use (daily or weekly) is associated with negative cognitive outcomes that can have long-term effects and mental health issues that can lead to addiction and future misuse. Similarly, high frequency use is associated with cardiovascular and respiratory

---

[29] Marijuana's Impact on California, California High Intensity Drug Trafficking Areas Report, 2018, https://ncric.org/files/D2DF/Marijuana_Impact_CA_2018.pdf

[30] S. 316.1933, F.S.

[31] Cerdá M, Wall M, Feng T, Keyes KM, Sarvet A, Schulenberg J, O'Malley PM, Pacula RL, Galea S, Hasin DS. 2017. "Association of State Recreational Marijuana Laws With Adolescent Marijuana Use." *JAMA Pediatr*, 171(2):142-149.

[32] Dilley JA, Richardson SM, Kilmer B, Pacula RL, Segawa MB, Cerdá M. 2019. "Prevalence of cannabis use in youths after legalization in Washington State." *JAMA Pediatr*, 173(2):192-193.

[33] Anderson DM, Hansen B, Rees DI, Sabia JJ. 2019. "Association of Marijuana Laws With Teen Marijuana Use: New Estimates From the Youth Risk Behavior Surveys." *JAMA Pediatr*, 173(9):879–881.

[34] https://www.npr.org/2019/05/26/727107486/colorado-court-complicates-life-for-drug-sniffing-dogs

[35] https://www.nytimes.com/2018/11/24/business/marijuana-legalization-police-dogs.html

issues, as well as effects from second-hand exposure (similar to smoked tobacco usage). As with other regulated substances, marijuana usage can lead to impaired motor skills, a cause of motor vehicle crashes. There is also an association between prenatal exposure and exposure through breast feeding and negative infant health outcomes similar to those of chronic users.[36]

While the potential for Florida's health care costs to increase exists, there is evidence of mitigating factors that may lower costs after legalizing marijuana. Analysis and research regarding the potential benefits of marijuana consumption is sparse due to legal issues and the amount of funding dedicated to researching the negative health effects. There is some evidence that hospitalizations and death from opioid pain medication overdoses are less prevalent in states with legal or medical marijuana compared to states without. Conflicting evidence exists as to whether marijuana use is associated with decreases in opioid use among chronic pain patients or those with chronic drug abuse issues.[37] There is, however, substantial evidence that cannabis or cannabinoids are effective in treating chronic pain, chemotherapy induced nausea, and spasticity symptoms in multiple sclerosis patients. Moderate evidence exists for improving short-term sleep outcomes.[38]

Regarding this amendment's discrete effect on Florida, the potential public health costs are largely limited to new users and expanded use by current users, since any health care issues would already exist for users of illicit or medical marijuana and would be a part of Florida's current public health costs. In addition, tourists would not be covered under the state's public health system. Further, the proposed amendment requires health and safety regulations and standards for the manufacture and testing of cannabis products and the cultivation of cannabis, as well as labeling and packaging requirements for cannabis and cannabis products to ensure consumers are informed and protected.

Because of the countervailing effects marijuana legalization may have on people's health, the ultimate effect on Florida's public health care costs is indeterminate and may evolve over many years. In part, this is because the vast majority of the affected population is already using and purchasing the product on the black market.

Sales Tax

Medical marijuana has been specifically exempted from the sales tax[39], but no such exemption currently exists for recreational marijuana. Therefore, its purchase will be subject to sales and use tax for the purposes of Chapter 212, "Tax on Sales, Use, and Other Transactions."

The purchasers in the legal retail market will come from the four groups discussed above. For each group, the FIEC has made assumptions regarding the amount and frequency of consumption of marijuana based on research and studies. However, the FIEC did not make any assumptions regarding the specific types of products that will be available on the market or the methods of consumption.

Further, the analysis does not assume that any atypical price volatility will occur in the early years of implementation. Most of the analysis focuses on a steady state period, with prices averaging around $10 per gram of flower product. The analysis assumes the potency of the product to be 20 percent[40]

---

[36] Retail Marijuana Public Health Advisory Committee. "Monitoring Health Concerns Related to Marijuana in Colorado: 2018 Summary." 2018.

[37] Ibid.

[38] National Academies of Sciences, Engineering, and Medicine. "The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research." The National Academies Press: Washington, DC. 2017.

[39] Section 212.08(2)(l), F.S. (2019).

[40] A 20 percent potency is equivalent to 1 gram (1000 mg) of dry weight marijuana containing 200 mg of THC, the euphoria-inducing substance in marijuana flower or concentrates.

based on the experience in Colorado.[41] In addition, it is assumed that the new legal retail market is competitive with the black market, such that many black market users elect to move to and stay in the legal retail market.

The estimates below are developed for FY 2021-22 and assume that the market is fully operational the entire year; however, it is not probable that this will be the case. This is due to a variety of reasons, including challenges seen in other states with establishing the regulatory structure and developing the initial product to meet the demand.

Black Market Assumptions and Results

The size of this group was estimated in stages. First, 2.1 million persons or slightly over 12 percent of the population 21 and older were identified as part of the potential universe of current marijuana users purchasing on the black market. This identification was based on Florida population projections for FY 2021-22 and prevalence rates from a special tabulation prepared by the Substance Abuse and Mental Health Services Administration for the FIEC from the 2016-17 National Surveys on Drug Use and Health (NSDUH).[42] Since medical marijuana users are included in the federal government data for Florida, the FIEC deducted approximately 266,000 medical marijuana users[43] 21 years of age and over to arrive at a black market estimate of approximately 1.8 million users. Based on two studies, the FIEC estimates that half of Florida's black market for this population would stay in the black market (slightly over 900,000 users), while 47.5 percent (approximately 871,000 users) would move to the legal retail market.[44, 45] The remaining 2.5 percent (approximately 46,000 users) would enter the legal homegrown market.[46, 47]

The conversion of approximately 871,000 users from the black market to the legal retail market is estimated to result in total sales of $1.7 billion as shown on the table on the following page. This estimate uses the assumptions regarding frequency of use[48] and quantity consumed per use day[49] based on Kilmer (2013) and Colorado's experience (see Appendix C).

---

[41] The average potency of flower was 19.6 percent in Colorado in 2017, up from 14.9 percent in 2015. Source: Orens, Adam, et al, Marijuana Policy Group LLC, University of Colorado Boulder, market Size and Demand for Marijuana in Colorado, 2017 Market Update, Prepared for the Colorado Department of Revenue, August 2018, https://www.colorado.gov/pacific/sites/default/files/MED%20Demand%20and%20Market%20%20Study%20%20082018.pdf

[42] Comparison between the 2015-2016 and the 2016-2017 Florida Past Year prevalence rates for the population 12 and over does not show statistically different results. This analysis assumes that prevalence rates will remain the same as in the 2016-17 NSDUH survey.

[43] Tabulations by Office of Economic and Demographic Research of data provided by the Department of Health, Office of Medical Marijuana Use, October 2019.

[44] Beau Kilmer, Steven Davenport, Rosanna Smart, Jonathan P. Caulkins, Gregory Midgette, After the Grand Opening Assessing Cannabis Supply and Demand in Washington State, Prepared for the Washington State Liquor and Cannabis Board, Published by the RAND Corporation, Santa Monica, Calif.

[45] 2019 Recreational Marijuana Supply and Demand Legislative Report, Oregon Liquor Control Commission, January 31, 2019.

[46] Kilmer, Beau, Jonathan P. Caulkins, Gregory Midgette, Linden Dahlkemper, Robert J. MacCoun and Rosalie Liccardo Pacula. Before the Grand Opening: Measuring Washington State's Cannabis Market in the Last Year Before Legalized Commercial Sales. Santa Monica, CA: RAND Corporation, 2013. http://www.rand.org/pubs/research_reports/RR466 .

[47] Azofeifa A, Mattson ME, Schauer G, McAfee T, Grant A, Lyerla R. National Estimates of Marijuana Use and Related Indicators — National Survey on Drug Use and Health, United States, 2002–2014. MMWR Surveill Summ 2016;65(No. SS-11):1–25. DOI: http://dx.doi.org/10.15585/mmwr.ss6511a1 , external, https://www.cdc.gov/mmwr/volumes/65/ss/ss6511a1.htm .

[48] Substance Abuse and Mental Health Services Administration, Substance Abuse and Mental Health Data Archive, The 2016-2017 National Surveys on Drug Use and Health, special tabulation provided by NSDUH.

[49] Market Size and Demand for Marijuana in Colorado, 2017 Market Update, Prepared for the Colorado Department of Revenue, Marijuana Policy Group, Leeds School of Business, University of Colorado Boulder, Appendix Table 1: Quantity Consumed per Use-Day, by Consumer Type.

Estimation of the Black Market to Legal Retail Market Conversion for Florida Residents

Frequency of Marijuana in the Past Year for Florida		Estimation									
		I	II	III	IV	V	VI=I x II x V	VII	VIII	IX=VI x VII	X
Number of Use Days[a]	Percent of All Past Year Users[a]	Florida Illegal Users to Move to Legal Retail Market	Quantity Consumed per Use-Day, Grams of Flower per Use Day (Mean US)[b]	Approximate Joints (EDR Assumption)[c]	Assumed use days per month (EDR assumption)	Assumed use days per year (EDR assumption)	Annual marijuana consumption (grams)	Cost per gram ($/gram flower)[d]	Cost per use day ($)	Marijuana Retail Sales ($)	State Sales Tax Collections ($)
271-365 days	21.0%	182,793	1.60	2.4	30	365	106,751,112	10	16.0	$ 1,067,511,120	$ 64,050,667
181-270 days	10.4%	90,268	1.60	2.4	19	226	32,568,694	10	16.0	$ 325,686,944	$ 19,541,217
91-180 days	13.8%	120,508	1.60	2.4	11	136	26,126,134	10	16.0	$ 261,261,344	$ 15,675,681
31-90 days	15.6%	135,402	0.67	1.0	5	61	5,488,520	10	6.7	$ 54,885,201	$ 3,293,112
15-30 days	6.7%	58,674	0.67	1.0	2	23	884,511	10	6.7	$ 8,845,106	$ 530,706
8-14 days	8.0%	69,958	0.67	1.0	1	11	515,590	10	6.7	$ 5,155,905	$ 309,354
2-7 days	18.6%	162,031	0.67	1.0	0	5	488,523	10	6.7	$ 4,885,235	$ 293,114
1 days	5.9%	51,000	0.30	0.5	<1	1	15,300	10	3.0	$ 153,000	$ 9,180
Total	**100.0%**	**870,634**					**172,838,385**	**10**		**$ 1,728,383,853**	**$ 103,703,031**

[a] Substance Abuse and Mental Health Services Administration, Substance Abuse and Mental Health Data Archive, The 2016-2017 National Surveys on Drug Use and Health, special tabulation provided by NSDUH.

[b] Kilmer, Beau, Jonathan P. Caulkins, Gregory Midgette, Linden Dahlkemper, Robert J. MacCoun, and Rosalie Liccardo Pacula. 2013. Before the Grand Opening: Measuring Washington State's Marijuana Market in the Last Year Before Legalized Commercial Sales. RAND Drug Policy Research Center. http://www.rand.org/pubs/research_reports/RR466.html. Market Size and Demand for Marijuana in Colorado, 2017 Market Update, Prepared for the Colorado Department of Revenue, Marijuana Policy Group, Leeds School of Business, University of Colorado Boulder, Appendix Table 1: Quantity Consumed per Use-Day, by Consumer Type.

[c] Assumes that one joint contains 0.66 grams of marijuana. Sources: Mariani, John J et al. "Quantification and comparison of marijuana smoking practices: blunts, joints, and pipes." Drug and alcohol dependence vol. 113,2-3 (2011): 249-51. doi:10.1016/j.drugalcdep.2010.08.008, accessed 10/10/2019. The Average Cost of Marijuana by State, Oxford Treatment Centers, https://www.oxfordtreatment.com/substance-abuse/marijuana/average-cost-of-marijuana/ , last updated September 20, 2019.

[d] Dara Kam, WJCTV, "Smokable Medical Marijuana Is Now Legal In Jacksonville And Other Parts Of Florida," March 21, 2019.

Medical Market Assumptions and Results

Approximately 266,000 (98 percent) of Florida's approximately 271,000 medical marijuana users were 21 years of age or over as of September 30, 2019. Based on the percentage decrease of 20.3 percent in Colorado's medical marijuana users from pre-legalization in 2013 to three years post-legalization in 2017, the FIEC estimated that the number of Florida's medical marijuana patients likely to transition to the legal retail market would be approximately 54,000. The FIEC assumed that these users would likely be daily users[50] and estimated the retail sales from this population to be $315.4 million (54,005 users x 365 days x 1.6 grams x $10 per gram).[51]

Tourism Assumptions and Results

The legalization of marijuana will likely attract additional tourists to Florida. This assumption is based on the experience of other states that have legalized marijuana (Colorado, California). In these states, a discrete marijuana tourism industry has developed. With Florida already a high tourism destination state with around 130 million annual tourists, the FIEC discussed the likelihood that a similar marijuana tourism industry would develop if the proposed amendment passes. The FIEC estimated that Florida's visitors would increase by an additional 1 percent each year, resulting not only in new retail sales of marijuana, but also additional expenditures generated by the typical visitor on hotels, food, transportation and entertainment. This 1 percent estimate was primarily based on two factors. First, regional visitors will likely increase, because Florida would be the only

[50] Testimony by a representative of the National Organization for the Normalization of Marijuana Laws (NORML) at the FIEC meeting dated 9/20/2019.

[51] Based on the prior assumption of a 20 percent potency, this calculation assumes a daily intake of 320 mg THC, the euphoria-inducing active substance in marijuana.

state in the Southeast to have recreational marijuana. Second, in 2018, Colorado estimated that 3 percent of all their visitors were attributed to recreational marijuana.[52] The FIEC used that percentage as an upper limit in developing its own estimate of Florida's marijuana tourism industry.

For new tourists, marijuana sales were estimated based on an assumed consumption level of two joints per person per trip. This results in $19.4 million in total marijuana sales, while the other visitor expenses were estimated to generate an additional $634.3 million in taxable sales.

The FIEC also assumed that a number of existing tourists purchase marijuana through the black market while visiting Florida. The FIEC estimated that 2.4 million tourists annually, representing 2 percent of all existing tourists, would switch to the new legal retail market. These current tourists are assumed to purchase the same quantity of marijuana as the new tourists, resulting in $32.2 million in marijuana sales.

New Users, Expanding Usage by Current Users and Returning Users Assumptions and Results
The FIEC reviewed survey data on first-time users, 21 years of age and over, tabulated by the Substance Abuse and Mental Health Services Administration from the National Surveys on Drug Use and Health for the FIEC, as well as other sources, in an attempt to create a proxy for the percentage of Florida's population who have never used marijuana but are likely to enter the new retail market. The FIEC determined that the number of users and the amount of sales from this group was indeterminate, but positive.

In addition, the FIEC estimated that there were approximately 4.8 million persons 21 years and over who were not active in the black market (i.e., they have not used marijuana within the past 12 months), but who previously used or tried marijuana more than 12 months ago.[53] This group represented 31 percent of Florida's population 21 years and over in 2016-17. Assuming that this percentage will remain constant in the future, the FIEC estimated that approximately 5.2 million persons 21 years and over would have tried marijuana at some point in their lifetimes but would not be categorized as "current users" in FY 2021-22. The FIEC determined that some members of this subgroup will resume use, but at unknown frequency levels from year to year. Further, there are current users in the black market who may increase their current intensity of use (increase the amount of THC per use or frequency of use) once they move to the legal retail market. The FIEC determined that both the number of users for this subgroup and the amount of their individual increases could not be discretely determined.

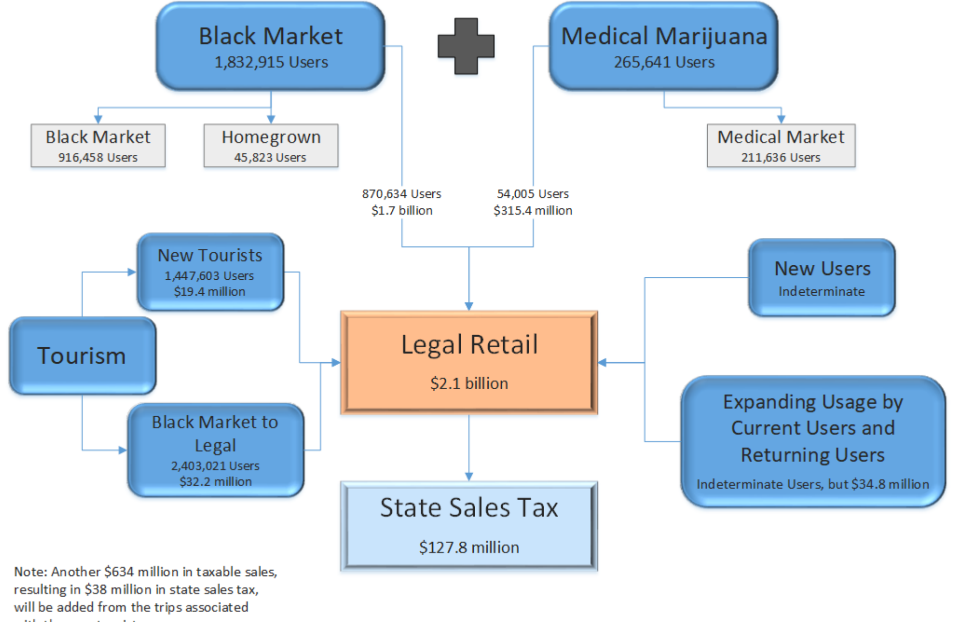
In lieu of addressing these subgroups directly, the FIEC developed a combined proxy for this usage that is at least equivalent to each person smoking approximately one joint per year (5.2 million persons x 0.67 grams marijuana (134 mg of THC) x 1 day/year x $10/gram).[54] Therefore, the amount of product required by "returning users" and the "expanded use among existing users" is expected to yield annual sales of at least $35 million.

The chart below shows the number of anticipated participants and the retail sales generated by each of the four identified sectors that are expected to comprise Florida's legal marijuana retail market. This chart reflects users and sales for FY 2021-22, assuming that the legal retail market is fully operational and that supply meets the level of demand.

[52] SMARInsights, "Colorado 2018-19 Winter Advertising Effectiveness Research", (2019).

[53] Tabulations by the Florida Legislature, Office of Economic and Demographic Research from the National Survey of Drug Use and Health, Substance Abuse and Mental Health Data Archive, Restricted Use Data Analysis System (R-DAS), https://rdas.samhsa.gov/#/.

[54] Assumptions for grams used, use days, and price per gram are from the table for the "black market to retail" users.



As shown below, the vast majority (82.7 percent) of the anticipated sales revenues are estimated to be from black market users moving to the legal retail market (Floridians and tourists). Combining sales revenue from these black market users with the medical marijuana users who also move to the legal retail market, the percentage of legal sales revenue associated with the current use of marijuana in Florida increases to 97.5 percent of total anticipated sales. The remaining 2.5 percent of sales is due to new tourists, new usage associated with returning users, and increased use by existing users.

Florida Marijuana Market Sales (Millions of $)	FY 2021-22
Black Market	
Black market stays in black market	
Black market to retail	1,728.4
Move to homegrown	
Medical Marijuana	
Florida medical stays in medical	
Florida medical to retail	315.4
Expanding Usage by Current Users and Returning Users	34.8
Total Florida Users	
Tourism	
New tourists	19.4
Tourists (black market to legal)	32.2
Total Retail Users in Florida	2,130.2
Black market to legal retail	1,760.6
Percent of Total Retail Users	82.7%
Black market and Florida medical to legal retail	2,076.0
Percent of Total Retail Users	97.5%

Assuming Florida's recreational marijuana market is fully operational by the beginning of FY 2021-22 and supply is sufficient to meet the demand, the minimum amount of state and local taxes that could be anticipated to be generated from the legal retail market is $146.4 million ($127.8 million state; $18.6 million direct local). Additionally, $43.6 million would be generated by the influx of new tourists to the state. Combined, the sales tax impact is $190.0 million ($165.8 million state; $24.1 million direct local). The table below displays the distribution of these revenues. Appendix D shows the amount of state and local sales taxes that are anticipated on a yearly basis through FY 2026-27. On the Appendix tables, the dollars below associated with Revenue Sharing (county and municipal) and the Half-Cent have been transferred to the Combined Local Taxes and Revenue Sharing category.

Fiscal Year 2020-21 (millions)

	State Sales Tax $127.8			Local Sales Tax* $18.6	
Legal Retail Market	General Revenue	State Trust	Revenue Sharing + Half-Cent	Direct Local Taxes	Total Impact
	$113.1	Insignificant	$14.6	$18.6	$146.4

	State Sales Tax $38.0			Local Sales Tax* $5.5	
Other Tourist Expenditures	General Revenue	State Trust	Revenue Sharing + Half-Cent	Direct Local Taxes	Total Impact
	$33.7	Insignificant	$4.3	$5.5	$43.6

	State Sales Tax $165.8			Local Sales Tax* $24.1	
Combined Total	General Revenue	State Trust	Revenue Sharing + Half-Cent	Direct Local Taxes	Total Impact
	$146.8	Insignificant	$18.9	$24.1	$190.0

*Local Sales Taxes include only the direct local option sales tax, but not revenue sharing and local half-cent.
Note: Numbers may not add due to rounding.

Gross Receipts Tax

The Gross Receipts Tax is a tax on the sale of utility services (electricity and natural or manufactured gas). The tax rate is 2.5% on all sales plus an additional 2.6% on the sales of electricity to non-residential customers. Under the proposed amendment, all recreational marijuana sold in Florida must be produced in Florida. The FIEC estimates that almost half of the adult residents of Florida who currently purchase on the black market (approximately 870,000 individuals) would purchase from the legal market if the amendment passed, and it also estimates that 75 percent of the black market marijuana is imported into the state. Therefore, production of marijuana must shift from outside to inside Florida in order to, at least, serve those almost 653,000 users. Further, the FIEC estimates that current users will expand their usage, that there will be residents of Florida who will become users for the first time and that there will be many tourists who engage in the legal market. Overall, the production of marijuana in Florida is expected to substantially increase under the proposed amendment, which would have a strong positive effect on revenue from the Gross Receipts Tax.

There are some factors that may partially offset that increase. First, local production may shift from indoors to greenhouses or outdoors, which require much less electricity to operate.[55, 56, 57] Historically,

[55] Mills, Evan (2012). The Carbon Footprint of Indoor Cannabis Production. Energy Policy. 46. 58-67.
[56] O-Hare, Sachez, Alstone (2013). Environmental Risks and Opportunities in Cannabis Cultivation. BOTEC Analysis Corporation.
[57] Hughes, Trevor (2018). Future of Legal Marijuana: Canadian Greenhouses Could Mean Cheaper, Safer Pot. USA Today. Nov 4.

most production of marijuana in the United States has been indoors, in large part because it is easier to keep indoor operations hidden, which would be a nonfactor in the production of legal recreational marijuana.[58] There is evidence that this shift to greenhouses has occurred or will occur in California, Vermont, and Canada.[57, 59, 60] In fact, some sources suggest that the falling price per pound of marijuana that has taken place in other states with legalized recreational marijuana may make indoor production, which is relatively expensive, much less viable.[57, 60] Second, production may shift from small or residential operations to large-scale commercial operations, which would allow for economies of scale and for producers to pay a commercial rate for electricity rather than the higher residential rate.[56, 60] Finally, legalization allows for energy performance standards, efficiency incentives, related education programs, and enforcement of construction codes.[55, 58]

Overall, the likely effect of legalizing recreational marijuana on revenue from the Gross Receipts Tax is positive, but indeterminate.

Excise Tax
Currently a separate excise tax is imposed at the distributor level on each gallon of alcoholic beverage (beer, wine, cider, and spirits) sold in the state. The FIEC has not assumed that this is the case for legal marijuana. This is because it would take additional legislation to impose this tax, and specifics related to the tax base and rate would be unknown until the Legislature acts.

Budget Analysis
The budget analysis was based on current procedures and protocols used by the Revenue Estimating Conference. The first full year of the static impact for the state General Revenue Fund discussed in "Costs and Revenues" above, was applied to the actual state budget and its supporting revenues for FY 2019-20. The total budget is segregated into major categorical areas for both general revenue and all funds. The sales tax gain benefiting the General Revenue Fund ($146.8 million) was evenly split between a state budget increase and a general sales tax rate reduction. The $73.4 million infused into the state budget was spread proportionally to each area's share of general revenue, with the exception of debt service and pension benefits/claims, which were held harmless. The sales tax rate reduction had a neutral effect since it was removing revenues that did not previously exist. In addition, $10.6 million in new trust fund costs (DBPR start-up of $1.5 million, plus DBPR recurring appropriations of $9.1 million) was added to the General Government categorical area to reflect the spending authority for the regulatory costs, assuming they are fully covered by new license fees. As a result of these adjustments, the state budget is increased by $84.1 million, less than one-tenth of one percent of the total budget. Further, the change is too small to affect the percentage distribution of the total budget by categorical area (see Appendix E).

Economic Analysis
In order to analyze the economic impact of the proposed amendment, a comprehensive policy analysis technique that evaluates the direct, indirect, and induced economic impacts of a policy change was used. In this regard, the following effects were estimated:

- Direct economic effects – changes in expenditures made by the industry(ies) directly impacted by the change in policy. Most analyses by the various estimating conferences focus on direct effects, which are generally static, immediate and "first round" effects.

[58] Warren, Gina S. (2015). Regulating Pot to Save the Polar Dear: Energy and Climate Impact of the Marijuana Industry. Columbia Journal of Environmental Law. 385.
[59] Wilson, Bodwitch, Carah, Daane, Getz, Grantham, and Butsic (2019). First Known Survey of Cannabis Production Practices in California. California Agriculture. 73(3): 119-127.
[60] Caulkins, Kilmer, Kleiman, MacCoun, Midgetle, Oglesby, Pacula, and Reuter (2015). Considering Marijuana Legalization: Insights for Vermont and Other Jurisdictions. RAND Research Report.

- Indirect economic effects – changes in expenditures made by industries that supply goods and services to the directly impacted industry(ies).
- Induced economic effects – commonly measured as the changes in expenditures by households whose income is changed by the direct and indirect activity. Similar effects exist for businesses and government.

For the proposed amendment, the goal was to predict and quantify the probable path of economic responses over time. Projections are relative to a forecast of the expected path of the economy absent the change caused by the petition; this is referred to as the economic baseline.

The analytical tool, the Statewide Model, is a state-of-the-art, customized, dynamic computable general equilibrium model (CGE) originally developed for Florida by Monash University (Melbourne, Australia) in 2011. This model:

- Contains a vast amount of data to replicate Florida's economy, tax structure, and state budget.
- Uses more than 388 equations with over 1,699,000 total elements within those equations to account for the relationships (linkages and interactions) between the various economic agents, as well as likely responses by businesses and households to changes in the economy.
- Has a time dimension that adheres to the state fiscal year (July 1 to June 30) to be useful in the state government budgeting process.
- Allows different programs to be evaluated on the same footing.
- Can be modified to reflect research results and targeted developments specific to the analysis being performed.

When the Statewide Model is deployed to evaluate economic effects, the model is shocked using static analyses to develop the initial or direct effects attributable to the petition-induced change that is under review. The economic analysis is based on the drivers and assumptions that were discussed above. In addition, this analysis considered the following direct effects (shocks):

- Shift in consumption of marijuana from the black market to the legal market, plus increased overall demand.
- Increase in the local (in-state) supply of marijuana.
- Increase in sales tax revenues associated with the legal retail market.
- Increase in tourism resulting from the legalization of marijuana.
- Purposed the increased revenues as a decrease in the sales tax rate, plus an increase in the budget.

In order to analyze the impact the proposed amendment would have on the economy, the model's baseline had to first be adjusted to include new industries which are currently not specified due to the classification of marijuana as illegal at the federal level.[61] In addition, the model's baseline had to be adjusted to reflect Florida's current medical marijuana market.

For the legal medical marijuana industry, the following activities were modeled that were not previously identified in the model: (1) cultivation modeled after greenhouses; (2) processing modeled after tobacco manufacturing; (3) pharmaceutical that transforms the nonsmokable into medical extracts; and (4) a viable retail market. The introduction of the new industries was modeled after research conducted by the Marijuana Policy Group (MPG).[62] Following MPG, the underlying structure of each industry was modeled after the comparable industries in the national input-output accounts for the U.S. The suggested

---

[61] The U.S. Bureau of Economic Analysis (BEA) has not yet included illegal market activity in the measured economy. This is due to the challenges inherent in identifying suitable source data. It is estimated that illegal drugs add $111 billion to nominal GDP in 2017 (or about 0.6%). For more information see Rachel Soloveichik, "Including Illegal Activity in the U.S. National Economic Accounts," July 2019, http://bea.gov/system\files\paper\WP2019-4_1.pdf.

[62] Light, Orens, Rowberry and Saloga, "The Economic Impact of Marijuana Legalization in Colorado," October 2016, Marijuana Policy Group, available upon request.

expenditure patterns were further modified to allow for the greater importance of utilities, security, and other inputs unique to these newly introduced industries. To analyze the impact of the proposed amendment, black market imports, which services the largest component of users, can be thought of as a leakage in spending that is brought back into the state.[63]

The current black market expenditures are already present in the Florida economy, but the production is not measured or discretely identifiable. The model adjustments allow the developing market to provide the supporting infrastructure needed to be in place by FY 2021-22. The existing black market would temper any price increases that otherwise would occur if initial market supply is not sufficient to meet demand on day one.

All of the static estimates previously discussed in this analysis were used as shocks to the baseline forecast. The results, which are shown in Appendix F, indicate that relative to the baseline, Real Gross Domestic Product is higher each year by an average of $3.8 billion. This represents 0.32 percent of the annual total (see Appendix F and a glossary of terms in Appendix G).

In summary, the economic analysis indicates a mildly expansionary impact on the state that results from the increased demand and related activity, as well as having increased state production by eliminating some of the current leakage caused by the import of illegal product.

[63] Note on Market Production: It appears that the majority of Florida's current marijuana black market comes from other states and/or other countries. In order to estimate the share of production that is grown locally versus that which is imported, the FIEC replicated analyses that were conducted in other states. From a public crop dataset, Florida had 1.68 percent of the annual production value nationally of marijuana (0.6/35.8 – in billions of dollars) [see Marijuana Production in the United States (2006) – Comparison with other Cash Crops, https://www.drugscience.org/Archive/bcr2/cashcrops.html]. In 2015-16, Florida had 6.21 percent of the annual marijuana users in the nation (2,096/33,747 – in thousands) [National Survey on Drug Use and Health, Annual Averages based on 2015-2016, 18+, past year marijuana use]. Looking at the ratio of production to use (1.68/6.21) results in 27.05 percent. Based on this analysis, the FIEC assumed that 25 percent of the current black market production is local, and the remaining 75 percent is imported. Future local production must be sufficient to cover the 75 percent of converted black market production previously imported, as well as the new demand.

FLORIDA FINANCIAL IMPACT ESTIMATING CONFERENCE

Regulate Marijuana in a Manner Similar to Alcohol
to Establish Age, Licensing, and Other Restrictions
Serial Number 16-02

Appendix A

SUPPLEMENTAL IMPACT ANALYSIS OF PETITION INITIATIVE 16-02

PREPARED UPON REQUEST OF THE FINANCIAL IMPACT ESTIMATING CONFERENCE FOR THE OCTOBER 11, 2019 FIEC PRINCIPALS WORKSHOP

I. INTRODUCTION

A. Petition Initiative 16-02

Petition Initiative 16-02,[1] titled "Regulate Marijuana in a Manner Similar to Alcohol to Establish Age, Licensing, and Other Restrictions," is a citizen petition initiative sponsored by Sensible Florida, Inc., which was approved as a petition initiative by the Florida Division of Elections on March 17, 2016. The petition initiative seeks to propose a constitutional amendment for consideration on the 2020 election year ballot to regulate marijuana for limited use and growing by persons twenty-one years of age or older.

On August 12, 2019, Petition Initiative 16-02 triggered review by a Financial Impact Estimating Conference of the Office of Economic and Demographic Research pursuant to section 100.371, Florida Statutes. Upon notice of workshops for this statutory review process, the Financial Impact Estimating Conference requested that the Department of Business and Professional Regulation (Department or DBPR) prepare an agency analysis providing projections on financial impacts related to establishing a regulatory program and administering regulations associated with a legal cannabis market if the constitutional amendment were placed on the ballot and approved by the voters as presented.

B. Initial Impact Analysis and Scope of Supplemental Analysis with Modified Assumptions

On October 4, 2019, the Department presented an impact analysis of Petition Initiative 16-02 during the FIEC principals workshop (initial analysis). The Department's initial analysis relied on a series of assumptions as detailed on pages 2 through 4 of the initial analysis report incorporated in the FIEC records.[2]

Subsequent to the Department's presentation, the FIEC requested that the Department prepare a supplemental analysis that provides an alternative projection with certain assumptions modified from the initial analysis. In particular, the FIEC requested that assumptions 2.6, 2.7, 2.8, 2.9, and 2.10 be modified or removed under an alternative assumption that the State of Florida would not impose any new excise tax on the cannabis products offered through the regulated market created by the constitutional amendment.

Accordingly, this supplemental impact analysis presents an alternative projection assuming the conditions requested by the FIEC. The tables related to core program staffing, support staffing, equipment, facilities, and resources as provided in sections III.A., III.B., and III.D. of the initial analysis have been reproduced herein with alternative projections relying on the FIEC's alternative assumptions.

---

[1] The full text of Petition Initiative 16-02, titled "Regulate Marijuana in a Manner Similar to Alcohol to Establish Age, Licensing, and Other Restrictions," is available from the Florida Division of Elections, accessible at: https://dos.elections.myflorida.com/initiatives/.

[2] The Department's initial analysis presented on October 4, 2019, is available from the Office of Economic and Demographic Research webpage associated with 2020 ballot measures, accessible at: http://edr.state.fl.us/Content/constitutional-amendments/index.cfm.

II. SUPPLEMENTAL ANALYSIS: IMPACT PROJECTIONS

A. Core Program Staffing Anticipated for Administering Regulatory Program[3]

1. Licensure

Position Class	FTE Positions	Total Rate/Benefits	Recurring
Chief of Licensing	1	105,318	Y
Deputy Chief of Licensing	1	96,008	Y
Senior Management Analyst II	1	79,739	Y
Regulatory Supervisor/Consultant	4	218,988	Y
Regulatory Specialist II	14	668,402	Y

2. Compliance

Position Class	FTE Positions	Total Rate/Benefits	Recurring: Y/N
Chief of Compliance	1	105,318	Y
Deputy Chief of Compliance	1	96,008	Y
Investigation Specialist II	28	1,500,324	Y
Inspector Specialist	2	143,244	Y

This projection has been reduced by 137 FTE positions from the initial analysis based on the modified assumptions utilized for this supplemental analysis.

3. Central Program Management

Position Class	FTE Positions	Total Rate/Benefits	Recurring: Y/N
Division Director	1	147,882	Y
Deputy Division Director	1	114,610	Y
Administrative Assistant III	1	61,462	Y
Budget Analyst	1	71,501	Y
Business Consultant I	3	160,743	Y
Information Specialist III	1	47,742	Y
Systems Programming Consultant	1	80,004	Y
Biological Scientist IV	1	96,324	Y
Human Resource Analyst	1	64,849	Y
Management Review Specialist	1	64,850	Y
Operations Review Specialist	1	84,668	Y

This projection has been reduced by one FTE position from the initial analysis based on the modified assumptions utilized for this supplemental analysis.

[3] *Note: The salaries and benefits projections may vary slightly from the initial analysis based on revised budget calculations.*

B. *Support Staffing Anticipated for Administering Regulatory Program*[4]

1. Administration – Projections Utilizing Alternative Assumption

Position Class	FTE Positions	Total Rate/Benefits	Recurring: Y/N
HR – Personnel Services Specialist	1	54,943	Y
AS – General Services Specialist	1	55,790	Y

2. Technology – Projections Utilizing Alternative Assumption

Position Class	FTE Positions	Total Rate/Benefits	Recurring: Y/N
IT – Systems Project Analyst	1	63,681	Y

This projection has been reduced by one FTE position from the initial analysis based on the modified assumptions utilized for this supplemental analysis. The two, temporary staff augmentation positions from the initial analysis have also been removed.

3. Service Operations – Projections Utilizing Alternative Assumption

Position Class	FTE Positions	Total Rate/Benefits	Recurring: Y/N
Regulatory Specialist III	2	102,986	Y

This projection has been reduced by two FTE positions from the initial analysis based on the modified assumptions utilized for this supplemental analysis.

4. General Counsel and Program Legal Services – Projections Utilizing Alternative Assumption

General Counsel			
Position Class	FTE Positions	Total Rate/Benefits	Recurring: Y/N
Attorney Supervisor – Chief	1	101,833	Y
Senior Attorney – Deputy Chief	1	86,731	Y
Senior Attorney	3	246,258	Y
Attorney	1	60,111	Y
Administrative Assistant I	2	86,524	Y
Administrative Assistant II	1	47,767	Y
Administrative Assistant III	1	61,462	Y
OPS Position	OPS Positions	Total Rate/Benefits	Recurring
OPS Paralegal – Law Clerk	1	31,200	Y
OPS Attorney	1	47,374	Y

Additional Program Legal Services			
Position Class	FTE Positions	Total Rate/Benefits	Recurring
Senior Attorney	2	202,502	Y

This projection has been reduced by one FTE position from the initial analysis based on the modified assumptions utilized for this supplemental analysis.

[4] *Note: The salaries and benefits projections may vary slightly from the initial analysis based on revised budget calculations.*

C. *Summary of Core Program and Support Staffing Projections*

Based on projected staffing needs identified in sections II.A. and II.B. above, the Department projects a total of 83 full-time positions as summarized with corresponding salaries, benefits, and standard expense factors in the table below:

Position Class	FTE Positions	Position Rate/Benefits	Professional Standard Expense	
			Recurring	Non-Recurring
Varied	83	5,178,581	497,502	342,458

This summary projection reflects an overall reduction of 142 FTE positions from the initial analysis based on the modified assumptions utilized for this supplemental analysis.

D. *Equipment, Facilities and Resources*

1. Facility Leasing – Projections Utilizing Alternative Assumption

Projected Facility Lease Expenses Utilizing Current State Rate				
Projected FTE Positions	Square Feet Per Position	Total Square Feet Needed	Current DMS Rate Per SF/Per Month	Total Projected Annual Lease Expense
83	180	14,940	$17.18	$3,080,030
Projected Facility Lease Expenses Utilizing Sample Rates at Private Facilities (Tallahassee)				
Projected FTE Positions	Square Feet Per Position	Total Square Feet Needed	Current Sample Rate Per SF/Per Month	Total Projected Annual Lease Expense
83	180	14,940	$20.00	$3,585,600

This projection has been reduced to calculate a range of projected leasing expenses based on the updated total FTE position projections derived from the modified assumptions utilized for this supplemental analysis.

2. Fleet Acquisition and Management – Projections Utilizing Alternative Assumption

	Expense Per Vehicle	**Expense Projected for 30 Vehicles**
Motor Vehicle Acquisition	$18,000	$540,000
Motor Vehicle Operation	$3,000	$90,000

3. Supplemental Technology Equipment – Projections Utilizing Alternative Assumption

	Initial Procurement and Setup of Technology Equipment					
	Network Drops	**Laptops**	**iPads**	**General Software Licenses**	**Specialized Software***	**Misc. Program Equipment**
Per Unit	$150	$1,100	$732.24	$800	Varied	Varied
Total Projected	$12,450	$19,800	$21,235	$66,400	$6,209	$8,576
Total Non-Recurring	$134,670					

	Ongoing Maintenance and Data Services			
	Program Equipment Maintenance	iPad Data Service and Maintenance	General Software Maintenance	Specialized Software Maintenance
Per Unit	$1,427	$483	$301	$400
Total Projected	$2,854	$14,007	$24,983	$800
Total Recurring	$42,644			

Per unit expenses are replicated from the initial analysis. The total projected expenses, which calculate this per unit expense with the number of FTE positions to which the expense may apply, have been reduced based on the updated FTE position arrangement derived from the modified assumptions utilized for this supplemental analysis.

E. Other Department Expenses Related to Implementation of Constitutional Amendment

Under the alternative assumptions employed for this supplemental analysis, the Department maintains the projections on other department expenses related to litigation as presented in the initial analysis. The projection provided in the initial analysis is copied for reference below.

1. Litigation Regarding Rule Development and Licensure Determinations

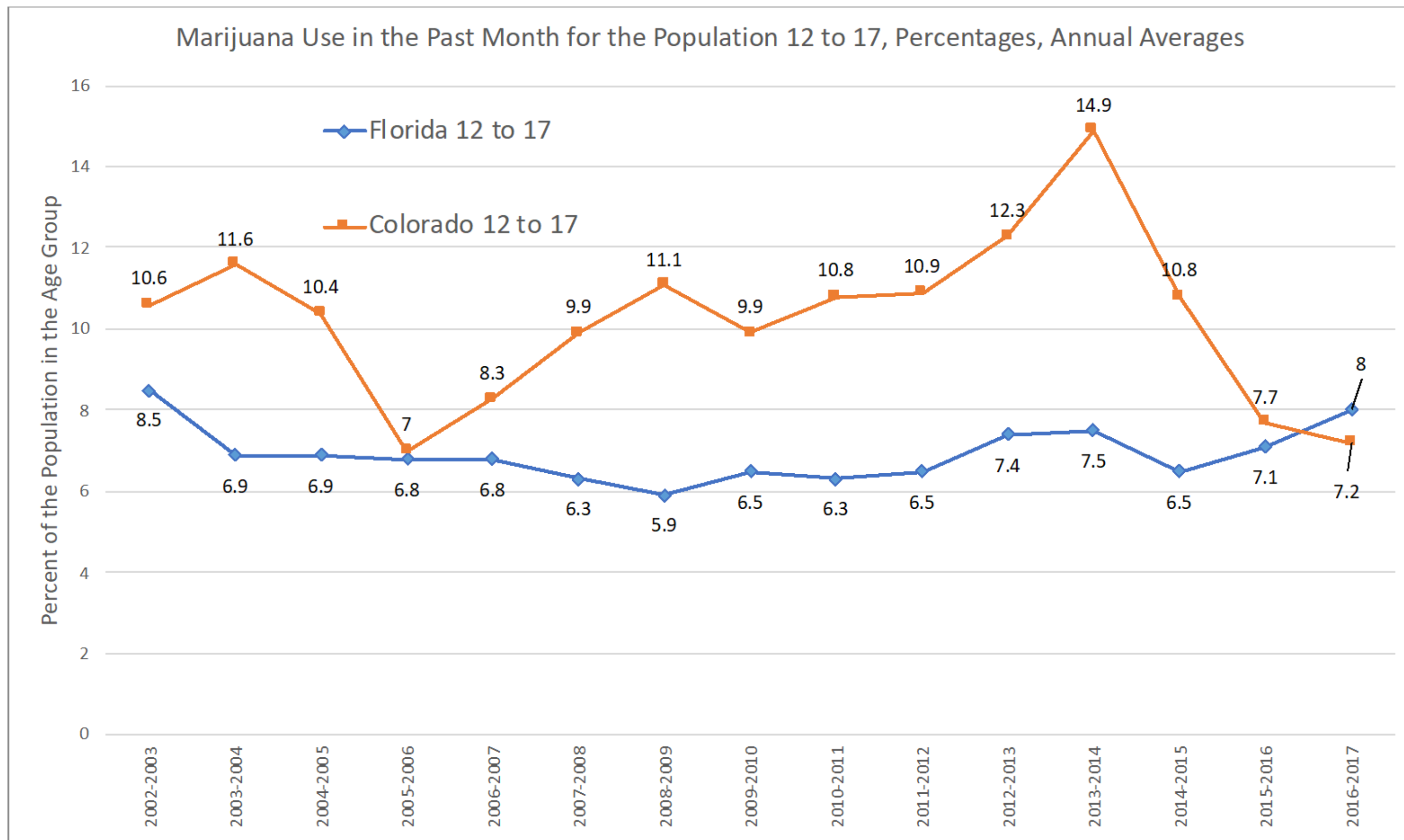
   The Department anticipates litigation relating to rulemaking development, licensure actions, and other regulatory actions arising during implementation of this new program will increase litigation expenses during the first 12-24 months of implementation. Reasonable projections forecast litigation expenses, depending on the volume of litigation involving the Department and the State of Florida, to be $250,000 or more per year in the first two years of program development. These litigation expense projections are highly variable and contingent upon needs for outside counsel, expert witnesses, testing and laboratory analyses, and other litigation factors beyond the reasonable ability to predict at the time of this analysis.

# # #

FLORIDA FINANCIAL IMPACT ESTIMATING CONFERENCE

Regulate Marijuana in a Manner Similar to Alcohol
to Establish Age, Licensing, and Other Restrictions
Serial Number 16-02

Appendix B



Sources: Years 2002 to 2014: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health, Florida and Colorado, 2002–2014, Alejandro Azofeifa, Margaret E. Mattson, and Rob Lyerla. Supplementary Material. State Level Data: Estimates of Marijuana Use and Related Indicators — National Survey on Drug Use and Health, Florida, 2002–2014. Center for Behavioral Health Statistics and Quality. (2016). Substance Abuse and Mental Health Services Administration, Rockville, MD. Years 2014-15, 2015-2016, and 2016-2017: Substance Abuse and Mental Health Services Administration, Substance Abuse and Mental Health Data Archive, The 2016-2017 National Surveys on Drug Use and Health, special tabulation provided by NSDUH. NSDUHs.
Prepared by: Florida Legislature, Office of Economic and Demographic Research, October 2019.

Appendix C

Colorado--- Quantity Consumed per Use-Day, by Consumer Type
Grams per Use Day

Use, Days per Month	Lower Bound	Mean Estimate	Upper Bound
<1	0.2	0.3	0.6
1-5	0.43	0.67	0.95
6-10	0.43	0.67	0.95
11-15	0.43	0.67	0.95
16-20	0.43	0.67	0.95
21-25	1.3	1.6	1.9
26-31	1.3	1.6	1.9

Sources: Kilmer, Beau, Jonathan P. Caulkins, Gregory Midgette, Linden Dahlkemper, Robert J. MacCoun, and Rosalie Liccardo Pacula. 2013. Before the Grand Opening: Measuring Washington State's Marijuana Market in the Last Year Before Legalized Commercial Sales. RAND Drug Policy Research Center. http://www.rand.org/pubs/research_reports/RR466.html. Market Size and Demand for Marijuana in Colorado, 2017 Market Update, Prepared for the Colorado Department of Revenue, Marijuana Policy Group, Leeds School of Business, University of Colorado Boulder, Appendix Table 1: Quantity Consumed per Use-Day, by Consumer Type.

FLORIDA FINANCIAL IMPACT ESTIMATING CONFERENCE

Regulate Marijuana in a Manner Similar to Alcohol
to Establish Age, Licensing, and Other Restrictions
Serial Number 16-02

Appendix D

Sales Tax from Marijuana Sales *(millions)*

Fiscal Year	State General Revenue	State Trust Funds	Combined Local Taxes and Revenue Sharing	Total Impact
FY 2021-22	$113.1	Insignificant	$33.3	$146.4
FY 2022-23	$114.7	Insignificant	$33.8	$148.5
FY 2023-24	$116.2	Insignificant	$34.2	$150.4
FY 2024-25	$117.8	Insignificant	$34.6	$152.4
FY 2025-26	$119.1	Insignificant	$35.1	$154.2
FY 2026-27	$120.5	Insignificant	$35.5	$156.0

Sales Tax from Other Tourist Expenditures *(millions)*

Fiscal Year	State General Revenue	State Trust Funds	Combined Local Taxes and Revenue Sharing	Total Impact
FY 2021-22	$33.7	Insignificant	$9.9	$43.6
FY 2022-23	$35.0	Insignificant	$10.3	$45.3
FY 2023-24	$36.3	Insignificant	$10.7	$47.0
FY 2024-25	$37.8	Insignificant	$11.1	$48.9
FY 2025-26	$39.3	Insignificant	$11.6	$50.9
FY 2026-27	$40.8	Insignificant	$12.0	$52.8

Total Sales Tax Impact *(millions)*

Fiscal Year	State General Revenue	State Trust Funds	Combined Local Taxes and Revenue Sharing	Total Impact
FY 2021-22	$146.8	Insignificant	$43.2	$190.0
FY 2022-23	$149.7	Insignificant	$44.1	$193.8
FY 2023-24	$152.5	Insignificant	$44.9	$197.4
FY 2024-25	$155.6	Insignificant	$45.7	$201.3
FY 2025-26	$158.4	Insignificant	$46.7	$205.1
FY 2026-27	$161.3	Insignificant	$47.5	$208.8

FLORIDA FINANCIAL IMPACT ESTIMATING CONFERENCE

Regulate Marijuana in a Manner Similar to Alcohol to Establish Age, Licensing, and Other Restrictions

Serial Number 16-02

Appendix E

Recreational Marijuana

2019-20 Appropriations	GEN REV	ALL FUNDS	GEN REV %	ALL FUNDS %
Debt Service	40,976,376	1,706,667,939	0.1%	1.9%
Pension Benefits/Claims	427,980,656	1,131,459,248	1.3%	1.2%
Education	17,112,724,393	23,747,347,771	50.4%	26.1%
Medicaid/TANF	7,545,611,743	29,827,719,870	22.2%	32.8%
Other Human Services	2,632,932,863	7,813,220,478	7.8%	8.6%
Judicial Branch	459,709,001	554,721,192	1.4%	0.6%
Criminal Justice and Corrections	4,046,379,211	4,790,575,874	11.9%	5.3%
Natural Resources/ Environment/ Growth Management/ Transportation	530,983,801	14,303,066,343	1.6%	15.7%
General Government	1,144,842,329	7,112,711,866	3.4%	7.8%
TOTAL	**33,942,140,373**	**90,987,490,581**	**100.0%**	**100.0%**

Change, Assuming Full Year Revenue Gain (GR) + DBPR Costs (TF) to FY 2019-20 Budget

General Revenue Increased Level	**73,400,000**		
% Change to GR Affected Areas	100.22%		
		DBPR Start-Up	*DBPR Recurring*
Trust Fund Change for DBPR	**10,658,670** ←	*1,517,128*	*9,141,542*

2019-20 Adj Appropriations	GEN REV	ALL FUNDS	GEN REV %	ALL FUNDS %
Debt Service	40,976,376	1,706,667,939	0.1%	1.9%
Pension Benefits/Claims	427,980,656	1,131,459,248	1.3%	1.2%
Education	17,150,249,177	23,784,872,555	50.4%	26.1%
Medicaid/TANF	7,562,157,761	29,844,265,888	22.2%	32.8%
Other Human Services	2,638,706,358	7,818,993,973	7.8%	8.6%
Judicial Branch	460,717,051	555,729,242	1.4%	0.6%
Criminal Justice and Corrections	4,055,252,112	4,799,448,775	11.9%	5.3%
Natural Resources/ Environment/ Growth Management/ Transportation	532,148,142	14,304,230,684	1.6%	15.7%
General Government	1,147,352,739	7,125,880,946	3.4%	7.8%
TOTAL	**34,015,540,373**	**91,071,549,251**	**100.0%**	**100.0%**

NOTE: Shaded Cells Held Harmless

2019-20 Differences	GEN REV	ALL FUNDS	GEN REV % Increase	ALL FUNDS % Increase
Debt Service	0	0		
Pension Benefits/Claims	0	0		
Education	37,524,784	37,524,784	0.22%	0.16%
Medicaid/TANF	16,546,018	16,546,018	0.22%	0.06%
Other Human Services	5,773,495	5,773,495	0.22%	0.07%
Judicial Branch	1,008,050	1,008,050	0.22%	0.18%
Criminal Justice and Corrections	8,872,901	8,872,901	0.22%	0.19%
Natural Resources/ Environment/ Growth Management/ Transportation	1,164,341	1,164,341	0.22%	0.01%
General Government	2,510,410	13,169,080	0.22%	0.19%
TOTAL	**73,400,000**	**84,058,670**	**0.22%**	**0.09%**

NOTE: Shaded Cells Held Harmless

FLORIDA FINANCIAL IMPACT ESTIMATING CONFERENCE

Regulate Marijuana in a Manner Similar to Alcohol
to Establish Age, Licensing, and Other Restrictions
Serial Number 16-02

Appendix F

Economic Analysis Results

Statewide Economic Model Impact Projections of Regulate Marijuana in a Manner Similar to Alcohol to Establish Age, Licensing, and Other Restrictions

Economic Indicator	Units	FY2022	FY2023	FY2024	FY2025	FY2026	Total		Average per Year
Personal Income	Nominal $ (M)	2,670.4	2,926.1	3,156.0	3,371.4	3,575.8	15,699.6		3,139.9
Personal Income Per Capita	Nominal $	123.4	118.5	113.0	107.3	101.5	563.7		112.7
Real Gross Domestic Product	Fixed 2019-20 $ (M)	3,646.4	3,691.6	3,769.0	3,870.6	3,983.7	18,961.3		3,792.3
Net State Revenues	Nominal $ (M)	218.7	238.1	243.6	251.3	260.2	1,212.0		242.4
Economic Indicator	**Units**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**	**Minimum**	**Maximum**	**Average per Year**
Net Employment	Jobs	57,897	51,900	48,717	47,273	46,846	*46,846*	*57,897*	50,527
Population	Persons	0	5,120	9,840	14,192	18,184	*0*	*18,184*	9,467

Statewide Economic Model Impact Projections of Regulate Marijuana in a Manner Similar to Alcohol to Establish Age, Licensing, and Other Restrictions

Economic Indicator	Units	FY2022	FY2023	FY2024	FY2025	FY2026	Minimum	Maximum
Personal Income	Nominal $ (M)	0.20%	0.21%	0.22%	0.22%	0.23%	*0.20%*	*0.23%*
Personal Income Per Capita	Nominal $	0.19%	0.20%	0.21%	0.21%	0.21%	*0.19%*	*0.21%*
Gross Domestic Product	Nominal $ (M)	0.32%	0.32%	0.32%	0.32%	0.32%	*0.32%*	*0.32%*
Net State Revenues	Nominal $ (M)	0.31%	0.32%	0.32%	0.33%	0.33%	*0.31%*	*0.33%*
Net Employment	Jobs	0.62%	0.55%	0.51%	0.48%	0.47%	*0.47%*	*0.62%*
Population	Persons	0.00%	0.02%	0.04%	0.06%	0.08%	*0.00%*	*0.08%*

Appendix G

Glossary

Economic Variables

Economic Variable	Definition
Personal Income	Income received by persons from all sources. It includes income received from participation in production as well as from government and business transfer payments. It is the sum of compensation of employees (received), supplements to wages and salaries, proprietors' income with inventory valuation adjustment (IVA) and capital consumption adjustment (CCAdj), rental income of persons with CCAdj, personal income receipts on assets, and personal current transfer receipts, less contributions for government social insurance.
Personal Income Per Capita	Measures the average income received per person in a given year. It is calculated by dividing personal income by population.
Real Gross Domestic Product	A measurement of the state's output; it is the sum of value added from all industries in the state. GDP by state is the state counterpart to the Nation's gross domestic product.
Net State Revenues	Consists of the total tax and fee collections across all revenue sources.
Net Employment	This comprises estimates of the number of jobs, full time plus part time, by place of work. Full time and part time jobs are counted at equal weight. Employees, sole proprietors, and active partners are included, but unpaid family workers and volunteers are not included.
Population	Total resident population as of July 1.

OMMU Office of MEDICAL MARIJUANA Use

Florida's Official Source for Medical Use

Annual Update on the Statewide Cannabis and Medical Marijuana Education and Illicit Use Prevention Campaign

January 31, 2023

Florida HEALTH

Ron DeSantis
GOVERNOR

Joseph A. Ladapo, MD, PhD
STATE SURGEON GENERAL

2023 ANNUAL REPORT TABLE OF CONTENTS

Introduction 1
Education and Outreach Efforts 2
    Events Conducted
Florida Impaired Driving Coalition 5
KnowTheFactsMMJ.com 8
    OMMU Weekly Updates
    KnowTheFactsMMJ.com Updates
Education Materials 12
    One-pagers
    Instructional Guides
    Law Enforcement Tip Cards
    Power Points
Stakeholder Support 15
    2022 Stakeholder Support Calls
    2022 Stakeholder Support Emails
The Medical Marijuana Use Registry 16
    Medical Marijuana Use Registry Updates
By The Numbers - Florida's Medical Marijuana Program 19
    Application Numbers
    Qualified Physician Numbers
    Number of Qualified Physicians in the Medical Marijuana Use Registry by Month and Year
    Treatment Centers
Growth of the Program 21
    Total Active Patients at the End of Each Year
2023 Marketing Plan 23
Year Six Reporting 24

INTRODUCTION

Legislative Direction

During Florida's Special Legislative Session held in June 2017, Senate Bill 8A was passed and subsequently signed by Governor Rick Scott on June 23, 2017. Senate Bill 8A amended section 381.989, Florida Statutes (F.S.), and includes provisions directing the Florida Department of Health (Department) to develop a statewide public education campaign to inform and educate Floridians on newly established medical marijuana laws and the importance of responsible use.

There are specific objectives established in statute including publicizing accurate information regarding the legal requirements for licit use and possession; the safe use of medical marijuana and preventing access by those other than the qualified patient, particularly children.

Additionally, the Office of Medical Marijuana Use (OMMU) develops and implements the Florida Department of Health's rules for medical marijuana; oversees the statewide Medical Marijuana Use Registry (MMUR); licenses Florida businesses to cultivate, process and dispense medical marijuana to qualified patients and caregivers; and certifies marijuana testing laboratories to ensure the health and safety of the public as it relates to marijuana.

Section 381.989(2), F.S.

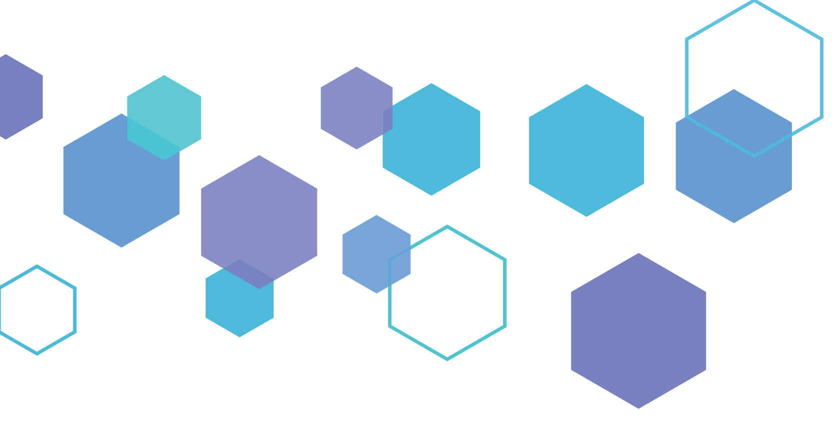
(2) STATEWIDE CANNABIS AND MARIJUANA EDUCATION AND ILLICIT USE PREVENTION CAMPAIGN.

(a) The department shall implement a statewide cannabis and marijuana education and illicit use prevention campaign to publicize accurate information regarding:

1. The legal requirements for licit use and possession of marijuana in this state.

2. Safe use of marijuana, including preventing access by persons other than the qualified patients as defined in s. 381.986, F.S., particularly children.

3. The short- and long-term health effects of cannabis and marijuana use, particularly on minors and young adults.



EDUCATION AND OUTREACH EFFORTS

Section 381.989(2)(a)4., F.S.
4. Other cannabis-related and marijuana-related education determined by the department to be necessary to the public health and safety.

Florida Behavioral Health Conference

24th Annual Family Café Conference

Florida Society of Ophthalmology

Pursuant to section 381.989, F.S., the OMMU is statutorily charged with implementing a statewide cannabis and marijuana education and illicit use prevention campaign to publicize accurate information regarding the legal, healthy and safe use of medical marijuana—particularly amongst children, and other related education determined necessary to protect public health and safety. The OMMU is also directed to provide educational materials regarding the eligibility for medical use of marijuana by individuals diagnosed with a terminal condition to individuals who provide palliative care or hospice services.

The Florida Department of Health and the OMMU continue to focus on the health and safety of Florida's families and are dedicated to ensuring patients have safe access to low-THC cannabis and medical marijuana.

As Florida's "Official Source for Medical Use," the OMMU provides the most current and accurate information on medical marijuana in Florida to patients, caregivers, physicians, medical marijuana treatment centers (Treatment Centers), lawmakers, law enforcement and the general public.

To reach our stakeholders, the OMMU develops resources and conducts education activities across the state. Below are key activities used by the OMMU to keep stakeholders up to date on the latest happenings in the Florida Medical Marijuana Use Program.

EDUCATION AND OUTREACH EFFORTS

The OMMU Communications Team conducted education and outreach events throughout the state in 2022. These events helped to educate and inform key stakeholders about the Florida Medical Marijuana Use Program, as well as licit and safe use. The OMMU visited various groups, including patients, caregivers, physicians, patient organizations and law enforcement entities.

Events Conducted in 2022:

DATE	EVENT
1/12/2022	Florida Public Safety Institute Training (Presentation)
1/18/2022	Madison County Sheriff's Office Training (Presentation)
1/20/2022	Madison County Sheriff's Office Training (Presentation)
2/2/2022	Parkinson's Association of Southwest Florida (Presentation)
2/23/2022	Florida Impaired Driving Coalition 1st Quarter Meeting (Presentation)
3/7/2022	Gadsden County Sheriff's Office Leadership Training (Presentation)
3/9/2022	Columbia County Sheriff's Department Leadership Training (Presentation)
3/16/2022	Santa Rosa County Family Services Counselors (Presentation)
3/22/2022	Hillsborough County Sheriff's Office – Countywide DUI Enforcement Squad, District 5 (Presentation)
4/8/2022 to 4/10/2022	Florida Academy of Family Physicians Spring Forum (Exhibit)
4/13/2022	Florida Department of Highway Safety and Motor Vehicle's Legal Team (Presentation)
4/27/2022	Florida Impaired Driving Coalition 2nd Quarter Meeting (Presentation)
5/17/2022	Gadsden County Sheriff's Office Leadership Meeting number 2 (Presentation)
5/18/2022	Multiple Sclerosis Center of Greater Orlando (Presentation)
5/19/2022	District Two and District Five Law Enforcement Liaison (Presentation)
5/19/2022 to 5/20/2022	Cannabis Clinical Outcomes Research Conference (Exhibit)
5/24/2022	Baptist Health Care Family and Children Counselors Welfare Training Conference (Presentation)
5/25/2022	Florida Society of Environmental Analysts (Presentation)
5/26/2022	Leon County Sheriff's Office Student Resource Officers Training (Presentation)
5/27/2022 to 5/29/2022	The 24th Annual Family Café Conference (Presentation and Exhibit)
6/2/2022	Florida Hospice Association (Presentation)
6/3/2022 to 6/5/2022	Florida Medical Cannabis Conference & Exhibition (Presentation and Exhibit)

EDUCATION AND OUTREACH EFFORTS

6/10/2022 to 6/11/2022	Florida Society of Ophthalmology Annual Meeting (Exhibit)
6/13/2022 to 6/16/2022	Symposium on Traffic Safety - Institute of Police Technology Management (Two Presentations)
6/23/2022 to 6/25/2022	2022 Aging Life Care Association Florida Chapter Annual Conference (Exhibit)
6/30/2022	Florida Association of DUI Programs (Presentation)
7/8/2022 to 7/10/2022	Florida Academy of Family Physicians Summer Forum (Exhibit)
7/22/2022	Collier County Sheriff's Office Training (Presentation)
7/26/2022 to 7/29/2022	Florida International Medical Expo (Presentation and Exhibit)
8/3/2022	Florida Environmental Health Association (Presentation)
8/4/2022 to 8/7/2022	Florida Medical Association Annual Meeting (Exhibit)
8/17/2022 to 8/19/2022	Florida Behavioral Health Conference (Exhibit)
9/13/2022 to 9/16/2022	Skin, Bones, Hearts and Private Parts Pensacola Medical Conference (Exhibit)
9/22/2022	Gadsden County Sheriff's Office Officer Training (Presentation)
9/24/2022	Cancer Chomp (Exhibit)
10/13/2022	Broward County Commission on Behavioral Health and Substance Abuse Prevention (Presentation)
10/20/2022	Florida Department of Health, Division of Medical Quality Assurance ISU Annual Training (Two Presentations)
10/24/2022 to 10/27/2022	Skin, Bones, Hearts and Private Parts Orlando Medical Conference (Exhibit)
11/7/2022 to 11/8/2022	Florida Impaired Driving Coalition 3rd Quarter Meeting (Presentation)
11/8/2022	Pensacola Police Department Training (Two Presentations)
12/7/2022 to 12/9/2022	Florida Academy of Family Physician's Family Medicine Winter Summit (Exhibit)

FMA Annual Meeting

Florida International Medical Expo

FLORIDA IMPAIRED DRIVING COALITION

The Florida Impaired Driving Coalition (FIDC) was formed to identify and prioritize the state's most pressing impaired driving issues. The FIDC reviews proven strategies that can effectively address these issues as well as develops and oversees a strategic plan that will guide the implementation of programs, policy and funding strategies to maximize the state's ability to reduce impaired driving crashes, fatalities and injuries.

The OMMU has participated in the FIDC since 2021. The OMMU joined the FIDC to bring its knowledge and expertise of medical marijuana to the FIDC. The OMMU is working with the FIDC to incorporate messaging about the illicit use of medical marijuana while operating motor vehicles, boats or aircraft into the group's strategies and programs.

Coalition Members Include:

- Florida Safety Council
- Florida Highway Patrol
- Lake Alfred Police Department
- Hillsborough County Sheriff's Office
- SunCoast Safety Council
- Florida Department of Law Enforcement, Alcohol Testing Program
- Florida Police Chiefs Association
- Second Judicial Circuit, Felony Division C
- Florida Department of Transportation, State Safety Office
- Florida Department of Health, Office of Medical Marijuana Use
- Collier County Sheriff's Office
- Florida Department of Law Enforcement, Toxicology
- Tampa Alcohol Coalition
- Miami-Dade State Attorney's Office
- The Florida Restaurant & Lodging Association
- Regulatory Compliance Services Inc.
- DUI Counterattack, Hillsborough, Inc.
- Advocate Program, Inc./Florida Association of Community Corrections
- St. Johns County Sheriff's Office
- Miami Beach Police Department
- International Association of Chiefs of Police
- Mothers Against Drunk Driving (MADD)
- University of Miami, Division of Toxicology
- United States Probation/United States Coast Guard
- Orange County Sheriff's Office

FLORIDA IMPAIRED DRIVING COALITION

- Pinellas County Sheriff's Office
- Pasco County Sheriff's Office
- Students Against Destructive Decisions (SADD)
- Lake County Sheriff's Office
- Palm Beach County Sheriff's Office
- Florida Association of State Prosecutors
- Florida Fish and Wildlife Conservation Commission, Division of Law Enforcement, Boating and Waterways Section, Statewide Boating Safety Unit
- Florida Department of Highway Safety and Motor Vehicles
- Broward County Sheriff's Office
- University of South Florida Police Department
- 7th Judicial Circuit State Attorney's Office
- Miami-Dade County State Attorney's Office
- University of North Florida, Institute of Police Technology and Management
- Seminole Police Department (Seminole Tribe of Florida)
- Tallahassee Community College, Florida Public Safety Institute
- Florida Department of Business and Professional Regulation
- Orlando Police Department
- Orange County Sheriff's Office
- Pinellas County Sheriff's Office
- Pasco County Sheriff's Office
- Students Against Destructive Decisions (SADD)
- Lake County Sheriff's Office
- Palm Beach County Sheriff's Office
- Florida Association of State Prosecutors
- Florida Fish and Wildlife Conservation Commission, Division of Law Enforcement, Boating and Waterways Section, Statewide Boating Safety Unit
- Broward County Sheriff's Office
- University of South Florida Police Department
- Florida Department of Criminal Justice System, Alcohol Testing Program
- 7th Judicial Circuit State Attorney's Office
- Miami-Dade County State Attorney's Office
- Florida Department of Law Enforcement, Alcohol Testing Program
- University of North Florida, Institute of Police Technology and Management
- Indian River Shores Public Safety
- Seminole Police Department (Seminole Tribe of Florida)
- Tallahassee Community College, Florida Public Safety Institute
- Florida Department of Business and Professional Regulation
- Orlando Police Department

Traffic Safety Partners
- Cambridge Systematics
- Center for Urban Transportation Research
- AAA
- SCRAM Systems
- United States Navy
- University of Miami Miller School of Medicine / Department of Surgery
- Great Bay Distributors

Family Medicine Summer Forum

Cannabis Clinical Outcomes Research

Aging Life Care Conference

Florida International Medical Expo

24th Annual Family Café Conference

Florida Behavioral Health Conference

KnowTheFactsMMJ.com

The Department's website, **KnowTheFactsMMJ.com** fulfills a need to have a stand-alone website that serves as a central repository for medical marijuana information in Florida. This comprehensive site was designed with the objectives of establishing the Department as the authority on responsible medical use by qualified patients and making information available in one location for all interested stakeholders. **KnowTheFactsMMJ.com** officially launched in March 2019 and has been continuously updated to meet the needs of key stakeholders.

The website is dedicated to offering the most current and accurate information related to medical marijuana in Florida. It is the information hub for patients, physicians, Treatment Centers, certified marijuana testing laboratories, law enforcement and others interested stakeholders requiring up-to-date and accurate information.

The website features an updated Resources page that contains links to the "Know the Facts" campaign one-pagers, OMMU educational materials and previous Statewide Cannabis and Medical Marijuana Education and Illicit Use Prevention Campaign annual reports.

The website makes it easy to locate licensed Treatment Center dispensing locations that are in closest proximity to qualified patients. An updated list of Treatment Centers includes the business's name, phone and email address, authorization status and license number, along with links to the Treatment Center's website.

Additionally, the website provides a list of qualified physicians who have completed the required training to recommend medical marijuana to qualified patients. The site provides patients and caregivers with the Medical Marijuana Qualified Physician Search Tool, enabling them to find a qualified physician by location and specialty.

The website's *About* section provides users with an overview of the OMMU and its responsibilities related to medical marijuana in Florida, as well as an archive of *OMMU Weekly Updates* by year going back to 2016. The site hosts an *FAQ* page with 16 of the most frequently asked questions that stakeholders may have. Several links are embedded within the *FAQ* page, which direct users to expanded information.

OMMU Weekly Updates

The OMMU provides a weekly update about Florida's medical marijuana program that keeps stakeholders up to date on the latest program numbers. The OMMU Weekly Update is emailed to stakeholders every Friday and contains the following information:

- Number of qualified patients (Active ID Card)
- Number of qualified physicians
- Newly approved Treatment Center dispensing locations
- Weekly dispensations from the Treatment Centers

KnowTheFactsMMJ.com Updates

Below is a list of the major updates that happened in 2022.

DATE	EVENT
January	• Added the new Treatment Center guide for creating and editing Medical Marijuana Treatment Center users and transporters
February	• Added Emergency Rule 64ER22-1 (This emergency rule implements section 381.986(8)(b), Florida Statutes, by establishing procedures and requirements for financial assurances submitted by a Treatment Center to the Department of Health) and its incorporated forms to the Treatment Center Emergency Rules section • Added the Second Physician Concurrence instructional guide
March	• Added Emergency Rule 64ER22-2 (This emergency rule establishes requirements for trade names and logos used by Treatment Centers) to the Treatment Center Emergency Rules section
April	• Created a new page to house the applications from the 2022 Pigford/ Black Farmers Litigation Treatment Center Application Process • Added language to the home page regarding the Pigford/Black Farmers Litigation application process • Uploaded and linked updated Law Enforcement Organization and Medical Marijuana Treatment Center instructional guides that changed all instances of "Master User" to "Executive User"
May	• Added a Notice of Rule Development for Rule 64-4.206 • Began adding a weekly list of the Treatment Center medical directors to the Treatment Center page

June	• Added Emergency Rules 64ER22-5 (This emergency rule repeals and replaces emergency rule 64ER20-5, “Suspension and Revocation of Certified Medical Testing Laboratory (CMTL) Certification.” This emergency rule implements sections 381.986 and 381.988, Florida Statutes, by establishing guidelines related to fines, suspension, and revocation imposed upon a certified marijuana testing laboratory (CMTL) for violations of rule and statute. The effect is to establish comprehensive and consistent disciplinary penalties related to CMTLs) and 64ER22-6 (This emergency rule establishes the requirements and process for the renewal of CMTL certifications and the renewal application form incorporated therein) and the incorporated form to the CMTL Emergency Rules section.
July	• Removed Emergency Rule 64ER20-5 from the CMTL Emergency Rules section • Added new/updated instructional guides for the July MMUR updates • Added a Notice of Rule Development for Rules 64-4.300-4.315
August	• Added Emergency Rule 64ER22-7 (This emergency rule establishes the requirements for websites and website purchasing used by Treatment Centers) and its incorporated forms to the Treatment Center Emergency Rules section • Added Emergency Rule 64ER22-8 (This emergency rule implements section 381.986(4)(f), Florida Statutes, by quantifying a daily dose amount with equivalent dose amounts for each allowable form of marijuana dispensed by a medical marijuana treatment center. This rule also establishes submission procedures of a request for an exception to the daily dose amount limit, the 35-day supply limit of marijuana in a form for smoking, and the 4-ounce possession limit of marijuana in a form for smoking) and its incorporated form to the MMUR Emergency Rules section. • Added/replaced nine patient, physician, and Treatment Center instructional guides reflecting the Daily Dose and Request for Exception update
September	• Added two new public meeting notices for upcoming workshops for Rules 64-4.300-4.315 and 64-4.206 • Added the cancellation notice for the two workshops due to Hurricane Ian

October	• Added language to the KnowTheFactsMMJ.com home page regarding Department of Health Emergency Order 22-005 (This emergency rule allows the use of telehealth, as defined in section 456.47(1)(a), Florida Statutes, by qualified physicians for recertifications of existing patients in Charlotte, Collier, DeSoto, Flagler, Hardee, Hendry, Highlands, Hillsborough, Lake, Lee, Manatee, Orange, Osceola, Pinellas, Polk, Putnam, St. Johns, Sarasota, Seminole, and Volusia counties until November 30, 2022. Telehealth services can only substitute the requirement to "conduct a physical examination while physically present in the same room as the patient," as required by section 381.986(4)(a)1., Florida Statutes).
November	• Added language to the KnowTheFactsMMJ.com home page regarding the expiration of Department of Health Emergency Order 22-005
December	• Added information to KnowTheFactsMMJ.com home page about Emergency Rule 64ER22-9 (This emergency rule repeals and replaces Emergency Rule 64ER17-2. This emergency rule establishes the medical marijuana treatment center application process for individuals or entities applying for licensure). • Added information to KnowTheFactsMMJ.com home page about Emergency Rule 64ER22-10 (This emergency rule replaces and supersedes Emergency Rule 64ER19-8 and establishes the requirements and process for the renewal of medical marijuana treatment center licenses and the renewal application form incorporated therein).

Skin, Bones, Hearts & Private Parts - Pensacola Conference

Florida Medical Cannabis Exhibit

Florida Behavioral Health Conference

Cancer CHOMP

EDUCATION MATERIALS

In addition to online resources, educational materials continue to be developed and updated to provide qualifying patients and caregivers with information on how to access Florida's Medical Marijuana Use Program.

One-Pagers

The following one-pagers are in development:

- Know the Facts about Medical Marijuana and Pain Management
- Know the Facts about Medical Marijuana and HIV/AIDS
- Know the Facts about Medical Marijuana and Post Traumatic Stress Disorder
- Know the Facts about Medical Marijuana and Cancer
- Know the Facts about Medical Marijuana and Multiple Sclerosis
- Know the Facts about Medical Marijuana and Legal Use
- Know the Facts about Medical Marijuana and Driving Impaired
- Know the Facts – What is Medical Marijuana?
- Know the Facts – How Marijuana Affects the Body
- Know the Facts – Cannabinoids: What Are They and What Do They Do?

Instructional Guides

The OMMU created or updated the following instructional guides for patients and caregivers:

- Certification Amount Available Calculations Page
- Understanding and Viewing Orders

OMMU created the following instructional guides for qualified physicians:

- Submitting a Request for Exception (RFE)
- Submitting a Second Physician's Concurrence (2PC)
- Submitting a Consent for Minor Patient (CMP)
- Creating New Certifications/Orders
- Editing/Cancelling Orders
- Adding an Existing Caregiver to a Patient's Profile
- Adding an Existing Patient Under My Care

The OMMU created or updated the following instructional guides for Medical Marijuana Treatment Centers:

- Certification Amount Available Calculations Page
- Creating and Editing Transporter Users
- Treatment Center User Dispensing – Delivery
- Treatment Center User Dispensing – In Person
- Understanding and Viewing Orders
- MMUR Guide for Treatment Center Managers
- MMUR Guide for Dispensers and Deliverers

The OMMU created or updated the following instructional guides for Law Enforcement Organizations:

- Patient and Caregiver Search

The OMMU created two 3"x5" tip cards as resources for law enforcement officers to reference while working in the field:

- Legal Use of Medical Marijuana
- Medical Marijuana Packaging

OMMU Office of MEDICAL MARIJUANA Use

MEDICAL MARIJUANA IN FLORIDA

Front Side

- Each qualified patient and caregiver is required to have a valid Medical Marijuana Use Registry (MMUR) identification (ID) card, which must be renewed annually. *[§ 381.986(7)(a), Fla. Stat.]*
- A qualified patient or caregiver in possession of marijuana or a marijuana delivery device who fails or refuses to present his or her MMUR ID card upon the request of a law enforcement officer commits a misdemeanor of the second degree. *[§ 381.986(12)(e)1., Fla. Stat.]*
- A person is prohibited from the operation of any vehicle, aircraft, train or boat while under the influence of medical marijuana. *[Art. X, § 29(c)(4), Fla. Const.]*
- Section 381.986, F.S., does not allow reciprocity agreements with other states. Bringing medical or recreational marijuana from another state into Florida violates s. 893.13, F.S.

Florida HEALTH

Back Side

- A qualified patient or caregiver who uses or administers marijuana, not including low-THC cannabis, in plain view of or in a place open to the general public; in a school bus; a vehicle; an aircraft or a boat; or on the grounds of a school except as provided in s. 1006.062, F.S., commits a misdemeanor of the first degree. *[§ 381.986(12)(c), Fla. Stat.]*
- A Florida qualified patient and the qualified patient's caregiver:
  - ✓ May purchase from a Medical Marijuana Treatment Center (MMTC) for the patient's medical use a marijuana delivery device and up to the amount of marijuana authorized in the physician certification.
  - ✓ May not possess more than a 70-day supply of marijuana, or the greater of 4 ounces of marijuana in a form for smoking or 1.6 times the number of ounces of the amount ordered for marijuana in a form for smoking approved by the department pursuant to s. 381.986(4)(f), F.S. and Emergency Rule 64ER22-3., at any given time.
  - ✓ ***Must*** keep all medical marijuana purchased in its original MMTC packaging. *[§ 381.986(14)(a), Fla. Stat.]*

10/20/22

OMMU Office of MEDICAL MARIJUANA Use

MEDICAL MARIJUANA PACKAGING

Front Side

Section 381.986(8)(e)11.f., F.S., requires Medical Marijuana Treatment Centers (MMTCs) to package the marijuana in a receptacle that has a firmly affixed and legible label stating the following information:

- The marijuana or low-THC cannabis meets the requirements of sub-subparagraph d
- The name of the medical marijuana treatment center
- The batch number, harvest number and the date dispensed
- Issuing physician's name
- Patient's name
- The product name, if applicable, and dosage form
- Recommended dose
- A warning that it is illegal to transfer medical marijuana to another person
- The marijuana universal symbol

Florida HEALTH

Back Side

- Qualified patients and the qualified patient's caregiver ***must*** keep all medical marijuana purchased in its original MMTC packaging.
- Packaging for marijuana in a form for smoking or edibles must be plain, opaque, and white. The universal symbol must be printed on the package and be no less than 10 percent of the overall surface area of the package. THC
- Receptacles for edibles must have a warning to keep away from children and pets, and a warning stating that the edible has not been produced or inspected pursuant to federal food safety laws.
- Receptacles for whole flower must have a warning to keep the product away from children and a warning stating that marijuana smoke contains carcinogens and may negatively affect health.

EDUCATION MATERIALS

PowerPoints

The OMMU developed a Master PowerPoint slide deck. Select slides from the Master slide deck were chosen to create all PowerPoint presentations the OMMU developed throughout the year.

PowerPoint presentations were developed for the following audiences:

- Patients and caregivers
- Physicians
- Patient groups
- Physician groups
- Not-for-profit organizations
- Community organizations
- State agencies
- Law enforcement entities

Skin, Bones, Hearts & Private Parts - Orlando Conference

Florida International Medical Expo

24th Annual Family Café Conference

Family Medicine Spring Forum

Florida Society of Ophthalmology

Aging Life Care Conference

STAKEHOLDER SUPPORT

The OMMU conducts stakeholder support through its Stakeholder Support Team. This team includes members of the call center and email request support personnel. Members of the team assist key stakeholders (patients, caregivers, qualified physicians, Treatment Center personnel and law enforcement) with issues and questions about the program and the MMUR. Stakeholder support ranges from helping a patient apply for an MMUR identification card, to assisting a physician's office with questions about patients' profiles, to clarifying questions for Treatment Center personnel and law enforcement entities.

Below is a synopsis of the calls and emails received by the OMMU in 2022.

2022 Stakeholder Support Calls

Month	Calls Received
January	41,332
February	38,993
March	48,483
April	41,934
May	38,549
June	38,182
July	33,868
August	41,256
September	36,521
October	37,041
November	39,165
December	42,278
Total	**477,602**

2022 Stakeholder Support Emails

Month	Emails Received
January	4,722
February	4,245
March	5,203
April	3,603
May	3,288
June	3,467
July	3,081
August	4,405
September	5,505
October	3,589
November	2,169
December	2,094
Total	**45,371**

Cancer CHOMP

Florida Behavioral Health Conference

THE MEDICAL MARIJUANA USE REGISTRY

The MMUR is a secure, online database for:

- Registration of qualified patients and caregivers
- Registration of qualified physicians
- Qualified physicians (create orders for patients and create Request for Exception Forms)
- Treatment Center personnel (verify patients' certifications and track what has been dispensed to patients and caregivers)
- Law Enforcement (verify registered patients and caregivers, patient orders and dispensations, or if a person is an approved and valid medical marijuana transporter)
- Prescription drug prescribers (search and review certifications and orders to ensure proper care for patients before medications that may interact with the medical use of marijuana are prescribed)

The MMUR is only accessible to patients, qualified physicians, law enforcement, medical marijuana treatment center staff, Office of Medical Marijuana Use staff or practitioners licensed to prescribe prescription drugs.

Pursuant to section 381.987, F.S., the Florida Department of Health allows access to confidential and exempt information in the MMUR to law enforcement agencies that are investigating a violation of law regarding marijuana in which the subject of the investigation claims an exception established under section 381.986, F.S.

Medical Marijuana Use Registry Updates

Month	Updates
January	• Treatment Center Transporter Onboarding Process • New Treatment Center User Profile and Transporter Fields • Editing Order Route Type Conditions • Application Auto-Approval in MMUR • Caregiver Background Verification Processing
February	• Dispensable Amount - Look back logic updated • Second Physician Concurrence
March	• Request For Exception / Dispensable Amount – Phase II
April	• Changed Role Names • Text Change on Payment Section of Application
July	• Added Caregiver Assist Statement to CRCE Qualifying Documents • Parent or Guardian Consent for Minor Patient (CMP) • Dispensation to Caregiver Logging

August	• Added Driver License Number to Patient/Caregiver Profile Page • New Application Restriction (This update prevents patients and/or caregivers from starting a change of address application while their renewal/initial application is being processed) • Request For Exception/Dispensable Amount - Phase III • Adjust Viewing Permissions for CMP Profile Message
September	• Display Carry Limit for Smoking Type • Application Expiration Date Timestamp Adjustment • Certification Documentation Dashboard - Filtering and Performance Improvements • Request For Exception Content Updates
November	• Request For Exception Process Update • Added Caregiver Identification Number
December	• Patient with Overlapping Orders update • “Save Order” - Processing Alterations - Cancelled, Expired, Completed update • MMUR Communication Efforts update • “Dispensable Amount” for Medical Marijuana Routes update • “Dispensable Amount” for Smoking Route update

The OMMU communicates MMUR updates to all user types that will be affected by the update, including patients, caregivers, qualified physicians and Treatment Centers. The OMMU uses multiple communication channels to inform stakeholders about these updates, including email and posting information on the MMUR home page and the KnowTheFactsMMJ.com website. Additionally, step-by-step instructional guides are created or updated to assist stakeholders in navigating these updates.

The OMMU posts the instructional guides and messaging about the upcoming update prior to the update being implemented. The OMMU Communications Team also sends an email with links to the new instructional guides to targeted stakeholders prior to the update and another email on the day the update is implemented.

Call center team staff is also informed and trained on the new updates prior to the update release to better help stakeholders who have questions.

THE MEDICAL MARIJUANA USE REGISTRY

Below is a list of MMUR communication efforts conducted in 2022:

Updates to New Treatment Center Staffs' MMUR Accounts	
Audience	**Update Sent**
Treatment Centers	• 1/19/2022 • 1/25/2022 • 1/31/2022
35-Day Rolling Limit MMUR Update	
Audience	**Update Sent**
Physicians	• 1/21/2022 • 3/1/2022
Patients/Caregivers	• 1/21/2022 • 3/1/2022
Treatment Centers	• 1/21/2022 • 3/1/2022
Second Physician Concurrence Form MMUR Update	
Audience	**Update Sent**
Physicians	• 1/24/2022 • 2/1/2022 • 2/18/2022 • 3/1/2022
Consent for Minor Patients MMUR Update	
Audience	**Update Sent**
Physicians	• 7/12/2022 • 7/20/2022 • 7/26/2022
Caregiver Dispensation Logging	
Audience	**Update Sent**
Treatment Centers	• 7/12/2022 • 7/20/2022 • 7/26/2022
Daily Dose and Supply Limits	
Audience	**Update Sent**
Patients	• 8/26/2022
Physicians	• 8/26/2022
Treatment Centers	• 8/26/2022

BY THE NUMBERS – FLORIDA'S MEDICAL MARIJUANA PROGRAM

Florida's Medical Marijuana Use Program is one of the largest in the United States, and the program continues to grow at an accelerated rate. Below are program numbers from 2022 and a look at the growth of the program since 2017.

Application Numbers

Below is the 2022 month-by-month breakdown of the MMUR identification card applications that the OMMU received and approved. "FLHSMV Applications" are ones that used the Florida Department of Highway Safety and Motor Vehicles (FLHSMV) database integration to gather photo and proof of residency information. The chart below shows the total number of applications reviewed, approved, FLHSMV applications (number is out of applications approved) and the percentage of approved applications where the patient/caregiver used the FLHSMV integration.

Month	Applications Reviewed	*Applications Approved	**Number of FLHSMV Applications	Percentage of FLHSMV Applications Received
January	62,424	62,306	56,071	90.8%
February	64,201	63,815	57,971	90.3%
March	76,838	76,655	69,633	90.6%
April	69,741	69,510	63,040	90.4%
May	70,362	69,822	63,065	89.6%
June	71,460	71,304	65,439	91.6%
July	67,478	67,357	62,511	92.6%
August	72,947	72,448	67,168	92.1%
September	63,539	63,381	58,142	91.5%
October	68,479	68,103	63,327	92.4%
November	61,767	61,536	57,706	93.4%
December	61,838	61,418	57,925	93.7%
Total	**811,174**	**807,655**	**741,998**	**91.5%**

**Approved Applications for active patients.*

***Starting on January 25, 2021, the OMMU implemented an integration with the FLHSMV database and the MMUR that would allow patients to pull their proof of residency (POR) and photo for their MMUR identification card application. Using this trusted source of data helped decrease the approval time for MMUR identification cards applied for in this manner by 5 days.*

Qualified Physician Numbers

Florida physicians who want to become qualified to recommend medical marijuana to their patients must:

- Have an active, unrestricted license as an allopathic physician under Chapter 458, F.S., or as an osteopathic physician under Chapter 459, F.S.
- Complete the required course and examination provided by the Florida Medical Association and Florida Osteopathic Medical Association.
- Not be employed by or have any direct or indirect economic interest in a medical marijuana treatment center or marijuana testing laboratory.

Number of Qualified Physicians in the MMUR by Month for 2022

Month	Qualified Physicians
January	2,530
February	2,552
March	2,567
April	2,601
May	2,632
June	2,652
July	2,667
August	2,700
September	2,727
October	2,754
November	2,767
December	2,783

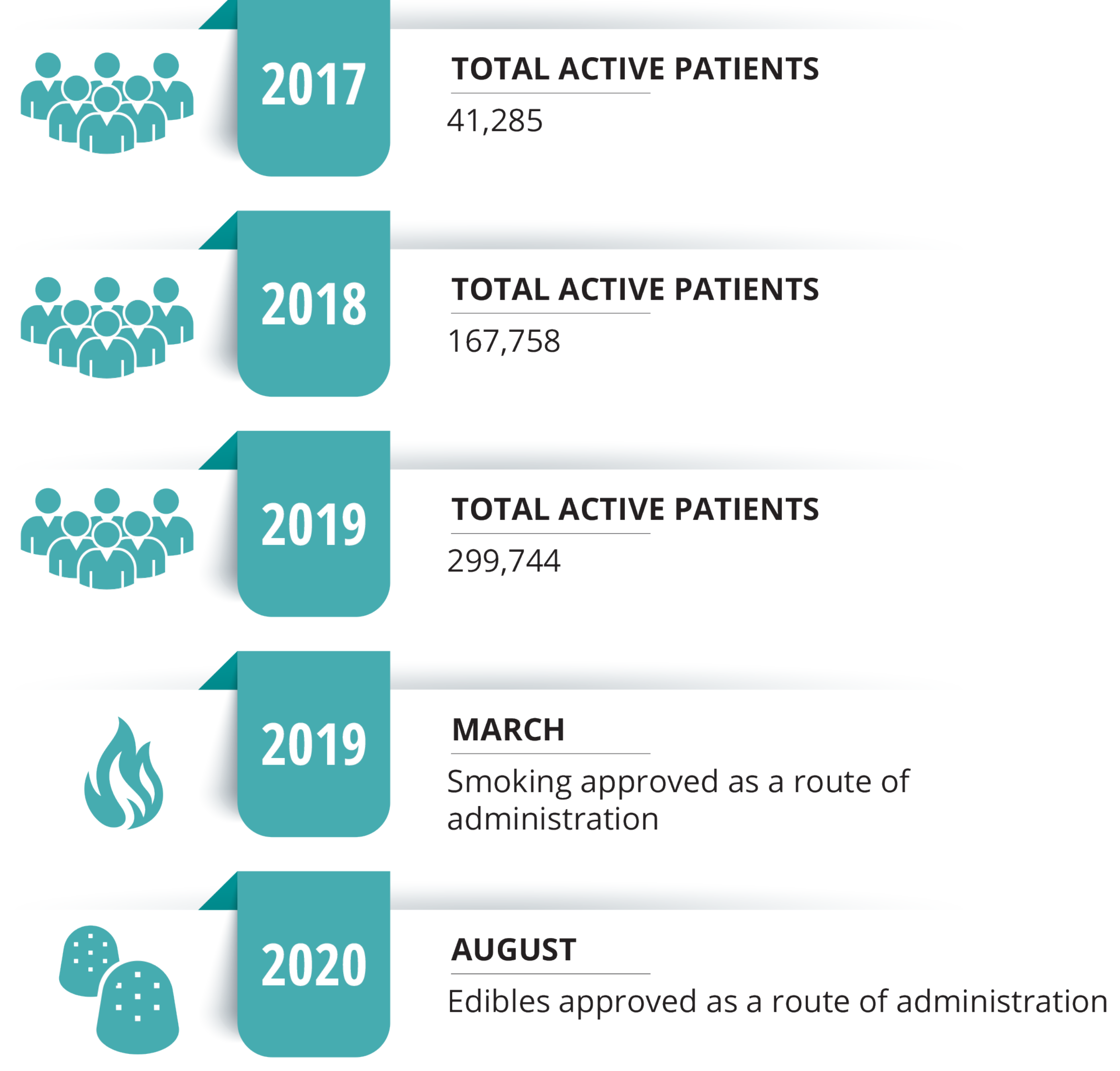
Medical Marijuana Treatment Centers

Licensed Treatment Centers are vertically integrated and are the only businesses in Florida authorized to dispense medical marijuana and low-THC cannabis to qualified patients and caregivers.

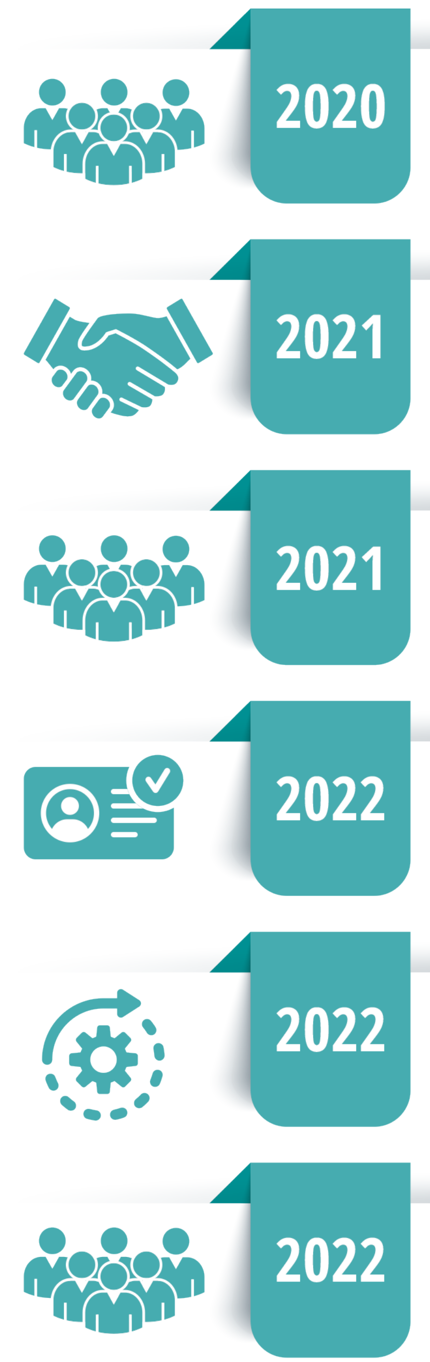
Each Treatment Center must receive authorization from the OMMU at three stages, (1) cultivation authorization, (2) processing authorization and (3) dispensing authorization prior to dispensing low-THC cannabis or medical marijuana.

At the end of 2022, Florida had **22** licensed Treatment Centers in Florida, with these businesses having a total of **509** dispensing locations statewide.

GROWTH OF



THE PROGRAM



2020

TOTAL ACTIVE PATIENTS

461,559

2021

JANUARY

Florida Department of Highway Safety and Motor Vehicle (FHSMV) database integration

2021

TOTAL ACTIVE PATIENTS

648,186

2022

JANUARY

Same day approval on MMUR identification cards that were created with the use of the FHSMV integration

2022

AUGUST

Implementation of Emergency Rule 64ER22-8, Dosing and Supply Limits for Medical Marijuana

2022

TOTAL ACTIVE PATIENTS

779,519

MARKETING PLAN

An integrated communications program will continue to be implemented to reach target audiences with OMMU's key messages. This plan will include using digital media, social media, earned media and education/outreach efforts.

Education/outreach efforts will include attending key events for organizations across the state, including non-profits, community groups, law enforcement, nursing homes/retirement communities, patient groups and physician organizations. These events may include training sessions, conferences, workshops, annual meetings, chapter meetings, etc. OMMU's goal is to participate in at least 26 outreach opportunities in 2023.

Additionally, the OMMU's education/outreach contact database will continue to be developed from contacted groups to create a network of partners that can be used each year to help spread OMMU's key messages.

Section 381.989(2)(c), F.S.
(c) The department may use television messaging, radio broadcasts, print media, digital strategies, social media, and any other form of messaging deemed necessary and appropriate by the department to implement the campaign. The department may work with school districts, community organizations, businesses and business organizations, and other entities to provide training and programming.

Section 381.989(2)(d), F.S.
(d) The department may contract with one or more vendors to implement the campaign.

Skin, Bones, Hearts & Private Parts - Orlando Conference

Family Medicine Winter Forum

Cannabis Clinical Outcomes Research

Florida Medical Cannabis Exhibit

YEAR SIX REPORTING

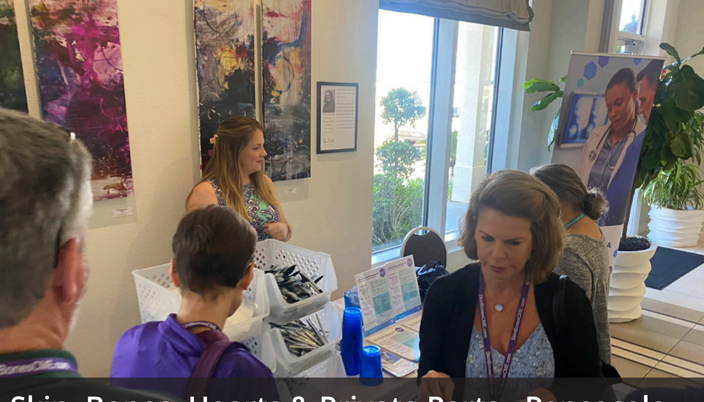
There is a continuous need for education on the proper procedures for obtaining a MMUR identification card, finding a qualified physician, understanding the qualifying medical conditions to obtain medical marijuana, as well as licit and safe use. The Department plans to continue to work with school districts, community organizations, business organizations, law enforcement, physician groups, disability non-profits, and other entities to provide education and training regarding Florida's Medical Marijuana Use Program.

Educational outreach for any future legislative decisions and changes to the current or future statutes will also be a key component moving forward as keeping our stakeholders informed is of the utmost importance.

Continuing the development of a partner network is an important undertaking for 2023. Partners, such as physician groups, retirement associations, community groups and targeted non-profits will be an important resource in spreading the messages of the OMMU and keeping key stakeholders informed.

The Department plans to use an integrated communications approach to maximize the efficiency of appropriated funds for 2023. Department staff will continue to monitor other states' medical marijuana programs and their campaigns to gauge their effectiveness and to determine if similar programs could be successful in Florida.

Florida Society of Ophthalmology



Skin, Bones, Hearts & Private Parts - Pensacola Conference

Florida International Medical Expo

Family Medicine Winter Forum

2023 ANNUAL REPORT

Office of Medical Marijuana Use
4052 Bald Cypress Way, Bin M-01
Tallahassee, FL 32399
Phone: 850-245-4657
Email: MedicalMarijuanaUse@FLHealth.gov
Website: www.KnowTheFactsMMJ.com

Florida's Official Source for Medical Use.

May 12, 2023

We are pleased to provide this weekly update on the Department of Health, Office of Medical Marijuana Use's (OMMU) diligent work implementing the many requirements in Amendment 2 and those set by the Florida Legislature in section 381.986, F.S. The Florida Department of Health (Department) continues to focus on the health and safety of Florida's families and is dedicated to ensuring patients have safe access to low-THC cannabis and medical marijuana.

Patients

Qualified Patients (Active ID Card): 816,944

Processing Time for Complete Application*: 5 business days
Processing Time for ID Card Printing: 5 business days

**Applications are not deemed to be complete until all required information is received and payment has successfully cleared.*

- Check your application status: https://MMURegistry.FLHealth.gov
- Questions about your application: Phone: 1-800-808-9580
- Consumer comments, and concerns: Email: MedicalMarijuanaUse@FLHealth.gov

Physicians

Qualified Physicians: 2,441

A physician must have an active, unrestricted license as a physician under Chapter 458, F.S., or osteopathic physician under Chapter 459, F.S., and complete a 2-hour course and exam before being qualified to order medical marijuana and low-THC cannabis for qualified patients.

Learn more here: https://KnowTheFactsMMJ.com/Physicians

- Find a qualified physician: https://KnowTheFactsMMJ.com/Physicians/List
- Verify your qualified physician: http://www.FLHealthSource.gov
- Health care complaint portal: https://www.FLHealthComplaint.gov

Weekly Highlights

The following dispensing locations were approved by the Department for the week of May 8 – 12, 2023*:

- The Flowery – Ocala

Medical Marijuana Treatment Centers

The department is charged with the licensing and regulation of medical marijuana treatment centers (MMTCs). MMTCs are vertically integrated businesses, and are the only businesses authorized to cultivate, process and dispense low-THC cannabis and medical marijuana.

MMTC Authorization

After initial licensure, each MMTC must receive authorization at three stages prior to dispensing low-THC cannabis or medical marijuana: (1) cultivation authorization, (2) processing authorization and (3) dispensing authorization.

Low-THC Cannabis & Medical Marijuana Dispensations

MMTCs dispense low-THC cannabis and medical marijuana to qualified patients and caregivers as recommended by their qualified ordering physician at approved dispensing locations and via delivery. Medical marijuana is dispensed in milligrams of active ingredient tetrahydrocannabinol (THC), and low-THC cannabis is dispensed in milligrams of active ingredient cannabidiol (CBD).

For MMTC contact information and dispensing location addresses, visit https://KnowTheFactsMMJ.com/MMTC.

MMTC Dispensations for May 5 – 11, 2023:

MMTC Name	Dispensing Locations	Medical Marijuana (mgs THC)	Low-THC Cannabis (mgs CBD)	Marijuana in a Form for Smoking (oz)
Trulieve	125	120,527,531	1,434,419	44,061.254
MüV	66	25,642,511	229,758	10,884.260
Ayr Cannabis Dispensary	60	40,170,095	0	7,628.135
Curaleaf	60	37,589,993	190,400	12,609.855
Surterra Wellness	45	28,321,494	1,340,596	4,382.328
Fluent	31	13,410,874	53,373	3,620.534
Sunnyside*	29	4,607,301	35,567	3,268.808
Green Dragon	28	3,948,959	3,897	956.626
VidaCann	27	4,608,095	122,405	1,533.751
GrowHealthy	18	6,052,133	31,003	3,984.631
Sanctuary Cannabis	18	2,834,860	19,371	2,314.653
Cannabist	14	3,137,835	18,630	1,418.122
Sunburn	10	3,868,681	2	1,251.359
GTI (Rise Dispensaries)	8	1,300,235	9,705	1,288.244
Insa – Cannabis for Real Life	8	991,627	0	817.163
Jungle Boys	7	1,624,499	0	2,929.797
The Flowery	5	3,200,983	2,294	1,237.127
House of Platinum Cannabis	4	522,210	1,568	195.101
Cookies Florida, Inc.	1	144,270	0	208.026
Gold Leaf	1	95,226	0	224.765
Planet 13 Florida, Inc.	0	0	0	0
Revolution Florida	0	0	0	0
Total	**565****	**302,599,412**	**3,492,988**	**104,814.539**

General Background Information

Medical Marijuana ID Card Application Process: Once a patient has been diagnosed by a qualified physician and entered into the Medical Marijuana Use Registry, they can immediately begin the identification card application process. The department encourages applicants to complete the process online for fastest service. Patients receive an email from the OMMU once their email address is added to the registry by their qualified physician, which directs them to the application. Once an application is approved, patients instantly receive an approval email which can be used to fill an order at an approved MMTC while the physical card is printed and mailed. Learn more here: https://KnowTheFactsMMJ.com/Patients/Cards.

Medical Marijuana Use Registry: All orders for medical marijuana are recorded and dispensed via the Medical Marijuana Use Registry. The Medical Marijuana Use Registry is accessible online, with real time information to ordering physicians, law enforcement and medical marijuana treatment center staff. Patients and caregivers may also access the Medical Marijuana Use Registry to submit a Medical Marijuana Use Registry Identification Card application, check the status of their application and review orders and dispensations. Learn more here: https://KnowTheFactsMMJ.com/Registry.

For more information visit www.KnowTheFactsMMJ.com.

**Any dispensing location approved after 12 00 p.m. ET on the date indicated at the top of this Weekly Update will be added to the following Weekly Update.*

***The total number of dispensing locations listed in the "MMTC Dispensations" table is current as of 12:00 p.m. ET on the date indicated at the top of this Weekly Update.*

Dave Kerner
Executive Director

2900 Apalachee Parkway
Tallahassee, Florida 32399-0500
www.flhsmv.gov

January 31, 2023

Honorable Ron DeSantis
Governor of Florida
PL5, The Capitol
400 South Monroe Street
Tallahassee, FL 32399

Honorable Kathleen Passidomo
Senate President
409 The Capitol
404 South Monroe Street
Tallahassee, FL 32399

Honorable Paul Renner
Speaker of the House
420 The Capitol
402 South Monroe Street
Tallahassee, FL 32399

Dear Governor, President and Speaker:

Pursuant to the provisions of section 381.989(3), Florida Statutes, the Department of Highway Safety and Motor Vehicles respectfully submits the enclosed summary report on the number of drug and alcohol related crashes and fatalities by year, age group and drug type.

Should you need additional assistance or have further questions, please do not hesitate to contact me at (850) 617-3100.

Respectfully,

Dave Kerner
Executive Director

Impaired Driving

January 31, 2023

Providing Highway Safety and Security through Excellence in Service, Education, and Enforcement

IMPAIRED DRIVING ANNUAL REPORT

January 31, 2023

EXECUTIVE SUMMARY

Note: For the purposes of this report, the Florida Department of Highway Safety and Motor Vehicles will be referred to as the department, or as FLHSMV.

Pursuant to section 381.989 of Florida Statutes, FLHSMV maintains statewide impaired driving education campaigns to raise awareness and prevent marijuana-related and cannabis-related impaired driving. Beginning in the year 2017, and annually thereafter, the statute requires the department to capture data on the number of marijuana-related citations, crashes and arrests, and to report this data on January 31st of each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

To assist in capturing the data on marijuana-related and other drug impairment crashes, the department implemented a supplement to Florida's Traffic Crash report. The supplement has been adopted by all law enforcement agencies in the state and captures seven drug types based on the National Highway Traffic Safety Administration's (NHTSA) recommendations for drug impairment. This supplement is required to be provided with all crash reports indicating a person was impaired by drugs at the time of the crash.

The department trains a number of Florida Highway Patrol Troopers as Drug Recognition Experts, also known as DREs. DREs are highly-trained law enforcement officers with expert knowledge in an extensive range of driver impairments and their associated signs and symptoms. DREs are dispatched to assist investigations and obtain convictions in cases involving impaired driving.

IMPAIRED DRIVING CAMPAIGNS

Each year, FLHSMV promotes public safety on Florida's roadways and educates residents and visitors to the state on the dangers of impaired driving through ongoing public awareness campaigns.

In March 2022, FLHSMV launched the annual "Never Drive Impaired" campaign, focusing on the message "Impairment is No Illusion" to drive home the point that impairment's consequences are real, and minimal amounts of alcohol or drugs can alter judgment and negatively affect cognitive abilities.

FLHSMV targeted motorists ages 18 to 39, and in March saw nearly 50,000 page views of its Impaired Driving web page, including an uptick in the age 24 to 35 demographic.

FLHSMV achieved nearly 37 million total impressions and over 2 million engagements through paid media such as Google, YouTube, Facebook, Instagram, Snapchat, Spotify, Pandora, and Gas Station TV, and through earned media across social media channels. The campaign-launch press release was viewed by over 11,000 individuals, leading to 24 broadcast TV and radio news segments and 16 online and print news stories. Total estimated reach of the 40 media pieces was 1.5 million. During Spring Break, over 49,000 clicks were made to FLHSMV's Spring Break campaign page.

March has one of the highest crash rates of the year and includes events such as St. Patrick's Day, Spring Break and Daytona Bike Week. The Florida Highway Patrol, or FHP, had a presence at Bike Week through FLHSMV's partnership with the Daytona International Speedway. This partnership and presence at Bike Week helped expand FLHSMV's footprint in an additional annual event with a large target audience.

FLHSMV developed messaging and graphics and provided marketing materials to FHP Public Affairs Officers, public safety partners, and other stakeholders throughout the state. FHP participated in 49 events during March, in direct correlation to the "Never Drive Impaired" campaign.

The "Never Drive Impaired" message continued throughout the 2022 calendar year, including the two-month "Safe Summer Travel" campaign, and during six holiday weeks in November and December, when FLHSMV launched its "Safe Holiday Travel" campaign, focusing on the message "Safety is Always in Season."

FLORIDA HIGHWAY PATROL DRUG RECOGNITION EXPERT PROGRAM

A Drug Recognition Expert, also known as a DRE, is an officer who has received specialized training and has been certified by the International Association of Chiefs of Police to evaluate suspects and determine if a subject is impaired, what drug categories are causing the impairment, and if a medical condition is causing the impairment.

Because of the complexity and technical aspects of the DRE training, not all law enforcement officers may be suited for the training. In Florida, an officer must have at least three years of law enforcement experience, must have completed the 24-hour National Highway Traffic Safety Administration Standardized Field Sobriety Testing course, as well as the 16-hour Advanced Roadside Impaired Driving Enforcement course. An application must be completed which includes proof of completion of the two prerequisite courses mentioned above, the endorsement of their local Assistant State Attorney, a recommendation of two other DREs, a recommendation from their department chief or designee, and copies of two DUI case reports the applicant has completed within the last year. This application is reviewed by the State DRE Coordinator at the Institute of Police Technology and Management.

In order to maintain certification, DREs must conduct a minimum of four evaluations within the two years, submit a rolling log and current resume, and attend eight hours of recertification training.

FHP currently has 55 Certified Drug Recognition Experts. Twelve of the 55 certified are DRE Instructors, three of which have been to the DRE Course Manager's Training. FHP provides a pay additive to those members who achieve and maintain their certification. The International Association of Chiefs of Police reported a total of 369 certified DRE officers in Florida as of January 1, 2023.

FHP is committed to the success of the program and recognizes the need for more certified officers, as well as the benefits of the highly-trained Troopers. We are scheduling Standardized Field Sobriety Testing and Advanced Roadside Impaired Driving Enforcement courses for our members to prepare them for D R E Training, as well as to provide our Troopers with the skills to more effectively combat Impaired Driving. The locations and number of DREs are listed in the following table:

Current Locations and Numbers of DREs	
Troop A	7 Active
Troop B	8 Active
Troop C	9 Active
Troop D	8 Active
Troop E	1 Active
Troop F	4 Active
Troop G	4 Active
Troop H	2 Active
Troop K	2 Active
Troop L	3 Active
Troop Q	7 Active

CRASH REPORTING DATA AND BASELINE INFORMATION

In accordance with section 381.989 of Florida Statutes, the department established baseline data and provides reports annually on the number of marijuana-related traffic crashes occurring in the state.

The table below depicts general impaired driving crash information as reported by the department in the Traffic Crash Facts Annual Reports.

Drug & Alcohol Confirmed Crashes and Fatalities by Year						
Year	Alcohol Confirmed Crashes	Alcohol Confirmed Fatalities	Drug Confirmed Crashes	Drug Confirmed Fatalities	Drug and Alcohol Confirmed Crashes	Drug and Alcohol Confirmed Fatalities
2017	5,125	374	668	338	355	274
2018	5,106	372	673	348	386	300
2019	4,984	378	730	381	420	342
2020	4,554	384	708	384	380	328
2021	5,111	407	747	420	414	383
TOTAL	**24,880**	**1,915**	**3,526**	**1,871**	**1,955**	**1,627**

The information in the following tables depicts data submitted to the department as of January 4, 2023, from the crash report supplements, but is considered preliminary and may change as updates become available.

The chart below depicts the number of times a type of drug was reported in a crash during the respective year. Please note that one crash can have multiple drugs reported. Please also note that more than one driver or non-motorist involved in a single crash may be tested for drugs. For example, if a crash involves two or more vehicles, all the drivers may be tested for drugs.

Prevalence of Drugs by Type by Year

Drugs Found	2018	2019	2020	2021	2022	Grand Total
Amphetamine	189	231	243	246	125	1,034
Cocaine	209	203	189	187	113	901
Marijuana	497	537	572	582	301	2,489
Opiate	155	172	149	147	70	693
Other Controlled Substance	508	509	413	452	213	2,095
Other Drug (excludes post-crash drugs)	93	151	158	143	65	610
PCP	0	2	0	1	1	4
Unknown	11	11	9	5	4	40
Grand Total	**1,662**	**1,816**	**1,733**	**1,763**	**892**	**7,866**

Of the drug types reported, Marijuana was the most prevalent category, followed by Other Controlled Substance, Amphetamine, Cocaine and Opiate.

Individuals aged 25-29 were the most reported age group in crashes with 725 drug-related crashes and 1,239 positive drug test results reported to the department. The most prevalent drug in this age group was Marijuana followed by Other Controlled Substance.

Marijuana is the most prevalent drug in teenagers and young adults, ages 10 through 24, involved in crashes. Marijuana prevalence begins to decrease at 25 years of age and older.

The Other Controlled Substance drug type includes prescription drugs such as benzodiazepines. The Other Drug type includes non-prescription drugs such as allergy medication or those without a specific category for the test result. Unknown is reported when the test produces an unknown result.

The table below depicts the prevalence of drugs by type and age group of persons involved in drug-related crashes.

Prevalence of Drug Types by Age Range, 2018-2022									
Age Range	Amphetamine	Cocaine	Marijuana	Opiate	Other Controlled Substance	Other Drug (excludes post-crash drugs)	PCP	Unknown	Grand Total
No age provided	2	2	0	0	1	3	0	0	8
10-14	1	0	3	0	0	0	0	0	4
15-19	18	23	199	15	53	11	0	3	322
20-24	89	95	476	41	185	38	1	4	929
25-29	155	133	463	87	321	73	0	7	1,239
30-34	164	136	349	113	256	91	1	4	1,114
35-39	175	107	260	99	297	81	0	6	1,025
40-44	134	86	197	57	211	50	0	2	737
45-49	95	87	140	58	164	52	1	2	599
50-54	91	84	115	63	174	52	0	3	582
55-59	49	67	124	60	170	53	0	3	526
60-64	32	52	77	37	112	43	0	2	355
65-69	16	14	50	39	78	27	0	1	225
70-74	6	12	30	10	37	19	0	1	115
75-79	4	2	5	5	23	8	0	0	47
80-84	2	1	0	5	9	2	1	1	21
85-89	1	0	1	3	4	6	0	1	16
90-94	0	0	0	0	0	1	0	0	1
95-99	0	0	0	1	0	0	0	0	1
Grand Total	1,034	901	2,489	693	2,095	610	4	40	7,866

The following table depicts the types of drugs and the total crashes in which that drug was reported. As there can be up to four drug results reported in drivers and non-motorists involved in a crash, a single crash may be counted in more than one drug type. For example, this table shows 518 crashes in 2019 in which Marijuana was reported. However, the Prevalence of Drugs by Type by Year table on page 5 shows Marijuana was reported 537 times, meaning more than one person in a single crash tested positive for Marijuana.

Prevalence of Drugs in Crashes

Drugs Found	2018	2019	2020	2021	2022	Grand Total
Amphetamine	186	227	222	121	125	881
Cocaine	209	202	181	104	112	808
Marijuana	486	518	529	332	283	2148
Opiate	149	166	134	76	66	591
Other Controlled Substance	393	393	339	203	180	1508
Other Drug (excludes post-crash drugs)	81	131	135	62	61	470
PCP	0	2	0	1	1	4
Unknown	11	11	8	5	4	39
Grand Total	**1,515**	**1,650**	**1,548**	**904**	**832**	**6,449**

The following table depicts the types of drugs involved in traffic crash fatalities or traffic crash injuries.
As there can be up to four drug results reported in drivers and non-motorists involved in a crash, a single fatality may be counted in more than one drug type.

Fatalities & Injuries by Year by Drug Type										
	2018		2019		2020		2021		2022	
Drugs Found	Fatalities	Injuries	Fatalities	Injuries	Fatalities	Injuries	Fatalities	Injuries	Fatalities	Injuries
Amphetamine	110	143	138	190	152	183	144	160	79	98
Cocaine	127	138	130	166	126	115	123	115	69	69
Marijuana	371	481	401	486	444	484	451	451	236	259
Opiate	59	145	79	149	55	148	75	109	44	45
Other Controlled Substance	253	420	231	415	199	312	205	288	110	152
Other Drug (excludes post-crash drugs)	65	44	105	116	117	92	97	99	41	43
PCP	0	0	0	3	0	0	0	1	1	0
Unknown	3	12	4	10	4	7	2	10	0	2

The following table depicts, by county and year of crash, the types of drugs and the total crashes where that drug was reported. As there can be up to four drug results reported in driver(s) and/or non-motorist(s) involved in a crash, a single crash may be counted in more than one drug type.

Fatalities and Injuries by County, by Drug Type, by Year

County Name	Drugs Found	2018	2019	2020	2021	2022
ALACHUA	Amphetamine	1	4	3	4	2
	Cocaine	3	3	6	5	5
	Marijuana	13	11	14	19	8
	Opiate	1	1	4	2	1
	Other Controlled Substance	3	8	10	11	7
	Other Drug (excludes post-crash drugs)	3	3	4	4	3
	PCP	0	0	0	0	0
	Unknown	0	1	1	1	0
BAKER	Amphetamine	0	2	0	1	0
	Cocaine	0	1	0	1	0
	Marijuana	2	4	1	1	0
	Opiate	0	0	0	0	1
	Other Controlled Substance	1	3	1	0	0
	Other Drug (excludes post-crash drugs)	0	1	0	1	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
BAY	Amphetamine	4	6	5	7	2
	Cocaine	2	1	0	1	1
	Marijuana	6	9	7	5	3
	Opiate	2	2	3	2	1
	Other Controlled Substance	4	4	6	3	1
	Other Drug (excludes post-crash drugs)	2	4	0	1	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
BRADFORD	Amphetamine	0	1	2	1	1
	Cocaine	1	1	2	1	1
	Marijuana	0	2	1	1	0
	Opiate	0	0	1	1	1
	Other Controlled Substance	2	2	1	1	2
	Other Drug (excludes post-crash drugs)	1	1	1	1	1
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
BREVARD	Amphetamine	8	9	4	4	2
	Cocaine	6	6	8	7	2
	Marijuana	15	8	13	6	6
	Opiate	7	10	4	5	2
	Other Controlled Substance	12	11	7	9	6
	Other Drug (excludes post-crash drugs)	1	5	4	2	1
	PCP	0	0	0	0	0
	Unknown	1	0	0	0	0

Fatalities and Injuries by County, by Drug Type, by Year

County Name	Drugs Found	2018	2019	2020	2021	2022
BROWARD	Amphetamine	3	4	7	1	1
	Cocaine	9	9	12	7	3
	Marijuana	15	12	13	21	3
	Opiate	5	2	3	3	1
	Other Controlled Substance	3	8	8	13	2
	Other Drug (excludes post-crash drugs)	1	4	5	2	1
	PCP	0	0	0	0	0
	Unknown	3	2	0	1	0
CALHOUN	Amphetamine	2	0	0	0	0
	Cocaine	0	0	0	0	0
	Marijuana	2	2	0	0	0
	Opiate	0	0	0	0	0
	Other Controlled Substance	1	0	0	1	0
	Other Drug (excludes post-crash drugs)	2	0	0	0	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
CHARLOTTE	Amphetamine	2	3	0	5	1
	Cocaine	2	0	0	2	0
	Marijuana	7	4	5	7	5
	Opiate	1	2	1	0	3
	Other Controlled Substance	4	2	1	7	1
	Other Drug (excludes post-crash drugs)	1	1	0	2	1
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
CITRUS	Amphetamine	3	4	6	0	1
	Cocaine	0	1	1	1	0
	Marijuana	7	4	16	11	2
	Opiate	1	2	2	2	0
	Other Controlled Substance	4	5	8	1	1
	Other Drug (excludes post-crash drugs)	1	1	1	2	1
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
CLAY	Amphetamine	3	1	2	4	0
	Cocaine	2	1	4	1	1
	Marijuana	8	6	9	7	3
	Opiate	5	0	3	0	0
	Other Controlled Substance	2	2	5	4	1
	Other Drug (excludes post-crash drugs)	1	4	1	3	0
	PCP	0	0	0	0	0
	Unknown	1	0	0	0	0
COLLIER	Amphetamine	1	2	0	4	2
	Cocaine	5	3	6	5	1
	Marijuana	5	4	7	14	5
	Opiate	2	0	2	6	2
	Other Controlled Substance	3	5	5	6	2
	Other Drug (excludes post-crash drugs)	0	3	3	1	3
	PCP	0	0	0	0	0
	Unknown	0	1	0	0	0

Fatalities and Injuries by County, by Drug Type, by Year						
County Name	**Drugs Found**	**2018**	**2019**	**2020**	**2021**	**2022**
COLUMBIA	Amphetamine	3	6	5	7	3
	Cocaine	3	3	2	5	0
	Marijuana	16	13	8	8	4
	Opiate	3	0	2	4	2
	Other Controlled Substance	10	11	6	8	4
	Other Drug (excludes post-crash drugs)	3	0	1	2	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
DESOTO	Amphetamine	1	0	1	0	2
	Cocaine	4	0	0	0	1
	Marijuana	4	0	0	1	3
	Opiate	0	0	0	0	0
	Other Controlled Substance	3	0	0	2	1
	Other Drug (excludes post-crash drugs)	0	0	0	0	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
DIXIE	Amphetamine	1	1	1	2	0
	Cocaine	0	0	0	0	0
	Marijuana	0	0	1	3	0
	Opiate	0	0	0	0	0
	Other Controlled Substance	1	1	0	1	0
	Other Drug (excludes post-crash drugs)	0	1	0	1	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
DUVAL	Amphetamine	12	18	13	18	9
	Cocaine	18	15	11	22	11
	Marijuana	42	54	48	50	35
	Opiate	8	12	3	10	6
	Other Controlled Substance	29	25	20	23	12
	Other Drug (excludes post-crash drugs)	11	10	12	21	8
	PCP	0	0	0	0	1
	Unknown	0	0	2	1	0
ESCAMBIA	Amphetamine	4	4	8	7	3
	Cocaine	7	3	3	4	2
	Marijuana	9	4	4	11	3
	Opiate	2	2	3	1	0
	Other Controlled Substance	4	7	6	7	3
	Other Drug (excludes post-crash drugs)	2	2	1	3	1
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
FLAGLER	Amphetamine	1	0	2	4	1
	Cocaine	0	0	4	2	0
	Marijuana	1	1	2	8	3
	Opiate	0	0	0	5	1
	Other Controlled Substance	2	0	4	7	0
	Other Drug (excludes post-crash drugs)	0	0	2	2	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0

Fatalities and Injuries by County, by Drug Type, by Year

County Name	Drugs Found	2018	2019	2020	2021	2022
FRANKLIN	Amphetamine	0	0	1	0	0
	Cocaine	1	1	0	0	0
	Marijuana	1	1	2	0	1
	Opiate	0	0	0	1	0
	Other Controlled Substance	1	0	1	1	1
	Other Drug (excludes post-crash drugs)	1	1	0	0	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
GADSDEN	Amphetamine	2	1	2	1	0
	Cocaine	0	2	1	0	2
	Marijuana	2	2	4	5	0
	Opiate	0	1	0	0	1
	Other Controlled Substance	0	1	4	1	2
	Other Drug (excludes post-crash drugs)	0	2	0	0	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
GILCHRIST	Amphetamine	0	1	1	1	0
	Cocaine	0	1	0	0	0
	Marijuana	1	5	2	0	1
	Opiate	0	0	0	0	0
	Other Controlled Substance	1	1	1	0	0
	Other Drug (excludes post-crash drugs)	1	1	2	0	2
	PCP	0	0	0	0	0
	Unknown	1	0	0	0	0
GLADES	Amphetamine	1	0	1	2	0
	Cocaine	0	0	1	0	0
	Marijuana	4	0	2	0	2
	Opiate	0	0	1	0	0
	Other Controlled Substance	1	1	2	1	0
	Other Drug (excludes post-crash drugs)	0	0	0	1	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
GULF	Amphetamine	0	0	0	0	0
	Cocaine	0	0	0	0	0
	Marijuana	0	0	0	0	0
	Opiate	0	0	0	0	0
	Other Controlled Substance	0	0	0	0	0
	Other Drug (excludes post-crash drugs)	0	0	0	0	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
HAMILTON	Amphetamine	0	1	2	0	0
	Cocaine	0	0	0	0	1
	Marijuana	1	1	5	1	2
	Opiate	1	0	0	0	0
	Other Controlled Substance	1	3	2	0	0
	Other Drug (excludes post-crash drugs)	1	0	0	1	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0

Fatalities and Injuries by County, by Drug Type, by Year						
County Name	**Drugs Found**	**2018**	**2019**	**2020**	**2021**	**2022**
HARDEE	Amphetamine	0	2	2	0	1
	Cocaine	0	1	1	0	0
	Marijuana	1	1	1	3	0
	Opiate	0	0	1	0	0
	Other Controlled Substance	1	2	1	2	1
	Other Drug (excludes post-crash drugs)	0	1	2	2	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
HENDRY	Amphetamine	1	0	0	1	1
	Cocaine	1	1	0	0	1
	Marijuana	2	2	1	4	1
	Opiate	0	0	0	0	1
	Other Controlled Substance	4	1	0	1	2
	Other Drug (excludes post-crash drugs)	2	1	0	0	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
HERNANDO	Amphetamine	3	1	8	0	2
	Cocaine	0	1	2	0	1
	Marijuana	5	7	20	5	6
	Opiate	0	3	2	1	1
	Other Controlled Substance	5	4	8	1	2
	Other Drug (excludes post-crash drugs)	0	1	4	1	1
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
HIGHLANDS	Amphetamine	1	2	6	3	1
	Cocaine	1	3	2	1	0
	Marijuana	0	4	6	5	2
	Opiate	1	0	0	1	0
	Other Controlled Substance	1	4	2	4	1
	Other Drug (excludes post-crash drugs)	2	2	7	4	1
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
HILLSBOROUGH	Amphetamine	24	10	15	14	6
	Cocaine	18	15	9	6	8
	Marijuana	32	33	33	41	18
	Opiate	12	16	10	12	3
	Other Controlled Substance	49	32	27	23	14
	Other Drug (excludes post-crash drugs)	2	8	11	9	0
	PCP	0	0	0	0	0
	Unknown	1	0	0	0	0
HOLMES	Amphetamine	0	0	2	1	0
	Cocaine	0	0	0	2	0
	Marijuana	2	1	2	1	1
	Opiate	1	0	0	0	0
	Other Controlled Substance	2	0	1	2	0
	Other Drug (excludes post-crash drugs)	0	0	0	0	0
	PCP	0	0	0	0	0
	Unknown	1	0	0	0	0

Fatalities and Injuries by County, by Drug Type, by Year						
County Name	**Drugs Found**	**2018**	**2019**	**2020**	**2021**	**2022**
INDIAN RIVER	Amphetamine	1	0	1	1	1
	Cocaine	1	1	0	2	1
	Marijuana	6	6	2	2	3
	Opiate	1	1	0	2	0
	Other Controlled Substance	4	3	1	2	1
	Other Drug (excludes post-crash drugs)	2	1	2	1	2
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
JACKSON	Amphetamine	3	2	1	1	0
	Cocaine	0	0	0	0	0
	Marijuana	1	3	2	2	0
	Opiate	0	3	1	0	0
	Other Controlled Substance	3	2	0	2	0
	Other Drug (excludes post-crash drugs)	0	3	0	0	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
JEFFERSON	Amphetamine	0	0	1	0	0
	Cocaine	0	0	1	0	0
	Marijuana	0	1	1	2	0
	Opiate	0	0	0	0	0
	Other Controlled Substance	0	0	1	0	0
	Other Drug (excludes post-crash drugs)	0	0	0	0	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
LAFAYETTE	Amphetamine	0	0	0	0	0
	Cocaine	0	0	0	0	0
	Marijuana	0	0	0	1	0
	Opiate	0	0	0	0	0
	Other Controlled Substance	0	0	1	0	0
	Other Drug (excludes post-crash drugs)	0	0	0	0	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
LAKE	Amphetamine	3	7	6	4	1
	Cocaine	2	5	1	2	0
	Marijuana	11	18	6	9	2
	Opiate	1	5	1	0	1
	Other Controlled Substance	4	9	4	4	0
	Other Drug (excludes post-crash drugs)	2	2	2	1	1
	PCP	0	0	0	0	0
	Unknown	0	0	1	0	0
LEE	Amphetamine	2	6	6	8	3
	Cocaine	13	8	11	3	4
	Marijuana	15	25	28	28	19
	Opiate	9	6	7	7	1
	Other Controlled Substance	13	13	21	10	8
	Other Drug (excludes post-crash drugs)	5	3	8	1	1
	PCP	0	0	0	0	0
	Unknown	0	1	2	0	2

Fatalities and Injuries by County, by Drug Type, by Year

County Name	Drugs Found	2018	2019	2020	2021	2022
LEON	Amphetamine	5	5	4	2	2
	Cocaine	4	5	3	2	1
	Marijuana	5	7	7	12	4
	Opiate	2	3	2	0	3
	Other Controlled Substance	4	4	4	3	2
	Other Drug (excludes post-crash drugs)	0	2	0	0	1
	PCP	0	1	0	0	0
	Unknown	0	0	0	0	0
LEVY	Amphetamine	2	3	0	3	0
	Cocaine	0	1	1	3	1
	Marijuana	3	6	6	6	1
	Opiate	0	1	1	0	0
	Other Controlled Substance	2	4	3	4	0
	Other Drug (excludes post-crash drugs)	0	1	3	1	0
	PCP	0	0	0	0	0
	Unknown	1	0	0	0	0
LIBERTY	Amphetamine	0	0	0	0	0
	Cocaine	2	0	0	0	0
	Marijuana	2	0	0	0	0
	Opiate	0	0	0	0	0
	Other Controlled Substance	1	0	0	0	0
	Other Drug (excludes post-crash drugs)	1	0	0	0	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
MADISON	Amphetamine	2	3	0	0	1
	Cocaine	0	1	0	0	0
	Marijuana	1	3	0	0	0
	Opiate	0	1	0	0	2
	Other Controlled Substance	1	2	0	0	2
	Other Drug (excludes post-crash drugs)	0	0	0	0	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
MANATEE	Amphetamine	7	5	4	6	1
	Cocaine	6	7	4	4	1
	Marijuana	12	10	11	15	7
	Opiate	2	6	1	4	0
	Other Controlled Substance	15	9	8	13	2
	Other Drug (excludes post-crash drugs)	1	4	3	4	4
	PCP	0	0	0	1	0
	Unknown	0	0	0	0	0
MARION	Amphetamine	7	20	8	11	7
	Cocaine	11	9	8	6	3
	Marijuana	36	28	35	30	16
	Opiate	8	11	12	5	4
	Other Controlled Substance	19	15	12	12	9
	Other Drug (excludes post-crash drugs)	3	11	5	2	2
	PCP	0	0	0	0	0
	Unknown	1	1	0	0	0

Fatalities and Injuries by County, by Drug Type, by Year

County Name	Drugs Found	2018	2019	2020	2021	2022
MARTIN	Amphetamine	0	1	1	1	1
	Cocaine	1	0	1	1	1
	Marijuana	7	8	2	3	3
	Opiate	3	1	2	1	0
	Other Controlled Substance	8	4	6	2	1
	Other Drug (excludes post-crash drugs)	1	3	1	1	1
	PCP	0	0	0	0	0
	Unknown	0	1	0	0	0
MIAMI-DADE	Amphetamine	5	2	2	0	2
	Cocaine	10	5	7	10	6
	Marijuana	20	6	15	15	9
	Opiate	0	0	1	3	0
	Other Controlled Substance	15	7	5	5	9
	Other Drug (excludes post-crash drugs)	2	6	4	4	3
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
MONROE	Amphetamine	1	0	0	1	1
	Cocaine	0	1	1	0	0
	Marijuana	0	1	2	0	1
	Opiate	0	0	1	0	0
	Other Controlled Substance	0	3	3	2	1
	Other Drug (excludes post-crash drugs)	1	0	1	1	0
	PCP	0	0	0	0	0
	Unknown	0	0	1	0	0
NASSAU	Amphetamine	3	2	2	2	0
	Cocaine	1	3	0	0	0
	Marijuana	4	5	4	4	1
	Opiate	3	1	0	0	0
	Other Controlled Substance	7	7	3	3	1
	Other Drug (excludes post-crash drugs)	1	2	1	0	3
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
OKALOOSA	Amphetamine	2	0	1	6	1
	Cocaine	1	1	4	1	1
	Marijuana	2	0	1	4	1
	Opiate	0	0	1	2	0
	Other Controlled Substance	6	1	2	7	3
	Other Drug (excludes post-crash drugs)	2	0	0	2	0
	PCP	0	0	0	0	0
	Unknown	0	1	0	0	0
OKEECHOBEE	Amphetamine	0	1	1	0	0
	Cocaine	0	3	0	1	0
	Marijuana	2	3	4	2	0
	Opiate	1	1	0	0	1
	Other Controlled Substance	2	3	3	2	2
	Other Drug (excludes post-crash drugs)	0	0	1	2	1
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0

Fatalities and Injuries by County, by Drug Type, by Year						
County Name	**Drugs Found**	**2018**	**2019**	**2020**	**2021**	**2022**
ORANGE	Amphetamine	9	5	11	12	4
	Cocaine	18	19	18	21	12
	Marijuana	19	18	14	17	4
	Opiate	4	9	3	3	2
	Other Controlled Substance	23	20	15	22	5
	Other Drug (excludes post-crash drugs)	3	2	7	7	1
	PCP	0	0	0	0	0
	Unknown	0	1	0	2	0
OSCEOLA	Amphetamine	0	2	2	2	3
	Cocaine	2	2	5	4	1
	Marijuana	3	3	7	7	1
	Opiate	0	1	3	2	2
	Other Controlled Substance	7	7	4	4	1
	Other Drug (excludes post-crash drugs)	0	2	2	2	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
PALM BEACH	Amphetamine	4	4	5	3	5
	Cocaine	7	9	7	11	4
	Marijuana	21	16	13	24	6
	Opiate	13	13	16	7	3
	Other Controlled Substance	17	22	24	21	8
	Other Drug (excludes post-crash drugs)	2	1	7	5	3
	PCP	0	0	0	0	0
	Unknown	0	0	1	0	2
PASCO	Amphetamine	13	15	29	21	5
	Cocaine	13	11	5	5	6
	Marijuana	26	23	36	22	11
	Opiate	16	10	12	10	3
	Other Controlled Substance	29	40	25	25	9
	Other Drug (excludes post-crash drugs)	4	7	9	2	1
	PCP	0	0	0	0	0
	Unknown	0	1	0	0	0
PINELLAS	Amphetamine	6	16	16	29	18
	Cocaine	8	10	8	21	16
	Marijuana	25	31	27	47	20
	Opiate	13	19	17	23	6
	Other Controlled Substance	20	24	32	52	14
	Other Drug (excludes post-crash drugs)	1	5	3	5	3
	PCP	0	0	0	0	0
	Unknown	1	1	0	0	0
POLK	Amphetamine	1	5	8	13	1
	Cocaine	1	5	3	5	1
	Marijuana	2	7	24	16	4
	Opiate	2	0	2	2	0
	Other Controlled Substance	3	3	7	6	0
	Other Drug (excludes post-crash drugs)	3	0	7	7	1
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0

Fatalities and Injuries by County, by Drug Type, by Year						
County Name	**Drugs Found**	**2018**	**2019**	**2020**	**2021**	**2022**
PUTNAM	Amphetamine	4	4	2	2	6
	Cocaine	6	6	4	0	3
	Marijuana	5	11	12	4	5
	Opiate	2	3	1	0	2
	Other Controlled Substance	3	4	6	3	2
	Other Drug (excludes post-crash drugs)	1	2	1	0	2
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
SANTA ROSA	Amphetamine	6	6	2	1	3
	Cocaine	1	2	0	1	1
	Marijuana	6	7	2	7	3
	Opiate	2	2	0	0	0
	Other Controlled Substance	6	6	2	3	2
	Other Drug (excludes post-crash drugs)	1	1	2	1	0
	PCP	0	1	0	0	0
	Unknown	0	0	0	0	0
SARASOTA	Amphetamine	4	0	2	3	2
	Cocaine	6	1	1	1	2
	Marijuana	9	6	2	6	7
	Opiate	4	1	1	2	1
	Other Controlled Substance	5	1	2	3	3
	Other Drug (excludes post-crash drugs)	2	2	1	1	1
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
SEMINOLE	Amphetamine	2	1	1	3	1
	Cocaine	2	2	3	1	0
	Marijuana	4	11	5	4	4
	Opiate	1	3	0	1	1
	Other Controlled Substance	1	5	1	0	3
	Other Drug (excludes post-crash drugs)	0	1	0	1	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
ST. JOHNS	Amphetamine	1	1	1	5	4
	Cocaine	1	2	4	3	2
	Marijuana	4	8	8	10	8
	Opiate	1	2	3	0	2
	Other Controlled Substance	2	2	0	6	6
	Other Drug (excludes post-crash drugs)	0	2	1	2	1
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
ST. LUCIE	Amphetamine	1	1	2	0	1
	Cocaine	0	0	2	2	0
	Marijuana	2	4	6	8	4
	Opiate	0	1	0	1	0
	Other Controlled Substance	1	2	4	4	3
	Other Drug (excludes post-crash drugs)	0	3	0	1	1
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0

Fatalities and Injuries by County, by Drug Type, by Year						
County Name	**Drugs Found**	**2018**	**2019**	**2020**	**2021**	**2022**
SUMTER	Amphetamine	2	5	1	0	0
	Cocaine	2	0	1	0	0
	Marijuana	4	5	8	4	2
	Opiate	2	2	0	0	0
	Other Controlled Substance	2	3	3	3	1
	Other Drug (excludes post-crash drugs)	1	1	0	1	1
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
SUWANNEE	Amphetamine	2	6	4	3	1
	Cocaine	1	2	3	0	0
	Marijuana	6	4	9	3	1
	Opiate	2	0	2	6	2
	Other Controlled Substance	1	2	0	2	1
	Other Drug (excludes post-crash drugs)	1	1	0	1	1
	PCP	0	0	0	0	0
	Unknown	0	0	1	0	0
TAYLOR	Amphetamine	3	2	2	1	1
	Cocaine	1	2	1	0	1
	Marijuana	1	3	4	1	1
	Opiate	1	1	0	0	0
	Other Controlled Substance	3	4	2	2	4
	Other Drug (excludes post-crash drugs)	0	0	0	2	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
UNION	Amphetamine	0	0	0	0	1
	Cocaine	0	0	0	1	0
	Marijuana	1	1	0	2	1
	Opiate	0	1	0	2	0
	Other Controlled Substance	1	0	0	0	1
	Other Drug (excludes post-crash drugs)	0	0	0	0	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
VOLUSIA	Amphetamine	3	6	7	3	6
	Cocaine	4	7	5	2	2
	Marijuana	14	22	19	17	13
	Opiate	4	4	5	4	2
	Other Controlled Substance	7	11	7	8	9
	Other Drug (excludes post-crash drugs)	2	2	4	0	1
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
WAKULLA	Amphetamine	0	3	1	4	1
	Cocaine	1	0	0	1	0
	Marijuana	3	5	2	2	1
	Opiate	0	0	0	0	0
	Other Controlled Substance	2	4	0	1	0
	Other Drug (excludes post-crash drugs)	1	0	0	0	1
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0

Fatalities and Injuries by County, by Drug Type, by Year						
County Name	Drugs Found	2018	2019	2020	2021	2022
WALTON	Amphetamine	0	1	2	2	0
	Cocaine	0	0	0	0	0
	Marijuana	1	4	2	1	2
	Opiate	0	0	1	0	0
	Other Controlled Substance	1	1	0	1	0
	Other Drug (excludes post-crash drugs)	0	3	2	0	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0
WASHINGTON	Amphetamine	1	4	2	0	0
	Cocaine	0	0	1	0	1
	Marijuana	0	4	1	0	1
	Opiate	0	1	0	0	1
	Other Controlled Substance	1	3	2	0	1
	Other Drug (excludes post-crash drugs)	0	1	0	0	0
	PCP	0	0	0	0	0
	Unknown	0	0	0	0	0

Tab 5

Reports

State Medical Cannabis Laws

Updated June 22, 2023

Medical-Use Update

As of Apr. 24, 2023, 38 states, three territories and the District of Columbia allow the medical use of cannabis products. See Table 1 below for additional information.

Non-Medical/Adult-Use Update

As of June 1, 2023, 23 states, two territories and the District of Columbia have enacted measures to regulate cannabis for adult non medical use.

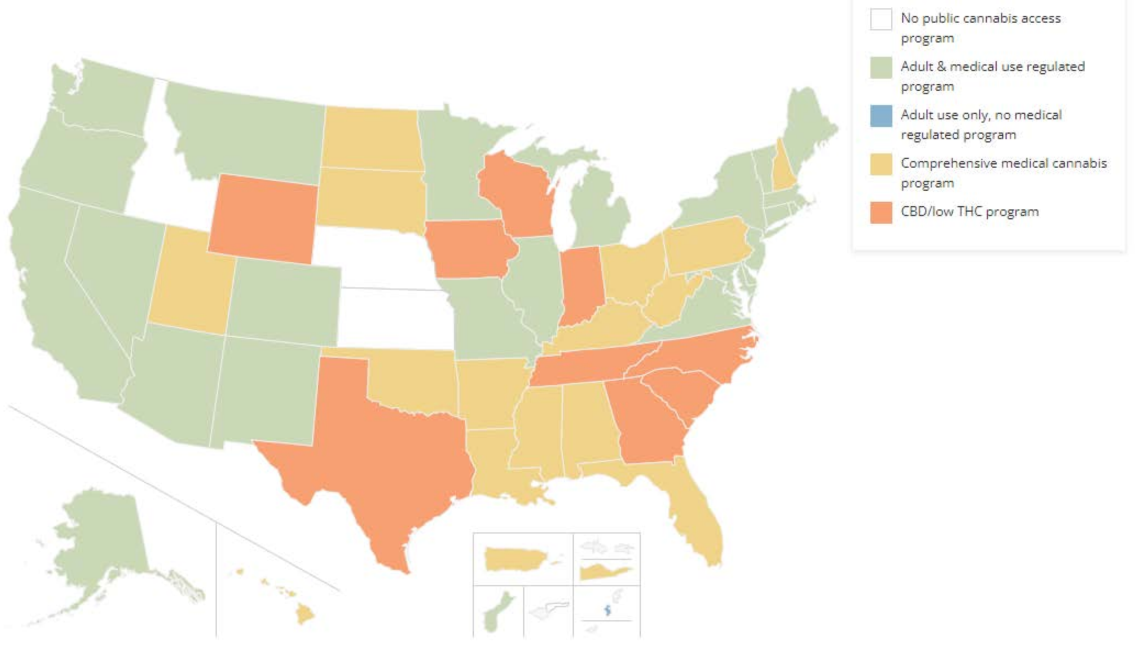
Low-THC Update

Approved measures in 9 states allow the use of "low THC, high cannabidiol (CBD)" products for medical reasons in limited situations or as a legal defense. (See Table 2 below for more information). Low-THC programs are not counted as comprehensive medical cannabis programs. NCSL uses criteria similar to other organizations tracking this issue to determine if a program is "comprehensive":

1. Protection from criminal penalties for using cannabis for a medical purpose.
2. Access to cannabis through home cultivation, dispensaries or some other system that is likely to be implemented.
3. It allows a variety of strains or products, including those with more than "low THC."
4. It allows either smoking or vaporization of some kind of cannabis products, plant material or extract.
5. Is not a limited trial program. (Nebraska has a trial program that is not open to the public.)

MAP: State Regulated Cannabis Programs

Notes: The District of Columbia allows limited adult possession and growing, no regulated production or sales.



Medical Uses of Cannabis

In response to California's Prop 215, the Institute of Medicine issued a report that examined potential therapeutic uses for cannabis. The report found that: "Scientific data indicate the potential therapeutic value of cannabinoid drugs, primarily THC, for pain relief, control of nausea and vomiting, and appetite stimulation; smoked marijuana, however, is a crude THC delivery system that also delivers harmful substances. The psychological effects of cannabinoids, such as anxiety reduction, sedation, and euphoria can influence their potential therapeutic value. Those effects are potentially undesirable for certain patients and situations and beneficial for others. In addition, psychological effects can complicate the interpretation of other aspects of the drug's effect."

Further studies have found that marijuana is effective in relieving some of the symptoms of HIV/AIDS, cancer, glaucoma, and multiple sclerosis.

In early 2017, the National Academies of Sciences, Engineering, and Medicine released a report based on the review of over 10,000 scientific abstracts from cannabis health research. They also made 100 conclusions related to health and suggest ways to improve cannabis research.

State vs Federal Perspective

At the federal level, cannabis remains classified as a Schedule I substance under the Controlled Substances Act, where Schedule I substances are considered to have a high potential for dependency and no accepted medical use, making distribution of cannabis a federal offense. In October of 2009, the Obama Administration sent a memo to federal prosecutors encouraging them not to prosecute people who distribute cannabis for medical purposes in accordance with state law.

In late August 2013, the U.S. Department of Justice announced an update to their marijuana enforcement policy. The statement read that while cannabis remains illegal federally, the USDOJ expects states like Colorado and Washington to create "strong, state-based enforcement efforts.... and will defer the right to challenge their legalization laws at this time." The department also reserves the right to challenge the states at any time they feel it's necessary.

More recently, in January 2018, former Attorney General Sessions issued a Marijuana Enforcement Memorandum that rescinded the Cole Memorandum, and allows federal prosecutors to decide how to prioritize enforcement of federal cannabis laws. Specifically, the Sessions memorandum directs U.S. Attorneys to “weigh all relevant considerations, including federal law enforcement priorities set by the Attorney General, the seriousness of the crime, the deterrent effect of criminal prosecution, and the cumulative impact of particular crimes on the community.”

Arizona and the District of Columbia voters passed initiatives to allow for medical use, only to have them overturned. In 1998, voters in the District of Columbia passed Initiative 59. However, Congress blocked the initiative from becoming law. In 2009, Congress reversed its previous decision, allowing the initiative to become law. The D.C. Council then put Initiative 59 on hold temporarily and unanimously approved modifications to the law.

Before passing Proposition 203 in 2010, Arizona voters originally passed a ballot initiative in 1996. However, the initiative stated that doctors would be allowed to write a "prescription" for cannabis. Since cannabis is a Schedule I substance, federal law prohibits its prescription, making the initiative invalid. Medical cannabis "prescriptions" are more often called "recommendations" or "referrals" because of the federal prescription prohibition.

States with medical cannabis laws generally have some form of patient registry, which may provide some protection against arrest for possession up to a certain amount of products for personal medicinal use.

Some of the most common policy questions regarding medical cannabis include how to regulate its recommendation, dispensing, and registration of approved patients. Some small cannabis growers or are often called "caregivers" and may grow a certain number of plants per patient. This issue may also be regulated on a local level, in addition to any state regulation.

Table 1. State Medical Marijuana/Cannabis Program Laws

State (click state name to jump to program information)	Statutory Language (year	Patient Registry or ID cards	Allows Dispensaries	Specifies Conditions	Recognizes Patients from other states	State Allows for Retail Sales/Non Medical Adult Use
Alabama	SB46 (2021)	Yes	Yes	Yes	No	
Alaska	Measure 8 (1998) SB 94 (1999) Statute Title 17, Chapter 37	Yes	Yes	Yes	No, but adults 21 and older may purchase at non medical retail dispensaries.	Yes. Ballot Measure 2 (2014) Marijuana Regulations
Arizona	Proposition 203 (2010)	Yes	Yes	Yes	Yes, for AZ-approved conditions, but not for dispensary purchases.	Yes. Proposition 207 (2020)
Arkansas	Issue 6 (2016)	Yes	Yes	Yes	Yes	
California	Proposition 215 (1996) SB 420 (2003)	Yes	Yes (cooperatives and collectives)	No	No	Yes. Proposition 64 (2016)
Colorado Medical program info -Non medical use info	Amendment 20 (2000)	Yes	Yes	Yes	No	Yes. Amendment 64 (2012) Task Force Implementation Recommendations (2013) Analysis of CO Amendment 64 (2013) Colorado Marijuana Sales and Tax Reports 2014 "Edibles" regulation measure FAQ about CO cannabis laws by the Denver Post.
Connecticut	HB 5389 (2012) Non medical use legislation SB 1201 (2021)	Yes	Yes	Yes		Yes. SB 1201 (2021)

Delaware	SB 17 (2011) Non medical adult-use legislation HB 1 and HB 2 (2023) passed the legislature and enacted without governor's signature.	Yes	Yes	Yes	Yes, for DE-approved conditions.	Yes. Non medical adult-use legislation HB 1 and HB 2 (2023) HB 371 passed the legislature and enacted without governor's signature. 4/21/2023
District of Columbia	Initiative 59 (Passed by voters but blocked by the Barr Amendment in 1998) L18-0210 or Act B18-622 (2010)	Yes	Yes	Yes		Yes. Initiative 71 (2014)
Florida	Amendment 2 (2016)	Yes	Yes	Yes	No	
Guam	Joaquin (KC) Concepcion II Compassionate Cannabis Use Act 2013 and Proposal 14A approved in Nov. 2014, fully operational.- home growing allowed. Non medical adult use- 2019 Bill No. 32-35 signed by governor in April, 2019	Yes	Yes	Yes	No	Yes. Non medical use- 2019 Bill No. 32-35 signed by governor in April, 2019
Hawaii	SB 862 (2000)	Yes	Yes	Yes	No	
Illinois	HB 1 (2013) *Eff. 1/1/2014* Rules Non medical use legalization SB 0007 bill passed legislature May, 2019, signed by governor June 25, 2019, Effective Jan. 1, 2020.	Yes	Yes	Yes	No	Yes. Measure approved by legislature in May, 2019, signed by governor June 25, 2019. Effective Jan. 1, 2020.
Kentucky	SB 47 (2023)	Yes	Yes	Yes	Yes	
Louisiana	SB 271 (2017)	No	Yes	Yes	No	

Maine	Question 2 (1999) LD 611 (2002) Question 5 (2009) LD 1811 (2010) LD 1296 (2011)	Yes	Yes	Yes	Yes, but not for dispensary purchases. Adults 21 and older may purchase from non medical retail dispensaries.	Yes. Question 1 (2016) page 4 Chapter 409 (2018)
Maryland	HB 702 (2003) SB 308 (2011) HB 180/SB 580 (2013) HB 1101- Chapter 403 (2013) SB 923 (signed 4/14/14) HB 881- similar to SB 923	Yes	Yes	Yes	No	Yes. Question 4 (2022)
Massachusetts	Question 3 (2012) Regulations (2013)	Yes	Yes	Yes	No	Yes. Question 4 (2016)
Michigan	Proposal 1 (2008)	Yes	Yes	Yes	Yes, for legal protection of possession, but not for dispensary purchases. Adults 21 and older may purchase from non medical retail dispensaries.	Yes. Proposal 18-1 (2018)
Minnesota	SF 2471, Chapter 311 (2014)	Yes	Yes, limited, liquid extract products only	Yes	No	Yes. HF 100 (2023)
Mississippi *overturned May 14, 2021	SB 2095 (2022) Initiative 65 (2020)*	Yes ~~Yes~~	Yes ~~Yes~~	Yes ~~Yes~~	Yes- must apply to MDOH. ~~Yet to be determined~~	

	News: Mississippi Supreme Court Overturns Medical Marijuana Amendment 65					
Missouri	Amendment 2 (2018)	Yes	Yes	Yes	Yes	Yes. Amendment 3 (2022)
Montana	Initiative 148 (2004) SB 423 (2011) Initiative 182 (2016)	Yes Yes	Yes Yes	Yes Yes	No	Yes. Initiative 190 (2020)
Nevada	Question 9 (2000) NRS 453A NAC 453A	Yes	Yes	Yes	Yes, if the other state's program are "substantially similar." Patients must fill out Nevada paperwork. Adults 21 and older may purchase at non medical retail dispensaries.	Yes. Question 2 (2016) page 25
New Hampshire	HB 573 (2013) HB 89 (2021)	Yes	Yes	Yes	Yes, with a note from their home state, but they cannot purchase through dispensaries.	
New Jersey	SB 119 (2010) Program information	Yes	Yes	Yes	No	Yes. Public Question 1 passed by voters in 2020 to allow legislature to enact legislation NJ AB 21 passed legislature, signed by governor March 1, 2021
New Mexico	SB 523 (2007) Medical Cannabis Program	Yes	Yes	Yes	No	Yes. HB 2 Cannabis regulation act passed legislature March 31, 2021 and signed by governor on 4/12/21.
New York	A6357 (2014) Signed by governor 7/5/14	Yes	Yes- Ingested doses may not contain more than 10 mg of	Yes	No	Yes. AB 1248A/SB 854 passed legislature, signed by governor on March 31, 2021.

			THC, product may not be combusted (smoked).			
North Dakota	Measure 5 (2016) NDCC 19-24.1 NDAC 33-44	Yes	Yes	Yes	No	
Northern Mariana Islands	Does not have a medical program.					Yes. HB 20-178 HD 4- Public Law 20-66 (2018)
Ohio	HB 523 (2016) Approved by legislature, signed by governor 6/8/16	Yes	Yes	Yes	Yes- If approved by the Board of Pharmacy on a state-by-state basis.	
Oklahoma	SQ 788 Approved by voters on 6/26/18	Yes	Yes	Yes, but list was not included in the initial ballot measure.	Yes but must apply as a temporary patient	
Oregon	Oregon Medical Marijuana Act (1998) SB 161 (2007)	Yes	Yes	Yes	No, but adults over 21 may purchase at adult retail dispensaries.	Yes. Measure 91 (2014)
Pennsylvania	SB 3 (2016) Signed by governor 4/17/16	Yes	Yes	Yes	No	
Puerto Rico	Public Health Department Regulation 155 (2016) in Spanish	Yes	Yes- Cannot be smoked	Yes	Yes	
Rhode Island	S 710 B (2006)- Legislature overturned governor's veto. SB 791 (2007) SB 185 (2009) 2022-S 2430Aaa and 2022-H 7593Aaa (2022) Rhode Island Cannabis Act	Yes	Yes	Yes	Yes	Yes. Rhode Island Cannabis Act 2022-S 2430Aaa and 2022-H 7593Aaa (2022)

South Dakota *Non medical use measure ruled unconstitutional as of Feb. 9, 2021.	Initiated Measure 26 (2020) News: Court rules measure unconstitutional Feb. 8, 2021 News: AG will not appeal court decision Feb. 12, 2021 News: Legislature considering legislation Feb. 9, 2021	Yes	Yes	Yes	Yet to be determined	Amendment A (2020) OVERTURNED BY COURTS Feb. 8, 2021 NOT COUNTED IN STATE TALLY ABOVE
US Virgin Islands	SB 135 (2017) signed by governor 1/19/19					
Utah	Prop 2 (2018) replaced by HB 3001 HB 3001 2018- Third Special Session	Yes	Yes	Yes	Yes	
Vermont	SB 76 (2004) SB 7 (2007) SB 17 (2011) H.511 (2018)	Yes	Yes	Yes	No, but adults 21 years old and older may purchase from the non medical market.	H.511 approved by legislature, signed by governor 1/22/18. Effective July 1, 2018. S.54 (2020) establishes sales regulations. Effective Oct. 7, 2020. Governor's letter re: S. 54, going into effect without his signature. Additional info: Governor's Marijuana Advisory Commission Final Report- December, 2018
Virginia	H 1460 (2020) S 646 (2020) H 1617 (2020)	Yes	Yes	No	No, but allows for temporary residents to apply with approval from the Board of Pharmacy.	Yes, legislature approved HB2312 and SB1406. Signed by governor 4/7/21.

	S 976 (2020) Legislative Timeline (2020) Board of Pharmacy overview Board of Pharmacy FAQ					
Washington	Initiative 692(1998) SB 5798 (2010) SB 5073 (2011)	Registry is voluntary.	Yes, approved as of Nov. 2012, stores opened in July, 2014.	Yes	No, but adults 21 and older may purchase at non medical retail dispensaries.	Initiative 502 (2012) WAC Marijuana rules: Chapter 314-55 WAC FAQ about WA cannabis laws by the Seattle Times.
West Virginia	SB 386 (2017)	Yes	Yes. No whole flower/cannot be smoked but can be vaporized.	Yes	No, but may allow their patients who are terminally ill to buy in other states. WV does not recognize other state cards.	

Table 2. Limited Access Cannabis Product Laws (low THC/high CBD – cannabidiol)

State	Program Name and Statutory Language (year)	Patient Registry or ID cards	Dispensaries or Source of Product(s)	Specifies Conditions	Recognizes Patients from other states	Definition of Products Allowed	Allows for Legal Defense	Allowed for Minors
Alabama *(SB46 of 2021 created a new medical cannabis law enacted on May 17, 2021 and is listed in Table 1.)*	SB 174 "Carly's Law" (Act 2014-277) Allows University of Alabama Birmingham to conduct effectiveness research using low-THC products for treating seizure disorders for up to 5 years. HB 61 (2016) Leni's Law allows more physicians to refer patients to use CBD for more conditions.	No	Provides legal defense for possession and/or use of CBD oil. Does not create an in-state production method.	Yes, debilitating epileptic conditions, life-threatening seizures, wasting syndrome, chronic pain, nausea, muscle spasms, any other sever condition resistant to conventional medicine.	No	Extracts that are low THC= below 3% THC	Yes	Yes
Florida (NEW comprehensive program approved in 2016, included in table above)	Compassionate Medical Cannabis Act of 2014 CS for SB 1030 (2014) Patient treatment information and outcomes will be collected and used for intractable childhood epilepsy research	Yes	Yes, 5 registered nurseries across the state by region, which have been in business at least 30 years in Florida.	Yes, cancer, medical condition or seizure disorders that chronically produces symptoms that can be alleviated by low-THC products	No	Cannabis with low THC= below .8% THC and above 10% CBD by weight		Yes, with approval from 2 doctors
Georgia	HB 1 (2015) (signed by governor 4/16/15)	Yes	Law allows University System of Georgia to develop a lot THC oil	Yes, end stage cancer, ALS, MS, seizure disorders,	No	Cannabis oils with low THC= below 5% THC and at least an equal amount of CDB.	Yes	Yes

			clinical research program that meets FDA trial compliance.	Crohn's, mitochondrial disease, Parkinson's, Sickle Cell disease				
Idaho- VETOED BY GOVERNOR	SB 1146 (VETOED by governor 4/16/15)	No	Doesn't define.	The possessor has, or is a parent or guardian of a person that has, cancer, amyotrophic lateral sclerosis, seizure disorders, multiple sclerosis, Crohn's disease, mitochondrial disease, fibromyalgia, Parkinson's disease or sickle cell disease;	No	Is composed of no more than three-tenths percent (0.3%) tetrahydrocannabidiol by weight; is composed of at least fifteen (15) times more cannabidiol than tetrahydrocannabidiol by weight; and contains no other psychoactive substance.	Yes	Yes
Indiana	HB 1148 (2017)	Yes	Doesn't define.	Treatment resistant epilepsy.	No	At least 5 percent CBD by weight. No more than .3 percent THC by weight.	Yes	Yes
Iowa	SF 2360, Medical Cannabidiol Act of 2014 (Effective 7/1/14 and repealed in 2017 and replaced) HF 524 of 2017 now Section 124E	Yes	Yes	Yes	Yes, for possession or use only, not for purchasing CBD in Iowa.	Less than 3 percent THC	Yes	Yes
Kansas* *(Not marked on map above because the state does not regulate the*	SB 28 Clare and Lola's law (5/20/2019)	No	No	No	No, may use possession of low-THC product from another state for a medical	Concentrated cannabidiol with THC of no more than 5% relative of weight by third party testing.	Yes	Yes

production or sale of low-CBD products.)					reason as as "affirmable defense to prosecution."			
Kentucky *(New comprehensive medical program approved in 2023 and listed in Table 1 above)*	SB 124 (2014) Clara Madeline Gilliam Act Exempt cannabidiol from the definition of marijuana and allows it to be administered by a public university or school of medicine in Kentucky for clinical trial or expanded access program approved by the FDA.	No	Universities in Kentucky with medical schools that are able to get a research trial. Doesn't allow for in-state production of CBD product.	Intractable seizure disorders	No	No, only "cannabidiol".		
Mississippi (Overturned Amendment 65 from 2020 included in table above.)	HB 1231 "Harper Grace's Law" 2014		All provided through National Center for Natural Products Research at the Univ. of Mississippi and dispensed by the Dept. of Pharmacy Services at the Univ. of Mississippi Medical Center	Yes, debilitating epileptic condition or related illness	No	"CBD oil" - processed cannabis plant extract, oil or resin that contains more than 15% cannabidiol, or a dilution of the resin that contains at least 50 milligrams of cannabidiol (CBD) per milliliter, but not more than one-half of one percent (0.5%) of tetrahydrocannabinol (THC)	Yes, if an authorized patient or guardian	Yes
Missouri (NEW comprehensive program approved in 2018, included in table above)	HB 2238 (2014)	Yes	Yes, creates cannabidiol oil care centers and cultivation and production facilities/laboratories.	Yes, intractable epilepsy that has not responded to three or more other treatment options.	No	"Hemp extracts" equal or less than .3% THC and at least 5% CBD by weight.	Yes	Yes
North Carolina	HB 1220 (2014) Epilepsy Alternative	Yes	University research studies with a hemp	Yes, intractable epilepsy	No	"Hemp extracts" with less than nine-tenths of one	Yes	Yes

	Treatment Act- Pilot Study HB 766 (2015) Removes Pilot Study designation		extract registration card from the state DHHS or obtained from another jurisdiction that allows removal of the products from the state.			percent (0.9%) tetrahydrocannabinol (THC) by weight. Is composed of at least five percent (5%) cannabidiol by weight. Contains no other psychoactive substance.		
Oklahoma (NEW comprehensive medical program approved in 2018 and listed above)	HB 2154 (2015)	Yes	No in-state production allowed, so products would have to be brought in. Any formal distribution system would require federal approval.	People under 18 (minors) Minors with Lennox-Gastaut Syndrome, Dravet Syndrome, or other severe epilepsy that is not adequately treated by traditional medical therapies	No	A preparation of cannabis with no more than .3% THC in liquid form.	Yes	Yes, only allowed for minors
South Carolina	SB 1035 (2014) Medical Cannabis Therapeutic Treatment Act- Julian's Law	Yes	Must use CBD product from an approved source; and (2) approved by the United States Food and Drug Administration to be used for treatment of a condition specified in an investigational new drug application. -The principal investigator and any subinvestigator may receive cannabidiol directly from an approved source or authorized distributor for an approved source for use in the expanded access clinical trials. Some have interpreted the law to	Lennox-Gastaut Syndrome, Dravet Syndrome, also known as severe myoclonic epilepsy of infancy, or any other form of refractory epilepsy that is not adequately treated by traditional medical therapies.	No	Cannabidiol or derivative of marijuana that contains 0.9% THC and over 15% CBD, or at east 98 percent cannabidiol (CBD) and not more than 0.90% tetrahydrocannabinol (THC) by volume that has been extracted from marijuana or synthesized in a laboratory	Yes	Yes

			allow patients and caregivers to produce their own products.					
Tennessee	SB 2531 (2014) Creates a four-year study of high CBD/low THC cannabis at Tenn. Tech Univ.	Researchers need to track patient information and outcomes	Only products produced by Tennessee Tech University. Patients may possess low THC oils only if they are purchased "legally in the United States and outside of Tennessee," from an assumed medical cannabis state, however most states do not allow products to leave the state.	Yes, intractable seizure conditions.	No	"Cannabis oil" with less than .9% THC as part of a clinical research study.	Yes	Yes
	HB 197 (2015)	No	Allows for legal defense for having the product as long as it was obtained legally in the US or other medical cannabis state.	Yes, intractable seizure conditions.	No	Same as above.	Yes	Yes
Texas	SB 339 (2015) Texas Compassionate Use Act HB 3703 (2019)	Yes	Yes, licensed by the Department of Public Safety.	Yes, intractable epilepsy, incurable neurodegenerative disease, terminal cancer, multiple sclerosis, spasticity, ALS, autism.	No	"Low-THC Cannabis" with not more than 0.5 percent by weight of tetrahydrocannabinols.	Yes	Yes
Utah (NEW comprehensive program approved in 2018, included in table above)	HB 105 (2014) Hemp Extract Registration Act	Yes	Not completely clear, however it may allow higher education institutions to grow or cultivate industrial hemp.	Yes, intractable epilepsy that hasn't responded to three or more treatment options suggested by a neurologist.	No	"Hemp extracts" with less than .3% THC by weight and at least 15% CBD by weight and contains no other psychoactive substances	Yes	Yes

Virginia *(NEW comprehensive medical program approved in 2020 and listed above)*	HB 1445- no longer in effect	No	No in-state means of acquiring cannabis products.	Intractable epilepsy	No	Cannabis oils with at least 15% CBD or THC-A and no more than 5% THC.	Yes	Yes
Wisconsin	AB 726 (2013 Act 267)	No	Physicians and pharmacies with an investigational drug permit by the FDA could dispense cannabidiol. Qualified patients would also be allowed to access CBD from an out-of-state medical cannabis dispensary that allows for out-of-state patients to use their dispensaries as well as remove the products from the state. No in-state production/manufacturing mechanism provided.	Seizure disorders		Exception to the definition of prohibited THC by state law, allows for possession of "cannabidiol in a form without a psychoactive effect." THC or CBD levels are not defined.	No	Yes
Wyoming	HB 32 (2015) Supervised medical use of hemp extracts. Effective 7/1/2015	Yes	No in-state production or purchase method defined.	Intractable epilepsy or seizure disorders	No	"Hemp extracts" with less than 0.3% THC and at least 5% CBD by weight.	Yes	Yes

**The links and resources are provided for information purposes only. NCSL does not endorse the views expressed in any of the articles linked from this page.*

Downloaded from https://www.ncsl.org/health/state-medical-cannabis-laws on July 6, 2023.

State	Program Name and Statutory Language (year)	Patient Registry or ID cards	Dispensaries or Source of Product(s)	Specifies Conditions	Recognizes Patients from other states	Definition of Products Allowed	Allows for Legal Defense	Allowed for Minors
			caregivers to produce their own products.					
Tennessee	SB 2531 (2014) Creates a four-year study of high CBD/low THC cannabis at Tenn. Tech Univ.	Researchers need to track patient information and outcomes	Only products produced by Tennessee Tech University. Patients may possess low THC oils only if they are purchased "legally in the United States and outside of Tennessee," from an assumed medical cannabis state, however most states do not allow products to leave the state.	Yes, intractable seizure conditions.	No	"Cannabis oil" with less than .9% THC as part of a clinical research study.	Yes	Yes
	HB 197 (2015)	No	Allows for legal defense for having the product as long as it was obtained legally in the US or other medical cannabis state.	Yes, intractable seizure conditions.	No	Same as above.	Yes	Yes
Texas	SB 339 (2015) Texas Compassionate Use Act HB 3703 (2019)	Yes	Yes, licensed by the Department of Public Safety.	Yes, intractable epilepsy, incurable neurodegenerative disease, terminal cancer, multiple sclerosis, spasticity, ALS, autism.	No	"Low-THC Cannabis" with not more than 0.5 percent by weight of tetrahydrocannabinols.	Yes	Yes
Utah (NEW comprehensive program approved in 2018, included in table above)	HB 105 (2014) Hemp Extract Registration Act	Yes	Not completely clear, however it may allow higher education institutions to grow or cultivate industrial hemp.	Yes, intractable epilepsy that hasn't responded to three or more treatment options suggested by a neurologist.	No	"Hemp extracts" with less than .3% THC by weight and at least 15% CBD by weight and contains no other psychoactive substances	Yes	Yes

State	Program Name and Statutory Language (year)	Patient Registry or ID cards	Dispensaries or Source of Product(s)	Specifies Conditions	Recognizes Patients from other states	Definition of Products Allowed	Allows for Legal Defense	Allowed for Minors
Virginia *(NEW comprehensive medical program approved in 2020 and listed above)*	HB 1445- no longer in effect	No	No in-state means of acquiring cannabis products.	Intractable epilepsy	No	Cannabis oils with at least 15% CBD or THC-A and no more than 5% THC.	Yes	Yes
Wisconsin	AB 726 (2013 Act 267)	No	Physicians and pharmacies with an investigational drug permit by the FDA could dispense cannabidiol. Qualified patients would also be allowed to access CBD from an out-of-state medical cannabis dispensary that allows for out-of-state patients to use their dispensaries as well as remove the products from the state. No in-state production/manufacturing mechanism provided.	Seizure disorders		Exception to the definition of prohibited THC by state law, allows for possession of "cannabidiol in a form without a psychoactive effect." THC or CBD levels are not defined.	No	Yes
Wyoming	HB 32 (2015) Supervised medical use of hemp extracts. Effective 7/1/2015	Yes	No in-state production or purchase method defined.	Intractable epilepsy or seizure disorders	No	"Hemp extracts" with less than 0.3% THC and at least 5% CBD by weight.	Yes	Yes

**The links and resources are provided for information purposes only. NCSL does not endorse the views expressed in any of the articles linked from this page.*

Source NCSL

Copied 5/19/23

https://www.ncsl.org/health/state-medical-cannabis-laws#anchor8841

Brief

State Cannabis Taxation

Updated January 07, 2021 | Jackson Brainerd

Related Topic: Fiscal

As states head into their 2021 legislative sessions, many will have to grapple with budget shortfalls caused by the coronavirus and efforts to mitigate its spread. For states that need to raise revenue, the legalization and taxation of recreational marijuana sales might be an option many consider.

Marijuana is no longer the flashpoint it once was; 15 states and D.C. have legalized recreational cannabis in some fashion and two-thirds of the public now supports doing so. Revenue collections in the states with established markets are outstripping alcohol and cigarette tax collections.
A Politico article in March 2020 noted that "Marijuana sales are booming, with some states seeing 20% spikes in sales as anxious Americans prepare to be hunkered down in their homes potentially for months. Weed sellers are staffing up too, hiring laid-off workers from other industries to meet demand." In 2020 alone, five states legalized it: Arizona, Montana, New Jersey, South Dakota, and Vermont. In four of the five, it was approved by voters at the November ballot by wide margins.

States have not coalesced around a uniform approach to marijuana taxation and many uncertainties linger surrounding the best design. This brief examines some of the most significant considerations and state experiences with legalization.

Tax Type

Most states have chosen to apply an excise tax to the sale of cannabis. (See Table 2 below.) These can be levied at the retail or wholesale level. Several states have excise taxes at both levels. In nine states, the excise tax is levied in addition to the general sales and use tax. Eleven states have also provided for an additional local option tax.

The excise taxes that states have imposed have follow three different approaches:

1. Based on price. In most states, marijuana excise taxes are based on the retail price and is levied at the point of sale.
2. Based on weight. Three states (Alaska, California, and Maine) levy a weight-based excise tax, which is collected by growers and/or processors. Most other sin taxes, like alcohol or tobacco, are based on weight or quantity rather than price. Weight-based taxes vary based on the part of the plant being sold. Some experts argue that weight-based taxes are more resistant to volatility in the long term as prices are expected to drop when markets mature, although they may incentivize consumption of higher potency products because taxing by weight does not account for quality.
3. Based on potency. Illinois is the only state that taxes marijuana based on its potency. Potency-based taxes are based on the THC (abbreviation of tetrahydrocannabinol, the main psychoactive compound in the marijuana plant) content, which is similar to liquor taxes based on alcohol content. Taxing based on potency allows the quality of the product to be taken into consideration, but it is likely more burdensome from both a compliance and administrative perspective.

Furthermore, studies suggest that THC content is not equivalent to alcohol content and does not necessarily determine potency; it may not be as reliable of a measure as alcohol content is for liquor taxes.

Tax Rates

When it comes to setting tax rates, states have attempted to engage in a balancing act. The rationale for imposing an excise tax on cannabis sales is the same as for any other type of sin tax. It is intended to dissuade consumption of the product by raising the price as well as offset costs to society that consumption of the product creates. Young or rare users may find high taxes cost prohibitive.

On the other hand, tax rates that are too high may continue to allow black markets to thrive. When all applicable taxes are combined, the effective tax rates on marijuana in many states are quite high; between 20 and 40 percent in most cases, which can keep black market products more desirable. A 2019 study found that illegal cannabis sellers outnumbered legal and regulated businesses almost 3-to-1 in California.

There is also downward pressure on recreational tax rates from medical marijuana, which typically predates recreational marijuana and is usually subject to lower rates. Furthermore, as more states legalize, significant differences in tax rates could contribute to consumers crossing the border to shop in neighboring states. States that were first to enact marijuana taxes, like Washington and Colorado, have considered lowering them. On the other hand, Massachusetts increased the marijuana excise tax from 3.5% to 10.75% when revenues were perceived to be underperforming relative to other states.

Tax Revenues

Revenue is a primary motivator for legalized recreational marijuana. In the seven states that had programs in place for the full year, marijuana tax revenues represented a small but not insignificant portion, about 0.36 percent, of overall state budgets in 2019. As the table below shows, revenues have grown annually in every state with a longer established market over the last three years. While marijuana has not provided a true windfall, tax collections were particularly resilient through the pandemic, displaying strong growth in many cases.

Table 1. Select State Marijuana Tax Collections (in millions)

	FY 2018	FY 2019	FY 2020
Alaska	$11.1	$19.2	$24.5
California*	$397.3	$636.9	$778.4
Colorado*	$266.5	$302.5	$355.1

	FY 2018	FY 2019	FY 2020
Nevada	$69.8	$99.2	$105.2
Oregon	$82.2	$102.1	$133.2
Washington	$362.0	$390.4	$469.2

*CA and CO numbers are by calendar year, not fiscal year, and do not reflect entirety of 2020.

While robust revenue collections are typically associated with recreational marijuana sales, there are states that are generating a significant amount of revenue from medical marijuana programs as well. For example, Oklahoma medical marijuana generated $105 million in state and local taxes in the first 10 months of 2020. This is atypical, however. What distinguishes Oklahoma from the other 36 states with medical marijuana programs is that there's no set of qualifying conditions in order to obtain a medical card and no limit on the number of business licenses that can be granted. More than 360,000 Oklahomans acquired medical marijuana cards over the last two years and there are now more than 9,000 licensed marijuana businesses in the state.

Forecasting Challenges and Tax Revenue Allocation

While marijuana tax collections have been performing well, it is important that states exercise caution when budgeting for anticipated revenues. The Pew Charitable Trusts has pointed out that it can be a difficult to accurately forecast marijuana tax revenues; Nevada exceeded initial estimates by 45% in the first six months of collecting marijuana taxes, while California was below projections by 45% in the first six months. Colorado estimated that it would bring in $67 million in the first full fiscal year of legal cannabis sales, and it collected $66.1 million. It could be prudent for states to set aside monies in trust fund when revenues are high to provide a buoy during low revenue periods.

For states looking to use marijuana funds to cover shortfalls, it is worth noting marijuana revenues will not materialize immediately. It takes time to develop regulations, issue licenses, and establish a legal market. Implementation typically takes at least several months and it could take years for revenues to mature as markets develop, as experiences documented by states like Colorado and Washington illustrate.

The Impact of Future Federal Actions

The growth in state activity around legal marijuana has increased the likelihood of the federal government reexamining the issue. Although the federal government has chosen not to interfere with states that have legalized it, marijuana is still classified as an illegal, schedule one controlled substance. Because of this, state marijuana businesses are not able to access banking services or many federal deductions that are available to most other businesses. As the Tax Foundation has noted, prices would most likely fall if these barriers were removed. While president-elect Joe Biden has voiced support for

decriminalizing marijuana, legalization remains uncertain. Regardless, federal decisions regarding marijuana regulation could have significant impacts on state tax collections.

Table 2. State Taxes on Recreational Marijuana

State	Year	Statutory Citation	Legislative or Voter Initiative	Type of Tax and Tax Rate
Alaska	2014	Alaska Stat. § 43.61.010	Voter Initiative	• $50 per ounce for flowers/mature buds. • $25 per ounce for immature or abnormal buds • $15 per ounce for trim • Clones: flat rate of $1 per clone • Local option retail sales taxes may also apply
Arizona	2020	A.R.S. § 42-5452	Voter Initiative	• 16% excise tax at retail • State (5.6%) and local sales tax rates apply
California	2016	Cal. Rev. & Tax Code §§ 34011; 34012	Voter Initiative	• 15% excise tax on retail sales • 7.25% state sales tax • Cultivation tax: $9.25 per ounce for flowers; $2.75 per ounce for leaves; $1.29 per ounce of fresh plant. • Local taxes may apply

State	Year	Statutory Citation	Legislative or Voter Initiative	Type of Tax and Tax Rate
Colorado	2012	Colo. Rev. Stat. § 39-28.8-302	Voter Initiative	• 15% excise tax • 15% retail sales tax • Local excise and sales taxes may apply
District of Columbia	2014	D.C. Code Ann. § 48-904.1	Voter Initiative	Ballot Initiative 71 allowed the possession of less than 2 ounces of marijuana. It did not permit the cultivation, distribution or retail sales.
Guam	2019	Bill No. 32-35	Legislative	• 15% excise tax
Illinois	2019	HB 1438	Legislative	Cultivation privilege tax: • 7% of the gross receipts from the sale of cannabis by a cultivator or craft grower to a dispensing organization Cannabis Purchaser Excise Tax: • 10% of purchase price – cannabis with THC level at or below 35% • 20% of purchase price – all cannabis infused products • 25% of the purchase price – cannabis with THC level above 35% • 6.25% state sales tax

State	Year	Statutory Citation	Legislative or Voter Initiative	Type of Tax and Tax Rate
				• Local option sales taxes may apply
Maine	2016	Me. Rev. Stat. Ann. tit. 28-B, §§ 1001; 1811	Voter Initiative	• $335 per pound excise tax – flower • Excise tax of $94 per pound – trim • Excise tax of $1.50 per seedling • Excise tax of $0.30 per seed • Retail excise tax of 10% • State sales tax 5.5%
Massachusetts	2016	Mass. Gen. Laws Ann. ch. 64N, § 2	Voter Initiative	• 10.75% excise tax • 6.25% state sales tax • Local option marijuana sales tax may apply
Michigan	2018	Mich. Comp. Laws § 333.27963	Voter Initiative	• 10% excise tax • 6% state sales tax
Montana	2020	Not yet codified. Initiative 190.	Voter Initiative	• 20% excise tax at retail
Nevada	2016	Nev. Rev. Stat. § 453D.500	Voter Initiative	• 15% wholesale excise tax

State	Year	Statutory Citation	Legislative or Voter Initiative	Type of Tax and Tax Rate
				• 10% retail tax/consumer sales tax • 6.85% state sales tax • Local sales taxes may apply
New Jersey	2020	N.J.S.A. Const. Art. 4, § 7, ¶ 13	Voter Initiative	• 6.625% sales tax rate • Local sales taxes up to 2% may apply
N. Mariana Islands	2018	C.N.M.I. Code Ann. tit. 4, § 53001, et seq.	Legislative	• 10% excise tax
Oregon	2014	Or. Rev. Stat. § 475B.705	Voter Initiative	• 17% retail tax • Local sales taxes may apply
South Dakota	2020	Not yet codified.	Voter Initiative	• 15% excise tax on marijuana sales
Vermont	2018, 2020	Vt. Stat. Ann. tit. 18, § 4230	Legislative	2018 HB 511 only authorized possession. 2020 SB 24 established a tax structure: • Excise tax of 14% of the sales price • State sales tax (6%)

State	Year	Statutory Citation	Legislative or Voter Initiative	Type of Tax and Tax Rate
				• Local sales taxes
Washington	2012	Wash. Rev. Code §§ 69.50.535; 69.50.540	Voter Initiative	• 37% excise tax on retail sales • 6.5% state sales tax • Local sales taxes may apply

Jackson Brainerd is a senior policy specialist in NCSL's Fiscal Affairs Program. He covers tax, economic development and gambling issues.

Related Resources

Updated May 26, 2023

FY 2024 State Budget Status

This page tracks the status of FY 2024 state budgets as they are passed by state legislatures and signed by governors.

Fiscal

Updated May 22, 2023

The Most Hated Tax- and What States Are Doing About It

With years of appreciation reflected in current property assessments, the pressure on lawmakers to provide property tax relief is intense.

Fiscal

Updated May 18, 2023

The Most-Hated Tax—and What States Are Doing About It

Two popular options for state property tax relief, homestead exemptions and circuit breakers, are covered here. However, years of appreciation are reflected in current property assessments, and the pressure on lawmakers to provide property tax relief remains intense.

Fiscal

State Legislatures News

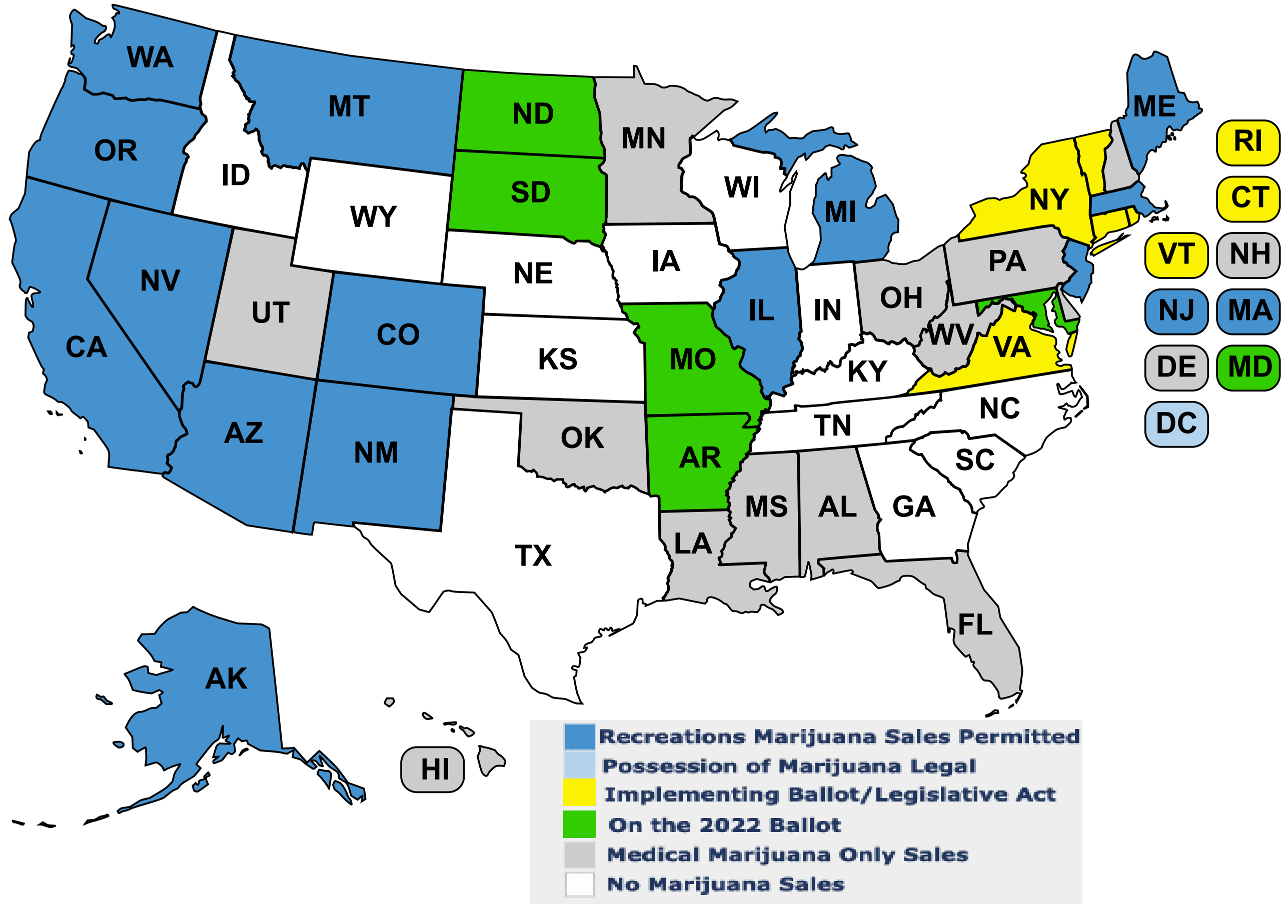
<- Return to FTA Home Page | <- Return to FTA Tax Rates Page

Status of State Taxation/Sales of Marijuana

click here to View Presentations on Marijuana Taxation Issues form FTA Conferences

Click on Blue/Yellow States to View Details of State Programs, or

[download pdf version]



Source: Federation of Tax Administrators from various sources
Updated - November 17, 2022

State Marijuana/Cannabis Taxes - 2022

Alaska

Legalization was approved with Ballot Measure 2 in 2014. The first cultivation license was granted in July 2016, with retail sales beginning in October 2016

Taxes:

- Excise tax of $50/ounce for flowers
- Excise tax of $15/ounce for stems and leaves
- Excise tax of $25/ounce for immature flowers/buds (added 10/2018)

FY 2017 Revenues $1.7 million.

Agencies Administering:

Licensing and Tracking: Marijuana Control Board
https://www.commerce.alaska.gov/web/AMCO

Tax Administration: Alaska Dept. of Revenue
http://tax.alaska.gov/

Arizona

Arizona Proposition 207, Marijuana Legalization Initiative approved on 2020 Ballot [59.9% to 40.1%]. Licensing of Retail establishments began January 16, 2021

Taxes:

- Proposition 207 would place a 16 percent tax on marijuana sales, in addition to the existing transaction privilege tax and use tax.

Agencies Administering:

- Arizona Department of Health Services (DHS) is responsible for adopting rules to regulate marijuana, including the licensing of marijuana retail stores, cultivation facilities, and production facilities.
https://www.azdhs.gov

- Taxes adiministered by the Department of Revenue
https://azdor.gov/

Arkansas

The Arkansas Marijuana Legalization Initiative was defeated [44%-56%] in Arkansas as an initiated constitutional amendment on November 8, 2022. Votes on the initiative may not be counted pending a supreme court ruling.

The initiative would legalizing the possession and use of up to one ounce of marijuana for persons who are at least 21 years old, enacting a 10% tax on marijuana sales, and requiring the state Alcoholic Beverage Control Division to develop rules to regulate marijuana businesses. Under the amendment, businesses that already hold licenses under the state's medical marijuana program would be authorized to sell marijuana. An additional 40 licenses would be given to businesses chosen by a lottery.

California

Legalization was approved with Proposition 64 in 2016. Personal use and growth were legal beginning in November 2016. Retail sales began January 2018

Taxes:

- Cultivation Tax of $9.25/ounce for flowers [$9.65 after 1/1/20]
$2.75/ounce for leaves [$2.87 after 1/1/20]
Fresh plant material $1.29/ounce [$1.35 after 1/1/20]
- Excise tax of 15% of Retail Sales
- State retail sales tax applies (7.25% plus local taxes)

notes, medical marijuana was exempted from the state sales tax on November 2016 by Prop. 64.

FY 2018 Revenues (two quarters) $134 million.

Agencies Administering:

Tracking and Licensing: Dept. of Cannabis Control
https://cannabis.ca.gov

Tax Administration: California Dept. of Tax and Fee Administration
https://www.cdtfa.ca.gov/

Colorado

Legalization began when voters approved Constitutional Amendment 64 in 2012. Colorado became the first state to begin legal sales when retail stores opened in January 2014.

Taxes:

- Excise Tax of 15% of Average Market Rate, sales to retail stores
- Retail Tax of 15% (10% before July 2017) - local government receive 10% of this tax.
- (2.9% retail sales tax before July 2017)
- Local Option Retail Tax up to 8%

FY 2018 State Revenues $251 million.

Agencies Administering:

Tracking, Licensing and Taxes: Colorado Dept. of Revenue
https://www.colorado.gov/pacific/enforcement/marijuanaenforcement

Revenue and Sales Data
https://www.colorado.gov/pacific/revenue/colorado-marijuana-sales-reports

https://www.colorado.gov/pacific/revenue

Connecticut

The Governor has sign SB 1201 providing for the possession and retail sales of recreational marijuana. Possession of up to 1.5 ounces will be allowed beginning July 1, 2021. **Retail sales are expected to begin by the end of 2022**

Taxes:

- Excise Tax of 0.625 cents per milligram of THC for cannabis flower
  0.9 cents per milligram for other product types
  2.75 cents per milligram for edibles
- 6.35% retail sales tax plus 3% municipal sales tax

Agencies Administering:

Tracking, Licensing and Taxes: Connecticut Department Consumer Protection
https://portal.ct.gov/DCP

Tax Collections: Connecticut Department of Revenue Services
https://portal.ct.gov/DRS

District of Columbia

Voters approved Ballot Initiative 71 in 2014 that allowed possession of less than two ounces of marijuana. However, Federal law does NOT permit the cultivation, distribution and retail sales of Marijuana.

Illinois

Bipartisan bill H.B. 1438, which the General Assembly passed May 31, will allow adults 21 and older to buy marijuana from licensed dispensaries **started January 1, 2020**. Pritzker signed the bill June 25, 2019.

Taxes:

- 7% Tax on Sales to Dispensaries
- Retail Excise Taxes
  10% on marijuana with THC level of 35% or less
  20% on cannabis-insused products
  25% for marijuana with THC level above 35%
  Local option tax up to 3% [7/1/2020]

Agencies Administering

Tracking and Licensing [Illinois Dept. of Financial & Professional Regulation]
https://www.idfpr.com/ILCannabis.asp

Taxes: Illinois Dept. of Revenue Cannabis Information Page -https://www2.illinois.gov/rev/
Information bulletin 2020-12

Maine

Voters approved marijuana legalization with the Ballot Question 1 in 2016. This allowed possession and individuals to grow marijuana beginning on January 30, 2017. On May 2, 2018, the Legislature overrode the Governor's veto of LD 1719, An Act to Implement a Regulatory Structure for Adult Use Marijuana. **Retail sales began on October 9, 2020.**

Taxes:

- Excise tax of $335 per pound - flower
- Excise tax of $94 per pound - trim
- Excise tax of $1.50 per seedling
- Excise tax of $0.35 per seed
- Retail sales tax of 10%

Agencies Administering:

Tracking and Licensing: Office of Marijuana Policy - Maine Department Administrative and Financial Services
https://www.maine.gov/dafs/ [draft rules released - April 23 2019]

Taxes: Maine Revenue Service
https://www.maine.gov/revenue/

Maryland

The voters approved Question 4 [67%-33%] on the November 2022 ballot to amend the constitution, which would legalize marijuana for adults 21 year of age or older **beginning in July 2023** and direct the Legislature to pass laws for the use, distribution, regulation and taxation of marijuana.

Massachusetts

Legalization was approved with Ballot Question 4 in 2016. While the ballot question set January 2018 as the date for retail sales to begin, legislation H 3818 delayed first sales until after July 1, 2018 and set various tax rates. It also created a Cannabis Control Commission with 5 appointed members.

The first cultivation license was issued on June 21, 2018, and the first retail store openned on November 20, 2018.

Taxes:

- 10.75% Excise Tax on Retail sales (initially 3.75% on ballot)
- 6.25% Retail Sales Tax applies
- Local Option Excise Tax of up to 3% is permitted (initially 2% on ballot)

Agencies Administering:

Tracking and Licensing: Massachusetts Cannabis Control Commission
https://mass-cannabis-control.com/

Taxes: Massachusetts Dept. of Revenue
https://www.mass.gov/marijuana-retail-taxes

Michigan

Voters recently approved Ballot Proposal 1 in the 2018 election authorizing the cultivation, distribution and retail sales of **recreational Marihuana**. State policymakers now need to approve legislation to implement the proposal. Details on taxes and regulation will be spelled out in future legislation. **Legal retail sales began on December 6, 2019.**

Taxes:

- 10% Retail Excise Tax
- 6% State Sales Tax (effective February 6, 2020)

Agencies Administering:

Tracking and Licensing: Michigan Dept. of Licensing and Regulatory Affairs
https://www.michigan.gov/lara/0,4601,7-154-89334_79571_90056---,00.html

Taxes: To Be Administered by the Michigan Department of Treasury
https://www.michigan.gov/treasury
The Department has recently released Bulletin 2019-17 discussing collections of retail excise tax.

Missouri

Voters, on the November 20222 ballot, approved [53%-47%] Amendment 3 titled the Marijuana Legalization Initiative. The initiative would legalize the purchase, possession, consumption, use, delivery, manufacturing, and sale of marijuana for personal use for persons who are 21 years old or older; allow individuals convicted of non-violent marijuana-related offenses to petition to be released from incarceration and/or have their records expunged; and impose a 6% tax on the sale of marijuana.

Montana

Montana I-190, Marijuana Legalization and Tax Initiative approved on the 2020 ballot [56.6% to 43.4%]. Retail sales to began January 2022.

Taxes:

- Marijuana and marijuana-infused products would be taxed at 20% of the retail price.
  Local option up to 3%
- Medical marijuana taxed at 4% of retail price

Agencies Administering:

The Montana Department of Revenue would be responsible for regulating the cultivation, manufacture, transport, and sale of marijuana in Montana. https://mtrevenue.gov/

Nevada

Legal sales of Marijuana were approved by the voters with Ballot Question 2 in 2016. While the Ballot Question setup January 1, 2017 as the start date for retail sales, the Dept. of Taxation approved regulations allowing sales to begin on July 1, 2017. Due to supply conditions, the Department temporarily permitted medical facilities to sell recreational marijuana.

Taxes:

- Wholesale Excise Tax 15% [Fair Market Value determined by DOT], also applied to medical marijuana
- Retail Tax 10%
- Sales tax imposed 6.85% (plus local)

Agencies Administering:

Tracking, Licensing and Taxes: Nevada Dept. of Taxation
http://marijuana.nv.gov/

New Mexico

The Governor recently sign HB 2 which provides for the retail sales of **recreational marijuana began April 2022**.

Taxes:

- Excise tax of 12% of Retail Sales
  [tax rate will increase annualy beginning in 2025 to 18%]
- Retail sales tax applies

Agencies Administering:

- The Cannabis Control Division (CCD) in the Regulation & Licensing Department will regulate and issue licenses for cannabis producers and retailers. https://ccd.rld.state.nm.us

- The Taxation and Revenue Department will collect and administer the Cannabis Excise and Gross Receipts [sales] Taxes. https://www.tax.newmexico.gov

---

New Jersey

New Jersey Marijuana Legalization Amendment was approved on the 2020 ballot [66.9% to 33.1%].
Retail sales began April 21, 2022.

Taxes:

- The ballot measure would apply the state sales tax (6.625 percent) to recreational marijuana.
- A Social Equity Excise Fee applies [initially set at 0.3%] will be set in the future by the CRC ranging from $10 to $40 per ounce.
- The state Legislature would be authorized to allow local governments to enact an additional 2 percent sales tax on recreational marijuana.

Agencies Administering:

- Licensing: Cannabis Regulatory Commission (CRC),
  https://www.nj.gov/cannabis/

- Tax: the state sales tax is administered by the Division of Taxation
  https://www.nj.gov/treasury/taxation/

New York

The legislature has approved and the Governor signed S. 854 which allows for **recreational marijuana sales scheduled to beginn April 1, 2022**. [has not started]

Taxes:

- A tax of 0.5 cent/milligram of THC in Flower
  A tax of 0.8 cent/milligram of THC in Consentrate
  A tax of 0.3 cent/milligram of THC in Edibles
- A Retail Tax of 9% plus a statewide 4% local tax

Agencies Administering:

- Licensing & Regulation: Office of Cannabis Management (OCM)
  https://cannabis.ny.gov/licensing

- Taxes: New York State Department of Taxation and Finance
  https://www.tax.ny.gov/bus/auc/

North Dakota

In November 2022, North Dakota voters defeated [45%-55%] an initiated state statute which would legalize the use and possession of up to one ounce of marijuana. The measure would require the Department of Health and Human Services, or another department or agency designated by the state legislature, to establish marijuana regulations, including for the production and distribution of marijuana **by October 1, 2023**. Under the measure, the department could license seven cultivation facilities and 18 marijuana retailers.

Oregon

Voters approved Initiative Measure 91 in 2014 that legalized recreational marijuana allowing possession of up to 8 ounces and four plants. It also required the Liquor Control Commission to regulate sales. Legislation was approved in the 2015 session that allowed retail sales to begin on October 1, 2015, initially through medical dispensaries on a temporary basis. Recreational marijuana retail licenses were granted beginning October 1, 2016.

Taxes:

- 17% Retail Sales Tax
- a temporary 25% tax was imposed on Medical Dispensary sales January - December 2016.
- Local Option sales tax up to 3%

Agencies Administering:

Tracking and Licensing: Oregon Liquor Control Commission
https://www.oregon.gov/olcc/Pages/index.aspx

Taxes: Oregon Dept. of Revenue
https://www.oregon.gov/DOR/Pages/index.aspx

Rhode Island

The Governor sign legislation [H 7593/S 2430] to allow the retail sales of recreational marijuana. While regulations still need to be written, **retail sales are scheduled to begin December 1, 2022**

Taxes:

- 10% Excise Tax
- 3% Local Excise Tax
- 7% State Sales Tax

Agencies Administering:

Tracking and Licensing: Rhode Island Cannabis Control Commission (to be created)

Taxes: Rhode Island Division of Taxation
https://tax.ri.gov

South Dakota

On November 8, 2022, voters decided against Measure 27 [47%-53%], which would have legalize the possession, distribution and use of marijuana for persons who are at least 21 years of age.

Previously, South Dakota Constitutional Amendment A, Marijuana Legalization Initiative was approved on the 2020 ballot [53.4% to 46.6%]. **NOTE: Constitutional Amendment A was declared invalid on November 24, 2021**. A separate provision for Medical Marijuana Legalization still goes into effect.

The amendment would require the South Dakota State Legislature to pass laws providing for a program for medical marijuana and the sale of hemp by April 1, 2022.

Taxes:

- Under the amendment, marijuana sales would be taxed at 15%. After the tax revenue is used by the Revenue Department to cover costs associated with implementing the amendment, 50% of the remaining revenue would be appropriated to fund state public schools and 50% would be deposited in the state's general fund. https://dor.sd.gov

---

Vermont

In September, the legislature approved S. 54. If signed by the governor, this bill would authorize **Retail Sales of recreational marijuana begining October 1, 2022**. The provisions of S. 54 are below.

Taxes

- Cannabis Excise Tax - 14% of Retail Price
- State Sales Tax

Agencies Administering:

- Licensing: Cannabis Control Board (CCB),
  https://ccb.vermont.gov

- Taxes: Department of Taxes [https://tax.vermont.gov]
  Vermont Cannabis Tax Guide [April 2022]

Previous Actions:
In January 2018, the governor signed H. 511 permitting the possession of 1 ounce of marijuana and two plants. It did NOT allow the retail sales of marijuana but created a Marijuana Advisory Commission which would submit recommendations to the legislature on future retail sales.

Agencies Administering:

Vermont Marijuana Advisory Commission
https://marijuanacommission.vermont.gov/

Virginia

The legislature approved and the governor signed SB 1406 [HB 2312] which legalizes possession and allows for the retail sales of Marijuana. Legal possession of of one ounce or less will be allowed July 1, 2021, while **retail sales will begin January 1, 2024**.

Taxes:

- Retail sales tax of 21% for all products sold through Marijuana stores
  a 3% local options sales tax may also apply

Agencies Administering:

Virginia Cannabis Control Authority https://www.cannabis.virginia.gov

Washington

Voters approved Measure Initiative 502 in 2012 which legalized the possession, distribution and sales of marijuana. It required the State Liquor Control Board to regulate and tax the retail sale of Marijuana. Legislation in 2015 (H 2136) changed the tax rate (from 25% wholesale and retail tax) to the current 37% rate and changed the name to the Washington State Liquor and Cannibas Board.

Retail sales began July 2014, with Washington became the second state to permit retail sales of recreational marijuana. Note, medical dispensaries were required to obtain a retail license after June 2016.

Taxes:

- 37% Tax on Retail Sales
- 6.5% Retail Sales Tax (plus local tax) [medical is exempt from sales taxes after June 2016]

Agencies Administering:

Tracking, Licensing and Taxes: Washington State Liquor and Canabis Board
https://lcb.wa.gov/

Information on past and future Ballot Initiatives.

https://ballotpedia.org/Marijuana_on_the_ballot#By_year

Return to Map View

Source: Federation of Tax Administrators from various sources
Updated - November 17, 2022

After the Grand Opening

Assessing Cannabis Supply and Demand in Washington State

By:
Beau Kilmer, Steven Davenport, Rosanna Smart,
Jonathan P. Caulkins, Gregory Midgette

Prepared for the Washington State Liquor and Cannabis Board

Published by the RAND Corporation, Santa Monica, Calif.

© Copyright 2019 RAND Corporation

PDF: https://www.rand.org/content/dam/rand/pubs/research_reports/RR3100/RR3138/RAND_RR3138.pdf

Website: https://www.rand.org/pubs/research_reports/RR3138.html

FLORIDA

Table 29A Substance Use, Perceptions of Great Risk, and Mental Health Measures: Among People Aged 12 or Older in *Florida*; by Age Group, Estimated Numbers (in Thousands), 2021

Measure	12+	12-17	18-25	26+	18+
ILLICIT DRUGS					
Illicit Drug Use in the Past Month[1,2]	2,179	76	432	1,671	2,103
Marijuana Use in the Past Year	2,805	142	608	2,055	2,663
Marijuana Use in the Past Month	1,996	59	395	1,542	1,937
Perceptions of Great Risk from Smoking Marijuana Once a Month	5,065	412	264	4,390	4,653
First Use of Marijuana in the Past Year among Those at Risk for Initiation of Marijuana Use[3,4]	192	59	80	53	134
Illicit Drug Use Other Than Marijuana in the Past Month[1,2]	468	27	63	379	441
Cocaine Use in the Past Year	246	2	54	190	244
Perceptions of Great Risk from Using Cocaine Once a Month	13,692	801	1,228	11,662	12,891
Heroin Use in the Past Year[5]	--	--	3	51	55
Perceptions of Great Risk from Trying Heroin Once or Twice	16,172	902	1,552	13,719	15,270
Methamphetamine Use in the Past Year	98	1	5	91	97
Prescription Pain Reliever Misuse in the Past Year[2]	471	34	59	378	437
Opioid Misuse in the Past Year[2,6]	505	34	57	414	471
ALCOHOL					
Alcohol Use in the Past Month	9,264	101	919	8,243	9,162
Binge Alcohol Use in the Past Month[7]	3,794	48	515	3,230	3,746
Perceptions of Great Risk from Having Five or More Drinks of an Alcoholic Beverage Once or Twice a Week	8,901	700	833	7,368	8,202
Alcohol Use in the Past Month[8] (People Aged 12 to 20)	373	--	--	--	--
Binge Alcohol Use in the Past Month[7,8] (People Aged 12 to 20)	190	--	--	--	--
TOBACCO PRODUCTS					
Tobacco Product Use in the Past Month[9]	3,344	31	268	3,045	3,313
Cigarette Use in the Past Month	2,737	14	160	2,563	2,723
Perceptions of Great Risk from Smoking One or More Packs of Cigarettes per Day	13,694	979	1,317	11,398	12,715
MENTAL HEALTH MEASURES IN THE PAST YEAR					
Any Mental Illness[4,10]	--	--	628	2,981	3,610
Serious Mental Illness[4,10]	--	--	237	664	901
Received Mental Health Services[11]	--	--	314	2,023	2,337
Major Depressive Episode[4,12]	--	337	383	914	1,297
Had Serious Thoughts of Suicide	--	--	269	509	778
Made Any Suicide Plans	--	--	93	155	249
Attempted Suicide	--	--	71	79	150

-- = not available.

NOTE: Estimates are based on a survey-weighted hierarchical Bayes small area estimation approach. For confidence intervals, see Tables 1 to 35 in *2021 National Survey on Drug Use and Health: Model-Based Estimated Totals (in Thousands) (50 States and the District of Columbia)* at https://www.samhsa.gov/data/report/2021-nsduh-estimated-totals-state.

NOTE: Estimated numbers appearing as 0 in this table mean that the estimate is greater than 0 but less than 500 because estimated numbers are shown in thousands.

1 Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use of marijuana (including vaping), cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. Illicit Drug Use Other Than Marijuana includes the misuse of prescription psychotherapeutics or the use of cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. Illicit Drugs Other Than Marijuana excludes respondents who used only marijuana but includes those who used marijuana in addition to other illicit drugs.

2 Prescription pain relievers are a type of prescription psychotherapeutic. Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

3 *First use of marijuana in the past year among those at risk for initiation* = $X_1 \div 2$, where X_1 is the number of marijuana initiates in the past 24 months.

4 For details, see Section B of *2021 National Survey on Drug Use and Health: Guide to State Tables and Summary of Small Area Estimation Methodology* at https://www.samhsa.gov/data/report/2021-nsduh-guide-state-tables-and-summary-sae-methodology.

5 Estimates for youths aged 12 to 17 are not available for past year heroin use because past year heroin use was extremely rare among youths aged 12 to 17 in the 2021 NSDUH. As a result, estimates for people aged 12 or older are also not produced.

6 Respondents were classified as misusing opioids in the past year if they reported using heroin or misusing prescription pain relievers in the past year.

7 Binge Alcohol Use is defined as drinking five or more drinks (for males) or four or more drinks (for females) on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

8 Underage drinking is defined for individuals aged 12 to 20; therefore, the "12+" estimate reflects that age group and not individuals aged 12 or older.

9 Tobacco Products include cigarettes, smokeless tobacco (i.e., snuff, dip, chewing tobacco, or snus), cigars, or pipe tobacco.

10 Mental Illness aligns with *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition (DSM-IV) criteria and is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. Estimates of serious mental illness (SMI) are a subset of estimates of any mental illness (AMI) because SMI is limited to people with AMI that resulted in serious functional impairment. These estimates are based on indicators of AMI and SMI rather than direct measures of diagnostic status.

11 Mental Health Services for adults includes inpatient treatment/counseling; outpatient treatment/counseling; or use of prescription medication for problems with emotions, nerves, or mental health.

12 Major depressive episode (MDE) is based on the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5) definition, which specifies a period of at least 2 weeks when an individual experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. There are minor wording differences in the questions in the adult and adolescent MDE modules. Therefore, data from youths aged 12 to 17 were not combined with data from adults aged 18 or older to produce an estimate for those aged 12 or older.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

FLORIDA

Table 29B Substance Use Disorder and Treatment in the Past Year: Among People Aged 12 or Older in *Florida*; by Age Group, Estimated Numbers (in Thousands), 2021

Measure	12+	12-17	18-25	26+	18+
SUBSTANCE USE DISORDER AND TREATMENT					
Drug Use Disorder[1,2]	1,413	89	269	1,055	1,324
Pain Reliever Use Disorder[1,3]	341	15	23	303	326
Opioid Use Disorder[1,3,4]	357	15	26	315	342
Alcohol Use Disorder[1]	1,838	51	250	1,537	1,788
Substance Use Disorder[1,2]	2,753	111	445	2,197	2,642
Needing But Not Receiving Treatment at a Specialty Facility for Illicit Drug Use[5,6,7]	1,011	76	264	671	935
Needing But Not Receiving Treatment at a Specialty Facility for Alcohol Use[5]	1,833	47	248	1,538	1,787
Needing But Not Receiving Treatment at a Specialty Facility for Substance Use[5,6,7]	2,348	101	419	1,827	2,247

NOTE: Estimates are based on a survey-weighted hierarchical Bayes small area estimation approach. For confidence intervals, see Tables 1 to 35 in *2021 National Survey on Drug Use and Health: Model-Based Estimated Totals (in Thousands) (50 States and the District of Columbia)* at https://www.samhsa.gov/data/report/2021-nsduh-estimated-totals-state.

NOTE: Estimated numbers appearing as 0 in this table mean that the estimate is greater than 0 but less than 500 because estimated numbers are shown in thousands.

[1] Substance Use Disorder (SUD) estimates are based on *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5) criteria. SUD is defined as meeting the criteria for drug or alcohol use disorder. Beginning with the 2021 NSDUH, questions on prescription drug use disorder were asked of all past year users of prescription drugs, regardless of whether they misused prescription drugs. The estimates in these rows include prescription drug use disorder data from all past year users of prescription drugs.

[2] Drug use includes the use of marijuana (including vaping), cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine in the past year or any use (i.e., not necessarily misuse) of prescription pain relievers, tranquilizers, stimulants, or sedatives in the past year.

[3] Pain relievers are a type of prescription drug.

[4] Opioid Use Disorder is defined as meeting the criteria for heroin or pain reliver use disorder.

[5] Respondents were classified as needing substance use treatment if they met the DSM-5 criteria for an illicit drug or alcohol use disorder or received treatment for illicit drug or alcohol use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient only], or mental health center). Substance use treatment questions are asked of respondents who used alcohol or illicit drugs in their lifetime. Respondents who used prescription drugs but who did not misuse prescription drugs in their lifetime may not receive these questions. Needing But Not Receiving Substance Use Treatment refers to respondents who are classified as needing illicit drug or alcohol use treatment but who did not receive illicit drug or alcohol use treatment at a specialty facility.

[6] Illicit drug or alcohol use disorder estimates are based on DSM-5 criteria. Beginning with the 2021 NSDUH, questions on prescription drug use disorder were asked of all past year users of prescription drugs, regardless of whether they misused prescription drugs. The estimates in these rows do not include prescription drug use disorder data from the past year users of prescription drugs who were not also misusers of prescription drugs.

[7] Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use of marijuana (including vaping), cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

FLORIDA

Table 30A Substance Use, Perceptions of Great Risk, and Mental Health Measures: Among People Aged 12 or Older in *Florida*; by Age Group, Percentages, 2021

Measure	12+	12-17	18-25	26+	18+
ILLICIT DRUGS					
Illicit Drug Use in the Past Month[1,2]	11.63	5.02	22.43	10.93	12.21
Marijuana Use in the Past Year	14.98	9.38	31.54	13.45	15.48
Marijuana Use in the Past Month	10.66	3.90	20.52	10.09	11.26
Perceptions of Great Risk from Smoking Marijuana Once a Month	27.03	27.21	13.68	28.72	27.02
First Use of Marijuana in the Past Year among Those at Risk for Initiation of Marijuana Use[3,4]	1.53	3.82	6.45	0.57	1.21
Illicit Drug Use Other Than Marijuana in the Past Month[1,2]	2.50	1.77	3.25	2.48	2.57
Cocaine Use in the Past Year	1.32	0.13	2.80	1.24	1.42
Perceptions of Great Risk from Using Cocaine Once a Month	73.11	52.89	63.77	76.30	74.88
Heroin Use in the Past Year[5]	--	--	0.17	0.34	0.32
Perceptions of Great Risk from Trying Heroin Once or Twice	86.39	59.55	80.56	89.76	88.72
Methamphetamine Use in the Past Year	0.52	0.10	0.28	0.60	0.56
Prescription Pain Reliever Misuse in the Past Year[2]	2.52	2.26	3.04	2.48	2.54
Opioid Misuse in the Past Year[2,6]	2.70	2.26	2.98	2.71	2.74
ALCOHOL					
Alcohol Use in the Past Month	49.49	6.69	47.71	53.93	53.26
Binge Alcohol Use in the Past Month[7]	20.26	3.16	26.76	21.14	21.77
Perceptions of Great Risk from Having Five or More Drinks of an Alcoholic Beverage Once or Twice a Week	47.54	46.18	43.27	48.21	47.66
Alcohol Use in the Past Month[8] (People Aged 12 to 20)	15.41	--	--	--	--
Binge Alcohol Use in the Past Month[7,8] (People Aged 12 to 20)	7.83	--	--	--	--
TOBACCO PRODUCTS					
Tobacco Product Use in the Past Month[9]	17.85	2.04	13.91	19.92	19.24
Cigarette Use in the Past Month	14.61	0.92	8.31	16.77	15.82
Perceptions of Great Risk from Smoking One or More Packs of Cigarettes per Day	73.13	64.60	68.38	74.57	73.88
MENTAL HEALTH MEASURES IN THE PAST YEAR					
Any Mental Illness[4,10]	--	--	32.63	19.51	20.98
Serious Mental Illness[4,10]	--	--	12.31	4.34	5.24
Received Mental Health Services[11]	--	--	16.33	13.24	13.58
Major Depressive Episode[4,12]	--	22.22	19.88	5.98	7.54
Had Serious Thoughts of Suicide	--	--	13.95	3.33	4.52
Made Any Suicide Plans	--	--	4.85	1.01	1.44
Attempted Suicide	--	--	3.70	0.51	0.87

-- = not available.

NOTE: Estimates are based on a survey-weighted hierarchical Bayes small area estimation approach. For confidence intervals, see Tables 1 to 35 in *2021 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia)* at https://www.samhsa.gov/data/report/2021-nsduh-state-prevalence-estimates.

[1] Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use of marijuana (including vaping), cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. Illicit Drug Use Other Than Marijuana includes the misuse of prescription psychotherapeutics or the use of cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. Illicit Drugs Other Than Marijuana excludes respondents who used only marijuana but includes those who used marijuana in addition to other illicit drugs.

[2] Prescription pain relievers are a type of prescription psychotherapeutic. Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

[3] *First use of marijuana in the past year among those at risk for initiation* (%) = 100 * $\{[X_1 \div (0.5 * X_1 + X_2)] \div 2\}$, where X_1 is the number of marijuana initiates in the past 24 months and X_2 is the number of individuals who never used marijuana (with the at-risk population defined as $0.5 * X_1 + X_2$). Both of the computation components, X_1 and X_2, are based on a survey-weighted hierarchical Bayes small area estimation approach. The age group shown is based on a respondent's age at the time of the interview, not his or her age at first use.

[4] For details, see Section B of *2021 National Survey on Drug Use and Health: Guide to State Tables and Summary of Small Area Estimation Methodology* at https://www.samhsa.gov/data/report/2021-nsduh-guide-state-tables-and-summary-sae-methodology.

[5] Estimates for youths aged 12 to 17 are not available for past year heroin use because past year heroin use was extremely rare among youths aged 12 to 17 in the 2021 NSDUH. As a result, estimates for people aged 12 or older are also not produced.

[6] Respondents were classified as misusing opioids in the past year if they reported using heroin or misusing prescription pain relievers in the past year.

[7] Binge Alcohol Use is defined as drinking five or more drinks (for males) or four or more drinks (for females) on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

[8] Underage drinking is defined for individuals aged 12 to 20; therefore, the "12+" estimate reflects that age group and not individuals aged 12 or older.

[9] Tobacco Products include cigarettes, smokeless tobacco (i.e., snuff, dip, chewing tobacco, or snus), cigars, or pipe tobacco.

[10] Mental Illness aligns with *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition (DSM-IV) criteria and is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. Estimates of serious mental illness (SMI) are a subset of estimates of any mental illness (AMI) because SMI is limited to people with AMI that resulted in serious functional impairment. These estimates are based on indicators of AMI and SMI rather than direct measures of diagnostic status.

[11] Mental Health Services for adults includes inpatient treatment/counseling; outpatient treatment/counseling; or use of prescription medication for problems with emotions, nerves, or mental health.

[12] Major depressive episode (MDE) is based on the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5) definition, which specifies a period of at least 2 weeks when an individual experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. There are minor wording differences in the questions in the adult and adolescent MDE modules. Therefore, data from youths aged 12 to 17 were not combined with data from adults aged 18 or older to produce an estimate for those aged 12 or older.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

FLORIDA

Table 30B Substance Use Disorder and Treatment in the Past Year: Among People Aged 12 or Older in *Florida*; by Age Group, Percentages, 2021

Measure	12+	12-17	18-25	26+	18+
SUBSTANCE USE DISORDER AND TREATMENT					
Drug Use Disorder[1,2]	7.55	5.89	13.97	6.90	7.69
Pain Reliever Use Disorder[1,3]	1.82	1.01	1.18	1.99	1.89
Opioid Use Disorder[1,3,4]	1.90	1.00	1.37	2.06	1.98
Alcohol Use Disorder[1]	9.82	3.34	13.00	10.06	10.40
Substance Use Disorder[1,2]	14.70	7.32	23.12	14.37	15.35
Needing But Not Receiving Treatment at a Specialty Facility for Illicit Drug Use[5,6,7]	5.40	5.01	13.71	4.39	5.43
Needing But Not Receiving Treatment at a Specialty Facility for Alcohol Use[5]	9.80	3.08	12.88	10.07	10.39
Needing But Not Receiving Treatment at a Specialty Facility for Substance Use[5,6,7]	12.54	6.65	21.77	11.96	13.06

NOTE: Estimates are based on a survey-weighted hierarchical Bayes small area estimation approach. For confidence intervals, see Tables 1 to 35 in *2021 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia)* at https://www.samhsa.gov/data/report/2021-nsduh-state-prevalence-estimates.

[1] Substance Use Disorder (SUD) estimates are based on *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5) criteria. SUD is defined as meeting the criteria for drug or alcohol use disorder. Beginning with the 2021 NSDUH, questions on prescription drug use disorder were asked of all past year users of prescription drugs, regardless of whether they misused prescription drugs. The estimates in these rows include prescription drug use disorder data from all past year users of prescription drugs.

[2] Drug use includes the use of marijuana (including vaping), cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine in the past year or any use (i.e., not necessarily misuse) of prescription pain relievers, tranquilizers, stimulants, or sedatives in the past year.

[3] Pain relievers are a type of prescription drug.

[4] Opioid Use Disorder is defined as meeting the criteria for heroin or pain reliver use disorder.

[5] Respondents were classified as needing substance use treatment if they met the DSM-5 criteria for an illicit drug or alcohol use disorder or received treatment for illicit drug or alcohol use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient only], or mental health center). Substance use treatment questions are asked of respondents who used alcohol or illicit drugs in their lifetime. Respondents who used prescription drugs but who did not misuse prescription drugs in their lifetime may not receive these questions. Needing But Not Receiving Substance Use Treatment refers to respondents who are classified as needing illicit drug or alcohol use treatment but who did not receive illicit drug or alcohol use treatment at a specialty facility.

[6] Illicit drug or alcohol use disorder estimates are based on DSM-5 criteria. Beginning with the 2021 NSDUH, questions on prescription drug use disorder were asked of all past year users of prescription drugs, regardless of whether they misused prescription drugs. The estimates in these rows do not include prescription drug use disorder data from the past year users of prescription drugs who were not also misusers of prescription drugs.

[7] Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use of marijuana (including vaping), cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

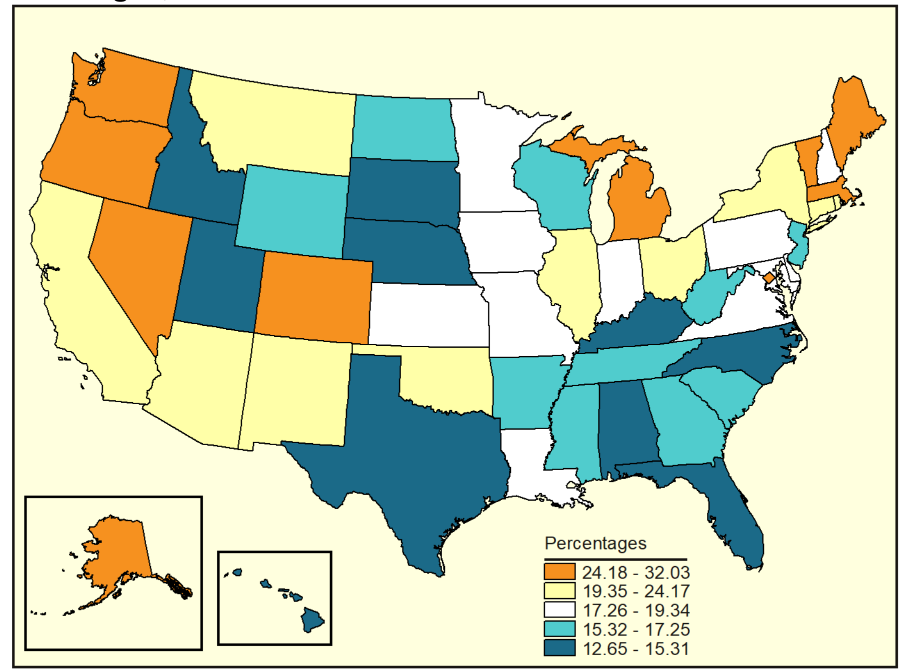
2021 National Survey on Drug Use and Health National Maps of Prevalence Estimates, by State

The 154 national maps presented here show the 2021 National Survey on Drug Use and Health (NSDUH) estimates for 34 substance use and mental health outcomes, by age group, for 50 states and the District of Columbia. Estimates for youths aged 12 to 17 are not available for past year heroin use because past year heroin use was extremely rare among youths aged 12 to 17 in the 2021 NSDUH. As a result, estimates for people aged 12 or older are also not produced. Thus, maps for these two age groups for past year heroin use are not available. In addition, maps were also not produced for the following three outcome/age groups due to suppression of certain state estimates: cocaine use in the past year among people 12 to 17, heroin use in the past year among people aged 18 to 25, and methamphetamine use in the past year among people aged 12 to 17. For details about the suppression, see Section A of the "2021 NSDUH: Guide to State Tables and Summary of Small Area Estimation Methodology" at https://www.samhsa.gov/data/report/2021-nsduh-guide-state-tables-and-summary-sae-methodology.

The color of each state on the U.S. maps indicates how the state ranks relative to other states for each measure. States could fall into one of five groups according to their ranking by quintiles. Because 51 states were ranked for each measure, the middle quintile was assigned to 11 states, and the remaining quintiles were assigned 10 states each. In some cases, a "quintile" could have more or fewer states than desired because two (or more) states had the same estimate (to two decimal places). When such ties occurred at the "boundary" between two quintiles, all of the states with the same estimate were conservatively assigned to the lower quintile. Those states with the highest rates for a given measure are in orange, with the exception of the perceptions of risk measures, for which the lowest perceptions of great risk are in orange. Those states with the lowest estimates are in dark blue, with the exception of the perceptions of risk measures, for which the highest perceptions of great risk are in dark blue. The upper and lower limits of each quintile shown in the map legend collectively define a continuum and are not necessarily the actual values of a particular state. For example, in Figure 1a, the values on the boundary in the lowest quintile correspond to Texas (8.51 percent) and Kentucky (11.49 percent) and are displayed in the legend. In the next to lowest quintile, Florida (11.63 percent) and New Jersey (13.06 percent) are the states with the lowest and highest values; however, in the continuum of the legend, the lower limit was assigned a value of 11.50 percent because the upper limit of the quintile below it is 11.49 percent.

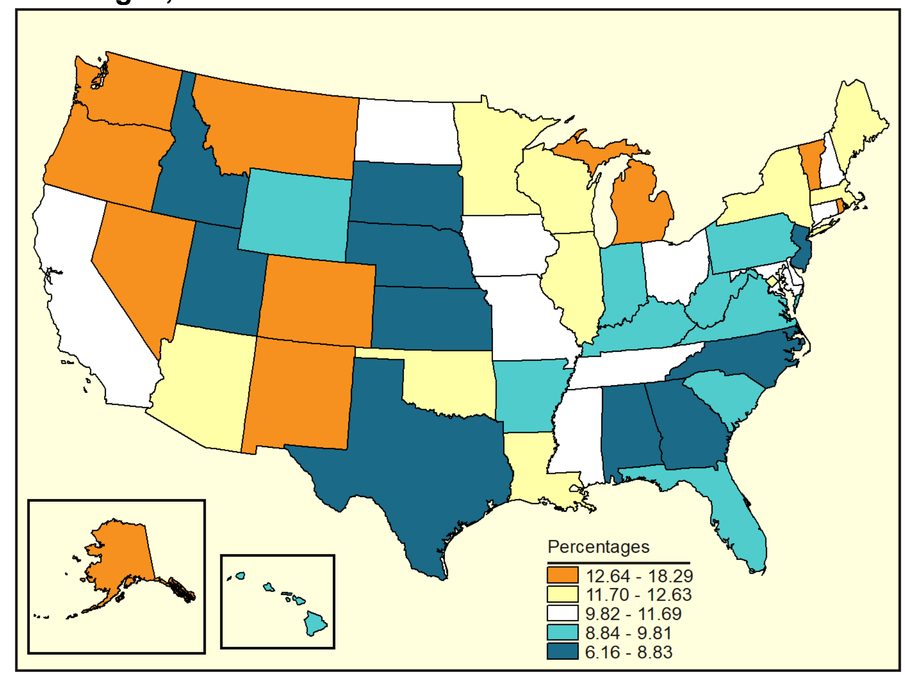
Tables containing specific estimates for these state maps are available on the 2021 NSDUH webpage at https://www.samhsa.gov/data/report/2021-nsduh-state-estimates-substance-use-and-mental-disorders. Specifically, see the file for the "2021 NSDUH State Prevalence Estimates (Tables 1 to 35, by Age Group)."

Figure 2a ***Marijuana Use in the Past Year: Among People Aged 12 or Older;*** **by State, Percentages, 2021**



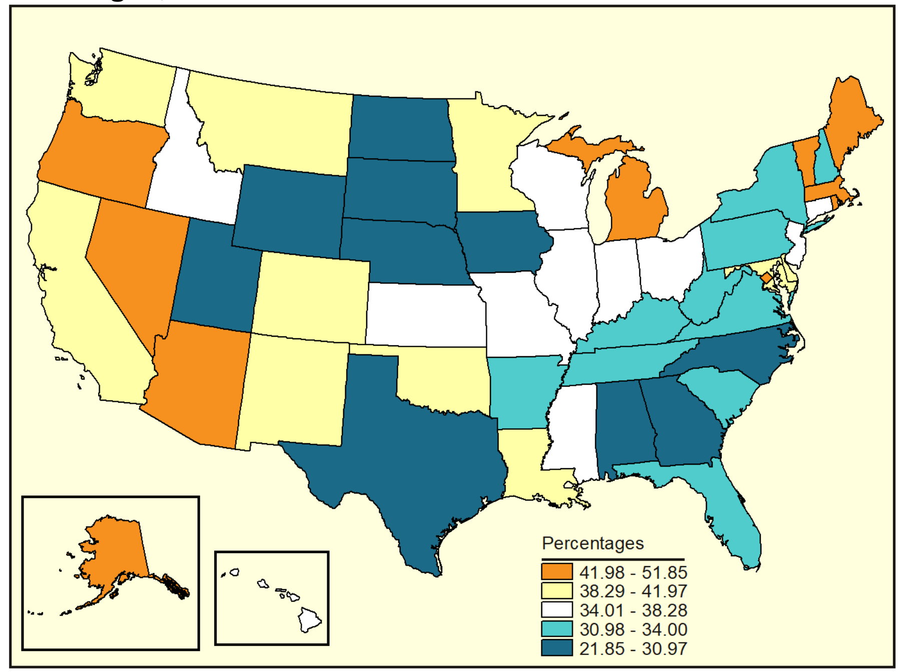
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 2b ***Marijuana Use in the Past Year: Among People Aged 12 to 17;*** **by State, Percentages, 2021**



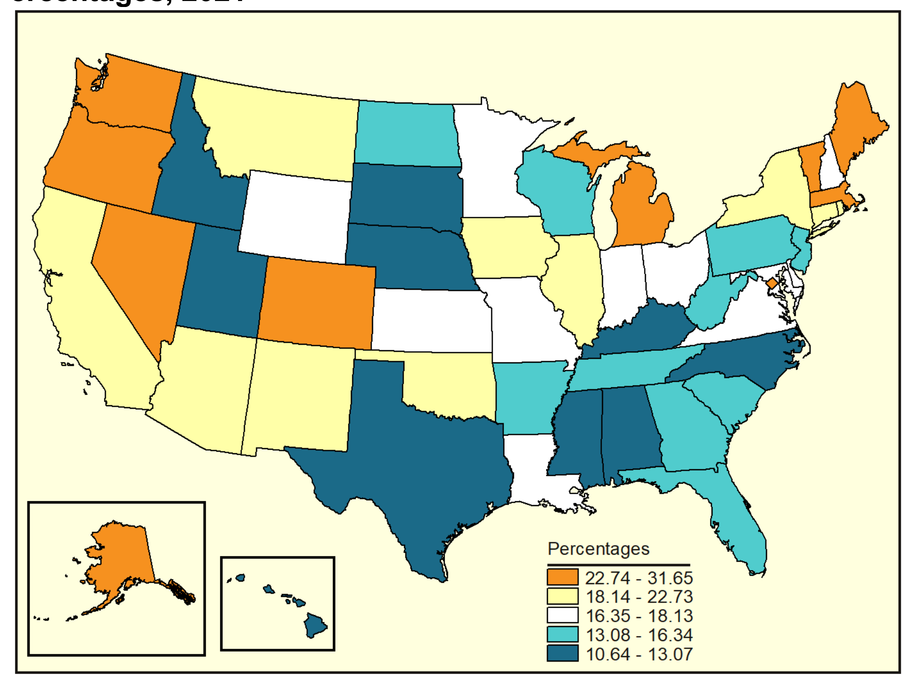
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 2c ***Marijuana Use in the Past Year: Among People Aged 18 to 25;*** **by State, Percentages, 2021**



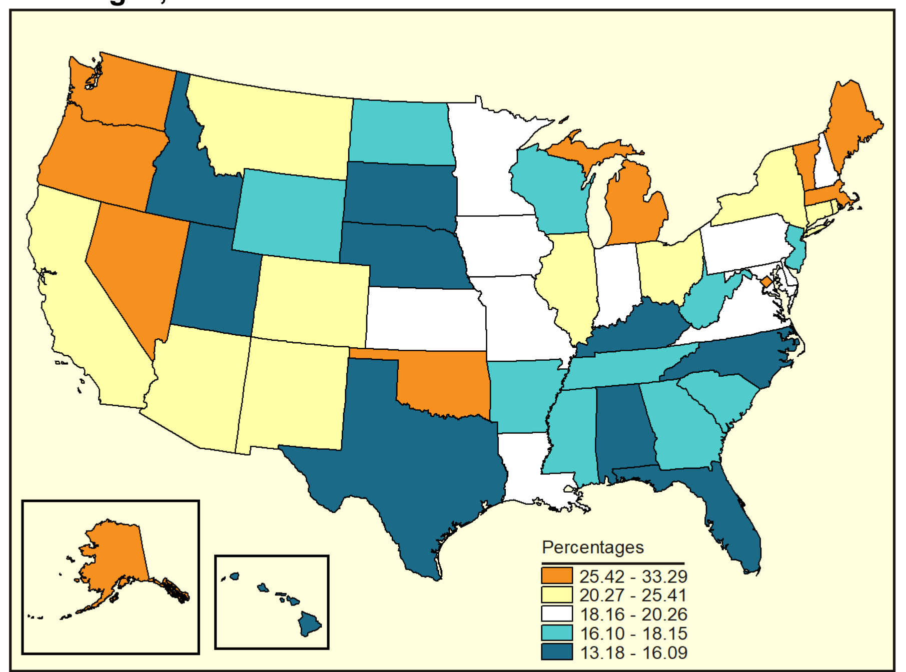
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 2d ***Marijuana Use in the Past Year: Among People Aged 26 or Older;*** **by State, Percentages, 2021**



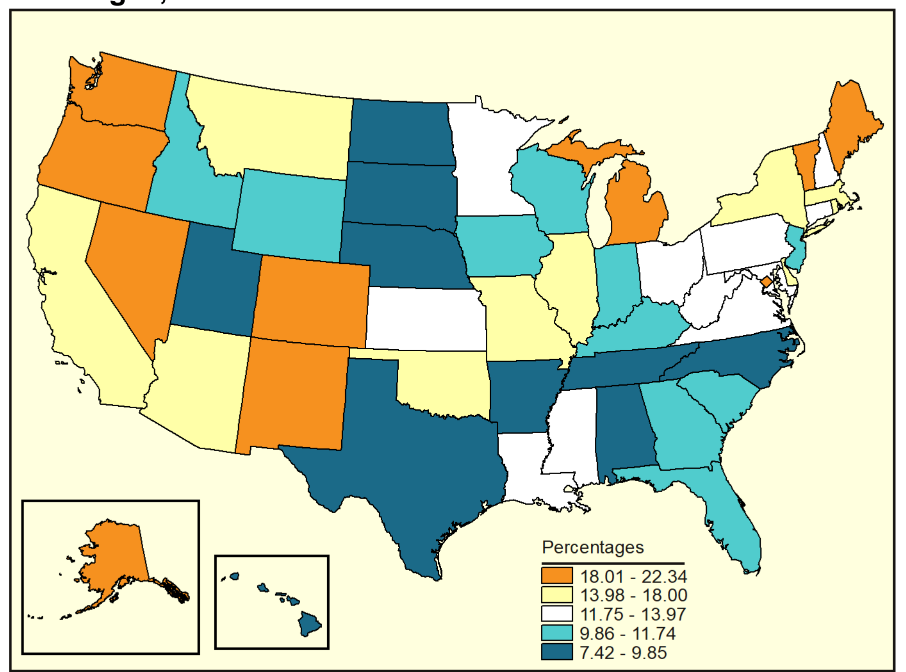
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 2e ***Marijuana Use in the Past Year: Among People Aged 18 or Older;*** **by State, Percentages, 2021**



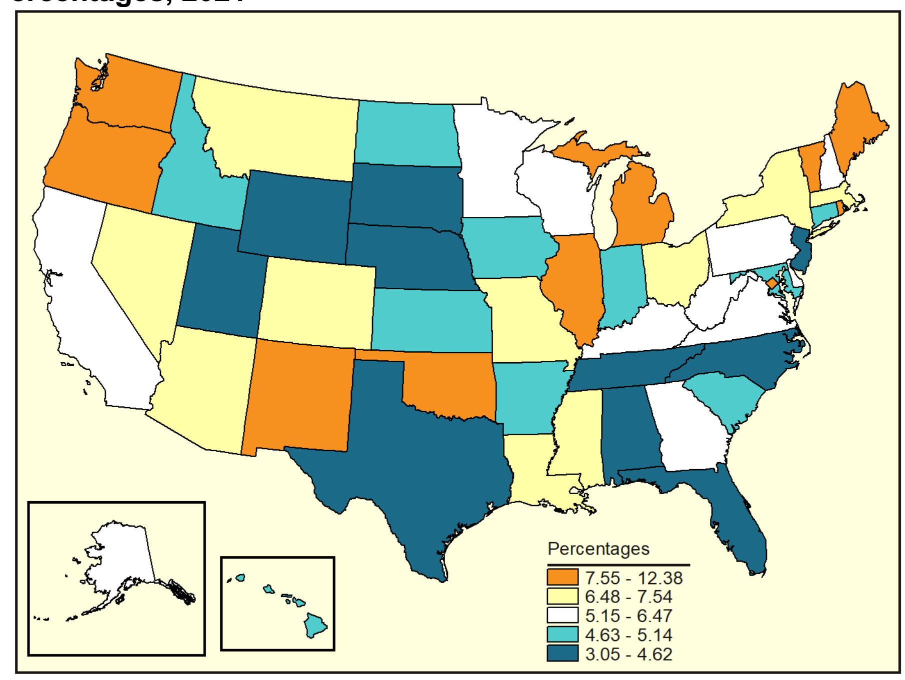
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 3a ***Marijuana Use in the Past Month: Among People Aged 12 or Older;* by State, Percentages, 2021**



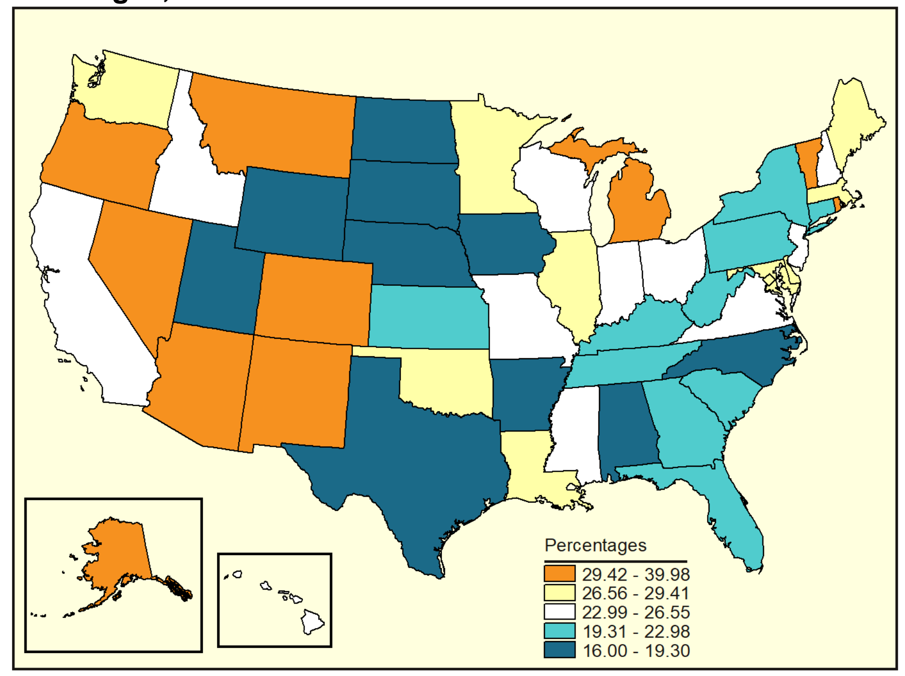
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 3b ***Marijuana Use in the Past Month: Among People Aged 12 to 17;* by State, Percentages, 2021**



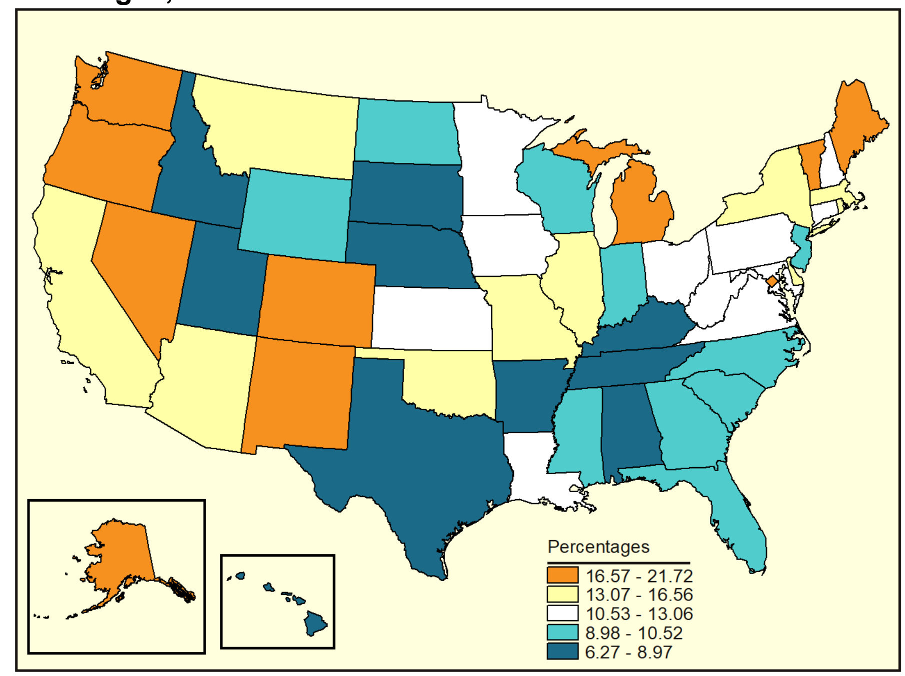
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 3c ***Marijuana Use in the Past Month: Among People Aged 18 to 25;*** **by State, Percentages, 2021**



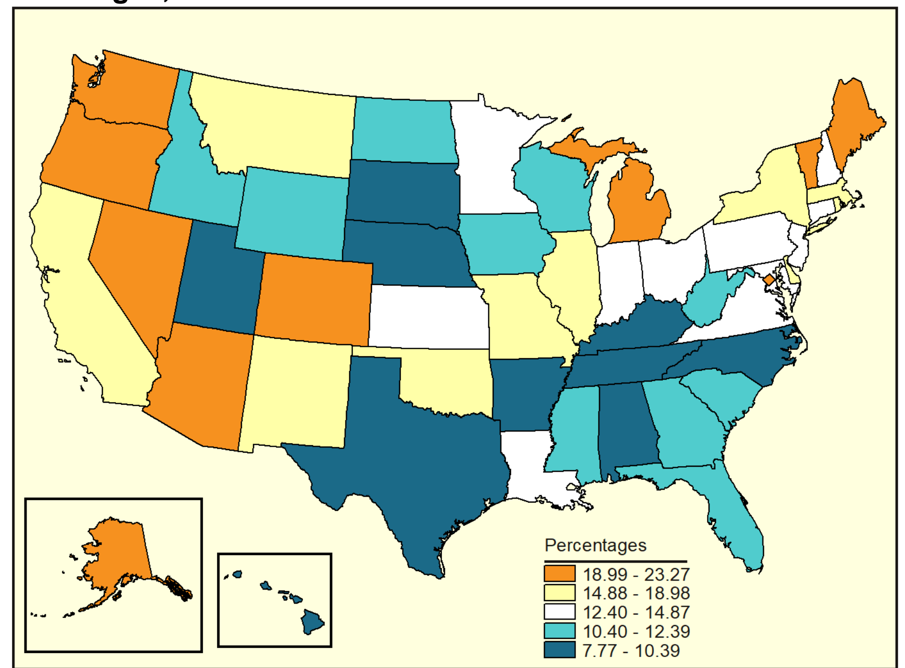
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 3d ***Marijuana Use in the Past Month: Among People Aged 26 or Older;*** **by State, Percentages, 2021**



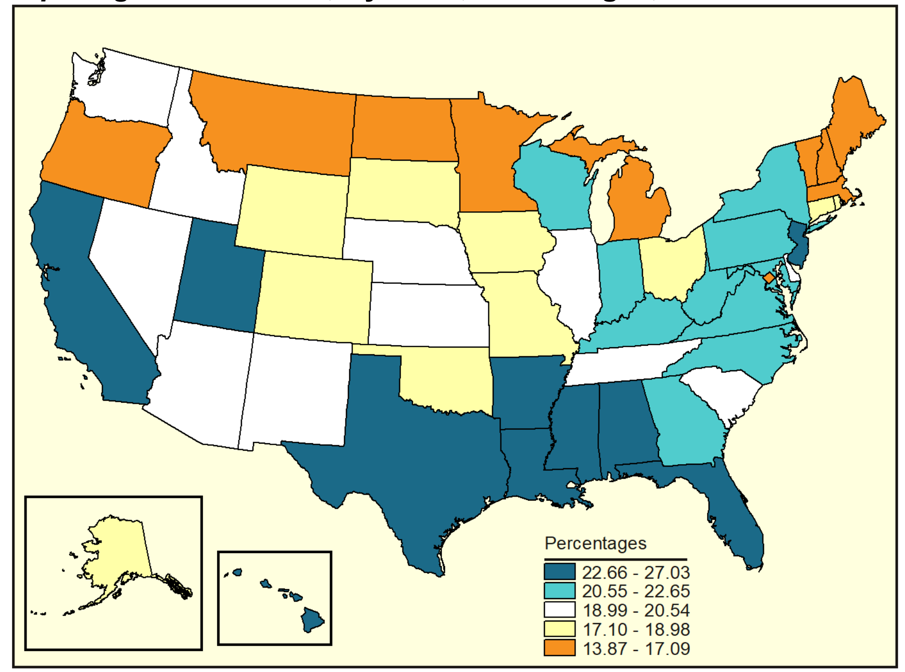
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 3e ***Marijuana Use in the Past Month: Among People Aged 18 or Older;*** **by State, Percentages, 2021**



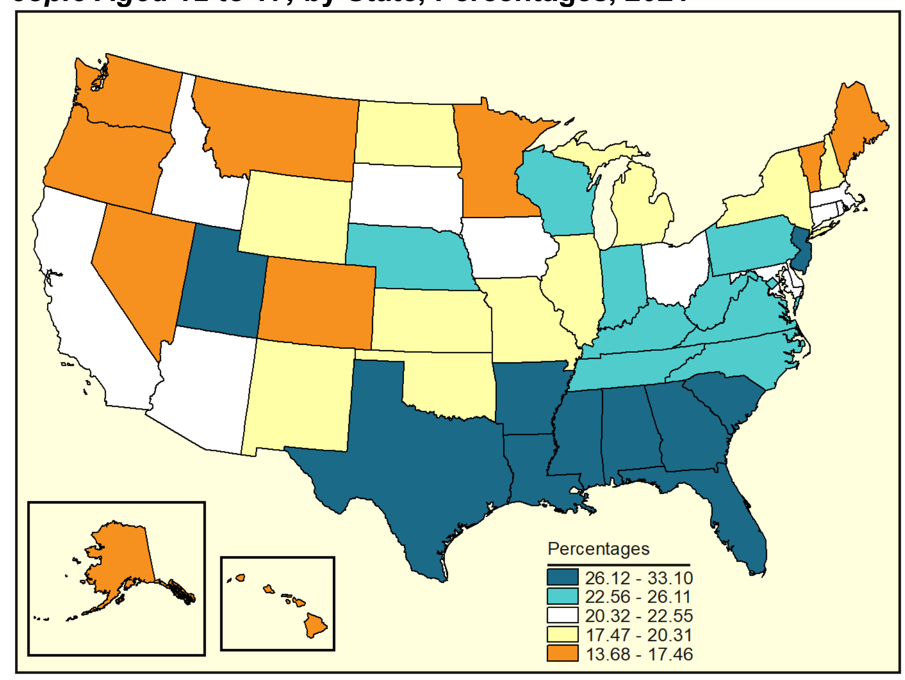
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 4a ***Perceptions of Great Risk from Smoking Marijuana Once a Month: Among People Aged 12 or Older;* by State, Percentages, 2021**



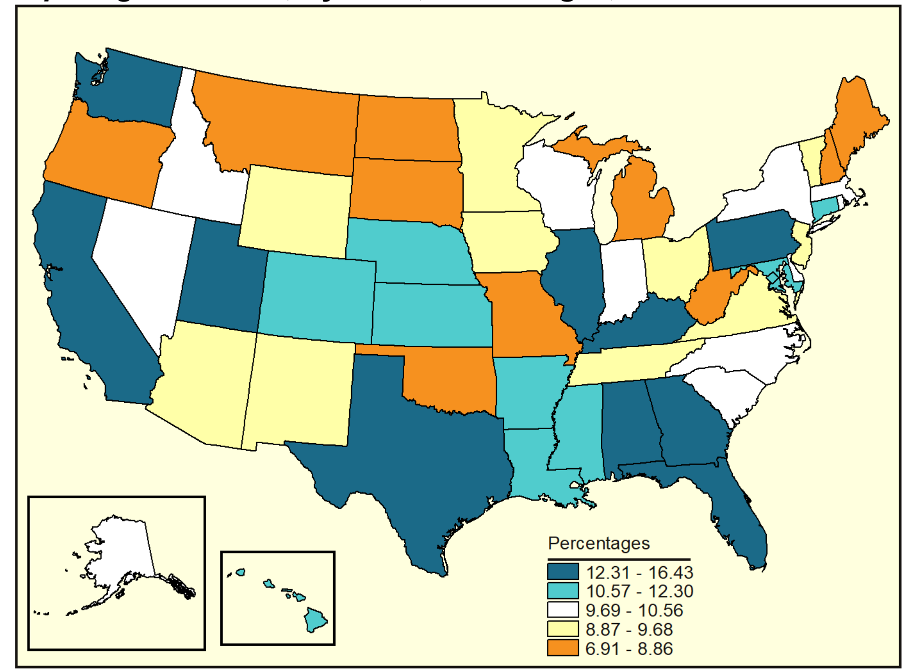
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 4b ***Perceptions of Great Risk from Smoking Marijuana Once a Month: Among People Aged 12 to 17;* by State, Percentages, 2021**



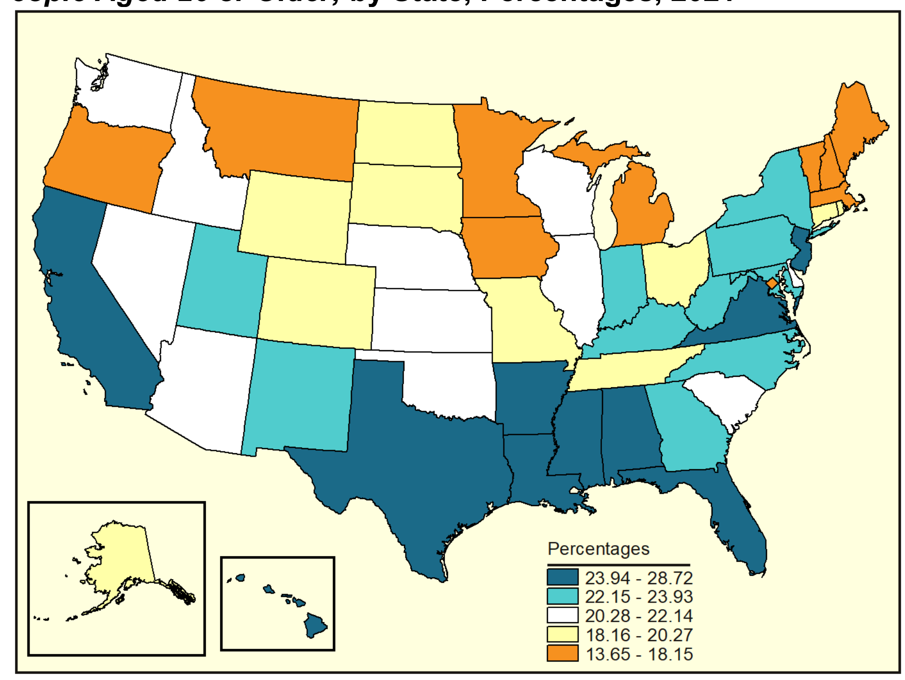
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 4c ***Perceptions of Great Risk from Smoking Marijuana Once a Month: Among People Aged 18 to 25;* by State, Percentages, 2021**



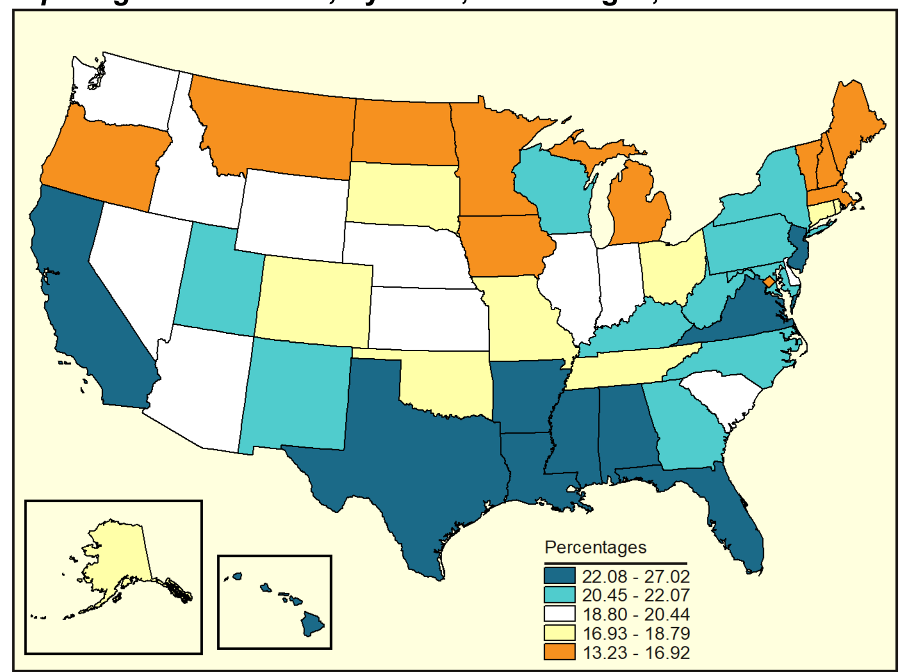
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 4d ***Perceptions of Great Risk from Smoking Marijuana Once a Month: Among People Aged 26 or Older;* by State, Percentages, 2021**



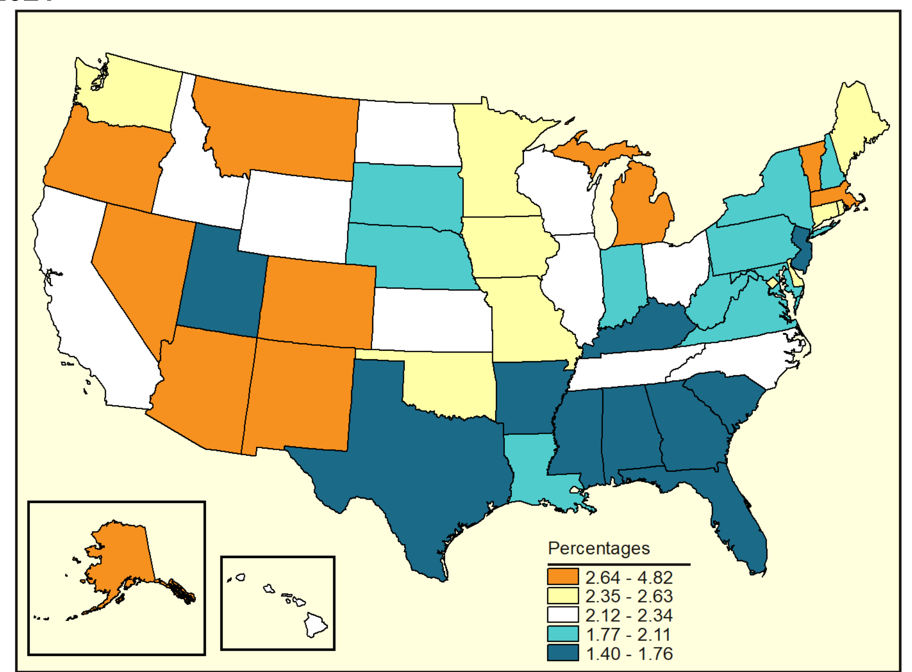
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 4e ***Perceptions of Great Risk from Smoking Marijuana Once a Month: Among People Aged 18 or Older;*** **by State, Percentages, 2021**



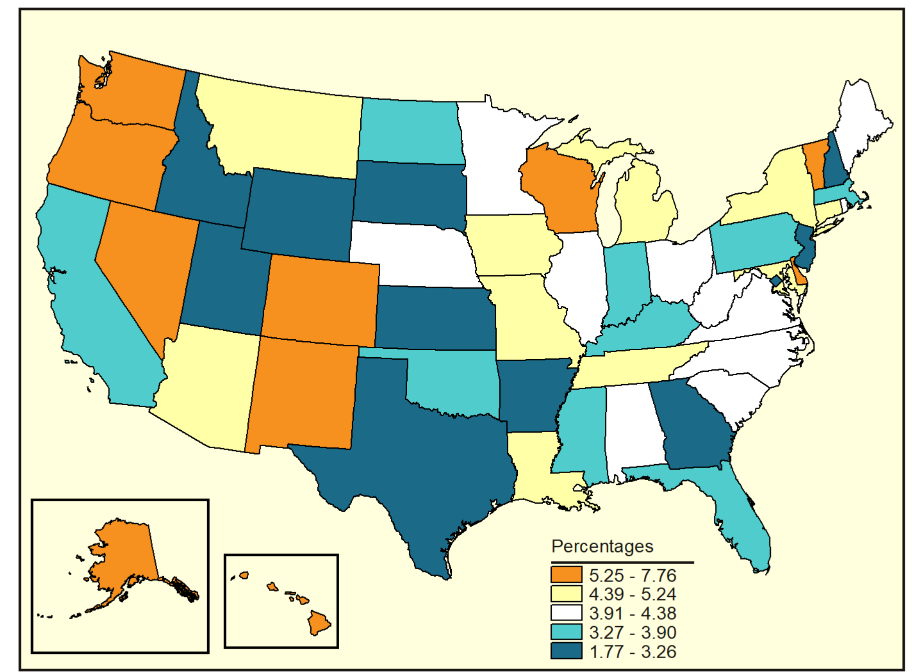
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 5a ***First Use of Marijuana in the Past Year: Among People Aged 12 or Older at Risk for Initiation of Marijuana Use;* by State, Percentages, 2021**



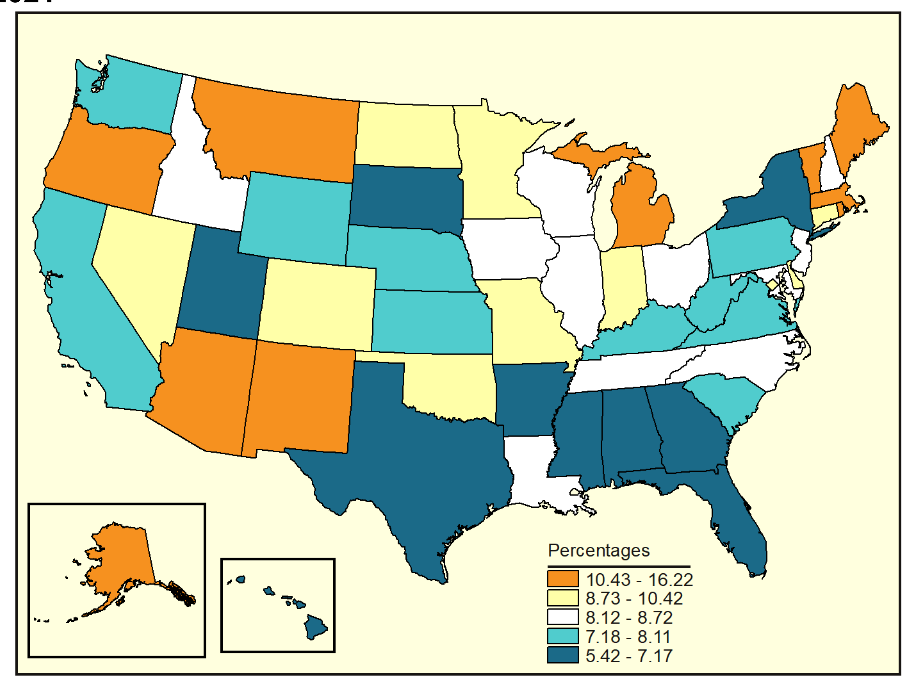
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 5b ***First Use of Marijuana in the Past Year: Among People Aged 12 to 17 at Risk for Initiation of Marijuana Use;* by State, Percentages, 2021**



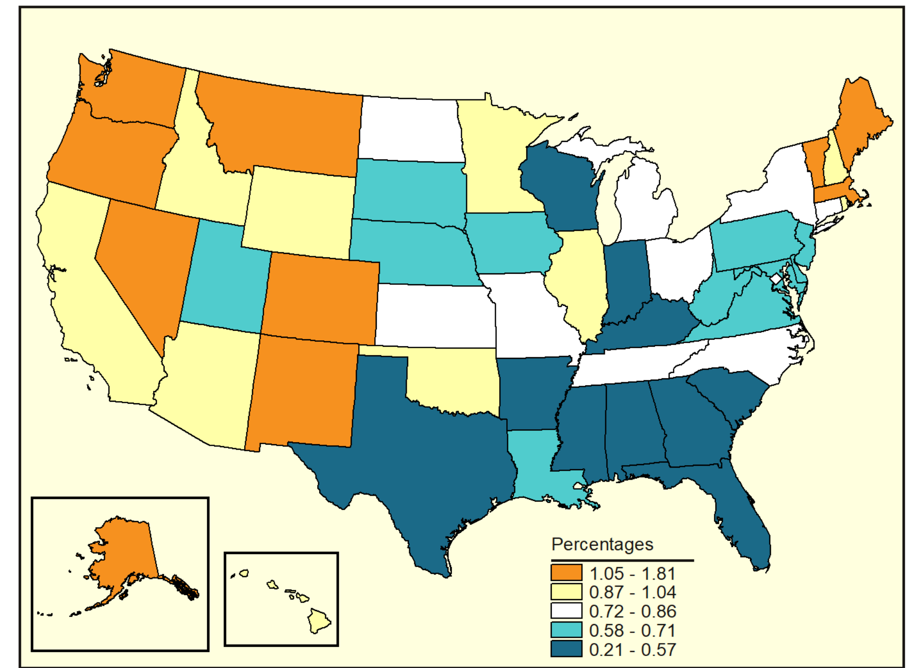
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 5c ***First Use of Marijuana in the Past Year: Among People Aged 18 to 25 at Risk for Initiation of Marijuana Use;* by State, Percentages, 2021**



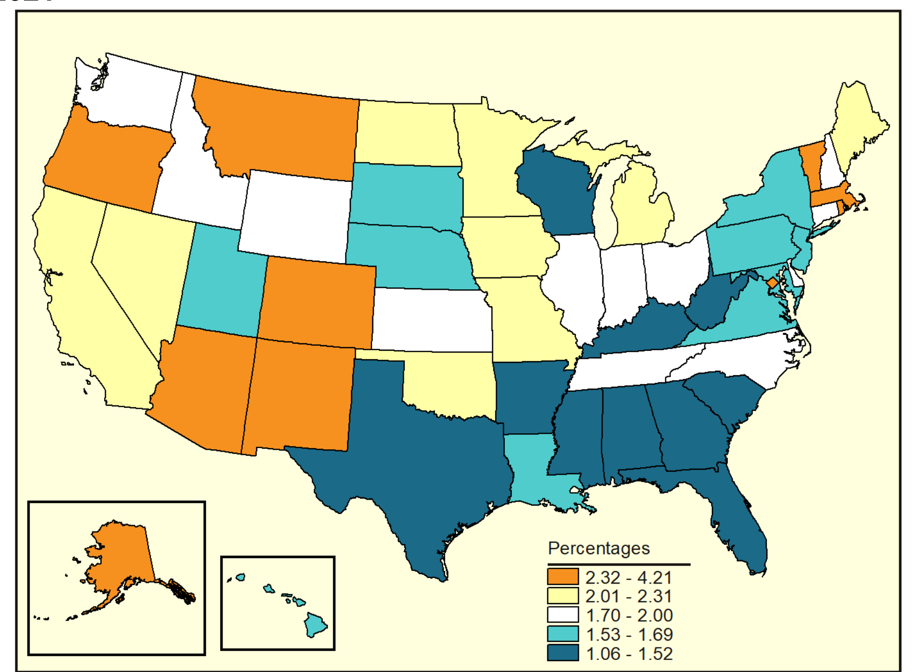
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 5d ***First Use of Marijuana in the Past Year: Among People Aged 26 or Older at Risk for Initiation of Marijuana Use;* by State, Percentages, 2021**



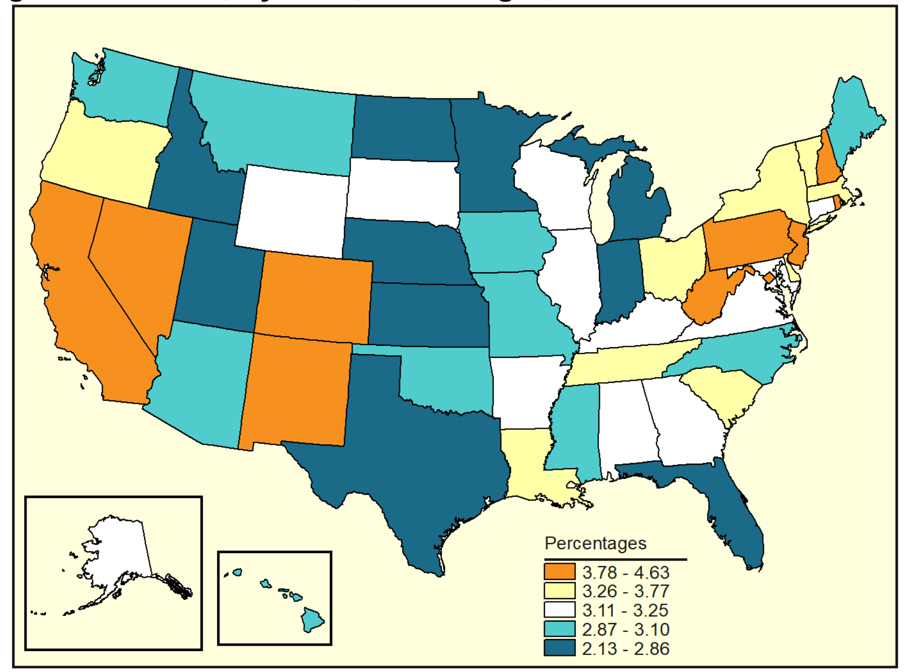
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 5e ***First Use of Marijuana in the Past Year: Among People Aged 18 or Older at Risk for Initiation of Marijuana Use;*** **by State, Percentages, 2021**



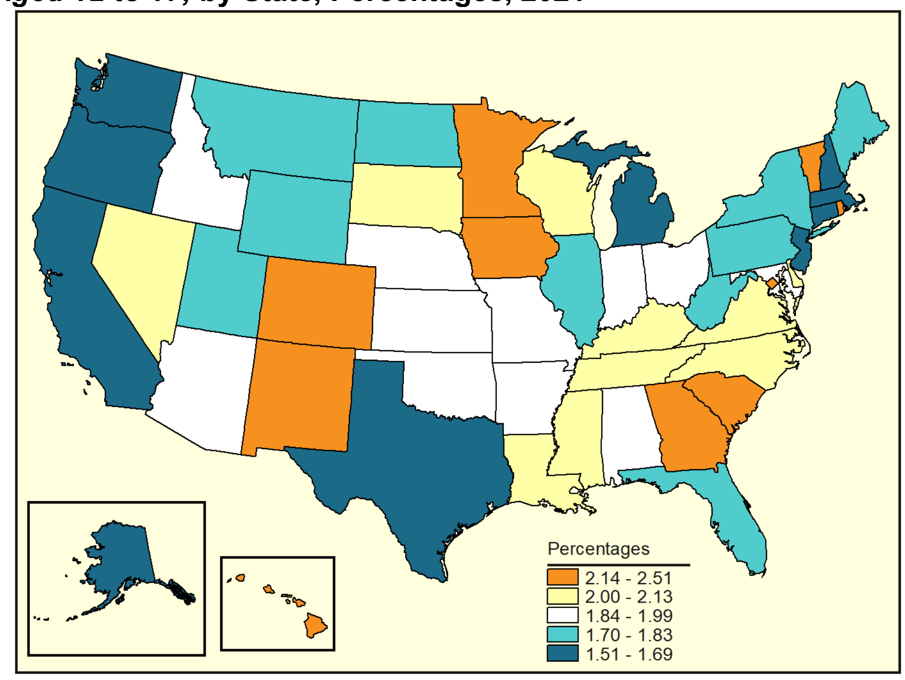
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 6a ***Illicit Drug Use Other Than Marijuana in the Past Month: Among People Aged 12 or Older;* by State, Percentages, 2021**



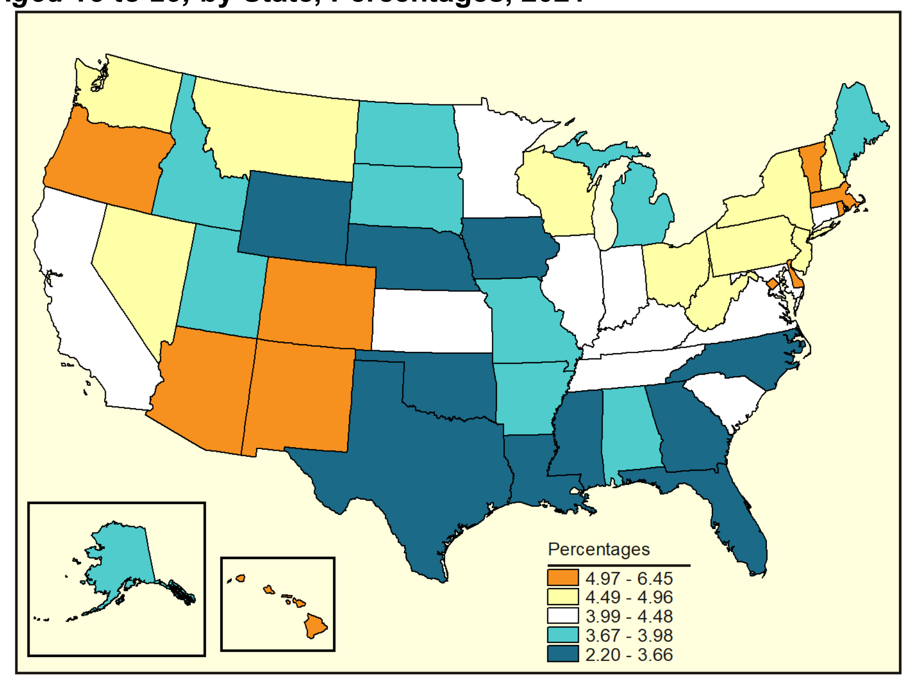
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 6b ***Illicit Drug Use Other Than Marijuana in the Past Month: Among People Aged 12 to 17;* by State, Percentages, 2021**



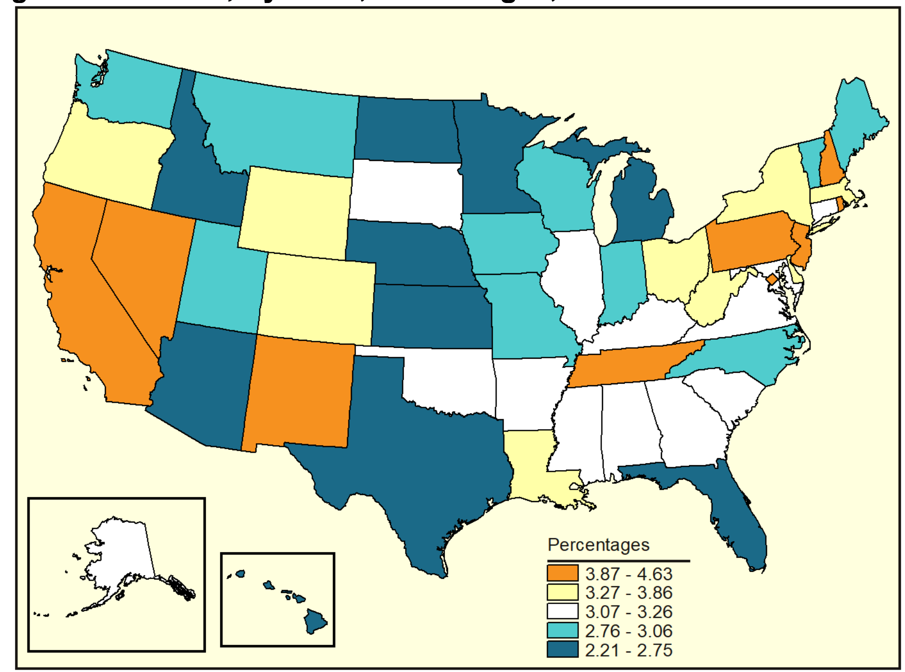
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 6c ***Illicit Drug Use Other Than Marijuana in the Past Month: Among People Aged 18 to 25;*** **by State, Percentages, 2021**



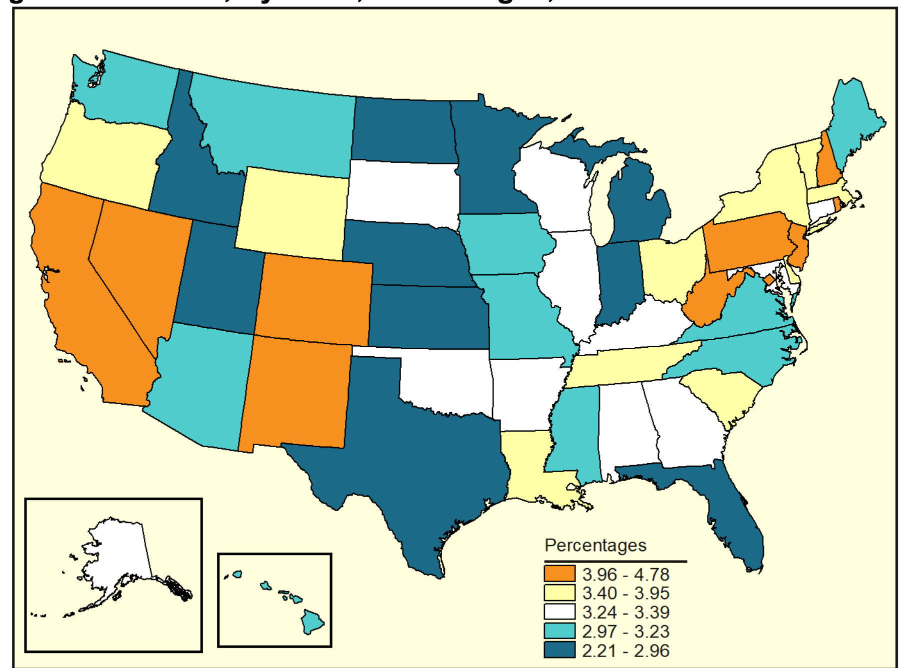
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 6d ***Illicit Drug Use Other Than Marijuana in the Past Month: Among People Aged 26 or Older;*** **by State, Percentages, 2021**



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Figure 6e ***Illicit Drug Use Other Than Marijuana in the Past Month: Among People Aged 18 or Older;* by State, Percentages, 2021**



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

Sponsored By GREENTANK Believe in what you breathe ZUBER LAWLER

The State of Legal Cannabis Markets

8TH EDITION

PUBLISHED BY

Greentank

At Greentank, we believe great extracts need great hardware. For too long, the cannabis industry has been flooded with inferior vaporization hardware built on outdated technology.

We're on a mission to change that.

Designed in North America, we develop and manufacture innovative, high-performance vaporization hardware exclusive to the cannabis industry. We provide licensed producers and extractors with state-of-the-art vaporization technology, engineered specifically for each brand's extract formulations. This delivers the full flavor and maximum terpene profiles that their premium oil extractions deserve.

Today, we work with cannabis brands around the world, providing them with vape hardware that is reliable, innovative, and best in class.

ZUBER LAWLER

Zuber Lawler

Zuber Lawler, one of the most selective law firms in the United States, represents clients throughout the world from offices in Chicago, Los Angeles, Silicon Valley, and New York. In addition to representing a long list of Fortune companies, as well as funds and government entities, Zuber Lawler has represented leading cannabis clients for over 12 years. Zuber Lawler's attorneys work in languages covering 90% of the world's population.

The worldwide market will more than triple
from $14.8 billion in 2019 to $46.8 billion (in 2025)…
these growth forecasts establish a reasonable foundation
upon which to build a more rational business plan
in the post-correction cannabis markets

The State of Legal Cannabis Markets

8TH EDITION

LETTER FROM THE PUBLISHER 9

EXECUTIVE SUMMARY
Legalization is Just the First Challenge 11

LETTER FROM THE EDITOR 18

CHAPTER 1: LEGAL CANNABIS IN THE 2020S
New Decade Brings New Challenges 23

CHAPTER 2: INVESTMENT
Perception Versus Reality 33

CHAPTER 3: FORECAST
Global Spending to Triple by 2025 44

CHAPTER 4: CANADA
Sales Soar Despite Early Struggles 54

CHAPTER 5: UNITED STATES
Legal Progress Fuels Dynamic Growth 61

CHAPTER 6: INTERNATIONAL
Medical Spending Jumped 91% in 2019 110

CHAPTER 7: CANNABIS TIMELINE
Before and After Prohibition 132

Acknowledgements

Publisher
Arcview Market Research
in partnership with BDSA

Editor In Chief
Tom Adams

Industry Intelligence Team
Tom Adams—Principal Analyst
Christine Arrington—Principal Advisor/Cannabis Science, Senior Analyst
Michael Arrington—Editorial Director, Senior Analyst
Brendan Mitchel-Chesebro—Analyst
Hans Dobbratz—Analyst
Maya Jasmin—Research Director, Senior Analyst
Laura Lee—Operations Director, Associate Analyst

Copy Editors
Sandra Leader
Antonn Park
Jan Saxton
Molly Woulfe

Report Design
Jason Deller
Micah Daigle

Advisors
Roy Bingham
Troy Dayton

Contributors:

NEW
CANNABIS
VENTURES

Special Thanks:

Disclosure
There are many companies mentioned in this report. Some of them are clients of The Arcview Group/Arcview Market Research, BDSA, and/or their officers and employees. In some cases, the publishers have minority stakes, warrants, or options in the companies featured. Neither Arcview nor BDSA has received any compensation for coverage in this report. Since such a high percentage of companies in the sector are Arcview or BDSA clients, it is part of what makes them most suited to have the deepest understanding of the markets.

Copyright
This report's copyright is owned by Arcview Market Research and BDSA. All rights reserved. No part of this publication may be reproduced, distributed, or transmitted in any form or by any means, including photocopying, recording, or other electronic or mechanical methods, without the prior written permission of the publisher, except in the case of brief quotations embodied in critical reviews and certain other non-commercial uses permitted by copyright law. For permission requests, contact the publisher at the email below.

Arcview Market Research
info@arcviewgroup.com | 855-892-1951

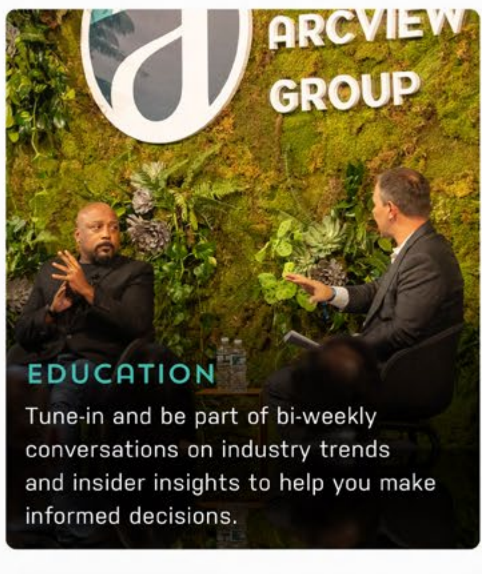
BDSA
info@bdsanalytics.com | 720-465-9692

The Arcview Group celebrates a decade of deal-making and watching recession-resistant cannabis go from illegal to ESSENTIAL.

Connect with us Today: ARCVIEWACCESS.COM

ARCVIEW 10th ANNIVERSARY

WE MEET YOU WHERE YOU ARE TO GET YOU WHERE YOU NEED TO BE.

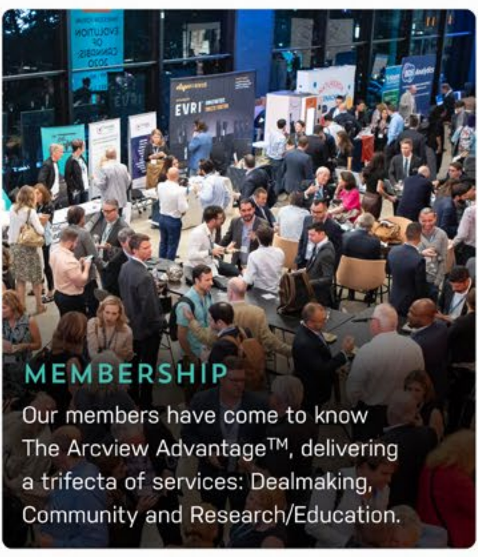


EDUCATION

Tune-in and be part of bi-weekly conversations on industry trends and insider insights to help you make informed decisions.

COMMUNITY

Join Groups and Events to make connections and foster collaborations to help grow your business. Your net-worth depends on your network.



MEMBERSHIP

Our members have come to know The Arcview Advantage™, delivering a trifecta of services: Dealmaking, Community and Research/Education.

INVESTMENT VENTURES

Seed & Early Stage Investment.
1st Member Managed Cannabis Fund.
Our members are highly experienced and executives of successful entities.

INDUSTRY INSIGHTS

The #1 cited market research for the cannabis industry, for the most informed analysis and projections about one of the fastest-growing industries in the world.

ArcviewAccess.com

The Arcview Group is the first and largest group of high-net worth investors in this sector. Bringing 10 years of experience and connectedness to its community and this industry.

Our members have invested more than $270 million in over 200 companies such as:

Letter From the Publisher

Thank you for purchasing the 8th edition of "The State of the Legal Cannabis Markets." It's an honor to serve you through this mind-bending time in the cannabis sector.

It's always been important to really understand the dynamics driving this industry to fully maximize your involvement in it, but as the COVID-19 response reframes the world of business and investing for so many global markets, it has put an exclamation point the value of good data and analysis.

In most places where cannabis is legal, it has been deemed an essential service in shelter-in-place orders. If you had told me ten years ago when we started Arcview, that governments would be declaring cannabis "essential" a decade later, I would have asked for a double dose of whatever you were inhaling.

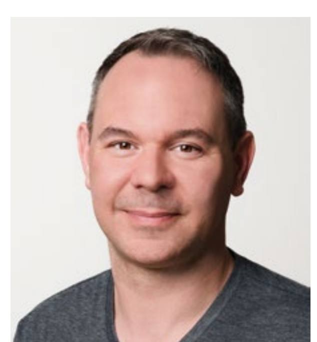
At the same time, cannabis companies and many ancillary businesses are being denied access to money being made available to less essential sectors under the U.S. federal relief package.

Rapid change is common in fast-growing markets like cannabis, and that presents both enormous opportunities to make life-changing money or lose your shirt…quickly.

That's why The Arcview Group and BDSA worked tirelessly to produce this report and keep you up to date, year-round.

Luck favors the most knowledgeable and prepared. With that in mind, good luck out there.

Be well, be free,



Troy Dayton
Founder & Chief Strategy Officer
The Arcview Group

INNOVATING TOGETHER

When you partner with Greentank
You're not just partnering with visionary hardware.
You're partnering with award-winning innovation
Industry-first initiatives
And a level of customization that is simply unparalleled.
From your extracts, to your customer's experience
When you choose Greentank
You get a partner that's all in, every step of the way.
Unrivaled vape hardware. Unmatched commitment.
It's Greentank Made or it's anyone's guess.

GREENTANK MADE GREENTANK MADE

Contact info@greentanktech.com to learn more about the most advanced vape hardware.

Play video to see what drives us. greentanktech.com

Legalization is Just the First Challenge

Just one year passed between cannabis stocks peaking March 21, 2019, and the first cannabis store closures due to the COVID-19 pandemic. It was a wrenching period for the industry as it found out the hard way that legalization is just the first step in building a regulated legal industry around Cannabis sativa.

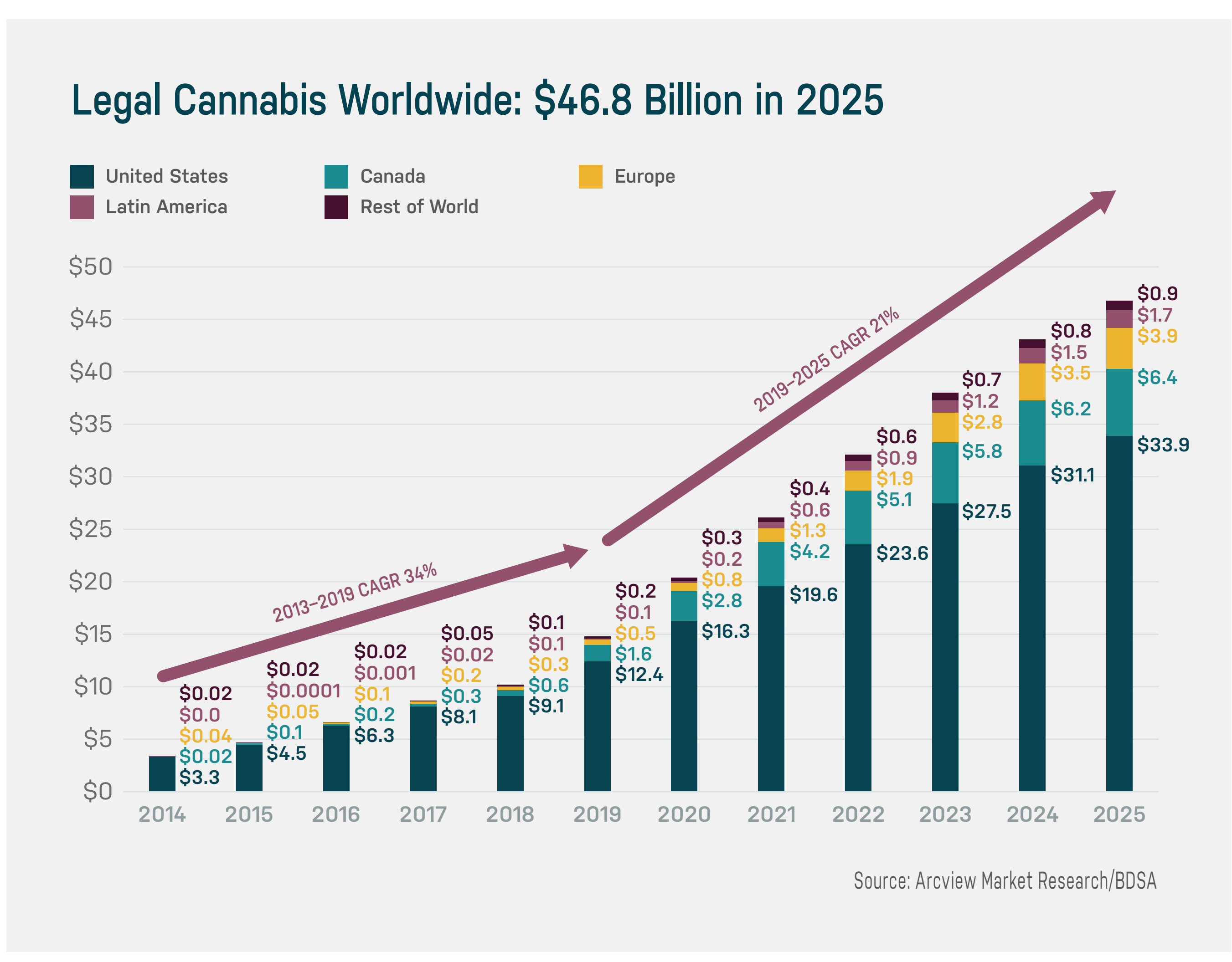
But fundamental growth overcomes all, and the legal cannabis industry has that assured as long as legalization continues to gain momentum. There seems little doubt that it will since:

- Support for full legalization among residents of the United States passed 50% for the first time in Gallup's five-decade tracking in 2013 in the wake of Colorado and Washington voters backing it in the November 2012 election. It is now at 66%.
- More than one-quarter of American adults already consume cannabis, with 29% of respondents in BDSA's fourth-quarter Consumer Insights study saying they have consumed it in the past six months. That is more than half of the 54% who reported consuming wine, beer or spirits during the same period.

Shifting views and baseline demand are the key drivers of the remarkable 34.3% compound annual growth rate (CAGR) the global legal cannabis industry has seen between 2013 (the last of the all-medical years), when spending was just $3.3 billion, and 2019 (the sixth year of the adult-use era) when it hit $14.8 billion.

Growth in 2019 alone was 46.1%, a dramatic reacceleration after industry growth slipped to just 15.8% in 2018 as the two largest single markets in California and Canada struggled in their initial 2018 adult-use rollouts. California's operators continued to find it challenging to compete with an illicit market that lacks their heavy tax and regulatory load. Revenue there grew just 18.4% in 2019.

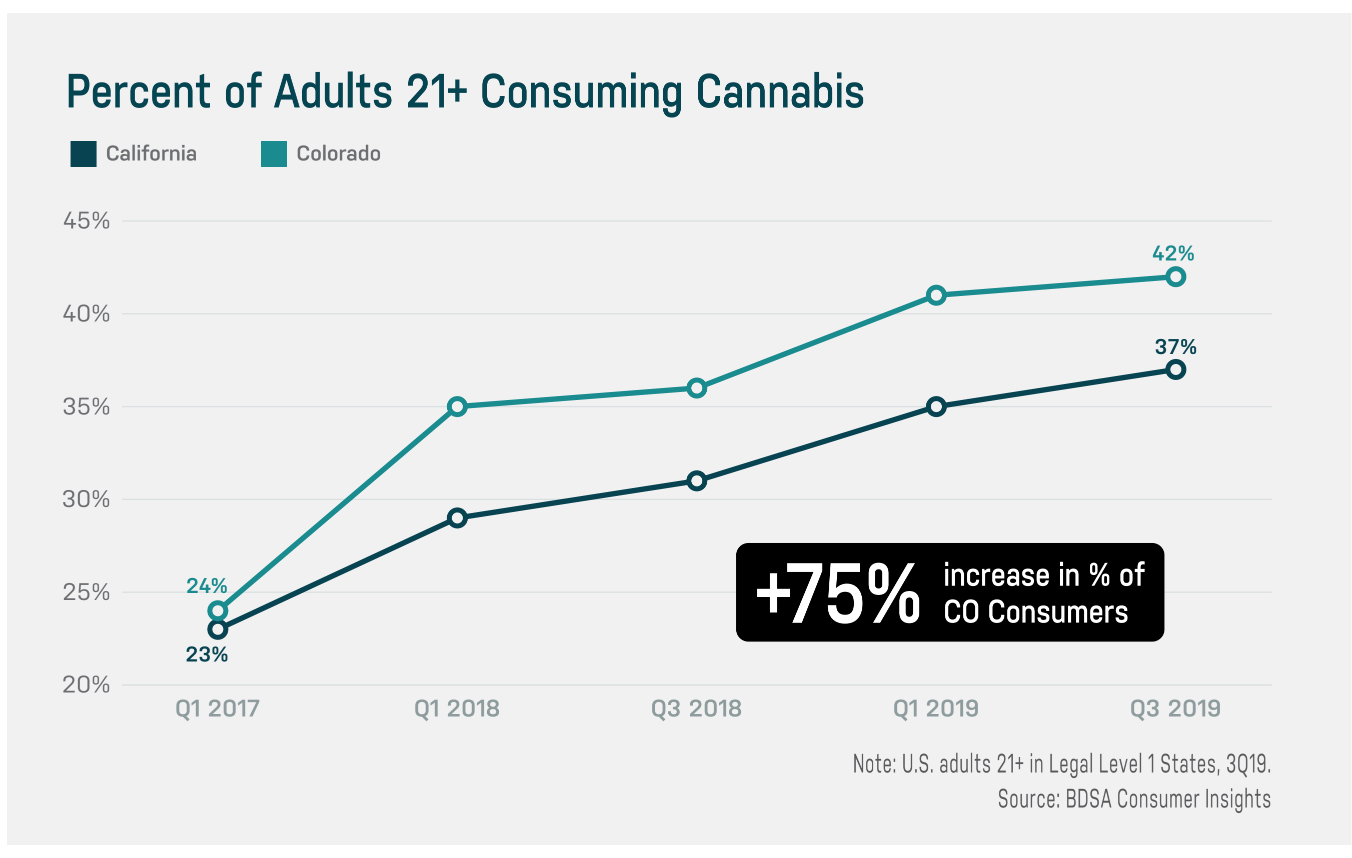
Canada's market fared much better as total revenue jumped from $582 million in 2018 to $1.6 billion (see chapter 4 "Canada"). Several U.S. states also showed enormous growth. Emerging adult-use states like Nevada, Massachusetts and Michigan posted some of the biggest growth percentages; but so did medical-only states like Illinois, Oklahoma and New York as store penetration expanded across those markets.



The Future: More Rapid Growth

Arcview Market Research and BDSA now forecast worldwide spending to grow 38% to $20.4 billion in 2020, meaning global legal cannabis spending will have doubled in two years. A second wave of growth is being driven in legal states by the fact that the percentage of consuming adults typically goes up post-legalization. Both California (+61%) and Colorado (+75%) have seen substantial gains in the percentage of adults consuming since the first quarter of 2017, according to BDSA Consumer Insights studies. They consume for recreational and social reasons (71%), or health and medical reasons (63%). Thirty-two percent say they do both.

The lion's share of total global spending remains in illicit channels. Even at $14.8 billion in legal sales in 2019, just 7% of an estimated $214-billion worldwide cannabis market is conducted through legal channels. In the U.S., even some of the markets that have had legal adult-use sales for five years or more still



see 30%-50% of sales go to the illicit pipeline. And, of course, in markets that have not even legalized medical cannabis, 100% of sales occurred in untaxed and unregulated illicit channels.

The U.S. had been poised make great strides against illicit sales in 2020. Eleven states had petition drives underway to put legalization ballot measures before voters Nov. 3, including efforts in the Deep South and Great Plains where little progress had previously been seen. COVID-19 quarantines may leave as few as four states able to vote to legalize medical or adult-use sales, with South Dakota to vote on both. Several legislative processes to legalize also have been deferred due to shelter-in-place orders (see chapter 1 "Legal Cannabis in the 2020s").

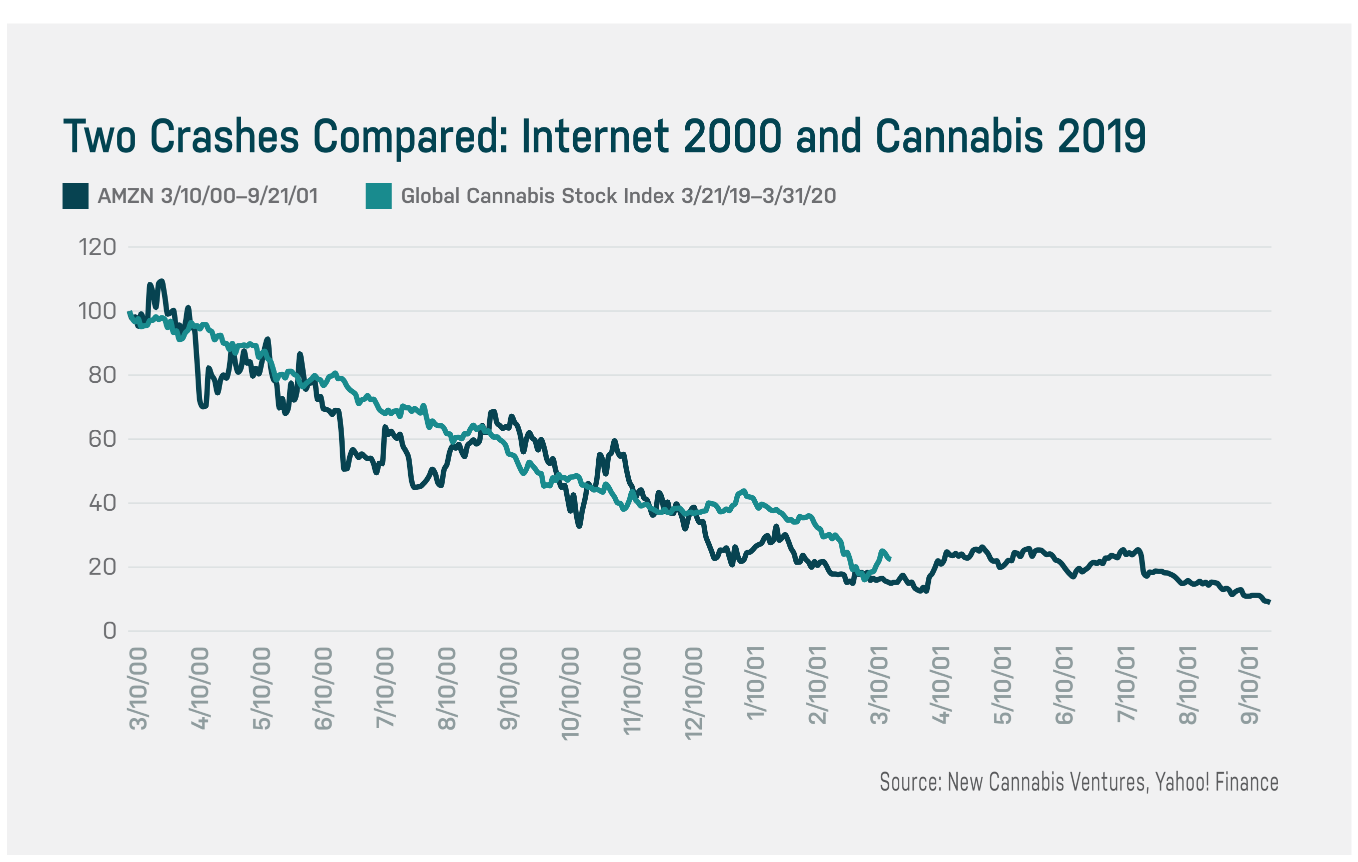
The declaration of cannabis as an "essential service" amid the COVID-19 pandemic was an historic moment for the industry. It is a clear signal of how dramatically the status of cannabis has changed in the last decade. That, in turn, suggests that legalization efforts will continue once quarantines are lifted, perhaps with newfound support from state officials looking to fill enormous budget shortfalls from the recession that started abruptly in March.

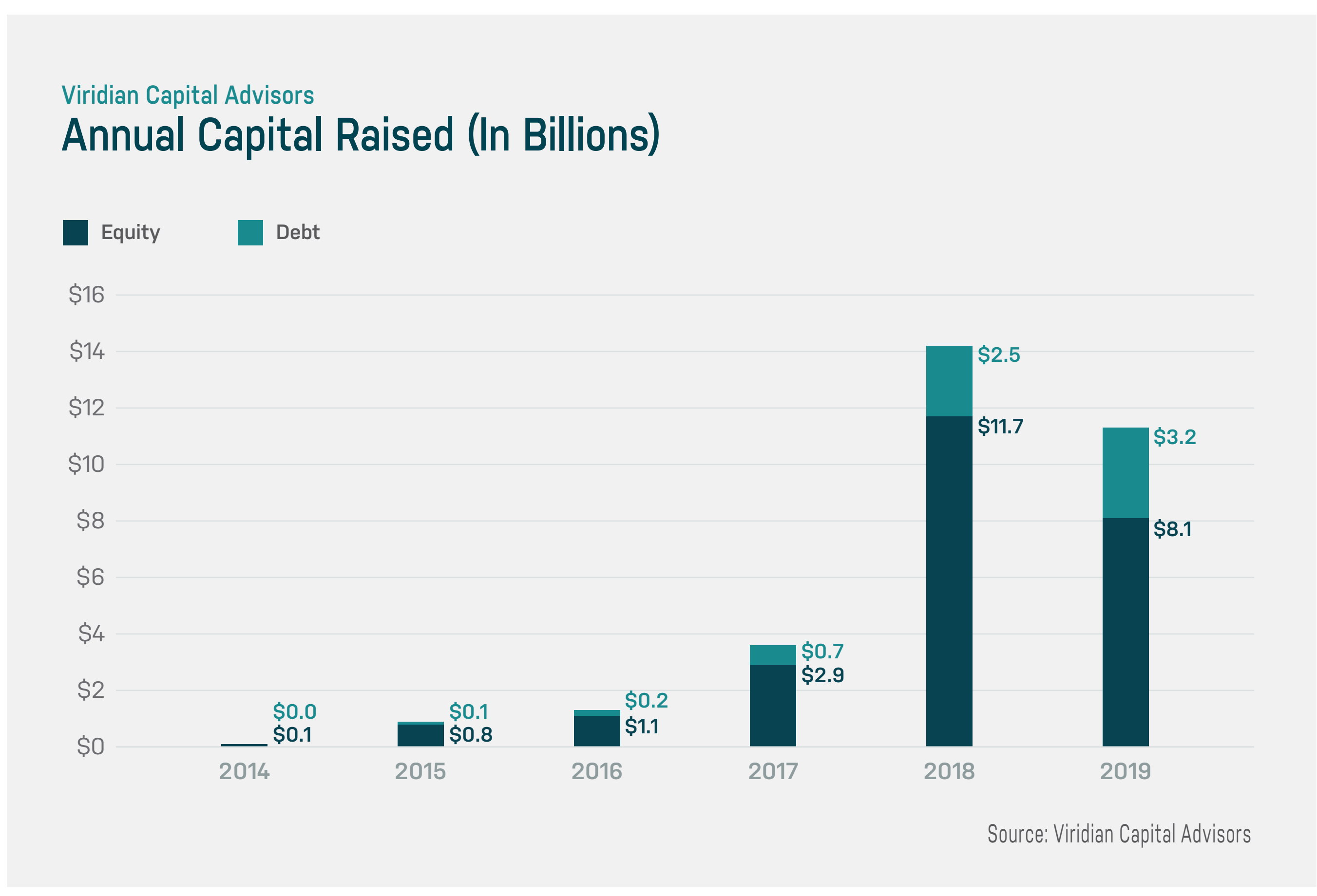
Arcview Market Research and BDSA forecast that all U.S. states will have medical cannabis by 2025, and nearly half will have adult-use legalization. The U.S. and Canada, then, will be the chief drivers of worldwide legal cannabis spending growth, with worldwide legal cannabis spending growing at a 21% CAGR over the next six years to $46.8 billion in revenue in 2025 (see chapter 3 "Forecast").

The Cannabis Crash of 2019

Exceptional growth, however, was not enough to save public cannabis stocks from one of the worst routs any sector has seen since the dot-com crash of 2000 (see chapter 2 "Investment"). New Cannabis Ventures' Global Cannabis Stock Index peaked March 21, 2019, almost 19 years to the day after the tech-heavy NASDAQ Average peaked March 10, 2000. At that point, the top five Canadian licensed producers sported a combined market cap of $48 billion and the top five American multistate operators were valued at a combined $15.4 billion. Both the internet and cannabis sectors then suffered 80% one-year declines.

The fact that Amazon's stock—now one of the most valuable in the world—survived that previous boom-bust cycle does not solve the immediate crisis for





cannabis companies, which has been intensified by the COVID-19-inspired bear market that mauled all equities in March 2020. Few cannabis companies have ever turned a profit, hence were wholly reliant on new capital coming in to sustain existing operations, much less expand.

Now, companies are essentially having to dust off their 2017 playbooks from before Canada opened up the public equity market to them. A flood of public offerings extended the pool of available investors well beyond the private offices and venture firms willing to invest in companies that "touched the plant" while under the shadow of federal prohibition. In 2018, more money was raised for cannabis companies, private and public, than in all prior years combined, as tracked by Viridian Capital Advisors Deal Tracker. The pace continued into the first half of 2019, but fourth-quarter raises were down 89% from the record $8.1 billion raised in fourth-quarter 2018.

Spotting the Opportunities Ahead

Not every cannabis company will have Amazon's success surviving the storm and going on to dominate a whole new global industry. But some will, likely those that best spot and capitalize on near-term regional opportunities to break even and then use the earnings to expand from that base. To that end, this 8th Edition of "The State of Legal Cannabis Markets" provides in-depth guides to the regulatory and market situations in the key U.S. states, Canadian provinces and countries outside North America.

U.S. states have been classified into six groups based on the legal cannabis program (medical or adult-use) expected to be in effect in each market in 2025, coupled with the launch date of that program ("mature markets" launched pre-2017, "emerging markets" prior to 2020, and "new markets" launching in the future). The typology throws light on which markets might be the most attractive for different types of businesses, depending on their financial resources and overall strategies.

There are many surprises and counterintuitive findings that only a comprehensive research effort such as the one undertaken for this 8th edition could uncover. They include:

- The success of Oklahoma's experiment in free-market medical regulations and the sudden acceleration in the long-languishing Florida, New York and New Jersey markets (see chapter 5 "United States").
- The patchwork of Canadian provincial approaches that still allowed for a near tripling of revenue in the country's first full year of adult-use sales.
- The doubling of German spending and the first stirrings of sleeping giants of Mexico and the United Kingdom (see chapter 6 "International").

It adds up to a compelling case: When the world emerges from sheltering in place, the legal cannabis industry will be one of its great hopes for driving renewed economic growth.

Author Manuscript
Author Manuscript
Author Manuscript
Author Manuscript

HHS Public Access

Author manuscript

Alcohol Clin Exp Res. Author manuscript; available in PMC 2017 January 01.

Published in final edited form as:

Alcohol Clin Exp Res. 2016 January ; 40(1): 33–46. doi:10.1111/acer.12942.

Impacts of Changing Marijuana Policies on Alcohol Use in the United States

Katarina Guttmannova, Ph.D.[1], **Christine M. Lee, Ph.D.**[2], **Jason R. Kilmer, Ph.D.**[2], **Charles B. Fleming, M.A.**[1], **Isaac C. Rhew, Ph.D.**[1,2], **Rick Kosterman, Ph.D.**, and **Mary E. Larimer, Ph.D.**[2]

[1]Katarina Guttmannova, Charles B. Fleming, Isaac C. Rhew, Rick Kosterman, Social Development Research Group, School of Social Work, University of Washington, 9725 3rd Ave NE, Suite 401, Seattle, WA 98115

[2]Christine M. Lee, Jason R. Kilmer, Isaac C. Rhew, and Mary E. Larimer, Department of Psychiatry and Behavioral Sciences, University of Washington, 1100 NE 45th St., Suite 300, Seattle, WA 98105

Abstract

Background—Marijuana policies are rapidly evolving. In the United States, recreational use of marijuana is now legal in four states and medical marijuana is legal in 23 states. Research evaluating such policies has focused primarily on how policies affect issues of price, access to, use, and consequences of marijuana. Due to potential spillover effects, researchers also need to examine how marijuana policies may impact use and consequences of alcohol.

Methods—The current paper is a critical review of articles evaluating alcohol outcomes associated with marijuana decriminalization, medical marijuana legalization, and non-medical or recreational marijuana legalization. We identified articles and reports through (1) online searches of EBSCO host database including Academic search premier, Econlit, Legal collection, Medline, Psych articles, and PsycINFO, as well as PubMed and Google Scholar databases; (2) review of additional articles cited in papers identified through electronic searches; and (3) targeted searches of state and local government records regarding marijuana law implementation. We reviewed studies with respect to their data sources and sample characteristics, methodology, and the margin of alcohol and marijuana use, timing of policy change, and the aspects of laws examined.

Results—The extant literature provides some evidence for both substitution (i.e., more liberal marijuana policies related to less alcohol use as marijuana becomes a substitute) and complementary (i.e., more liberal marijuana policies related to increases in both marijuana and alcohol use) relationships in the context of liberalization of marijuana policies in the United States.

Conclusions—Impact of more liberal marijuana policies on alcohol use is complex, and likely depends on specific aspects of policy implementation, including how long the policy has been in place. Further, evaluation of marijuana policy effects on alcohol use may be sensitive to the age

Please send correspondence concerning this article to Katarina Guttmannova, Social Development Research Group, University of Washington, 9725 3rd Ave NE, Suite 401, Seattle, WA 98115; Tel.: 206.685.3945; Fax: 206.543.4507. kg27@uw.edu.

group studied and the margin of alcohol use examined. Design of policy evaluation research requires careful consideration of these issues.

Keywords

marijuana; cannabis; policy; legalization; alcohol

"Marijuana policy is nothing if not complicated (Chokshi, 2014)." This opening sentence in a Washington Post article prior to the November 2014 elections in the United States (US) summarized the changing climate surrounding marijuana. Starting with Oregon in 1973, eleven US states reduced criminal penalties for possession of small amounts of marijuana during the 1970s. However, these policies varied widely across states (for review see Pacula et al., 2003) with the common denominator being no specific minimum jail or prison sentence for first-time possession of small amount of marijuana. The issue of heterogeneity across the so-called "decriminalization" policies has only increased over time but, as of 2015, 19 US states are considered to have some form of marijuana decriminalization policy.

United States Drug Enforcement Agency scheduling recognizes marijuana as a "Schedule I" drug, meaning there is no accepted medical use in the US. Nonetheless, in 1996 California adopted "medical marijuana" laws allowing use of marijuana to treat a variety of medical conditions, despite federal laws that prohibit marijuana use and possession (Annas, 2014). In 1998, Alaska, Oregon, and Washington followed, as did Maine in 1999 and a number of other states since 2000. Currently, 23 of the nation's 50 states, as well as the District of Columbia and US territories of Guam and Puerto Rico, allow use of marijuana for medical purposes.

Moreover, in 2012, Washington and Colorado legalized marijuana use and possession for non-medical or recreational purposes (hereafter referred to as recreational marijuana laws) for those over 21 years of age, and established regulations governing production, distribution, and sale of marijuana in retail stores (Pardo, 2014). Alaska, Oregon, and the District of Columbia passed their own laws related to recreational use in 2014.

These state-level marijuana policies raise public health and economic concerns because they can have implications not just for marijuana use and consequences, but also for use and consequences of alcohol and other substances (Pacula and Sevigny, 2014). Changes in alcohol use, in particular, are of great concern because the majority of the adults in the US use alcohol and alcohol consumption, especially excessive alcohol use, is extremely costly: between 2006 and 2010, it was responsible for an average of almost 88,000 deaths per year (Stahre et al., 2014), and in 2006 alone it amounted to a median state-cost of 2.9 billion dollars (Sacks et al., 2013). Understanding the impact of marijuana-related legislation on alcohol use is crucial to estimating costs and benefits to society, as well as guiding the design of prevention and intervention efforts (e.g., Caulkins et al., 2012; Kilmer et al., 2010).

Many proponents of marijuana legalization view marijuana as less harmful than alcohol. Proponents also emphasize that even if marijuana legalization increases marijuana use, costs of treating marijuana dependence and related problems are smaller than the potential savings

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

in criminal justice system spending stemming from legalizing marijuana (e.g., Gieringer, 2009). Additionally, if marijuana and alcohol are *substitutes* and increases in marijuana use result in *decreased* alcohol use, this could lead to a great reduction in individual and societal alcohol-related costs due to improved workplace productivity and reductions in healthcare costs and traffic accidents (Centers for Disease Control & Prevention, 2014).

Yet, the cost of changes in marijuana legislation could increase dramatically if marijuana and alcohol are *complements* and changes in marijuana policy lead to *increases* in *both* marijuana and alcohol (e.g., Pacula and Sevigny, 2014). Further, the costs of a complementary increase in marijuana and alcohol use may be more than additive since those who report using alcohol and marijuana tend to use them at the same time (Subbaraman and Kerr, 2015). Simultaneous use has been shown to be more risky and dangerous than use of alcohol or marijuana alone. For example, those who use marijuana and alcohol together have the highest rates of unsafe driving (e.g., Downey et al., 2013a; Ronen et al., 2010; Subbaraman and Kerr, 2015; Terry-McElrath et al., 2014). Clearly, understanding the impact of marijuana-related policies on alcohol use is of paramount public health and safety importance.

In the first section of this review, we provide a summary of the existing knowledge about the relationship between marijuana and alcohol in general, and in the context of well-established alcohol-related policies in particular. We then apply these perspectives to a comprehensive review of publications focused on the impact of marijuana-related policies on alcohol use including the effects of decriminalization, medical marijuana legalization (MML), and findings and future directions from the initial evaluation of recreational marijuana legalization (RML) policies. We conclude with areas for future research that can inform our understanding of how population levels of alcohol use and consequences may be influenced by more liberal marijuana policies.

Why might marijuana and alcohol be substitutes in the context of marijuana policy changes?

The propensity to substitute intoxicants depends on the similarity of anticipated effects of the intoxicants (Moore, 2010). For decades, alcohol and marijuana have been the two most commonly used intoxicants in the United States (e.g., Substance Abuse and Mental Health Services Administration, 2014). Neuroscience research indicates that marijuana and low-dose alcohol use share neuro-pharmacologic effects of reward and sedation (e.g., Heishman et al., 1997), which could lead to alcohol and marijuana being substitutes, particularly for occasional, low-consumption users (Wen et al., 2015). An individual chooses an intoxicant not only on the basis of the desired effects of the drug but also based on the expected costs (i.e., price, health, legal and social consequences). If marijuana and alcohol share their intoxicating effects, one might expect a heightened interchangeability among these substances in the context of marijuana policy changes that lead to lowered cost (be it legal, social or financial) of marijuana use. Decriminalizing or legalizing marijuana could lead to greater availability and lower costs for marijuana use due both to lower monetary price and lower likelihood of legal consequences. This is likely to lead to increases in marijuana use, and a number of studies document this effect (for review see Chu, 2014). If costs of

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

marijuana use decrease and costs of alcohol use do not, some individuals may decide to substitute marijuana for alcohol, achieving similar intoxication effects at a lower price. Thus, decriminalizing or legalizing marijuana could lead to increases in marijuana use, but decreases in alcohol use. This substitution hypothesis is consistent with findings from some econometric studies that policies designed to limit alcohol use, such as those that increase the minimum legal drinking age or raise alcohol tax rates, have the unintended consequence of increasing the prevalence of marijuana use (e.g., Crost and Guerrero, 2012; DiNardo and Lemieux, 2001).

Why might marijuana and alcohol be complements in the context of marijuana policy changes?

Opponents of decriminalization or legalization of marijuana suggest that liberalization of laws would be associated with increases in marijuana use, as well as increased alcohol use. Partial support for this view comes again from pharmacologic studies that show that the plasma THC (tetrahydrocannabinol) levels increase if alcohol is consumed simultaneously (e.g., Downey et al., 2013b; Lukas and Orozco, 2001), resulting in reports of more pleasurable subjective mood effects of marijuana (Lukas and Orozco, 2001). Thus, the quest for a “better high” might lead individuals to combine the use of both substances. This might be particularly the case for regular users and at higher end of the alcohol consumption continuum (Wen et al., 2015). In addition, marijuana use might impair judgment or decision-making capacity, leading to greater alcohol use than intended; create situations where individuals have more opportunities to combine marijuana and alcohol use to enhance the effects of both substances; or lead individuals to develop more permissive attitudes toward substance use in general (e.g., Kilmer, 2014). Complementarity is also supported by etiology research that has found a positive relationship between marijuana and alcohol use (e.g., Fergusson and Horwood, 2000; Kandel et al., 1992; Lynskey et al., 2003; Morral et al., 2002). Finally, some econometrics studies (e.g., Chaloupka et al., 1999; Saffer and Chaloupka, 1999; Williams et al., 2004) on the effects of alcohol-related policies on marijuana use also point to the plausibility of complementary effects. For example, using data from the National Household Survey of Drug Abuse (NHSDA, now known as the National Survey on Drug Use and Health, NSDUH), higher alcohol prices were related to both lower alcohol and marijuana participation (Saffer and Chaloupka, 1999). Other research using NHSDA data has found that an increase in the price of alcohol or tobacco was associated with lower probability of marijuana use among youth but not adults (Farrelly et al., 1999).

Materials and Methods

The current review was conducted utilizing online search databases, including EBSCO host that includes Academic Search Premier, Econlit, Legal Collection, Medline, PsycINFO, Psych Articles, as well as PubMed and Google Scholar. The primary search terms algorithm included medical/non-medical/recreat*/decrim* and polic*/law/legislation/legal and marijuana/marijuana/pot/weed/THC and alcohol/ethanol/etoh/drink*. Additional searches in all search engines were conducted using the terms spillover/complement*/substit*. These

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

searches yielded 751 articles. Only articles examining policy changes in the U.S. were included in the review of marijuana law changes on alcohol use. We also excluded articles not written in English, published in a peer-reviewed journal, or relevant to the topic. Figure 1 summarizes the search algorithm and results. Upon reading literature from identified searches, additional articles and government reports were identified and evaluated for relevance to understanding impact or association of marijuana legalization or policies on alcohol use. This search yielded 2 additional articles describing studies relevant to the topic area. In summary, articles were included in the review if they addressed the topic through including at least one outcome measure of alcohol use related to at least one aspect of change in, association with, or difference between marijuana policies. Articles that focused only on the impact of marijuana policies or laws on marijuana use were not included. Table 1 summarizes the studies along 6 key dimensions: the sample, the age groups examined, the type of marijuana policy, and the dimensions of the policy evaluated as well as the operationalization of marijuana and alcohol use. The following section discusses the findings with respect to the potential impacts of different types of marijuana legislation (decriminalization, MML, and RML) on alcohol.

Impact of Marijuana Policies on Alcohol Use

Decriminalization of marijuana possession—Decriminalization of marijuana continues to be an umbrella term for a wide range of statutes across US states varying across dimensions such as classification of the possession offense, the applicability of the reduced penalties to subsequent offenses, and specification of maximum fine or minimum jail time (Pacula et al., 2003). However, the general term refers to reduced criminal penalties for marijuana possession.

As shown in Table 1, our search identified eight studies describing effects of marijuana decriminalization on alcohol use. Model (1993) examined drug-related emergency room visits from 1975-1979 using the Drug Abuse Warning Network (DAWN) data. She found cities within states with changes in marijuana policy toward or including decriminalization showed increases in emergency room visits related to marijuana but a decrease in the number of visits mentioning other drugs including alcohol. Model was not, however, able to examine episodes involving alcohol only because that data was not recorded by DAWN. Studies using Monitoring the Future (MTF) data have yielded mixed results. On one hand, using the 1982-1989 from MTF, Chaloupka and Laixuthai (1997) reported that high school seniors living in states with decriminalization of marijuana policies used alcohol less frequently and were less likely to engage in heavy drinking than adolescents in states with stricter marijuana policies, although once the monetary price of marijuana was included, this relationship was somewhat attenuated. On the other hand, DiNardo and Lemieux (2001) used state-aggregated MTF data from 1980 through 1989 and found no statistically significant relationship between decriminalization and marijuana or alcohol use. Saffer and Chaloupka (1999) pooled three years (1988, 1990, and 1991) of NHDSU data and examined changes in the number of days of past month alcohol use and two dichotomous indicators of marijuana use – any use in the past month as well as in the past year – in the context of marijuana decriminalization. The results indicated that decriminalization was associated

Author Manuscript

with increases in prevalence of both past month and past year marijuana use but was not associated with alcohol use. However, in a sample of twelfth graders from the 1982 National Longitudinal Survey of Youth (NLSY) study, Yamada, Kendix, & Yamada (1996) found decriminalization was not significantly associated with marijuana use but was associated with less alcohol use, including lower likelihood of becoming a frequent drinker.

Using data on a sample of males from 1984 and 1988 NLSY surveys, Thies & Register (1993) report mixed findings for the impact of marijuana decriminalization on alcohol use. While decriminalization was not associated with marijuana use at either time point, it was associated with higher prevalence of any alcohol use in the 1984 data and lower prevalence of problem alcohol use in the 1988 data. While controlling for legal sanctions for possession of small amounts of marijuana in addition to other measures of state control of drug use, this study did not control for the variation in price of alcohol and marijuana. Pacula (1998) extended the analyses using the NLSY 1984 data to include both the monetary and legal cost of using alcohol and marijuana. In these analyses, the state decriminalization was positively associated with prevalence of alcohol, although there was no relationship between decriminalization status and the prevalence or the conditional quantity of marijuana use.

Finally, Williams and colleagues (2004) pooled data from 1993, 1997 and 1999 waves of the College Alcohol Study (CAS), a nationally representative study of full-time students attending 4-year colleges, to examine the interplay between substance use policies and college students' alcohol and marijuana use. While the results of the study generally indicate a complementary relationship between alcohol and marijuana, the relationship between alcohol- and marijuana-related policies was not symmetrical. Marijuana-related legal sanctions were not related to past month prevalence of alcohol use but alcohol-related policies such as college ban on alcohol were negatively related to both alcohol and marijuana use.

Medical marijuana legislation

Medical marijuana legislation (MML) in the US permits the sale and use of marijuana for medical purposes under widely varying degrees of regulation across and within states (e.g., Pacula et al., 2014). As shown in Table 1, our search identified 6 studies describing effects of medical marijuana legislation on alcohol use.

Evidence of substitution effects to alcohol—Anderson and colleagues (2013) examined the relationship between MML, traffic fatalities and alcohol consumption in 15 states, using multiple sources of data including Fatal Accident Report System (FARS), Behavioral Risk Factor Surveillance System (BRFSS), and alcohol industry data on sales, while also linking data obtained from advertisements in a *High Times*, a magazine for marijuana users, on changes in prices of marijuana. They found that MML was associated with (1) a significant drop in the price of potent marijuana; (2) a decrease in per-capita sales of beer; (3) reduced total alcohol consumption, particularly among young adults; and (4) a decrease in alcohol-related traffic fatalities. Solomonsen-Sautel and colleagues (2014) also examined FARS data. Using data from 1994-2011 for Colorado and 34 states without medical marijuana, they looked at changes occurring after mid-2009 when Colorado, due to

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

both federal and state law changes, experienced a large increase in medical marijuana commerce. Differences between the pre-commercial time period in Colorado (1994 to mid-2009) and post-commercialization period (late-2009 to 2011) indicated that commercialization of medical marijuana in Colorado was related to increases in the proportion of drivers in a fatal motor vehicle crash who tested positive for marijuana. There were no significant changes, however, in the proportion of drivers who tested positive for alcohol relative to states without medical marijuana. The differences in findings between Anderson & Rees (2014) and Solomonsen-Sautel et al. (2014) with respect to traffic fatalities involving alcohol likely stem from Anderson's study including multiple MML states, whereas Solomonsen-Sautel's study focused on Colorado's MML only. In addition, Anderson & Rees modeled the effect of initial passage of the medical marijuana legislation (which, for example, occurred in 2000 in Colorado) whereas Solomonsen-Sautel and colleagues focused on the proliferation of medical marijuana dispensaries.

Our review uncovered two additional studies that explicitly examined evidence of substitution focusing on marijuana-using adult samples of marijuana users within the MML context, though these studies do not examine the impact of MML policies, per se. Reiman (2009) surveyed 350 adult customers of a medical marijuana dispensary in Berkeley, CA. She found that 40% of patients reported using marijuana as a substitute for alcohol. The reasons for substitution included less severe side effects, better symptom management, and less withdrawal potential than alcohol, illicit or prescription drugs. Richmond and colleagues (2015) used data collected between 2012-2013 at Denver Health Medical Center to examine differences in marijuana and other substance use between patients in Colorado with and without state medical marijuana cards who have reported marijuana use in the past 90 day. Patients with state-issued marijuana cards had higher frequency of marijuana use and lower use of other substances, including alcohol, providing tentative evidence of substitution relationship between marijuana and alcohol.

Evidence of Complementary Effects—Pacula and colleagues (2013) found evidence that effects of MML on alcohol use depend on particular aspects of MML. Using data from Youth Risk Behavior Survey (YRBS), NLSY97 and Treatment Episodes Data System (TEDS), they examined the impact of different dimensions of MML across states on marijuana and alcohol use. Consistent with Anderson and colleagues (2013), they found that a dichotomous indicator of any MML vs. none was negatively associated with self-reported alcohol use. However, when accounting for differences in the dimensions of MMLs across states, the study showed that individuals living in states with MMLs allowing for dispensaries had a higher likelihood of past month marijuana use as well as alcohol use in the full sample (i.e., including all age groups) of NLSY. Similarly, they found evidence of the complementary relationship between alcohol and marijuana in the full sample analyses of the TEDS data where states with MML dispensaries had higher rates of both marijuana and alcohol treatment admissions, pointing to potential complementarity at the high-end of marijuana and alcohol misuse. However, the complementary relationship between alcohol and marijuana was not evidenced in the sub-sample analyses of those under the age of 21. They also found that a provision for medical marijuana dispensaries was important for alcohol-related fatalities. This study replicated Anderson et al.'s (2013) findings that states

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

with any type of MML policies had fewer alcohol-related fatalities according to FARS, but those states allowing for medical marijuana dispensaries specifically had higher alcohol-related fatalities. Pacula and colleagues found that a patient registry requirement was associated with both lower likelihood of past month marijuana as well as alcohol use in the full sample of NLSY. However, the patient registry provision was positively associated with the number of alcohol treatment admissions in the TEDS data, which suggests the effects of MML policy may differ along the alcohol use-to-disorder continuum.

In a comprehensive evaluation of the effects MML on substance use based on NSDUH data, Wen and colleagues (2015) compared participants from ten states that legalized medical marijuana between 2004 and 2012 with eight states that legalized medical marijuana prior to 2004 as well as the rest of the US states that did not have any MML by the end of 2012. The data were analyzed separately for youth and adults, and different levels of drinking and marijuana use were considered. To assess the frequency, intensity and problem use, five marijuana use outcomes and four alcohol-related outcomes were examined. The study also examined two measures of concurrent use of alcohol and marijuana. Moreover, the study also examined the variation in the timing of the effects of MML, using different time-leads and lags around the dates of MML legislation in their analysis models, and the dimensions of MML heterogeneity specified by Pacula and colleagues (2013). The results, largely consistent across the different specifications, revealed that while MML was not associated with any level of underage drinking among youth (12-20 year-olds) nor the overall past month quantity of alcohol drinks among adults (21+), MML was positively associated with increases in frequency of binge drinking and the probability of simultaneous use of alcohol and marijuana among those of legal drinking age. Finally, the study examined the issue of timing of the policy effect, estimating contemporary as well as six-months, one- and two-year time leads and lags. The results suggest that there are both contemporary effects of MML adoption that influence the changes in the probability of past month marijuana use as well as delayed policy effects on marijuana abuse/dependence among those over the age of 21. Overall, this study suggests there may be complementary effects between marijuana and alcohol among adults but not youth, and these effects may only be evident at higher levels of alcohol use, as well as in the form of increases in simultaneous use of marijuana and alcohol in the context of MML.

Recreational marijuana legalization

Implementation of the new recreational marijuana laws and development of legal recreational marijuana markets in Washington State and Colorado are still unfolding. Legislation passed in both states in 2012, but sale of recreational marijuana in state-regulated stores did not begin until January of 2014 in Colorado and July of 2014 in Washington. As of 2015, RML markets were growing in both states but had not yet matched MML markets in terms of amount of marijuana sold (Washington State Department of Revenue, 2015).

In Washington, understanding the associations between recreational marijuana legalization and alcohol use is complicated by recent change in laws regulating the sale of alcohol. In fall 2011, Washington voted to privatize the sale of hard liquor (Initiative 1183), which

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

previously had only been available for onsite consumption in bars or restaurants or through state-run liquor stores. Likely due to this law change, there was a 13% increase in retail sales in fiscal year 2013 compared to the prior year; thus, it may be hard to isolate the effects of marijuana legalization on alcohol use in Washington from the effects of the change in alcohol policy (Washington State Office of Financial Management, 2015).

Data from Colorado and Washington on alcohol sales (Colorado Department of Revenue, 2014; Washington State Department of Revenue, 2015) and alcohol-related crime (Denver Department of Safety Public Information Standards, 2014; Drug Policy Alliance, 2014) and traffic accidents (Colorado Department of Transportation, 2015; Washington Traffic Safety Commission, 2014) indicate no dramatic, immediate changes post-RML.

Similarly, adolescent survey data from the two states show changes in alcohol use consistent with longer term trends (Colorado Department of Public Health and Environment, 2013; Washington State Health Youth Survey, 2015). A recent study of a community sample of 238 students in Washington found two cohorts experiencing the law change in Washington at different ages differed in the relative likelihood of using marijuana versus alcohol (Mason et al., 2015), with the cohort that had experienced the law change prior to their 9th grade data collection being relatively more likely to use marijuana compared to their likelihood of using alcohol. Although based on a convenience sample and looking at the effects of legislation soon after passage rather than after full implementation, this study provides a blueprint for modeling the relative likelihood of marijuana and alcohol use as a test of substitution effects.

General conclusions

It is clear that more work is needed to fully understand how the marijuana policy changes affect alcohol use. Across the reviewed studies, we have found support for marijuana and alcohol as both substitutes and complements. There is evidence for substitution effects resulting from liberalization of marijuana laws for some aspects of alcohol consumption. From data sources capturing state variation in marijuana laws, the evidence for substitution includes the MML-associated declines in traffic fatalities and measures of total alcohol consumption among young adults (Anderson et al., 2013; Pacula et al., 2013) and in alcohol use, particularly among youth (Chaloupka and Laixutha, 1997). There is also some weaker evidence of substitution in the studies of community samples based on medical marijuana user self-report of substitution (Reiman, 2009), comparison of alcohol use among medical marijuana card holders compared to non-card-holding marijuana users (Richmond et al., 2015), and comparison of different age cohorts in Washington (Mason et al., 2015). With respect to complementary effects in which liberalization of marijuana laws results in increased use of both marijuana and alcohol use, the strongest support comes from studies of MML by Pacula et al. (2013) and Wen et al. (2015). These studies, using nation-wide data and examining variation across states, suggest that MML, particularly in less restrictive and regulated forms, is associated with increases in some margins of alcohol use among certain age groups. In particular, the Wen et al. study points to increases in heavy drinking and alcohol use combined with marijuana use among adults that can occur in the context of MML.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

To gain a more complete picture of the effects of marijuana policy changes on other substance use, it is important to examine changes in overall prevalence, initiation, and regular use as well as to distinguish between casual or occasional users, heavy or regular users, and, if possible, those with abuse or dependence problems. The importance of such distinctions has been aptly demonstrated in the work of Wen and colleagues (2015) who reported the effects of MML on frequency of binge drinking but not on past month quantity of drinking. Also, Pacula and colleagues (2013) found that the effects of MML policy differed along the severity of alcohol use continuum, with MMLs that have patient registry requirement being related to lower prevalence of past month alcohol use but higher number of alcohol treatment admissions indexing a "problem" or "disordered" use. Furthermore, the studies by Wen et al. (2015) and Pacula et al. (2013) highlight that it is important to account for multiple key dimensions of MML including laws about patient registry, dispensaries, and home cultivation and decriminalization and price of marijuana, and therefore also the use of marijuana as well as alcohol. Regarding decriminalization, a similar point can be made about the need to better capture the heterogeneity in decriminalization policies. Studies should focus on different dimensions of marijuana decriminalization policies including variation in statutory penalties such as minimum jail time and maximum fines, among others (Pacula et al., 2003). No study to date has comprehensively evaluated the effects of these dimensions on both marijuana and alcohol use. Furthermore, as the review of studies on the effects of decriminalization on alcohol use demonstrated, these effects are sensitive to the inclusion of the monetary price of marijuana (e.g., Chaloupka & Laixuthai, 1997; Pacula, 1998). Therefore, studies assessing the potential substitution effects between marijuana and alcohol in the context of marijuana policy changes need to capture the changes in the legal and financial price of marijuana use.

Moreover, although all studies included in this critical review included some indicator of decriminalization or MML, researchers should be familiar with actual implementation of policies and account for delays between the date of the policy change and the implementation. For example, Maine and New Jersey medical marijuana dispensaries did not open until two years after they were legalized (Anderson and Rees, 2014). To assess whether the presence of medical marijuana dispensaries affects marijuana and other substance use, the researchers should account for both, the "de-jure" as well as the "de-facto" dimension of the policy change (Anderson and Rees, 2014; Salomonsen-Sautel et al., 2014). A number of studies have examined potential effects on substance use behavior shortly after the passage of legislation even though putative effects may take time to take hold due to delays with implementation of the law and fluctuations in pricing until stabilization. It is plausible that the difference in findings between the Anderson et al. (2013) and Salomonsen-Sautel et al. (2014) with respect to alcohol-related traffic accidents stems from differences in how the timing of effects of MML were evaluated.

Recommendations for future research

In the absence of randomized trials, no single design is ideal to examine potential effects of legislation on other substance use. Thus, findings from multiple designs can complement one another to provide a more complete picture of how policies may influence substance use over time.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

One important study approach compares substance use outcomes between states that have enacted pro-marijuana legislation and those that have not. For conducting these between-state comparisons, the difference-in-difference (DD) approach may be a useful method, which accounts for unmeasured time-fixed state-level characteristics. Using national data that have sufficiently representative samples for multiple states, researchers can utilize DD methods to compare differences in the change in prevalence of marijuana and alcohol use from pre- to post-legislation among states that pass legislation to states that do not pass such legislation over the corresponding period. However, it is important for researchers to understand the nuances of the different policies and how these policies were implemented in order to account for the important dimensions of the policy change and their timing.

Yet, there are also important opportunities to utilize data collected from within a single state. Using state-representative repeated cross-sectional samples, investigators could use interrupted time-series approaches to assess whether passage of a marijuana-related policy is associated with deflections off prior trajectories of substance use outcomes over time. A notable limitation is that it is not possible to account for important concurrent or temporally proximal events that could also influence use (e.g., the privatization of liquor sales initiative 1183 in WA that went into effect in 2012), and thus it may be difficult to disentangle the true impact of policy changes.

In addition, similar to work conducted by Mason and colleagues (2015), within-state multiple prospective cohorts from a single research study that traverse the period of policy change at different ages could offer information as to potential spillover effects of legislation. Additionally, within-state studies may allow for studies of specific aspects of the law that vary over smaller-area geographies (e.g., counties) and how they are related to substance use outcomes.

There are other important research questions to explore in addition to whether policies affect use, including impact on risk factors such as individuals' perceived social norms and risks and harms of other substances and how policies may influence co-occurring and concurrent substance use. There may be also differential impacts of policies according to variables such as age, race/ethnicity, income, education, and gender. Using the MTF data from 1976-2013, Lanza and colleagues (2015) found that recently the rates of marijuana use have increased, particularly for male and African American students. In addition, they found that the strength of positive relationship between marijuana use and heavy episodic drinking has increased since 2008 for African American adolescents. While not tested in this study, some of these trends may be sensitive to changes in marijuana related policy. Additional research may guide public health practitioners in selecting relevant tested and effective programs that target marijuana-related risk factors or populations that experience higher levels of problems related to marijuana and alcohol use.

It is important that collection of data at the local, state and national level keeps up with the policy evaluation needs. This means that consistent information is collected over time to allow for time trend analyses. At the same time, however, data should be collected to capture the emerging trends in substance use such as “dabbing” (inhalation of a concentrated THC manufactured through butane extraction, Stogner and Miller, 2015) or the

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

simultaneous use of marijuana, alcohol and other substances. Finally, the existing datasets should be augmented with variables that allow for disentangling of alcohol and other substance use. For example, the revised DAWN database could include data on alcohol-only episodes for the full sample of patients, not just for underage drinkers, in order to allow for evaluation of effects of marijuana policy changes on alcohol use.

The studies reviewed here highlight that marijuana policies are complex and evolving, and characteristics of these policies have the potential to impact the use of marijuana as well as alcohol. As the current review documented, it is likely that the relationship between marijuana and alcohol varies for different segments of population, and the type and course of marijuana and alcohol use. In the context of legalization, understanding whether alcohol and marijuana are complements or substitutes influences the policy tools to be employed in order to improve public health. This is particularly important if marijuana and alcohol are complements and tools such as increased taxation and decreased availability of marijuana through state monopolization could be used to curb increases in use. Yet, such controlling policy tools should be approached cautiously given the possibility of empowering the illicit, unregulated market that may expose consumers to potentially greater harm. What is clear is that our current understanding of the impact of marijuana-related policy changes on alcohol use is limited, and further study that carefully considers the heterogeneity in marijuana policy and its implementation, as well as the full range of marijuana and alcohol outcomes and the characteristics of the users is needed. Who is up for the challenge?

Acknowledgments

Manuscript preparation was supported by the National Institute on Alcohol Abuse and Alcoholism of the National Institutes of Health under award #R01AA018276 to Dr. Larimer, as well as by the National Institute on Drug Abuse of the National Institutes of Health under award #R21DA037341 to Dr. Guttmannova and #R01DA033956 to Dr. Kosterman. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

References

Anderson DM, Hansen B, Rees DI. Medical marijuana laws, traffic fatalities, and alcohol consumption. Journal of Law and Economics. 2013; 56:333–369.

Anderson DM, Rees DI. The role of dispensaries: the devil is in the details. Journal of Policy Analysis and Management. 2014; 33:235–240. [PubMed: 24358532]

Annas GJ. Medical marijuana, physicians, and state law. The New England Journal of Medicine. 2014; 371:983–983. [PubMed: 25099473]

Caulkins, JP.; Hawken, A.; Kilmer, B.; Kleiman, MAR. Marijuana legalization: What everyone needs to know. New York: Oxford University Press; 2012.

Centers for Disease Control & Prevention. Excessive drinking costs U S $223.5 billion. 2014. Retrieved May 29, 2015, from the World Wide Web: http://www.cdc.gov/Features/AlcoholConsumption/

Chaloupka FJ, Laixutha A. Do youths substitute alcohol and marijuana? Some econometric evidence. 1997; 23:3.

Chaloupka, FJ.; Pacula, RL.; Farrelly, MC.; Johnston, LD.; O'Malley, PM. Do higher cigarette prices encourage youth to use marijuana? (NBER Working Paper No 6939). National Bureau of Economic Research; 1999. Retrieved May 29, 2015, from the World Wide Web: http://www.nber.org/papers/w6939

Chokshi, N. Where marijuana is legalized, decriminalized, or on the November ballot. Washington Post; 2014 Oct 13. Retrieved May 29, 2015, from the World Wide Web: http://

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

www.washingtonpost.com/blogs/govbeat/wp/2014/10/13/where-marijuana-is-legalized-decriminalized-or-on-the-november-ballot

Chu YW. The effects of medical marijuana laws on illegal marijuana use. Journal of Health Economics. 2014; 38:43–61. [PubMed: 25205609]

Colorado Department of Public Health and Environment. Marijuana: Overview of 2013 data from the Healthy Kids Colorado Survey. 2011. Retrieved May 29, 2015, from the World Wide Web: http://www.chd.dphe.state.co.us/topics.aspx?q=Adolescent_Health_Data

Colorado Department of Revenue. Annual Report: July 1, 2013–June 30, 2014. 2014. Retrieved May 29, 2015, from the World Wide Web: https://www.colorado.gov/pacific/sites/default/files/2014%20Annual%20Report1.pdf

Colorado Department of Transportation. National Traffic Highway Association, Fatality Analysis Reporting System Colorado historical fatal crash trends since 2002. 2015. Retrieved May 29, 2015, from the World Wide Web: https://www.codot.gov/library/traffic/traffic-manuals-guidelines/safety-crash-data/fatal-crash-data-city-county/Colorado_Historical_Fatalities_Graphs.pdf/view

Crost B, Guerrero S. The effect of alcohol availability on marijuana use: evidence from the minimum legal drinking age. Journal of Health Economics. 2012; 31:112–121. [PubMed: 22381404]

Denver Department of Safety Public Information Standards. [Retrieved Accessed May 29, 2015] Part 1: Crime in the city and county of Denver based on UCR standards. 2014. from the World Wide Web: http://www.denvergov.org/Portals/720/documents/statistics/2014/UCR_Citywide_Reported%20_Offenses_2014.pdf

DiNardo J, Lemieux T. Alcohol, marijuana, and American youth: the unintended consequences of government regulation. Journal of Health Economics. 2001; 20:991–1010. [PubMed: 11758056]

Downey LA, King R, Papafotiou K, Swann P, Ogden E, Boorman M, Stough C. The effects of cannabis and alcohol on simulated driving: Influences of dose and experience. Accident Analysis and Prevention. 2013a; 50:879–886. [PubMed: 22871272]

Downey LA, King R, Papafotiou K, Swann P, Ogden E, Boorman M, Stough C. The effects of cannabis and alcohol on simulated driving: Influences of dose and experience. Accident Analysis & Prevention. 2013b; 50:879–886. [PubMed: 22871272]

Drug Policy Alliance. Marijuana legalization in Colorado after one year of retail sales and two years of decriminalization. 2014. Retrieved May 29, 2015, from the World Wide Web: https://www.drugpolicy.org/sites/default/files/Colorado_Marijuana_Legalization_One_Year_Status_Report.pdf

Farrelly, MC.; Bray, JW.; Zarkin, GA.; Wendling, BW.; Pacula, RL. The effects of prices and policies on the demand for marijuana: Evidence from the National Household Surveys on Drug Abuse (NBER Working Paper 6940). National Bureau of Economic Research; 1999. Retrieved the World Wide Web: http://www.nber.org/papers/w6940

Fergusson DM, Horwood LJ. Does cannabis use encourage other forms of illicit drug use? Addiction. 2000; 95:505–520. [PubMed: 10829327]

Freisthler B, Gruenewald PJ. Examining the relationship between the physical availability of medical marijuana and marijuana use across fifty California cities. Drug and Alcohol Dependence. 2014; 143:244–250. [PubMed: 25156224]

Gieringer, D. Marijuana legalization could yield California taxpayers over $1.2 billion per year [CA NORML Web site]. 2009. Retrieved May 29, 2015, from the World Wide Web: http://www.canorml.org/background/CA_legalization2.html

Gruenewald PJ. The spatial ecology of alcohol problems: Niche theory and assortative drinking. Addiction. 2007; 102:870–878. [PubMed: 17523980]

Heishman SJ, Arasteh K, Stitzer ML. Comparative effects of alcohol and marijuana on mood, memory, and performance. Pharmacology, Biochemistry and Behavior. 1997; 58:93–101.

Kandel DB, Yamaguchi K, Chen K. Stages of progression in drug involvement from adolescence to adulthood: Further evidence for the gateway theory. Journal of Studies on Alcohol. 1992; 53:447–457. [PubMed: 1405637]

Kilmer B. Policy designs for cannabis legalization: Starting with the eight Ps. The American Journal of Drug and Alcohol Abuse. 2014; 40:259–261. [PubMed: 24853283]

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Kilmer, B.; Caulkins, JP.; Midgette, G.; Dahlkemper, L.; MacCoun, RJ.; Pacula, RL. Before the grand opening: Measuring Washington state's marijuana market in the last year before legalized commercial sales. RAND; 2013. Retrieved May 29, 2015, from the World Wide Web: http://www.rand.org/pubs/research_reports/RR466.html

Kilmer, B.; Caulkins, JP.; Pacula, RL.; MacCoun, R.; Reuter, PH. Altered state? Assessing how marijuana legalization in California could influence marijuana consumption and public budgets No OP-315-RC. Santa Monica, CA: RAND; 2010.

Lanza ST, Vasilenko SA, Dziak JJ, Butera NM. Trends among U.S. high school seniors in recent marijuana use and associations with other substances: 1976-2013. Journal of Adolescent Health. 2015; 57:198–204. [PubMed: 26206440]

Light, MK.; Orens, A.; Lewandowski, B.; Pickton, T. Market size and demand for marijuana in Colorado. 2014. Retrieved May 29, 2015, from the World Wide Web: https://www.colorado.gov/pacific/sites/default/files/Market%20Size%20and%20Demand%20Study,%20July%209,%202014%5B1%5D.pdf

Lukas SE, Orozco S. Ethanol increases plasma Delta(9)-tetrahydrocannabinol (THC) levels and subjective effects after marihuana smoking in human volunteers. Drug and Alcohol Dependence. 2001; 64:143–149. [PubMed: 11543984]

Lynskey MT, Heath AC, Bucholz KK, Slutske WS, Madden PAF, Nelson EC, Statham DJ, Martin NG. Escalation of drug use in early-onset cannabis users vs co-twin controls. JAMA. 2003; 289:427–433. [PubMed: 12533121]

MacCoun, RJ.; Reuter, P. Drug war heresies: Learning from other vices, times, and places. Cambridge, UK: Cambridge University Press; 2001.

Mair C, Freisthler B, Ponicki WR, Gaidus A. The impacts of marijuana dispensary density and neighborhood ecology on marijuana abuse and dependence. Drug and Alcohol Dependence. 2015

Mason WA, Hanson K, Fleming CB, Ringle JL, Haggerty KP. Washington State recreational marijuana legalization: Parent and adolescent perceptions, knowledge, and discussions in a sample of low-income families. Substance Use and Misuse. 2015; 50:541–545. [PubMed: 25671633]

Model KE. The effect of marijuana decriminalization on hospital emergency room drug episodes: 1975–1978. Journal of the American Statistical Association. 1993; 88:737–747.

Moore SC. Substitution and complementarity in the face of alcohol-specific policy interventions. Alcohol and Alcoholism. 2010; 45:403–408. [PubMed: 20729529]

Morral AR, McCaffrey DF, Paddock SM. Reassessing the marijuana gateway effect. Addiction. 2002; 97:1493–1504. [PubMed: 12472629]

Pacula RL. Does increasing the beer tax reduce marijuana consumption? Journal of Health Economics. 1998; 17:557–585. [PubMed: 10185512]

Pacula, RL.; Chriqui, JF.; King, J. Marijuana decriminalization: What does it mean in the United States? (NBER Working Paper No 9690). National Bureau of Economic Research; 2003. Retrieved May 29, 2015, from the World Wide Web: http://www.nber.org/papers/w9690

Pacula RL, Hunt P, Boustead A. Words can be deceiving: A review of variation among legally effective medical marijuana laws in the United States. Journal of Drug Policy Analysis. 2014; 7:1–19. [PubMed: 25657828]

Pacula, RL.; MacCoun, RJ.; Reuter, P.; Chriqui, J.; Kilmer, B.; Harris, K.; Paoli, L.; Schaefer, C. What does it mean to decriminalize marijuana? A cross-national empirical examination. In: Lindgren, B.; Grossman, M., editors. Substance use: Individual behaviour, social interactions, markets and politics. North-Holland: Elsevier; 2005. p. 347-370.

Pacula, RL.; Powell, D.; Heaton, P.; Sevigny, EL. Assessing the effects of medical marijuana laws on marijuana use: the devil is in the details (NBER Working Paper No 19302). National Bureau of Economic Research; 2013. Retrieved May 29, 2015, from the World Wide Web: http://www.nber.org/papers/w19302

Pacula RL, Sevigny EL. Marijuana liberalization policies: Why we can't learn much from policy still in motion. Journal of Policy Analysis and Management. 2014; 33:212–221. [PubMed: 24358530]

Pardo B. Cannabis policy reforms in the Americas: A comparative analysis of Colorado, Washington, and Uruguay. International Journal of Drug Policy. 2014; 25:727–735. [PubMed: 24970383]

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Reiman A. Cannabis as a substitute for alcohol and other drugs. Harm Reduction Journal. 2009; 6:35. [PubMed: 19958538]

Richmond MK, Pampel FC, Rivera LS, Broderick KB, Reimann B, Fischer L. Frequency and risk of marijuana use among substance-using health care patients in Colorado with and without access to state legalized medical marijuana. Journal of Psychoactive Drugs. 2015; 47:1–9. [PubMed: 25715066]

Ronen A, Chassidim HS, Gershon P, Parmet Y, Rabinovich A, Bar-Hamburger R, Cassuto Y, Shinar D. The effect of alcohol, THC and their combination on perceived effects, willingness to drive and performance of driving and non-driving tasks. Accident Analysis and Prevention. 2010; 42:1855–1865. [PubMed: 20728636]

Sacks JJ, Roeber J, Bouchery EE, Gonzales K, Chaloupka FJ, Brewer RD. State costs of excessive alcohol consumption, 2006. American Journal of Preventive Medicine. 2013; 45:474–485. [PubMed: 24050424]

Saffer, H.; Chaloupka, F. Demographic differentials in the demand for alcohol and illicit drugs. In: Chaloupka, J.; Grossman, M.; Bickel, WK.; Saffer, H., editors. The Economic Analysis of Substance Use and Abuse. University of Chicago Press; Chicago: 1999.

Saffer, H.; Chaloupka, F. Demographic differentials in the demand for alcohol and illicit drugs. In: Chaloupka, J.; Grossman, M.; Bickel, WK.; Saffer, H., editors. The Economic Analysis of Substance Use and Abuse. University of Chicago Press; Chicago: 1999.

Salomonsen-Sautel S, Min SJ, Sakai JT, Thurstone C, Hopfer C. Trends in fatal motor vehicle crashes before and after marijuana commercialization in Colorado. Drug and Alcohol Dependence. 2014; 140:137–144. [PubMed: 24831752]

Stahre M, Roeber J, Kanny D, Brewer RD, Zhang X. Contribution of excessive alcohol consumption to deaths and years of potential life lost in the United States. Preventing Chronic Disease. 2014; 11:E109. [PubMed: 24967831]

Stogner JM, Miller BL. Assessing the dangers of "dabbing": Mere marijuana or harmful new trend? Pediatrics. 2015; 136:1–3. [PubMed: 26077476]

Subbaraman MS, Kerr WC. Simultaneous versus concurrent use of alcohol and cannabis in the National Alcohol Survey. Alcoholism: Clinical and Experimental Research. 2015; 39:872–879.

Substance Abuse and Mental Health Services Administration. Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2014.

Terry-McElrath YM, O'Malley PM, Johnston LD. Alcohol and marijuana use patterns associated with unsafe driving among U.S. high school seniors: High use frequency, concurrent use, and simultaneous use. Journal of Studies on Alcohol and Drugs. 2014; 75:378–389. [PubMed: 24766749]

Theall KP, Lancaster BP, Lynch S, Haines RT, Scribner S, Scribner R, Kishore V. The neighborhood alcohol environment and at-risk drinking among African-Americans. Alcoholism: Clinical and Experimental Research. 2011; 35:996–1003.

Thies CF, Register CA. Decriminalization of marijuana and the demand for alcohol, marijuana and cocaine. The Social Science Journal. 1993; 30:385–399.

Truong KD, Sturm R. Alcohol outlets and problem drinking among adults in California. Journal of Studies on Alcohol and Drugs. 2007; 68:923–933. [PubMed: 17960311]

Washington State Department of Revenue. Spirits Tax. 2015. Retrieved May 29, 2015, from the World Wide Web: http://dor.wa.gov/Content/AboutUs/StatisticsAndReports/stats_SpiritsTaxes.aspx

Washington State Health Youth Survey. Healthy youth survey fact sheets. 2015 Apr 14. Retrieved May 29, 2015, from the World Wide Web: https://www.askhys.net/FactSheets

Washington State Office of Financial Management. Forecasting and Research Division. Washington state: Privatization of liquor: The impact of initiative 1183. 2015 Retrieved May 29, 2015, from the World Wide Web: Forecasting and Research Division. Washington state: Privatization of liquor: The impact of initiative 1183.

Washington Traffic Safety Commission. Quarterly Crash Data. 2014. Retrieved May 29, 2015, from the World Wide Web: http://wtsc.wa.gov/research-data/crash-data/

Author Manuscript
Author Manuscript
Author Manuscript
Author Manuscript

Wen H, Hockenberry JM, Cummings JR. The effect of medical marijuana laws on adolescent and adult use of marijuana, alcohol, and other substances. Journal of Health Economics. 2015; 42:64–80. [PubMed: 25863001]

Williams J, Liccardo Pacula R, Chaloupka FJ, Wechsler H. Alcohol and marijuana use among college students: economic complements or substitutes? Health Economics. 2004; 13:825–843. [PubMed: 15362176]

Yamada T, Kendix M, Yamada T. The impact of alcohol consumption and marijuana use on high school graduation. Health Economics. 1996; 5:77–92. [PubMed: 8653193]

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

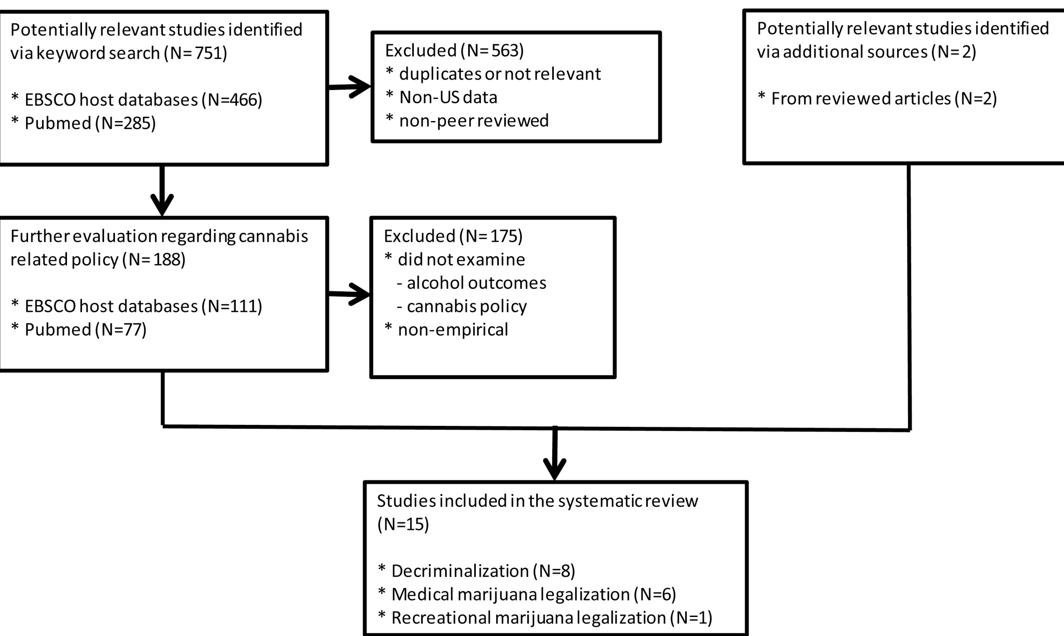


Figure 1. Flow diagram showing the search algorithm and the number of studies included and excluded from the systematic review

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Table 1

Summary of the Reviewed Studies

First Author (year)	Sample	Age group considered	Cannabis policy evaluated	Specific dimensions of the policy evaluated	Measures of Cannabis Use	Measures of Alcohol Use	Key findings
Chaloupka & Laixuthai (1997)	MTF 1982 and 1989 data	High-school Grade 12	Decrim	marijuana decriminalization, and price of marijuana	not examined	frequency of alcohol in PY, drinking in past 30 days, heavy drinking past 2 weeks	decriminalization associated with less frequent alcohol use and lower likelihood of heavy drinking; findings somewhat attenuated once controlling for monetary price of cannabis
Chaloupka & Laixuthai (1997) **continued**	FARS 1975-1988 data	age 18-20, 15-24	Decrim	decriminalized in the state of residence y/n	not examined	total fatality rate; night driver fatality rate; alcohol involved driver fatality rate	decriminalization associated with decreases in alcohol-related driver fatality rates among youth
Dinardo & Lemieux (2001)	MTF 1980-1989 data	High school; controls for >=18 years of age	Decrim	decriminalization	any PM cannabis use	any PM alcohol use	no statistically significant relationship between decriminalization and cannabis or alcohol use
Model (1993)	DAWN 1975-1977 data	All ages but controlling for % of 18-34	Decrim	decriminalized in the state of residence y/n, and the time elapsed since the enactment of the new law (up to 3 years ago)	Number of mentions in ER drug-related visits	# of mentions of ER drug-related visits not mentioning cannabis (not alcohol specific); alcohol is recorded in ER visit if used in conjunction with another illicit drug or with a prescription drug used for nonmedical purposes; alcohol-related episodes separately are not examined because data unavailable	decriminalization was associated with an increase in the number of ER cannabis episodes and decrease in the number of episodes mentioning other substances
Pacula (1998)	NLSY 1984 data		Decrim	marijuana decriminalization,	any PM cannabis use;	any PM alcohol use;	decriminalization associated with higher

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

First Author (year)	Sample	Age group considered	Cannabis policy evaluated	Specific dimensions of the policy evaluated	Measures of Cannabis Use	Measures of Alcohol Use	Key findings
				and price of marijuana and price of marijuana	number of times cannabis consumed in PM	number of drinks drunk in PM	prevalence of alcohol use but not related to cannabis use
Saffer & Chaloupka (1999)	NHSDA 1988, 1990, and 1991 data	age 12-20, age 21-30	Decrim	marijuana decriminalization, and price of marijuana	any PM cannabis use, any PY cannabis use	number of days in the past alcohol use	decriminalization associated with higher prevalence of PM and PY cannabis use but not related to alcohol use
Thies & Register (1993)	NLSY 1984 and 1988 data (but males only)	age 14-21	Decrim	marijuana decriminalization, enforcement index measuring state law enforcement of common crimes	any PM cannabis use and number of joints during the last month for cannabis users	any PM alcohol use, any binge drinking defined as 6 or more drinks of alcohol at one time and the amount each in the PM	decriminalization not associated with cannabis use in 1984 or 1989; but positively associated with any alcohol use in 1984 and negatively associated with problem drinking
Williams et al. (2004)	CAS 1993, 1997 and 1999 data	college students; separate analyses testing age interaction >=21 years of age	Decrim	marijuana decriminalization; and state-level maximum fine for possession of 1 oz of cannabis; also price of cannabis	PM and PY cannabis use	PM and PY alcohol use	no statistically significant relationship between cannabis-related policies and alcohol use but alcohol-related sanctions related to lower cannabis use; also negative relationship between monetary price of cannabis and both cannabis and alcohol use
Yamada et al. (1996)	NLSY 1982 data	High school Grade 12	Decrim	decriminalized in the state of residence y/n	Whether used marijuana in each of the ten months during the academic year	Used alcohol two or more days in the past week; number of drinks consumed in the prior week	Decriminalization was associated with lower probability of frequent drinking but no relationship with cannabis use
Anderson et al. (2013)	FARS 1990-2010 data	15-19; 20-29; 30-39; 40-49; 50-59; 60+ years of age	MML	passage of MML	not examined	Traffic fatalities overall; TF not involving alcohol; TF involving alcohol BAC>0; and BAC>=.10	MML is related to a significant decrease in TF from accidents involving BAC>=.10. Evidence of effects by age - MML related 16.7% decrease in TF of 20-29 yos. And some evidence of greater impact of MML on fatalities among males (trend).

First Author (year)	Sample	Age group considered	Cannabis policy evaluated	Specific dimensions of the policy evaluated	Measures of Cannabis Use	Measures of Alcohol Use	Key findings
Anderson et al. (2013) - **continued**	BRFSS 1993-2010 data	all; and 18-19; 20-29; 30-39; 40-49; 50-59; 60+ years of age	MML	passage of MML	not examined	PM use: any, 15+; 30+; 60+; Binge drank; 2+ Binges; Number of drinks	MML related to reduction in the probability of some forms on PM alcohol consumption in all age groups except the oldest (60+ yos): any and daily drinking among 18-19 yos; 60+ drinks and number of drinks among 20-29yos; 15+ drinks among 30-39 yos; binge drinking among 40-49 yos; 15+ and 30+ drinks among 50-59 yos binge drinking
Anderson et al. (2013) - **continued**	Cannabis price data from High Times 1990-2011 data	N/A	MML	passage of MML	price of low- and high-quality cannabis in a given state and year	N/A	MML related to 9.8% decrease in the price of high quality cannabis but the effect of MML on the price of cannabis was delayed - in the 4th full year after MML, there was a 24% decrease in the price of high-quality cannabis
Anderson et al. (2013) - **continued**	Alcohol sales from the Beer Institute in Brewers Almanac 1990-2010 data	N/A	MML	passage of MML	N/A	per capita sales of beer, wine and spirits in a given state and year	MML passage associated with lower beer sales; also, lower beer sales associated with lower traffic fatalities overall and those involving BAC>0 and >.10
Pacula et al. (2013) **(NBER working paper)**	FARS 1990-2009 data	<21 and total sample	MML	Laws concerning (1) registry, (2) home cultivation, (3) dispensaries, and (4) whether allow MM for non-specific pain. Exclude non-specific pain rules from analysis due to collinearity with other dimensions	not examined	FARS: rate of alcohol rated traffic accident fatalities	negative association between general MML indicator and alcohol related fatalities; positive association between dispensaries and fatalities
Pacula et al. (2013) **(NBER working paper) continued**	TEDS 1992-2008 data	<21 and total sample	MML	Laws concerning (1) registry, (2) dispensaries, (3) home cultivation, and (4) whether allow MM for non-specific pain. Exclude non-	Marijuana Treatments per 1,000	Alcohol Treatments per 1,000;	in both <21 and full samples, MML associated with fewer marijuana admissions but dispensaries and home cultivation associated with more marijuana

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

First Author (year)	Sample	Age group considered	Cannabis policy evaluated	Specific dimensions of the policy evaluated	Measures of Cannabis Use	Measures of Alcohol Use	Key findings
				specific pain rules from analysis due to collinearity with other dimensions specific pain rules from analysis due to collinearity with other dimensions specific pain rules from analysis due to collinearity with other dimensions specific pain rules from analysis due to collinearity with other dimensions			admissions; no association between general MML and alcohol admissions for <21 or full sample; positive associations between alcohol admission and dispensaries in <21 sample and between alcohol admissions and dispensaries, registries and home cultivation in full sample
Pacula et al. (2013) **(NBER working paper) continued**	NLSY97 1997-2008 data	<21 and total sample (although NLSY sample 12-17 in 1997, so lack coverage of ages in a given year)	MML	Laws concerning (1) registry, (2) dispensaries, (3) home cultivation, and (4) whether allow MM for non-specific pain. Exclude non-specific pain rules from analysis due to collinearity with other dimensions	% use any marijuana past 30 days, % used marijuana 16+ days in past 30, % used 21+ in past 30	% use any alcohol past 30 days, % used alcohol 16+ days in past 30, % used 21+ in past 30	in the <21 sample, no association between MML and any or heavy marijuana use but positive association between home cultivation and heavy marijuana use; in the full sample, negative association between MML and PM marijuana use and between registries and PM marijuana use and positive association between dispensaries and PM marijuana use; no association between MML and alcohol use; positive associations between alcohol use and home cultivation in <21 and full samples and between alcohol use and dispensaries in full sample; negative association between alcohol use and registries in <21 and full samples
Pacula et al. (2013) **(NBER working paper) continued**	YRBS 1993-2009 data	High school Grades 9-12	MML	Laws concerning (1) registry, (2) dispensaries, (3) home cultivation, and (4) whether allow MM for non-specific pain. Exclude non-specific pain rules from analysis due to	% used marijuana in past 30 days	% used alcohol in past 30 days	no association between MML and PM marijuana use; negative association between home cultivation and PM marijuana use; no overall association between MML and alcohol use; negative associations between alcohol use and both

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

First Author (year)	Sample	Age group considered	Cannabis policy evaluated	Specific dimensions of the policy evaluated	Measures of Cannabis Use	Measures of Alcohol Use	Key findings
				collinearity with other dimensions collinearity with other dimensions			dispensaries and home cultivation
Salomonsen-Sautel et al. (2013)	FARS 1994-2011 data	all, controlling for proportion of drivers 21-24 years of age	MML	Commercialization of MM that took place after Ogden memo and changes in Colorado rules that involved lifting limit on number of patients a caregiver could aid.	Proportion of drivers involved in fatal crash testing positive for marijuana	Proportion of drivers involved in fatal crashes with BAC 0.08%	No evidence of the effects of medical cannabis commercialization on proportion of drivers testing positive for alcohol. Evidence of increase in proportion testing positive for marijuana after medical cannabis commercialization.
Wen et al. (2015)	NSDUH 2004-2012 data	Examined 12-20 and 21+ separately (although also looked at other possible cut points (18, 25, 30)).	MML	Examined MML as a dichotomous variable, but also ran models examining effects of laws on (1) non-specific pain, (2) patient registries, (3) retail dispensaries, and (4) home cultivation	1) any use in prior month, 2) 20+ days of use in prior month, 3) days of use in past 30 among users, 4) initiation in prior year, and 5) dependence in prior year according to DSM-IV criteria	1) number of drinks in PM, 2) frequency of binge drinking days in PM, 3) abuse/ dependence during PY according to DSM-IV criteria, 4) used both marijuana and binge drank in prior month, and 5) used marijuana while drinking alcohol (i.e., on the same occasion) during prior month	For ages 12-20: no evidence of any effect on any measure of alcohol use; for ages 21+: no effect on number of drinks in PM or alcohol abuse/dependence, but more frequent binge drinking and higher likelihood of both marijuana use and binge drinking in PM and of simultaneous use of cannabis and alcohol. For specific dimensions of MML: no consistent effect of patient registry or allowance for retail dispensaries, consistent and significant effect of the “non-specific pain” provision on increasing marijuana use and binge drinking and simultaneous use of marijuana and alcohol.
Reiman (2009)	Users of a medical cannabis dispensary in Berkely, CA (N=350)	Ages 18 through 81 (mean = 39.4) years of age	N/A	N/A but within the context of MML	PM cannabis use, any and frequency	PM alcohol use, any and number of days, and treatment history	Over half of the participants were current drinkers. 40% reported substituting cannabis for alcohol.
Richmond et al. (2015)	SBIRT screened patients who reported cannabis use from health care	Ages 18 through 94 (mean age = 36.8) years of age	N/A	Whether a medical marijuana card holder	number of days using cannabis in the	ASSIST screen for severity of alcohol risk	Cardholders had higher frequency of cannabis use and lower odds of moderate/high risk of

First Author (year)	Sample	Age group considered	Cannabis policy evaluated	Specific dimensions of the policy evaluated	Measures of Cannabis Use	Measures of Alcohol Use	Key findings
	facilities in Denver, CO in study period (N=2030) facilities in Denver, CO in study period (N=2030)				PM and risky use		alcohol use than non-cardholders (i.e., those without access to state legalized medical cannabis)
Mason et al. (2015)	two cohorts from community sample of 238 students in Washinton State 2011, 2012	9th grade students, longitudinal	RML	passage of RML	any PM cannabis use	any PM alcohol use	cohort experiencing RML change prior to 9th grade data collection relatively more likely to use marijuana compared to likelihood of using alcohol than younger cohort that had not experienced the law change

Notes: MML= Medical Marijuana Legislation; RML= Recreational Marijuana Legislation; Decrim=Decriminalization of marijuana; PM=past month; PY=past year; TF=traffic fatalities; BAC=blood alcohol concentration; CAS=College Alcohol Study; DAWN=Drug Abuse Warning Network; FARS=Fatal Accident Report System; MTF=Monitoring the Future; NHSDA=National Household Survey of Drug Abuse; NLSY=National Longitudinal Study of Youth; TEDS=Treatment Episodes Data System; YRBS=Youth Risk Behavior Survey.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

MARIJUANA TAXATION: THEORY AND PRACTICE

BENJAMIN M. LEFF*

ABSTRACT

Marijuana legalization creates a host of complex legal problems, not the least of which is how to best tax the emerging legal market. This Essay attempts to bridge the gap between tax theory and marijuana policy to make some modest claims. First, it roots the discussion of state-level marijuana taxation in the theoretical distinction between ordinary revenue-raising taxes and "Pigouvian" or regulatory taxes. It makes the somewhat controversial claim that the best taxing strategy for states is to attempt to capture as much of the marijuana legalization premium as possible without driving consumers into the illegal market and that other Pigouvian policy concerns are likely to be less important. Second, it roots the discussion of federal taxes in the many factors that will change if federal prohibition ends, again recognizing the importance of possible additional legalization surplus if marijuana is legalized at the federal level. It concludes that the most pronounced difficulty at both levels of taxation is ensuring that excessive taxes do not stymie efforts to move consumers out of the existing illegal market and into the newly regulated legal market while keeping taxes high enough to capture the majority of the legalization surplus.

* Professor of Law, American University Washington College of Law. I would like to thank Jay Wexler, Pat Oglesby, Sam Kamin, and especially the *Boston University Law Review* and its staff for hosting the symposium "Marijuana Law 2020: Lessons From the Past, Ideas for the Future."

CONTENTS

INTRODUCTION 917
I. STATE TAXATION OF MARIJUANA BUSINESSES 918
A. *Introduction to Tax Theory* 918
B. *Implications of Theory for Marijuana Taxation* 921
II. FEDERAL TAXATION OF MARIJUANA BUSINESSES 929
CONCLUSION 932

INTRODUCTION

On April 9, 2014, the radio show (and podcast) *Planet Money* ran a story about a "fun, wonky question[]": What is the best way to tax marijuana?[1] In the introduction to this four-minute piece, *Planet Money*'s host, Jacob Goldstein, promised that after listening to the episode, "you will be able to design a tax on marijuana."[2] Needless to say, that claim was hyperbolic.[3] Designing a good tax on marijuana is actually an extremely challenging undertaking. A more accurate summary of the difficulty of designing a marijuana tax was provided by Pat Oglesby, the leading expert on marijuana taxation: "We don't know the best way to tax marijuana, and even if we knew at first, that way would soon prove wrong."[4]

I make no claim that after reading this Essay you will be able to design a tax on marijuana.[5] Instead, I hope to provide a very brief theoretical basis to discuss two major topics in the design of a marijuana tax. The first topic is relevant to designing a state tax on a newly legalized and regulated marijuana industry. The second topic relates to federal attempts to revise (or not) its current taxation of marijuana sales, especially if federal law is changed to decriminalize marijuana.

Part I discusses the design of a state marijuana tax. The conventional wisdom has it that there are two very different theoretical approaches to determining how much tax to apply to any particular behavior or transaction: "ordinary" revenue-maximizing taxes and so-called "Pigouvian" taxes.[6] All taxes increase the cost of the thing being taxed and therefore, at least theoretically, drive some actors away from that thing. Most voluntary transactions in a market economy increase overall social utility, so driving actors away from voluntary transactions

---

[1] Planet Money, *Episode 530: Marijuana, Law School, and Centuries of Inequality*, NPR, at 0:42 (Apr. 9, 2014, 6:49 PM), https://www.npr.org/sections/money/2014/04/09/301010519/episode-530-marijuana-law-school-and-centuries-of-inequality. The story originally appeared as a segment on *All Things Considered*. All Things Considered, *What's the Best Way to Tax Marijuana? It Depends on What You Want*, NPR (Nov. 22, 2013, 4:22 PM), https://www.npr.org/blogs/money/2013/11/22/246743018/whats-the-best-way-to-tax-marijuana-it-depends-on-what-you-want [https://perma.cc/QLZ8-KTTP].

[2] Planet Money, *supra* note 1, at 0:14.

[3] The episode was actually an excellent brief introduction to work by Jacob Goldin, who was then at Princeton University but is now an Assistant Professor at Stanford Law School. Planet Money, *supra* note 1, at 1:21. He discussed how consumers differentially respond to sales taxes applied at the cash register versus those built into the sticker price of goods. *See, e.g.*, Jacob Goldin, Note, *Sales Tax Not Included: Designing Commodity Taxes for Inattentive Consumers*, 122 YALE. L.J. 258, 260 (2012).

[4] Pat Oglesby, *Marijuana Taxes — Present and Future Traps*, 83 ST. TAX NOTES 391, 392 (2017) [hereinafter Oglesby, *Present and Future Traps*].

[5] In this Essay, I consistently use the term "marijuana," despite its flaws, instead of "cannabis," because the term marijuana generally applies to cannabis products that have historically been subject to state and federal prohibition.

[6] Pigouvian taxes are also called corrective or regulatory taxes. *See, e.g.*, Victor Fleischer, *Curb Your Enthusiasm for Pigovian Taxes*, 68 VAND. L. REV. 1673, 1675 (2015).

generally decreases overall social utility.[7] The goal of ordinary revenue-maximizing taxes, then, is to raise revenue while decreasing participation in the transaction as little as possible.[8] Pigouvian taxes, on the other hand, are taxes that apply to transactions that *decrease* overall social utility, even though they are voluntary, generally because the transactions produce externalities.[9] In this case, decreasing participation in the transactions through taxes both raises revenue for the government *and* increases overall social utility by reducing participation in a harmful transaction.[10] Pigouvian taxes are a win-win from an efficiency perspective. While it is widely recognized that marijuana taxes may be ordinary or Pigouvian, explanations that bridge theory and practice are rare and sometimes misleading. I attempt an explanation, concluding that for the purposes of creating a taxing regime for a newly legalized marijuana market,[11] an ordinary analysis will generally be more important than a Pigouvian analysis.

Part II addresses federal marijuana taxes. The conventional wisdom is that the existing taxing regime under § 280E of the Internal Revenue Code (or "Tax Code") is ludicrously bad policy and that it should be repealed or replaced with an alternative taxing regime.[12] Section 280E is a provision of the Tax Code that denies marijuana sellers the ability to deduct any ordinary business expenses (other than cost of goods sold) in calculating their taxable income.[13] It effectively turns the taxation of marijuana businesses into a (partial) gross receipts tax instead of an income tax.[14] It is better policy to replace § 280E with some sort of federal excise or sales tax on marijuana—especially if marijuana is legalized or decriminalized at the federal level. Here again, I attempt an explanation that grounds the discussion in tax policy theory.

I. State Taxation of Marijuana Businesses

A. *Introduction to Tax Theory*

When an essay has a grandiose title, like "Marijuana Taxation: Theory and Practice," it is probably best to start as close to the beginning as possible. So, what is the beginning of tax policy theory? Modern tax policy theory is grounded

---

[7] *See* N. Gregory Mankiw, Principles of Microeconomics 163 (5th ed. 2009).

[8] *See* Lawrence B. Lindsey, *Individual Taxpayer Response to Tax Cuts: 1982–1984*, 33 J. Pub. Econ. 173, 174 (1987) ("[T]he revenue maximizing rate provides an upper bound on the range of socially optimal tax rates.").

[9] Fleischer, *supra* note 6, at 1687.

[10] *Id.* at 1683-84.

[11] This Essay refers to marijuana markets in states that have legalized and are regulating these markets as "legal" to distinguish them from marijuana markets that continue to be illegal under state law. Of course, all marijuana markets in the United States are federally illegal unless and until Congress changes federal law. *See* 21 U.S.C. § 812.

[12] *See* Benjamin Moses Leff, *Tax Planning for Marijuana Dealers*, 99 Iowa L. Rev. 523, 532 (2014) [hereinafter Leff, *Tax Planning*] (noting the large impediment that I.R.C. § 280E poses to the legal marijuana industry).

[13] I.R.C. § 280E.

[14] Leff, *Tax Planning*, *supra* note 12, at 532-33.

in some very basic assumptions derived from classical economics. First, voluntary market transactions generally increase social utility.[15] Second, increases in price generally result in decreases in demand as some consumers at the margins substitute something for the transaction that has become more expensive.[16] Third, increases in price caused by taxation are different from increases in price caused by other sources, and therefore the reduction in demand caused by the increase in price is inefficient because it reduces overall social utility.[17] Fourth, some voluntary market transactions do *not* increase social utility, probably because of externalities.[18] Fifth, in those cases, taxes (called Pigouvian taxes) may increase social utility because the decline in demand caused by the increase in price is actually a good thing that increases efficiency rather than decreasing it.[19] This Section explains each step a little more fully.

The most basic assumption in any discussion of taxation is that imposing a financial cost on some activity affects the incentives of actors to participate in that activity.[20] So, for example, if the cost of producing marijuana goes up, that increase in cost will affect the supply curve and may result in less marijuana being sold depending on the shape of the demand curve. A tax is an example of a cost of production that is imposed by the government; the interaction of the supply curve and the demand curve will determine the extent to which a tax-induced increase in the cost of production will change the behavior of consumers and producers.[21]

Generally, this change in behavior is viewed negatively because a tax is likely to raise prices and drive out of the market the consumers who would like the good at the market price but are unwilling to pay for the good once the cost of the tax is added to the market price.[22] Thus, the tax results in a suboptimal distribution of the product. How much the tax affects behavior is an empirical question in each case. And it may be a very complicated one because it depends in each instance on difficult questions like the elasticity of supply and demand.[23] Of course, just because the tax decreases efficiency in the transaction does not mean that it is a bad thing in each case. If it were, taxation would have no economic justification. In fact, so long as the government uses the revenue it raises for something that increases social utility in excess of the loss of utility caused by the tax itself, then the tax is justified.[24] The trick is to raise as much

[15] *E.g.*, MANKIW, *supra* note 7, at 147-50.

[16] *Id.* at 137-46.

[17] Jerry A. Hausman, *Taxes and Labor Supply*, *in* 1 HANDBOOK OF PUBLIC ECONOMICS 213, 244 (Alan J. Auerbach & Martin Feldstein eds., 1985).

[18] A.C. PIGOU, THE ECONOMICS OF WELFARE 222 (4th ed. 1932).

[19] *Id.* at 224.

[20] *E.g.*, MANKIW, *supra* note 7, at 4-5.

[21] *Id.* at 123-27.

[22] *Id.* at 160-62.

[23] *E.g.*, Shanjun Li, Joshua Linn & Erich Muehlegger, *Gasoline Taxes and Consumer Behavior*, AM. ECON. J.: ECON. POL'Y, Nov. 2014, at 302, 304 (using price elasticities to predict consumer response to gasoline taxes).

[24] Incidentally, this justification for taxation is also, plausibly, the justification for having

revenue for social-utility-enhancing government expenditures with the least possible taxation-caused inefficiency. That is, maximize the revenue raised with minimal distortion to market outcomes. This is the goal of what I have been calling ordinary revenue-maximizing taxation.[25]

Our most common taxes generally fall into this category of ordinary revenue-maximizing taxes. For example, taxes on labor income are generally believed to affect workers' choices of whether to work and earn money or, instead, not work and substitute leisure for labor.[26] While a thousand caveats are recognized, it is generally presumed that sufficiently competitive markets overall create labor/leisure choices that are good for the workers, their employers, and the overall society.[27] Taxes increase the cost of labor for employers, decrease the return on labor for workers, or both, thereby distorting the labor market to the detriment of both workers and employers.[28] This type of distortion is inevitable in almost all taxes, and again, good tax policy seeks to minimize its effect when possible.

However, at least since the philosopher/economist Arthur Pigou pointed it out, tax theorists have recognized that there are some cases in which a tax—rather than distorting the optimal market distribution—actually *improves* the efficiency of a transaction.[29] This improvement may be possible when the transaction includes externalities.[30] The efficiency of a market transaction depends on the idea that the costs of the transaction are internalized to the parties agreeing to a price. If there are costs that are not borne by the transacting parties, they are externalized to other noncontracting parties. In that case, those costs will not be considered in the transaction, and the quantity of the good produced will be above a socially optimal level. Some social actors will experience costs (or harms) created by the transaction, but because they are not parties to the transaction, they will not be compensated for their costs. Thus, the price will be too low to reflect the costs of producing the good, and so the transaction is inefficient.

Pigou argued that in externality-producing transactions, governmentally imposed taxes can be used to force the externalities to be internalized into the transaction.[31] If the taxes equal the cost of the externalities, then the transaction

any government at all. *Cf.* PIGOU, *supra* note 18, at 224.

[25] *See* David Gamage & Darien Shanske, *Tax Cannabalization and Fiscal Federalism in the United States*, 111 NW. U. L. REV. 295, 311 (2017).

[26] *See* Hausman, *supra* note 17, at 240-43.

[27] *See id.* at 216.

[28] *Id.* at 244.

[29] PIGOU, *supra* note 18, at 223-25.

[30] *Id.*; *see also* Jonathan S. Masur & Eric A. Posner, *Toward a Pigouvian State*, 164 U. PA. L. REV. 93, 100 (2015).

[31] PIGOU, *supra* note 18, at 224 ("[F]or every industry in which the value of the marginal social net product is less than that of the marginal private net product, there will be certain rates of tax, the imposition of which by the State would increase the size of the national dividend and increase economic welfare; and one rate of tax, which would have the *optimum* effect in this respect.").

will produce an efficient and therefore socially optimal result.[32] The most commonly used example of a Pigouvian tax is a tax on air pollution. Air pollution is a harm that is caused by certain behaviors and that is not fully absorbed by the participants in those behaviors. So, for example, when I burn gasoline, I cause air pollution that harms not only me and the gasoline producer (or retailer) but also all of my neighbors and fellow human beings around the globe. This harm accrues to all because of the interaction of carbon dioxide and global warming. Therefore, if the cost of gasoline were increased by the imposition of a tax, then the demand for gasoline would go down, better reflecting the aggregate social costs and benefits associated with my use of gasoline. If the tax could perfectly match the aggregate harm to all other parties from the use of gasoline, then the transaction—my purchase of gasoline—would be efficient because the external harms to others would be internalized into the price.[33]

Pigouvian taxes are therefore the holy grail of taxes, at least theoretically. They raise revenue for the government, which is presumably good if government expenditures improve social welfare. *And* they avoid the negative effect of other taxes because, rather than decreasing the efficiency of transactions by imposing nonmarket disincentives to transact at an optimal level, they increase the efficiency of transactions by internalizing at least some negative externalities. Contemporary popular Pigouvian tax enthusiasts, such as Robert Frank, laud Pigouvian taxes for "kill[ing] two birds with one stone, helping to bring government budgets into balance while discouraging activities that cause more harm than good."[34]

B. *Implications of Theory for Marijuana Taxation*

The vast majority of scholars and commentators who have discussed taxes on marijuana have identified this tension between taxes meant to raise revenue and those meant to discourage consumption.[35] While marijuana policy

[32] *See, e.g.*, Masur & Posner, *supra* note 30, at 95 (explaining how Pigouvian taxes achieve socially positive results from activities with externalities); *see also* Dennis W. Carlton & Glenn C. Loury, *The Limitations of Pigouvian Taxes as a Long-Run Remedy for Externalities*, 95 Q.J. ECON. 559, 559 (1980) (criticizing Pigouvian taxes, but arguing that charging taxes equal to externalities in a lump sum rather than per unit will achieve optimal results).

[33] *See* MANKIW, *supra* note 7, at 211-14.

[34] ROBERT H. FRANK, THE DARWIN ECONOMY: LIBERTY, COMPETITION, AND THE COMMON GOOD 172 (2011).

[35] For example, a decade ago, Robert Mikos thoughtfully explained that a state tax on marijuana would serve two purposes. Robert A. Mikos, *State Taxation of Marijuana Distribution and Other Federal Crimes*, 2010 U. CHI. LEGAL F. 223, 228-29 (noting that as a "vice tax," a state tax would "internalize some of the societal costs of drug use[,] . . . . bring[ing] marijuana use closer to the socially optimal level, namely, where private benefits most exceed total social costs," and explaining that the tax is intended to raise revenue). The 2014 *Planet Money* episode that promised the listener they "would be able to design a tax on marijuana" explained that good design of a marijuana tax depended on whether the tax was a Pigouvian tax (though they used the term "sin tax") or an ordinary revenue-

commentators understand the primacy of revenue-raising concerns, there is a strong temptation to import the theoretical apparatus of Pigouvian taxes.[36] In this Section, I attempt to explain why tax policy theory permits a convergence of these two apparently divergent approaches, and I correct potential misapplications of theory to practice.

One excellent recent analysis illustrates well how an emphasis on traditional Pigouvian analysis could lead one astray in designing a marijuana tax for a newly emergent legal market.[37] Among the six "Key Points" of a recent Tax Foundation's *Fiscal Fact*, the third is that "[a]n excise tax on recreational marijuana should target the externality and raise sufficient revenue to fund marijuana-related spending while simultaneously outcompeting illicit operators. Excise taxes should not be implemented in an effort to raise general fund revenue."[38] The sixth point similarly states, "A potency- and weight-based tax defined by [tetrahydrocannabinol ("THC")] levels may be the best short-term solution for lawmakers assuming that THC is an appropriate proxy for the externalities associated with consuming marijuana."[39] Both of these observations come from traditional Pigouvian analysis: a tax meant to internalize externalities should attempt to match the level of tax to the magnitude of those externalities and should not be used generally to raise revenue.[40] Identifying the costs of the externalities related to marijuana consumption is both inherently difficult and controversial. A traditional Pigouvian analysis compels policy makers to attempt to ascertain this information as a prerequisite to designing a good tax.

There is a hint about how to integrate the Pigouvian analysis with ordinary revenue-maximizing analysis in the *Fiscal Facts* quoted above. The author,

maximizing tax. Planet Money, *supra* note 1, at 2:46; *see also* Benjamin M. Leff, *Tax Benefits of Government-Owned Marijuana Stores*, 50 U.C. DAVIS L. REV. 659, 684-85 (2016) [hereinafter Leff, *Tax Benefits*] (arguing that a functional marijuana-tax regime must balance keeping marijuana prices low enough to avoid driving consumers back into the illegal market with keeping prices high enough to avoid creating "dramatic growth in demand, since most people still view marijuana as having some adverse medical or social effects").

[36] *See* ULRIK BOESEN, TAX FOUND., FISCAL FACT NO. 713, A ROAD MAP TO RECREATIONAL MARIJUANA TAXATION 23 (2020) [hereinafter BOESEN, ROAD MAP], https://files.taxfoundation.org/20200608144852/A-Road-Map-to-Recreational-Marijuana-Taxation.pdf [https://perma.cc/8QD6-UE3Z].

[37] *Id.* at 1 ("Low taxes may allow easy conversion from the illicit market but could increase consumption among non-users and minors."); *see also* Ulrik Boesen, *Flawed Federal Taxation of Recreational Marijuana*, TAX FOUND. (Sept. 3, 2020) [hereinafter Boesen, *Flawed Federal Taxation*], https://taxfoundation.org/more-act-federal-taxation-of-recreational-marijuana/ [https://perma.cc/S623-EYA8] (criticizing federal marijuana ad valorem tax proposal in the MORE Act of 2020, H.R. 3884, 116th Cong. (2020), because "[a]n excise tax should correspond to the harm it is addressing, or the cost it is internalizing," and arguing that "excise taxes should only be levied when appropriate to capture some externality or to create a 'user pays' system").

[38] BOESEN, ROAD MAP, *supra* note 36, at 1.

[39] *Id.*

[40] *See* PIGOU, *supra* note 18, at 224.

Ulrik Boesen, argued that marijuana taxes should "target the externality" (an insight from Pigouvian analysis) "while simultaneously outcompeting illicit operators."[41] It is this second observation that is the key to understanding how to integrate Pigouvian with ordinary analysis. Both Pigouvian and ordinary revenue-maximizing analyses assume that when taxes raise prices for the taxed transaction, some actors on the margin will decrease their participation in that transaction.[42] The key point is that the decrease in participation in the transaction being taxed is caused by those actors switching to *some other transaction*: a second-best substitute.[43] The only way to know whether the decrease in participation in the taxed transaction decreases social utility (like ordinary revenue-maximizing taxes) or increases social utility (like Pigouvian taxes) is to compare the original transaction to the substituted transaction. If the externalities associated with the substituted transaction are worse than the externalities associated with the original transaction, then the tax is not Pigouvian, even if the tax perfectly matches the costs of the externalities associated with the original transaction.[44]

A simple example can illustrate the point: imagine a tax on gasoline imposed because the burning of gasoline pollutes the atmosphere and causes global warming.[45] If the tax on gasoline raises the price so that consumers of gasoline respond exclusively by substituting coal for gasoline, and if coal is more polluting than gasoline, then the tax is not Pigouvian, and social utility is decreased by the imposition of the tax.[46]

When Boesen says that a marijuana tax must permit taxed sellers to "outcompete illicit operators,"[47] he is acknowledging the most important substitute for most consumers in the legal taxed marijuana market: *illegal* marijuana.[48] Boesen relied on an estimate that illegal sales would account for

---

[41] BOESEN, ROAD MAP, *supra* note 36, at 1.

[42] *See supra* note 20 and accompanying text.

[43] *See* Meenakshi Sabina Subbaraman, *Substitution and Complementarity of Alcohol and Cannabis: A Review of the Literature*, 51 SUBSTANCE USE & MISUSE 1399, 1411 (2016).

[44] *See supra* note 31-32 and accompanying text.

[45] *See* Li, Linn & Muehlegger, *supra* note 23, at 302.

[46] Of course, the tax may still enhance overall utility because of the way the government spends the revenue generated from the tax, just as with any revenue-maximizing tax. But the fact that the tax decreases consumption of gasoline is not beneficial because the decreased consumption of gasoline is matched by increased consumption of an even more harmful product—coal.

[47] BOESEN, ROAD MAP, *supra* note 36, at 22.

[48] It should also be noted that jurisdictions with thriving legal *medical* marijuana markets may find that their newly legalized *recreational* marijuana markets face competition from existing medical markets, which may not be subject to the same taxes. *See* Sam Kamin, *Marijuana Legalization in Colorado - Lessons for Colombia*, 75 REV. INSTITUTO COLOMBIANO DE DERECHO TRIBUTARIO 339, 352 (2016). The implications of cross elasticity of demand between medical and recreational marijuana presents its own challenges to the design of a marijuana tax regime.

approximately 78% of the U.S. marijuana market in 2020.[49] That is after quite a few years of maturity of the leading legal marijuana markets.[50] When a jurisdiction introduces a new legal marijuana market, it is generally contending with an existing illegal market that is very large and in which many consumers have been obtaining illegal marijuana for years.[51] The most important challenge for any newly introduced legal marijuana regime is to move existing consumers from the well-entrenched and functional illegal market to the legal market.[52] For most existing marijuana consumers, the substitute for legal marijuana is illegal marijuana. Therefore, if taxes drive people away from legal marijuana transactions, it drives them to untaxed illegal marijuana.

While it is notoriously controversial to estimate the social cost of marijuana consumption (and difficult to decide which costs are rightly considered externalities and which should be considered internalities), it is quite clear that marijuana sold on an illegal market produces more social costs than marijuana sold on a legal market.[53] That is because many of the clearest social costs of marijuana consumption come not from the effects of the product itself but from illegality.[54] These costs include the devastation caused to communities, especially communities of color, driven by overpolicing, police violence, and mass incarceration.[55] They also likely include the costs of at least some violence or other harmful criminal activity by producers or distributors in some marijuana markets. These costs are high enough that it seems uncontroversial to assert that if consumers substitute *illegal* marijuana for a purchase of legal marijuana,

---

[49] BOESEN, ROAD MAP, *supra* note 36, at 5.

[50] *See id.* at 11 (noting that Colorado's recreational marijuana market opened in 2014).

[51] Of course, some consumers in the new legal market may not have previously been marijuana consumers or may have been infrequent marijuana consumers. For these consumers, the substitute for legal marijuana may truly be abstinence, or it may be some other substance, legal or not, such as alcohol, prescription opiates, or antidepressants. *See* Subbaraman, *supra* note 43, at 1411-12. The primary point is that a Pigouvian tax is one for which the substitute transaction has fewer social costs than the transaction being taxed, and in the case of a newly legal marijuana market there are many reasons to believe that the substitute transaction will have more social costs for the vast majority of consumers. *See* BOESEN, ROAD MAP, *supra* note 36, at 23-24.

[52] *See, e.g.*, Kamin, *supra* note 48, at 349 ("[I]t became evident early in the regulatory process [in Colorado] that . . . a punitive sin-tax on marijuana would keep the prices in the regulated market artificially high, allowing a black market to thrive and giving licensed entities incentives to avoid the tax.").

[53] *Id.* at 342.

[54] *See id.* at 345 (recognizing that the Obama Justice Department reprioritized enforcement around marijuana to, inter alia, prevent criminal enterprises from receiving money from marijuana sales).

[55] *See* ACLU, A TALE OF TWO COUNTRIES: RACIALLY TARGETED ARRESTS IN THE ERA OF MARIJUANA REFORM 5 (2020), https://www.aclu.org/sites/default/files/field_document/tale_of_two_countries_racially_targeted_arrests_in_the_era_of_marijuana_reform_revised_7.1.20_0.pdf [https://perma.cc/T6FY-3RSC] ("On average, a Black person is 3.64 times more likely to be arrested for marijuana possession than a white person, even though Black and white people use marijuana at similar rates.").

social utility will not increase. In fact, one of the major reasons that jurisdictions legalize marijuana is to decrease or mitigate the perceived social harms caused by the illegal market.[56]

If marijuana taxes are too high, that might make prices of marijuana in the newly legal market too high, which might cause some consumers to choose to purchase marijuana in the illegal market or to continue to do so.[57] Obviously, taxes are only one among many factors that influence whether consumers who are used to purchasing marijuana on an illegal market move to the legal market.[58] But the point is that a tax is only Pigouvian if the increase in cost that it produces causes some consumers on the margin to replace the high-social-cost transaction with a *lower*-social-cost transaction. In any case in which the consumer purchases illegal marijuana (more social harm) instead of legal marijuana (less social harm) because of a tax on legal marijuana, the total social harm has increased, so the tax is not Pigouvian.

Why does it matter if designers of a marijuana tax are guided by Pigouvian analysis or not? One possibility is that the implications are primarily or exclusively "academic," in the sense that they are only interesting to people who care about tax theory and do not impact the design of a good tax on marijuana. On the other hand, because a good Pigouvian tax matches the level of tax to the externalities produced by the taxed transaction, the design of a Pigouvian tax demands some consensus on what those externalities are. This consensus is notoriously difficult to achieve.[59] Boesen (to take just one example) argued that special marijuana taxes should be based on weight or potency because he assumes "that THC is an appropriate proxy for the externalities associated with consuming marijuana."[60] But it is not at all clear that potency is an appropriate proxy for the harms caused by marijuana. As is often pointed out, the majority of marijuana is consumed by a minority of consumers, and it is not at all clear that externalities rise in tandem with these users' quantity or potency of use.[61] In addition, significant harm may be caused by relatively small quantities of use

[56] Natalie Fertig, *How Legal Marijuana Is Helping the Black Market*, POLITICO MAG. (July 21, 2019), https://www.politico.com/magazine/story/2019/07/21/legal-marijuana-black-market-227414 [https://perma.cc/4855-RMQ3].

[57] *See* Kamin, *supra* note 48, at 349.

[58] *See, e.g.*, Pat Oglesby, *Marijuana Revenue Competition – Look Out Below*, 88 ST. TAX NOTES 541, 541 (2018) [hereinafter Oglesby, *Marijuana Revenue Competition*] ("Buyers will prefer legal marijuana over illegal marijuana for a variety of reasons, like quality assurance, safety, and legal recourse against sellers. But they still might buy the illegal product if it's noticeably cheaper.").

[59] Some critics of Pigouvian taxation argue that externalities can never be known sufficiently to design an efficient Pigouvian tax. *E.g.*, R.H. Coase, *The Problem of Social Cost*, 3 J.L. & ECON. 1, 39-42 (1960).

[60] BOESEN, ROAD MAP, *supra* note 36, at 1.

[61] *See, e.g.*, *id.* at 4 (noting that most marijuana is consumed by very "heavy users," and that "[t]his point is important to remember when designing excise taxes as this group will pay most of the taxes, which in turn can increase the regressive effects of high excise taxes on marijuana. A similar characteristic is seen with alcohol consumption").

by certain consumers, especially new users, children, or young adults.[62] Pigouvian analysis is generally a poor tool for reducing harm when the harm caused is unevenly distributed among different consumers of the taxed transaction.[63] In addition to everything else, because money itself has heterogeneous marginal utility, taxes (especially those that do not depend on income or wealth) impact different consumers differently and have a presumably smaller impact on wealthier consumers than on less wealthy ones.[64] This critique of Pigouvian taxes as applied to goods like marijuana might lead policy makers to decide to set marijuana tax rates very low or eliminate them entirely.[65] When marijuana taxes are compared to other revenue-maximizing taxes as a means of raising general revenue, these flaws with the application of Pigouvian analysis to marijuana dissipate.

So, if Pigouvian analysis is generally inappropriate for a new legal marijuana market, what is the correct analysis? Boesen says, "While excise taxes should not be considered a tool to raise funds for general spending due to their narrow bases and distortionary effects, other taxes, like sales taxes, property taxes, and income taxes levied on newly-legal businesses can provide meaningful revenue for all levels of government."[66] Presumably, he means that these other taxes should be applied to newly legal marijuana businesses on the same terms as they are applied to all other businesses. But it would be appropriate to apply *special* taxes to newly legal marijuana businesses that are not applied to other businesses, even if the revenue from those taxes is used for general spending (so long as general spending is socially beneficial). The question, then, just like with any tax, is how to raise the most revenue possible while driving as few people as possible out of the newly legal marijuana market and into the existing illegal marijuana market? The answer to that question will determine whether the "special" tax on marijuana would be better as an excise tax, a sales tax, a property tax, or an income tax.

---

[62] Kara S. Bagot, Robert Milin & Yifrah Kaminer, *Adolescent Initiation of Cannabis Use and Early-Onset Psychosis*, 36 SUBSTANCE ABUSE 524, 524-25 (2015).

[63] *See, e.g.*, Fleischer, *supra* note 6, at 1676-77 ("[W]hen marginal social cost varies, average cost does not equal marginal cost, and Pigovian taxes may not lead to an optimal allocation of economic resources.").

[64] Sarah B. Lawsky, *On the Edge: Declining Marginal Utility and Tax Policy*, 95 MINN. L. REV. 904, 904 (2011).

[65] One recent critique of certain "state-level controlled substance taxes" goes even further, arguing that some taxes on controlled substances are not justified by ordinary revenue-maximizing or Pigouvian taxation but are instead designed to avoid procedural safeguards in the enforcement of direct regulation of controlled substances, and therefore are "insidious regulatory taxes." Hayes R. Holderness, Insidious Regulatory Taxes 3 (Jan. 24, 2021) (unpublished manuscript), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3665440 [https://perma.cc/X4KG-LHE2]. Evaluating marijuana taxes under a normal revenue-raising paradigm enables policy makers to avoid both creating insidious regulatory taxes and becoming involved with the difficult or contentious issues associated with Pigouvian taxes.

[66] BOESEN, ROAD MAP, *supra* note 36, at 6.

In the case of a newly legalized marijuana market, the most important factor in creating an optimal taxing instrument is the prediction that legalization is likely to cause the retail price of marijuana to fall precipitously.[67] That prediction has been, at least partially, confirmed repeatedly.[68] The price is predicted to fall, and actually falls, because marijuana prohibition limits competition and creates the very dramatic costs mentioned above.[69] Marijuana producers, distributors, and sellers "must operate covertly, forgo advertising, pay higher wages to compensate for the risk of arrest, and lack recourse to civil courts for resolving contract disputes. Legal companies in contrast endure none of these costs and also can benefit from economies of scale that push production costs down."[70] Therefore, legalization creates *surplus value* as costs associated with production, transportation, and selling marijuana go down. In a competitive market, one would expect much of the surplus to result in a price drop as the surplus is captured by consumers. Traditional revenue-maximizing tax policy theory would ask: What portion of this legalization surplus can and should the government capture with special marijuana taxes?[71]

Proponents of Pigouvian taxation of marijuana point out that as the price drops, one would predict that demand would increase assuming that (1) some existing consumers of marijuana will increase their consumption as prices go down and (2) some new consumers who were kept out of the market by existing high prices will now enter the market.[72] The legalization price drop, therefore,

---

[67] *See, e.g.*, Kamin, *supra* note 48, at 351 ("[T]he price has since fallen, taking much of the profit out of the black market."); Oglesby, *Marijuana Revenue Competition*, *supra* note 58, at 542 ("After legalization, pretax marijuana prices fall, as the legal market gains efficiency and cuts costs."); Keith Humphreys, *So, Something Interesting Happens to Weed After It's Legal*, WASH. POST (May 4, 2016, 6:30 AM) [hereinafter Humphreys, *Something Interesting*], https://www.washingtonpost.com/news/wonk/wp/2016/05/04/the-price-of-legal-pot-is-collapsing/ (quoting Jonathan Caulkins, "It's just a plant. . . . [N]o-frills generic forms could become cheap enough to give away as a loss leader – the way bars give patrons beer nuts and hotels leave chocolates on your pillow").

[68] *See, e.g.*, Keith Humphreys, *How Legalization Caused the Price of Marijuana to Collapse*, WASH. POST (Sept. 5, 2017, 8:42 AM), https://www.washingtonpost.com/news/wonk/wp/2017/09/05/how-legalization-caused-the-price-of-marijuana-to-collapse/ (reporting that in Washington State "[t]he current [2017] retail price of $7.38 per gram (including tax) represents a 67 percent decrease in just three years of the legalization, with more decline likely in the future" (citation omitted)).

[69] *See supra* text accompanying notes 55-56.

[70] Humphreys, *Something Interesting*, *supra* note 67 (citing JONATHAN P. CAULKINS, BEAU KILMER & MARK A.R. KLEIMAN, MARIJUANA LEGALIZATION: WHAT EVERYONE NEEDS TO KNOW (2d ed. 2016)).

[71] *See* Pat Oglesby, *States May Be Stuck with Second-Best Marijuana Taxes*, 72 ST. TAX NOTES 539, 539 (2014) [hereinafter Oglesby, *Second-Best Marijuana Taxes*] ("After marijuana is legalized, the costs of producing and selling it will collapse and a windfall economic gain will be up for grabs. . . . [T]hrough revenue measures, [policy makers] might direct the gain to society as a whole.").

[72] It is also possible that some potential consumers of marijuana were kept out of the market by illegality not just because of high prices but also because of other factors associated

might cause demand from consumers who may substitute less use or abstinence (instead of illegal marijuana) for legal marijuana if the price of legal marijuana were higher. In this case, a Pigouvian analysis is appropriate for them and may justify taxes on marijuana to prevent prices from dropping due to legalization. But even when Pigouvian analysis supports taxes on marijuana to prevent the price from dropping, it is unnecessary. Ordinary revenue-maximizing tax theory justifies attempting to keep taxes as high as possible (while still avoiding driving consumers into the illegal market), so there is no need to ascertain the externalities associated with increased marijuana consumption.[73] Avoiding this conceptually and practically difficult question makes designing the appropriate taxing instrument at least a little simpler.

Once it is clear that the goal of the taxation of a newly legalized marijuana market is for the government to take the appropriate portion of the surplus value created by legalization, then a much stronger case can be made for the government to take a more substantial share than is commonly acknowledged in tax policy circles. In other words, if legalization creates surplus value as compared to prohibition, that surplus is available as a windfall for (1) newly legalized producers, (2) consumers in a newly legal market, or (3) government. There is a plausible argument that government claiming (some of) the surplus value created by legalization is less distortive than other sources of revenue so long as tax rates are kept low enough to avoid driving consumers back into the illegal market. If the government uses even some of the revenue generated from this legalization surplus to mitigate the damage caused to communities by decades of prohibition, then the government's claiming of a significant part of the surplus is even more justified.[74]

If the goal of a good marijuana tax is to capture a significant portion of the legalization surplus, then the most important consideration in designing such a tax is how to make that tax *dynamic*.[75] As others have repeated often, a tax on the legalization surplus must be low enough at the outset to permit legal suppliers to draw consumers out of the illegal market. But the legalization surplus grows over time, as the production and sale of marijuana gets cheaper and cheaper for legal suppliers, so the tax has to have some ability to increase as legalization creates this surplus. A tax on the price of marijuana (a sales tax or other ad valorem tax) does exactly the opposite: as the price falls, so does the

with illegality (e.g., they did not like or trust the product, they did not like breaking the law, and/or they were prevented from finding the product due to a lack of advertising or fixed selling locations).

[73] *See* Pat Oglesby, *Gangs, Ganjapreneurs, or Government: Marijuana Revenue Up for Grabs*, 66 ST. TAX NOTES 255, 263 (2012) ("A priori, government might seem to be able to maintain [prelegalization] price — and to claim nearly all that price as revenue — by seizing the entire illegality premium that compensates lawbreakers for risk.").

[74] Jonathan P. Caulkins, *A Principled Approach to Taxing Marijuana*, NAT'L AFFS., Summer 2017, at 22, 24-25.

[75] George Theofanis, Note, *The Golden State's 'High' Expectations: Will California Realize the Fiscal Benefits of Cannabis Legalization?*, 49 U. PAC. L. REV. 155, 158-59 (2017).

quantity of tax.[76] An excise tax on weight or potency at least does not decrease as the price drops, but neither does it increase.[77] There is no known tax that is inversely related to price, and so no currently existing tax instrument serves the need of a good marijuana tax to be dynamic. This has led astute commentators such as Oglesby to advocate for a government monopoly on marijuana sales, because that is the best way for the government to dynamically capture the legalization surplus.[78]

In other words, even without any Pigouvian analysis, designers of marijuana taxes for newly legalized marijuana markets have theoretical justification for seeking a "Goldilocks" tax: low enough to enable the regulatory regime to bring consumers into the newly legal market but high enough to capture a significant portion (as much as possible?) of the legalization surplus. Designers of a marijuana tax should not get distracted by asking (1) what are the externalities (if any) associated with expanded marijuana consumption, or (2) what tax is best designed to minimize these externalities. They should focus on designing a tax instrument that enables taxing authorities to capture the legalization surplus dynamically as it is created—which is no small feat.

II. FEDERAL TAXATION OF MARIJUANA BUSINESSES

As described in the previous Section, the most important issue in designing a state tax on marijuana businesses is choosing a taxing instrument that optimizes the state government's ability to simultaneously set rates low enough to facilitate the transition from the illegal to the newly legal market and high enough to capture as much of the legalization surplus as possible. The same challenges of choosing the right "Goldilocks" taxing instrument and setting the right rates are likely the most important issues in designing a federal tax as well. If federal legalization ever occurs, it is likely to alter the legal landscape in multiple ways relevant to taxation, and that will impact the legalization surplus in a way that will play out over time. Therefore, it will be important to adopt a federal taxing instrument that enables the federal government to coordinate its tax with state taxing jurisdictions, ideally dynamically, to meet the challenge of finding the right tax rate and design.[79]

The purpose of this Essay is to explicitly root discussion of marijuana tax design in tax policy theory. A discussion of the federal taxation of marijuana, then, must start with the theory of interjurisdictional tax coordination, which is generally called "fiscal federalism."[80] Fiscal federalism attempts to answer the

---

[76] *See* Oglesby, *Present and Future Traps*, *supra* note 4, at 393.

[77] *See id.* at 393-94.

[78] *See* Oglesby, *Second-Best Marijuana Taxes*, *supra* note 71, at 540-41; *see also* Leff, *supra* note 35, at 664.

[79] Boesen, *Flawed Federal Taxation*, *supra* note 36, at 37 ("Designing [federal] excise taxes (and regulations) will play a key role in allowing the legal market to undercut and outcompete the illicit market, which should be one of the first priorities.").

[80] Richard M. Bird, *Fiscal Federalism*, *in* THE ENCYCLOPEDIA OF TAXATION & TAX POLICY 146, 146-47 (Joseph J. Cordes, Robert D. Ebel & Jane G. Gravelle eds., 2d ed. 2005).

questions of how taxation and provision of government services should be divided across levels of government. While any actual discussion of fiscal federalism is well beyond the scope of this brief Essay, a few points are worth making. First, federal taxes on marijuana may well crowd out state taxes on marijuana or otherwise impede state tax efforts to create a "Goldilocks" tax on marijuana. Second, federal legalization (if it ever occurs) is likely to create additional legalization surplus, which will create additional dynamic effects in the price of marijuana. And, finally, federal legalization is likely to create dramatic changes to price competition between the states in which marijuana sales are legal, and these dynamic changes will affect states' attempts to craft good marijuana taxes as well.

The general question of whether and to what degree taxes at one jurisdictional level crowd out taxes at another jurisdictional level is contested.[81] One jurisdiction's tax would be said to "crowd out" another jurisdiction's tax if the imposition of that tax makes it more difficult for the second jurisdiction to impose its own tax.[82] While there is some intuitive appeal to the general idea that aggregate high federal taxes limit the ability of state or local governments to impose overall tax burdens as high as they would want,[83] Brian Galle has argued that the empirical evidence for a general theory of crowd out is lacking, and there is evidence (including his own study) to suggest that the opposite effect may be more common.[84] The intuitive case that a federal tax on a specific base would crowd out the state's ability to tax that very same base is stronger though. One would imagine that very high taxes on cigarettes, for example, would make it harder for states to raise revenue by taxing cigarettes. That is because one would expect that the higher the price on cigarettes, the stronger the incentive for consumers to substitute abstinence or some other product for cigarettes. But even in this context, the empirical evidence is mixed, with some studies showing evidence of crowd out and some not.[85] As Galle points out, "[T]he outcome depends on how humans respond to changes in the price of different commodities—the elasticity of demand and supply."[86] And the choices that humans make are subject to countless factors, including whether they aggregate the different taxes when considering the price of the goods sold.[87]

[81] Brian Galle, *Does Federal Spending "Coerce" States? Evidence from State Budgets*, 108 NW. U. L. REV. 989, 1001 (2014).

[82] *Id.* at 992, 1001.

[83] *See, e.g.*, Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 680 n.13 (2012) (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting) ("[H]eavy federal taxation diminishes the practical ability of States to collect their own taxes.").

[84] Galle, *supra* note 81, at 993.

[85] *Id.* at 1018.

[86] *Id.* at 1003.

[87] The *Planet Money* podcast, *supra* note 1, featured Jacob Goldin's work about the differential "salience" of sales taxes depending on whether the posted price included the sales tax or not. Goldin found that consumers respond differently to different designs, even when the rate of tax was the same. Goldin, *supra* note 3, at 281-82.

However, in the case of the search for a "Goldilocks" marijuana tax instrument, the intuitive case for crowd out is arguably the strongest. Certainly, to the degree that states consider the prices available in the illegal market to be a ceiling on their ability to tax marijuana in the legal market, they would need to consider any federal tax on legal sales that appears in the sticker price of marijuana sold in the legal market. If the federal tax is built in to the price of marijuana sold in their states, the chance is highest that consumers would react to the aggregate federal and state tax imposed. In which case, federal taxes imposed in a way that increases marijuana prices too high, at least, would presumably crowd out state taxes.[88]

It is possible, of course, that state marijuana taxes could crowd out federal marijuana taxes (instead of the other way around), in the sense that existing state taxes will impede the ability of the federal government to impose taxes as high as it would like. One could think about this either as an economic question (what will happen if the federal government imposes taxes too high when combined with existing state taxes?) or as a political question (will federal legislators choose to impose lower taxes because of the existence of state taxes?). Since the same federal taxes will apply to multiple states, each with their own distinct taxing regime, the number of variations will be very high indeed. But the bottom line is that a good federal tax design should account for its effect on the price of marijuana in various states by keeping the price low enough to not fundamentally undermine the regulation of marijuana by driving a significant number of consumers back into illegal markets.[89]

The competition between the federal government and state governments over marijuana revenue will be mitigated, at least partially, by the fact that federal legalization is likely to create additional legalization surplus value.[90] Federal prohibition makes problems for producers and suppliers by making banking and revenue raising from investors difficult and by preventing the creation of large interstate markets. There may also be costs associated with fear of more robust criminal prohibition at the federal level, which creates very serious (if unlikely) risks for entrepreneurs in the market. Once these federal impediments are removed, the cost of producing and distributing marijuana should decrease, creating additional surplus value available to be taxed.

In addition, federal legalization may destroy state internal monopolies on marijuana production and distribution, permitting interstate competition. As Oglesby has pointed out, "As long as marijuana is federally illegal, states can legally prevent imports, so they can tax consumption by taxing producers."[91] But as soon as the federal government legalizes marijuana, the U.S. Constitution's

---

[88] Oglesby, *Marijuana Revenue Competition*, *supra* note 58, at 545-46 ("[A] new federal [excise] tax may constitute in itself a kind of tax competition for states, which may need to adjust to collect less tax to keep the illegal market at bay – by keeping the after-all-taxes price down.").

[89] *Id.*

[90] *See id.* at 546.

[91] *Id.* at 545.

Interstate Commerce Clause is likely to prevent states from prohibiting the sale within their borders of out-of-state marijuana.[92] That will produce competition between the states, including competition to decrease the taxes applied to producers. Oglesby identifies this prospective competition between states as an argument for high federal taxes, since state producer taxes will be subject to tax competition.[93] If the prospect of the federal government cannibalizing state revenue from marijuana legalization is distressing (or unjust), Oglesby argues that the federal government could share revenue from its marijuana taxes with the states.[94] This is an extremely common solution when taxing is most efficient at the federal level, while spending choices are more appropriate at the state level.

CONCLUSION

What, then, is the best way to tax marijuana? The answer is that taxing marijuana well is a devilishly difficult problem. But the primary considerations are *not* those (also devilishly difficult) problems associated with designing a good Pigouvian or regulatory tax: How to craft the tax to increase costs where externalities are pronounced and refrain from taxing where externalities are low? Rather, the most pronounced difficulty is ensuring that excessive taxes do not stymie efforts to move consumers out of the existing illegal market and into the newly regulated legal market while keeping taxes high enough to capture the majority of the legalization surplus. This is a difficult question primarily because legalization induces changes in market conditions in a dynamic way—what is true in the early days of a legal market changes over time, and higher taxes become more justified as prices drop.

This central question is deeply complicated by changes that are likely to occur if or when the federal government legalizes or decriminalizes marijuana at the federal level. The federal government is likely to become a competitor and collaborator in the project of taxing marijuana, and that will introduce a new round of unpredictable and evolving alterations to the economic realities of marijuana markets. Thus, the challenge is to create flexible, dynamic marijuana taxes at both the state and federal level with designs that permit coordination of both taxing regimes in multiple jurisdictions.

[92] *See id.*; U.S. CONST. art. I, § 8, cl. 3.

[93] *See* Oglesby, *Present and Future Traps*, *supra* note 4, at 399 ("Unless federal taxation dominates, a race to the bottom may put every competing jurisdiction's marijuana taxes at risk. . . . A high federal tax, high enough to dominate the field, would address that problem.").

[94] *See* Oglesby, *Marijuana Revenue Competition*, *supra* note 58, at 546.

2021 ANNUAL REPORT

CALIFORNIA CANNABIS ADVISORY COMMITTEE

TABLE OF CONTENTS

INTRODUCTION 1

ILLICIT MARKET 1

RETAIL BANS 2

CANNABIS TAX RATE 2

PUBLIC HEALTH AND SAFETY 3

DEPARTMENT OF CANNABIS CONTROL 4

EQUITY RULEMAKING 5

CANNABIS ADVISORY COMMITTEE SUBCOMMITTEES 5

SUBCOMMITTEE ON LICENSING 6

CREATION OF A COTTAGE/LEGACY LICENSE TYPE 6

CALIFORNIA ENVIRONMENTAL QUALITY ACT (CEQA) REGULATIONS 9

Advisory Committee Recommendation 10

NUMBER OF LICENSES BY TYPE 10

SUBCOMMITTEE ON ENFORCEMENT 10

Advisory Committee Recommendation 11

Advisory Committee Recommendation 11

INFORMATIONAL PRESENTATIONS 11

Budget Proposal to Consolidate Licensing Authorities 11

State of Cannabis Equity The United CORE Alliance 11

CONCLUSIONS 11

ACKNOWLEDGMENTS 13

Cannabis Advisory Committee Members 13

Acknowledgment of Former Advisory Committee Members 14

Leadership 14

DCC Leadership 14

DCC Committee Support Staff 14

INTRODUCTION

Given the truncated schedule of the Cannabis Advisory Committee (Advisory Committee) meetings due to the pandemic, this report seeks to provide an annual update, highlight the work of the newly formed Department of Cannabis Control (DCC), and capture the recommendations that culminated from public input. Consistent with previous years, the principles of protecting public health and safety while ensuring commercial cannabis regulations do not impose barriers that perpetuate the illicit cannabis market guided our work and our recommendations. We appreciate the public participation and dedication of the DCC in support of the work of the committee. We welcome Nicole Elliott, Director of the DCC, and her team. We look towards bold leadership to build out effective, streamlined, and coordinated programs and the opportunity to develop the collaboration needed to craft comprehensive solutions to address persistent structural challenges.

In 2021, the California cannabis industry, the world's largest legal cannabis market, is shifting towards a critical inflection point brought forth by longstanding global challenges associated with the illicit market and exacerbated by the impacts of the COVID-19 pandemic. Because of the federal designation of cannabis, cannabis businesses have historically been excluded from many protections afforded to other industries. The COVID-19 related protections and budget investments made by the Newsom Administration in the last two years proved beneficial to the state, resulting in economic recovery and an anticipated $31 billion budget surplus. Fortunately, because of consumer demand coupled with pandemic-related in-home adult-use, the cannabis market experienced pronounced growth in sales in 2020 by nearly 57.5 percent.[1] This growth however tapered off dramatically in 2021, to 19 percent[2] compared to the same period last year. The lack of stability in sustaining sales can be in part attributed to the competition of the illicit market, which offers cannabis products at a fraction of the price of legal products.

ILLICIT MARKET

Since the passage of the Compassionate Use Act 25 years ago and subsequent adult-use legalization five years ago, the vision of a legal market reaching full maturation has not materialized. The size of the illicit market and the significant number of jurisdictions that do not allow legal cannabis activity have posed difficult challenges for the legal market and its participants.

Many of the issues that plague the legal market have been identified by the Advisory Committee and stakeholders in prior years; the majority of these longstanding challenges require more than just regulatory changes. The consequences of prolonging the resolution of these issues have proved detrimental. Some license holders have expressed that they are struggling with operational costs associated with permitting and licensing fees, extensive compliance requirements, and local and state cannabis taxes. Some commercial cannabis businesses, including legacy operators and Black, Indigenous, People of Color (BIPOC) entrepreneurs, who could not secure a license due to lack of local licensing opportunities and California Environmental Quality Act (CEQA) challenges, have indicated they have experienced unrecoverable debt. Vulnerable Californians and their

---

1 *MJBizDaily*: https://mjbizdaily.com/adult-use-cannabis-sales-slip-from-2020-pace-after-lackluster-summer/
2 *MJBizDaily*: https://mjbizdaily.com/adult-use-cannabis-sales-slip-from-2020-pace-after-lackluster-summer/

caregivers may be forced to seek illicit cannabis products that are untested and potentially contaminated because there are no legal retailers within reasonable distances to their residences.

RETAIL BANS

Retail bans also continue to pose an ongoing challenge to a fully realized safe and regulated adult-use market. For context, in the 482 cities in California, approximately 41 percent allow for legal commercial cannabis business activity within their jurisdiction, while approximately 55 percent of counties allow for this activity. Legal access in the state remains out of reach for most Californians even though the number of retail licenses issued by the state has grown by nearly 15 percent in the last six months, bringing the number of licensed retailers to just over 1,100 retailers statewide. According to Politico, California is estimated to have a ratio of two legal retailers per 100,000 residents as compared to Oregon and Colorado where the ratio for access is approximately 18 retail shops for every 100,000 residents.[3] That means the residents of Oregon and Colorado have approximately nine times the amount of access to legal cannabis as California's residents.

The lack of legal retail outlets significantly impacts the amount of cannabis being sold. The New York Times has reported that all of the cannabis grown in California is not consumed in the state and the remainder makes its way to other states.[4] Additionally, it has been alleged that some licensees operate in both the legal and illegal markets.

CANNABIS TAX RATE

In addition to local challenges and illicit competition constraining the growth of the legal market, many legal cannabis businesses and consumers continue to struggle with the state's cannabis tax rates. Proposition 64 established two commercial cannabis taxes that went into effect on January 1, 2018. The excise tax is imposed upon the retail sale of cannabis products at a rate of 15 percent, and the cultivation tax is imposed on all harvested cannabis that enters the commercial market at a rate of nine dollars and twenty-five cents ($9.25) per ounce of dry-weight flower, and two dollars and seventy-five cents ($2.75) per ounce of dry-weight leaf or trim. The tax statute requires that the cultivation tax be adjusted on an annual basis to account for inflation, and on January 1, 2020 the cultivation tax was increased by 4 percent.

Faced with economic uncertainty brought on by the emerging COVID-19 pandemic, the Legislature approved Assembly Bill 1872 (2020) providing for a one year reprieve, precluding the California Department of Tax and Fee Administration (CDTFA) from increasing the cannabis excise tax mark-up rate during the period between September 18, 2020 and July 1, 2021. CDTFA announced that it would maintain the 80 percent mark-up rate for the cannabis excise tax for the remainder of the 2021 calendar year. Assembly Bill 1872 also prohibited the annual inflation adjustment to the cultivation tax during the calendar year, which allowed the rate to remain unchanged from January 1, 2020 through December 31, 2021.

---

3 *Politico*: https://www.politico.com/news/2021/10/23/california-legal-illicit-weed-market-516868
4 *NYTimes*: https://www.nytimes.com/2019/04/27/us/marijuana-california-legalization.html

With the upcoming sunset of the bill, CDTFA recently announced that the cultivation tax will be increased by 4 percent to account for inflation, effective January 1, 2022. This tax increase comes at a time when taxable legal sales during quarter 3 in California fell by approximately 12.4 percent compared to quarter 2 of this year. According to MJBizDaily, California is not alone as many other Western states have experienced a similar decrease in sales.[5] In response, some local jurisdictions, including the City of Oakland and the County of Mendocino, recently passed resolutions requesting the state immediately eliminate the cultivation tax.

The Advisory Committee has repeatedly heard public comment expressing concerns about challenges brought about by the state's cannabis tax structure and noted in previous annual reports that comprehensive tax changes will be necessary to ensure that commercial cannabis businesses are able to compete with the illicit market. While the devil lies in the details and taking a balanced approach, tax changes can help prevent price collapse of products and allow cannabis businesses to stabilize financially in order to help grow revenue funds in the long-run that many essential programs in the state rely on, including high quality, affordable childcare for working families.

In addition, a 2019 Legislative Analyst Office (LAO) report, *How high? Adjusting California's Cannabis Taxes*, recommended that the Legislature replace the state's existing cannabis taxes with a tax structure designed to reduce harmful cannabis use and change the way the state collects cannabis taxes, and to the tax rate itself in order to undercut illicit market prices, generate sufficient revenues, and discourage youth use.[6]

PUBLIC HEALTH AND SAFETY

This year, reports of a rise in organized retail thefts along with associated shootings and vandalizations have devastated several licensed cannabis retailers, distributors, and cultivators throughout the state. Adding to the costs of operations, these incidents can completely bankrupt a business, especially brick and mortar operations that are particularly vulnerable to organized break-ins in a cash-dominated economy challenged by limited banking options. Some of the impacted businesses have indicated that they have closed down or are resorting to personal loans to cover the property damage as their insurance claims have been denied. Local jurisdictions, like San Francisco, have moved to support these hard-hit businesses by temporarily suspending the local cannabis tax.

These incidents not only pose a significant financial threat to businesses, but also pose a direct threat to the health and safety of cannabis workers. More work needs to be done around increasing security for the workers and implementing, for example, risk management policies that improve public health and safety.

Public health and safety is also being threatened in our state's great outdoors. According to NBC News, an estimated 80 to 85 percent of illicit cultivation on public land is conducted in our national forests.[7] These massive illegal operations conducted by drug traffickers

---

5 *MJBizDaily:* https://mjbizdaily.com/adult-use-cannabis-sales-slip-from-2020-pace-after-lackluster-summer/
6 Legislative Analyst's Office: https://lao.ca.gov/Publications/Report/4125
7 NBC News: https://www.nbcnews.com/news/us-news/fire-guns-poison-illegal-marijuana-farms-pose-deadly-risks-californias-rcna7153

have proved to be destructive to the environment with expensive clean-up costs. Negative impacts from illegal cannabis cultivation also include diverting surface water, introducing pesticides into the ecosystem while polluting local water supplies and wildlife, engaging in labor violations, and posing significant fire risk to the surrounding area. Wildfires in the past dozen years have been attributed to this illegal cultivation. More resources to counteract these illicit activities to protect public health and safety

DEPARTMENT OF CANNABIS CONTROL (DCC)

Due to the pandemic, many policies in 2020 that would have strengthened the legal market and laid the groundwork for significant programmatic changes were shifted to this year's budget process. Following the passage of Assembly Bill 141, the long-awaited Department of Cannabis Control was established, consolidating the Bureau of Cannabis Control (BCC), the Department of Public Health's Manufactured Cannabis Safety Branch (CDPH), and the Department of Food and Agriculture's CalCannabis Cultivation Licensing Division (CDFA) into one agency.

The formation of the DCC and the transfer of responsibilities of the three licensing authorities into one department prevents fragmentation and siloing of operations. By providing a single point of contact, the DCC is better equipped to license, regulate, manage the track and trace system for all commercial cannabis license holders, and coordinate with stakeholders including cannabis businesses, local governments, and members of the public.

In September 2021, the DCC adopted emergency regulations to consolidate, clarify, and make consistent licensing and enforcement requirements previously adopted by the three former state cannabis licensing authorities.

In October 2021, the DCC marked its first 100 days as a new California State department. Some of DCC's major achievements include:

- The establishment of a $100 million Local Jurisdiction Assistance Grant Program that provides aid for local jurisdictions to transition a vast amount of provisional cannabis licenses into annual licenses. This funding was made available to local governments facing significant workloads associated with transitioning these businesses from provisional licenses into annual licenses in an expeditious manner without sacrificing the state's environmental commitments. 17 cities and counties have been deemed eligible for grant funding in amounts ranging from $400,000 to $22,000,000.

- Notably, a large number of small, legacy and equity businesses operate within these areas. Local jurisdictions with established equity programs were made eligible for additional grant funding. Grant award notifications have started to go out with final grant funding expenditures by March 31, 2025.

- Transitioned hundreds of provisional licenses to annual licenses, recently surpassing 3,000 annual licenses.

- Served/assisted on over 100 search warrants targeting unlicensed activity, resulting in the seizure and/or destruction of over 70,000 pounds of cannabis and cannabis

product worth nearly $121.6 million. This includes the eradication of 273,326 plants, seizure of $655,000 in cash and 14 firearms.

- Merged organizational structure of the three main cannabis programs in the state into one and consolidated three sets of regulations into one, reducing duplicative and conflicting regulations.

EQUITY RULEMAKING

In September 2021, building upon the work and equity grant funding distributed in prior years, Governor Gavin Newsom signed Senate Bill 166. The bill requires the DCC to develop and implement a program to provide waivers and deferrals for state cannabis licensing fees, with at least 60 percent of the total amount of fee waivers and deferrals to be allocated to local equity applicants and license holders. Senate Bill 166 required the DCC to implement the fee waiver program in 2022 and the fee deferral program in 2023. In December 2021, the DCC released proposed emergency regulations to implement the fee waiver program. The DCC anticipates beginning to accept requests for these waivers on January 1, 2022.

This action is important because one of the largest barriers to entry in the regulated cannabis industry is access to capital, and this program, intended specifically for individuals who have been disproportionately impacted by the War on Drugs, provides financial support to equity businesses. There are at least 348 applicants and licensees who could be eligible under the DCC's proposed fee waiver program. The fee waivers lower barriers to entry into the legal cannabis market and help ensure license retention.

The Advisory Committee's work is informed and driven by current events and public comment. We want to acknowledge and thank the public, stakeholders, license holders, and applicants for their ongoing participation as the input received is crucial to the committee's ability to provide meaningful recommendations to the licensing authority. We hope this section provides context to the work of our Subcommittees and the full Advisory Committee and we look forward to continued participation and input.

CANNABIS ADVISORY COMMITTEE SUBCOMMITTEES

During the first Advisory Committee meeting of 2021, a number of subcommittees were discussed for development. Advisory Committee members discussed, and heard from the public, the need to address a myriad of issues related to social equity, inclusion and diversity; license types; local permitting challenges and widespread commercial cannabis bans; enforcement; the Metrc Track and Trace system; and a variety of public health issues including the use of minor decoys, high THC concentrates, prevention, treatment, education, and research.

However, due to a reduced meeting schedule caused by the ongoing COVID-19 pandemic, and the transition from three licensing authorities to the DCC administrative structure, it is important to note that the Advisory Committee did not make substantial progress this year on "the protection of the public," which chapter 27, section 10 of MAUCRSA established "shall be the highest priority for all license authorities" because "whenever the protection of the public is inconsistent with other interests thought to be promoted, the protection of the

public shall be paramount." These challenges also led to the decision to limit subcommittee development. Licensing and enforcement issues were determined to be the priority as the state had announced the consolidation of the three licensing authorities. Additionally, the provisional licensing program was slated to expire at the end of the year, jeopardizing approximately 75 percent of license holders supply chain wide, and the illicit market has continued to impact those in the legal licensed market.

The following subcommittees were established by the Advisory Committee.

- Annual Report Subcommittee which is composed of two committee members tasked with drafting the annual year-end report,
- Subcommittee on License Types, and
- Subcommittee on Enforcement.

SUBCOMMITTEE ON LICENSING

The Subcommittee on Licensing held a one-day virtual meeting on May 17, 2021. The meeting agenda was broad and contained the following three items for discussion and possible action:

- Creation of a Cottage/Legacy License Type,
- California Environmental Quality Act (CEQA) Regulations, and
- Number of Licenses by Type.

CREATION OF A COTTAGE/LEGACY LICENSE TYPE

The Medicinal and Adult-Use Cannabis Regulation and Safety Act (MAUCRSA) provides for several small scale cultivation license types including small, specialty, and specialty cottage cultivation, as well as the microbusiness license type which requires license holders to conduct three out of five allowed activities:

- Cultivation of up to 10,000 square feet,
- Nursery operations,
- Nonvolatile solvent manufacturing,
- Distribution, and/or
- Retail sales.

The microbusiness license type was originally seen by many as a pathway to onramp legacy operators, who had traditionally conducted a variety of cannabis activities. Legacy and equity cannabis operators have expressed that challenges related to premises restrictions, local land use restrictions, and licensing costs have rendered the microbusiness license type inaccessible to many of them. As a result, the Advisory

Committee and licensing authorities have continuously received feedback from stakeholders and members of the legacy cannabis industry that operated under Proposition 215, that the license types provided for in MAUCRSA do not address the needs of legacy operators.

As the licensing authorities moved towards consolidation, the Advisory Committee was asked to consider the following question: should a cottage/legacy license type be created and if so, what should the requirements and parameters for the license type be? The concerns raised by the legacy cannabis industry and this question about the development of a cottage/legacy license type is not new to the Advisory Committee.

In 2018, the Advisory Committee established the Subcommittee on Microbusiness which met multiple times that year. In an effort to ensure that legacy operators had access to the microbusiness license type, the Subcommittee on Microbusiness made a total of nine recommendations to the Advisory Committee for consideration. Four of which were adopted by the Advisory Committee, but only one was implemented by the Bureau of Cannabis Control.

Microbusiness recommendations approved by the Advisory Committee in 2018 included:

- Recommend, the Bureau, in an effort to create an onramp to legalization, there should be a clarification of microbusiness that includes tiers based on gross receipts and number of employees. The fee schedule should be redefined to include a ceiling that delineates when the business is no longer considered a microbusiness. Incentives should be provided based on equity for compassionate use and rural operators.
- Recommend the Bureau provide a "sub-microbusiness" or "microbusiness A" license that allows up to 10,000 square feet of cultivation including nurseries, three out of four activities to be fulfilled by allowing any type of non-volatile solvent manufacturing including shared space manufacturing, retail sales to happen at events in addition to storefront sale and delivery, and distribution to be fulfilled by full distribution or distribution transport only,
- Recommend the Bureau and CDPH should work together to create a document that they could distribute jointly to clarify that local governments may further limit the types of activities that are permitted to occur under a microbusiness authorized to engage in level one manufacturing within their jurisdiction. Even though the state permits multiple activities under the license type, the community could restrict certain types of activities if they so choose, and
- Recommend the Bureau should consider removing the prohibition on activities allowed within the home, so long as the activities that the applicant is choosing to conduct are activities commonly allowed under cottage business.

In 2020, the licensing authorities posed a number of microbusiness related questions to the Advisory Committee for discussion and possible action. Advisory Committee members were asked to consider the following questions:

- Should the state consider amending the number of commercial cannabis activities and qualifying commercial cannabis activities under the microbusiness license?

- Should the requirements for a microbusiness premises be amended?

- Are the current security requirements in regulation sufficient, or does the state need to consider other security measures?

In an effort to make the microbusiness license more accessible, and address concerns raised during public comment, the Advisory Committee passed three additional recommendations, as follows:

- Recommend that the Bureau allow processing as one of the three permissible activities under the microbusiness license,

- Recommend that the licensing authority allow for microbusiness license holders to utilize sales at licensed events to qualify as licensed retailer activity without having to be a delivery service or storefront, and

- Recommend that the licensing authority take out the requirements to have all the different activities be separated by a physical wall or barrier in a microbusiness.

The Department implemented the Advisory Committee's recommendation to remove the requirement that the different activities be separated by a physical wall or barrier in a microbusiness in the emergency regulations adopted in September 2021. The regulations now require separation only between the retail area and the other activities.

During the last three years of Advisory Committee meetings the challenges experienced by legacy operators regarding the microbusiness and licensing constraints have been consistently prominent. A significant number of stakeholders and license holders have repeatedly requested the development of a cottage microbusiness license to ease the challenges.

Public comment during the May 17, 2021, Subcommittee on Licensing was robust with organizations, members of the public, and legacy operators, from throughout the state and located in urban and rural areas, expressing many of the same concerns the Advisory Committee has heard over the last few years. Notable amongst these comments was the fear expressed by legacy and equity commercial cannabis business owners about falling prices in the legal market, the inability to compete with the illicit market, and ongoing struggles with connectivity to the broader supply chain. Local land use restrictions were also cited as rendering the microbusiness license inaccessible, as well as the cost of compliance with the California Environmental Quality Act (CEQA).

Additionally, public comments have indicated that the inability to make products in their home kitchen such as salves, tinctures, and pre-rolled cannabis joints, has impacted the viability of some legacy operators as many of these small businesses used to rely on consumer direct sales at organized events to dispensaries. Under MAUCRSA, only licensed retailers are allowed to sell directly to patients and consumers. Additionally, many licensed cultivators are prohibited from selling, and sharing, their genetics within the legal supply chain.

The Subcommittee had a robust conversation about the need to change regulations to allow for consumer direct sales, and expanded genetic sharing and sales. This conversation resulted in a motion to recommend that the licensing authority consider providing a pathway that allows licensed cultivators and licensed manufacturers to conduct consumer-direct-sales, and secondly, that the licensing authority consider a pathway that allows licensed cultivators to move their genetics into the retail marketplace via a nursery or a licensed retail sales entity.

However, because this motion was not tied to the development of a cottage/legacy license type, counsel determined that the Subcommittee could not consider the motion. In an effort to move these beneficial changes forward the Subcommittee rephrased the motion as components of a cottage/legacy license type. During public comment on the motion, stakeholders expressed significant concern that the Subcommittee had missed the point. In the end, the motion failed. Ultimately, a new license type is not the solution, reiterating that regulatory reform of the current license types was what stakeholders and legacy operators really need.

CALIFORNIA ENVIRONMENTAL QUALITY ACT (CEQA) REGULATIONS

CEQA, the state's law related to the impact of certain activities on the environment. CEQA applies to all permits or licenses determined by a public agency to be a 'project', or discretionary in nature, and triggers a project-specific CEQA analysis before issuance of a license or permit. Because many local jurisdictions require a local permit to engage in commercial cannabis activity, the project-specific CEQA analysis is most often completed during the local permitting process. Obtaining a local discretionary permit and meeting the CEQA requirements have proven incredibly time consuming for both applicants and local jurisdictions, and adds to the cost of obtaining commercial cannabis licensure.

Many local jurisdictions that allowed commercial cannabis businesses to operate under Proposition 215 and Senate Bill 420 guidelines, have high volumes of legacy applicants, which has resulted in backlogs in permit processing, significantly delaying the issuance of local permits, and further increasing costs as applicants pay leases and/or mortgages to maintain control of the project's location during the CEQA review.

In an effort to ensure that legacy operators maintain commercial cannabis businesses while achieving local permits and state annual licenses, the Legislature passed a series of bills starting in 2018, establishing a provisional licensing program, which allows applicants to operate while completing their project-specific CEQA analysis and local permitting.

As the licensing authorities prepared to move towards consolidation, the Subcommittee on Licensing was asked to consider the regulatory requirements regarding annual licensure. Specifically, what should be required for an applicant to demonstrate evidence of compliance with, or exemption from, the CEQA?

In an effort to reduce barriers to entry and streamline the permitting and licensing process for commercial cannabis businesses, the Subcommittee passed one recommendation, which was also passed by the full Advisory Committee.

Advisory Committee Recommendation: Recommend that the licensing authorities consider uncoupling the project-specific CEQA analysis from annual licenses and instead, provide guidance to local jurisdictions to ensure that applicants meet CEQA compliance during the local permitting process.

NUMBER OF LICENSES BY TYPE

For background information on this item, the licensing authorities provided a statistical update on the number of provisional licenses versus annual licenses issued by the state as of May 13, 2021. The statistical report showed that roughly 75 percent of California's licensed commercial cannabis businesses were still operating under provisional licenses, and that 100 percent of the state's testing laboratories were operating under provisional licenses. The statistical report also highlighted that overall license growth had been slow, since the licensing authorities last statistical report in 2019. The number of manufacturing licenses throughout the state actually declined by approximately 7 percent between 2019 and 2021.

The slow growth of licensed commercial cannabis businesses throughout the state, especially in the retail sector, coupled with the high percentage of licenses operating under provisional licenses led to a robust discussion by the Advisory Committee about the need to extend the provisional licensing program beyond December 31, 2021. During public comment, stakeholders expressed alarm over the expiring provisional license program, and noted that the slow growth in the retail sector was resulting in an excess of cannabis material further challenging the viability of licensed cultivators.

Alarmed by market conditions, the Subcommittee moved to recommend an extension to the provisional licensing program. However, counsel determined that such a motion was not appropriate for the agenda item and instead redirected the conversation toward the establishment of license caps and/or floors. Feeling unprepared to suggest either, the Subcommittee decided to close the item and adjourn the Subcommittee meeting.

SUBCOMMITTEE ON ENFORCEMENT

The Subcommittee on Enforcement held one virtual meeting on May 19, 2021. During this meeting the Subcommittee was asked to consider the different enforcement models established by the Bureau of Cannabis Control, and the California Department of Agriculture, and to consider what type of enforcement priorities the licensing authority should pursue to curb noncompliant activities in the legal market, and unlicensed activities in the illicit market.

After a thoughtful discussion by the Subcommittee about the disciplinary tiers of regulatory and statutory violations in the Bureau and CDFA disciplinary guidelines, and public comment, the Subcommittee agreed that it was too early to consider changes to the disciplinary tiers and disciplinary guidelines.

The Subcommittee did, however, pass two motions that were adopted by the Advisory Committee in relationship to enforcement priorities. The first motion passed addressed enforcement priorities of licensed commercial cannabis businesses.

Advisory Committee Recommendation: Recommend that the licensing authority prioritize for disciplinary action, violations that impact public health or result in environmental degradation. Specifically focus on sales to minors, sales and distribution of contaminated or unsafe products, and egregious environmental damage. Motion passed unanimously.

The second motion addressed enforcement priorities for unlicensed commercial cannabis businesses.

Advisory Committee Recommendation: Recommend that the licensing authority focus enforcement efforts in jurisdictions that allow licensed commercial cannabis operators over jurisdictions that do not so that the licensed operators can thrive and prioritize enforcement efforts against unlicensed businesses that are selling to minors, selling contaminated products, or that cause egregious environmental harm. Motion passed unanimously.

INFORMATIONAL PRESENTATIONS

The Advisory Committee was fortunate to receive two informational presentations during the 2021 calendar year.

"Budget Proposal to Consolidate Cannabis Licensing Authorities"

Nicole Elliott, Former Senior Advisor on Cannabis, Governor Gavin Newsom, Office of Business and Economic Development

"State of Cannabis Equity The United CORE Alliance"

Brandon Bolton and Khaleel Ferguson from the United CORE Alliance. Mr. Ferguson presented.

CONCLUSION

Throughout the course of this year's Advisory Committee meetings, several committee members and members of the public expressed the desire to have new members appointed to the committee. The Committee has experienced a reduction in members due to several factors given the time frame since the establishment in 2017. Advisory Committee members and the public have expressed the need to appoint individuals to fill the vacant seats with backgrounds in:

- Equity, diversity, and inclusion,
- Public health and safety,
- Patient advocacy, and
- Local government.

The diversity and extensive knowledge that committee members bring to the meetings are fundamental to shaping meaningful recommendations for the licensing authority.

Based on December 2021 numbers, compared to the licensing statistics presented by the licensing authorities on May 15, 2021, the number of licenses have increased slightly in most categories, distribution remained the constant, and manufacturing slightly decreased.

- Retail licenses increased by approximately 9 percent,
- Testing licenses increased by approximately 8 percent with all testing licensees operating under provisional licenses,
- Distribution licenses remained the same,
- Manufacturing licenses decreased by approximately .43 percent, and
- Cultivation licenses increased by approximately 21 percent.

The Advisory Committee acknowledges that significant reforms are still needed to meet the Administration's objectives of developing a medical and adult-use framework that protects public health and safety, while ensuring commercial cannabis regulations do not unduly limit the development of the legal market and in so doing perpetuate the illicit market.

California has always been a leader, paving the way for legalization, with four additional states, New York, Virginia, New Mexico, and Connecticut joining in decriminalization this year. The DCC is well positioned to take intentional and thoughtful steps towards building out programs to help expand licensing in the legal market and create equity for underserved communities. We all have a role to play in ensuring the success of California's legal medical and adult-use market and working together to bring forward necessary legislative and political action to reach our goals inside and outside of the regulatory process.

ACKNOWLEDGMENTS

CANNABIS ADVISORY COMMITTEE MEMBERS

JEFFREY P. FERRO (Chair), Labor Organization Representative; Director, Cannabis Workers Rising/Executive Assistant to the Director of Organizing, United Food and Commercial Workers International Union

KRISTIN HEIDELBACH (Vice Chair), Labor Organization Representative; International Representative/Cannabis Division Director, Teamsters

AVIS BULBULYAN, Cannabis Industry Representative; CEO, SIVA Enterprises/President, Los Angeles Cannabis Task Force

TIMMEN CERMAK, MD, Physician Representative; Psychiatrist, California Society of Addiction Medicine

MATT CLIFFORD, Environmental Expert Representative; California Water Project Attorney, Trout Unlimited; Chair of the Subcommittee on Enforcement

ERIC HIRATA, Alcoholic Beverage Control Representative; Director, Department of Alcoholic Beverage Control

KRISTIN NEVEDAL, Cannabis Industry Representative; Mendocino County Cannabis Program Director; Member of the Committee on the Annual Public Report, Chair of the Subcommittee on Licensing

LAVONNE PECK, Cannabis Industry Representative; Owner, Native Network Consulting

MATT RAHN, City Representative; City Council Member, City of Temecula

KEITH STEPHENSON, Cannabis Industry Representative; Founder and CEO, Purple Heart

TAMAR TODD, Community Equity Representative

DAVID WOOLSEY, Local Law Enforcement Representative; Sergeant, Division of Cannabis Regulation, San Jose Police Department

BEN WU, Cannabis Industry Representative; Former Chief Operating Officer, Kush Bottles

BEVERLY YU, Labor Organization Representative; State Government Affairs Director, UDW/AFSCME Local 3930; Member of the Committee on the Annual Public Report

ACKNOWLEDGMENT OF FORMER ADVISORY COMMITTEE MEMBERS

We would like to thank the following Advisory Committee members for their service on the Committee.

ALICE A. HUFFMAN, Community Equity Representative; Former President, California Hawaii NAACP (Resigned, 2021)

KRISTIN LYNCH, Labor Organization Representative; Director of Strategic Growth, Service Employees International Union (Resigned, 2021)

HELENA WILLIAMS, State Law Enforcement Representative; Captain, Drug Evaluation & Classification Program, California Highway Patrol (Resigned, 2021)

LEADERSHIP

Gavin Newsom, Governor

Lourdes Castro Ramírez, Secretary, California Business, Consumer Services and Housing Agency

DCC LEADERSHIP TEAM

Nicole Elliott, Director

Rasha Salama, Chief Deputy Director

Matthew Lee, General Counsel

Melissa Eidson, Deputy Director of Administration

Richard Parrott, Deputy Director of Compliance

Eugene Hillsman, Deputy Director of Equity & Inclusion

Tamara Colson, Deputy Director of Legal Affairs

Bill Jones, Acting Deputy Director of Enforcement

Christina Dempsey, Acting Deputy Director of External Affairs

Jason Piccione, Acting Deputy Director of Information Technology

Gordon Vrdoljak, Acting Deputy Director of Laboratory Services

Michael Cheng, Acting Deputy Director of Licensing

DCC COMMITTEE SUPPORT STAFF

Sara Gardner, Attorney IV

Angela McIntire, Attorney III

Ashlynn Blackshire, Staff Service Analyst

Kaila Fayne, Associate Governmental Program Analyst

2021

ANNUAL REPORT

DECEMBER 2021

California Department of Tax and Fee Administration
Cannabis Tax Revenues

Cannabis Tax Revenues

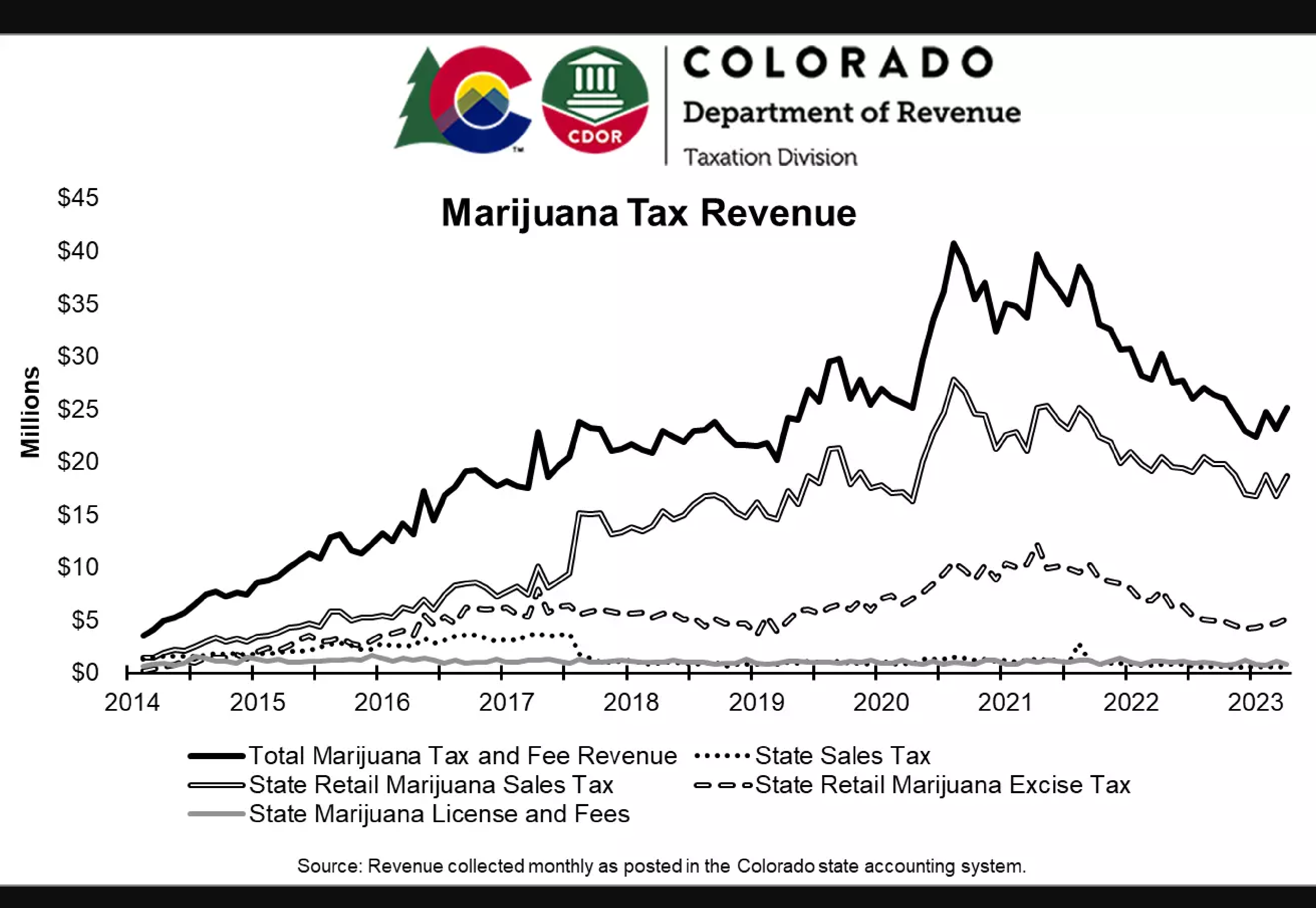
Calendar Year	Quarter	Excise Tax	Cultivation Tax	Sales Tax	Total Tax	Year-Quarter	Excise Tax Paid to Distributors	Vendor Compensation	Cannabis Sales	Taxable Sales
2023	Q1	104,277,620	-	111,892,563	216,170,183	2023Q1	24,917,764	-	858,715,250	1,249,584,223
2022	Q4	128,425,656	-	120,074,448	248,500,104	2022Q4	-	-	-	1,343,064,338
2022	Q3	135,524,413	-	116,200,688	251,725,101	2022Q3	-	-	-	1,297,789,490
2022	Q2	147,865,454	27,727,101	126,042,518	301,635,073	2022Q2	-	-	-	1,412,650,213
2022	Q1	155,124,161	37,654,430	118,826,505	311,605,096	2022Q1	-	-	-	1,328,165,141
2021	Q4	160,983,530	40,090,205	129,491,191	330,564,926	2021Q4	-	-	-	1,445,801,056
2021	Q3	177,453,322	43,418,896	127,989,885	348,862,103	2021Q3	-	-	-	1,429,639,352
2021	Q2	180,434,103	42,521,801	138,944,559	361,900,463	2021Q2	-	-	-	1,565,577,030
2021	Q1	162,185,994	40,367,175	118,289,958	320,843,127	2021Q1	-	-	-	1,340,919,763
2020	Q4	154,482,053	42,694,071	118,065,537	315,241,661	2020Q4	-	-	-	1,332,162,720
2020	Q3	169,391,645	43,394,834	119,313,966	332,100,445	2020Q3	-	-	-	1,343,466,891
2020	Q2	137,591,607	30,874,243	101,978,470	270,444,320	2020Q2	-	-	-	1,153,285,028
2020	Q1	112,754,119	27,654,908	77,778,305	218,187,332	2020Q1	-	-	-	877,037,901
2019	Q4	86,765,478	24,666,163	70,930,768	182,362,409	2019Q4	-	-	-	799,246,267
2019	Q3	84,887,286	22,809,108	65,839,929	173,536,323	2019Q3	-	-	-	742,703,422
2019	Q2	75,731,295	23,037,243	60,373,132	159,141,670	2019Q2	-	-	-	682,027,411
2019	Q1	63,702,235	17,277,125	50,698,481	131,677,841	2019Q1	-	-	-	579,063,823
2018	Q4	57,134,451	17,305,538	49,220,226	123,660,215	2018Q4	-	-	-	563,932,953
2018	Q3	55,452,365	12,965,879	42,661,438	111,079,682	2018Q3	-	-	-	487,906,977
2018	Q2	43,202,987	4,963,720	45,453,449	93,620,156	2018Q2	-	-	-	520,051,356
2018	Q1	35,867,466	1,849,146	35,511,626	73,228,238	2018Q1	-	-	-	408,509,470

Notes

- Revenue represents amounts reported based on the reporting period of the return. Amounts are subject to change and updated every quarter.
- Beginning January 1, 2023, cannabis excise tax reporting shifted from the distributor to the retailer.
- Excise tax amounts reported are net amounts due after adjustments for tax paid to distributors prior to January 1, 2023, and vendor compensation. With the shift in reporting of excise tax to the retailer, retailers may claim a credit for excise tax paid to a distributor prior to January 1, 2023. Certain retailers are also eligible to retain vendor compensation.
- Sales Tax - Sales tax applies to sales of cannabis, cannabis products, and other tangible personal property.
- Cannabis Sales - Cannabis sales represents amounts reported by retailers subject to the excise tax.
- Taxable Sales - Taxable sales include sales of cannabis, cannabis products, and other retail sales of tangible personal property reported on sales and use tax returns.

Marijuana Sales

Source: State Sales Tax Returns (DR 100) and Retail Marijuana Sales Tax Returns


COLORADO
Department of Revenue
Taxation Division
CDOR
Marijuana Tax Revenue
Millions
$45
$40
$35
$30
$25
$20
$15
$10
$5
$0
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
Total Marijuana Tax and Fee Revenue
State Sales Tax
State Retail Marijuana Sales Tax
State Retail Marijuana Excise Tax
State Marijuana License and Fees
Source: Revenue collected monthly as posted in the Colorado state accounting system.

Current & Prior Retail Marijuana Average Market Rates (Median Market Prices)

Average Market Rate as of:	Bud ($/lb)	Trim ($/lb)	Bud Allocated for Extraction ($/lb)	Trim Allocated for Extraction ($/lb)	Immature Plant ($/ea)	Wet Whole Plant ($/lb)	Seed ($/ea)	Contaminated Product Allocated for Extraction ($/lb)
April 1, 2023	$649	$253	$405	$51	$13	$81	$8	N/A
January 1, 2023	$658	$253	$350	$61	$13	$101	$9	N/A
October 1, 2022	$658	$249	$277	$76	$13	$126	$4	N/A
July 1, 2022	$709	$227	$275	$120	$12	$123	$4	N/A
April 1, 2022	$799	$275	$228	$180	$10	$130	$4	N/A
January 1, 2022	$948	$354	$345	$253	$10	$172	$4	N/A
October 1, 2021	$1,316	$425	$405	$302	$10	$181	$3	N/A
July 1, 2021	$1,309	$425	$901	$240	$10	$191	$4	N/A
April 1, 2021	$1,308	$354	$525	$225	$10	$197	$8	N/A
January 1, 2021	$1,721	$400	$502	$250	$10	$176	$6	N/A
October 1, 2020	$1,316	$350	$502	$175	$9	$175	$8	N/A
July 1, 2020	$1,000	$300	$599	$202	$9	$176	$4	N/A
April 1, 2020	$1,164	$319	$744	$250	$9	$176	$5	N/A
January 1, 2020	$1,316	$350	$299	$247	$9	$191	$5	N/A
October 1, 2019	$999	$325	$254	$200	$8	$173	$5	N/A
July 1, 2019	$850	$325	$227	$177	$8	$152	$4	N/A
April 1, 2019	$806	$425	$227	$177	$4	$151	$5	N/A
January 1, 2019	$781	$396	$200	$200	$4	$151	$5	N/A
October 1, 2018	$759	$325	$228	$225	$8	$100	$4	N/A
July 1, 2018	$846	$404	$230	$300	$1	$150	$5	N/A
April 1, 2018	$1,012	$700	$349	$302	$5	$230	$5	N/A

Current & Prior Retail Marijuana Average Market Rates (Median Market Prices)

Average Market Rate as of:	Bud ($/lb)	Trim ($/lb)	Bud Allocated for Extraction ($/lb)	Trim Allocated for Extraction ($/lb)	Immature Plant ($/ea)	Wet Whole Plant ($/lb)	Seed ($/ea)	Contaminated Product Allocated for Extraction ($/lb)
January 1, 2018	$1,265	$506	$376	$325	$10	$215	$3	N/A
October 1, 2017	$1,305	$405	N/A	N/A	$5	$227	$3	$403
August 9, 2017	$1,298	$426	N/A	N/A	$4	$227	$3	$403
July 1, 2017	$1,298	$426	N/A	N/A	$4	$227	$3	N/A
January 1, 2017	$1,471	$499	N/A	N/A	$10	$223	$6	N/A
July 1, 2016	$1,816	$505	N/A	N/A	$10	$209	$2	N/A
January 1, 2016	$1,948	$464	N/A	N/A	$9	N/A	N/A	N/A
July 1, 2015	$1,868	$370	N/A	N/A	$8	N/A	N/A	N/A
January 1, 2015	$2,007	$364	N/A	N/A	$9	N/A	N/A	N/A
July 1, 2014	$1,876	$296	N/A	N/A	$9	N/A	N/A	N/A
January 1, 2014	$1,876	$296	N/A	N/A	$9	N/A	N/A	N/A

Colorado Department of Revenue
Marijuana Sales Report
January 2014 to Date

Month	Year	Total Medical Marijuana Sales [1]	Total Retail Marijuana Sales [2]	Total Marijuana Sales
1	2014	$32,541,720	$14,022,213	$46,563,933
2	2014	$31,738,572	$14,248,473	$45,987,045
3	2014	$34,821,878	$19,881,631	$54,703,509
4	2014	$32,686,869	$20,765,986	$53,452,855
5	2014	$31,355,208	$21,375,001	$52,730,209
6	2014	$29,950,309	$23,978,082	$53,928,391
7	2014	$31,137,623	$29,866,792	$61,004,415
8	2014	$33,912,226	$33,520,608	$67,432,834
9	2014	$32,721,238	$30,345,357	$63,066,595
10	2014	$31,779,216	$31,185,985	$62,965,201
11	2014	$28,978,462	$29,470,126	$58,448,588
12	2014	$28,660,719	$34,579,445	$63,240,164
1	2015	$30,181,833	$37,224,033	$67,405,866
2	2015	$29,066,073	$35,843,189	$64,909,262
3	2015	$32,820,548	$42,952,626	$75,773,174
4	2015	$32,878,517	$43,832,944	$76,711,461
5	2015	$33,609,116	$44,590,853	$78,199,969
6	2015	$34,552,396	$46,460,218	$81,012,614
7	2015	$40,611,139	$55,315,111	$95,926,250
8	2015	$40,819,368	$57,679,482	$98,498,850
9	2015	$39,991,813	$53,639,366	$93,631,179
10	2015	$36,742,780	$54,467,764	$91,210,544
11	2015	$30,770,436	$49,453,755	$80,224,191
12	2015	$36,010,893	$56,077,002	$92,087,895
1	2016	$32,860,544	$55,896,018	$88,756,562
2	2016	$34,019,234	$57,045,314	$91,064,548
3	2016	$38,116,173	$65,121,388	$103,237,561
4	2016	$38,294,503	$63,841,328	$102,135,831
5	2016	$37,636,295	$63,831,071	$101,467,366
6	2016	$38,177,550	$67,881,863	$106,059,413
7	2016	$40,129,985	$81,478,447	$121,608,432
8	2016	$41,056,948	$84,055,363	$125,112,311
9	2016	$39,672,483	$86,137,409	$125,809,892
10	2016	$35,940,555	$80,695,313	$116,635,868
11	2016	$34,839,439	$74,382,892	$109,222,331
12	2016	$34,872,353	$81,221,005	$116,093,358
1	2017	$31,712,608	$76,018,423	$107,731,031
2	2017	$31,074,413	$75,665,966	$106,740,379
3	2017	$37,451,683	$92,912,147	$130,363,830
4	2017	$38,049,392	$86,223,281	$124,272,673
5	2017	$36,521,894	$87,012,525	$123,534,419
6	2017	$36,125,578	$92,825,639	$128,951,217
7	2017	$35,256,994	$101,037,453	$136,294,447

Colorado Department of Revenue
Marijuana Sales Report
January 2014 to Date

Month	Year	Total Medical Marijuana Sales [1]	Total Retail Marijuana Sales [2]	Total Marijuana Sales
8	2017	$36,921,075	$101,548,082	$138,469,157
9	2017	$35,518,033	$100,280,636	$135,798,669
10	2017	$34,082,247	$93,623,919	$127,706,166
11	2017	$31,878,468	$87,689,309	$119,567,777
12	2017	$31,924,397	$96,348,057	$128,272,454
1	2018	$29,263,308	$88,729,914	$117,993,222
2	2018	$26,640,302	$85,869,215	$112,509,517
3	2018	$29,238,678	$105,945,278	$135,183,956
4	2018	$27,019,073	$97,290,806	$124,309,879
5	2018	$26,225,775	$96,642,441	$122,868,216
6	2018	$27,096,966	$102,426,064	$129,523,030
7	2018	$27,239,015	$111,296,569	$138,535,584
8	2018	$28,323,863	$112,998,245	$141,322,108
9	2018	$27,897,573	$107,638,880	$135,536,453
10	2018	$27,919,377	$101,305,394	$129,224,771
11	2018	$26,062,807	$97,877,084	$123,939,891
12	2018	$29,246,755	$105,497,699	$134,744,454
1	2019	$25,680,596	$99,193,678	$124,874,274
2	2019	$24,082,927	$95,324,933	$119,407,860
3	2019	$28,097,865	$114,317,739	$142,415,604
4	2019	$27,943,394	$107,938,775	$135,882,169
5	2019	$29,446,360	$113,660,919	$143,107,279
6	2019	$29,653,362	$122,372,729	$152,026,091
7	2019	$30,389,970	$135,904,745	$166,294,715
8	2019	$31,350,310	$141,869,549	$173,219,859
9	2019	$28,601,353	$126,853,814	$155,455,167
10	2019	$29,229,660	$121,246,599	$150,476,259
11	2019	$26,697,731	$114,381,244	$141,078,975
12	2019	$27,314,662	$116,437,714	$143,752,376
1	2020	$27,471,535	$111,660,730	$139,132,265
2	2020	$26,557,708	$112,068,640	$138,626,348
3	2020	$32,929,194	$128,117,512	$161,046,706
4	2020	$36,485,700	$112,010,018	$148,495,718
5	2020	$42,989,322	$149,186,615	$192,175,937
6	2020	$40,770,582	$158,102,628	$198,873,210
7	2020	$43,268,565	$183,106,003	$226,374,568
8	2020	$42,034,746	$176,566,595	$218,601,341
9	2020	$39,941,149	$166,547,119	$206,488,268
10	2020	$38,788,945	$160,999,919	$199,788,864
11	2020	$34,650,013	$140,495,233	$175,145,246
12	2020	$36,651,909	$149,691,299	$186,343,208
1	2021	$35,869,373	$151,734,324	$187,603,697
2	2021	$32,452,819	$134,584,956	$167,037,775

Colorado Department of Revenue
Marijuana Sales Report
January 2014 to Date

Month	Year	Total Medical Marijuana Sales [1]	Total Retail Marijuana Sales [2]	Total Marijuana Sales
3	2021	$40,372,910	$166,729,153	$207,102,063
4	2021	$39,817,606	$166,506,561	$206,324,167
5	2021	$36,781,683	$157,221,754	$194,003,437
6	2021	$34,534,293	$152,719,813	$187,254,106
7	2021	$35,010,274	$167,805,366	$202,815,640
8	2021	$34,871,389	$157,994,708	$192,866,097
9	2021	$30,349,138	$150,781,653	$181,130,791
10	2021	$29,214,748	$147,137,979	$176,352,727
11	2021	$26,821,676	$131,640,783	$158,462,459
12	2021	$28,314,622	$139,726,972	$168,041,594
1	2022	$21,135,544	$129,984,038	$151,119,582
2	2022	$20,341,170	$124,925,581	$145,266,751
3	2022	$22,898,925	$139,607,877	$162,506,802
4	2022	$21,315,278	$131,708,527	$153,023,805
5	2022	$20,742,830	$127,061,610	$147,804,440
6	2022	$19,235,656	$127,157,358	$146,393,014
7	2022	$18,326,459	$135,574,507	$153,900,966
8	2022	$18,930,580	$131,508,945	$150,439,525
9	2022	$17,603,178	$129,277,399	$146,880,577
10	2022	$17,030,219	$124,986,296	$142,016,515
11	2022	$16,406,527	$113,914,889	$130,321,416
12	2022	$16,858,222	$122,157,222	$139,015,444
1	2023	$16,217,940	$113,152,226	$129,370,166
2	2023	$15,409,686	$109,438,491	$124,848,177
3	2023	$17,270,140	$122,351,090	$139,621,230

Source: State Sales Tax Returns (DR 100) and Retail Marijuana Sales Tax Returns

Note: This table represents a snapshot of the tax returns at the time the data was retrieved.

[1] This column summarizes all sales made at medical marijuana stores. It includes medical marijuana and accessories/other products that do not contain medical marijuana. This value does not include wholesale sales.

[2] This column summarizes retail marijuana sales made at retail marijuana stores. It does not include accessories/other products that do not contain retail marijuana. This value does not include wholesale sales.

Prepared by: Office of Research and Analysis, Colorado Department of Revenue | dor_ora@state.co.us

Publish date: May 2023

Colorado Department of Revenue
Marijuana Tax and Fee Revenue Report [1]
February 2014 to Date

		State Sales Tax 2.9%			Retail Marijuana Sales Tax (RMS) [2]					Retail Marijuana Excise Tax (RME) 15%					
Revenue Month	**Revenue Year**	**State Sales Tax Total**	Medical Marijuana [3]	Retail Marijuana [3, 4]	**RMS Tax Total [5]**	RMS Local Government Distribution	RMS Marijuana Tax Cash Fund	RMS Public School Fund	RMS General Fund	**RME Tax Total [5]**	RME Public School Capital Construction Assistance Fund	RME Public School Fund	**Total Taxes**	**License & Other Fees Total [6]**	**Total Taxes & Fees**
	Calculation	*A=B+C*	*B*	*C*	*D=E+F+G+H*	*E*	*F*	*G*	*H*	*I=J+K*	*J*	*K*	*L=A+D+I*	*M*	*N=L+M*
1	2014														
2	2014	**$1,330,209**	$913,519	$416,690	**$1,401,568**	$210,269	$1,191,534	NA	NA	**$195,318**	$195,286	$0	**$2,927,095**	**$592,661**	**$3,519,755**
3	2014	**$1,460,429**	$1,022,176	$438,253	**$1,434,916**	$212,674	$1,210,786	NA	NA	**$339,615**	$339,531	$0	**$3,234,960**	**$857,615**	**$4,092,575**
4	2014	**$1,569,405**	$999,900	$569,505	**$1,898,685**	$285,215	$1,613,861	NA	NA	**$609,907**	$609,887	$0	**$4,077,997**	**$902,995**	**$4,980,992**
5	2014	**$1,559,710**	$919,982	$639,728	**$2,217,607**	$330,057	$1,864,829	NA	NA	**$734,351**	$732,406	$0	**$4,511,668**	**$761,687**	**$5,273,355**
6	2014	**$1,569,454**	$927,330	$642,124	**$2,070,577**	$315,356	$1,787,025	NA	NA	**$1,135,648**	$1,135,718	$0	**$4,775,679**	**$940,028**	**$5,715,707**
7	2014	**$1,530,968**	$830,861	$700,107	**$2,473,627**	$368,231	$2,086,648	NA	NA	**$969,637**	$963,551	$0	**$4,974,232**	**$1,547,853**	**$6,522,085**
8	2014	**$1,659,789**	$838,711	$821,078	**$2,970,183**	$443,498	$2,513,164	NA	NA	**$1,397,930**	$1,399,496	$0	**$6,027,901**	**$1,379,549**	**$7,407,450**
9	2014	**$1,892,780**	$935,807	$956,973	**$3,307,078**	$496,211	$2,811,874	NA	NA	**$1,464,796**	$1,458,036	$0	**$6,664,654**	**$1,076,513**	**$7,741,167**
10	2014	**$1,795,545**	$908,630	$886,915	**$2,940,346**	$443,937	$2,515,663	NA	NA	**$1,446,105**	$1,454,528	$0	**$6,181,996**	**$1,050,874**	**$7,232,870**
11	2014	**$1,816,579**	$928,329	$888,250	**$3,244,159**	$488,236	$2,766,687	NA	NA	**$1,718,273**	$1,711,909	$0	**$6,779,010**	**$863,790**	**$7,642,800**
12	2014	**$1,649,935**	$772,472	$877,463	**$2,933,821**	$411,774	$2,333,413	NA	NA	**$1,363,689**	$1,350,161	$0	**$5,947,445**	**$1,518,123**	**$7,465,568**
1	2015	**$1,874,283**	$889,249	$985,034	**$3,472,230**	$547,664	$3,103,439	NA	NA	**$1,965,731**	$1,952,855	$0	**$7,312,244**	**$1,245,897**	**$8,558,141**
2	2015	**$1,808,419**	$785,792	$1,022,627	**$3,547,864**	$524,468	$2,971,998	NA	NA	**$2,349,219**	$2,332,843	$0	**$7,705,502**	**$1,096,793**	**$8,802,295**
3	2015	**$1,919,649**	$820,635	$1,099,014	**$3,792,120**	$573,091	$3,247,540	NA	NA	**$2,123,091**	$2,140,582	$0	**$7,834,860**	**$1,264,534**	**$9,099,395**
4	2015	**$2,093,101**	$895,193	$1,197,908	**$4,282,160**	$640,453	$3,629,248	NA	NA	**$2,587,352**	$2,592,768	$0	**$8,962,612**	**$1,017,030**	**$9,979,643**
5	2015	**$2,084,081**	$895,205	$1,188,876	**$4,390,362**	$655,390	$3,713,895	NA	NA	**$3,103,722**	$3,103,286	$0	**$9,578,166**	**$1,039,145**	**$10,617,311**
6	2015	**$2,100,621**	$908,456	$1,192,165	**$4,663,848**	$679,403	$3,849,973	NA	NA	**$3,506,230**	$3,489,550	$0	**$10,270,699**	**$1,055,753**	**$11,326,452**
7	2015	**$2,394,910**	$988,108	$1,406,802	**$4,394,550**	$686,426	$3,889,760	NA	NA	**$2,933,200**	$2,955,423	$0	**$9,722,660**	**$1,133,924**	**$10,856,584**
8	2015	**$2,698,757**	$1,116,515	$1,582,242	**$5,839,613**	$826,146	$4,681,413	NA	NA	**$3,070,314**	$3,058,722	$0	**$11,608,684**	**$1,202,753**	**$12,811,437**
9	2015	**$2,821,102**	$1,161,129	$1,659,972	**$5,813,123**	$871,601	$4,939,404	NA	NA	**$3,328,898**	$3,330,002	$0	**$11,963,123**	**$1,218,635**	**$13,181,758**
10	2015	**$2,656,088**	$1,073,428	$1,582,659	**$4,955,077**	$778,874	$4,413,086	NA	NA	**$2,796,865**	$2,780,595	$0	**$10,408,030**	**$1,248,706**	**$11,656,736**
11	2015	**$2,256,473**	$879,643	$1,376,830	**$5,207,345**	$714,083	$4,046,508	NA	NA	**$2,604,672**	$2,232,560	$0	**$10,068,491**	**$1,221,521**	**$11,290,012**
12	2015	**$2,261,503**	$830,044	$1,431,459	**$5,258,248**	$740,305	$4,195,079	NA	NA	**$3,048,539**	$3,080,548	$0	**$10,568,290**	**$1,663,120**	**$12,231,410**
1	2016	**$2,841,308**	$1,097,227	$1,744,081	**$5,438,522**	$936,682	$5,307,892	NA	NA	**$3,608,488**	$3,930,162	$0	**$11,888,317**	**$1,359,117**	**$13,247,434**
2	2016	**$2,482,086**	$897,973	$1,584,113	**$5,213,363**	$778,816	$4,413,310	NA	NA	**$3,671,875**	$3,682,750	$0	**$11,367,325**	**$1,099,292**	**$12,466,617**
3	2016	**$2,599,446**	$966,798	$1,632,648	**$6,163,941**	$932,723	$5,285,456	NA	NA	**$4,015,437**	$4,022,055	$0	**$12,778,824**	**$1,417,099**	**$14,195,923**
4	2016	**$2,493,845**	$937,464	$1,556,381	**$5,876,965**	$872,826	$4,946,047	NA	NA	**$3,489,694**	$3,489,728	$0	**$11,860,504**	**$1,236,794**	**$13,097,298**
5	2016	**$3,292,341**	$1,145,069	$2,147,272	**$6,944,330**	$1,040,812	$5,897,974	NA	NA	**$5,538,327**	$5,460,252	$0	**$15,774,997**	**$1,408,164**	**$17,183,162**
6	2016	**$2,763,721**	$1,057,227	$1,706,494	**$5,989,446**	$904,531	$5,125,808	NA	NA	**$4,524,531**	$1,977,205	$2,450,958	**$13,277,698**	**$1,204,950**	**$14,482,648**
7	2016	**$3,130,847**	$1,068,298	$2,062,550	**$7,414,551**	$1,113,641	$6,310,657	NA	NA	**$5,378,690**	$5,424,344	$0	**$15,924,089**	**$899,760**	**$16,823,849**
8	2016	**$3,440,132**	$1,089,298	$2,350,834	**$8,263,335**	$1,237,545	$7,012,788	NA	NA	**$4,711,405**	$4,801,195	$0	**$16,414,872**	**$1,159,277**	**$17,574,149**
9	2016	**$3,535,768**	$1,160,762	$2,375,006	**$8,492,129**	$1,277,189	$7,237,444	NA	NA	**$6,233,494**	$6,257,954	$0	**$18,261,391**	**$884,601**	**$19,145,992**
10	2016	**$3,584,480**	$1,110,073	$2,474,407	**$8,584,952**	$1,287,094	$7,293,338	NA	NA	**$6,071,105**	$6,043,651	$0	**$18,240,537**	**$1,026,385**	**$19,266,922**
11	2016	**$3,304,756**	$982,998	$2,321,758	**$8,115,943**	$1,195,742	$6,775,917	NA	NA	**$6,045,927**	$6,022,864	$0	**$17,466,626**	**$959,239**	**$18,425,864**
12	2016	**$2,980,227**	$949,280	$2,030,946	**$7,252,646**	$1,058,889	$6,000,632	NA	NA	**$6,131,564**	$6,174,435	$0	**$16,364,437**	**$1,330,517**	**$17,694,953**
1	2017	**$3,217,201**	$914,206	$2,302,994	**$7,746,575**	$1,207,325	$6,841,538	NA	NA	**$6,174,352**	$5,275,557	$788,750	**$17,138,128**	**$1,026,660**	**$18,164,787**
2	2017	**$3,056,541**	$872,813	$2,183,728	**$8,186,608**	$1,232,199	$6,982,488	NA	NA	**$5,503,295**	$0	$5,628,748	**$16,746,444**	**$977,414**	**$17,723,858**
3	2017	**$3,534,708**	$1,111,314	$2,423,393	**$7,410,258**	$1,109,557	$6,287,519	NA	NA	**$5,367,365**	$0	$5,306,783	**$16,312,330**	**$1,238,362**	**$17,550,692**
4	2017	**$3,692,930**	$1,076,901	$2,616,029	**$10,107,620**	$1,424,219	$8,070,624	NA	NA	**$7,867,853**	$0	$7,349,850	**$21,668,402**	**$1,199,185**	**$22,867,587**
5	2017	**$3,511,986**	$1,034,080	$2,477,906	**$8,105,694**	$1,298,307	$7,357,102	NA	NA	**$5,699,916**	$0	$6,245,836	**$17,317,596**	**$1,246,343**	**$18,563,939**
6	2017	**$3,579,867**	$1,051,989	$2,527,878	**$8,744,941**	$1,302,854	$7,382,852	NA	NA	**$6,238,143**	$0	$6,238,416	**$18,562,951**	**$1,099,512**	**$19,662,464**
7	2017	**$3,691,932**	$1,012,756	$2,679,177	**$9,413,260**	$1,411,879	$8,000,674	NA	NA	**$6,416,003**	$6,406,321	$0	**$19,521,195**	**$916,556**	**$20,437,751**
8	2017	**$1,738,885**	$1,003,560	$735,326	**$15,171,154**	$1,523,657	$9,779,608	$3,831,537	$0	**$5,536,495**	$5,506,771	$0	**$22,446,534**	**$1,328,509**	**$23,775,043**
9	2017	**$1,353,514**	$1,024,530	$328,984	**$15,044,994**	$1,526,986	$9,776,803	$3,830,439	$0	**$5,816,240**	$5,819,396	$0	**$22,214,748**	**$1,020,759**	**$23,235,507**
10	2017	**$999,826**	$1,003,258	($3,432)	**$15,125,886**	$1,516,847	$9,796,383	$3,838,110	$0	**$5,997,375**	$5,999,951	$0	**$22,123,088**	**$975,320**	**$23,098,408**
11	2017	**$1,021,820**	$950,866	$70,955	**$13,148,705**	$1,315,279	$8,486,605	$3,324,954	$0	**$5,771,416**	$5,715,235	$0	**$19,941,941**	**$1,135,051**	**$21,076,993**
12	2017	**$1,137,691**	$801,639	$336,052	**$13,307,123**	$1,335,562	$8,612,539	$3,374,293	$0	**$5,576,575**	$5,533,311	$0	**$20,021,389**	**$1,190,056**	**$21,211,445**
1	2018	**$1,181,904**	$902,251	$279,652	**$13,816,947**	$1,388,748	$8,960,789	$3,510,734	$0	**$5,619,025**	$5,019,016	$505,460	**$20,617,876**	**$1,063,563**	**$21,681,438**
2	2018	**$949,653**	$792,938	$156,715	**$13,445,106**	$1,342,910	$8,675,933	$3,399,130	$0	**$5,756,281**	$0	$5,650,273	**$20,151,041**	**$983,823**	**$21,134,864**
3	2018	**$812,244**	$734,961	$77,283	**$13,853,459**	$1,384,223	$8,924,059	$3,496,343	$0	**$5,233,996**	$0	$5,452,274	**$19,899,698**	**$972,122**	**$20,871,820**
4	2018	**$966,721**	$783,704	$183,018	**$15,340,824**	$1,528,938	$9,876,583	$1,394,460	$2,475,071	**$5,598,581**	$0	$5,565,403	**$21,906,126**	**$1,041,014**	**$22,947,141**
5	2018	**$1,014,752**	$859,914	$154,838	**$14,608,085**	$1,469,223	$9,484,136	$0	$3,715,775	**$5,586,593**	$0	$5,558,173	**$21,209,430**	**$1,158,277**	**$22,367,707**
6	2018	**$949,473**	$734,771	$214,702	**$14,911,288**	$1,491,211	$9,630,487	$0	$3,773,114	**$5,051,632**	$0	$5,021,385	**$20,912,393**	**$1,016,300**	**$21,928,692**
7	2018	**$792,289**	$751,516	$40,774	**$15,968,272**	$1,594,915	$10,311,185	$0	$4,039,803	**$5,215,347**	$5,290,259	$0	**$21,975,908**	**$987,870**	**$22,963,778**
8	2018	**$868,750**	$765,088	$103,663	**$16,723,420**	$1,681,573	$10,870,929	$1,904,871	$2,354,233	**$4,428,503**	$4,413,164	$0	**$22,020,673**	**$1,024,144**	**$23,044,818**
9	2018	**$963,946**	$825,978	$137,967	**$16,891,913**	$1,687,354	$10,910,904	$1,911,876	$2,362,890	**$5,115,741**	$4,547,036	$0	**$22,971,599**	**$798,797**	**$23,770,397**
10	2018	**$628,947**	$790,984	($162,036)	**$16,335,453**	$1,625,720	$10,515,879	$1,842,657	$2,277,343	**$4,683,825**	$4,768,484	$0	**$21,648,225**	**$941,454**	**$22,589,679**
11	2018	**$856,553**	$758,726	$97,826	**$15,192,351**	$1,525,650	$9,865,096	$1,728,623	$2,136,408	**$4,630,333**	$4,525,278	$0	**$20,679,237**	**$927,558**	**$21,606,794**
12	2018	**$843,005**	$779,150	$63,854	**$14,767,104**	$1,470,342	$9,507,484	$1,665,960	$2,058,962	**$4,692,813**	$4,489,226	$0	**$20,302,922**	**$1,319,588**	**$21,622,509**
1	2019	**$768,831**	$714,538	$54,293	**$16,133,789**	$1,614,090	$10,437,445	$1,828,913	$2,260,357	**$3,657,559**	$3,946,124	$0	**$20,560,178**	**$940,956**	**$21,501,134**
2	2019	**$836,403**	$727,348	$109,055	**$14,823,830**	$1,484,437	$9,599,146	$1,682,021	$2,078,813	**$5,285,313**	$5,342,992	$0	**$20,945,546**	**$836,429**	**$21,781,975**
3	2019	**$845,176**	$720,668	$124,508	**$14,565,504**	$1,456,781	$9,420,126	$1,650,653	$2,040,044	**$3,894,393**	$2,677,436	$1,735,323	**$19,305,073**	**$901,935**	**$20,207,008**
4	2019	**$964,709**	$822,343	$142,365	**$17,186,221**	$1,722,157	$11,136,286	$1,951,369	$2,411,700	**$4,955,331**	$1,967,042	$2,927,681	**$23,106,261**	**$1,066,187**	**$24,172,448**

Colorado Department of Revenue
Marijuana Tax and Fee Revenue Report [1]
February 2014 to Date

Revenue Month	Revenue Year	State Sales Tax 2.9%			Retail Marijuana Sales Tax (RMS) [2]					Retail Marijuana Excise Tax (RME) 15%				License & Other Fees Total [6]	Total Taxes & Fees
		State Sales Tax Total	Medical Marijuana [3]	Retail Marijuana [3, 4]	**RMS Tax Total [5]**	RMS Local Government Distribution	RMS Marijuana Tax Cash Fund	RMS Public School Fund	RMS General Fund	**RME Tax Total [5]**	RME Public School Capital Construction Assistance Fund	RME Public School Fund	**Total Taxes**		
	Calculation	*A=B+C*	*B*	*C*	*D=E+F+G+H*	*E*	*F*	*G*	*H*	*I=J+K*	*J*	*K*	*L=A+D+I*	*M*	*N=L+M*
5	2019	**$930,131**	$791,528	$138,602	**$16,022,901**	$1,597,781	$10,332,069	$1,810,449	$2,237,536	**$5,883,220**	$5,320,932	$591,215	**$22,836,252**	**$1,112,902**	**$23,949,154**
6	2019	**$1,121,264**	$931,414	$189,850	**$18,698,640**	$1,863,668	$12,047,684	$2,111,069	$2,609,074	**$6,004,970**	$5,360,466	$595,607	**$25,824,874**	**$1,016,198**	**$26,841,073**
7	2019	**$986,552**	$837,774	$148,778	**$17,996,004**	$1,809,745	$11,702,730	$2,050,624	$2,534,370	**$5,645,908**	$5,667,982	$0	**$24,628,464**	**$1,034,098**	**$25,662,562**
8	2019	**$1,036,711**	$866,237	$170,474	**$21,255,391**	$2,123,026	$13,693,411	$2,399,444	$2,965,476	**$6,187,794**	$6,281,444	$0	**$28,479,896**	**$992,717**	**$29,472,614**
9	2019	**$1,069,409**	$895,901	$173,508	**$21,279,128**	$2,129,017	$13,767,313	$2,412,393	$2,981,481	**$6,495,588**	$6,396,684	$0	**$28,844,125**	**$901,640**	**$29,745,766**
10	2019	**$952,001**	$844,284	$107,717	**$17,936,550**	$1,795,623	$11,610,735	$2,034,505	$2,514,447	**$5,971,603**	$5,994,184	$0	**$24,860,154**	**$1,084,682**	**$25,944,836**
11	2019	**$902,607**	$799,376	$103,230	**$19,077,121**	$1,858,692	$12,019,061	$2,106,054	$2,602,875	**$6,827,928**	$6,814,268	$0	**$26,807,656**	**$975,024**	**$27,782,680**
12	2019	**$821,116**	$787,053	$34,063	**$17,512,843**	$1,750,592	$11,320,225	$1,983,600	$2,451,534	**$5,857,518**	$5,857,070	$0	**$24,191,477**	**$1,205,700**	**$25,397,177**
1	2020	**$1,207,787**	$1,068,091	$139,697	**$17,821,262**	$1,805,455	$11,674,991	$2,045,764	$2,528,363	**$7,050,247**	$7,046,620	$0	**$26,079,297**	**$875,855**	**$26,955,151**
2	2020	**$835,058**	$742,691	$92,367	**$17,051,241**	$1,705,689	$11,026,766	$1,932,178	$2,387,982	**$7,350,167**	$7,200,059	$0	**$25,236,466**	**$879,353**	**$26,115,819**
3	2020	**$862,244**	$738,261	$123,983	**$17,108,035**	$1,704,262	$11,079,073	$1,941,344	$2,399,309	**$6,509,959**	$6,547,986	$0	**$24,480,238**	**$1,152,355**	**$25,632,593**
4	2020	**$811,888**	$817,745	($5,857)	**$16,305,176**	$1,624,673	$10,504,051	$1,840,585	$2,274,781	**$7,090,119**	$7,073,525	$0	**$24,207,183**	**$902,061**	**$25,109,244**
5	2020	**$1,274,008**	$1,140,632	$133,376	**$20,054,312**	$2,026,307	$13,100,291	$2,295,514	$2,837,029	**$7,625,293**	$7,669,190	$0	**$28,953,613**	**$787,161**	**$29,740,774**
6	2020	**$1,287,667**	$1,180,878	$106,789	**$22,814,211**	$2,279,818	$14,739,280	$2,582,707	$3,191,972	**$8,454,927**	$8,270,424	$0	**$32,556,806**	**$1,067,803**	**$33,624,609**
7	2020	**$1,288,715**	$1,230,009	$58,706	**$24,644,660**	$2,435,426	$15,750,206	$2,759,848	$3,410,900	**$9,381,481**	$9,586,680	$0	**$35,314,856**	**$814,882**	**$36,129,738**
8	2020	**$1,433,419**	$1,265,203	$168,216	**$27,794,380**	$2,810,429	$18,164,625	$3,182,918	$3,933,773	**$10,470,917**	$10,427,317	$0	**$39,698,715**	**$996,898**	**$40,695,613**
9	2020	**$1,339,939**	$1,177,949	$161,990	**$26,656,923**	$2,653,063	$17,156,055	$3,006,190	$3,715,354	**$9,682,085**	$9,537,148	$0	**$37,678,947**	**$947,467**	**$38,626,414**
10	2020	**$1,170,328**	$1,028,091	$142,236	**$24,593,888**	$2,474,375	$16,000,557	$2,803,716	$3,465,117	**$8,821,260**	$8,854,426	$0	**$34,585,476**	**$824,817**	**$35,410,293**
11	2020	**$1,249,321**	$1,108,382	$140,939	**$24,426,723**	$2,436,218	$15,753,820	$2,760,482	$3,411,683	**$10,201,749**	$1,594,429	$7,981,406	**$35,877,794**	**$1,178,975**	**$37,056,769**
12	2020	**$1,098,511**	$958,535	$139,976	**$21,257,250**	$2,115,909	$13,682,531	$2,397,537	$2,963,120	**$8,860,838**	$0	$8,707,327	**$31,216,599**	**$1,166,495**	**$32,383,094**
1	2021	**$1,182,812**	$1,025,920	$156,892	**$22,535,988**	$2,217,994	$14,342,110	$2,513,113	$3,105,960	**$10,403,821**	$0	$10,499,701	**$34,122,621**	**$858,325**	**$34,980,946**
2	2021	**$1,013,729**	$952,011	$61,719	**$22,870,352**	$2,302,182	$14,887,087	$2,608,607	$3,223,981	**$10,018,411**	$0	$9,991,996	**$33,902,493**	**$845,082**	**$34,747,575**
3	2021	**$1,171,984**	$991,724	$180,261	**$21,039,474**	$2,113,860	$13,669,038	$2,395,173	$2,960,198	**$10,268,995**	$0	$10,903,483	**$32,480,453**	**$1,197,776**	**$33,678,229**
4	2021	**$1,248,451**	$1,139,747	$108,704	**$25,153,143**	$2,532,556	$16,376,590	$2,869,607	$3,546,552	**$12,228,763**	$0	$12,032,996	**$38,630,356**	**$1,017,911**	**$39,648,267**
5	2021	**$1,161,923**	$1,086,448	$75,475	**$25,336,486**	$2,539,738	$16,423,229	$2,877,779	$3,556,652	**$9,933,908**	$0	$10,136,141	**$36,432,317**	**$1,227,776**	**$37,660,093**
6	2021	**$1,226,201**	$1,062,484	$163,718	**$23,936,478**	$2,371,607	$15,336,012	$2,687,271	$3,321,202	**$10,066,050**	$0	$10,093,601	**$35,228,730**	**$1,092,276**	**$36,321,006**
7	2021	**$951,766**	$953,814	($2,047)	**$23,165,152**	$2,337,874	$15,116,691	$2,648,840	$3,273,705	**$9,867,846**	$9,849,045	$0	**$33,984,763**	**$966,159**	**$34,950,923**
8	2021	**$2,765,144**	$1,771,977	$993,168	**$25,103,189**	$2,510,091	$16,231,515	$2,844,186	$3,515,134	**$9,480,366**	$9,546,374	$0	**$37,348,698**	**$1,197,596**	**$38,546,294**
9	2021	**$1,214,312**	$978,959	$235,353	**$24,213,820**	$2,422,564	$15,664,087	$2,744,758	$3,392,250	**$10,244,161**	$9,609,309	$0	**$35,672,293**	**$1,166,172**	**$36,838,465**
10	2021	**$822,475**	$810,713	$11,763	**$22,403,066**	$2,227,304	$14,456,743	$2,533,200	$3,130,785	**$8,931,121**	$8,838,123	$0	**$32,156,662**	**$824,817**	**$32,981,479**
11	2021	**$886,371**	$774,670	$111,701	**$21,930,130**	$2,200,063	$14,226,719	$2,492,893	$3,080,971	**$8,647,969**	$9,274,809	$0	**$31,464,470**	**$1,058,743**	**$32,523,213**
12	2021	**$886,161**	$741,637	$144,524	**$19,931,254**	$1,975,891	$12,777,133	$2,238,888	$2,767,045	**$8,447,062**	$8,366,060	$0	**$29,264,477**	**$1,345,086**	**$30,609,563**
1	2022	**$845,070**	$759,420	$85,650	**$20,977,072**	$2,112,585	$13,661,052	$2,393,774	$2,958,469	**$7,972,363**	$8,017,738	$0	**$29,794,505**	**$986,517**	**$30,781,021**
2	2022	**$707,133**	$594,368	$112,765	**$19,784,421**	$1,965,071	$12,707,126	$2,226,621	$2,751,884	**$6,860,278**	$6,857,377	$0	**$27,351,833**	**$787,973**	**$28,139,806**
3	2022	**$757,371**	$596,734	$160,637	**$19,090,304**	$1,928,531	$12,470,867	$2,185,222	$2,700,719	**$6,817,459**	$6,838,549	$0	**$26,665,134**	**$1,135,947**	**$27,801,081**
4	2022	**$834,267**	$651,845	$182,423	**$20,485,934**	$2,044,830	$13,222,892	$2,316,997	$2,863,580	**$7,846,052**	$7,850,748	$0	**$29,166,253**	**$1,134,208**	**$30,300,460**
5	2022	**$766,534**	$623,561	$142,974	**$19,502,031**	$1,957,923	$12,660,938	$2,218,528	$2,741,882	**$6,228,500**	$6,144,363	$0	**$26,497,065**	**$1,023,385**	**$27,520,451**
6	2022	**$784,619**	$617,809	$166,810	**$19,449,994**	$1,937,400	$12,528,193	$2,195,267	$2,713,134	**$6,336,766**	$6,151,783	$0	**$26,571,378**	**$1,142,856**	**$27,714,234**
7	2022	**$651,133**	$505,603	$145,529	**$19,021,651**	$1,903,660	$12,310,027	$2,157,039	$2,665,887	**$5,400,834**	$5,428,082	$0	**$25,073,618**	**$946,208**	**$26,019,826**
8	2022	**$545,656**	$524,086	$21,570	**$20,453,175**	$2,045,738	$13,228,769	$2,318,026	$2,864,852	**$5,023,514**	$5,168,203	$0	**$26,022,345**	**$1,010,299**	**$27,032,644**
9	2022	**$641,409**	$547,179	$94,230	**$19,822,451**	$1,972,584	$12,755,729	$2,235,138	$2,762,410	**$4,963,135**	$4,923,702	$0	**$25,426,995**	**$943,674**	**$26,370,669**
10	2022	**$629,506**	$504,141	$125,365	**$19,788,966**	$1,978,469	$12,793,766	$2,241,803	$2,770,647	**$4,850,874**	$4,849,420	$0	**$25,269,346**	**$726,744**	**$25,996,090**
11	2022	**$450,954**	$483,723	($32,769)	**$18,773,175**	$1,878,685	$12,148,538	$2,128,742	$2,630,915	**$4,481,536**	$4,431,712	$0	**$23,705,664**	**$800,517**	**$24,506,181**
12	2022	**$593,965**	$473,547	$120,418	**$16,906,751**	$1,698,437	$10,982,948	$1,924,500	$2,378,492	**$4,196,798**	$3,956,280	$0	**$21,697,513**	**$1,223,707**	**$22,921,221**
1	2023	**$537,291**	$453,756	$83,535	**$16,719,473**	$1,675,275	$10,833,170	$1,898,255	$2,346,056	**$4,322,426**	$4,486,144	$0	**$21,579,191**	**$772,851**	**$22,352,041**
2	2023	**$668,583**	$578,296	$90,287	**$18,761,526**	$1,877,231	$12,139,109	$2,127,089	$2,628,873	**$4,609,452**	$4,449,405	$0	**$24,039,560**	**$713,130**	**$24,752,691**
3	2023	**$563,507**	$444,417	$119,090	**$16,735,449**	$1,674,078	$10,825,430	$1,896,899	$2,344,380	**$4,693,889**	$4,753,634	$0	**$21,992,844**	**$1,108,192**	**$23,101,036**
4	2023	**$582,003**	$459,036	$122,967	**$18,633,442**	$1,861,331	$12,036,305	$2,109,076	$2,606,610	**$5,107,633**	$5,089,910	$0	**$24,323,079**	**$805,142**	**$25,128,221**

Source: Revenue collected monthly as posted in the Colorado state accounting system

[1] Tax remitted includes marijuana tax, license, and fee revenue received as well as penalties and other adjustments in a given month.

[2] Retail marijuana sales tax on the sale of retail marijuana and marijuana products increased from 10% to 15% beginning July 1, 2017. The first revenue month that reflects the 15% rate is August 2017.

[3] State sales tax revenue from medical marijuana and retail marijuana is distributed to the Marijuana Tax Cash Fund.

[4] Retail marijuana, retail marijuana products, and retail marijuana concentrates sold beginning July 1, 2017 are exempt from the 2.9% state sales tax; however, products that do not contain marijuana (i.e., accessories) are still subject to the 2.9% state sales tax. The first revenue month that reflects this exemption is August 2017.

[5] Total includes collections not yet allocated which are receipts that have posted to the accounting system but have not yet been reconciled to the relevant sales/excise tax return.

[6] Revenue from license fees and other fees is distributed to the Marijuana Cash Fund.

Prepared by: Office of Research and Analysis, Colorado Department of Revenue | dor_ora@state.co.us
Publish date: May 2023

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2022

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 FOR THE TRANSITION PERIOD FROM TO**

Commission File Number 000-56248

TRULIEVE CANNABIS CORP.
(Exact name of Registrant as specified in its Charter)

British Columbia	84-2231905
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
6749 Ben Bostic Road Quincy, FL	32351
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: (850) 480-7955

Securities registered pursuant to Section 12(b) of the Act: None

Title of each class	Trading Symbol(s)	Name of each exchange on which registered

Securities registered pursuant to Section 12(g) of the Act: **Subordinate Voting Shares, no par value**

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. YES ☒ NO ☐

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act. YES ☐ NO ☒

Indicate by check mark whether the Registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the Registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. YES ☒ NO ☐

Indicate by check mark whether the Registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the Registrant was required to submit such files). YES ☒ NO ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐	Smaller reporting company	☐
Emerging growth company	☐		

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☒

If securities are registered pursuant to Section 12(b) of the Act, indicate by check mark whether the financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements. ☐

Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to §240.10D-1(b). ☐

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). YES ☐ NO ☒

The aggregate market value of the Subordinate Voting Shares, and Multiple Voting Shares and Super Voting Shares (on an as converted basis, based on the closing price of these shares on the Canadian Securities Exchange) on June 30, 2022, the last business day of the registrant's most recently completed second fiscal quarter, held by non-affiliates was $1,583,303,238.

As of March 1, 2023, there were 341 Subordinate Voting Shares, 14 Multiple Voting Shares (on an as converted basis) and zero Super Voting Shares (on an as converted basis) outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Part III incorporates certain information by reference from the definitive proxy statement to be filed by the registrant in connection with the 2023 Annual Meeting of Stockholders (the “2023 Proxy Statement”). The 2023 Proxy Statement will be filed by the registrant with the Securities and Exchange Commission not later than 120 days after December 31, 2022, the end of the registrant’s fiscal year.

Table of Contents

		Page
PART I		
Item 1.	Business	3
Item 1A.	Risk Factors	36
Item 1B.	Unresolved Staff Comments	50
Item 2.	Properties	50
Item 3.	Legal Proceedings	50
Item 4.	Mine Safety Disclosures	50
PART II		
Item 5.	Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities	51
Item 6.	[Reserved]	52
Item 7.	Management's Discussion and Analysis of Financial Condition and Results of Operations	53
Item 7A.	Quantitative and Qualitative Disclosures About Market Risk	66
Item 8.	Financial Statements and Supplementary Data	68
Item 9.	Changes in and Disagreements With Accountants on Accounting and Financial Disclosure	68
Item 9A.	Controls and Procedures	68
Item 9B.	Other Information	70
Item 9C.	Disclosure Regarding Foreign Jurisdictions that Prevent Inspections	70
PART III		
Item 10.	Directors, Executive Officers and Corporate Governance	71
Item 11.	Executive Compensation	71
Item 12.	Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters	71
Item 13.	Certain Relationships and Related Transactions, and Director Independence	71
Item 14.	Principal Accounting Fees and Services	71
PART IV		
Item 15.	Exhibits, Financial Statement Schedules	72
Item 16	Form 10-K Summary	75

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations.

FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion of our financial condition and results of operations should be read together with our consolidated financial statements and the related notes included elsewhere in this Annual Report on Form 10-K. This discussion contains forward-looking statements and involves numerous risks and uncertainties, including but not limited to those described in the "Risk Factors" section of this Annual Report on Form 10-K. Actual results may differ materially from those contained in any forward-looking statements. You should read "Cautionary Note Regarding Forward-Looking Statements" and "Risk Factors" contained in this Annual Report on Form 10-K.

Overview

Trulieve is a vertically integrated cannabis company and multi-state operator which currently directly holds licenses to operate in ten states and has received notice of intent to award a license in an eleventh state. Headquartered in Quincy, Florida, we are the market leader for quality medical cannabis products and services in Florida and we have market leading retail operations in Arizona, Pennsylvania, and West Virginia. By providing innovative, high-quality products across our brand portfolio, we aim to be the brand of choice for medical and adult-use customers in all of the markets that we serve. We operate in highly regulated markets that require expertise in cultivation, manufacturing, retail and logistics. We have developed proficiencies in each of these functions and are committed to expanding access to high quality cannabis products and delivering exceptional customer experiences.

All of the states in which we operate have developed programs to permit the use of cannabis products for medicinal purposes to treat specific conditions and diseases, which we refer to as medical cannabis. Recreational marijuana, or adult-use cannabis, is legal marijuana sold in licensed dispensaries to adults ages 21 and older. Thus far, of the states in which we operate, Arizona, California, Colorado, Connecticut, Maryland, and Massachusetts, have adopted legislation permitting the commercialization of adult-use cannabis products. Trulieve operates its business through its directly and indirectly owned subsidiaries that hold licenses and have entered managed service agreements in the states in which they operate.

As of December 31, 2022, we operated 181 dispensaries, with 123 dispensaries in Florida, 20 dispensaries in Arizona, 19 affiliated dispensaries in Pennsylvania, three dispensaries in California, three dispensaries in Maryland, three dispensaries in Massachusetts, nine dispensaries in West Virginia and one dispensary in Connecticut, and we operated cultivation and processing facilities in Arizona, Colorado, Florida, Georgia, Maryland, Massachusetts, Pennsylvania, and West Virginia.

Components of Results of Continuing Operations

Revenue

We derive our revenue from cannabis products which we manufacture, sell and distribute to our customers by home delivery and in our dispensaries.

Gross Profit

Gross profit includes revenue less the costs directly attributable to product sales and includes amounts paid to produce finished goods, such as flower, and concentrates, as well as packaging and other supplies, fees for services and processing, allocated overhead which includes allocations of rent, administrative salaries, utilities, and related costs. Cannabis costs are affected by various state regulations that limit the sourcing and procurement of cannabis product, which may create fluctuations in margins over comparative periods as the regulatory environment changes.

Sales and Marketing

Sales and marketing expenses consist of marketing expenses related to marketing programs for our products. Personnel related costs related to dispensaries are the primary costs of sales and marketing. As we continue to expand and open additional dispensaries, we expect our sales and marketing expenses to continue to increase.

General and Administrative

General and administrative expenses represent costs incurred at our corporate offices, primarily related to personnel costs, including salaries, incentive compensation, benefits, and other professional service costs, including legal and accounting. We expect to continue to invest considerably in this area to support our expansion plans and to support the increasing complexity of the cannabis business.

Depreciation and Amortization

Depreciation expense is calculated on a straight-line basis using the estimated useful life of each asset. Estimated useful life is determined by asset class and is reviewed on an annual basis and revised if necessary. Amortization expense is amortized using the straight-line method over the estimated useful life of the intangible assets. Useful lives for intangible assets are determined by type of asset with the initial determination of useful life determined during the valuation of the business combination. On an annual basis, the useful lives of each intangible class of assets are evaluated for appropriateness and adjusted if appropriate.

Other Income (Expense), Net

Other income (expense), net consist primarily of interest expense, interest income, and the impact of the revaluation of the liability classified warrants and our interest rate swap.

Provision for Income Taxes

Provision for income taxes is calculated using the asset and liability method. Deferred income tax assets and liabilities are determined based on enacted tax rates and laws for the years in which the differences are expected to reverse. Deferred tax assets are reduced by a valuation allowance when, in the opinion of management, it is more likely than not that some portion or all of the deferred tax assets will not be realized. As we operate in the cannabis industry, we are subject to the limits of IRC Section 280E under which we are only allowed to deduct expenses directly related to costs of goods sold.

Financial Review

Highlights for the 2022 year include:

- **Revenue, net:** We generated revenues of $1.24 billion from the sale of cannabis and cannabis related products, driven by our continued expansion in both our new and legacy markets.
- **Gross profit:** We generated gross profit of $682.0 million.
- **Inventory:** We ended the year with $297.8 million in inventories.
- **Net Cash from Operations**: We generated cash from operations of $23.1 million.

Results of Continuing Operations

This section of this Form 10-K generally discusses 2022 and 2021 items and year-to-year comparisons between 2022 and 2021 and 2021 and 2020 for continuing operations, except as noted. Refer to *Note 18. Discontinued Operations* to the consolidated financial statements included in this Annual Report on Form 10-K for additional financial information related to our discontinued operations.

Year Ended December 31, 2022 Compared to Year Ended December 31, 2021

	Year Ended December 31,				
	2022		**2021**		**2022 vs. 2021**
	(in thousands)				
Statement of operations data:	**Amount**	**Percentage of revenue**	**Amount**	**Percentage of revenue**	**Amount Change**
Revenue, net	$ 1,239,812	100.0 %	$ 937,981	100.0 %	301,831
Cost of goods sold	557,820	45.0 %	370,169	39.5 %	187,651
Gross profit	681,992	55.0 %	567,812	60.5 %	114,180
Expenses:					
Sales and marketing	284,936	23.0 %	215,146	22.9 %	69,790
General and administrative	169,731	13.7 %	100,509	10.7 %	69,222
Depreciation and amortization	119,371	9.6 %	47,229	5.0 %	72,142
Impairment and disposal of long-lived assets, net	75,547	6.1 %	5,371	0.6 %	70,176
Total expenses	649,585	52.4 %	368,255	39.3 %	281,330
Income from operations	32,407	2.6 %	199,557	21.3 %	(167,150)
Other income (expense):					
Interest expense	(79,771)	(6.4 %)	(34,787)	(3.7 %)	(44,984)
Change in fair value of derivative liabilities - warrants	2,643	0.2 %	208	0.0 %	2,435
Other income, net	1,376	0.1 %	1,109	0.1 %	267
Total other expense, net	(75,752)	(6.1 %)	(33,470)	(3.6 %)	(42,282)
(Loss) income before provision for income taxes	(43,345)	(3.5 %)	166,087	17.7 %	(209,432)
Provision for income taxes	161,820	13.1 %	146,703	15.6 %	15,117
Net (loss) income from continuing operations and comprehensive (loss) income	(205,165)	(16.5 %)	19,384	2.1 %	(224,549)
Net loss from discontinued operations, net of tax benefit of $10,663 and $642, respectively	(47,562)	(3.8 %)	(1,939)	(0.2 %)	(45,623)
Net (loss) income	(252,727)	(20.4 %)	17,445	1.9 %	(270,172)
Less: Net loss and comprehensive loss attributable to non-controlling interest from continuing operations	(6,663)	(0.5 %)	(587)	(0.1 %)	(6,076)
Net (loss) income and comprehensive (loss) income attributable to common shareholders	$ (246,064)	(19.8 %)	$ 18,032	1.9 %	$ (264,096)

Revenue, Net

Revenue for the year ended December 31, 2022, was $1,239.8 million, an increase of $301.8 million or 32%, from $938.0 million for the year ended December 31, 2021. The increase in revenue is due to contributions from acquisitions, most notably, Harvest Health & Recreation, Inc. ("Harvest") in October 2021 and Anna Holdings, LLC ("Keystone Shops") in July 2021, continued expansion into new states such as Massachusetts and West Virginia, and additional dispensaries opened in existing markets.

Cost of Goods Sold

Cost of goods sold for the year ended December 31, 2022, was $557.8 million, an increase of $187.7 million or 51%, from $370.2 million for the year ended December 31, 2021, primarily in correlation with the increase in revenues. Cost of goods sold as a percentage of revenue was 45% for the year ended December 31, 2022 as compared to 39% for the year ended December 31, 2021, primarily due to increased depreciation related to capital expenditures to support business growth, new production facilities in existing markets where economies of scale are anticipated in the future, and expansion into new markets which are not fully vertical, resulting in the sale of third-party products, and therefore yield lower margin than our vertical markets.

Gross Profit

Gross profit for the year ended December 31, 2022, was $682.0 million, an increase of $114.2 million or 20% from $567.8 million for the year ended December 31, 2021. Gross profit as a percentage of revenue was 55% for the year ended December 31, 2022 as compared to 61% for the year ended December 31, 2021, due to higher revenue offset by many factors including, increased wholesale business, which is generally lower margin than retail sales, increased depreciation related to capital expenditures to support business growth, new production facilities where economies of scale are anticipated in the future, and expansion into new markets which are not fully vertical, resulting in the sale of third-party products, and therefore yield lower margin than our vertical markets.

Sales and Marketing Expense

Sales and marketing expense for the year ended December 31, 2022, was $284.9 million, an increase of $69.8 million, or 32% from $215.1 million for the year ended December 31, 2021, but remained consistent as a percentage of revenue. The increase in sales and marketing is the result of a higher headcount for the year, as we continue to add additional dispensaries in efforts to maintain and further drive higher growth in sales and market share as well as expanding into new markets.

General and Administrative Expense

General and administrative expense for the year ended December 31, 2022, was $169.7 million an increase of $69.2 million or 69% from $100.5 million for the year ended December 31, 2021. General and administrative expense as a percentage of revenue increased from 11% to 14%. The increase in general and administrative expense is the result of entering new markets, ramping our infrastructure to support growth initiatives, repositioning of facilities which have been temporarily idled, and amounts related to specific non-recurring items such as legal settlements. We also contributed $20.0 million to the Smart and Safe Florida campaign during 2022.

Depreciation and Amortization Expense

Depreciation and amortization expense for the year ended December 31, 2022, was $119.4 million, an increase of $72.1 million, or 153%, from $47.2 million for the year ended December 31, 2021. The overall increase in depreciation and amortization expense is due to increased depreciation from acquired facilities, and increased amortization related to acquired licenses and other intangibles, from the investment in infrastructure for additional dispensaries and cultivation facilities.

Impairment and Disposal of Long-lived Assets, Net

Loss on impairment and disposal of long-lived assets for the year ended December 31, 2022, was $75.5 million an increase of $70.2 million as compared to $5.4 million for the year ended December 31, 2021. The increase in the current period is primarily due to exited facilities and the repositioning of assets, primarily in our Southeast hub. The prior year primarily consisted of the write-off of certain licenses in our Southwest hub due to market changes and the disposal of certain long-lived assets.

Other Expense, Net

Total other expense, net for the year ended December 31, 2022 was $75.8 million, an increase of $42.3 million or 126%, from $33.5 million for the year ended December 31, 2021. The increase is primarily the result of an increase in interest expense related to additional private placement notes, notes payable, and finance leases to support business growth and loss on disposal of non-operational assets in the Northeast and Southeast as the Company continues to streamline its operations.

Provision for Income Taxes

The provision for income taxes for the year ended December 31, 2022 was $161.8 million an increase of $15.1 million from $146.7 million for the year ended December 31, 2021. Provision for income taxes as a percentage of revenue decreased from 16% to 13%. Under IRC Section 280E, cannabis companies are only allowed to deduct expenses that are directly related to production of the products. During the third quarter of the 2022, the Company adopted a more favorable tax position with respect to intercompany management fees based on an IRS position taken in audit of a similar businesses. The increase in income tax expense is primarily due to the increase in gross profit as a result of increased revenue, partially offset by the more favorable tax position on intercompany management fees.

Net (Loss) Income from Continuing Operations and Comprehensive (Loss) Income

Net loss from continuing operations for the year ended December 31, 2022 was $205.2 million, a decrease of $224.5 million from net income from continuing operations of $19.4 million for the year ended December 31, 2021. A significant factor in the

decrease in net income is the Company's repositioning and continued work to streamline our cultivation and production facilities

and the markets in which we operate. This resulted in a loss on disposal of long-lived assets and non-operating assets of $75.5 million. The Company expects to continue to incur such costs in the near-term as we continue to focus on streamlining our business and the markets in which we operate or may enter into. The increase to sales and marketing expenses, general and administrative expenses, depreciation and amortization, and interest expense, as described above, were also factors in the decreased net income.

Net Loss from Discontinued Operations, Net of Tax Benefit

Net loss from discontinued operations, net of tax benefit, for the year ended December 31, 2022 was $47.6 million an increase of $45.6 million from net loss from discontinued operations of $1.9 million for the year ended December 31, 2021. The increase is primarily the result of our continued efforts to reposition assets and streamline operations which resulted in a one-time impairment of long-lived assets related to discontinued operations of $49.1 million, primarily consisting of a license and facility lease and related assets.

Year Ended December 31, 2021 Compared to Year Ended December 31, 2020

	Year Ended December 31,				
	2021		2020		2021 vs. 2020
	(in thousands)				
Statement of operations data:	**Amount**	**Percentage of revenue**	**Amount**	**Percentage of revenue**	**Amount Change**
Revenue, net	$ 937,981	100.0 %	$ 521,533	100.0 %	416,448
Cost of goods sold	370,169	39.5 %	135,116	25.9 %	235,053
Gross profit	567,812	60.5 %	386,417	74.1 %	181,395
Expenses:					
Sales and marketing	215,146	22.9 %	119,395	22.9 %	95,751
General and administrative	100,509	10.7 %	36,056	6.9 %	64,453
Depreciation and amortization	47,229	5.0 %	12,600	2.4 %	34,629
Impairment and disposal of long-lived assets, net	5,371	0.6 %	63	0.0 %	5,308
Total expenses	368,255	39.3 %	168,114	32.2 %	200,141
Income from operations	199,557	21.3 %	218,303	41.9 %	(18,746)
Other income (expense):					
Interest expense	(34,787)	-3.7 %	(20,237)	(3.9 %)	(14,550)
Change in fair value of derivative liabilities - warrants	208	0.0 %	(42,679)	(8.2 %)	42,887
Other income, net	1,109	0.1 %	2,062	0.4 %	(953)
Total other expense, net	(33,470)	-3.6 %	(60,854)	(11.7 %)	27,384
Income before provision for income taxes	166,087	17.7 %	157,449	30.2 %	8,638
Provision for income taxes	146,703	15.6 %	94,451	18.1 %	52,252
Net income from continuing operations and comprehensive income	19,384	2.1 %	62,998	12.1 %	(43,614)
Net loss from discontinued operations, net of tax benefit of $642 and $0, respectively	(1,939)	-0.2 %	—	0.0 %	(1,939)
Net income	17,445	1.9 %	62,998	12.1 %	(45,553)
Less: Net loss and comprehensive loss attributable to non-controlling interest from continuing operations	(587)	-0.1 %	—	0.0 %	(587)

Net income and comprehensive income attributable to common shareholders	$ 18,032	1.9 %	$ 62,998	12.1 %	$ (44,966)

Revenue, Net

Revenue for the year ended December 31, 2021, was $938.0 million, an increase of $416.5 million or 80% from $521.5 million for the year ended December 31, 2020. The increase in revenue is primarily the result of increased locations, increased or new wholesale operations in specific markets, organic growth in retail sales due to an increase in products available for purchase, and acquisitions, most notably the acquisition of Harvest Health & Recreation, Inc. ("Harvest") in October 2021.

Cost of Goods Sold

Cost of goods sold for the year ended December 31, 2021, was $370.2 million, an increase of $235.1 million or 174% from $135.1 million for the year ended December 31, 2020, primarily in correlation with the increase in revenue. Cost of goods sold as a percentage of revenue increased from 26% for the year ended December 31, 2020 to 40% for the year ended December 31, 2021 due to our inventory step-up related to acquisitions, increased wholesale business which is generally lower margin than retail sales, increased depreciation related to capital expenditures in cultivation and processing to support business growth and expansion into new markets which are not fully vertical, resulting in the sale of third party products, and therefore yield lower margin than the Florida vertical market.

Gross Profit

Gross profit for the year ended December 31, 2021, was $567.8 million, an increase of $181.4 million or 47% from $386.4 million for the year ended December 31, 2020, as a result of an increase in retail sales due to an increase in the number of dispensaries and customer count. Gross profit as a percentage of revenue decreased from 74% for the year ended December 31, 2020 to 61%, for the year ended December 31, 2021. This decrease is caused by inventory step-up related to acquisitions, increased wholesale business, which is generally lower margin than retail sales, increased depreciation related to capital expenditures in cultivation and processing to support business growth, expansion into new markets which are not fully vertical and therefore yield lower margin than the Florida vertical market and macro-economic factors centered around prices and labor.

Sales and Marketing Expense

Sales and marketing expense for the year ended December 31, 2021, was $215.1 million an increase of $95.7 million, or 80% from $119.4 million for the year ended December 31, 2020. The increase in sales and marketing is the result of a higher headcount for the year, as we continue to add additional dispensaries in efforts to maintain and further drive higher growth in sales and market share. This increased headcount resulted in higher personnel costs, which is the primary driver for the increase year over year.

General and Administrative Expense

General and administrative expense for the year ended December 31, 2021, was $100.5 million an increase $64.5 million or 179% from $36.1 million for the year ended December 31, 2020. The increase in general and administrative expense is primarily the result of significant expenses incurred to acquire and integrate new subsidiaries, most notably Harvest and entering new markets and ramping up our infrastructure.

Depreciation and Amortization Expense

Depreciation and amortization expense for the year ended December 31, 2021, was $47.2 million, an increase of $34.6 million, or 275% from $12.6 million for the year ended December 31, 2020. The overall increase in depreciation and amortization expenses was due to amortization of intangibles acquired and fair valued in acquisitions, and investment in infrastructure that resulted in more capitalized assets from additional dispensaries. Furthermore, depreciation expense increased due to additional finance leases added.

Impairment and Disposal of Long-lived Assets

Loss on impairment and disposal of long-lived assets for the year ended December 31, 2021, was $5.4 million an increase of $5.3 million from $0.1 million for the year ended December 31, 2020. The increase is primarily due to the write off of certain licenses in the Southwest due to market changes and the disposal of certain long-lived assets.

Other Expense, Net

Total other expense, net for the year ended December 31, 2021, was $33.5 million, a decrease of $27.4 million, or 45%, from $60.9 million for the year ended December 31, 2020. The overall decrease is primarily driven by $42.7 million of other expense due to revaluation of warrants, offset by increased interest expense due to additional financings.

On December 10, 2020, the Company entered into a Supplemental Warrant Indenture with Odyssey Trust Company pursuant to which it amended the terms of the issued and outstanding subordinate voting share purchase warrants of the Company (the “Public Warrants”) to convert the exercise price of the Public Warrants to $13.47 per share, the U.S. dollar equivalent of the Canadian dollar exercise price of the Public Warrants of C$17.25. As a result of this, the Public Warrants converted to equity and eliminated the necessity of revaluation expense on these warrants. The Company did acquire Canadian dollar warrants in the acquisition of Harvest and recorded income related to the revaluation of these warrants in the fourth quarter of the year ended December 31, 2021.

Additionally, interest expense increased as a result of new debt to support business growth, additional finance leases and additional construction finance liabilities acquired in the Harvest acquisition.

Provision for Income Taxes

The provision for income taxes for the year ended December 31, 2021 was $146.7 million an increase of $52.3 million from $94.5 million for the year ended December 31, 2020, due to an increase in gross profit of $181.4 million for the same period. Under IRC Section 280E, cannabis companies are only allowed to deduct expenses that are directly related to production of the products. The increase in income tax expense is due to the significant increase in gross profit as well as an increase in expenses with are not tax deductible under 280E.

Net Income and Comprehensive Income from Continuing Operations

Net income for the year ended December 31, 2021 was $19.4 million, a decrease of $43.6 million from $63.0 million for the year ended December 31, 2020. The decrease in net income was driven primarily by an increase in revenue due to increased dispensary locations, expansion of wholesale business, and acquisitions that was offset by the increased cost of goods sold and income tax expenses due to 280E, as described above. In addition, increases in sales and marketing and general and administrative expenses such significant expenses incurred to acquire and integrate new subsidiaries, most notably Harvest, increases in personnel costs, dispensary expenses, depreciation and amortization, interest expense, ramping infrastructure and go-forward compliance, all contributed to the offset in net income.

Net Loss from Discontinued Operations, Net of Tax Benefit

Net loss from discontinued operations, net of tax benefit, for the year ended December 31, 2021 was $1.9 million an increase of $1.9 million from zero for the year ended December 31, 2020, as there were no operations in the prior year 2020.

Liquidity and Capital Resources

Sources of Liquidity

Since our inception, we have funded our operations and capital spending through cash flows from product sales, third-party debt, proceeds from the sale of our capital stock and loans from affiliates and entities controlled by our affiliates. We are generating cash from sales and are deploying our capital reserves to acquire and develop assets capable of producing additional revenues and earnings over both the immediate and near term to support our business growth and expansion. Our current principal sources of liquidity are our cash and cash equivalents provided by our operations and debt and equity offerings. Cash and cash equivalents consist primarily of cash on deposit with banks and money market funds.

Our primary uses of cash are for working capital requirements, capital expenditures, debt service payments, income tax payments, and acquisitions. Additionally, from time to time, we may use capital for other investing and financing activities. Working capital is used principally for our personnel as well as costs related to the growth, manufacture and production of our products. Our capital expenditures consist primarily of additional facilities and dispensaries, and improvements to existing facilities. Our debt service payments consist primarily of interest payments. Income tax payments are mainly represented by federal income tax payments due to IRC Section 280E. Acquisitions consist of expanding the cultivation and dispensary footprint.

Cash and cash equivalents were $212.3 million as of December 31, 2022. We believe our existing cash balances will be sufficient to meet our anticipated cash requirements from the date of this Annual Report on Form 10-K through at least the next 12 months. Any additional future requirements will be funded through the following sources of capital:

- Cash from ongoing operations,
- Market offerings - the Company has the ability to offer equity in the market for significant potential proceeds, as evidenced by previous recent private placements,
- Debt - the Company has the ability to obtain additional debt from additional creditors,
- Exercise of share-based awards - the Company may receive funds from exercise of options and warrants from the holders of such securities.

Cash Flows

The consolidated statements of cash flows include continuing operations and discontinued operations for the year ended December 31, 2022 and 2021. There were no discontinued operations for the year ended December 31, 2020. The table below highlights our cash flows for the periods indicated.

	Year Ended December 31,		
	2022	2021	2020
		(in thousands)	
Net cash provided by operating activities	$ 23,096	$ 12,898	$ 99,643
Net cash used in investing activities	(215,057)	(215,184)	(174,654)
Net cash provided by financing activities	177,796	289,232	129,911
Net (decrease) increase in cash and cash equivalents	(14,165)	86,946	54,900
Cash, cash equivalents, and restricted cash, beginning of year	233,098	146,713	91,813
Cash and cash equivalents of discontinued operations, beginning of period	561	—	—
Less: cash and cash equivalents of discontinued operations, end of period	(621)	(561)	—
Cash, cash equivalents, and restricted cash, end of year	$ 218,873	$ 233,098	$ 146,713

Cash Flow from Operating Activities

Net cash provided by operating activities was $23.1 million for the year ended December 31, 2022, an increase of $10.2 million, compared to $12.9 million net cash provided by operating activities during the year ended December 31, 2021. This is primarily due to favorable changes in working capital, including the timing of income tax payments that were offset by increases in inventory.

Cash Flow from Investing Activities

Net cash used in investing activities was $215.1 million for the year ended December 31, 2022, a decrease of $0.1 million, compared to the $215.2 million net cash used in investing activities for the year ended December 31, 2021. The decrease is mainly due to the decrease of property and equipment purchases offset by cash provided by the Harvest acquisition.

Cash Flow from Financing Activities

Net cash provided by financing activities was $177.8 million for the year ended December 31, 2022, a decrease of $111.4 million, compared to the $289.2 million net cash provided by financing activities for the year ended December 31, 2021. The decrease is primarily related to a decrease in proceeds from borrowings compared to the prior year.

Balance Sheet Exposure

As of December 31, 2022 and 2021, 100% of our balance sheet is exposed to U.S. cannabis-related activities. We believe our operations are in material compliance with all applicable state and local laws, regulations and licensing requirements in the states in which we operate. However, cannabis remains illegal under U.S. federal law. Substantially all our revenue is derived from U.S. cannabis operations. For information about risks related to U.S. cannabis operations, please refer to the "Risk Factors" section of this Annual Report on Form 10-K.

Contractual Obligations

As of December 31, 2022, we had the following contractual obligations to make future payments, representing contracts and other commitments that are known and committed:

	<1 Year	1 to 3 Years	3 to 5 Years	>5 Years	Total
	(in thousands)				
Notes payable	$ 12,453	$ 7,251	$ 72,428	$ 16,401	$ 108,533
Private placement notes	—	130,000	425,000	—	555,000
Operating lease liabilities	21,807	43,019	41,430	92,038	198,294
Finance lease liabilities	15,629	29,919	26,276	48,076	119,900
Construction finance liabilities	23,406	47,911	49,606	403,934	524,857
Lease settlements	2,041	1,429	847	2,647	6,964
Total [1]	$ 75,336	$ 259,529	$ 615,587	$ 563,096	$ 1,513,548

(1) Includes liabilities due in relation to our discontinued operations.

For additional information on our commitments for financing arrangements, future lease payments, lease guarantees, and other obligations, see Item 8, Note 10. *Notes Payable*, Note 11. *Private Placement Notes,* Note 12. *Leases*, Note 13. *Construction Finance Liabilities,* and Note 22. *Commitments and Contingencies.*

As of the date of this Annual Report on Form 10-K, we do not have any off-balance-sheet arrangements that have, or are reasonably likely to have, a current or future effect on the results of operations or financial condition of, including, and without limitation, such considerations as liquidity and capital resources.

Critical accounting policies and estimates

Critical accounting estimates

The preparation of the consolidated financial statements in conformity with Generally Accepted Accounting Principles ("GAAP") requires management to make judgments, estimates, and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and underlying assumptions are reviewed on an ongoing basis. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from these estimates, and revisions to accounting estimates are recognized in the period in which the estimate is revised.

Significant judgments, estimates, and assumptions that have the most significant effect on the amounts recognized in the consolidated financial statements are described below. See *Note 3. Summary of Significant Accounting Policies* to the consolidated financial statements included in this Annual Report on Form 10-K for further information.

Inventory

The net realizable value of inventories represents the estimated selling price for inventories in the ordinary course of business, less all estimated costs of completion and costs necessary to make the sale. The determination of net realizable value requires significant judgment, including consideration of factors such as shrinkage, the aging of and future demand for inventory, expected future selling price, what we expect to realize by selling the inventory and the contractual arrangements with customers. Reserves for excess and obsolete inventory are based upon quantities on hand, projected volumes from demand forecasts and net realizable value. The estimates are judgmental in nature and are made at a point in time, using available information, expected business plans and expected market conditions. As a result, the actual amount received on sale could differ from the estimated value of inventory. Periodic reviews are performed on the inventory balance. The impact of changes in inventory reserves is reflected in cost of goods sold.

Estimated Useful Lives and Depreciation and Amortization of Property and Equipment and Intangible Assets

Depreciation and amortization of property and equipment and intangible assets are dependent upon estimates of useful lives, which are determined through the exercise of judgment. The assessment of any impairment of these assets is dependent upon estimates of recoverable amounts that take into account factors such as economic and market conditions and the useful lives of assets.

Accounting for Acquisitions and Business Combinations

Classification of an acquisition as a business combination or an asset acquisition depends on whether the assets acquired constitute a business, which can be a complex judgment. Whether an acquisition is classified as a business combination or asset acquisition can have a significant impact on the entries made on and after acquisition.

In determining the fair value of all identifiable assets, liabilities and contingent liabilities acquired, the most significant estimates relate to contingent consideration and intangible assets. Management exercises judgement in estimating the probability and timing of when earn-outs are expected to be achieved, which is used as the basis for estimating fair value. For any intangible asset identified, depending on the type of intangible asset and the complexity of determining its fair value, an independent valuation expert or management may develop the fair value, using appropriate valuation techniques, which are generally based on a forecast of the total expected future net cash flows.

Cannabis licenses are the primary intangible asset acquired in business combinations as they provide the Company the ability to operate in each market. However, some cannabis licenses are subject to renewal and therefore there is some risk of non-renewal for several reasons, including operational, regulatory, legal or economic. To appropriately consider the risk of non-renewal, the Company applies probability weighting to the expected future net cash flows in calculating the fair value of these intangible assets. The key assumptions used in these cash flow projections include discount rates and terminal growth rates. Of the key assumptions used, the impact of the estimated fair value of the intangible assets has the greatest sensitivity to the estimated discount rate used in the valuation. The terminal growth rate represents the rate at which these businesses will continue to grow into perpetuity. Other significant assumptions include revenue, gross profit, operating expenses and anticipated capital expenditures which are based upon the Corporation's historical operations along with management projections.

The evaluations are linked closely to the assumptions made by management regarding the future performance of these assets and any changes in the discount rate applied.

Income Taxes

The Company uses the asset and liability method to account for income taxes. Deferred income tax assets and liabilities are determined based on enacted tax rates and laws for the years in which the differences are expected to reverse. Deferred tax assets are reduced by a valuation allowance when, in the opinion of management, it is more likely than not that some portion or all of the deferred tax assets will not be realized. As the Company operates in the cannabis industry, it is subject to the limits of IRC Section 280E under which the Company is only allowed to deduct expenses directly related to the cost of producing the products or cost of production.

The Company recognizes uncertain income tax positions at the largest amount that is more-likely-than-not to be sustained upon examination by the relevant taxing authority. An uncertain income tax position will not be recognized if it has less than a 50% likelihood of being sustained. Recognition or measurement is reflected in the period in which the likelihood changes.

Long-lived Asset Impairment Assessment

The Company reviews long-lived assets, including property and equipment, definite life intangible assets, and right-of-use assets for impairment whenever events or changes in circumstances indicate that the carrying value of an asset may not be recoverable. Factors which could trigger an impairment review include significant underperformance relative to historical or projected future operating results, significant changes in the manner of use of the assets or the strategy of the business, a significant decrease in the market value of the assets or significant negative industry or economic trends. In accordance with ASC 360-10, when evaluating long-lived assets with impairment indicators for potential impairment, we first compare the carrying value of the asset to its estimated undiscounted cash flows. If the sum of the estimated undiscounted cash flows is less than the carrying value of the asset, we calculate an impairment loss. The impairment loss calculation compares the carrying value of the asset to its estimated fair value, which is typically based on estimated discounted future cash flows. We recognize an impairment loss if the amount of the asset's carrying value exceeds the asset's estimated fair value.

Goodwill Impairment Assessment

Goodwill is allocated at the date the goodwill is initially recorded. We conclude we operate one operating segment and reporting unit evaluating goodwill for impairment as one singular reporting unit. We evaluate our goodwill for impairment annually at the beginning of the fourth quarter or earlier upon the occurrence of substantive unfavorable changes in economic conditions, industry trends, costs, cash flows, or ongoing declines in market capitalization. The Company applies the guidance in Financial Accounting Standards Board ("FASB") Accounting Standards Update ("ASU") 2011-08 "Intangibles-Goodwill and Other-Testing Goodwill for Impairment," which provides entities with an option to perform a qualitative assessment (commonly referred to as "Step Zero") to

determine whether further quantitative analysis for impairment of goodwill is necessary. In performing Step Zero for the Company's

goodwill impairment test, the Company is required to make assumptions and judgments including but not limited to the following: the evaluation of macroeconomic conditions as related to the Company's business, industry and market trends, and the overall future financial performance of its reporting units and future opportunities in the markets in which they operate. If impairment indicators are present after performing Step Zero, the Company would perform a quantitative impairment analysis to estimate the fair value of goodwill.

The quantitative impairment test requires judgment, including the identification of reporting units, the assignment of assets, liabilities, and goodwill to reporting units, and the determination of fair value of each reporting unit. The impairment test requires the comparison of the fair value of a reporting unit with the carrying amount, including goodwill. If the Company would conclude a quantitative impairment test is required, the Company would review fair value techniques for the most appropriate technique generally applying the income approach by using discounted cash flow ("DCF") analyses. Determining fair value requires the Company to make judgments about appropriate forecasted revenue and related revenue growth rate, the earnings before interest, taxes, depreciation, and amortization ("EBITDA") margins rate and the weighted average cost of capital. The cash flows employed in the DCF analysis are based the budget of the reporting unit, long-term business plan and recent operating performance. Discount rate assumptions are based on an assessment of the risk inherent in the future cash flows of the reporting unit and market conditions. Given the inherent uncertainty in determining the assumptions underlying a DCF analysis, actual results may differ from those used in our valuations. The reporting unit may be at risk of failing the quantitative impairment test if it had a fair value that is not substantially in excess of the carrying amount at the assessment date.

At the time of our assessment, the Company's share price had declined affecting the Company's market capitalization. This is considered a risk indicator for goodwill impairment. In assessing the reasonableness of the Company's fair value, we reconciled the Company's market capitalization to the aggregate determined fair value of the Company, which, as of December 31, 2022, included a control premium. In order to determine the control premium, the Company assessed transactions of comparable multi-state operators in the cannabis industry. We determined the control premium was in line with other comparable transactions. The resulting fair value of the Company, including control premium, exceeded its carrying value. Therefore, management has concluded the market capitalization as of December 31, 2022 was not a triggering event that would require the Company to perform a quantitative assessment of goodwill.

Management will continue to monitor the Company's market capitalization and estimated control premium for changes that could impact recoverability of goodwill. The recoverability of goodwill is dependent upon the continued growth of cash flows from our business activities. If the Company's market capitalization continues to decline for a longer sustained period, there is additional risk that goodwill impairment could occur.

Share-Based Payment Arrangements

We use the Black-Scholes pricing model to determine the fair value of options and warrants granted to employees and directors under share-based payment arrangements, where appropriate. In estimating fair value, management is required to make certain assumptions and estimates such as the expected life of units, volatility of future share price, risk free rates, and future dividend yields at the initial grant date. Changes in assumptions used to estimate fair value could result in materially different results.

Commitments and Contingencies

From time to time, the Company may be involved in litigation relating to claims arising out of operations in the normal course of business. Periodically, the Company reviews the status of each significant matter and assesses the potential financial exposure. If the potential loss from any claim or legal proceeding is considered probable, and the amount can be reliably estimated, such amount is recognized in contingencies. Contingent liabilities are measured at management's best estimate of the expenditure required to settle the obligation at the end of the reporting period and are discounted to present value where the effect is material. The Company performs evaluations to identify onerous contracts and, where applicable, records contingent liabilities for such contracts.

Fair Value of Financial Instruments

The Company applies fair value accounting for all financial assets and liabilities that are recognized or disclosed at fair value in the financial statements on a recurring basis. The Company uses judgment to select the methods used to make certain assumptions and in performing the fair value calculations in order to determine (a) the values attributed to each component of a transaction at the time of their issuance; (b) the fair value measurements for certain instruments that require subsequent measurement at fair value on a recurring basis; and (c) for disclosing the fair value of financial instruments. These valuation estimates could be significantly

different because of the use of judgment and the inherent uncertainty in estimating the fair value of these instruments that are not quoted in an active market.

Critical accounting policies

Inventory

Our inventories primarily consist of raw materials, work in process, and finished goods. Costs incurred during the growing and production process are capitalized as incurred to the extent that cost is less than net realizable value. The costs include materials, labor and manufacturing overhead used in the growing and production processes. Pre-harvest costs are capitalized. Our inventory of purchased finished goods and packing materials are initially valued at cost and subsequently at the lower of cost and net realizable value.

Leases

ASC Topic 842 is a standard that requires lessees to increase transparency and comparability among organization by requiring the recognition of Right of Use Assets “ROU” assets and lease liabilities on the balance sheet. The requirements of this standard include a significant increase in required disclosures to meet the objectives of enabling users of financial statements to assess the amount, timing, and uncertainty of cash flows arising from leases.

Revenue Recognition

We recognize revenue in accordance with ASU 2014-09, Revenue from Contracts with Customers (Topic 606). Through our application of the standard, we recognize revenue to depict the transfer of promised goods to our customers in an amount that reflects the consideration of which we expect to be entitled to in exchange for those goods. Revenues consist of retail and wholesale sales of cannabis and cannabis related products, which are recognized when control of the goods has transferred to the customer and collectability is reasonably assured. This is generally when goods have been delivered, which is also when the performance obligation has been fulfilled under the terms of the related sales contract.

Share Based Compensation

We account for share-based compensation expense in accordance with FASB ASC 718 Compensation – Stock Compensation, which requires the measurement and recognition of share-based compensation expense based on estimated fair values, for all stock-based payment awards made to employees. We measure the share-based payment awards based on its estimated fair value of the awards using the Black-Scholes option pricing model, and the fair value of the Company’s common stock on the date of grant, for the warrants and options. We measure the share-based payment awards based on its estimated fair value of the awards using the Black-Scholes option pricing model for warrants and options, and the fair value of the Company’s common stock on the date of grant for restricted stock awards ("RSUs").

Acquisitions

We account for business combinations using the acquisition method in accordance with Accounting Standards Codification ASC 805, Business Combinations which requires recognition of assets acquired and liabilities assumed, including contingent assets and liabilities, at their respective fair values on the date of acquisition.

Contingent consideration is measured at its acquisition-date fair value and included as part of the consideration transferred in a business combination. Contingent consideration that is classified as equity is not remeasured at subsequent reporting dates and its subsequent settlement is accounted for within equity. Contingent consideration that is classified as an asset or liability is remeasured at subsequent reporting dates, with the corresponding gain or loss recognized within the consolidated statements of operations and comprehensive income.

Non-controlling interests in the acquiree are measured at fair value on acquisition date. Acquisition-related costs are recognized as expenses in the periods in which the costs are incurred and the services are received.

Loans acquired in business combinations are initially recorded at fair value, which includes an estimate of credit losses expected to be realized over the remaining lives of the loans and, therefore, no corresponding allowance for loan losses is recorded for such loans at acquisition.

Purchase price allocations may be preliminary and, during the measurement period not to exceed one year from the date of acquisition, changes in assumptions and estimates that result in adjustments to the fair value of assets acquired and liabilities assumed are recorded in the period the adjustments are determined.

Cannabis licenses are the primary intangible asset acquired in business combinations as they provide the Company the ability to operate in each market. However, some cannabis licenses are subject to renewal and therefore there is some risk of non-renewal for several reasons, including operational, regulatory, legal or economic. To appropriately consider the risk of non-renewal, the Company applies probability weighting to the expected future net cash flows in calculating the fair value of these intangible assets. The key assumptions used in these cash flow projections include discount rates and terminal growth rates. Of the key assumptions used, the impact of the estimated fair value of the intangible assets has the greatest sensitivity to the discount rate used in the valuation. The terminal growth rate represents the rate at which these businesses are expected to grow into perpetuity. Other significant assumptions include revenue, gross profit, operating expenses and anticipated capital expenditures which are based upon the Corporation's historical operations along with management projections. The evaluations are linked closely to the assumptions made by management regarding the future performance of these assets and any changes in the discount rate applied.

Financial Instruments

We apply fair value accounting for all financial assets and liabilities that are recognized or disclosed at fair value in the financial statements on a recurring basis. Fair value is defined as the price that would be received from selling an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. When determining the fair value measurements for assets and liabilities that are required to be recorded at fair value, we consider all related factors of the asset by market participants in which the Company would transact and the market-based risk measurements or assumptions that market participants would use in pricing the asset or liability, such as inherent risk, transfer restrictions, and credit risk.

Management's Use of Non-GAAP Measures

Our management uses a financial measure that is not in accordance with generally accepted accounting principles in the U.S., or GAAP, in addition to financial measures in accordance with GAAP to evaluate our operating results. This non-GAAP financial measure should be considered supplemental to, and not a substitute for, our reported financial results prepared in accordance with GAAP. Adjusted EBITDA is a financial measure that is not defined under GAAP. Our management uses this non-GAAP financial measure and believes it enhances an investor's understanding of our financial and operating performance from period to period because it excludes certain material non-cash items and certain other adjustments management believes are not reflective of our ongoing operations and performance. Adjusted EBITDA excludes from net income as reported interest, provision for income taxes, and depreciation and amortization to arrive at EBITDA. This is then adjusted for items that do not represent the operations of the core business such as inventory step-up for fair value adjustments in purchase accounting, integration and transition costs, acquisition and transaction costs, other non-recurring costs such as contributions to specific initiative campaigns (such as Smart and Safe Florida), expenses related to the COVID-19 pandemic, impairments and disposals of long-lived assets, the results of entities consolidated as variable interest entities ("VIEs") but not legally controlled and operated by the Company, discontinued operations, and other income and expense items. Integration and transition costs include those costs related to integration of acquired entities and to transition major systems or processes. Acquisition and transaction costs relate to specific transactions such as acquisitions whether contemplated or completed and regulatory filings and costs related to equity and debt issuances. Other non-recurring costs includes miscellaneous items which are not expected to reoccur frequently such as inventory adjustments related to specific issues and unusual litigation. Adjusted EBITDA for the period ended December 31, 2021, has been adjusted to reflect this current definition and to conform with the current period presentation.

Trulieve reports Adjusted EBITDA to help investors assess the operating performance of the Company's business. The financial measures noted above are metrics that have been adjusted from the GAAP net income measure in an effort to provide readers with a normalized metric in making comparisons more meaningful across the cannabis industry, as well as to remove non-recurring, irregular and one-time items that may otherwise distort the GAAP net income measure.

As noted above, our Adjusted EBITDA is not prepared in accordance with GAAP, and should not be considered in isolation of, or as an alternative to, measures prepared in accordance with GAAP. There are a number of limitations related to the use of Adjusted EBITDA rather than net income, which is the most directly comparable financial measure calculated and presented in accordance with GAAP. Because of these limitations, we consider, and you should consider, Adjusted EBITDA together with other operating and financial performance measures presented in accordance with GAAP. A reconciliation of Adjusted EBITDA from net income, the most directly comparable financial measure calculated in accordance with GAAP, has been included herein immediately following our discussion of "Adjusted EBITDA".

Adjusted EBITDA

	Year Ended December 31,		Change Increase / (Decrease)	
	2022	2021	$	%
	(in thousands)			
Adjusted EBITDA	$ 400,137	$ 384,581	$ 15,556	4%

Adjusted EBITDA for the year ended December 31, 2022, was $400.1 million, an increase of $15.6 million or 4%, from $384.6 million for the year ended December 31, 2021. The following table presents a reconciliation of GAAP net income (loss) to non-GAAP Adjusted EBITDA, for each of the periods presented:

	Year Ended December 31,		
	2022	2021	2020
	(in thousands)		
Net (loss) income and comprehensive (loss) income attributable to common shareholders	$ (246,064)	$ 18,032	$ 62,998
Add (deduct) impact of:			
Interest expense	79,771	34,787	20,237
Provision for income taxes	161,820	146,703	94,451
Depreciation and amortization	119,371	47,229	12,600
Depreciation included in cost of goods sold	52,541	24,073	11,542
EBITDA	$ 167,439	$ 270,824	$ 201,828
Loss on impairment and disposal of long-lived assets, net	$ 75,547	$ 5,371	$ 63
Discontinued operations	47,562	1,939	—
Acquisition and transaction costs	24,756	15,831	4,724
Integration and transition costs	21,085	25,601	—
Legislative campaign contributions	20,000	—	—
Other non-recurring expenses	27,818	5,053	—
Share-based compensation and related premiums	18,124	13,444	2,765
Inventory step up, fair value	1,048	41,189	955
COVID related expenses	796	6,188	9,125
Change in fair value of derivative liabilities - warrants	(2,643)	(208)	42,679
Other income, net	(1,376)	(1,109)	(2,062)
Results of entities not legally controlled	(19)	458	—
Total adjustments	232,698	113,757	58,249
Adjusted EBITDA	$ 400,137	$ 384,581	$ 260,077

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

Market Risk

Strategic and operational risks arise if we fail to carry out business operations and/or to raise sufficient equity and/or debt financing. These strategic opportunities or threats arise from a range of factors that might include changing economic and political circumstances and regulatory approvals and competitor actions. The risk is mitigated by consideration of other potential development opportunities and challenges which management may undertake.

Currency Risk

Our operating results and financial position are reported in U.S. dollars. Some of our financial transactions are denominated in currencies other than the U.S. dollar. The results of operations are subject to currency transaction risks.

We have no hedging agreements in place with respect to foreign exchange rates. We have not entered into any agreements or purchased any instruments to hedge possible currency risks at this time.

Credit Risk

Management does not believe that the Company has credit risk related to its customers, as the Company's revenue is generated primarily through cash transactions. The Company deals almost entirely with on demand sales and does not have any material

wholesale agreements as of December 31, 2022. Concentrations of credit risk with respect to our cash and cash equivalents are limited primarily to amounts held with financial institutions.

Liquidity Risk

Liquidity risk is the risk that we will not be able to meet our financial obligations associated with financial liabilities. We manage liquidity risk through the management of our capital structure. Our approach to managing liquidity is to ensure that we will have sufficient liquidity to settle obligations and liabilities when due.

Asset forfeiture risk

Because the cannabis industry remains illegal under U.S. federal law, any property owned by participants in the cannabis industry which are either used in the course of conducting such business, or are the proceeds of such business, could be subject to seizure by law enforcement and subsequent civil asset forfeiture. Even if the owner of the property were never charged with a crime, the property in question could still be seized and subject to an administrative proceeding by which, with minimal due process, it could be subject to forfeiture.

Interest Rate Risk

Interest rate risk is the risk that the fair value or the future cash flows of a financial instrument will fluctuate as a result of changes in market interest rates. Our debt exposes us to risk of fluctuations in interest rates. Fixed rate debt, where the interest rate is fixed over the life of the instrument, exposes us to changes in market interest rates reflected in the fair value of the debt and to the risk that we may need to refinance maturing debt with new debt at higher rates. Floating rate debt, where the interest rate fluctuates periodically, exposes us to short-term changes in market interest rates. We manage our debt portfolio to achieve an overall desired proportion of fixed and floating rate debts and may employ interest rate swaps ("Swaps") as a tool from time to time to achieve that position. To manage our interest rate risk exposure, we entered into one Swap contract during the year ended December 31, 2022, to hedge the floating rate term loans. Changes in market interest rates impact the fair value of our Swap contract the balance of which is $2.5 million as of December 31, 2022. See *Note 11. Notes Payable* to the consolidated financial statements in this Annual Report on Form 10-K for additional information.

In addition to our private placement notes payable and long-term debt, we also have lease obligations and construction finance liabilities that bare interest. Interest rates on existing leases and construction finance liabilities typically do not change unless there is a modification to an underlying agreement.

See Item 7, *Liquidity and Capital Resources*, for additional information.

Concentration Risk

Our operations are substantially located in Florida and to a lesser extent Arizona and Pennsylvania. Should economic conditions deteriorate, or competitive pressure intensify within that region, our results of operations and financial position would be negatively impacted.

General Economic Risk

Our operations could be affected by the economic context should the unemployment level, interest rates or inflation reach levels that influence consumer trends and spending and, consequently, impact our sales and profitability.

Banking Risk

Notwithstanding that a majority of states have legalized medical marijuana, there has been no change in U.S. federal banking laws related to the deposit and holding of funds derived from activities related to the marijuana industry. Given that U.S. federal law provides that the production and possession of cannabis is illegal, there is a strong argument that banks cannot accept for deposit funds from businesses involved with the marijuana industry. Consequently, businesses involved in the marijuana industry often have difficulty accessing the U.S. banking system and traditional financing sources. The inability to open bank accounts with certain institutions may make it difficult to operate the businesses of Trulieve, its subsidiaries and investee companies, and leaves their cash holdings vulnerable. We have banking relationships in all jurisdictions in which we operate.

Inflation Risk

During the year ended December 31, 2022, inflation in the United States has accelerated and is currently expected to continue at an elevated level for the near-term. Rising inflation could have an adverse impact on expenses, as these costs could increase at a

higher rate than revenues. Our costs are subject to fluctuations, particularly due to changes in the prices of raw product and packaging materials and the costs of labor, transportation and energy. Inflation pressures could also result in increases in these input costs. Therefore, our business results depend, in part, on our continued ability to manage these fluctuations through pricing actions, cost saving projects and sourcing decisions, while maintaining and improving margins and market share. Failure to manage these fluctuations could adversely impact our results of operations or cash flows. In addition, unfavorable macroeconomic conditions, such as a recession or continued slowed economic growth, could negatively affect consumer demand for cannabis products, which consequently, may negatively affect the results of operations. Under difficult economic conditions, consumers may seek to reduce discretionary spending by forgoing purchases of cannabis products, negatively impacting our net sales and margins. Softer consumer demand for cannabis products could reduce our profitability and could negatively affect our overall financial performance.

Financial Instruments and Financial Risk Management

We are exposed in varying degrees to a variety of financial instrument related risks. The board of directors of Trulieve mitigate these risks by assessing, monitoring and approving the risk management processes.

The Company's financial instruments that are measured at fair valued on a recurring basis consist of money market funds, an interest rate swap, and a warrant liability. Our financial instruments where carrying value approximates the fair value include cash, accounts payable and accrued liabilities, notes payable, notes payable related party, operating lease liability, finance lease liability, other long-term liabilities and construction finance liability. Financial instruments recorded at fair value are classified using a fair value hierarchy that reflects the significance of the inputs to fair value measurements. The three levels of hierarchy are:

Level 1: Observable inputs based on unadjusted quoted prices in active markets for identical assets or liabilities;

Level 2: Inputs other than quoted prices in active markets, which are observable for the asset or liability, either directly or indirectly; and

Level 3: Unobservable inputs for which there is little or no market data requiring the Company to develop its own assumptions.

Item 8. Financial Statements and Supplementary Data.

The financial information required by Item 8 is located beginning on page F-1 of this Annual Report.

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure.

None.

Item 9A. Controls and Procedures.

Conclusion Regarding the Effectiveness of Disclosure Controls and Procedures

We maintain disclosure controls and procedures that are designed to ensure that information required to be disclosed in our reports under the Securities Exchange Act of 1934, as amended (the Exchange Act), is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms, and that such information is accumulated and communicated to management, including our Chief Executive Officer (CEO) and Chief Financial Officer (CFO), as appropriate, to allow timely decisions regarding required disclosure. In designing and evaluating the disclosure controls and procedures, management recognized that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives, as ours are designed to do, and management necessarily was required to apply its judgment in evaluating the risk related to controls and procedures.

In connection with the preparation of this Form 10-K, as of December 31, 2022, an evaluation was performed under the supervision and with the participation of our management, including the CEO and CFO, of the effectiveness of the design and operation of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act). Based on that evaluation, our management concluded that as of December 31, 2022, we did not maintain effective disclosure controls and procedures because of the material weaknesses in internal control over financial reporting described below under the caption "—Material Weakness in Internal Control Over Financial Reporting."

Tab 6

Media Sources

(None Provided)

Tab 7

EDR Supporting Materials

Criminal Justice System - June 12, 2023

The legalization of recreational marijuana has the potential to affect the criminal justice system in a number of ways, and much of the research is mixed when it comes to what direction the impact will take. Research on the relationship between recreational marijuana legalization and crime at the state level has found no significant impact,[1] [2] [3] while a study at the county level found a reduction in certain types of crime when comparing Washington and Oregon, which legalized in different years.[4] However, research at the neighborhood level has yielded conflicting results regarding the extent or direction of an impact.[5] [6] [7] [8]

Marijuana specific crime is one area where a reduction might be expected, since much of the current law will no longer apply for people over 21 years of age. However, an annual report published by the Colorado Division of Criminal Justice has indicated that while they saw significant decreases in marijuana possession arrests (-71%) and sales arrests (-56%) between 2012 and 2019, production arrests saw a slight increase (+3%).[9] This updated report indicates greater decreases in possession and sales arrests since assessing the 2012 to 2017 time period, while the increase in production arrests has slowed considerably (+51% through 2017).[10] Additionally, marijuana-related felony court case filings declined by -55% between 2012 and 2019. At the same time, there are mixed findings in other research on whether or not police clearance rates have improved under legalization,[11] [12] which could be an indicator of resources previously dedicated to marijuana arrests now focusing on other offenses. While current research has not examined such an argument, an increase in clearance rates could lead to more arrests, and thus increased costs to the criminal justice system.

---

[1] Maier, S, Mannes, S, Koppenhofer, E. 2017. "The Implications of Marijuana Decriminalization and Legalization on Crime in the United States." *Contemporary Drug Problems*, 44(2):125-146.
[2] Ruibin L, Willits, D, Stohr, M., Makin, D, Snyder, J, Lovrich, N, Meize, M, Stanton, D, Wu, G, Hemmens, C. 2019. "The Cannabis Effect on Crime: Time-Series Analysis of Crime in Colorado and Washington State." *Justice Quarterly*.
[3] Sabia J. J., Dave D. M., Alotaibi F., Rees D. I. 2021. "Is recreational marijuana a gateway to harder drug use and crime?" [NBER Working Paper Series]. http://www.nber.org/papers/w29038
[4] Dragone, D, Prarolo, G, Vanin, P, Zanella, G. 2019. "Crime and the legalization of recreational marijuana. Journal of Economic Behavior & Organization." *Journal of Economic Behavior & Organization*, 159: 488-501.
[5] Freisthler, B, Gaidus, A, Tam, C, Ponicki, W, Gruenewald, P. 2017 "From Medical to Recreational Marijuana Sales: Marijuana Outlets and Crime in an Era of Changing Marijuana Legislation." *The Journal of Primary Prevention*, 38(3):249-263.
[6] Hughes, L, Schaible, L, Jimmerson, K. 2019. "Marijuana Dispensaries and Neighborhood Crime and Disorder in Denver, Colorado." *Justice Quarterly*.
[7] Burkhardt, J, Goemans, C. 2019. "The short-run effects of marijuana dispensary openings on local crime." *The Annals of Regional Science*, 63(1): 163-189.
[8] Brinkman, J, Mok-Lamme, D. 2019. "Not in my backyard? Not so fast. The effect of marijuana legalization on neighborhood crime." *Regional Science and Urban Economics*, 78.
[9] Reed, J. "Impacts of Marijuana Legalization in Colorado: A Report Pursuant to C.R.S. 23–33.4-516." Report, Colorado Division of Criminal Justice, July 2021.
[10] Reed, J. "Impacts of Marijuana Legalization in Colorado: A Report Pursuant to Senate Bill 13–283." Report, Colorado Division of Criminal Justice, October 2018.
[11] Makin, D, Willits, D, Wu, G, DuBois, K, Lu, R, Stohr, M, Koslicki, W, Stanton, D, Hemmens, C, Snyder, J, Lovrich, N. 2019. "Marijuana Legalization and Crime Clearance Rates: Testing Proponent Assertions in Colorado and Washington State." *Police Quarterly*, 22(1), 31–55.
[12] Jorgensen, C and Harper, A. 2020. "Examining the effect of marijuana legalization in Colorado and Washington on clearance rates: A quasi-experimental design." *Journal of Experimental Criminology*, 1-22.

According to the Florida Department of Corrections, as of May 31st, 2023, there were 136 inmates in prison with marijuana violations listed as primary offenses. In FY 21-22, the majority of strictly marijuana-related new commitments were for sale/manufacture/delivery (39) and possession of marijuana over 20 grams (32), while trafficking in cannabis between 25 pounds and 2,000 pounds (16) also brought in double digit new commitments. However, it is not known how many new commitments for selling drugs within 1,000 feet of restricted areas were trying to sell marijuana, since multiple drugs are included in that data. In FY 21-22 roughly 1.6% of offenders were sentenced to prison for possession, while 5% were sentenced to prison for sale/manufacture/delivery. Additionally, trafficking in cannabis between 25 pounds and 2,000 pounds sent 20% of offenders to prison. Given the information available from Colorado, it is also not known how sale/manufacture/delivery or trafficking might be affected, since a similar black market has the potential to develop here. Furthermore, with low incarceration rates for possession, it is entirely possible that those receiving prison for these offenses did so because they committed other offenses, pled down from sale/manufacture/delivery, or were technical violators under community supervision, so it is not known if a reduction in these admissions would occur. For the vast majority of offenders receiving a sentence other than prison, the Florida Department of Corrections has indicated that there will not be a significant impact on their operations, even with a reduction in the population under supervision for marijuana crimes.

Another area where crime and cost could be impacted is in driving under the influence, where a possibility exists that these numbers could increase with the introduction of a new drug into mainstream usage. The Colorado Division of Criminal Justice found that while the number of marijuana only citations issued remained relatively stable between 2014 and 2020, the prevalence of marijuana and alcohol identified as the impairing substances increased from 3.7% of all DUIs in 2014 to 18% in 2020.[13] Additionally, the report notes that these findings should be interpreted with the understanding that there has been a significant increase in the number of peace officers trained to identify impairment from drugs other than alcohol. Furthermore, the number of fatalities in which a driver tested positive for Delta-9 THC with five or more nanograms in the driver's blood, a possible indicator of impairment, saw a decrease from 14% of all fatalities in 2016 to 8% of all fatalities in 2017, followed by slight growth up to 13% in 2019. Other research has indicated evidence of impaired driving in states where recreational marijuana was legalized, while the relationship between legalization and motor vehicle accidents, including those with traumatic injuries or fatalities, continues to be mixed regarding whether or not there is an increase.[14] [15] [16] [17] A more recent review of this growing literature continues to find mixed results regarding whether or not there is an impact on traffic fatalities, with some studies finding declines in recreational states, others finding increases, and still others finding no effect at all.[18] It is not

---

[13] Reed, J. "Impacts of Marijuana Legalization in Colorado: A Report Pursuant to C.R.S. 23–33.4-516." Report, Colorado Division of Criminal Justice, July 2021.
[14] Chung, C, Salottolo, K, Tanner II, A, Carrick, M, Madayag, R, Berg, G, Lieser, M, Bar-Or, D. "The impact of recreational marijuana commercialization on traumatic injury." *Injury Epidemiology*, 6.
[15] Lynch, J, McMahon, Lucian. 2019. "A Rocky Road So Far: Recreational Marijuana and Impaired Driving." Report, Insurance Information Institute, March 2019.
[16] Leyton M. 2019. "Cannabis legalization: Did we make a mistake? Update 2019." *Journal of Psychiatry & Neuroscience*, 44(5): 291–293.
[17] Farrelly, K. N., Wardell, J. D., Marsden, E., Scarfe, M. L., Najdzionek, P., Turna, J., & MacKillop, J. 2023. "The impact of recreational cannabis legalization on cannabis use and associated outcomes: a systematic review." *Substance abuse: research and treatment*, 17.
[18] Anderson, D. M., & Rees, D. I. 2023. "The public health effects of legalizing marijuana." *Journal of Economic Literature*, 61(1), 86-143.

known what impact this could have on the state of Florida, especially given the difficulties inherent in testing THC levels and blood tests only required in cases of death or serious bodily injury.[19]

Lastly, there is a possibility that the preponderance of marijuana could lead to increased underage marijuana use, which would be illegal under the proposed amendment. According to the Colorado Division of Criminal Justice, marijuana arrests declined for both the 10 to 17 age group and the 18 to 20 age group between 2019 and 2020. Additional studies of marijuana use amongst adolescents yielded mixed results when analyzing Washington and Colorado between 2010-2012 and 2013-2015, showing increased use among eighth graders (+2.0%) and tenth graders (+4.1%) in Washington, which was significantly different from the decreases found for those grades in states that did not legalize recreational marijuana use, while no significant differences in use were found in Colorado.[20] However, more recent studies utilizing different data sets have indicated small decreases for Washington 8th and 10th graders following legalization[21] and a decrease in teenage use for recreational marijuana legalization states relative to other states.[22] Similar to the findings for traffic fatalities, the reviews of existing literature note that studies found both increases and decreases in adolescent and young adult marijuana use, as well as no effect at all when living in a recreational marijuana state.[23] [24]

Overall, given the mixed results under current research, and the possibility of the effects on costs pulling in different directions, the impact is proposed to be indeterminate.

---

[19] S. 316.1933, F.S.

[20] Cerdá M, Wall M, Feng T, Keyes KM, Sarvet A, Schulenberg J, O'Malley PM, Pacula RL, Galea S, Hasin DS. 2017. "Association of State Recreational Marijuana Laws With Adolescent Marijuana Use." *JAMA Pediatr*, 171(2):142-149.

[21] Dilley JA, Richardson SM, Kilmer B, Pacula RL, Segawa MB, Cerdá M. 2019. "Prevalence of cannabis use in youths after legalization in Washington State." *JAMA Pediatr*, 173(2):192-193.

[22] Anderson DM, Hansen B, Rees DI, Sabia JJ. 2019. "Association of Marijuana Laws With Teen Marijuana Use: New Estimates From the Youth Risk Behavior Surveys." *JAMA Pediatr*, 173(9):879–881.

[23] Anderson, D. M., & Rees, D. I. 2023. "The public health effects of legalizing marijuana." Journal of Economic Literature, 61(1), 86-143.

[24] O'Grady, M. A., Iverson, M. G., Suleiman, A. O., & Rhee, T. G. 2022. "Is legalization of recreational cannabis associated with levels of use and cannabis use disorder among youth in the United States? A rapid systematic review." *European Child & Adolescent Psychiatry*, 1-23.

Adult Personal Use of Marijuana:

Capacity for Legalizing Recreational Marijuana

June 12, 2023

Presented by:

The Florida Legislature
Office of Economic and
Demographic Research
850.487.1402
http://edr.state.fl.us

In General…

- Medical marijuana became legal in Florida in 2017.
  - As of June 1, 2023 there are 571 dispensing locations.
  - There are 822,818 active qualified patients
  - Trulieve has the largest market share, dispensing 40% of medical marijuana and 44% of Low-THC cannabis https://knowthefactsmmj.com/2023/01/05/2023-ommu-updates/
  - MMTCs are the only businesses authorized to cultivate, process and dispense low-THC cannabis and medical marijuana.

- Growing Marijuana
  - Indoors – can be grown in warehouse-like facilities that manipulate the light cycle of plants.
    - Cons
      - Higher upfront costs
      - Higher maintenance costs
    - Pros
      - Shorter time to harvest (around 70 days)
      - Control elements
      - Control theft/animal damage

Indoor Growing

- Can grow:
  - Cannabis sativa
  - Cannabis indica

- Life Cycle:
  - Seed Germination 7 to 14 days
  - Seedling stage – 2 to 3 weeks.
  - Vegetative stage – 3 to 6 weeks (light cycle is manipulated here to force plant into flower state)
  - Flowering Stage – 6 to 16 weeks
- The plant is then harvested, which could take 2 to 7 days.

Image from Orlando Weekly, April 20, 2022

Source: https://leafwell.com/blog/when-to-harvest-cannabis/

MMTC Barriers to Entry

- s.381.986, F.S - Some of the requirements:
  - Florida business for 5 years
  - Valid nursery certificate
  - Ability to produce marijuana, including low-THC cannabis
  - Ability to secure the premises, resources and personnel to operate as an MMTC
- High licensing and renewal fees, bonding requirements.
- Limited number of licenses
- Still illegal federally – impact on intrastate commerce.
- Capital intense

Outdoor Growing

- Looked at hemp farmers for outdoor growing ability
- Hemp is Cannabis sativa, but can not have a higher concentration of THC of more than 0.3%
- Higher levels of CBD

- Capacity for Hemp Farmers to grow marijuana
  - Outdoors
    - 2022 – 210 acres of hemp were planted, of which 125 were harvested
    - 2021 – 300 acres planted, 165 harvested
  - Under protection
    - 2022 - 704,862 square feet
    - 2021 – 990,822 square feet

Industrial hemp plants grown in a controlled greenhouse environment | UF/IFAS video still

Source: National Hemp Report, 2023 USDA

Overview of the Current Medical Marijuana Market in Florida
Prepared by Florida Legislature, Office of Economic and Demographic Research - June 12, 2023

Information from the National Institutes of Health, National Institute on Drug Abuse

1. US Definitions According to the National Institutes of Health, National Institute on Drug Abuse, DrugFacts: Cannabis (Marijuana) DrugFacts

Doctors can't legally prescribe marijuana to patients since it is a Schedule I substance, but they can assign a right to visit a company or a cooperative that provides medical marijuana to patients.

Marijuana refers to the dried leaves, flowers, stems, and seeds from the Cannabis sativa or Cannabis indica plant. The plant contains the mind-altering chemical THC and other similar compounds. Extracts can also be made from the cannabis plant.

According to the National Survey on Drug Use and Health, cannabis (marijuana) is one of the most used drugs in the United States, and its use is widespread among young people. In 2021, 35.4% of young adults aged 18 to 25 (11.8 million people) reported using marijuana in the past year.[1] According to the Monitoring the Future survey, rates of past year marijuana use among middle and high school students have remained relatively steady since the late 1990s. In 2022, 30.7% of 12th graders reported using marijuana in the past year and 6.3% reported using marijuana daily. In addition, many young people also use vaping devices to consume cannabis products. In 2022, nearly 20.6% of 12th graders reported that they vaped marijuana in the past year and 2.1% reported that they did so daily.[2][3]

A Rise in Marijuana's THC Levels
The amount of THC in marijuana has been increasing steadily over the past few decades. For a person who's new to marijuana use, this may mean exposure to higher THC levels with a greater chance of a harmful reaction. Higher THC levels may explain the rise in emergency room visits involving marijuana use.

The popularity of edibles also increases the chance of harmful reactions. Edibles take longer to digest and produce a high. Therefore, people may consume more to feel the effects faster, leading to dangerous results. Higher THC levels may also mean a greater risk for addiction if people are regularly exposing themselves to high doses.

Mental Effects

- Long-term marijuana use has been linked to mental illness in some people, such as:
- temporary hallucinations
- temporary paranoia

---

[1] Substance Abuse Center for Behavioral Health Statistics and Quality. Results from the 2018 National Survey on Drug Use and Health: Detailed Tables. SAMHSA. https://www.samhsa.gov/data/report/2018-nsduh-detailed-tables Accessed December 2019.

[2] Miech, R. A., Johnston, L. D., Patrick, M. E., O'Malley, P. M., Bachman, J. G., & Schulenberg J. E. (2023). Monitoring the Future National Survey Results on Drug Use, 1975-2022. Monitoring the Future Monograph Series. Ann Arbor: Institute for Social Research, The University of Michigan.

[3] National Institutes of Health, https://nida.nih.gov/publications/drugfacts/cannabis-marijuana

- worsening symptoms in patients with schizophrenia—a severe mental disorder with symptoms such as hallucinations, paranoia, and disorganized thinking

Marijuana use has also been linked to other mental health problems, such as depression, anxiety, and suicidal thoughts among teens. However, study findings have been mixed.

Information from IBIS World

2. US Market
    a. Growing marijuana: $22.6 billion in 2023

This industry's establishments grow marijuana for medical and recreational use. Most operators are nonprofit collectives that provide medical marijuana to other collective members. Transactions are typically conducted on a donation basis because the sale and distribution of marijuana is illegal in most states that permit medical marijuana. The industry also includes operators in Colorado and Washington, which row medical and recreational marijuana on a for-profit basis.

    b. Medical and recreational marijuana stores in the US: $36.1 billion in 2023

This industry includes stores that retail medical marijuana (by prescription only) and recreational marijuana. However, the legal sale of recreational marijuana is currently limited to the states of Alaska, Arizona, California, Colorado, Connecticut, Illinois, Maine, Maryland, Massachusetts, Michigan, Missouri, Montana, Nevada, New Jersey, New Mexico, New York, Oregon, Rhode Island, Vermont, Virginia and Washington and Washington, DC.

Information from the Florida Department of Health

As of June 9, 2023, the number of Qualified Patients (Active ID Card) in Florida was 825,109.

Active Patients

OMMU	OMMU	EDR Calculation	
Year	Number of Active Patient	OTY Growth Rate	
2017	41,295		SB 8-A: Medical Use of Marijuana, effective 6/23/2017
2018	167,758	306%	
2019	288,709	72%	CS/CS/CS/SB 182: Medical Use of Marijuana, effective 3/18/2019
2020	455,425	58%	(smoking)
2021	656,551	44%	
2022	800,832	22%	
2023*	819,278	2%	*as of 5/22/2023*

Source: Florida Department of Health, Office of Medical Marijuana Use, June 2023.

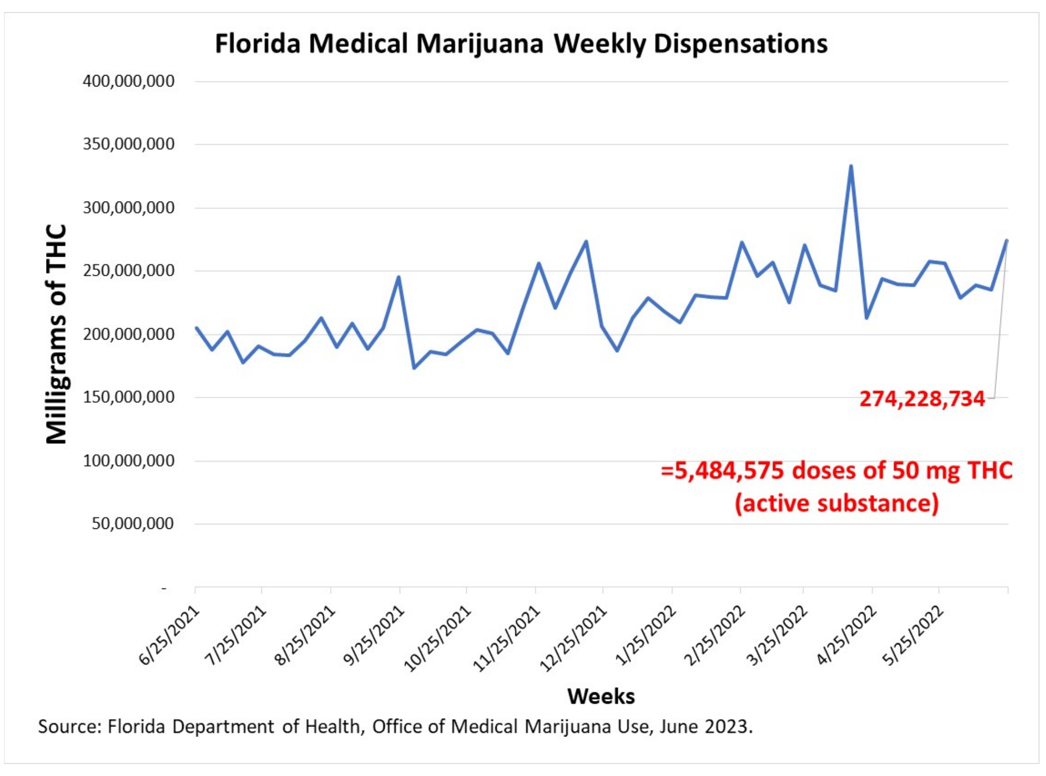
Authorized Dispensaries Count by MMTC

MMTC	Count
Trulieve	125
MuV	67
Ayr Cannabis Dispensary	61
Curaleaf	60
Surterra Wellness	45
Fluent	31
Sunnyside	29
Green Dragon	28
VidaCann	27
GrowHealthy	18
Sanctuary Cannabis	18
Cannabist	14
Sunburn	10
GTI Florida, LLC	8
Insa - Cannabis for Real Life	8
Jungle Boys	7
The Flowery	5
House of Platinum Cannabis	4
Cookies Florida, Inc.	2
Gold Leaf	1
Total	**568**

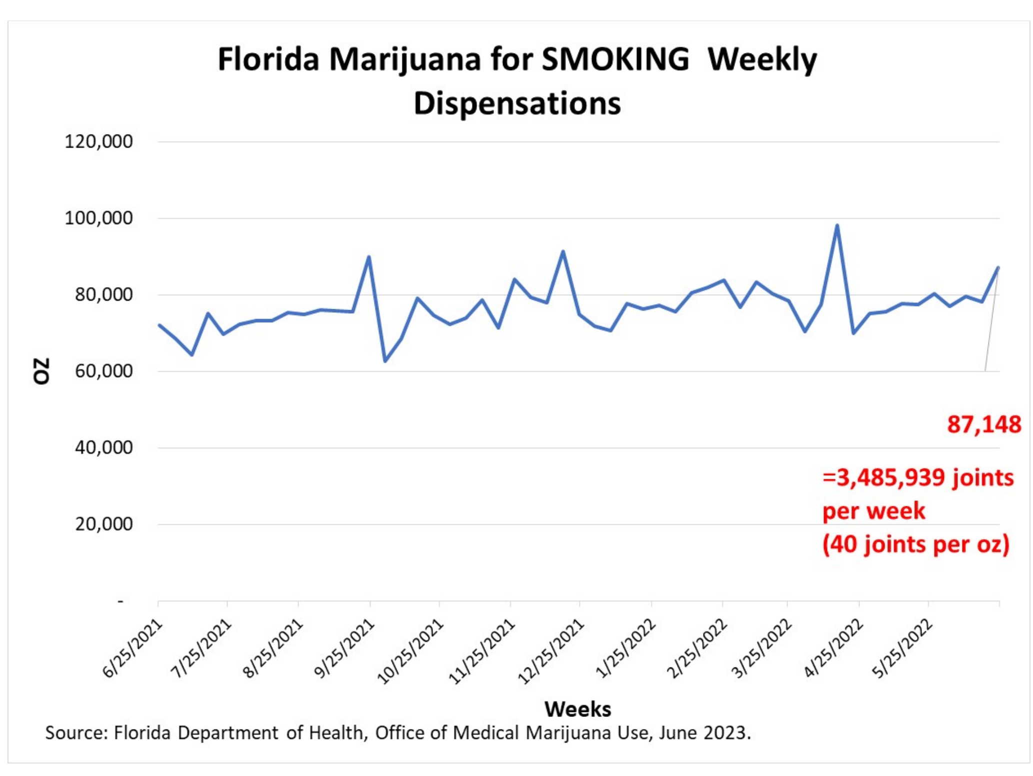
Authorized Facilities by Type

Facility Types	2016	2017	2018	2019	2020	2021	2022	2023	Grand Total
Cultivation Facility	1	6	4	6	5	8	8	1	**39**
Dispensing Facility	4	16	58	118	91	105	118	58	**568**
Fulfillment and Storage Facility		1	3	4	3	1	2	1	**15**
Processing Facility	1	1	8	2	6	7	5	2	**32**
Total	**6**	**24**	**73**	**130**	**105**	**121**	**133**	**62**	**654**

Department of Health - Amount Dispensed[4]



Source: Florida Department of Health, Office of Medical Marijuana Use, June 2023.



Source: Florida Department of Health, Office of Medical Marijuana Use, June 2023.

[4] THC dosage: Find the right mg dose for you, WEEDMAPS, https://weedmaps.com/learn/products-and-how-to-consume/decide-how-much-to-take ., last accessed 6/9/2023 and How many grams in an ounce of weed?, https://stuffstonerslike.com/how-many-joints-are-in-an-ounce-of-weed/ .

Information from Other States

Medical and Recreational Marijuana Taxable Sales

	California*		Colorado	
	Taxable Sales	Per Capita (18+) Taxable Sales	Taxable Sales	Per Capita (18+) Taxable Sales
2014			683,523,739	167
2015			995,591,255	237
2016			1,307,203,473	306
2017			1,507,702,219	347
2018	1,980,400,756	65	1,545,691,080	349
2019	2,803,040,923	92	1,747,990,628	389
2020	4,705,952,540	154	2,191,091,679	484
2021	5,781,937,201	190	2,228,994,553	488
2022	5,381,669,182	176	1,768,688,837	382
2023			393,839,573	

* Excludes medical, which was exempted from the state sales tax in 2016.

Sources: California Department of Tax and Fee Administration, Cannabis Tax Revenues. Colorado Department of Revenue, State Sales Tax Returns (DR 100) and Retail Marijuana Sales Tax Returns.

Capacity

Yield estimates are grounded in Toonen et al.'s (2006) study of 77 illegal, indoor growing operations in the Netherlands. They found a median planting density of 15 plants per square meter, or 1.4 plants per square foot, and an average yield of 1.2 ounces of saleable material per plant per harvest. That translates to 0.105 pounds per square [5]foot per harvest or 2.625 pounds per 25 square feet per harvest.

With an outdoor production yield of 2,500 pounds per acre (1,134 kgs/acre), 4,400 acres of crop land would be needed to serve a 5,000 metric ton U.S. market. The U.S. has 922 million acres of farmland of which a little over 300 million is harvested each year,33 so marijuana cultivation would only require 0.0014% of harvested cropland.

---

[5] RAND Corporation, Estimated Cost of Production for Legalized Cannabis JONATHAN P. CAULKINS, WR-764-RC, July 2010 https://www.rand.org/content/dam/rand/pubs/working_papers/2010/RAND_WR764.pdf

Health and Human Services – June 26, 2023

Legalizing recreational marijuana and increasing the availability to the public may have health effects on the population. Like other controlled substances (i.e. alcohol, tobacco and prescription drugs), misuse and abuse of marijuana has health consequences. The scientific literature related to the health effects of marijuana shows an association between marijuana use and potential negative health outcomes. However, there is a paucity of conclusive evidence to indicate causal effects. While there are many factors precluding proof of causality, the health outcomes associated with marijuana use exist. The research into the association between marijuana use and potential adverse health outcomes is limited by the changes in legality, potency, consumption methods, and many other factors.

High frequency use (daily or weekly) is associated with negative cognitive outcomes that can have long-term effects and mental health issues that can lead to addiction and future misuse. However, the research is often equivocal regarding specific interactions and outcomes. In 2017, the National Academy of Sciences concluded that marijuana use is associated with the development of psychotic disorders, although this relationship "may be multidirectional and complex." The relationship between marijuana use and other mental health outcomes, it concluded, is mixed and frequently confounded by alcohol use. It is also important to note that association is not causation and that mental health conditions might drive some people to use marijuana rather than marijuana use causing mental health conditions.[1] A 2022 article in Substance Use & Misuse concluded that "overall, the relationship between cannabis use and mental health is complex, disorder specific, and may include a combination of perceived benefits as well as harms".[2]

Similarly, high frequency use is associated with cardiovascular and respiratory issues as well as effects from second-hand exposure (similar to smoked tobacco usage). As with other controlled substances, marijuana usage can lead to impaired motor skills that can lead to motor vehicle crashes.[3] There is also an association between prenatal exposure and exposure through breast feeding on negative infant health outcomes similar to those of chronic users.[4] Regarding this amendment, the potential public health costs relate to new and expanding users as well as new tourists. Many of these health care costs already exist for users of illicit or medical marijuana and are a part of Florida's current public health costs.

While the potential for Florida's health care costs to increase exists, there is evidence of mitigating factors that have the potential to lower these costs from legalizing marijuana. Analysis and research regarding the potential benefits of marijuana consumption is sparse due to legal issues and the majority of funding aimed at finding the negative health effects. There is some evidence that hospitalizations and death from opioid pain medication overdoses are less prevalent in states with legal or medical marijuana compared to states without. One study found recreational marijuana is associated with a 4% reduction in opioid-related mortality; and recreational sales are associated with a 16-21%

---

[1] National Academies of Sciences, Engineering, and Medicine. "The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research." The National Academies Press: Washington, DC. 2017.

[2] Jennifer Rup, Tom P. Freeman, Chris Perlman & David Hammond (2022): Cannabis and Mental Health: Adverse Outcomes and Self-Reported Impact of Cannabis Use by Mental Health Status, Substance Use & Misuse.

[3] Bannigan P, Evans JC, Allen C (2022) Shifting the paradigm on cannabis safety, *Cannabis and Cannabinoid Research* 7:1, 3–10.

[4] Retail Marijuana Public Health Advisory Committee. "Monitoring Health Concerns Related to Marijuana in Colorado: 2020 Summary." 2020.

reduction in opioid-related mortality.[5] Conflicting evidence exists as to whether marijuana use is associated with decreases in opioid use among chronic pain patients or those with chronic drug abuse issues.[6] There is substantial evidence that cannabis or cannabinoids are effective in treating chronic pain, chemotherapy induced nausea, and spasticity symptoms in multiple sclerosis patients. Moderate evidence exists for improving short-term sleep outcomes.[7] A 2022 long-term study on the effects of cannabis on Post-Traumatic Stress Disorder found evidence that the types of cannabis available in recreational and medical cannabis dispensaries might hold promise as an alternative treatment for PTSD.[8] Another study published in 2022 concluded, "phytocannabinoids derived from *Cannabis sativa* have therapeutic potential due to its anti-inflammatory, antioxidant, and neuroprotective properties, making the plant a study option to reduce and reverse inflammation and comorbidities associated with obesity."[9] Because of the countervailing effects marijuana legalization potential has on people's health, the effect on Florida's health care cost in indeterminate.

---

[5] Chan, Nathan W., Jesse Burkhardt, and Matthew Flyr. 2020. "The Effects of Recreational Marijuana Legalization and Dispensing on Opioid Mortality." *Economic Inquiry*, 58(2): 589-606.
[6] Retail Marijuana Public Health Advisory Committee. "Monitoring Health Concerns Related to Marijuana in Colorado: 2020 Summary." 2020.
[7] National Academies of Sciences, Engineering, and Medicine. "The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research." The National Academies Press: Washington, DC. 2017.
[8] Bonn-Miller MO, Brunstetter M, Simonian A, Loflin MJ, Vandrey R, Babson KA, Wortzel H (2022) The long-term, prospective, therapeutic impact of cannabis on posttraumatic stress disorder, *Cannabis and Cannabinoid Research* 7:2, 214–223.
[9] Cavalheiro EKFF, Costa AB, Salla DH, da Silva MR, Mendes TF, da Silva LE, da Rosa Turatti C, de Bitencourt RM, Rezin GT (2022) *Cannabis sativa* as a treatment for obesity: from anti-inflammatory indirect support to a promising metabolic re-establishment target, *Cannabis and Cannabinoid Research* 7:2, 135–151.

Local Water Utilities – June 26, 2023

Under current law and rule, cultivation facilities must be enclosed.[1] This can mean either nurseries inside buildings like warehouses, or greenhouse cultivation. Approximately 3% of Florida's irrigated acreage is categorized by FDACS as greenhouse/nursery, though that category accounts for approximately 7% of the demand until 2030.[2] According to national estimates for marijuana cultivation water usage, annual water efficiency (gallons/square foot) is higher, that is far more efficient, for outdoor cultivation. Despite this, the less frequent harvests (once per year versus up to five times a year) and lack of precise environmental control makes outdoor cultivation less water efficient than indoor and greenhouse cultivation per gram of grown.[3] Thanks to Florida's abundant ground water, agricultural water demand is overwhelmingly met by self-supply (wells, for example); agricultural water supply was long the largest water use category in the state and has only recently been surpassed by public supply.[4] Among the currently operating cannabis cultivation facilities, there are some that rely on municipal drinking water. In conversations with industry professionals, there are benefits to using water from a public utility despite the higher cost per gallon, such as proximity to customers, highways, and simplicity of use.

Among the facilities located, only 12 were in municipalities. Though being located in an unincorporated area is not a guarantee of self-supply, it is probable the majority of these rely on well water. Overall, given the prevalence of facilities relying on self-supply and the probability of any facilities in incorporated areas focusing on conservation, the impact of this amendment is indeterminate positive, with a small effect on municipal revenues.

---

[1] Section 381.981(8)(e)6.b. "When growing marijuana, a medical marijuana treatment center: … b. Must grow marijuana within an enclosed structure and in a room separate from any other plant."

[2] "Florida Statewide Agricultural Irrigation Demand: Estimated Agricultural Water Demand, 2020-2045", Florida Department of Agriculture and Consumer Services, 2022. https://www.fdacs.gov/content/download/105676/file/FSAID-IX-Water-Use-Estimates-Final-Report-ADA.pdf.

[3] "Cannabis H2O: Water Use & Sustainability in Cultivation," New Frontier Data, 2021, 40-41. https://f.hubspotusercontent10.net/hubfs/3324860/Reports/NFD-CannabisH2O.pdf

[4] EDR, "Annual Assessment of Florida's Water Resources: Supply and Demand," 2023, 10. http://edr.state.fl.us/Content/natural-resources/2023_AnnualAssessmentWaterResources_Chapter3.pdf.

Summary of Impact on Alcohol and Tobacco Use, June 26, 2023

There remains a question if the legalization of recreational marijuana impacts the consumption of alcohol and tobacco. There have been many studies done, in 2020 the *Journal of Psychopharmacology*[1] reviewed 65 articles that found, overall, the evidence regarding complementarity and substitution of cannabis and alcohol is mixed. Also in 2020, the *International Journal of Drug Policy*[2] reviewed per capita consumption of alcohol and cigarettes from all 50 states, based on state tax receipts, and found no evidence of a causal association between medical or recreational cannabis legalization and changes in either alcohol or cigarette sales per capita. While there are some older studies[3] that have found evidence that alcohol and marijuana are economically related, the studies cannot point to either a substitute or complementarity effect.

Because of the countervailing views on the effects of marijuana legalization has on the consumption of alcohol and tobacco, the impact on Florida's tax collection on these is indeterminate.

---

[1] Risso C, Boniface S, Subbaraman MS, Englund A. Does cannabis complement or substitute alcohol consumption? A systematic review of human and animal studies. Journal of Psychopharmacology. 2020;34(9):938-954. doi:10.1177/0269881120919970

[2] Veligati S, Howdeshell S, Beeler-Stinn S, Lingam D, Allen PC, Chen LS, Grucza RA. Changes in alcohol and cigarette consumption in response to medical and recreational cannabis legalization: Evidence from U.S. state tax receipt data. Int J Drug Policy. 2020 Jan;75:102585. doi: 10.1016/j.drugpo.2019.10.011. Epub 2019 Nov 15. PMID: 31739147; PMCID: PMC6957726.

[3] Guttmannova K, Lee CM, Kilmer JR, Fleming CB, Rhew IC, Kosterman R, Larimer ME. Impacts of Changing Marijuana Policies on Alcohol Use in the United States. Alcohol Clin Exp Res. 2016 Jan;40(1):33-46. doi: 10.1111/acer.12942. Epub 2015 Dec 21. PMID: 26727520; PMCID: PMC4700545.

A "black market" is defined as an underground economy where the transactions involve the exchange of illegal goods or services. The legal retail market authorized by the petition initiative will be directly competing with the existing black market. Ultimately, the number of people who convert is expected to be a function of both the price difference (if any) and the reduction of risk. In 2019, the FIEC principals for the petition initiative entitled *Regulate Marijuana in a Manner Similar to Alcohol to Establish Age, Licensing, and Other Restrictions* indicated that "the vast majority of the new legal market participants are already using and purchasing the product on the black market." Further, the principals found that half of Florida's black market would stay in the black market, while 47.5 percent would move to the legal retail market.[1]

Recent substitutability studies continue to support the earlier assumptions. In a study that came out in 2019, Amlung and MacKillop found that "the availability of legal cannabis substantially decreased demand for illegal cannabis," but that this finding was conditioned on price.[2] They further found that legal marijuana was a "superior good based on the qualities of regulated products," implying that even a marginally higher legal price would be acceptable under the right circumstances.

Contemporary academic work suggests that these circumstances will be largely colored by consumer perceptions about the developing legal market. According to a study already considered foundational by Fataar, Goodman, Wadsworth and Hammond:

> "Compared to illegal sources, at least one third of respondents perceived legal cannabis to be higher quality (37.6%) and safer to use (40.3%). More than half reported legal cannabis was more convenient to buy (59.2%) and safer to purchase (56.1%), whereas 30.6% of respondents perceived legal cannabis as more expensive. Perceptions varied according to the length of time since legal cannabis sales began: respondents living in more 'mature' legal markets were more likely to perceive legal cannabis as higher quality...less expensive...more convenient to buy...and safer to purchase..."[3]

A subsequent study by Robertson and Thyne indicated that a perception of safety (meaning variously: known potency; not laced; no pesticides; no drug dealers) was the main factor (63.1%) for the surveyed university students to switch to a legal market. The next highest factor (42.7%) was price when the legal product price was cheaper than the illegal product price. Conversely, a lower price was perceived to be the main reason

[1] See generally http://edr.state.fl.us/Content/constitutional-amendments/2020Ballot/MarijuanaRegulation_Report.pdf. The remainder (2.5 percent) would participate in the homegrown market contemplated by that initiative.
[2] Amlung, M., & MacKillop, J. (2019). Availability of legalized cannabis reduces demand for illegal cannabis among Canadian cannabis users: evidence from a behavioural economic substitution paradigm. Canadian Journal of Public Health, 110, 216–221. https://doi.org/10.17269/s41997-018-0160-4
[3] Fataar, F., Goodman, S., & Wadsworth, E. & Hammond, D. (2021). Consumer perceptions of 'legal' and 'illegal' cannabis in US states with legal cannabis sales. Addictive Behaviors, 112, 106563. https://doi.org/10.1016/j.addbeh.2020.106563

(66.4%) to stay in the black market. Because price is the chief barrier to the conversion, it is considered to be the "primary driver of choice between sources."[4]

A more recent analysis of surveys that were conducted among a broader class of cannabis users living in legal markets in Canada and the United States found that "higher prices and inconvenience of legal sources were common barriers to purchasing legal cannabis."[5] The percentage of respondents citing the inconvenience of legal sources seemed to diminish over time as the relevant local legal market matured.

While the new studies are increasingly based on experience rather than theory, they have not fundamentally altered the assumptions that led the FIEC principals in 2019 to conclude that the majority of the new legal market participants will come from the black market—even though about one-half of the black market would continue to exist. This is not inconsistent with the 2021 Cannabis Report for the United States which found that in states where marijuana is legal, consumers purchased 76% of all cannabis products from a legal retail source.[6]

[4] Robertson, K., & Thyne, M. (2021). Legalization of recreational cannabis: facilitators and barriers to switching from an illegal to a legal source. Preventive Medicine Reports, Volume 24, 2021, 101639. https://doi.org/10.1016/j.pmedr.2021.101639
[5] Goodman, S., Wadsworth, E., & Hammond, D. (2022). Reasons for purchasing cannabis from illegal sources in legal markets: findings among cannabis consumers in Canada and U.S. States, 2019–2020. Journal of Studies on Alcohol and Drugs, 2022, 83:3, 392-401. https://doi.org/10.15288/jsad.2022.83.392. The study used data from cannabis users aged 18 to 65, but the respondents from the legal states in the U.S. were limited to the age bracket 21 to 65.
[6] Hammond, D., Corsetti, D., Goodman S., Iraniparast, M., Danh Hong, D., & Burkhalter, R., on behalf of the ICPS Research Team. (September 2022). International Cannabis Policy Study – United States 2021 Summary. http://cannabisproject.ca/wp-content/uploads/2022/10/2021-ICPS-US-National-Report-Sept-27-1.pdf

Financial Impact Estimating Conference on Adult Personal Use of Marijuana (22-05)

Analysis of the Potential Impact on Sales Tax of the Proposed Constitutional Amendment July 12, 2023

I. Regulatory framework of the Florida medical Marijuana market

A few milestones in the program's development are:

- As of March 2019, patients who have discussed smokable flower with their physician and received the proper recommendation can purchase whole flower and smoking related accessories.
- As of August 2020, patients are able to buy edibles.
- Effective 8/29/22 , maximum purchasing/ dispensing limit are:
  - Flower (smokable): 2.5oz within (every) 35 days. **The law does not specify the potency of smokable and does not have limits on it.**
  - For nonsmokable marijuana: 70-day total supply limit of 24,500 mg of THC.
  - Possession of medical marijuana is up to 4 oz of flower.

The Florida Department of Health has promulgated rules about the daily THC dosage limits. These are determined by type of product and detailed in the table below.

Type of Marijuana Product	Daily Dosage Limit (mg)	Converted to Weekly Dosage (mg)	Converted to 70-day Supply (mg)
edibles	60	420	4200
vaporization	350	2450	24500
capsules and tinctures	200	1400	14000
sublingual tinctures	190	1330	13300
suppositories	190	1330	13300
topicals	150	1050	10500
Florida law 70-day limit			**24500**

Research from the International Cannabis Policy Study found that daily consumers accounted for 87% of all dried flower consumed due to more frequent consumption and higher consumption amounts on days of use compared to non-daily consumers, consistent with prior studies[1].

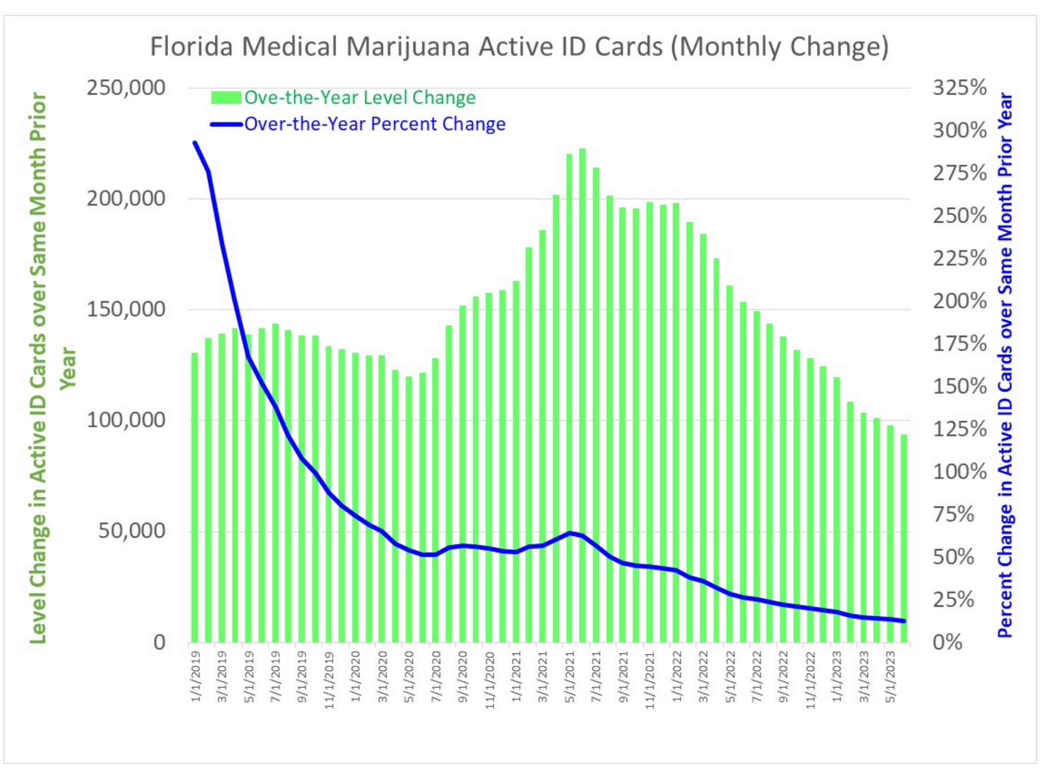
[1] Trends in the use of cannabis products in Canada and the USA, 2018 –2020: Findings from the International Cannabis Policy Study, International Journal of Drug Policy, David Hammond, Samantha Goodman, Elle Wadsworth, Tom P Freeman, Beau Kilmer, Gillian Schauer, Rosalie Liccardo Pacula, Wayne Hall, 105 (2022) 103716.

II. Florida medical marijuana program statistics

There are currently 828,560 Qualified Patients (Active ID Card) in the Florida Medical Marijuana registry. The adopted impact of SB 8A (2017A), implementing Amendment 2 "Use of Marijuana for Debilitating Medical Conditions" (article X, section 29 of the Florida Constitution), estimated that there will be 349,503 patients as of June 2022 (the last forecasted month).

There are 578 dispensing locations in Florida owned by 22 licensed Medical Marijuana Treatment Centers (MMTCs). Deliveries from the MMTCs are also authorized by law. Over 93 percent of Florida's total population lives within 10 miles of a Medical Marijuana Treatment Center dispensing location according to 2020 Census data tabulated by the Florida Legislature, Office of Economic and Demographic Research (EDR).

The graph below shows the growth in the number of medical marijuana active ID cards over the same month prior year from January 2019 to the present on the left axis and the corresponding percent change in IDs over the same month prior year.



The tables below show the age profile and qualifying condition profile of holders of ID cards.

Age breakout for current patients with active cards in the OMMU Registry

Age Bracket	Active Patient Cards
1-17	805
18-24	53,912
25-54	468,818
55-64	146,468
65+	157,058
Total	**827,061**

Numbers as of 6/19/2023

Number of medical marijuana patients by type of qualifying condition
Patients may have 1 to 5 medical conditions

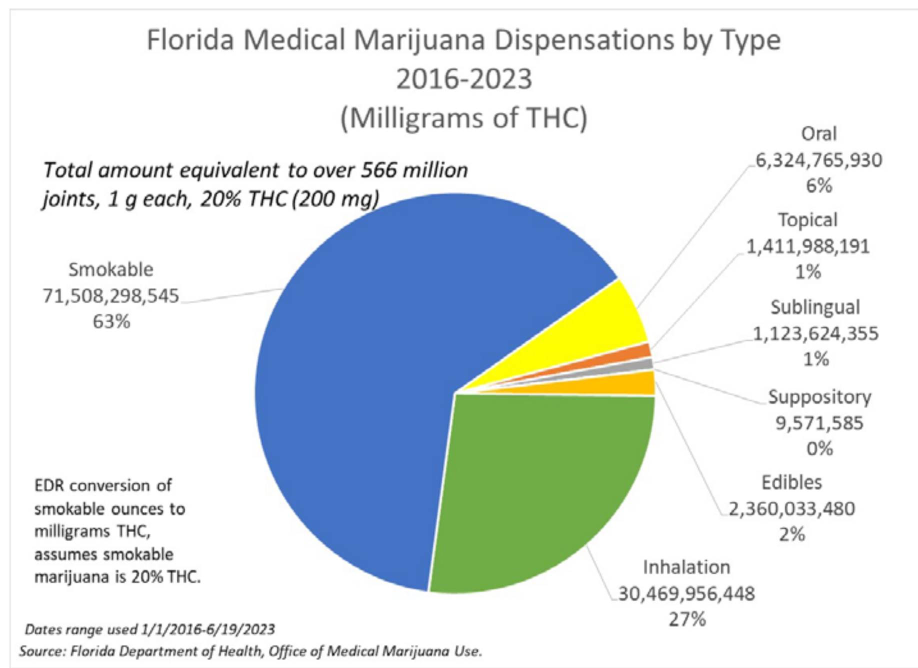
Qualifying Condition	Number of Distinct Patients with Conditions
Cancer	115,641
Epilepsy	31,214
Glaucoma	23,270
HIV Positive	17,868
AIDS	5,354
PTSD	893,883
ALS	16,040
Crohn's	51,541
Parkinson's	17,208
MS	277,587
Same Kind or Class	702,609
Terminal Condition	9,318
Chronic Nonmalignant Pain	447,727

**Dates range used 1/1/2016-6/19/2023*

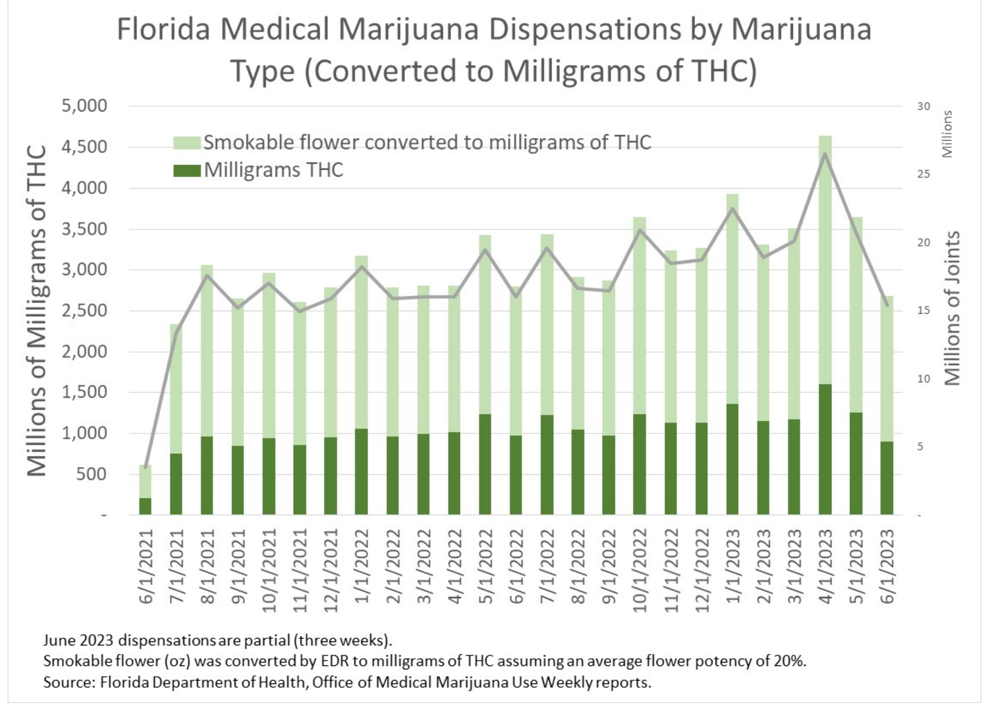
Florida Medical Marijuana Dispensations

Florida Medical Marijuana Dispensations were based on published reports from the Florida Department Health. The reported ounces of smokable medical marijuana dispensed were converted to milligrams of THC by EDR assuming an average potency of 20%, e.g. one gram of flower contains 200 mg of THC active substance. Florida law does not limit the amount of purchases of medical marijuana according to its potency and the DOH registry does not record the milligrams of THC dispensed per each ounce dispensed. EDR made the 20% potency assumption based on research and consistent with the prior impact for the proposed constitutional amendment “Regulate Marijuana in a Manner Similar to Alcohol to Establish Age, Licensing, and Other Restrictions” from 2019. Based on website research, the actual potency of medical marijuana dispensed in Florida may be even higher. However, the stated potency of marijuana based on THC [-9] alone does not necessarily correlate with the psychoactive effect of the product.

The chart on the following page shows the share each of the dispensed products accounts for in the total milligrams of THC dispensed. Smokable marijuana (joints, blunts, etc.) accounts for 63 percent of the total milligrams of THC dispensed.



The graph below shows milligrams of THC dispensed by month on the left axis and a millions-of-joints equivalent (converted by EDR) on the right axis. Again, smokable marijuana holds a dominant share.

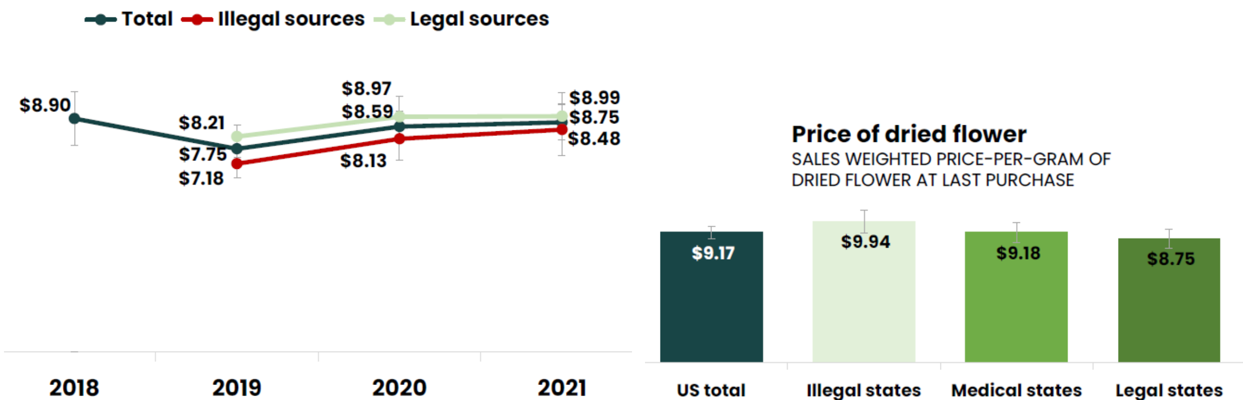


The graph shows total dispensations of over 3,056 million of milligrams of THC (or 3,056,758,968 milligrams of THC) in August 2021. This comprises 965,414,878 milligrams of THC in non-smokable marijuana and 2,091,344,090.40 milligrams of THC in smokable marijuana, converted using a 20% potency assumption. This is approximately equivalent to over 17 million joints dispensed for the month. There were over 600,000 active ID cards in the medical marijuana registry in that month. In April 2023, dispensations reached a high of 4,637,984,806 mg of THC or an equivalent of 26.5 million joints.

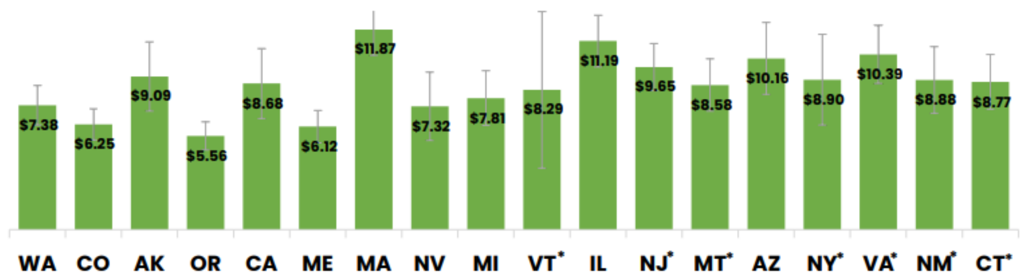
III. Marijuana Prices

This analysis used prices from the 2021 International Cannabis Policy Study (ICPS) of the US market as shown below. These prices were cross-checked against prices at Florida MMTC websites. Current Florida prices may sometimes be even lower that the 2021 ICPS prices. The research discovered a number of “sales” of marijuana on various websites. There are multiple reports that marijuana prices have been falling across the country since the early years of legalization.[2]

Price paid for dried flower
SALES WEIGHTED PRICE-PER-GRAM OF DRIED FLOWER AT LAST PURCHASE, LEGAL STATES ONLY, 2018-2021, n=9,700



Price of Dried Flower (Marijuana) in Recreational Sales States
Sales-Weighted Price-per-Gram of Last Purchase
Among ‘legal’ states 2021



* STATES IN WHICH LEGAL RETAIL STORES HAVE YET TO OPEN

Source: United States, 2021 CANNABIS REPORT, International Cannabis Policy Study, September 2022, https://cannabisproject.ca/wp-content/uploads/2022/10/2021-ICPS-US-National-Report-Sept-27-1.pdf .

[2] Marijuana growers are between a rock and a hard place as they face oversupply and interstate commerce woes: ‘I'm tired of running a failing business’, Fortune, April 19, 2023, https://fortune.com/2023/04/19/marijuana-growers-hurting-oversupply-no-interstate-commerce/ .

IV. Florida Medical Marijuana Sales (EDR Estimate)

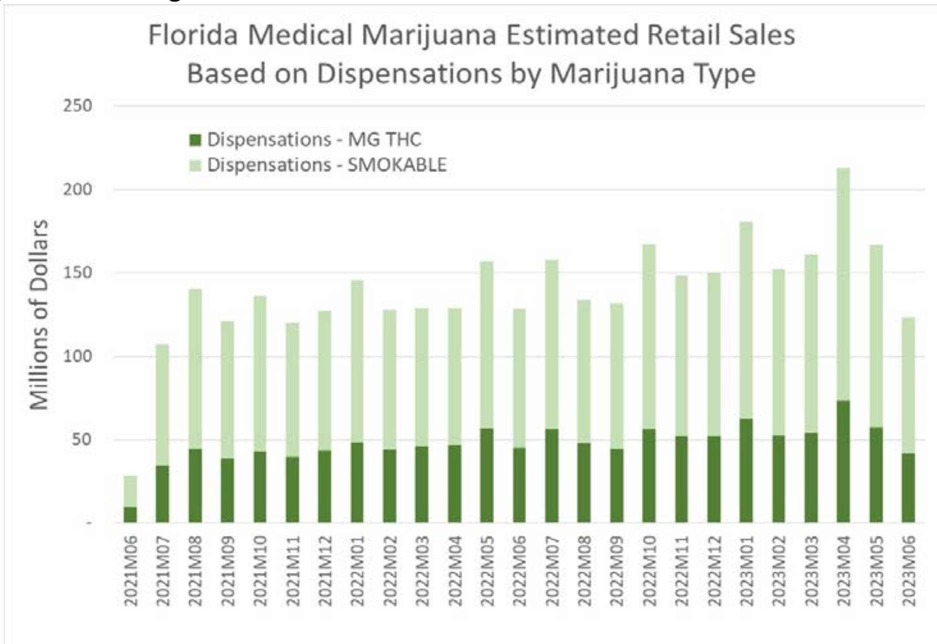
Sales of medical marijuana and accessories are exempt from sales tax in Florida. DOH, the agency regulating medical marijuana, only publishes data on the milligrams of THC or the ounces of smokable marijuana dispensed. EDR estimated the equivalent retail sales associated with the reported quantity of medical marijuana dispensations as follows.

1. The smokable marijuana, reported in ounces, was converted to grams, aggregated to monthly dispensations, and multiplied by a price of $9.18 per gram, the reported average price per gram of flower in 2021 in medical states in the US in the ICPS study.
2. The non-smokable marijuana, reported in milligrams of THC, was aggregated into months, and it was multiplied by a price of $0.0459 per mg of THC. This price was derived from the ICPS study medical price of $9.18/ gram of flower, assuming 20% potency (200 mg of THC per 1 gram of flower). The price of concentrates may be higher due to the extended processing required. On the other hand, concentrates may be extracted from any part of the plant, so the raw ingredients may not be as expensive as flower, which is the most expensive part of the marijuana plant.
3. This analysis excludes any sales of cannabis products derived from hemp as they are not regulated as medical marijuana.

Florida Medical Marijuana Sales ($)

FL_FY Ending	Retail Sales ($)
2022	1,570,146,649
2023	1,886,948,132
Average of FY 2022&2023	1,728,547,390

Florida medical marijuana retail sales are estimated by EDR at $1.7 billion dollars on average for fiscal years 2022 and 2023. The chart below shows the retail sales estimate by month with smokable marijuana again dominating sales for medical use.



Source: Florida Department of Health, Office of Medical Marijuana Use and Florida Legislature, Office of Economic and Demographic Research.

V. Florida Recreational Marijuana Sales: EDR Estimate Using States with Recreational Programs

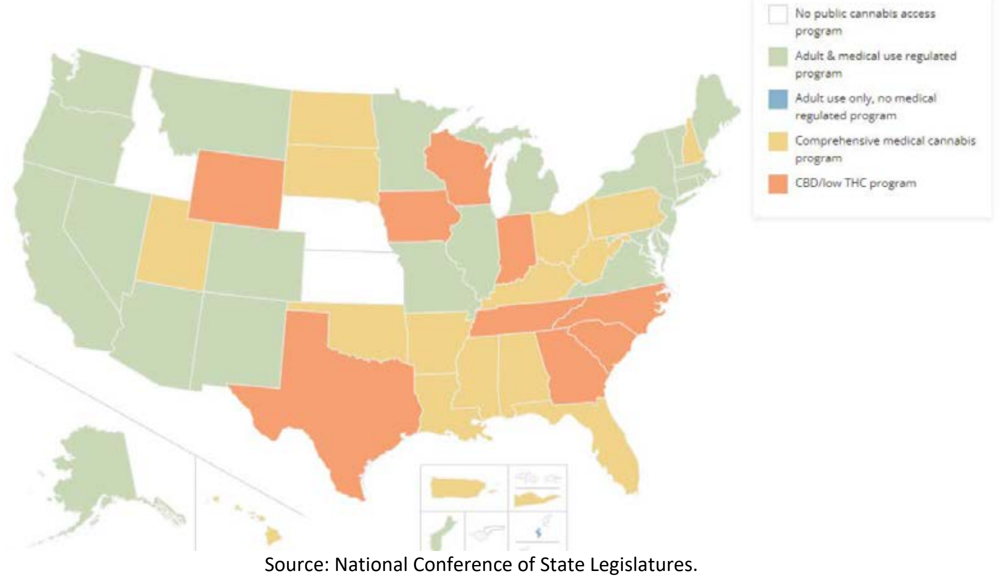
There are 23 states and the District of Colombia that have "legalized" the recreational use of marijuana. Cannabis is still illegal under federal law. Four of these do not levy sales tax but may impose other marijuana taxes. Sales data was found for Arizona, California, Colorado, Massachusetts, Michigan, Nevada, New Jersey, Oregon, and Washington. The analysis focuses on these nine states.

States with Decriminalized Recreational Marijuana

States with Recreational Marijuana

Row Labels	Home grow allowed?*	Year recreational sales authorized
No Sales Tax		
Alaska	Yes	10/1/2016
Oregon	Yes	10/1/2016
Montana		1/1/2022
Delaware		4/21/2023
Taxable (Sales Tax)		
Missouri		
Colorado	Yes	1/1/2014
District of Columbia	Yes	1/1/2014
Washington		7/1/2014
Nevada	Yes	1/1/2017
California	Yes	1/1/2018
Massachusetts	Yes	11/1/2018
Michigan	Yes	12/6/2019
Minnesota	Yes	8/1/2023
Illinois		1/1/2020
Maine	Yes	10/9/2020
Arizona	Yes	1/16/2021
Connecticut		7/1/2021
New Mexico		4/1/2022
New Jersey		4/21/2022
Vermont	Yes	10/1/2022
Rhode Island		12/1/2022
Maryland		7/1/2023
Virginia		1/1/2024
Taxable Until April 1, 2022		
New York		4/1/2022

Medical and Recreational Cannabis Programs by State (NCSL)



Source: National Conference of State Legislatures.

The analysis aimed to collect retail sales or taxable sales for each of the focus states. Some retail sales may contain wholesale or other types of taxes built into the retail marijuana price. Similarly to alcohol and tobacco, states impose various taxes on marijuana to discourage its use. Taxes may account for 20 to 40 percent of the final retail price of the product.

A number of states mandated seed-to-sales marijuana tracking systems that record each seed planted, each plant grown down to the retail sale. The vendor typically used for the system is METRC. These states publish especially detailed monthly sales data and some of them were included in the analysis even if they did not levy sales tax.

First, sales tax data (taxable retail sales) was collected for recreational and medical marijuana at the lowest periodicity available (monthly). For some states, only quarterly data were available. EDR estimated monthly sales from the quarterly data and sometimes interpolated missing data. Data were generally available through the first quarter of 2023 and for some months of the second quarter of calendar 2023. Data for the missing months of the second quarter of 2023 were estimated by EDR to create a full fiscal year of sales. Data were aggregated to create Florida fiscal years. Some states, such as California, do not tax medical sales and do not collect medical sales data. When possible, excise sales were deducted from the final retail sales (California). The NCSL documents list more details about the marijuana tax structure in each state.

For Nevada, total marijuana sales were found and their recreational taxable sales were calculated using reported excise tax collections only levied on recreational marijuana based on information received from the Nevada Legislature. The remaining taxable sales after recreational taxable sales were subtracted from total sales could include medical marijuana sales as well as paraphernalia and other tangible personal property sold at marijuana stores.

Recreational Marijuana Taxable Retail Sales in Select States

RECREATIONAL SALES									
	State								
FL_FY	Arizona	California	Colorado	Massachusetts	Michigan	Nevada	New Jersey	Oregon	Washington
2014	-	-	114,271,386	-	-	-	-	-	-
2015	-	-	439,872,176	-	-	-	-	-	297,533,000
2016	-	-	700,249,462	-	-	-	-	-	580,026,000
2017	-	-	998,628,410	-	-	-	-	212,675,200	841,289,000
2018	-	849,490,373	1,157,431,174	-	-	424,892,017	-	524,270,520	964,394,000
2019	-	2,060,910,818	1,289,422,644	183,656,708	-	551,849,150	-	645,416,039	1,038,705,000
2020	-	3,150,274,128	1,527,839,808	503,777,269	165,417,535	604,102,730	-	859,863,586	1,251,780,000
2021	249,073,886	4,915,632,609	1,906,902,729	1,072,008,236	901,262,908	921,382,860	-	1,095,955,751	1,484,022,000
2022	774,920,407	4,974,829,295	1,675,532,452	1,445,502,813	1,634,635,923	892,790,874	79,698,831	1,001,035,122	1,347,165,000
2023	971,233,086	4,500,926,374	1,465,394,008	1,524,491,732	2,524,938,643	794,755,224	547,668,971	896,717,108	1,211,301,192

With updated Nevada data.

Second, per capita sales estimates were calculated for each of the select states by dividing taxable sales in each state by its population 21 and over. Since recreational marijuana is often only available to the population 21 years of age and over, only this population group was included in the calculation of the per capita sales. The US Census Bureau's Population Estimates by single year of age were used for each state, including Florida.

Per Capita Recreational Marijuana Taxable Retail Sales in Select States

PER CAPITA RECREATIONAL MARIJUANA SALES, POPULATION 21 AND OVER ($)									
	State								
FL FY Ending in:	Arizona	California	Colorado	Massachusetts	Michigan	Nevada	New Jersey	Oregon	Washington
2014	0	0	30	0	0	0	0	0	0
2015	0	0	114	0	0	0	0	0	58
2016	0	0	177	0	0	0	0	0	111
2017	0	0	247	0	0	0	0	69	157
2018	0	30	282	0	0	195	0	168	176
2019	0	72	308	35	0	247	0	204	187
2020	0	109	360	96	22	264	0	269	222
2021	47	170	447	202	120	400	0	340	260
2022	144	172	388	272	218	382	12	308	234
2023	178	156	336	286	335	335	79	276	208

With updated Nevada data.

Third, the per capita recreational retail sales for the population 21 and older from each of the select states were multiplied by the respective Florida population 21 and over for the respective year to produce a range of estimates of recreational marijuana sales based on the various experiences in each state and for varying historical periods as authorized.

Florida Recreational Retail Sales Estimates Using per Capita Sales from Select States

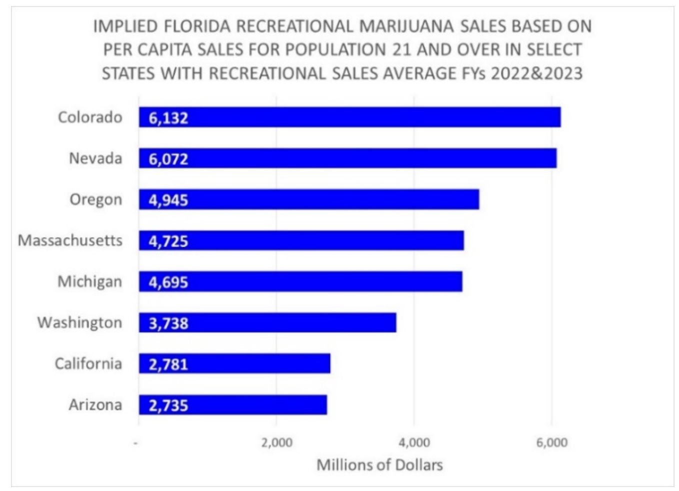
FLORIDA RECREATIONAL MARIJUANA SALES BASED ON PER CAPITA SALES FOR POPULATION 21 AND OVER									
	State								
FL FY Ending:	Arizona	California	Colorado	Massachusetts	Michigan	Nevada	New Jersey	Oregon	Washington
2014	-	-	445,228,565	-	-	-	-	-	-
2015	-	-	1,712,157,972	-	-	-	-	-	869,196,572
2016	-	-	2,718,808,964	-	-	-	-	-	1,698,147,430
2017	-	-	3,881,886,446	-	-	-	-	1,086,293,697	2,466,016,557
2018	-	474,954,967	4,508,370,406	-	-	3,114,418,940	-	2,684,532,784	2,822,246,581
2019	-	1,162,636,321	5,006,974,931	573,129,184	-	4,015,225,080	-	3,314,220,449	3,036,333,523
2020	-	1,795,730,244	5,922,712,925	1,587,270,840	366,175,260	4,354,429,813	-	4,425,549,593	3,656,450,503
2021	781,853,874	2,807,172,920	7,385,127,715	3,333,971,043	1,987,535,735	6,609,957,025	-	5,617,136,380	4,286,957,490
2022	2,421,508,655	2,890,022,071	6,509,377,776	4,555,172,616	3,646,994,583	6,403,112,133	193,240,117	5,165,134,326	3,913,335,690
2023	3,048,098,267	2,671,842,465	5,754,437,226	4,895,774,021	5,742,898,855	5,739,937,326	1,353,861,945	4,725,027,445	3,562,003,038
AVERAGE FYs 2022&2023	2,734,803,461	2,780,932,268	6,131,907,501	4,725,473,319	4,694,946,719	6,071,524,729	773,551,031	4,945,080,886	3,737,669,364

With updated Nevada data.

New Jersey was excluded from the analysis since its program started operating fairly recently.

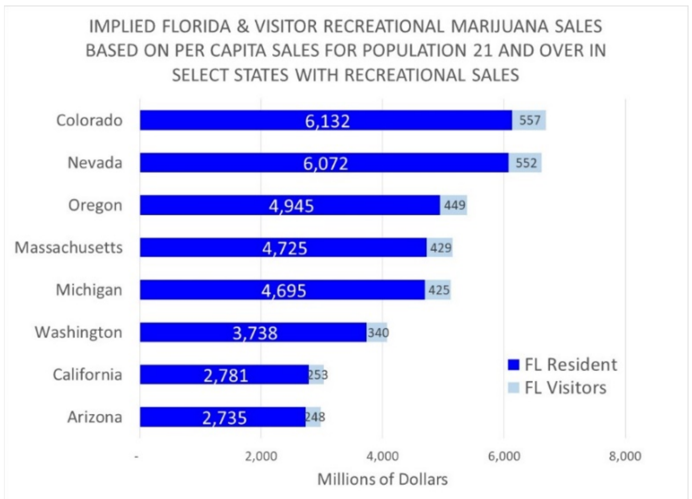
The last two fiscal years, 2022 and 2023 were averaged. The per capita (21 and over) for the select states applied to Florida's population of the same age produces a range of estimates of the potential market size of the Florida recreational market. Since most of these markets would be considered mature, they provide insights to what a mature Florida market would look like depending on the regulatory structure adopted. Judging by tax collections for these states, maturing may take several years. Many states also took several years to establish the regulatory framework and did not allow recreational retail sales immediately after a ballot initiative had been approved by the voters. All of the select states already had medical programs. The interplay of the regulatory and tax frameworks of the medical and recreational programs as well as the regulatory framework for growing marijuana at home or in "gardens" may account for differences in per capita retail sales.

At the high end, Colorado's market, with 10 years of recreational sales, suggests that Florida recreational sales may top $6 billion when matured. Of note is that Colorado's neighboring states, Kansas, Nebraska, and Wyoming, have neither medical nor recreational marijuana and Wyoming has only CBD/ low THC cannabis. Colorado has been accused in the past of allowing marijuana to leave its boundaries. At the low end, Arizona's experience, with three years of recreational sales, suggests that Florida's market may be over $2.7 billion when mature. To emphasize, retail sales include a layer of upstream taxation that, if excluded, may significantly reduce the estimate for retail sales in Florida since the current regulatory framework does not have in place taxes other than sales tax.



With updated Nevada data.

Since Florida has a significant number of visitors each year and the constitutional amendment does not explicitly prohibit the use by visitors, an estimate of potential visitor sales is developed using the same methodology applied to the FTE Tourists estimate from the FEEC. To the extent to which tourists are allowed to or do use recreational marijuana, sales to tourists may be embedded in the reported retail sales by state. Also, to the extent to which there is diversion to other states or to the black market, these would also be embedded in reported sales.



With updated Nevada data.

The approach above relies on actual sales data over several years across various states. All of the above states had medical programs prior to the passage of recreational marijuana decriminalization and continued to have such programs. All states experienced either stagnation or decline in their medical patients. The use of FYs 2022 and 2023 may still somewhat overestimate sales due to the "COVID" swell effect of temporary much higher consumption observed across some states. However, these two years also are the best available years to take into account the evolution of the medical programs relative to the recreational ones. In addition, these two years are the best available years to incorporate the evolution of the black market relative to the "legalized" market. The per capita sales calculated in this approach already reflect the experience of a number of states with declining medical patients, conversion from the black market, and a resistance level, beyond which the black market continues to coexist. One caveat of this approach is the potential overestimation of retail sales due to multiple levels of taxation included in the supply chain.

The table below shows the resulting estimated state sales tax collections (6 percent) based on the estimated range from eight states out of the nine initial states with recreational marijuana. As discussed above, since the year used form other states is assumed to be a "steady state" year, no further assumptions are made to reduce these collections due to medical sales and continued black market sales. This analysis does not take into account the potential interaction of the hemp and recreational marijuana markets.

FLORIDA RECREATIONAL MARIJUANA SALES TAX COLLECTIONS Average of FY 2022 and 2023			
State	**FL Resident**	**FL Visitors**	**Total**
Arizona	164,088,208	14,886,254	178,974,462
California	166,855,936	15,159,505	182,015,441
Washington	224,260,162	20,376,405	244,636,567
Michigan	281,696,803	25,529,398	307,226,201
Massachusetts	283,528,399	25,741,219	309,269,618
Oregon	296,704,853	26,958,130	323,662,984
Nevada	364,291,484	33,102,126	397,393,610
Colorado	367,914,450	33,433,541	401,347,991

EDR Estimate; with updated Nevada data.

VI. Florida Medical Sales Estimation Based on Medical Sales in Recreational States

The collected data on medical marijuana sales for the same recreational states above was used to calculate per capital medical sales and to apply these to Florida's population. The missing months in the second quarter of 2023 were estimated by EDR to complete the fiscal year. Since the medical sales trends were typically downward month-over-month, the missing months were generally estimated to maintain the sales of the last actual month rather than further decline. These estimates are compared to the EDR estimates derived from medical marijuana dispensations.

Medical Marijuana Taxable Retail Sales in Select States

MEDICAL MARIJUANA SALES									
	State								
FL_FY	Arizona	California	Colorado	Massachusetts	Michigan	Nevada	New Jersey	Oregon	Washington
2014	-	-	193,094,556	-	-	-	-	-	-
2015	-	-	380,297,967	-	-	-	-	-	117,902,000
2016	-	-	444,050,728	-	-	-	-	-	78,078,000
2017	-	-	437,447,331	-	-	-	12,253,372	34,883,667	9,647,000
2018	-	-	371,065,316	-	-	104,959,228	40,283,715	70,000,240	12,086,000
2019	-	-	331,593,893	23,248,023	127,390,685	87,186,440	68,911,989	60,608,720	12,415,000
2020	-	-	380,787,727	205,484,838	377,854,480	80,856,421	106,555,510	89,539,103	14,623,000
2021	380,219,697	-	455,164,011	307,233,694	529,962,643	82,084,805	151,512,726	113,589,517	17,306,000
2022	689,326,045	-	310,251,250	296,587,712	377,054,173	72,300,249	209,103,514	78,962,047	14,613,000
2023	386,011,155	-	205,863,370	247,678,785	151,352,155	48,525,210	174,016,559	55,443,352	12,395,111

EDR Estimate; with updated Nevada data.

Per Capita Medical Marijuana Taxable Retail Sales in Select States

PER CAPITA MEDICAL MARIJUANA SALES POPULATION 21 AND OVER									
	State								
FL FY Ending in:	Arizona	California	Colorado	Massachusetts	Michigan	Nevada	New Jersey	Oregon	Washington
2014	0	0	51	0	0	0	0	0	0
2015	0	0	98	0	0	0	0	0	23
2016	0	0	112	0	0	0	0	0	15
2017	0	0	108	0	0	0	2	11	2
2018	0	0	90	0	0	48	6	22	2
2019	0	0	79	4	17	39	10	19	2
2020	0	0	90	39	51	35	16	28	3
2021	72	0	107	58	71	36	22	35	3
2022	129	0	72	56	50	31	30	24	3
2023	71	0	47	46	20	20	25	17	2

EDR Estimate; with updated Nevada data.

Florida Medical Retail Sales Estimates Using per Capita Sales from Select States

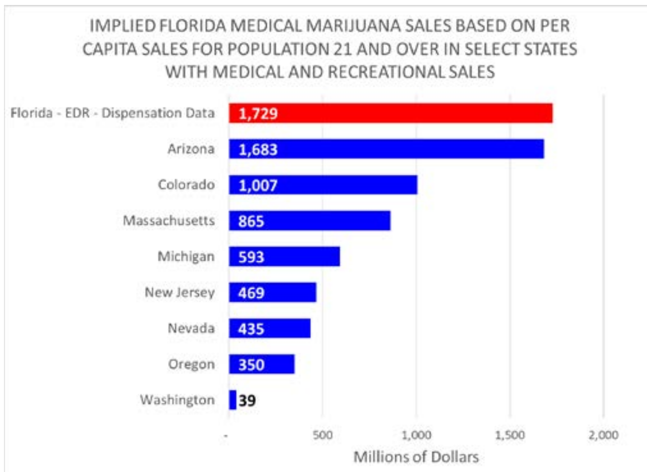
FLORIDA MEDICAL MARIJUANA SALES BASED ON PER CAPITA SALES FOR POPULATION 21 AND OVER IN "LEGAL" RECREATIONAL STATES									
	State								
FL FY Ending in:	Arizona	California	Colorado	Massachusetts	Michigan	Nevada	New Jersey	Oregon	Washington
2014	-	-	752,342,429	-	-	-	-	-	-
2015	-	-	1,480,271,387	-	-	-	-	-	344,432,430
2016	-	-	1,724,084,295	-	-	-	-	-	228,589,675
2017	-	-	1,700,453,190	-	-	-	29,262,844	178,177,370	28,277,633
2018	-	-	1,445,355,823	-	-	769,341,369	97,695,486	358,436,973	35,369,022
2019	-	-	1,287,616,841	72,549,054	278,910,392	634,363,903	169,322,752	311,226,629	36,291,421
2020	-	-	1,476,134,069	647,429,155	836,434,674	582,820,757	265,006,372	460,840,240	42,713,796
2021	1,193,526,339	-	1,762,777,043	955,504,076	1,168,715,236	588,872,506	363,516,376	582,183,916	49,992,578
2022	2,154,039,265	-	1,205,313,923	934,628,568	841,235,964	518,538,680	506,998,497	407,427,840	42,448,827
2023	1,211,449,599	-	808,402,269	795,399,106	344,246,034	350,462,201	430,176,638	292,144,932	36,449,583
AVERAGE FYs 2022&2023	1,682,744,432	-	1,006,858,096	865,013,837	592,740,999	434,500,441	468,587,568	349,786,386	39,449,205

EDR Estimate; with updated Nevada data.

Comparison of Florida sales estimates based on dispensations and estimates based on per capita medical sales in other states suggest that there is a significant number of medical patients that may choose to go the recreational route rather than maintain their registry cards. However, the transition of medical patients to the recreational program may be influenced by the regulatory framework that will be set up in Florida if the proposed amendment passes. The price differential between medical and recreational due to the tax regimes of each, the ease and cost of the medical program, the perceived "defense" (however not statutory) a medical ID card may give an employee are factors that may affect Florida patients in different ways.

California was excluded from further analysis since the state does not collect medical marijuana data.

Based on marijuana retail sales in states with recreational marijuana programs, it is estimated that if recreational sales are decriminalized in Florida, sales for medical use may range from $39 million to 1.68 billion annually. In comparison, based on current marijuana dispensations data, EDR estimates that sales for medical use are approximately $1.7 billion annually.



EDR Estimate; with updated Nevada data.

Based on per capital retail sales data from select states with marijuana decriminalized for medical and recreational use, it is estimated that if the proposed constitutional amendment is approved by voters and if medical marijuana is taxable in Florida, sales tax collections may potentially be in the range of $2 million to $101 million. In comparison, current marijuana for medical use dispensations suggest that sales tax collections may potentially be approximately $104 million if the sales tax exemption in current law did not exist.

FLORIDA MEDICAL MARIJUANA SALES TAX COLLECTIONS
IF TAXABLE, Average of FY 2022 and 2023, Florida Residents

State	Taxable Sales	Sales Tax Collections	
		State 6%	Local Option
Washington	39,449,205	**2,366,952**	**286,474**
Oregon	349,786,386	**20,987,183**	**2,540,091**
Nevada	434,500,441	**26,070,026**	**3,155,270**
New Jersey	468,587,568	**28,115,254**	**3,402,805**
Michigan	592,740,999	**35,564,460**	**4,304,387**
Massachusetts	865,013,837	**51,900,830**	**6,281,587**
Colorado	1,006,858,096	**60,411,486**	**7,311,636**
Arizona	1,682,744,432	**100,964,666**	**12,219,810**
Florida - EDR - Dispensations	1,728,547,390	**103,712,843**	**12,552,424**

VII. Sales Tax Estimation Scenarios Based on Legal Recreational States' Experiences

Florida recreational marijuana retail sales (or market size) were estimated based on the average sales from nine states, Arizona, California, Colorado, Massachusetts, Michigan, Nevada, New Jersey, Oregon, and Washington as available from FY 2013-14 forward. The last two fiscal years of data, 2021-22 and 2022-23, were chosen for further analysis to avoid the ramp-up periods in each state and focus on more mature stages of the markets associated with more steady-state level of per capita expenditures on the product. Due to the timing of the analysis, the last quarter of FY 2022-23 was partially or entirely estimated by EDR to create full fiscal year sales. Sales for these last two fiscal years were averaged. New Jersey was excluded from the group due to the nascent state of the program and lack of a full fiscal year of reported actual sales. This resulted in eight unique estimates of a potential Florida market size in a mature stage of development. The ramp-up period is not estimated in this analysis. To develop the estimate, the conference considered several scenarios and made the following further adjustments.

- As noted above, New Jersey was excluded from the analysis for lack of sufficient historical data.
- The conference attempted to exclude programs without sufficient history prior to the coronavirus pandemic or those enacted during the pandemic to avoid the period of increased marijuana use observed during the "safer-at-home" periods of the pandemic. As a result, Arizona and Michigan were excluded due to insufficient maturity of the programs or enactment during the pandemic, which would have skewed use to the high side.
- The conference preserved Nevada in the analysis as further data was obtained via NCSL from the Nevada Legislature to help EDR estimate recreational sales in that state.

Several scenarios for potential sales tax collections were calculated assuming the proposed constitutional amendment will pass. The calculations for these scenarios are an average of FY 2021-22 and FY 2022-23. The market is assumed to be at a mature stage, e.g. sales have passed the initial period of ramp-up.

I. Average of the estimates based on the complete series of eight states (eight unique states, after excluding New Jersey).
II. Average of the estimates for six unique states, after excluding Arizona and Michigan.
III. Average of the low and high, California and Colorado respectively, after excluding Arizona.
IV. Average of three states, California, Colorado, and Nevada, considered similar to Florida in terms of a high-tourism profile.
V. Minimum size equivalent to California's realized sales, after Arizona was excluded.
VI. Maximum size equivalent to Colorado's realized sales.

The average of FY 2021-22 and FY 2022-23 from the five scenarios above was grown to FY 2025-26 by the growth rate in population 21 and over estimated for this analysis using data consistent with the FDEC 202302. If the proposed amendment passes, FY 2025-26 will be the first full year of implementation. For the purposes of this analysis, it is assumed that a level of recreational sales associated with a mature recreational market is possible immediately after decriminalization.

Florida sales tax collections were developed within the existing taxing framework under the assumption that the current state and local sales tax rates on Tangible Personal Property will apply if the proposed constitutional amendment passes. No assumption was made about any future legislative action that may impose a different sales tax rate or a different tax structure, for example, an excise tax. These estimates are also colored by the assumed continued existence of the marijuana black market gleaned from experience in other recreational states that have not been able to eliminate the black market despite decriminalizing recreational marijuana.

These revenue estimates do not take into account the effect of observed continued falling prices in the marijuana market and the effect of products sold "on sale" at a discounted price resulting from a market glut. On the

contrary, it is assumed that the average price of marijuana observed in 2021 will remain the same in FY 2025-26. Considering recent price developments, no price growth adjustment is made.

FLORIDA RECREATIONAL MARIJUANA STATE AND LOCAL SALES TAX COLLECTIONS						
ESTIMATES FOR A MATURE MARKET STAGE						
Average of FY 2021-22 and FY 2022-23						
Scenarios	**I.**	**II.**	**III.**	**IV.**	**V.**	**VI.**
	Eight-State Average	**Six-State Average**	**Low-High Range**	**Tourism States**	**At Least**	**Maximum**
State	**FL Resident**	**FL Resident**	**FL Resident**	**FL Resident**	**FL Resident**	**FL Resident**
Arizona	164,088,208					
California	166,855,936	166,855,936	166,855,936	166,855,936	166,855,936	
Washington	224,260,162	224,260,162				
Michigan	281,696,803					
Massachusetts	283,528,399	283,528,399				
Oregon	296,704,853	296,704,853				
Nevada	364,291,484	364,291,484		364,291,484		
Colorado	367,914,450	367,914,450	367,914,450	367,914,450		367,914,450
STATE Sales Tax	**268,667,537**	**283,925,881**	**267,385,193**	**299,687,290**	**166,855,936**	**367,914,450**
Local Option Sales Tax	**32,516,982**	**34,363,708**	**32,361,780**	**36,271,320**	**20,194,667**	**44,528,892**
TOTAL Sales Tax (State & Local)	***301,184,519***	***318,289,589***	***299,746,973***	***335,958,610***	***187,050,603***	***412,443,342***
FY 2025-26						
Using growth in FL population 21+. Assumes a mature market is likely in the first full FY of implementation.						
STATE Sales Tax	**280,944,708**	**296,900,305**	**279,603,765**	**313,381,956**	**174,480,671**	**384,726,859**
Local Option Sales Tax	**34,002,895**	**35,934,010**	**33,840,600**	**37,928,794**	**21,117,493**	**46,563,707**
TOTAL Sales Tax (State & Local)	***314,947,603***	***332,834,315***	***313,444,365***	***351,310,750***	***195,598,164***	***431,290,566***
		FY 2024	FY 2025	FY 2026		
Growth in Florida Population 21+		1.6%	1.5%	1.4%		
FDEC 202302						

VIII. Medical Marijuana Sales Tax Estimation Scenarios

Florida medical marijuana retail sales (or market size) were estimated based on sales reported from eight states with recreational and medical marijuana programs, Arizona, Colorado, Massachusetts, Michigan, Nevada, New Jersey, Oregon, and Washington. The estimation process is outlined in the medical marijuana section above. California does not record or report medical marijuana sales, so the state was excluded from the medical marijuana estimation. The last two fiscal years of data, 2021-22 and 2022-23, were chosen to parallel the recreational estimate above and to focus on more mature stages of the markets associated with more steady-state level of per capita expenditures on the product. Due to the timing of the analysis, the last quarter of FY 2022-23 was partially or entirely estimated by EDR to create full fiscal year sales. Sales for these last two fiscal years were averaged. This resulted in eight unique estimates of a potential Florida market size in a mature stage of development. Focusing on a more mature recreational market allows for a self-selection to occur amongst users on whether they will stay in the medical use market or move to the recreational use market once recreational use was decriminalized. To develop the estimate, the following further adjustments were made.

Several scenarios for potential sales tax collections were calculated parallel to the recreational estimate above.

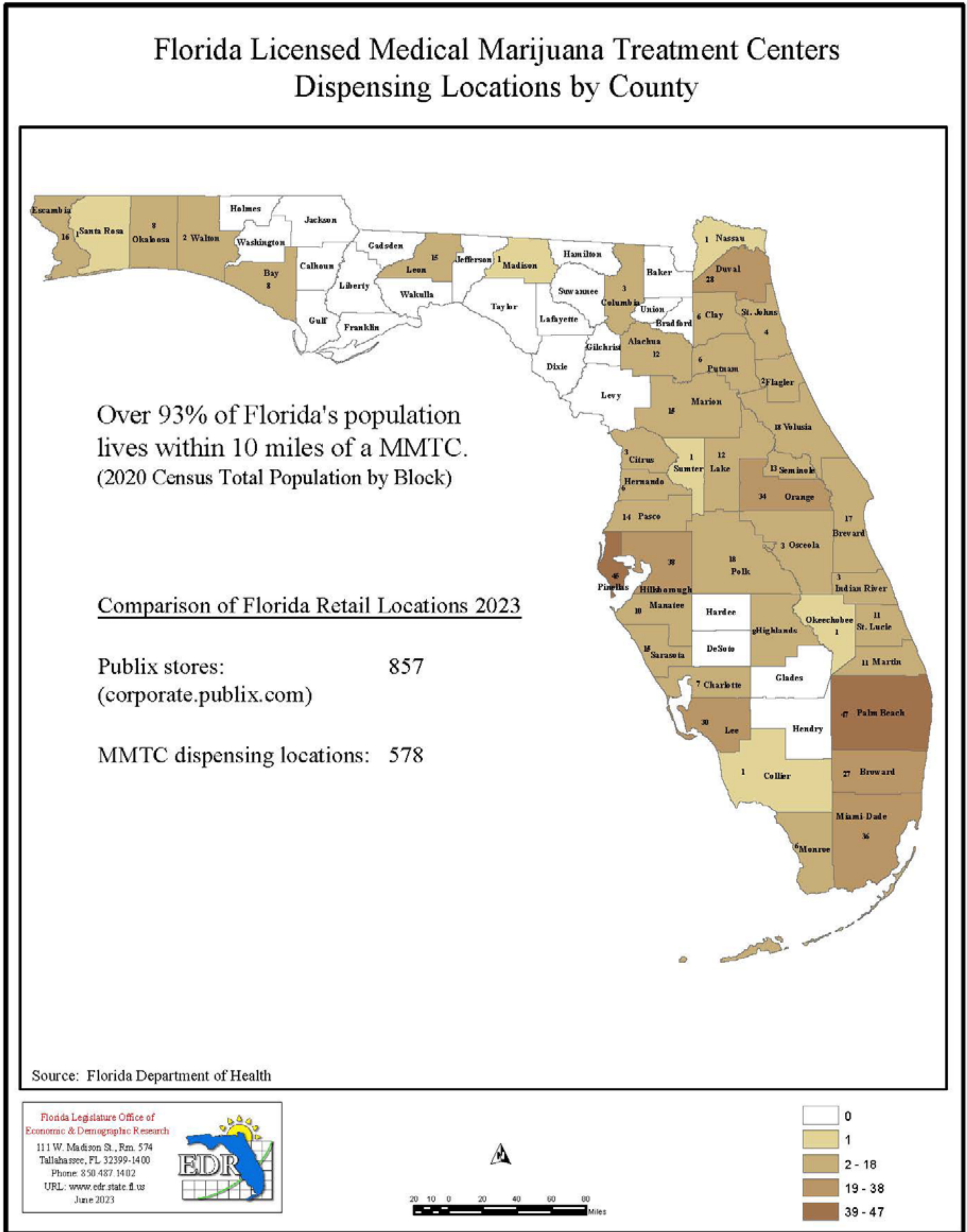
I. Average of the estimates based on eight unique states, after excluding California for lack of reported data.
II. Average of the estimates for six unique states, after excluding Arizona and Washington. Arizona's recreational program is fairly new, so its medical use levels may be still adjusting to the availability of recreational use. Washington allows cooperative gardens to grow for own use and also allows home grow, so its medical retail sales may not fully account for total medical use of the product. Washington State was also excluded.
III. Average of the low and high, Oregon and Colorado respectively.
IV. Average of two states, Colorado, and Nevada, considered similar to Florida in terms of a high-tourism profile.
V. A minimum size equivalent to Oregon's realized sales.
VI. A maximum size equivalent to sales in Arizona.

The average of FY 2021-22 and FY 2022-23 from the five scenarios above was grown to FY 2025-26 by the growth rate in population 21 and over estimated for this analysis using data consistent with the FDEC 202302. If the proposed amendment passes, FY 2025-26 will be the first full year of implementation.

Marijuana sales for medical use have generally declined after the decriminalization of marijuana for recreational use in the states selected for analysis. This has happened despite a differential tax regime imposed on medical and recreational use that favors medical use in existence in most states. Oregon is the only state from the selected group that does not show a consistent decline in medical sales but this may due to other characteristics of the program. Using the EDR-developed estimate of current medical marijuana sales based on dispensations data from the Department of Health, it is estimated that current sales tax collections would have exceeded $100 million annually had marijuana for medical use been taxable (state 6% only). Using per capita data from other states, it is estimated that Florida medical marijuana sales tax collections in Florida may range between $2 million and $100 million in a mature recreational market (state 6%). If recreational marijuana is decriminalized in Florida by the voters and if medical marijuana is taxable, then the six scenarios suggest medical marijuana sales tax collections are likely to decline to 97 percent and 20 percent of current levels. This is due to the medical users moving to the recreational market.

FLORIDA MEDICAL MARIJUANA STATE AND LOCAL SALES TAX COLLECTIONS IF TAXABLE						
ESTIMATES FOR A MATURE MARKET STAGE						
Average of FY 2021-22 and FY 2022-23						
Scenarios	**I.**	**II.**	**III.**	**IV.**	**V.**	**VI.**
	Eight-State Average	**Six-State Average (Trimmed)**	**Low-High Range (Trimmed)**	**Tourism States**	**At Least (Trimmed)**	**Maximum**
State	**FL Resident**	**FL Resident**	**FL Resident**	**FL Resident**	**FL Resident**	**FL Resident**
Washington	2,366,952					
Oregon	20,987,183	20,987,183	20,987,183		20,987,183	
Nevada	26,070,026	26,070,026		26,070,026		
New Jersey	28,115,254	28,115,254				
Michigan	35,564,460	35,564,460				
Massachusetts	51,900,830	51,900,830				
Colorado	60,411,486	60,411,486	60,411,486	60,411,486		
Arizona	100,964,666					100,964,666
STATE Sales Tax 6%	**40,797,607**	**37,174,873**	**40,699,334**	**43,240,756**	**20,987,183**	**100,964,666**
FOR COMPARISON: CURRENT FL MEDICAL USE ESTIMATED SALES TAX IF TAXABLE						
Florida - EDR - Dispensations	*103,712,843*	*103,712,843*	*103,712,843*	*103,712,843*	*103,712,843*	*103,712,843*
Converted to Retail Sales ($)						
Percent of CURRENT FL MEDICAL	*39%*	*36%*	*39%*	*42%*	*20%*	*97%*
Local Option Sales Tax	**4,937,757**	**4,499,296**	**4,925,863**	**5,233,453**	**2,540,091**	**12,219,810**
TOTAL Sales Tax (State & Local)	**45,735,364**	**41,674,169**	**45,625,198**	**48,474,209**	**23,527,274**	**113,184,476**
FY 2025-26						
Using growth in FL population 21+. Assumes a mature market is likely in the first full FY of implementation.						
STATE Sales Tax	**42,661,916**	**38,873,636**	**42,559,152**	**45,216,708**	**21,946,224**	**105,578,400**
Local Option Sales Tax	**5,163,396**	**4,704,898**	**5,150,958**	**5,472,603**	**2,656,164**	**12,778,213**
TOTAL Sales Tax (State & Local)	***47,825,311***	***43,578,533***	***47,710,110***	***50,689,312***	***24,602,388***	***118,356,612***
		FY 2024	FY 2025	FY 2026		
Growth in Florida Population 21+		1.6%	1.5%	1.4%		
FDEC 202302						

Appendix A



Appendix B

Sources and Notes

Arizona
Arizona Department of Revenue
Arizona Marijuana TPT and Excise Tax Collections and Taxable Sales, by Period Covered, TOTAL Tax Collections (for all Jurisdictions) and TAXABLE Sales (Estimated) to Date. Taxable Sales is estimated based on revenue received. The Taxable Sales for each period covered will change as late returns, late payments, amendments and audits are processed. Arizona's marijuana excise tax is not included in the tax base for Arizona's Transaction Privilege Tax and Use Tax or similar local taxes. Ariz. Rev. Stat. Ann. § 42-5452(D), as added by Arizona Prop. 207, effective Nov. 30, 2020. For more information on Arizona's marijuana excise tax, see the Arizona Excise Tax Navigator, at Arizona 13.1.
https://azdor.gov/sites/default/files/2023-06/OERA_MJ_byPeriodCovered.pdf

California
California Department of Tax and Fee Administration, Cannabis Tax Revenues.
Notes
Revenue represents amounts reported based on the reporting period of the return. Amounts are subject to change and updated every quarter.
Beginning January 1, 2023, cannabis excise tax reporting shifted from the distributor to the retailer.
Excise tax amounts reported are net amounts due after adjustments for tax paid to distributors prior to January 1, 2023, and vendor compensation. With the shift in reporting of excise tax to the retailer, retailers may claim a credit for excise tax paid to a distributor prior to January 1, 2023. Certain retailers are also eligible to retain vendor compensation.
Sales Tax - Sales tax applies to sales of cannabis, cannabis products, and other tangible personal property.
Cannabis Sales - Cannabis sales represents amounts reported by retailers subject to the excise tax.
Taxable Sales - Taxable sales include sales of cannabis, cannabis products, and other retail sales of tangible personal property reported on sales and use tax returns.
Taxable sales does not include exempt sales such as sales made to those with a Medical Marijuana Identification Card (MMIC). These exempt sales are listed as Other Deductions and are not subject to sales tax.
The sales amount of exempt sales are not included in taxable sales.
CDTFA does not publish data on Medical Marijuana sales.
https://cdtfa.ca.gov/dataportal/dataset.htm?url=CannabisTaxRevenues

Colorado
Colorado Department of Revenue, Marijuana Sales Report, January 2014 to Date, Medical Marijuana Sales and Retail Marijuana Sales. Source: State Sales Tax Returns (DR 100) and Retail Marijuana Sales Tax Returns.
Note: This table represents a snapshot of the tax returns at the time the data was retrieved.
In the data used, [Medical Marijuana Sales] summarizes all sales made at medical marijuana stores. It includes medical marijuana and accessories/other products that do not contain medical marijuana. This value does not include wholesale sales.
In the data used, [Retail Marijuana Sales] summarizes retail marijuana sales made at retail marijuana stores. It does not include accessories/other products that do not contain retail marijuana. This value does not include wholesale sales.
Prepared by: Office of Research and Analysis, Colorado Department of Revenue | dor_ora@state.co.us
Publish date: May 2023
https://cdor.colorado.gov/data-and-reports/marijuana-data/marijuana-sales-reports

Massachusetts

Massachusetts Cannabis Control Commission, Data Catalog, Medical Treatment Centers - Facility Statistics, Marijuana Establishment Facility Sales and Statistics (By day and product types, 2018-current).

https://masscannabiscontrol.com/open-data/data-catalog/

Michigan

Michigan Marijuana Regulatory Agency, Medical Marijuana Sales and Adult Use Marijuana Sales, Total Sales, Monthly and Quarterly Statistical Reports, various dates.
https://www.michigan.gov/cra/resources/cannabis-regulatory-agency-licensing-reports/cannabis-regulatory-agency-statistical-report

Nevada

State of Nevada Department of Taxation, Cannabis Statistics and Reports, State of Nevada Marijuana Tax Revenue. Taxable sales includes sales of adult -use cannabis, medical cannabis, tangible personal property transferred for value, and all other amounts subject to Sales or Use Tax, as reported by licensed cannabis establishments.
https://tax.nv.gov/Publications/Cannabis_Statistics_and_Reports/

New Jersey

New Jersey Cannabis Regulatory Commission, Cannabis Sales Reports, Cannabis Sales Totals, Recreational Cannabis Reported Gross Receipts, https://www.nj.gov/cannabis/resources/reports-stats-info/index.shtml
https://www.nj.gov/cannabis/documents/reports/2017-2018BIENNIAL%20REPORT.pdf

Oregon

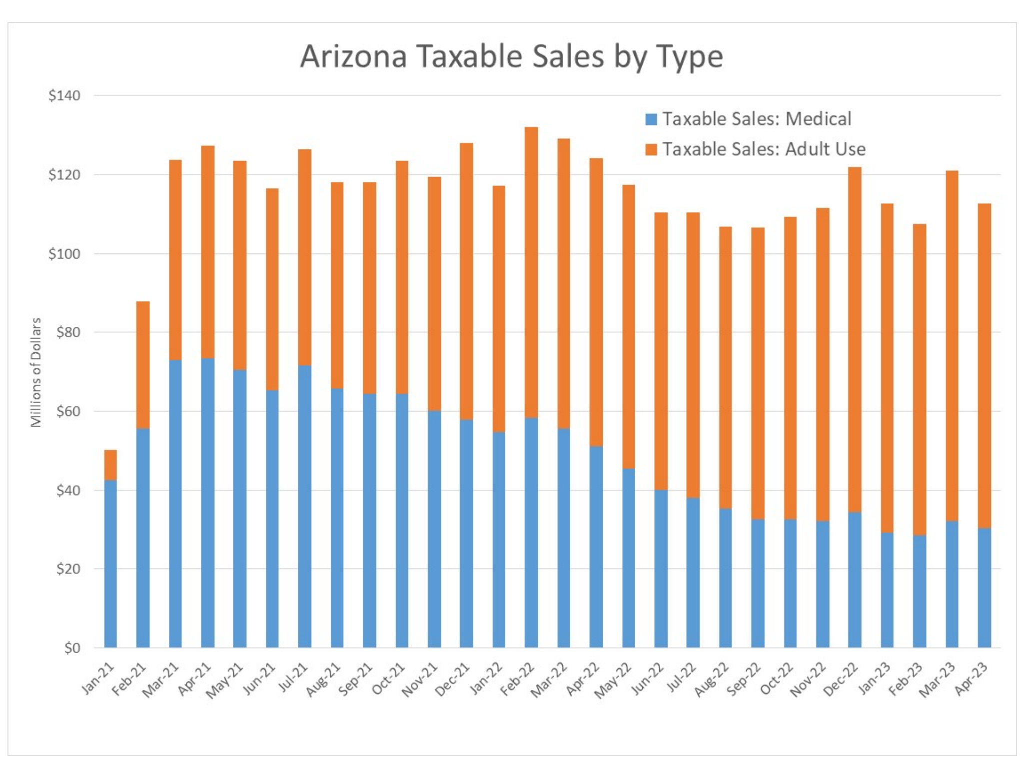
Oregon Liquor and Cannabis Commission, Marijuana and Hemp (Cannabis), Harvest, Price, & Sales Market Data, Metrc, Oregon's Cannabis Tracking System, https://www.oregon.gov/olcc/marijuana/Pages/Marijuana-Market-Data.aspx

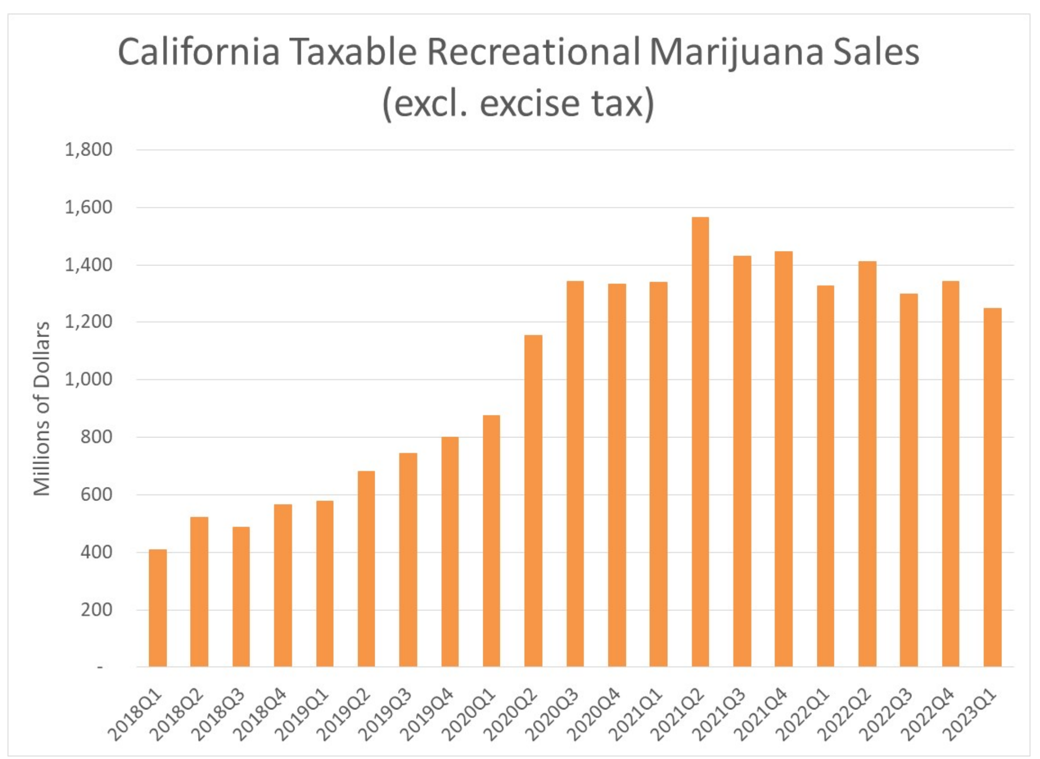
Washington

Washington Liquor and Cannabis Board, Recreational and medical cannabis taxes
On November 6, 2012, Washington State voters passed Initiative 502 (I-502). The initiative makes it legal for businesses holding the appropriate cannabis license(s) to produce, process, or make retail sales of cannabis for recreational use.
The Liquor and Cannabis Board (LCB) approves, regulates, and enforces cannabis licenses. The LCB also administers and collects the 37 percent cannabis excise tax.
The data contained in this report includes the following:
Estimated sales tax collections on cannabis and cannabis products for businesses with a cannabis retailer license
Estimated sales of cannabis and cannabis products that are exempt from sales tax for medical purposes
Cannabis sales tax table
https://dor.wa.gov/about/statistics-reports/recreational-and-medical-cannabis-taxes

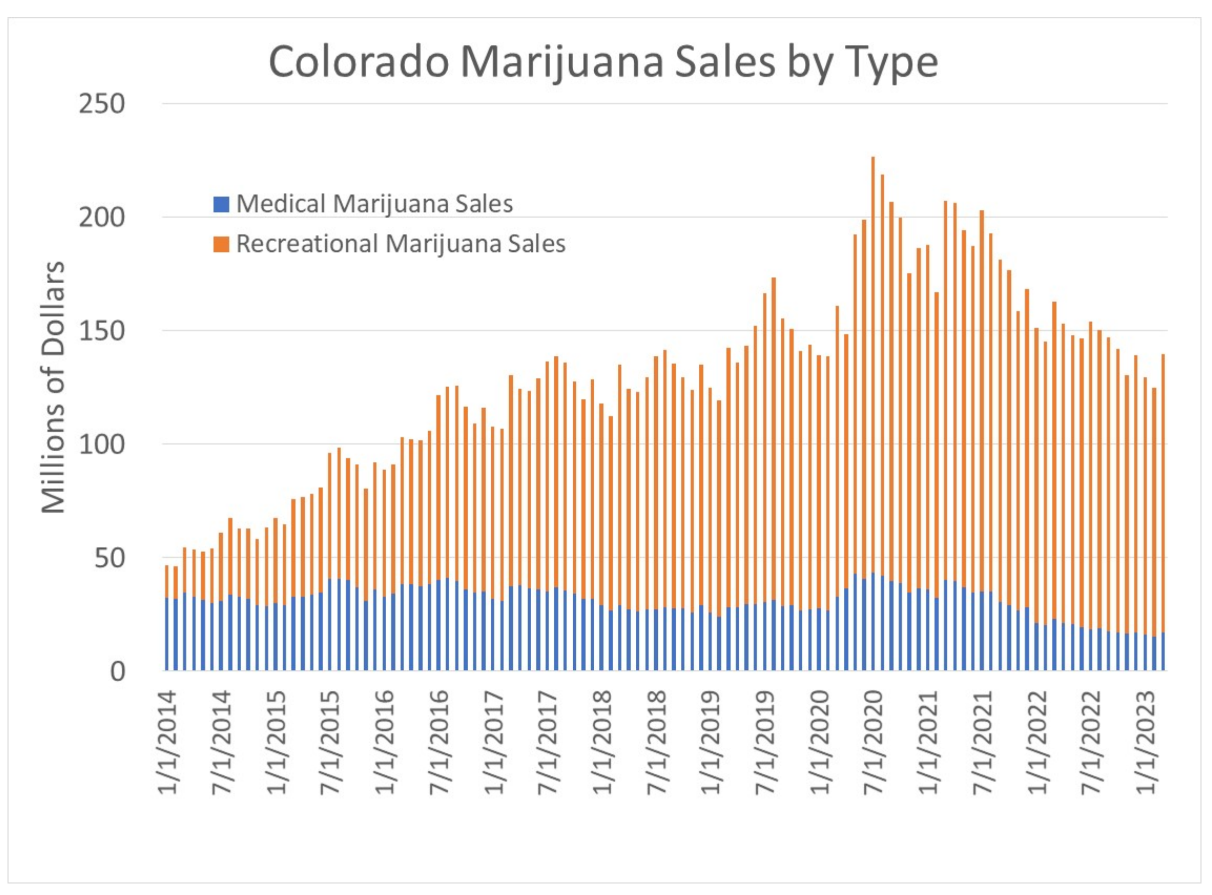
Appendix C

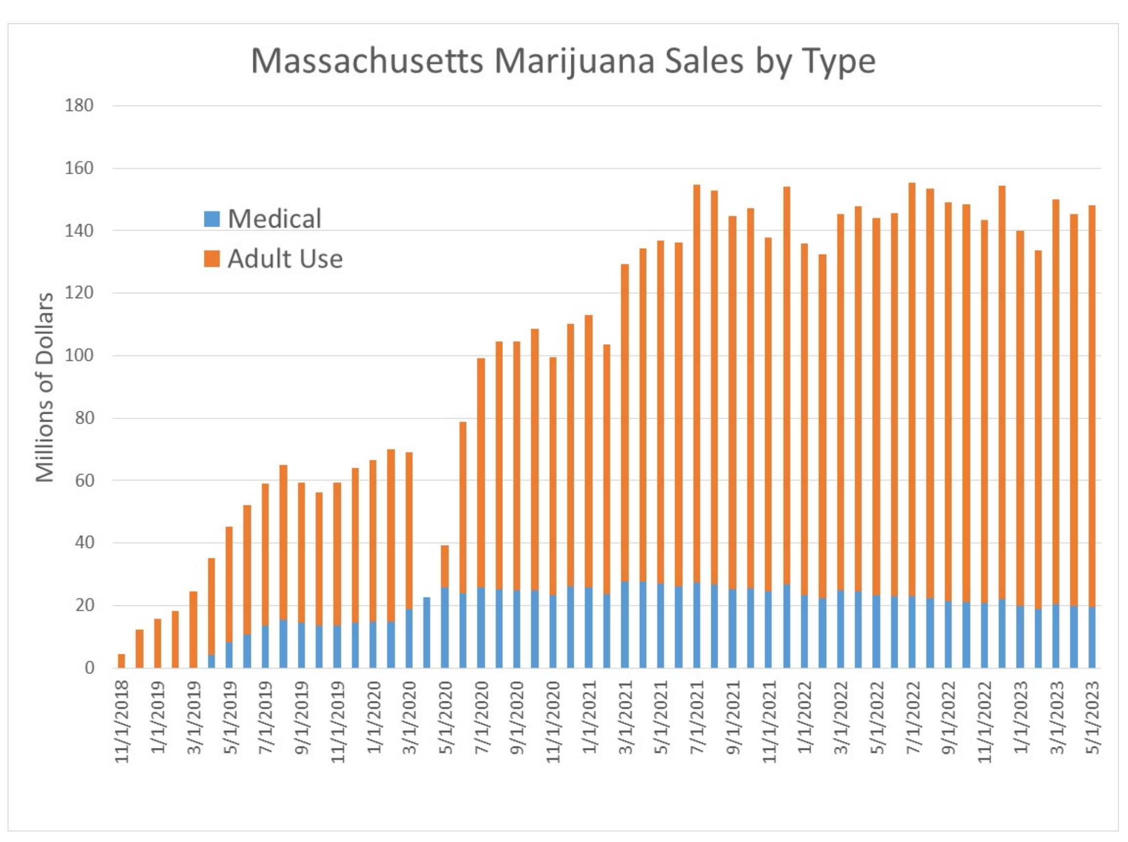
RECREATIONAL AND MEDICAL MARIJUANA SALES FOR SELECT STATES

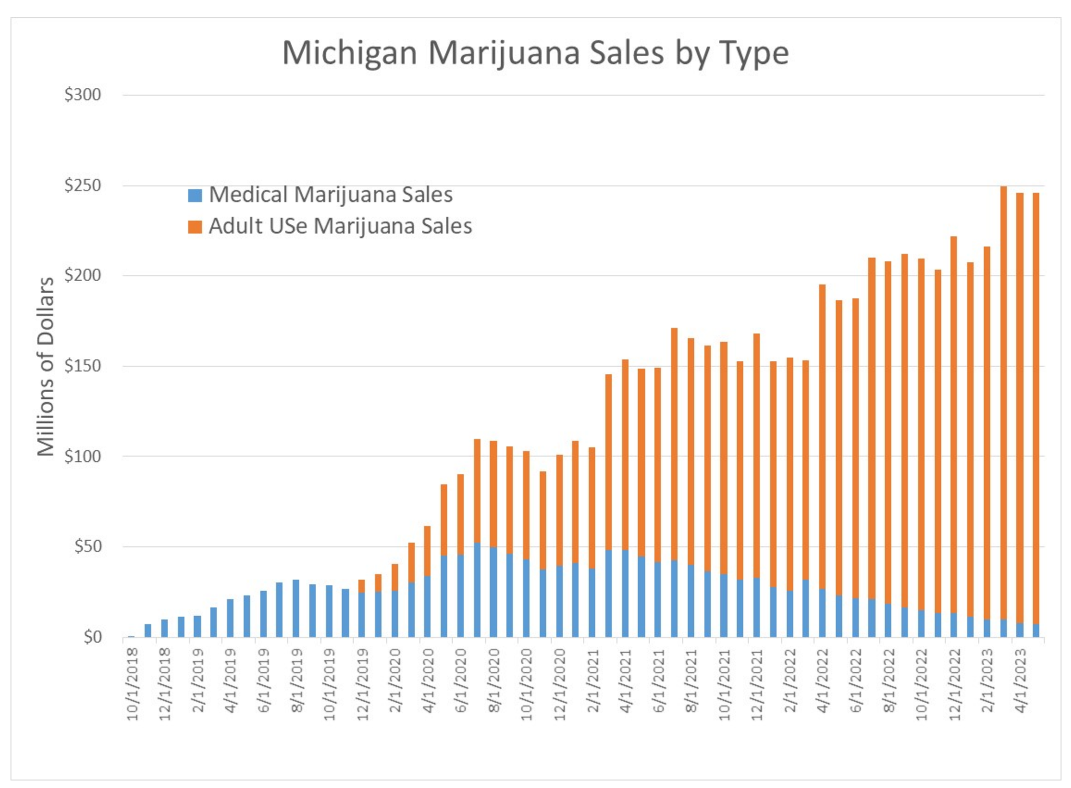


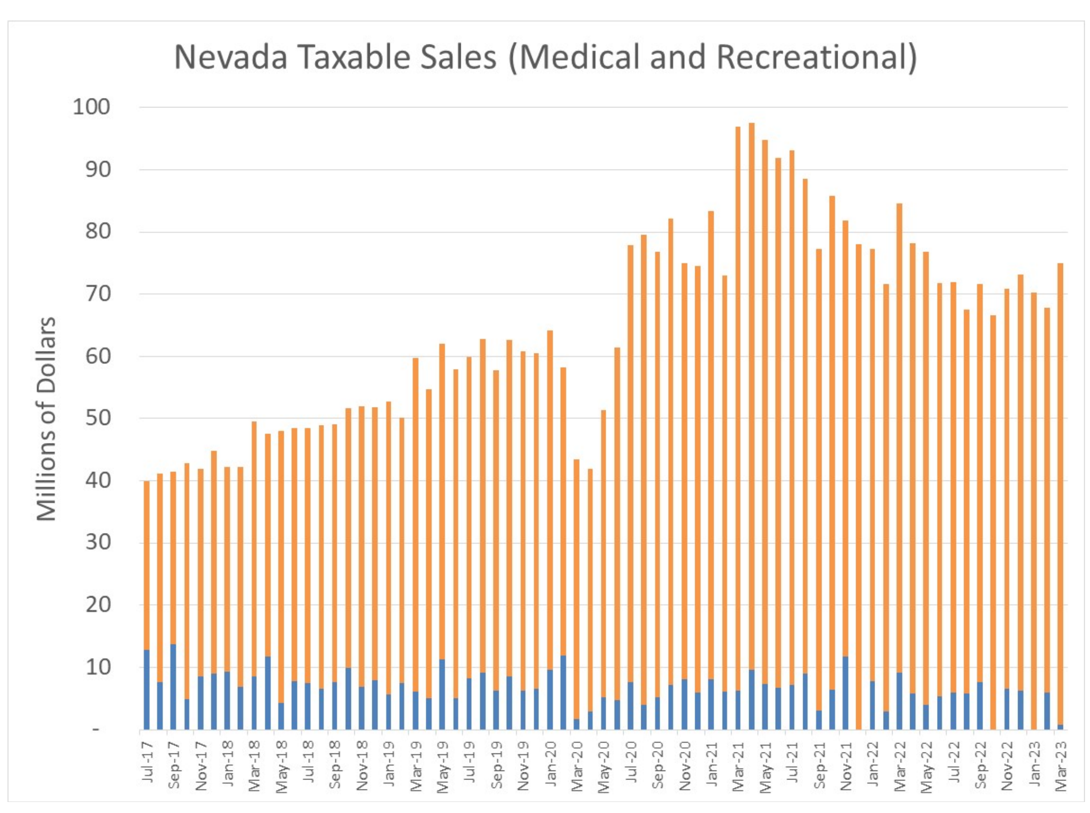


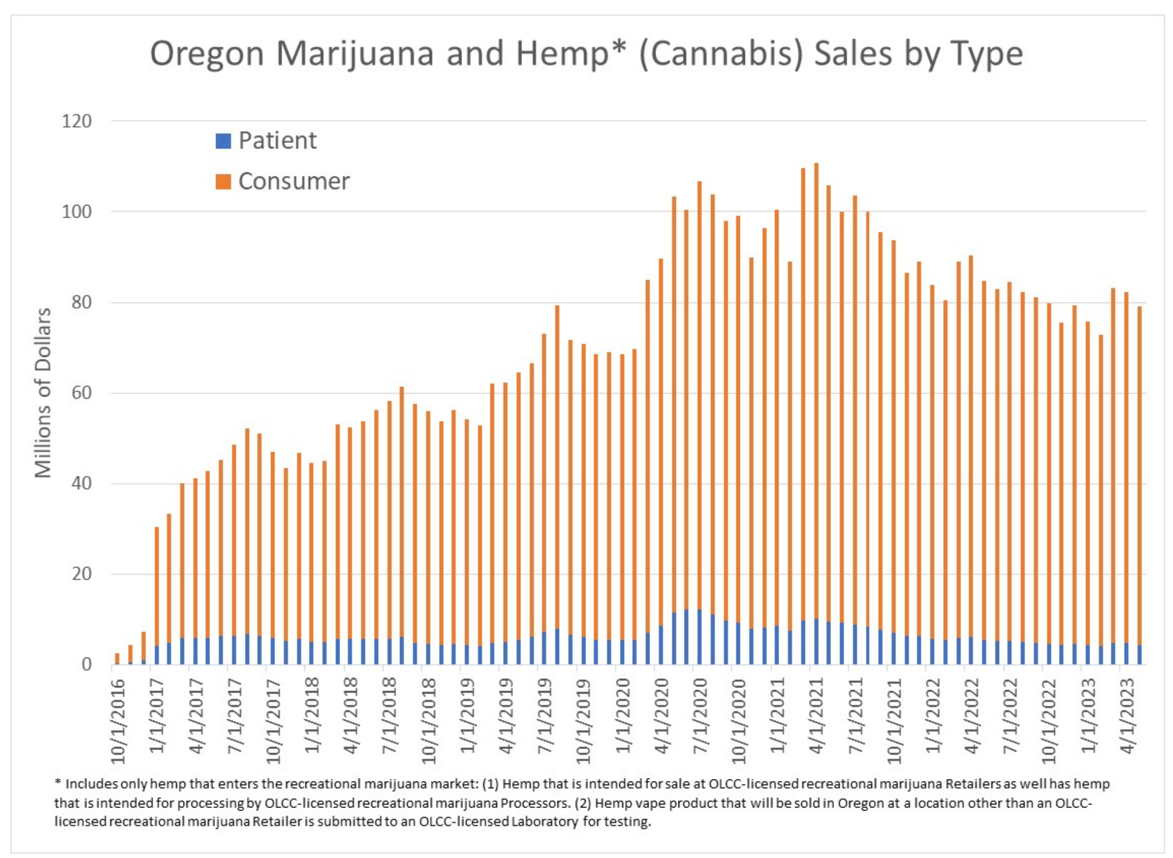
Note: California does not record medical marijuana sales.


Colorado Marijuana Sales by Type
Medical Marijuana Sales
Recreational Marijuana Sales
Millions of Dollars
250
200
150
100
50
0
1/1/2014
7/1/2014
1/1/2015
7/1/2015
1/1/2016
7/1/2016
1/1/2017
7/1/2017
1/1/2018
7/1/2018
1/1/2019
7/1/2019
1/1/2020
7/1/2020
1/1/2021
7/1/2021
1/1/2022
7/1/2022
1/1/2023

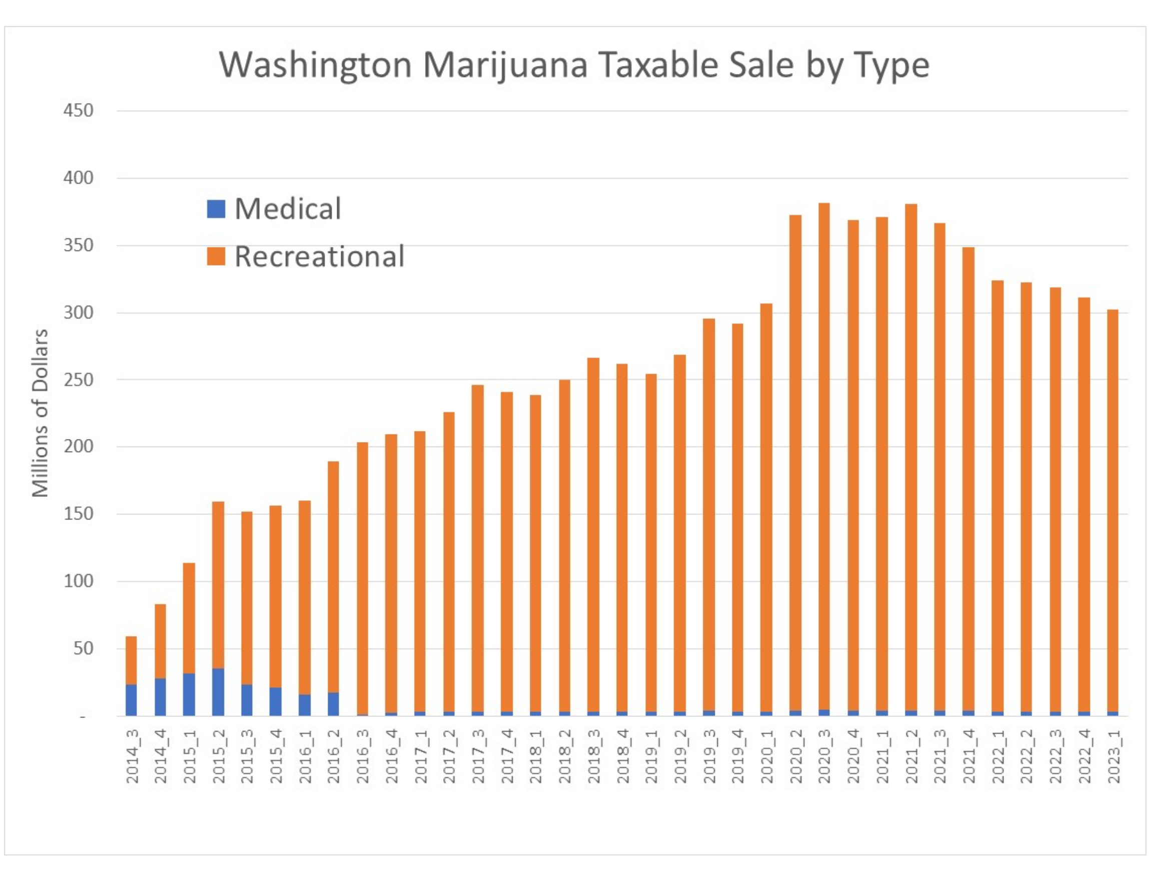

Massachusetts Marijuana Sales by Type
Medical
Adult Use
Millions of Dollars
180
160
140
120
100
80
60
40
20
0
11/1/2018
1/1/2019
3/1/2019
5/1/2019
7/1/2019
9/1/2019
11/1/2019
1/1/2020
3/1/2020
5/1/2020
7/1/2020
9/1/2020
11/1/2020
1/1/2021
3/1/2021
5/1/2021
7/1/2021
9/1/2021
11/1/2021
1/1/2022
3/1/2022
5/1/2022
7/1/2022
9/1/2022
11/1/2022
1/1/2023
3/1/2023
5/1/2023


Michigan Marijuana Sales by Type
Medical Marijuana Sales
Adult USe Marijuana Sales
Millions of Dollars
$300
$250
$200
$150
$100
$50
$0
10/1/2018
12/1/2018
2/1/2019
4/1/2019
6/1/2019
8/1/2019
10/1/2019
12/1/2019
2/1/2020
4/1/2020
6/1/2020
8/1/2020
10/1/2020
12/1/2020
2/1/2021
4/1/2021
6/1/2021
8/1/2021
10/1/2021
12/1/2021
2/1/2022
4/1/2022
6/1/2022
8/1/2022
10/1/2022
12/1/2022
2/1/2023
4/1/2023


Nevada Taxable Sales (Medical and Recreational)
Millions of Dollars
100
90
80
70
60
50
40
30
20
10
-
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Jul-18
Sep-18
Nov-18
Jan-19
Mar-19
May-19
Jul-19
Sep-19
Nov-19
Jan-20
Mar-20
May-20
Jul-20
Sep-20
Nov-20
Jan-21
Mar-21
May-21
Jul-21
Sep-21
Nov-21
Jan-22
Mar-22
May-22
Jul-22
Sep-22
Nov-22
Jan-23
Mar-23



* Includes only hemp that enters the recreational marijuana market: (1) Hemp that is intended for sale at OLCC-licensed recreational marijuana Retailers as well has hemp that is intended for processing by OLCC-licensed recreational marijuana Processors. (2) Hemp vape product that will be sold in Oregon at a location other than an OLCC-licensed recreational marijuana Retailer is submitted to an OLCC-licensed Laboratory for testing.



Tab 8

Materials from the Sponsor

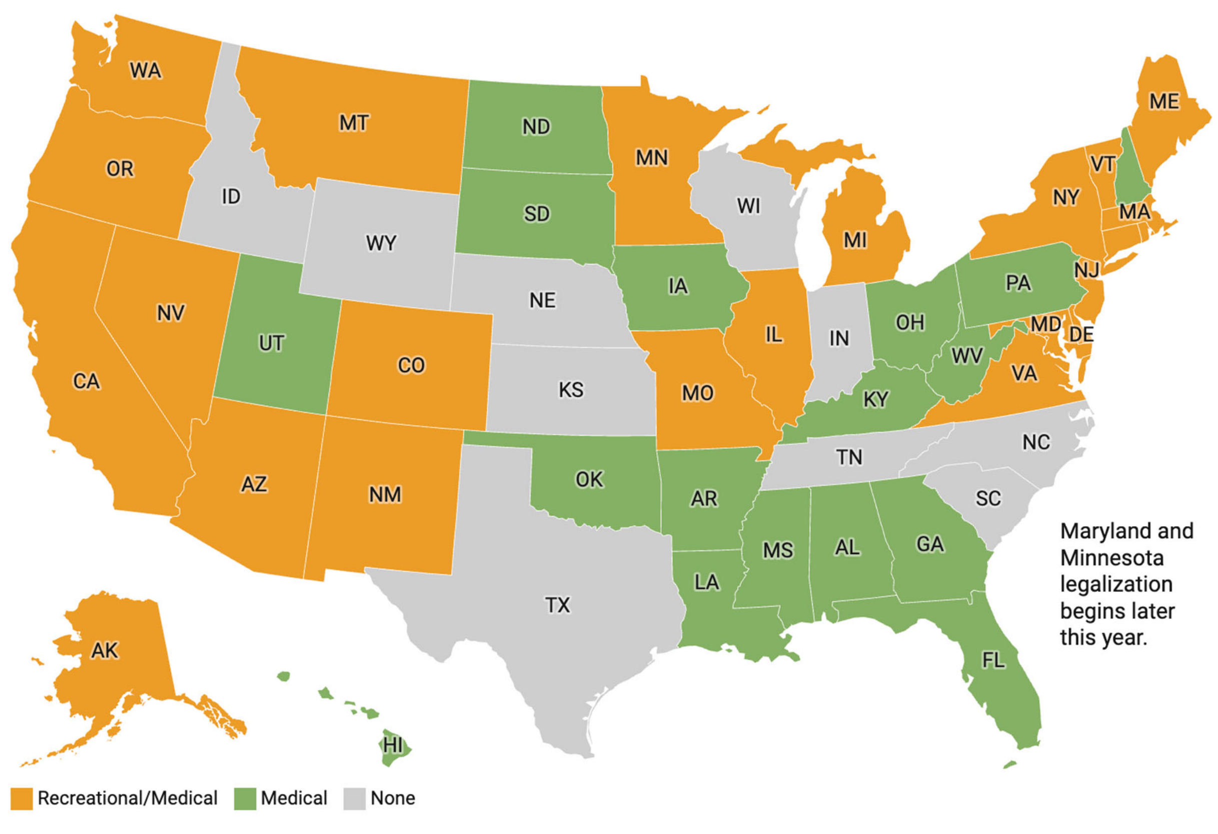
Adult Personal Use of Marijuana (22-05)

Sponsor's Submission to the Financial Impact Estimating Conference

June 9, 2023

I. Background

Currently the medical use of cannabis is authorized in 40 states plus the District of Columbia and Puerto Rico, and the non-medical adult use of cannabis is authorized in 23 states plus the District of Columbia, Guam, and the US Virgin Islands.



[1]

The first authorization of cannabis use in Florida occurred in 2014 when the legislature passed the Compassionate Medical Cannabis Act of 2014.[2] This legislation allowed for the use of non-euphoric, low tetrahydrocannabinol (THC) and high cannabidiol (CBD) cannabis for medical use by patients suffering from cancer, seizures, or severe or persistent muscle spasms.

In the 2016 General Election, Florida voters passed a constitutional amendment titled Use of Marijuana for Debilitating Medical Conditions (serial number 15-01) with 71% of the vote.[3] That

[1] https://mjbizdaily.com/map-of-us-marijuana-legalization-by-state/

[2] Chapter 2014-157, Laws of Fla., codified in s. 381.986, F.S

[3] Florida Department of State - Election Results (myflorida.com)

amendment provided for the use of medical marijuana by qualified patients suffering from specified medical conditions, and the establishment and licensure of Medical Marijuana Treatment Centers pursuant to a robust regulatory scheme.

In October 2019, the Florida Financial Impact Estimating Conference issued its Financial Impact Statement for the proposed amendment titled Regulate Marijuana in a Manner Similar to Alcohol to Establish Age, Licensing, and Other Restrictions (serial number 16-02),[4] and concluded :

> "The amendment permits legal sales of recreational marijuana which will be subject to sales tax. As a result of those sales and an accompanying increase in tourism, sales tax collections increase by at least $190 million per year once the legal retail market is fully operational. The estimated impacts increase the state's overall budget by less than 0.1%. At a minimum, the required state regulatory structure will cost $1.5 million for startup and $9.1 million annually to operate; however, it is probable that this cost will be offset by fees. Local governments' regulatory costs are unknown. The net impact of additional costs and savings associated with the criminal justice system cannot be determined. As a result of the identified impacts, the amendment has slightly positive effects on the economy. Florida's GDP is higher each year by an average of $3.8 billion. This represents 0.32% of the annual total."

Smart & Safe Florida believes that the FIEC's 2019 analysis was thorough, sound and likely remains largely the same. This report supplements that 2019 analysis where possible.

II. State Revenue Impact

From when Colorado and Washington began the first sales of marijuana for non-medical adult use in 2014 through the end of 2022, states have generated more than $15 billion in tax revenue. 2022 was the first year that that amount decreased slightly – from $3.86 billion in 2021 to $3.77 billion in 2022. This decrease is attributed to macro-economic headwinds as well as re-normalizing of the market post the COVID boom. However, states authorizing the adult recreational use of marijuana more recently still saw an increase in revenue.[5]

Below is a list of factors shown to affect state revenue following the authorization of adult use of marijuana:

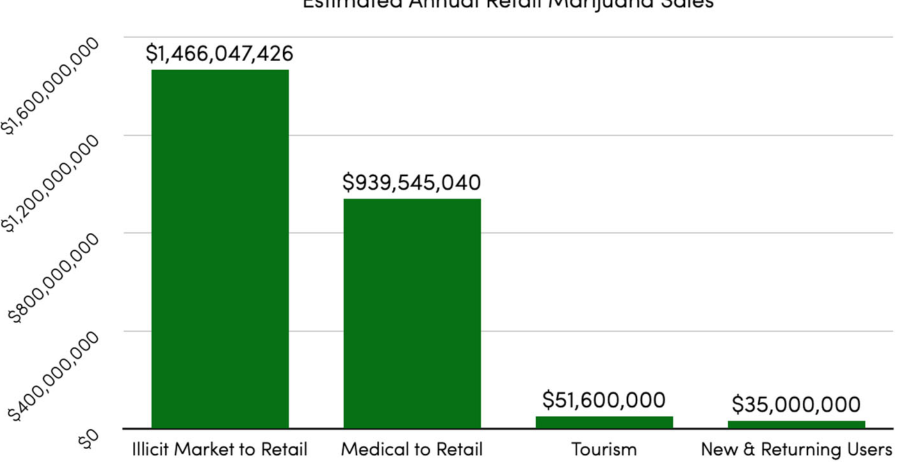
- Increased sales tax revenue from non-medical marijuana sales,
- Increased sales tax revenue from tourists seeking authorized non-medical marijuana,
- Economic growth from the creation of new jobs, and
- Increased state revenue from potential excise taxes.

[4] http://edr.state.fl.us/Content/constitutional-amendments/2020Ballot/MarijuanaRegulation_Report.pdf

[5] https://www.mpp.org/issues/legalization/cannabis-tax-revenue-states-regulate-cannabis-adult-use/#:~:text=Through%20the%20end%20of%202022,revenue%20from%20adult%2Duse%20sales

A. Sales Tax Revenue

While medical marijuana is exempt from sales tax, non-medical marijuana would be subject to state and local sales taxes per Florida Statutes Chapter 212.[6] As the FIEC identified in 2019, there will be four primary groups of participants in the non-medical retail market: current illicit market consumers, current medical marijuana market participants, tourists, and new or returning cannabis consumers.



Illicit Market Estimations

Based on preliminary data released by the Substance Abuse and Mental Health Service Administration (SAMHSA) and based upon the 2021 National Survey of Drug Use and Health (NSDUH), we can estimate the number of current marijuana consumers in Florida. The research indicates that approximately 2.1 million, or 13.45%, of persons ages 26+ in Florida have used marijuana in the last year.[7] (Data is grouped by those 18-25 and 26+; as non-medical marijuana in Florida would only be available to those ages 21+ and because SSF relies on conservative estimates, these projections are based on the number of persons ages 26+ instead of 18+.) This estimate includes medical marijuana consumers, by deducting 98% of Florida's qualified medical marijuana patients,[8] estimate that Florida's illicit marijuana market consists of approximately 1,295,593 persons.

According to research conducted and compiled by the International Cannabis Policy Study, 57% of marijuana consumers purchased their marijuana from a store, co-op, or dispensary in states where retail sale is authorized. Based on this, we conservatively estimate 738,488 current illicit market marijuana consumers would enter the regulated retail market if non-medical marijuana is authorized under Florida law.[9]

---

[6] Section 212.08(2)(1), F.S. (2022).

[7] https://www.samhsa.gov/data/nsduh/state-reports-NSDUH-2021

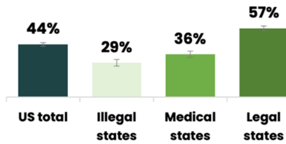
[8] On 9/20/2019, the National Organization for the Normalization of Marijuana Laws (NORML) provided testimony to the FIEC that approximately 98% of Florida's medical marijuana users were ages 21+. This report assumes 98% remains accurate.

[9] http://cannabisproject.ca/wp-content/uploads/2022/10/2021-ICPS-US-National-Report-Sept-27-1.pdf

Cannabis sources

Past 12-month consumers from legal states were more likely to report sourcing cannabis from a store, and past 12-month consumers from illegal states were more likely to report sourcing cannabis from family/friends or a dealer.

Store, co-op, or dispensary



The FIEC's 2019 analysis concluded that the state sales tax revenue generated from 870,634 retail consumers who transitioned from the illicit market would be $103,703,031 per year. Assuming the same methodology, but based on an estimate of 738,488 retail consumers who transition from the illicit market, results in $87,962,845 in estimated annual state sales tax revenue generated by the conversion of illicit market to regulated retail market participants.[10]

There will be additional sales tax revenue to individual counties based on local options sales taxes. This report does not contemplate that revenue.

Medical Market Estimations

While there are many reasons to believe that the authorization of non-medical marijuana for adult use would not significantly impact the medical marijuana market – including an increased range of product types and potencies for medical marijuana and lower prices without added excise taxes imposed on non-medical marijuana – the FIEC estimated a 20% decrease in the number of medical marijuana consumers after non-medical authorization based on data from Colorado. Using the FIEC's 2019 calculations, these consumers would generate approximately $939.5 million in annual retail sales, from which tax revenue would be generated (160,881 formal medical consumers[11] x 365 days x 1.6 grams per day x $10 per gram).

Tourism Estimations

In 2022, Forbes estimated that cannabis tourism is a $17 billion industry nationwide.[12] Research demonstrates that 37% of the "active leisure travel audience" in the US are motivated by the authorization of and access to marijuana and 70% of Gen Z travelers say that access to marijuana is important to them while on vacation.[13]

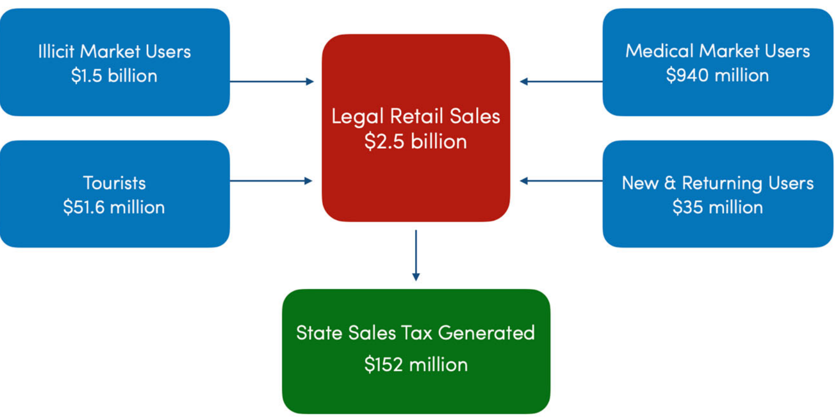
With no other state in the southeastern United States with authorized access to non-medical marijuana, the FIEC's 2019 assessment that Florida's tourism industry would likely grow by 1% if adult personal use of marijuana were authorized in Florida remains

[10] Our downward revision of the number of estimated consumers resulted in a corresponding decrease in estimated revenue from the 2019 estimate of $1.7bn to approximately $1.5bn.
[11] https://knowthefactsmmj.com/wp-content/uploads/ommu_updates/2023/052623-OMMU-Update.pdf
[12] https://www.forbes.com/sites/willyakowicz/2022/05/29/cannabis-tourism-is-now-a-17-billion-industry-and-its-just-taking-off/?sh=34a57da62056
[13] https://www.huffpost.com/entry/what-is-cannabis-tourism_l_63026695e4b0f72c09d86293

reasonable. Combining new cannabis tourists and existing tourists who would participate in the regulated retail marijuana market, the FIEC estimated $51.6 million in marijuana sales generated as well as $634.3 million in additional taxable sales. We believe that to be a reasonable estimate.

New and Returning Consumer Estimations
In its 2019 report, the FIEC used a number of proxy data points to estimate $35 million in annual marijuana sales from new consumers entering the retail market. Because of the impossibility of determining how many adult Floridians who have not used marijuana in the past year may use marijuana if the amendment is adopted, this report will also use $35 million in annual sales as a reasonable estimate.

Sales Tax Summary
Based on the calculations and assumptions outlined above, the retail marijuana market is estimated to be approximately $2.5 billion per year. Applying the FIEC's 2019 methodology, this will yield approximately $152 million in additional state sales tax revenue per year.



B. Job Growth

Estimating the number of new jobs that would be created by authorizing non-medical marijuana for adult use is difficult but can be done by comparing Florida and its anticipated retail sales to other states that transitioned from a medical-only market to non-medical adult use market.

For example, Colorado had $1,768,688,837 in retail sales in 2022 which supported 38,337 jobs.[14, 15] In 2022, Michigan had $2,037,808,000 in retail sales which supported 31,152

[14] https://cdor.colorado.gov/data-and-reports/marijuana-data/marijuana-sales-reports
[15] Leafly, "Jobs Report 2022", https://leafly-cms-production.imgix.net/wp-content/uploads/2022/02/18122113/Leafly-JobsReport-2022-12.pdf

jobs.[16] Arizona had approximately $886,726,000 in retail sales in 2022 which supported 23,333 jobs.[17] Based on these ratios of retail sales to jobs in Colorado, Michigan, and Arizona (assuming the mean of those ratios) and the estimated retail sales in Florida, we estimate that this initiative would result in approximately 50,110 jobs in the overall retail marijuana market. Adjusting for Florida's existing 25,895 jobs in the medical cannabis market yields 24,215 new jobs created.

C. Excise Tax

Currently, Florida imposes excise taxes on alcoholic beverages (including beer, wine, and liquor) distributed and sold in the state.[18] The proposed amendment is silent on the issue of excise (or any other taxes) and preserves the Florida Legislature's authority with respect to same. However, even the most modest excise tax would generate, at a minimum, millions of dollars in state tax revenue.

III. Criminal Justice Impact

The overall impact of the authorization of non-medical marijuana on the criminal justice system is indeterminate at this time. Generally, marijuana-specific crime is an area where a reduction in crime is to be expected. Colorado saw a 68% decrease in marijuana arrests between 2012 and 2019 (non-medical marijuana became authorized on January 1, 2014 in Colorado) and a 55% decrease in marijuana-related court case filings. [19]

A. Driving Under the Influence

A potential criminal justice-related impact is the cost of DUIs on the state. While the prevalence of marijuana in DUI cases in Colorado increased from 2014 to 2020, the total number of DUIs decreased. The number of law enforcement officers trained to recognize marijuana use nearly doubled in that time as well, which likely contributed to the increase in the rate of detection. Overall, research suggests no significant change in driving fatalities between states studied following non-medical marijuana authorization and the national average.[20]

B. Juvenile Justice

Colorado saw a 42% decrease in juvenile arrests for marijuana-related crimes from 2012 to 2019. Results from Washington's Healthy Youth Survey found a decrease in cannabis use among 8th and 10th graders following the authorization of non-medical cannabis for adult use. The same research found no change in use among 12th graders during the same

[16] https://www.michigan.gov/cra/resources/cannabis-regulatory-agency-licensing-reports/cannabis-regulatory-agency-statistical-report
[17] https://azdor.gov/sites/default/files/media/OERA_MJ_202303_byPeriodCovered.pdf
[18] Section 546.06, F.S. (2022).
[19] https://dcj.colorado.gov/news-article/colorado-division-of-criminal-justice-publishes-report-on-impacts-of-marijuana
[20] Benjamin Hansen, Keaton Miller, and Caroline Weber, "Early Evidence on Recreational Marijuana Legalization and Traffic Fatalities," Economic Inquiry 58, no. 2 (April 2020): 547–68.

period.[21] This data all suggests a potential decrease in law enforcement costs related to youth crime.

C. Allocation of Resources

As expected, the authorization of non-medical marijuana for adult use is strongly correlated with a decrease in arrests for possession of small amounts of marijuana.[22]
For example, Washington saw a notable increase in clearance rates for several types of crimes, "suggesting that legalization [of marijuana] may result in a new positive redistribution in police human resource allocation."[23] Research from Oregon also demonstrates an increase in the clearance rates for violent crime following the authorization of non-medical marijuana.[24]

IV. Regulation Revenue

This amendment specifies that retail non-medical marijuana must be sold by licensed Medical Marijuana Treatment Centers (MMTCs), which are currently regulated by the Department of Health and directly overseen by the Office of Medical Marijuana Use (OMMU).[25]

The authorization of non-medical marijuana for adult use will certainly increase the workload of the OMMU as they process new MMTC licensure applications, but this cost is offset by the fee for such an application which is $146,000. MMTCs must renew their license every two years, which costs $1.2 million.[26] There are currently 22 licensed MMTCs in Florida, generating $26.4 million every two years in license renewal fees.[27]

The amendment also provides for other entities to be licensed and regulated by the state. As with the MMTCs, it seems likely that the state would be able to capture revenue via application and licensing fees to recover regulatory costs.

---

[21] Washington State Department of Social and Health Services, Department of Health, Office of the Superintendent of Public Instruction, and Liquor and Cannabis Board Healthy Youth Survey 2021 Analytic Report, Olympia, WA. http://www.AskHYS.net.
[22] Gunadi, Christian, and Yuyan Shi. "Association of Recreational Cannabis Legalization with Cannabis Possession Arrest Rates in the US." JAMA Network Open 5, no. 12 (2022).
[23] Stohr, Mary, Dale Willits, Craig Hemmens, Nicholas Lovrich, Duace Stanton, and Mikala Meize. "Effects of Marijuana Legalization on Law Enforcement and Crime: Executive Summary." National Criminal Justice Reference Service, June 30, 2020.
[24] Guangzhen Wu, Yongtao Li, Xiaodong (Eric) Lang, Effects of recreational marijuana legalization on clearance rates for violent crimes: Evidence from Oregon, International Journal of Drug Policy, Volume 100, 2022, 103528, ISSN 0955-3959, https://doi.org/10.1016/j.drugpo.2021.103528.
[25] https://knowthefactsmmj.com/about/
[26] https://moderncanna.com/laws-regulations/22-new-licenses-for-florida-mmtcs/#:~:text=Application%20fee&text=MMTC%20operators%20are%20required%20to,%2C%20and%20December%2031%2C%202024.
[27] https://knowthefactsmmj.com/mmtc/

V. Conclusion

Based on the research cited throughout, we believe that the analysis conducted by the FIEC in 2019 was based upon sound methodology, reliable data sources and reasonable assumptions, and remains generally accurate. We concur with the conclusion reached in that analysis that, “the economic analysis indicates a mildly expansionary impact on the state” when considering impact to the state budget.

Tab 9

Materials from Proponents

(None Provided)

Tab 10

Materials from Opponents

From: Jeremy Bailie <jeremy.bailie@webercrabb.com>
Sent: Thursday, July 06, 2023 7:15 PM
To: edrcoordinator
Subject: Fwd: fiscal costs of legalization

Please see below information submitted by the Drug Free America Foundation, an opponent to the amendment.

Thank you,
Jeremy

Jeremy D. Bailie, Esq.
Weber, Crabb & Wein, P.A.
5453 Central Avenue
Saint Petersburg, FL 33710
P: 727-828-9919
E: jeremy.bailie@webercrabb.com

From: Amy Ronshausen <aronshausen@dfaf.org>
Sent: Thursday, July 6, 2023 3:05:08 PM
To: Jeremy Bailie <jeremy.bailie@webercrabb.com>
Subject: fiscal costs of legalization

Follow up on the costs of marijuana legalization. I found a few things that might be helpful to the fiscal estimating committee on the cost of marijuana legalization.

This one is a study done by SAM (Smart Approaches to Marijuana), its specific to NY but I think they can use some of it. https://learnaboutsam.org/wp-content/uploads/2019/06/FINAL-Marijuana-Pot-Legalization-Costs-to-New-York-Law-Enforcement-and-Emergency-Services-Study.pdf

This one is the Centennial Institute in Colorado https://centennial.ccu.edu/briefs/marijuana-costs/

These last two are looking at hospitalization costs:

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9482056/ Changes in Emergency Department Visits for Cannabis Hyperemesis Syndrome Following Recreational Cannabis Legalization and Subsequent Commercialization in Ontario, Canada
- https://journals.lww.com/journaladdictionmedicine/fulltext/2022/05000/changes_in_rates_of_hospitalizations_due_to.27.aspx Changes in Rates of Hospitalizations due to Cannabis Harms i... : Journal of Addiction Medicine

Hope this is helpful to them. I didn't really have the time to get all the numbers specific to FL in order to do the math on each of these things. They probably have better access to that data than I would.

Amy Ronshausen
Executive Director, Drug Free America Foundation, Inc.
President, World Federation Against Drugs

Tab 11

Materials from Interested Parties

(None Provided)

Tab 12

Requested Agency Material

STATE TAXATION OF ADULT USE MARIJUANA

STATE	TAX RATE	2022 REVENUE
Alaska	-$50/oz. mature flowers -$25/oz. immature flowers -$15/oz. trim, $1 per clone	$28,650,355
Arizona	-16% excise tax (retail price) *-State 5.6% sales and use tax rate also applies*	$223,863,799
California	-15% excise tax (levied on wholesale at average market rate) -$9.65/oz. flowers & $2.87/oz. leaves cultivation tax -$1.35/oz fresh cannabis plant *-State 7.25% sales and use tax rate also applies*	$1,074,560,287
Colorado	-15% excise tax (levied on wholesale at average market rate) -15% excise tax (retail price)	$305,034,034
Connecticut	-$0.00625 per milligram of THC in plant material -$0.0275 per milligram of THC in edibles -$0.09 per milligram of THC in non-edible products *-6.35% state general sales tax also applies*	*Sales began January 10, 2023*
Illinois	-10% of the retail price when THC content is 35% or less -25% of the retail price when THC content is 36% or higher -All marijuana-infused products are taxed at 20% of the retail price	$562,119,019
Maine	-10% excise tax (retail price) -$335/lb. flower -$94/lb. trim -$1.5 per immature plant or seedling -$0.3 per seed *-5.5% state sales and use tax also applies*	$25,329,534
Massachusetts	-10.75% excise tax (retail price) *-6.25% state sales and use tax also applies*	$250,710,415.39
Michigan	-10% excise tax (retail price) *-6% state sales and use tax also applies*	$326,049,074.16
Missouri	-6% excise tax (retails sales) *-4.225% state sales and use tax also applies*	*Sales began January 1, 2023*
Montana	-20% excise tax (retail price)	$41,989,466
Nevada	-15% excise tax (fair market value at wholesale) -10% excise tax (retail price) *-6.85% state general sales tax also applies*	$196,952,338.14
New Jersey	-Up to $10 per ounce, if the average retail price of an ounce of usable cannabis was $350 or more -Up to $30 per ounce, if the average retail price of an ounce of usable cannabis was less than $350 but at least $250 -Up to $40 per ounce, if the average retail price of an ounce of usable cannabis was less than $250 but at least $200 -Up to $60 per ounce, if the average retail price of an ounce of usable cannabis was less than $200	$20,139,655
New Mexico	-12% excise tax (retail price) -Each year the tax will rise 1% until it reaches 18% in 2030	$36,684,235
New York	-$0.005 per milligram of THC in flower -$0.008 per milligram of THC in concentrates -$0.03 per milligram of THC in edibles -13% excise tax (retail price)	*Sales began on December 29, 2022*
Oregon	-17% excise tax (retail price)	$150,316,424
Rhode Island	-10% excise tax (retail price) *-7% state general sales tax also applies*	$579,439
Virginia	-21% excise tax (retail price) *-5.3% state general sales tax also applies*	*Sales begin in January 2024*
Vermont	-14% excise tax (retail price) -6% state general sales tax also applies	$2,363,000
Washington	-37% excise tax (retail price) *-6.5% state general sales tax also applies*	$529,443,420

Compiled by Florida Department of Revenue - 6/12/23

Sources:

1. Lozier, Blair. "State Approaches to Taxing Recreational Marijuana." *The Council of State Governments,* https://www.csg.org/2022/09/06/state-approaches-to-taxing-recreational-marijuana/

2. "Cannabis Tax Revenue in States that Regulate Cannabis for Adult Use." *Marijuana Policy Project*, https://www.mpp.org/issues/legalization/cannabis-tax-revenue-states-regulate-cannabis-adult-use/

Florida Department of Revenue
Technical Assistance and Dispute Resolution

Jim Zingale
Executive Director

5050 West Tennessee Street, Tallahassee, FL 32399

floridarevenue.com

MEMORANDUM

TO: Jim Zingale, Executive Director

THRU: Alec Yarger, Director
Legislative and Cabinet Services

Tammy Miller, Director
Technical Assistance and Dispute Resolution

FROM: Brinton Hevey
Technical Assistance and Dispute Resolution

SUBJECT: Financial Impact Estimating Conference
Adult Personal Use of Marijuana (Constitutional Amendment 22-05)

A Financial Impact Estimating Conference (FIEC) met on Monday, June 12, 2023, regarding the proposed constitutional amendment entitled *Adult Personal Use of Marijuana, 22-05*. The Department of Revenue was identified as an entity that has necessary information for a more complete understanding of the proposed amendment.

The FIEC requested information regarding the taxability of marijuana under existing Florida tax law. This memorandum will address the possible Florida sales and use tax implications under Ch. 212, F.S.

General Analysis:

The sale of tangible personal property in Florida is subject to sales tax unless an exemption applies. Exemptions are strictly construed, and if an exemption does not clearly apply, the sale is presumed taxable.

The exemption from sales tax for marijuana provided in s. 212.08(2)1(l), F.S., is limited specifically to sales to a qualified patient by a medical marijuana treatment center. Sales of marijuana sold by a medical marijuana treatment center to a qualified patient are exempt from sales tax. Absent any other applicable exemption, all other sales of marijuana products are sales of tangible personal property that are subject to sales tax.

Absent legislation or additional guidance from another agency or the judicial system, the following analysis of potential exemptions would apply.

<u>Common household remedies</u>:

- Adult personal use marijuana would not be considered a common household remedy, absent a change to the DR-46NT by DBPR or other legislative or judicial guidance.
- Section 212.08(2)(a), F.S., provides an exemption for common household remedies recommended and generally sold for internal or external use in the cure, mitigation, treatment, or prevention of illness or disease in human beings are exempt from tax.
- "Common household remedies" are limited to those found on Form DR-46NT, which is a list statutorily prescribed and approved by the Department of Business and Professional Regulation.
- Currently, the DR-46NT includes the following as "other exempt medical items":

  > Marijuana and marijuana delivery devices when sold for medicinal use to a qualified patient by a medical marijuana treatment center, except that delivery devices intended for the medical use of marijuana by smoking need not be dispensed from a medical marijuana treatment center in order to qualify as marijuana delivery devices.

- The DR-46NT also includes the following as common household remedies:
  - Burn ointments and lotions, including sunburn ointments generally sold for use in treatment of sunburn
  - Lip balms, ices, and salves
  - Lotions, medicated
  - Ointments, medicated
- In the absence additional legislation or judicial guidance, it is unclear whether a medicated ointment or lotion that includes marijuana would be considered an exempt common household remedy.

<u>Agricultural products</u>:

- Section 212.07(5)(a), F.S., provides an exemption for the sale of "farm products" when sales are made directly from the producers. Sales of marijuana made by the producer could apply.

<u>Electricity:</u>

- Section 212.08(5)(e)2., F.S., provides that electricity used for the production or processing of agricultural products on a farm is exempt from sales tax. The exemption could apply to producers of marijuana as an agricultural product.

- Similarly, s. 212.08(7)(ff), F.S., provides an exemption for purchases of electricity or steam used to operate machinery and equipment at a fixed location in Florida when the machinery and equipment is used to manufacture, process, compound, produce, or prepare for shipment tangible personal property for sale. The exemption could apply to a taxpayer that processes marijuana products for sale.

- Gross Receipts Tax on Utility Services
  Section 203.01, F.S., imposes a 2.5% gross receipts tax on the sale, delivery, or transportation of natural gas, manufactured gas (excluding liquefied petroleum [LP] gas), or electricity to a retail consumer in Florida.

Food:

- A sales tax exemption could apply.
- Food products are statutorily defined as "edible commodities, whether processed, cooked, raw, canned, or in any other form, which are generally regarded as food."
- If foods containing marijuana are distinguishable from other food products and are not to be considered "food products" (as that term is currently used in statute and rule), then the purchase of marijuana in food form would be taxable and would not qualify for possible food-based exemptions.
- Assuming food products containing marijuana are to be treated under existing statutory and administrative provisions for "food products," then the following analysis applies:

Section 212.08(1), F.S., and Rule 12A-1.011, F.A.C., apply to the taxability of food products.

- In general, food products for human consumption are exempt.
- However, certain categories of food products are always taxable (e.g., soft drinks, ice cream and popsicle-type products, and candy, gum, and mints). Items in these categories which contained marijuana (e.g., soda, candy or lollipops with marijuana ingredients) would be taxable.
- Prepared food is frequently subject to tax and has a separate analysis for taxability.

Prepared food:

- Prepared food, whether prepared on or off the seller's premises which is sold for immediate consumption or is a "hot prepared food" is subject to tax. This does not apply to food prepared off the seller's premises and sold in the original sealed container, or to the slicing of products into smaller portions.
- Baked goods excluding items sold as hot prepared food products, sold for consumption off the premises, are exempt.

Tinctures:

- Tinctures would be subject to tax.
- Tinctures are generally prepared by combining and cooking marijuana and alcohol. The resulting product is then taken in liquid or pill form, which is consumed orally.
- Despite the oral consumption of these products, tinctures would likely not be considered "food." Accordingly, there is no exemption that would appear to apply to this item.

Aerosols:

- Aerosols would be subject to tax.
- Aerosols are generally consumed orally (under the tongue), but would likely not be considered a food product. Accordingly, there is no exemption that would appear to apply to this item.

Oils:

- Oils may be subject to tax, depending on the type and intended use of the oil is meant to be edible (e.g., cooking oil or butter) or topical.
- As an edible, the oil would likely be subject to the standard rules regarding food.
- As a topical item, the oil would likely be taxable.

Machinery and equipment:

Florida law provides the following exemptions for purchases of machinery and equipment under certain conditions:

- Section 212.08(5)(b), F.S., provides an exemption for purchases of machinery and equipment purchased for exclusive use by a new business that will manufacture, process, compound, or produce items of tangible personal property for sale.
- The purchase of machinery and/or equipment by a new business for the production or processing of adult use marijuana or adult use marijuana products may be exempt.

- Section 212.08(7)(jjj), F.S., provides an exemption for purchases of machinery and equipment purchased by manufacturing businesses, including businesses that conduct postharvest crop activities, when the machinery and equipment is used at a fixed location in Florida for the manufacture, processing, compounding, or production of items of tangible personal property for sale.
- The purchase of machinery and/or equipment by a manufacturing business for the production or processing of adult use marijuana or adult use marijuana products may be exempt if the machinery and/or equipment is used at a fixed location in Florida.

Exempt entities:

Exemption from Florida sales and use tax is granted to certain nonprofit organizations and governmental entities that meet the criteria set forth in ss. 212.08(6), 212.08(7), and 213.12(2), F.S. Florida law requires that these nonprofit organizations and governmental entities obtain an exemption certificate from the Department. The exempt nature of a transaction must be determined by the exempt entity.

- Section 212.08(7)(p), F.S., provides an exemption from the tax imposed on sales or leases to a section 501(c)(3), I.R.C., organization, when such leases or purchases are used in carrying on its customary nonprofit activities.
- The purchase of adult use marijuana or adult use marijuana products by a 501(c)(3) organization may be exempt if it is determined that the marijuana or marijuana product is used to carry out the organization's customary nonprofit activities.

- Section 212.08(7)(m), F.S., provides an exemption from sales tax for "transactions involving sales or leases directly to religious institutions when used in carrying on their customary nonprofit religious activities or sales or leases of tangible personal property by religious institutions having an established physical place for worship at which nonprofit religious services and activities are regularly conducted and carried on."
- The purchase of adult use marijuana or adult use marijuana products by a religious institution may be exempt if it is determined that the marijuana or marijuana product is used to carry out the religious institution's customary nonprofit religious activities.
- The sale of adult use marijuana or adult use marijuana products by a religious institution may be exempt if the religious institution has an established physical place for worship at which nonprofit religious services and activities are regularly conducted and carried on.

Florida Department of Revenue
Medical Marijuana Parcel Summary Estimate

	Cultivation Only	Cultivation and Processing	Processing only	* Total Value
Number of Real Property Parcels	12	24	5	41
Number of TPP Accounts				25
Just Value	$ 43,871,762	$ 90,020,119	$ 12,882,512	$ 146,774,393
Assessed Value - Non School	$ 41,332,570	$ 79,598,492	$ 12,882,512	$ 133,813,574
Assessed Value - School	$ 41,682,691	$ 84,013,564	$ 12,882,512	$ 138,578,767
Taxable Value - Non School	$ 41,332,570	$ 79,598,492	$ 12,882,512	$ 133,813,574
Taxable Value -School	$ 41,682,691	$ 84,013,564	$ 12,882,512	$ 138,578,767
TPP - Taxable Value				$ 59,326,573

* Total Value may be overstated due to parcels with improvements or land unrelated to cultivation or processing of marijuana

Parcel Classification based on Florida Department of Health licensing information

36 of 37 Cultivation sites located using address information

30 of 31 processing facilities located using address information

Licensees may have both cultivation and processing on the same parcel

Land Use Codes on the tax roll vary from agricultural to light industrial

School Millage Rate	5.9581
Non School Millage Rate	10.5827

Estimated Taxes Levied including TPP	
School	$ 1,179,140
Non School	$ 2,043,944
Total	$ 3,223,084

New construction

Nine parcels with 2021 new construction totaling $41.3 Million (Just Value)
Six parcels with deletions totaling $3.16 Million (Just Value)

Classified Use

	Cultivation Only	Cultivation and Processing	Processing only	* Total Value
Just Value Classified Use - Agriculture	$ 4,227,095	$ 7,271,195	$ -	$ 11,498,290
Assessed Value Classified Use Agriculture	$ 2,038,024	$ 1,264,640	$ -	$ 3,302,664

Sixteen of the forty-one parcels have some land with agricultural classified use, which was generally land under cultivation facilities such as greenhouses, commercial canopy, but some were for additional mixed agricultural usage.

Examples of parcels with classified use agricultural land:

Example 1 - Three land lines
9.68 - Classified Use agricultural under greenhouses & 1.7 acres - agricultural waste/limited use
3.5 acres industrial under processing facility

Example 2 - Three land lines
225 acres Classified use agriculture and 23.2 productive swamp - Timber unrelated to the cultivation license
25 acres at market rate - under industrial buildings which included cultivation and processing facilities

Example 3 - One land line
85 acres classified use agricultural which includes all acreage under and around numerous industrial buildings and greenhouses which all appear to be for cultivation and processing

Example of parcels with industrial land use classification - warehouse /light industrial

Example 1 - Cultivation and/or Processing Facilities on a warehouse parcel contains 9 warehouses with a total value of over $9 million. However not all warehouses related to cultivation/processing. The facility has multiple tenants.

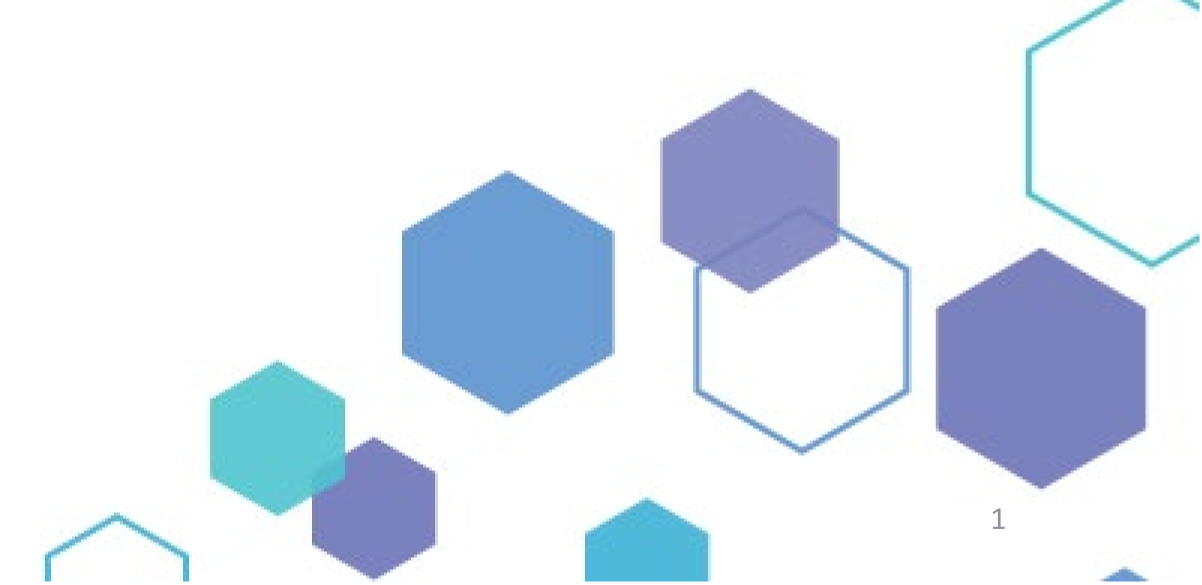
Example 2 - Parcel with multiple warehouses or structures - all related to parcel owner and used in cultivation or processing.

FLORIDA DEPARTMENT OF HEALTH (DOH)

Office of Medical Marijuana Use

Petition Initiative 22-05 FIEC Presentation

Florida's Official Source for Medical Use.



Office of Medical Marijuana Use (OMMU)

The Office of Medical Marijuana Use (OMMU):

- Develops and implements the Department of Health's rules for medical marijuana.
- Oversees the statewide Medical Marijuana Use Registry (MMUR).
- Licenses Florida businesses to cultivate, process, and dispense medical marijuana to qualified patients.
- Certifies and inspects marijuana testing laboratories to ensure the health and safety of the public as it relates to medical marijuana.

Medical Marijuana Patients

- As of June 23, 2023, the Medical Marijuana Use Registry has **828,560** active qualified patients (valid identification card).

Total Patients with Approved Medical Marijuana Use Registry ID Cards

900,000
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
0

Mar 17 · Apr 17 · May 17 · Jun 17 · Jul 17 · Aug 17 · Sep 17 · Oct 17 · Nov 17 · Dec 17 · Jan 18 · Feb 18 · Mar 18 · Apr 18 · May 18 · Jun 18 · Jul 18 · Aug 18 · Sep 18 · Oct 18 · Nov 18 · Dec 18 · Jan 19 · Feb 19 · Mar 19 · Apr 19 · May 19 · Jun 19 · Jul 19 · Aug 19 · Sep 19 · Oct 19 · Nov 19 · Dec 19 · Jan 20 · Feb 20 · Mar 20 · Apr 20 · May 20 · Jun 20 · Jul 20 · Aug 20 · Sep 20 · Oct 20 · Nov 20 · Dec 20 · Jan 21 · Feb 21 · Mar 21 · Apr 21 · May 21 · Jun 21 · Jul 21 · Aug 21 · Sep 21 · Oct 21 · Nov 21 · Dec 21 · Jan 22 · Feb 22 · Mar 22 · Apr 22 · May 22 · Jun 22 · Jul 22 · Aug 22 · Sep 22 · Oct 22 · Nov 22 · Dec 22 · Jan 23 · Feb 23 · Mar 23 · Apr 23 · May 23

Approved Cards
1.5% of Florida Population
2.5% of Florida Population

Office of Medical Marijuana Use (OMMU)

The OMMU regulates:

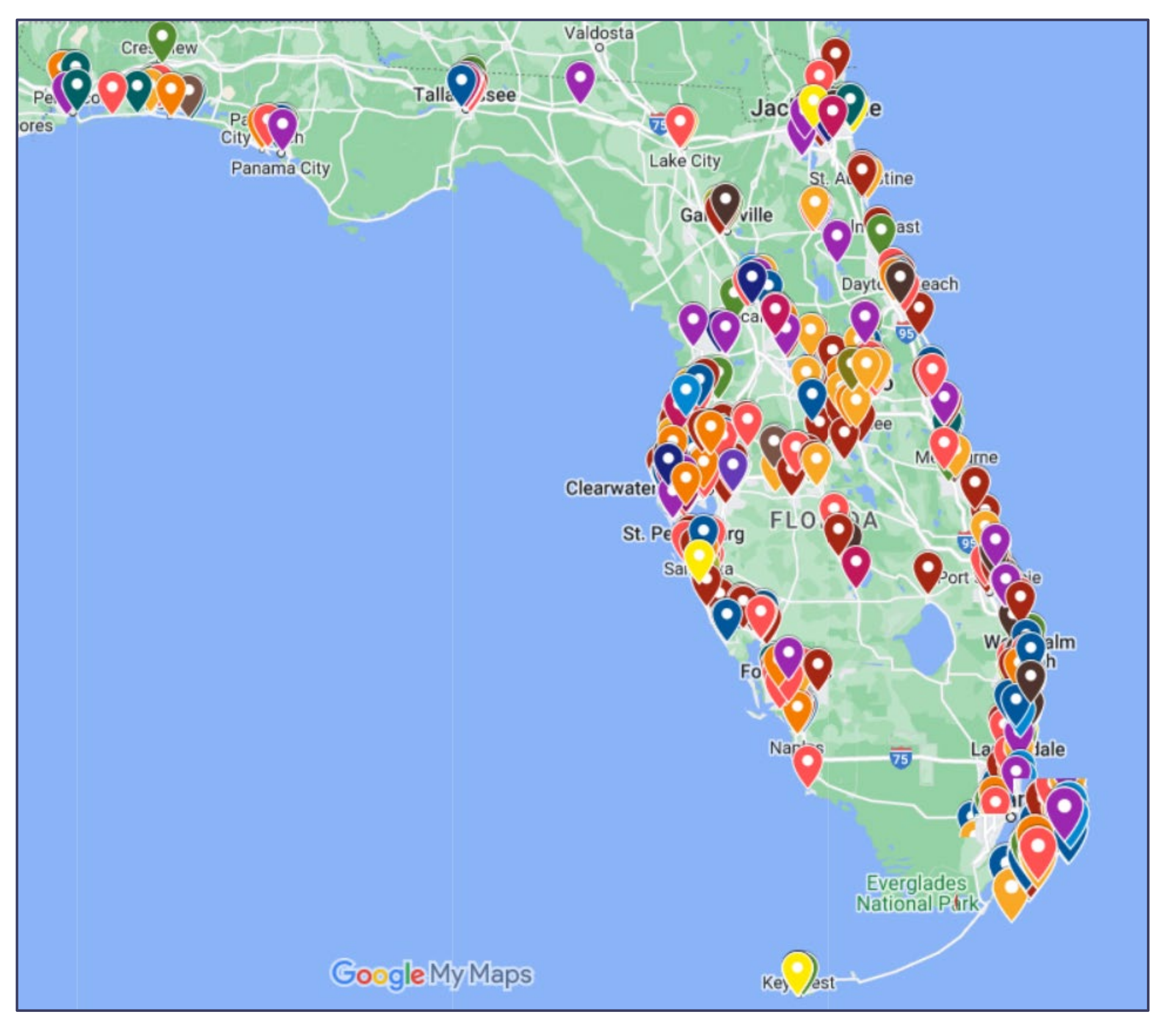
- Vertically integrated medical marijuana treatment centers (MMTCs) which cultivate, process, transport, and dispense medical marijuana products.
  - 22 licensed MMTCs operating 38 cultivation facilities and 578 dispensing facilities.
  - An additional 23 MMTC licenses have been made available.
  - Section 381.986 F.S. authorizes an additional 4 MMTC licenses for each 100,000 growth in active patient population.
- Certified Marijuana Testing Laboratories (CMTLs) which are the only entities authorized to test MMTC products before they may be dispensed to qualified patients or their caregivers.
  - 10 CMTLs are currently certified.

OMMU Organization

Director's Office

- Operations Unit
- Compliance & Labs Unit
- Licensing & Regulation

MMTC Dispensing Locations



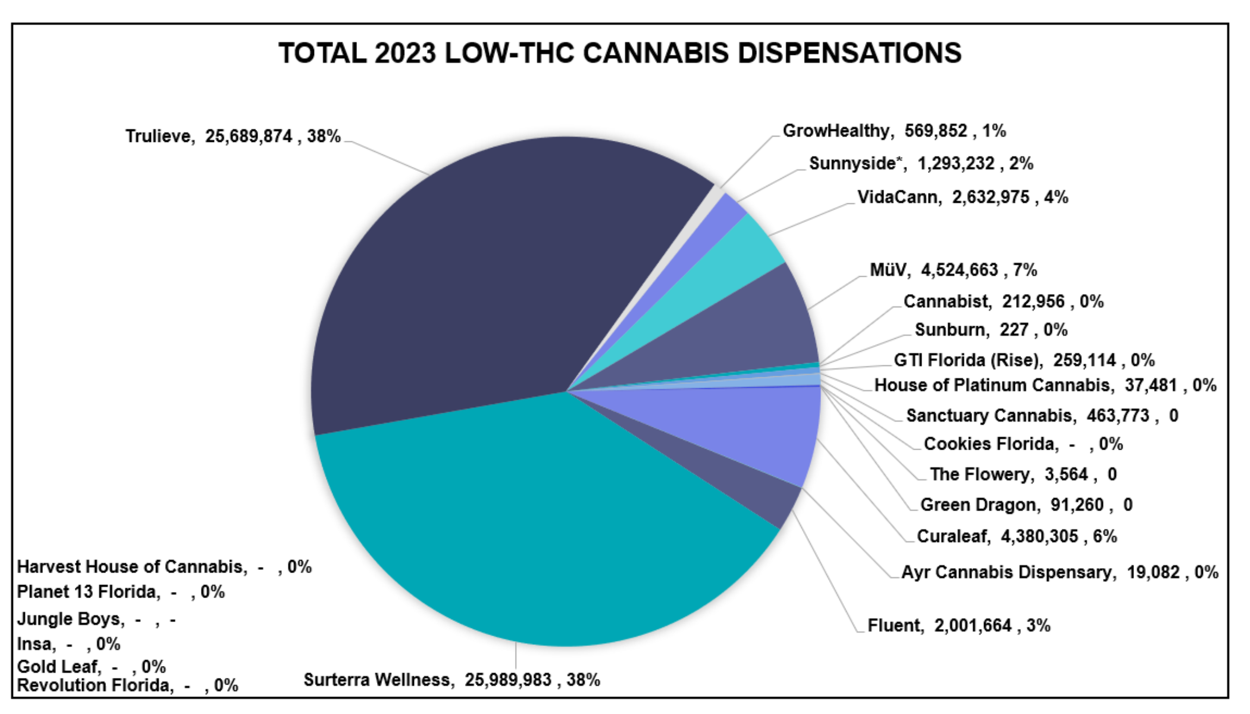
** MMTC locations as of 6/16/2023*

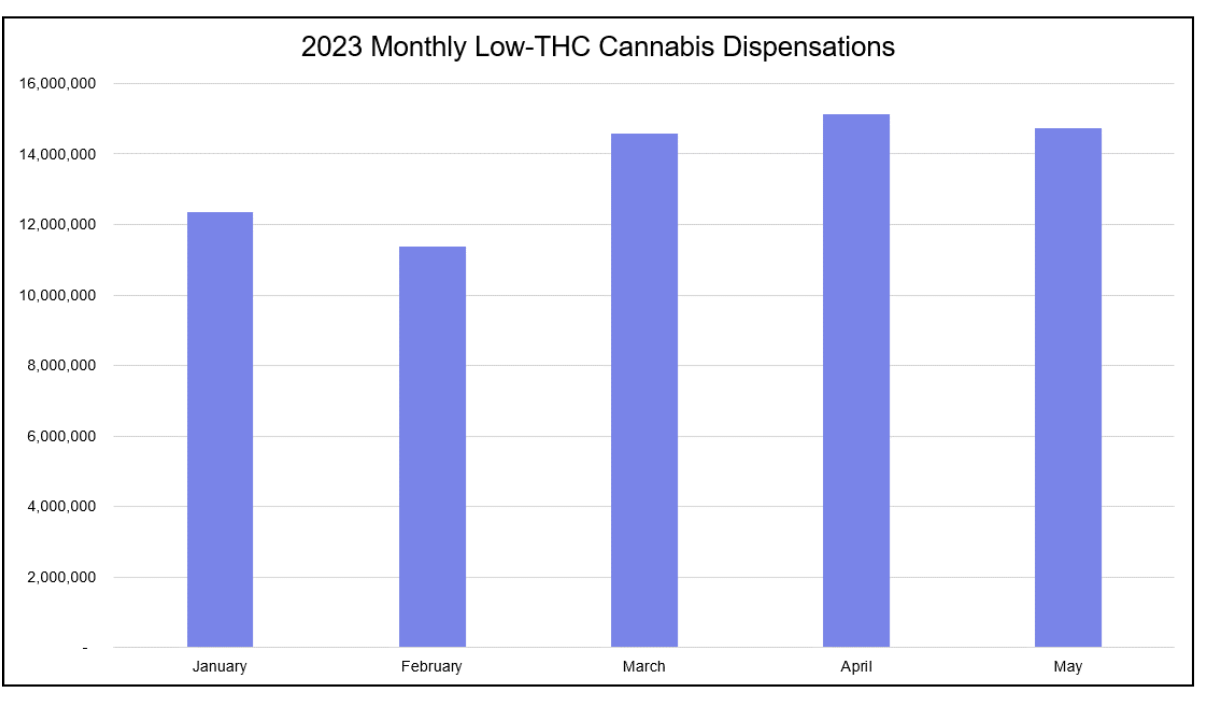
MMTC	No.
Trulieve	126
MuV	68
Ayr Cannabis Dispensary	61
Curaleaf	60
Surterra Wellness	45
Fluent	32
Sunnyside	31
Green Dragon	31
VidaCann	26
Sanctuary Cannabis	19
GrowHealthy	18
Cannabist	14
Sunburn	10
Insa - Cannabis for Real Life	9
GTI Florida, LLC	8
Jungle Boys	7
The Flowery	5
House of Platinum Cannabis	4
Cookies Florida, Inc.	3
Gold Leaf	1
Revolution Florida	0
Planet 13 Florida, Inc.	0
Total	**578**

Low-THC Cannabis Dispensed

January 1, 2023 – May 31, 2023, **68,170,005** mg of Low-THC Cannabis has been dispensed.

- Total milligrams of Low-THC Cannabis dispensed in 2022: **172,703,754** mg
- Total milligrams of Low-THC Cannabis dispensed in 2021: **205,490,977** mg
- Total milligrams of Low-THC Cannabis dispensed in 2020: **167,407,133** mg
- Total milligrams of Low-THC Cannabis dispensed in 2019: **120,780,603** mg
- Total milligrams of Low-THC Cannabis dispensed in 2018: **78,013,623** mg
- Total milligrams of Low-THC Cannabis in 2017: **21,348,731** mg

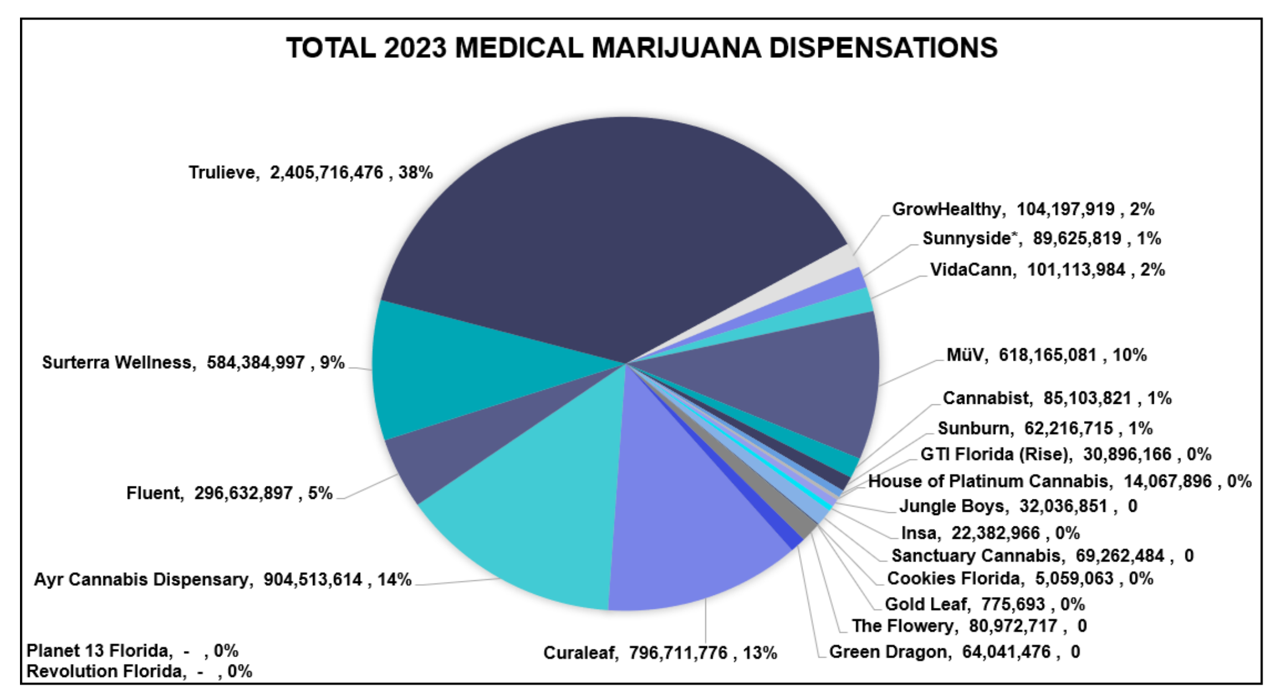


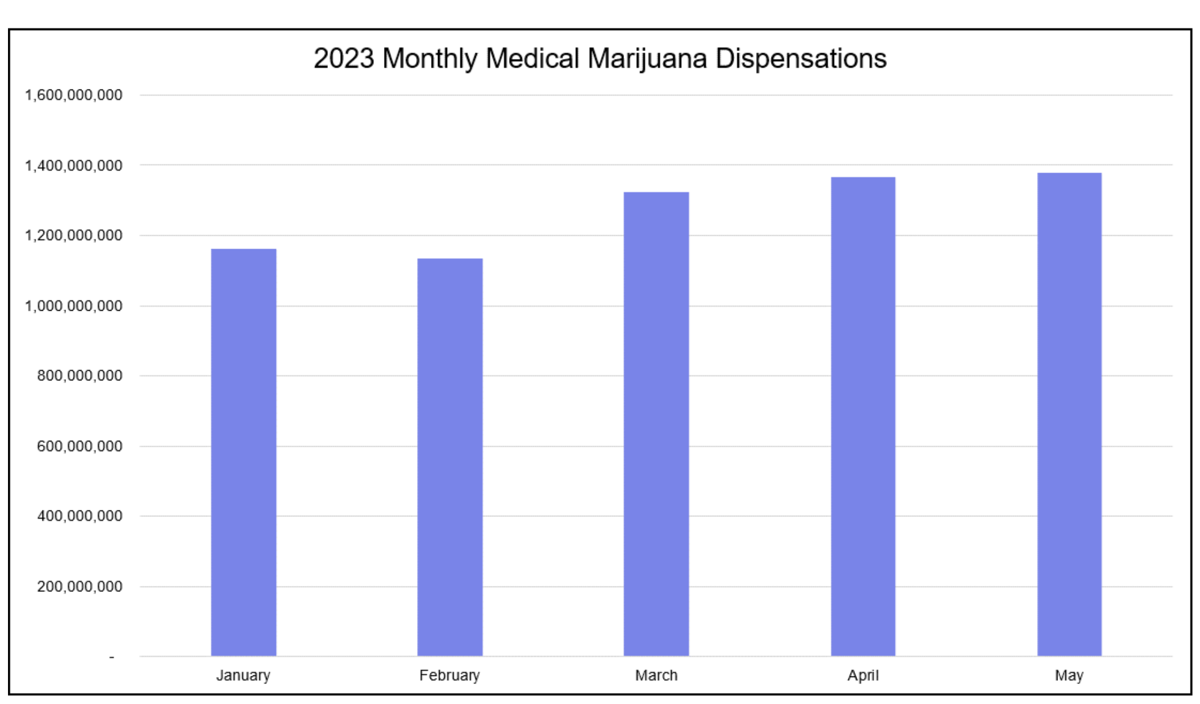


Medical Marijuana Dispensed

January 1, 2023 – May 31, 2023, **6,367,878,411** mg of Medical Marijuana has been dispensed.

- Total milligrams of Medical Marijuana dispensed in 2022: **13,012,432,512** mg
- Total milligrams of Medical Marijuana dispensed in 2021: **10,098,533,157** mg
- Total milligrams of Medical Marijuana dispensed in 2020: **6,044,241,078** mg
- Total milligrams of Medical Marijuana dispensed in 2019: **3,601,136,288** mg
- Total milligrams of Medical Marijuana dispensed in 2018: **1,564,938,078** mg
- Total milligrams of Medical Marijuana dispensed in 2017: **184,063,963** mg

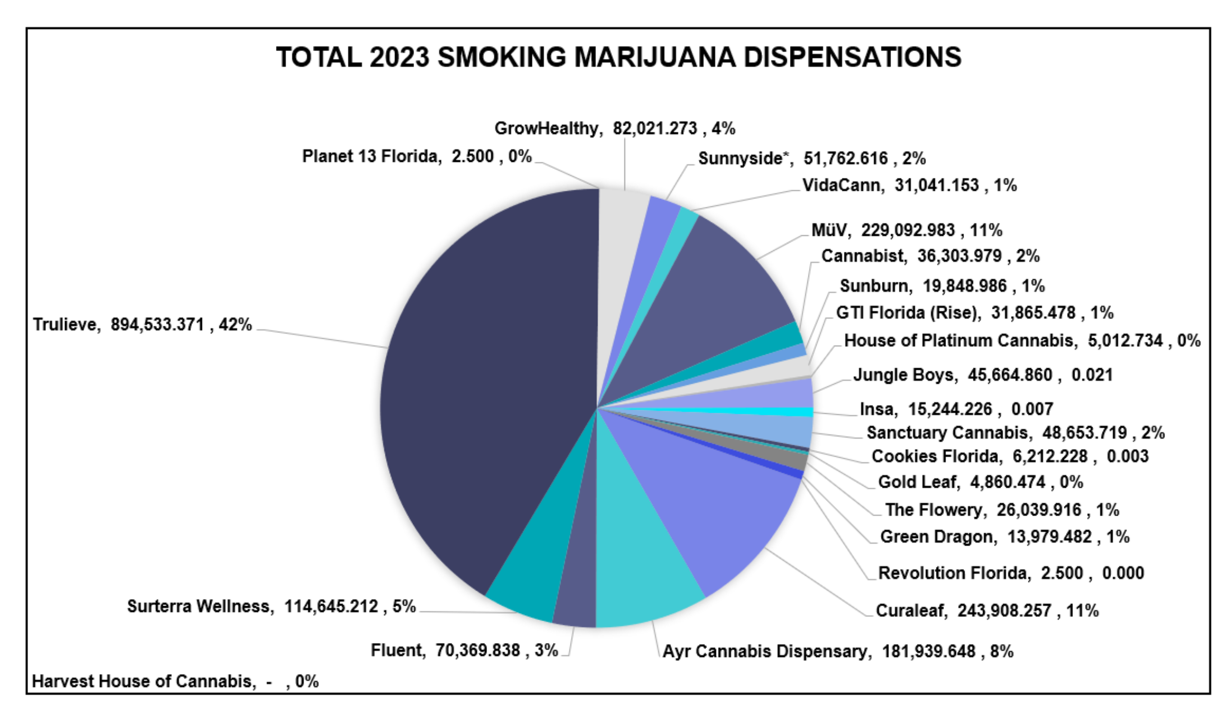


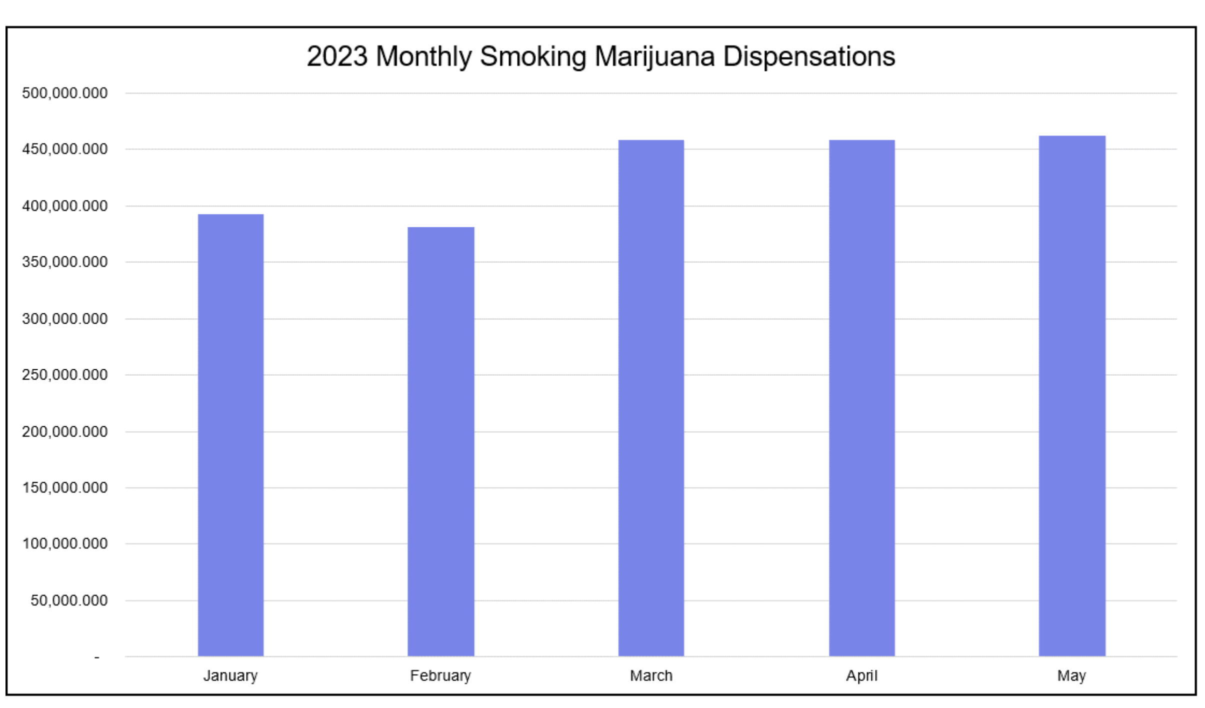


Smoking Marijuana Dispensed

January 1, 2023 – May 31, 2023, **2,153,002.933** oz of Smoking Marijuana has been dispensed.

- Total milligrams of Smoking Marijuana dispensed in 2022: **4,284,992.862** oz
- Total milligrams of Smoking Marijuana dispensed in 2021: **3,546,192.670** oz
- Total milligrams of Smoking Marijuana dispensed in 2020: **1,979,525.886** oz
- Total milligrams of Smoking Marijuana dispensed in 2019: **363,703.967** oz **from June 1, 2019 – December 31, 2019*





Impact Analysis of Petition Initiative 22-05

Prepared Upon Request of the Financial Impact Estimating Conference
July 7, 2023

I. INTRODUCTION

A. Petition Initiative 22-05

Petition Initiative 22-05, titled "Adult Personal Use of Marijuana," is a citizen petition initiative sponsored by Smart & Safe Florida, which was approved as a petition initiative by the Florida Division of Elections on August 23, 2022. The petition initiative seeks to propose a constitutional amendment for consideration on the 2024 election year ballot to regulate marijuana for limited use by persons twenty-one years of age or older ("adult personal use") and permit the licensure of additional entities to acquire, cultivate, process, manufacture, sell, and distribute marijuana for adult personal use.

On May 5, 2023, Petition Initiative 22-05 triggered review by a Financial Impact Estimating Conference of the Office of Economic and Demographic Research pursuant to section 100.371, Florida Statutes. Upon notice of workshops for this statutory review process, the Financial Impact Estimating Conference requested that the Department of Health (Department or DOH) prepare an agency analysis providing projections on financial impacts related to establishing a regulatory program and administering regulations associated with an adult personal use marijuana market if the Constitutional Amendment were placed on the ballot and approved by the voters as presented.

B. Regulatory Responsibilities of the Department in Petition Initiative 22-05

Petition Initiative 22-05 does not expressly direct the Department to promulgate regulations for the adult personal use of marijuana. The proposed amendment maintains the Department's existing authority set forth under Article X, Section 29(d) of the Florida Constitution, specifically retaining the following directive: "[t]he Department shall issue reasonable regulations necessary for the implementation and enforcement of this section." The proposed amendment language provides for an effective date of six months subsequent to voter approval.

Pursuant to section 20.43, F.S., the purpose of the Department of Health is to protect and promote the health of all residents and visitors in the state through organized state and community efforts, including cooperative agreements with counties. The Department is further directed to engage in specific health protection and regulatory actions to accomplish its public health purpose.

The regulation of adult personal use of marijuana is outside of the purpose for which the Department of Health was created. Nevertheless, the Department's experience regulating medical marijuana can assist with the development of the financial impact of the regulation of the adult personal use of marijuana for the agency that will be charged with that duty.

Based on the general regulatory scope outlined in Petition Initiative 22-05, the Department addresses in this analysis the projected needs for program personnel, support personnel,

equipment, facilities, and other resources that would be necessary for the establishment and ongoing maintenance of a licensing and compliance program associated with regulating adult personal use of marijuana in Florida.

II. DEPARTMENT ANALYSIS: ASSUMPTIONS AND APPROACH

A. Analysis Assumptions

The Department has relied upon a series of assumptions related to the viability of the ballot initiative, the authorization of the constitutional amendment, and if adopted by voters, the subsequent legislative and regulatory approach to implementing the licensing and compliance elements of a state program for administering laws and regulations related to the adult personal use marijuana market. The assumptions utilized to inform this analysis have been designed solely for the purpose of establishing a baseline expectation and a basic set of parameters through which organizational design, operational costs, and other factors influencing this analysis can be measurably projected. Accordingly, none of the assumptions reflect an official statement of position related to the proposed constitutional amendment and should not be construed to represent the Department as a proponent or opponent of any particular assumption or any alternative assumption not incorporated in this analysis.

1. Assumptions Regarding the Constitutional Amendment Proposed by Petition Initiative 22-05

   1.1. The Constitutional Amendment proposed by Petition Initiative 22-05 will appear on the November 2024 election ballot.
   1.2. The Constitutional Amendment proposed by Petition Initiative 22-05 will be approved by Florida voters and be effective in May 2025.

2. Assumptions Regarding State Implementation of the Constitutional Amendment

   2.1. Legislation implementing the Constitutional Amendment will be effective after the effective date of the Constitutional Amendment.
   2.2. (HIGH-RISK ASSUMPTION) All entities authorized for licensure to dispense marijuana will be required by statute to be vertically integrated, mirroring the existing structure of Medical Marijuana Treatment Center (MMTC) licenses. Florida's vertical integration framework requires that MMTCs cultivate, process, transport, and dispense marijuana and prohibits MMTCs from contracting for services directly related thereto. This assumption is high risk in that a contrary outcome could result in a large population of entities to be regulated by the responsible state agency, resulting in a need for significantly more resources to perform all regulatory functions.

2.3. The Department will be granted statutory authority to develop and promulgate additional administrative rules necessary for the implementation of adult personal use of marijuana.
2.4. Statutes and regulations relating to advertising and marketing, packaging and labeling, facility inspections, and product testing will be similar to existing requirements for the medical use of marijuana.
2.5. There will not be a statutory cap on the number of adult personal use marijuana dispensary locations.
2.6. Comparable to licenses authorized in the regulation of medical marijuana, each license type administered by the program will have a biennial license fee. License fee amounts to be established upon implementation are undetermined and not factored into this analysis.
2.7. Applications for licensure will be available electronically and required to be filed for direct processing by Department licensing staff.
2.8. The Department will develop an expanded module of its existing medical marijuana seed-to-sale tracking system to capture sales by licensees authorized to distribute marijuana.
2.9. The Department will utilize existing regulatory information technology systems with significant modifications to accommodate an adult personal use licensing scheme.
2.10. Regulations of adult personal use marijuana testing and reporting of those testing results will mirror existing requirements for medical marijuana.
2.11. The Department will expand an existing DOH laboratory for any regulatory compliance testing functions.
2.12. The Department will monitor and track level 2 background screening results for owners, managers, and employees of the new licensees.

3. <u>Assumptions Regarding Industry Changes Upon Adoption of Constitutional Amendment</u>

3.1. Currently licensed MMTCs will increase their cultivation, processing, and dispensation footprints upon approval of the Constitutional Amendment.
3.2. Currently licensed MMTCs will begin to dispense marijuana from their previously approved medical marijuana dispensing facilities on the effective date of the Constitutional Amendment.
3.3. The adult personal use sales of marijuana will compete with currently available intoxicating (e.g., Delta-8) and non-intoxicating (e.g., CBD) hemp-derived products for adult personal use customers. The dynamic of that competition will be shaped in part by future legislative and regulatory actions at the federal and state levels.
3.4. Florida's medical marijuana population will contract by an indeterminate amount, consistent with the patient populations in other states that approved adult personal use of marijuana.

3.5. The combined medical marijuana and adult personal use marijuana dispensations will grow by an indeterminate yet significant amount.

4. Assumptions Regarding Organizational Design and Operational Costs Upon Adoption of Constitutional Amendment

    4.1. Additional positions and regulatory functions will be added to the existing Office of Medical Marijuana Use (OMMU) to become the Division of Marijuana Use.
    4.2. Hiring of projected staff positions, particularly central program leadership and counsel positions, will need to be expedited following adoption to maximize time available for program development and implementation. Licensure and compliance positions will need to be expedited to afford reasonable time for internal staff training and development regarding procedures and regulations adopted as part of the implementation.
    4.3. Interest in the new program, including legislative, industry, public, media, legal, and other inquiries, will be significant through the immediate launch and the first 12-24 months of the program's implementation, creating unique operational burdens that compound resource needs.

NOTE: If the presented assumptions do not materialize, the Department will reevaluate and modify or revise program planning.

III. DEPARTMENT ANALYSIS: IMPACT PROJECTIONS

A. Core Program Staffing Anticipated for Administering Regulatory Program

Pursuant to the analysis assumptions utilized herein, the Department projects an expansion of the existing Office of Medical Marijuana Use (OMMU) to the Division of Marijuana Use (DMU) within the agency for purposes of administering the regulation of the adult personal use marijuana market authorized by the amendment. The Department has evaluated the immediately apparent functions that may be necessary based on the ballot initiative language and the assumptions regarding implementation of the amendment. Based on the Department's initial analysis, the following existing areas of the OMMU will need to be expanded into bureaus to accommodate the DMU: (1) licensing and regulation, with staff and resources to monitor product offerings; process applications of persons or entities seeking licensure, including ongoing license maintenance, renewal, and recordkeeping; and development and adoption of administrative rules; (2) compliance, with staff and resources to facilitate routine compliance inspections and other field-based compliance activities; process and track background screening results; monitor and investigate complaints; and audit testing activities; and (3) operations, with staff and resources to oversee information technology systems, personnel

management, communications, office management, and quality assurance and reporting. The Department also estimates the need for additional Other Personal Services (OPS) positions to support the three newly established bureaus.

1. Licensing and Regulation

Position Class	Full-Time Equivalent (FTE) Positions	Total Salary/Benefits	Recurring: Y/N
General Operations Manager II (Licensing Administrator)	1.0	$138,478	Y
Government Operations Consultant I (Intake Consultant)	1.0	$81,092	Y
General Operations Manager I (Licensing Manager)	1.0	$129,589	Y
Operations & Mgmt Consultant II (Renewal Supervisor)	1.0	$93,218	Y
Government Operations Consultant I (Renewal Processor)	1.0	$81,092	Y
Operations & Mgmt Consultant II (Rules Supervisor)	1.0	$93,218	Y
Government Analyst II (Rules Coordinator)	1.0	$106,333	Y

2. Compliance

Position Class	FTE Positions	Total Salary/Benefits	Recurring: Y/N
Environment Consultant (Lab Inspectors)	2.0	$212,667	Y
Government Operations Consultant II (Background Screening Reviewer)	2.0	$181,775	Y

Operations & Mgmt Consultant II (Compliance Supervisor)	2.0	$186,436	Y
Inspector Specialist (Compliance Officer)	11.0	$1,065,011	Y
Investigation Manager	1.0	$118,877	Y
Investigator Supervisor	3.0	$298,443	Y
Inspector Specialist (Inspector)	26.0	$2,517,298	Y

3. Operations

Position Class	FTE Positions	Total Salary/Benefits	Recurring: Y/N
Government Analyst II (Quality Assurance)	2.0	$212,667	Y
Regulatory Supervisor/Consultant	1.0	$77,981	Y
Regulatory Specialist II (Call Center Agents)	7.0	$450,307	Y
Systems Project Analyst (Seed-to-Sale Analysts)	2.0	$193,638	Y
Government Operations Consultant II (Procurement)	2.0	$181,775	Y
Government Operations Consultant II (Personnel Management)	1.0	$90,888	Y

4. OPS

Position Class	FTE Positions	Total Salary/Benefits	Recurring
Varied	10.0	$1,186,560	N

B. Support Staffing Anticipated for Administering Regulatory Program

1. <u>Program Legal Services</u>

The Department's Office of General Counsel projects the need for the following additional full-time staff to support legal challenges to agency action, including rulemaking, license approval and denial, litigation, and administrative enforcement actions:

Position Class	FTE Positions	Total Salary/Benefits	Recurring
Chief Legal Counsel	1.0	$182,850	Y
Senior Attorney	2.0	$292,559	Y
Paralegal	1.0	$56,279	Y

2. <u>Office of Budget and Revenue Management</u>

The Department's Office of Budget and Revenue Management (OBRM) has identified a need for 4 new positions if this amendment passes. This amendment would increase the workload for OBRM as it pertains to debt memos, deposits, ACH transfers, budget amendments, Legislative Budget Request issues, financial monitoring, reporting, training, revenue and expenditure forecasting, and compliance.

Position Class	FTE Positions	Total Salary/Benefits	Recurring
Budget Analyst B- SES	2.0	$198,962	Y
Professional Accountant	1.0	$79,427	Y
Accountant IV	1.0	$79,427	Y

C. Summary of Program and Support Staffing Projections

Based on projected staffing needs identified in sections II.A. and II.B. above, the Department projects a total of 77.0 FTE positions and 10.0 OPS positions as summarized with corresponding salaries, benefits, and standard expense factors in the tables below:

Core Program Staffing					
Bureau	Positions	Position Rates/Benefits	Standard Expense		HR Outsourcing
			Recurring	Non-Recurring	
Licensing and Regulation	7.0	$723,022	$74,431	$33,873	$2,391
Compliance	47.0	$4,580,508	$916,511	$227,433	$16,054
Operations	15.0	$1,207,257	$111,495	$72,585	$5,124
OPS	10.0	$1,186,560	N/A	N/A	$977
Total	79.0	$7,697,347	$1,102,437	$333,891	$24,546

Support Staffing					
Office	Positions	Position Rates/Benefits	Standard Expense		HR Outsourcing
			Recurring	Non-Recurring	
Program Legal Services	4.0	$531,689	$38,220	$19,007	$1,367
OBRM	4.0	$357,817	$52,004	$19,356	$1,367
Total	8.0	$889,505	$90,224	$38,363	$2,733

Total Staffing				
Positions	Position Rates/Benefits	Standard Expense		HR Outsourcing
		Recurring	Non-Recurring	
87.0	$8,586,852	$1,192,661	$372,254	$27,279

D. Equipment, Facilities, and Resources

The Department anticipates financial impacts will be realized in the procurement of facilities, supplemental equipment, and other resources needed to support the daily operation of the new regulatory program.

1. Facility Leasing
   Rule 60H-2.002, Florida Administrative Code, directs state agencies to obtain an average of 180 net useable square feet of space per full-time employee. Based on analysis of space in the Department's current central office location at the Capital Commerce Center, the available square footage under the Department's current lease and other available space at the same facility is insufficient to support the square footage per full-time employee recommended by state regulations for the number of

positions projected in this analysis. Therefore, the new program is projected to be located at a new location to be leased within a state-managed or privately-owned facility. For efficiency of analysis, the Department has presented a range of potential facility lease expenses based on current state and private rates per square foot.

Projected Facility Lease Expenses Utilizing Current State Rate				
Projected FTE Positions	Square Feet Per Position	Total Square Feet Needed	Current DMS Rate Per SF/Annual	Total Projected Annual Lease Expense
87	180	15,660	$17.18	$269,039
Projected Facility Lease Expenses Utilizing Sample Rates at Private Facilities (Tallahassee)				
Projected FTE Positions	Square Feet Per Position	Total Square Feet Needed	Current DMS Rate Per SF/Annual	Total Projected Annual Lease Expense
87	180	15,660	$23.02	$360,494

Source Data: Office of Program Policy Analysis and Government Accountability (OPPAGA)

87 FTE Positions X 180 SF Per Position = 15,660 Total SF Needed

15,660 Total SF Needed X $17.18 Rate Per SF Annual = $269,039 DMS Rate

15,660 Total SF Needed X $23.02 Rate Per SF Annual = $360,494 Private Rate

The above projections do not factor the potential assignment of projected positions to field-based locations dependent on final organizational design upon implementation. Lease expenses may vary based on the number of positions assigned to a field office location, the current capacity of existing department facilities to absorb additional assigned positions, and the competitive market rates for private facility space leases should new field-location leasing be necessary.

2. Fleet Acquisition and Management

   The Department projects a need for acquisition of fleet vehicles to support the daily compliance inspection activity assumed for purposes of this analysis. Based on projected compliance inspection positions, including positions associated with testing inspection, the Department projects a minimum need of the following vehicle assets:

	Expense Per Vehicle	**Expense Projected for 30 Vehicles**
Motor Vehicle Acquisition	$23,990	$719,700
Motor Vehicle Operation	$3,000	$90,000

3. Supplemental Technology Equipment

The Department's Division of Technology projects non-recurring, initial expenses for establishing network drops, procuring software licenses, and equipping field-based personnel with mobile technology assets to support implementation of regulatory functions in this program as follows:

	Network Drops	Laptops	iPads	General Software Licenses	Specialized Software	Misc. Program Equipment
Per Unit	$235	$1,306	$1,100	$400	Varied	Varied
Total Projected	$17,155	$95,338	$60,500	$29,200	$378,724	$26,791
Total Non-Recurring	$607,708					

The Department's Division of Technology projects recurring expenses for maintenance, support, and data services on the technology assets that are procured in support of the regulatory program as follows:

	Program Equipment Maintenance	iPad Data Service and Maintenance	General Software Maintenance	General Software Licenses	Specialized Software Maintenance
Per Unit	$3,000	$450	$350	$400	$520
Total Projected	$9,000	$24,750	$25,550	$29,200	$37,960
Total Recurring	$126,460				

E. Other Department Expenses Related to Implementation of Constitutional Amendment

1. Litigation Regarding Rule Development and Licensure Determinations

The Department anticipates litigation relating to rulemaking, licensure actions, litigation, and other regulatory actions arising during implementation of this new program will increase litigation expenses during the first 12-24 months of implementation. Reasonable projections forecast litigation expenses, depending on the volume of litigation involving the Department and the State of Florida, to be $2,500,000 or more per year in the first two years of program development. These litigation expense projections are highly variable and contingent upon needs for

outside counsel, expert witnesses, testing and laboratory analyses, and other litigation factors beyond the reasonable ability to predict at the time of this analysis.

2. Public Health Laboratory Facilities and Expenses

2.1 Staffing Projections

The Department's Bureau of Public Health Laboratories projects the need for the following additional full-time staff to support to support implementation of regulatory functions in this program as follows:

Laboratory Staff			
Position Class	**FTE Positions**	**Total Salary/Benefits**	**Recurring: Y/N**
Medical Laboratory Scientist III	3.0	$237,631	Y
Chemist III	3.0	$253,622	Y
Laboratory Technician III	2.0	$133,989	Y
Data Entry Operator	2.0	$114,400	Y
Total	10.0	$739,642	Y

2.2 Supplemental Technology Equipment

The Department's Bureau of Public Health Laboratories projects non-recurring, initial expenses for procuring laboratory instruments, laptops, laboratory equipment, and program equipment to support implementation of regulatory functions in this program as follows:

	Lab Instruments	**Laptops**	**Misc. Lab Equipment**	**Misc. Program Equipment**
Per Unit	Varied	$1,200	Varied	Varied
Total Projected	$2,005,106	$12,000	$230,194	$6,440
Total Non-Recurring	$2,253,740			

The Department's Bureau of Public Health Laboratories projects recurring expenses for maintenance, support, and data services on the laboratory,

laboratory equipment, accreditations, and specialized software assets that are procured in support of the regulatory program as follows:

	Lab Maintenance	General Equipment Maintenance	General Accreditations	Specialized LIMS Software Maintenance
Per Unit	$18,570	$2,800	$2,056	$2,160
Total Projected	$204,270	$5,600	$18,504	$75,600
Total Recurring	$303,974			

June 23, 2023

Coordinator Amy Baker
Office of Economic & Demographic Research
111 West Madison Street
Suite 574
Tallahassee, FL 32399-6588

RE: Constitutional Amendment Titled: Adult Personal Use of Marijuana

Dear Coordinator Baker:

The Florida Sheriffs Association (FSA) and the Florida Police Chiefs Association (FPCA) have been asked if the proposed Constitutional Amendment "Adult Personal Use of Marijuana" would have a fiscal impact on law enforcement. In our research to provide an accurate response, we have learned that this is a difficult question to answer - because the impact of decriminalizing the use of a controlled substance has a multitude of impacts in states that currently have such a model, but identifying a model for measuring this in fiscal terms is not simple.

We felt the need to respond collectively as Associations representing the highest levels of law enforcement leadership in Florida - Sheriffs, and Chiefs of Police - as we know that moving in the direction of legalization will undoubtedly impact public safety, even if we can't put a specific dollar amount on what this impact will ultimately cost Floridians and our visitors.

We think it is important to note that the lessons learned from other states suggest that there are some common trends –potency increases in marijuana available for use, upticks in homelessness, emergence of illegal markets and criminal cartels, impaired driving and traffic fatality increases, and hospitalization as a result of marijuana use. As the United States continues in its experiment with legal marijuana, we also know that the number of Americans who heavily use marijuana is soaring. According to a recent National Survey of Drug Use and Health, the number of Americans who are heavily use marijuana (at least 300 times a year) has risen from 3 million in 2006 to 8 million in 2017, coming close to the alcohol abuse numbers.

There are twenty-three states and the District of Columbia that have legalized recreational use of marijuana. Detailed data from all these states is not available but from the states that have published reports there are some key findings which we would like to offer, along with some broader law enforcement impacts.

Notable State Specific Findings:

Colorado[1]

Colorado legalized recreational marijuana in 2012.

Driving Fatalities

- From 2013 to 2019, marijuana related traffic deaths increased 140%[2].

Arrests

- Marijuana possession arrests, which make up the majority of all marijuana arrests, decre ased by more than half (59%).
- Marijuana sales arrests decreased by 17%
- Arrests for marijuana production increased markedly (+51%).

Washington[3]

Washington state legalized marijuana for recreational use in 2012. Washington modeled their marijuana laws after the state's alcohol laws.

Driving Fatalities

- In 2017, fatal crashes involving drivers who tested THC positive were double the level before marijuana legalization.
- 21% of Washington drivers involved in a fatal crash in 2017 tested positive for marijuana.

California[4]

California legalized marijuana for recreational use in 2016. Over 10,000 cannabis businesses operate throughout the state.

Driving Fatalities

From 2005 to 2015, drivers testing positive for marijuana involved in a fatal crash increased by 52.8%

Illegal Market

80% of the cannabis sold in California, worth an estimated $3.7 billion, comes from the illegal black market[5].

- The illegal market for cannabis continues to thrive in California.

---

[1] Rocky Mountain High Intensity Drug Trafficking Area (2018). The legalization of marijuana in Colorado: The Impact, Update. September 2021 https://www.dfaf.org/new-rocky-mountain-hidta-report-on-impact-of-marijuana-legalization-now-available/.

[2] Colorado Division of Criminal Justice, Impacts of Marijuana in Colorado. https://dcj.colorado.gov/news-article/colorado-division-of-criminal-justice-publishes-report-on-impacts-of-marijuana.

[3] AAA Foundation for Traffic Safety. Cannabis Use Among Drivers in Fatal Crashes in Washington State Before and After Legalization. https://aaafoundation.org/cannabis-use-among-drivers-in-fatal-crashes-in-washington-state-before-and-after-legalization/.

[4] Marijuana's Impact on California, HIDTA Report, 2018.

[5] Murphy, K. "Cannabis 'Black Market Problem." Forbes. April 4, 2019. Retrieved from https://www.forbes.com/sites/kevinmurphy/2019/04/04/cannabis-black-market-problem/#56b039b0134f.

- California's governor, Gavin Newsom, has declared that illegal grows in Northern California "are getting worse, not better" and two months ago redeployed a contingent of National Guard troops stationed on the border with Mexico to go after illegal cannabis farms instead[6].
- Recreational cannabis in California has likely invited more criminality connected to the production and transportation of the drug. Human trafficking and smuggling, strong-armed robberies, home invasions, and murder have been linked to the marijuana trade. Violent criminals take products and proceeds by force and have created or partnered with legal businesses to conduct illicit production and trafficking[7].

Arizona
Arizona legalized marijuana for recreational use in 2020. Data identifying pre-legalization and post-legalization trends are not yet available.

Vehicle Crashes
Marijuana is the most frequently detected drug (other than alcohol) found in drivers involved in traffic crashes[8].

As we were also specifically asked about impaired driving issues, the issue of vehicle crashes and impairments was mentioned in many of the state reports we have included. Nationally, the percentage of traffic fatalities involving cannabis more than doubled from 9% in 2000 to 21.5% in 2018[9]. During 2018, 12 million (4.7%) U.S. residents reported driving under the influence of marijuana in the past 12 months[10].

Marijuana Legalization & Potential Impact on Law Enforcement
Advocates of marijuana legalization claim that legalization will reduce minor arrests and allow law enforcement to focus on more serious, violent crimes. While fewer possession arrests may in fact result in "time saved" it is impossible to know, as so many of our calls for service and arrests for marijuana possession start with the investigation of some other type of event.

There is little data that distinguishes marijuana incidents from general drug or narcotics incidents or from other types of calls for service. But simply based on the experience of other states, we know that law enforcement resources, as well as public health and other governmental services, will be taxed with new call volume due to the nature of marijuana impairment and its relationship to criminality (including victimization) as well as mental health.

---

[6] Fuller, T. (April 27, 2019). Getting worse, not better: Illegal pot market booming in California despite legalization. New York Times. Retrieved from https://www.nytimes.com/2019/04/27/us/marijuana-california-legalization.html.
[7] HIDTA 2022 Report to Congress. https://www.whitehouse.gov/wp-content/uploads/2022/12/HIDTA-Annual-Report-to-Congress-2022.pdf.
[8] Arizona High Intensity Drug Trafficking Area. Marijuana Legalization in Arizona: A Baseline Report. August 2022. https://azhidta.sharepoint.com/:b:/s/Public/EXzMnuOrV5RMosJqQOAgZxABWs9vXl9g4YUPymA-AlaNfQ?e=qu0EbZ.
[9] Trends in Cannabis Involvement and Risk of Alcohol Involvement in Motor Vehicle Crash Fatalities in the United States, 2000–2018. The American Journal of Public Health. November 2021. https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2021.306466?role=tab.
[10] Driving Under the Influence of Marijuana and Illicit Drugs Among Persons Aged ≥16 Years — United States, 2018. Centers for Disease Control and Prevention. December 2019. https://www.cdc.gov/mmwr/volumes/68/wr/mm6850a1.htm?s_cid=mm6850a1_w.

It has been clearly established that the use of alcohol and other drugs is a major risk factor for assaultive injuries and violent deaths. At least one study we reviewed (cite is Nazarov,O., Li, G. Trends in Alcohol and Marijuana Detected in Homicide Victims in 9 US states, 2004-2016, Injury Epidemiology 7,2. (2020) https://injepijournal.biomedcentral.com/articles/10.1186/s40621-019-0229-4) indicated that alcohol and marijuana were found in similar percentages of homicide victims (37.5% and 31% respectively, 11.4% positive for both) and that the prevalence of marijuana is highest in younger victims (15-20 years, 46.8%) and that black victims had a considerably higher prevalence of marijuana (38%) than white victims (23.4%). It is our belief that wider spread legal availability of marijuana could include increased victimization. While most would think that law enforcement leaders would be focused on how to enforce the law, we do so ever mindful of the ultimate goal being to deter or prevent crime and victimization from ever happening.

In closing, we believe it is evident that there will be considerable impact to law enforcement should this amendment pass but it is impossible for us to provide an accurate cost projection. We have been fortunate to benefit from the administration of Governor DeSantis where Florida has become the best state in the nation to serve as a law enforcement officer; it would be unfortunate if the passage of this amendment leads to increased victimization to include but certainly not limited to impaired driving and crimes of violence when our deputies and officers are working so hard to prevent such crimes.

We appreciate the opportunity to provide this information.

Sincerely,

Sheriff Al Nienhuis, Hernando County
President
Florida Sheriffs Association

Chief Keith Touchberry, Fellsmere Police Dept.
President
Florida Police Chiefs Association

LEE CONSTANTINE
PRESIDENT
SEMINOLE

BILL TRUEX
PRESIDENT-ELECT
CHARLOTTE

TERRY BURROUGHS
FIRST VICE PRESIDENT
OKEECHOBEE

MICHELLE LINCOLN
SECOND VICE PRESIDENT
MONROE

RALPH C. THOMAS, JR.
IMMEDIATE PAST PRESIDENT
WAKULLA

VIRGINIA "GINGER" DELEGAL
EXECUTIVE DIRECTOR

Coordinator Amy Baker
Office of Economic & Demographic Research
111 West Madison Street
Suite 574
Tallahassee, FL 32399-6588

July 7, 2023

re: Financial Impact Estimating Conference for Adult Personal Use of Marijuana Proposed Constitutional Amendment (22-05)

Coordinator Baker:

Thank you for reaching out to us to seek input on the possible cost and revenue impacts to Florida's counties from the proposed constitutional amendment - **Adult Personal Use of Marijuana (22-05)**. Below is a brief discussion of county expectations regarding the potential passage of the proposed amendment.

Cost Impacts

Law Enforcement

Counties fund the operations of the Sheriff's office, as well as for the costs of providing the county jail. To the extent the proposed constitutional amendment impacts law enforcement, either through increased costs such as marijuana related traffic offenses or from reduced costs such as from incarcerations for minor possession charges that would no longer apply, counties would experience the cost impact. In this area, we defer to the Florida Sheriffs Association and the Florida Police Chiefs Association as the experts in law enforcement and to the information they submitted to the Conference. From reviewing the experiences in other states referenced by these associations, it appears that the impact to law enforcement is unclear.

Social Programs

Many counties provide residents with various social programs in support of the community. Legalization of marijuana for adult personal use may impact these programs through increased demand for services, particularly in substance abuse programs. However, to the extent the current demand for such programs is generated from court ordered diversion programs due to marijuana possession charges, the demand may also decrease. As with law enforcement, the cost impact appears unclear.

Revenue Impacts

Sales Tax

The Florida Department of Revenue has submitted a memo to the Conference opining that, absent any change in law, sales of marijuana for personal use would be generally taxable for sales tax purposes. Counties receive revenues

100 South Monroe Street • Tallahassee, FL 32301 • Phone: (850) 922-4300 • Fax: (850) 488-7501
WWW.FL-COUNTIES.COM

LEE CONSTANTINE
PRESIDENT
SEMINOLE

BILL TRUEX
PRESIDENT-ELECT
CHARLOTTE

TERRY BURROUGHS
FIRST VICE PRESIDENT
OKEECHOBEE

MICHELLE LINCOLN
SECOND VICE PRESIDENT
MONROE

RALPH C. THOMAS, JR.
IMMEDIATE PAST PRESIDENT
WAKULLA

VIRGINIA "GINGER"
DELEGAL
EXECUTIVE DIRECTOR

from sales tax through local option sales surtaxes and through state shared revenues. Passage of the proposed constitutional amendment allowing for adult personal use of marijuana may result in additional revenues to counties.

The passage of the amendment will generate additional sales tax only in certain instances:

- A legal marijuana purchase replaces a black-market marijuana purchase
- New tourism is generated that would not have been attracted to Florida in the absence of legal adult uses in excess of any tourism lost due to concerns about legal use.
- Enhanced private security necessitated by the cash nature of the marijuana business that would not otherwise be necessary. Security services are taxable for sales tax.
- Shifts in consumer preferences within their budget constraints from nontaxable consumption to purchases of legal marijuana.
    - Shifts in consumer preferences within their budget constraints from other taxable consumption like alcohol consumption to purchases of legal marijuana does not generate additional sales tax revenue.

Property Tax
Possible impacts to the property tax base come from:
New construction and tangible personal property related to retail facilities for the sale of marijuana for adult personal use may expand the property tax base, to the extent that new construction would not have otherwise occurred. Similarly, new construction and associated tangible personal property related to legal marijuana growing facilities and processing facilities would expand the property tax base, to the extent that new construction would not have otherwise occurred.

Conclusions
Ultimately, it appears the costs are unclear both in amount and direction, with it possible that passage of the amendment could either increase or decrease law enforcement or social service costs. With respect to revenues, there may be sales tax and property tax revenue increases if certain conditions exist, but in an amount that is unknown.

Thank you again for the opportunity to provide information for the consideration of the Financial Impact Estimating Conference.

Sincerely,

Bob McKee
Deputy Director of Public Policy

100 South Monroe Street • Tallahassee, FL 32301 • Phone (850) 922-4300 • Fax: (850) 488-7501
WWW.FL-COUNTIES.COM

Tab 13

Impact

(Pending Conference Decision)