Financial Impact Estimating Conference

Use of Marijuana for Debilitating Medical Conditions

Serial Number 15-01

Reference Materials

Financial Impact Estimating Conference

Use of Marijuana for Debilitating Medical Conditions
Serial Number 15-01

Contents

Official Notification

Letter from the Florida Department of State

Letter from the Florida Department of State to the Financial Impact Estimating Conference (FIEC) dated September 3, 2015, to initiate an analysis and financial impact statement per Florida Statutes 100.371.

The 45-day window began on September 8th when the official transmittal letter was hand-delivered to EDR. This means that all of the FIEC work has to be completed by October 23rd.

The notice of workshops and conference for the FIEC is also enclosed.

FLORIDA DEPARTMENT of STATE

RICK SCOTT
Governor

KEN DETZNER
Secretary of State

September 3, 2015

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

Dear Ms. Baker:

Section 15.21, Florida Statutes, provides that the Secretary of State shall submit an initiative petition to the Financial Impact Estimating Conference when a sponsoring political committee has met the registration, petition form submission and signature criteria set forth in that section.

The criteria in section 15.21, Florida Statutes, has now been met for the initiative petition titled *Use of Marijuana for Debilitating Medical Conditions*, Serial Number 15-01. Therefore, I am submitting the proposed constitutional amendment petition form, along with a status update for the initiative petition, and a chart that provides a statewide signature count and count by congressional districts.

Sincerely,

Ken Detzner
Secretary of State

KD/am

pc: John Morgan, Chairperson
People United for Medical Marijuana

RECEIVED
9-8-15
@ 12:22 pm
SB

CONSTITUTIONAL AMENDMENT PETITION FORM

Note:

- *All information on this form, including your signature, becomes a public record upon receipt by the Supervisor of Elections.*
- *Under Florida law, it is a first degree misdemeanor, punishable as provided in s. 775.082 or s. 775.08, Florida Statutes, to knowingly sign more than one petition for an issue. [Section 104.185, Florida Statutes]*
- *If all requested information on this form is not completed, the form will not be valid.*

Your name_____

Please Print Name *as it appears on your Voter Information Card*

Your address_____

City_____ Zip_____ County_____

□ Please change my legal residence address on my voter registration record to the above residence address (check box, if applicable).

Voter Registration Number_____ **or** Date of Birth_____

I am a registered voter of Florida and hereby petition the Secretary of State to place the following proposed amendment to the Florida Constitution on the ballot in the general election:

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.

ARTICLE AND SECTION BEING CREATED OR AMENDED: Article X, Section 29

FULL TEXT OF THE PROPOSED CONSTITUTIONAL AMENDMENT:

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.

(Continues on next page)

(Continued from previous page)

(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.

_____
DATE OF SIGNATURE

X_____
SIGNATURE OF REGISTERED VOTER

Initiative petition sponsored by People United for Medical Marijuana, 20 North Orange Avenue, Suite 1600, Orlando, FL 32801.

If paid petitioner circulator is used:

Circulator's name: _____

Circulator's address: _____

_____

RETURN TO:
People United for Medical Marijuana
Post Office Box 402527
Miami Beach, FL 33140

For Official Use Only: Serial Number: 15-01
Date Approved: 1/9/2015

Attachment for Initiative Petition
Use of Marijuana for Debilitating Medical Conditions
Serial Number 15-01

1. **Name and address of the sponsor of the initiative petition:**
   John Morgan, Chairperson
   People United for Medical Marijuana
   20 North Orange Avenue, Suite 1600
   Orlando, FL 32801
2. **Name and address of the sponsor's attorney, if the sponsor is represented:** Unknown

3. **A statement as to whether the sponsor has obtained the requisite number of signatures on the initiative petition to have the proposed amendment put on the ballot:** As of September 3, 2015, the sponsor has not obtained the requisite number of signatures to have the proposed amendment placed on the ballot. A total of 683,149 valid signatures are required for placement on the 2016 general election ballot.

4. **If the sponsor has not obtained the requisite number of signatures on the initiative petition to have the proposed amendment put on the ballot, the current status of the signature-collection process:** As of September 3, 2015, the Supervisors of Elections have certified a total of 82,986 valid petition signatures to the Division of Elections for this initiative petition. This number represents more than 10% of the total number of valid signatures needed from electors statewide and in at least one-fourth of the congressional districts in order to have the initiative placed on the 2016 general election ballot.

5. **The date of the election during which the sponsor is planning to submit the proposed amendment to the voters:** Unknown. The earliest date of election that this proposed amendment can be placed on the ballot is November 8, 2016, provided the sponsor successfully obtains the requisite number of valid signatures by February 1, 2016.

6. **The last possible date that the ballot for the target election can be printed in order to be ready for the election:** Unknown

7. **A statement identifying the date by which the Financial Impact Statement will be filed, if the Financial Impact Statement is not filed concurrently with the request:** The Secretary of State forwarded a letter to the Financial Impact Estimating Conference in the care of the coordinator on September 3, 2015.

8. **The names and complete mailing addresses of all of the parties who are to be served:** This information is unknown at this time.

FLORIDA DEPARTMENT OF STATE
DIVISION OF ELECTIONS

SUMMARY OF PETITION SIGNATURES

Political Committee: **People United for Medical Marijuana**

Amendment Title: **Use of Marijuana for Debilitating Medical Conditions**

Congressional District	Voting Electors in 2012 Presidential Election	For Review 10% of 8% Required By Section 15.21 Florida Statutes	For Ballot 8% Required By Article XI, Section 3 Florida Constitution	Signatures Certified	
FIRST	356,435	2,851	28,515	0	
SECOND	343,558	2,748	27,485	1,468	
THIRD	329,165	2,633	26,333	741	
FOURTH	351,564	2,813	28,125	4,567	***
FIFTH	279,598	2,237	22,368	5,795	***
SIXTH	363,402	2,907	29,072	3,389	***
SEVENTH	333,990	2,672	26,719	3,166	***
EIGHTH	365,738	2,926	29,259	5,212	***
NINTH	277,101	2,217	22,168	2,438	***
TENTH	329,366	2,635	26,349	2,488	
ELEVENTH	359,004	2,872	28,720	3,156	***
TWELFTH	345,407	2,763	27,633	3,512	***
THIRTEENTH	344,500	2,756	27,560	12,472	***
FOURTEENTH	295,917	2,367	23,673	7,740	***
FIFTEENTH	304,932	2,439	24,395	2,617	***
SIXTEENTH	360,734	2,886	28,859	1,679	
SEVENTEENTH	299,464	2,396	23,957	2,749	***
EIGHTEENTH	345,399	2,763	27,632	867	
NINETEENTH	323,317	2,587	25,865	2,203	
TWENTIETH	264,721	2,118	21,178	2,412	***
TWENTY-FIRST	326,392	2,611	26,111	1,668	
TWENTY-SECOND	329,816	2,639	26,385	2,969	***
TWENTY-THIRD	290,042	2,320	23,203	3,264	***
TWENTY-FOURTH	263,367	2,107	21,069	3,231	***
TWENTY-FIFTH	240,521	1,924	19,242	629	
TWENTY-SIXTH	268,898	2,151	21,512	1,324	
TWENTY-SEVENTH	247,023	1,976	19,762	1,230	
TOTAL:	**8,539,371**	**68,314**	**683,149**	**82,986**	

Date: 9/3/2015 12:10:33 PM

Notice of workshops and conference for the FIEC.

NOTICE OF WORKSHOPS AND CONFERENCE
FINANCIAL IMPACT ESTIMATING CONFERENCE

The Financial Impact Estimating Conference (FIEC) will be holding workshops and a conference on the petition initiative entitled "***Use of Marijuana for Debilitating Medical Conditions***". Unless otherwise indicated on the schedule below, all meetings will begin at 12:30 p.m. in Room 117, Knott Building, 415 W. St. Augustine Street, Tallahassee, Florida. They will continue until completion of the agenda.

The FIEC is required by s. 100.371, Florida Statutes, to review, analyze, and estimate the financial impact of amendments to or revisions of the State Constitution proposed by initiative. In this regard, the FIEC is now in the process of preparing financial impact statements to be placed on the ballot that show the estimated increase or decrease in any revenues or costs to state and local governments resulting from proposed initiatives.

The purpose of the Public Workshop is to provide an opportunity for proponents and opponents of the initiative to make formal presentations to the FIEC regarding the probable financial impact of the initiative. In addition to the workshop, proponents and opponents may submit information at any time to the FIEC by contacting the Legislative Office of Economic and Demographic Research (contact information below).

Use of Marijuana for Debilitating Medical Conditions

- Public Workshop – September 30, 2015
- Principals' Workshop – October 12, 2015
- Formal Conference – October 19, 2015

For additional information regarding the meetings, please contact the Florida Legislature's Office of Economic and Demographic Research at (850) 487-1402.

Address for submitting information to the FIEC:

The Florida Legislature
Office of Economic and Demographic Research
111 West Madison, Suite 574
Tallahassee, FL 32399-6588
Email:edrcoordinator@leg.state.fl.us
FAX: (850)922-6436

For additional information regarding the Financial Impact Estimating Conference process and the Initiative Petition process, please visit the Florida Legislature's Office of Economic and Demographic Research's website at: http://edr.state.fl.us/Content/constitutional-amendments/index.cfm and the Florida Department of State, Division of Elections' website at: http://election.dos.state.fl.us/initiatives/initiativelist.asp

Statutory Authorization for FIEC

Statutory Authorization for FIEC

Section 100.371, Florida Statutes: Initiatives; procedure for placement on ballot.

Select Year: 2015 Go

The 2015 Florida Statutes

Title IX
ELECTORS AND ELECTIONS

Chapter 100
GENERAL, PRIMARY, SPECIAL, BOND, AND REFERENDUM ELECTIONS

View Entire Chapter

100.371 Initiatives; procedure for placement on ballot.—

(1) Constitutional amendments proposed by initiative shall be placed on the ballot for the general election, provided the initiative petition has been filed with the Secretary of State no later than February 1 of the year the general election is held. A petition shall be deemed to be filed with the Secretary of State upon the date the secretary determines that valid and verified petition forms have been signed by the constitutionally required number and distribution of electors under this code.

(2) The sponsor of an initiative amendment shall, prior to obtaining any signatures, register as a political committee pursuant to s. 106.03 and submit the text of the proposed amendment to the Secretary of State, with the form on which the signatures will be affixed, and shall obtain the approval of the Secretary of State of such form. The Secretary of State shall adopt rules pursuant to s. 120.54 prescribing the style and requirements of such form. Upon filing with the Secretary of State, the text of the proposed amendment and all forms filed in connection with this section must, upon request, be made available in alternative formats.

(3) An initiative petition form circulated for signature may not be bundled with or attached to any other petition. Each signature shall be dated when made and shall be valid for a period of 2 years following such date, provided all other requirements of law are met. The sponsor shall submit signed and dated forms to the supervisor of elections for the county of residence listed by the person signing the form for verification of the number of valid signatures obtained. If a signature on a petition is from a registered voter in another county, the supervisor shall notify the petition sponsor of the misfiled petition. The supervisor shall promptly verify the signatures within 30 days after receipt of the petition forms and payment of the fee required by s. 99.097. The supervisor shall promptly record, in the manner prescribed by the Secretary of State, the date each form is received by the supervisor, and the date the signature on the form is verified as valid. The supervisor may verify that the signature on a form is valid only if:

(a) The form contains the original signature of the purported elector.

(b) The purported elector has accurately recorded on the form the date on which he or she signed the form.

(c) The form sets forth the purported elector's name, address, city, county, and voter registration number or date of birth.

(d) The purported elector is, at the time he or she signs the form and at the time the form is verified, a duly qualified and registered elector in the state.

The supervisor shall retain the signature forms for at least 1 year following the election in which the issue appeared on the ballot or until the Division of Elections notifies the supervisors of elections that the committee that circulated the petition is no longer seeking to obtain ballot position.

(4) The Secretary of State shall determine from the signatures verified by the supervisors of elections the

total number of verified valid signatures and the distribution of such signatures by congressional districts. Upon a determination that the requisite number and distribution of valid signatures have been obtained, the secretary shall issue a certificate of ballot position for that proposed amendment and shall assign a designating number pursuant to s. 101.161.

(5)(a) Within 45 days after receipt of a proposed revision or amendment to the State Constitution by initiative petition from the Secretary of State, the Financial Impact Estimating Conference shall complete an analysis and financial impact statement to be placed on the ballot of the estimated increase or decrease in any revenues or costs to state or local governments resulting from the proposed initiative. The Financial Impact Estimating Conference shall submit the financial impact statement to the Attorney General and Secretary of State.

(b) The Financial Impact Estimating Conference shall provide an opportunity for any proponents or opponents of the initiative to submit information and may solicit information or analysis from any other entities or agencies, including the Office of Economic and Demographic Research.

(c) All meetings of the Financial Impact Estimating Conference shall be open to the public. The President of the Senate and the Speaker of the House of Representatives, jointly, shall be the sole judge for the interpretation, implementation, and enforcement of this subsection.

1. The Financial Impact Estimating Conference is established to review, analyze, and estimate the financial impact of amendments to or revisions of the State Constitution proposed by initiative. The Financial Impact Estimating Conference shall consist of four principals: one person from the Executive Office of the Governor; the coordinator of the Office of Economic and Demographic Research, or his or her designee; one person from the professional staff of the Senate; and one person from the professional staff of the House of Representatives. Each principal shall have appropriate fiscal expertise in the subject matter of the initiative. A Financial Impact Estimating Conference may be appointed for each initiative.

2. Principals of the Financial Impact Estimating Conference shall reach a consensus or majority concurrence on a clear and unambiguous financial impact statement, no more than 75 words in length, and immediately submit the statement to the Attorney General. Nothing in this subsection prohibits the Financial Impact Estimating Conference from setting forth a range of potential impacts in the financial impact statement. Any financial impact statement that a court finds not to be in accordance with this section shall be remanded solely to the Financial Impact Estimating Conference for redrafting. The Financial Impact Estimating Conference shall redraft the financial impact statement within 15 days.

3. If the members of the Financial Impact Estimating Conference are unable to agree on the statement required by this subsection, or if the Supreme Court has rejected the initial submission by the Financial Impact Estimating Conference and no redraft has been approved by the Supreme Court by 5 p.m. on the 75th day before the election, the following statement shall appear on the ballot pursuant to s. 101.161(1): “The financial impact of this measure, if any, cannot be reasonably determined at this time.”

(d) The financial impact statement must be separately contained and be set forth after the ballot summary as required in s. 101.161(1).

(e)1. Any financial impact statement that the Supreme Court finds not to be in accordance with this subsection shall be remanded solely to the Financial Impact Estimating Conference for redrafting, provided the court’s advisory opinion is rendered at least 75 days before the election at which the question of ratifying the amendment will be presented. The Financial Impact Estimating Conference shall prepare and adopt a revised financial impact statement no later than 5 p.m. on the 15th day after the date of the court’s opinion.

2. If, by 5 p.m. on the 75th day before the election, the Supreme Court has not issued an advisory opinion on the initial financial impact statement prepared by the Financial Impact Estimating Conference for an initiative amendment that otherwise meets the legal requirements for ballot placement, the financial impact

statement shall be deemed approved for placement on the ballot.

3. In addition to the financial impact statement required by this subsection, the Financial Impact Estimating Conference shall draft an initiative financial information statement. The initiative financial information statement should describe in greater detail than the financial impact statement any projected increase or decrease in revenues or costs that the state or local governments would likely experience if the ballot measure were approved. If appropriate, the initiative financial information statement may include both estimated dollar amounts and a description placing the estimated dollar amounts into context. The initiative financial information statement must include both a summary of not more than 500 words and additional detailed information that includes the assumptions that were made to develop the financial impacts, workpapers, and any other information deemed relevant by the Financial Impact Estimating Conference.

4. The Department of State shall have printed, and shall furnish to each supervisor of elections, a copy of the summary from the initiative financial information statements. The supervisors shall have the summary from the initiative financial information statements available at each polling place and at the main office of the supervisor of elections upon request.

5. The Secretary of State and the Office of Economic and Demographic Research shall make available on the Internet each initiative financial information statement in its entirety. In addition, each supervisor of elections whose office has a website shall post the summary from each initiative financial information statement on the website. Each supervisor shall include the Internet addresses for the information statements on the Secretary of State's and the Office of Economic and Demographic Research's websites in the publication or mailing required by s. 101.20.

(6) The Department of State may adopt rules in accordance with s. 120.54 to carry out the provisions of subsections (1)-(5).

(7) No provision of this code shall be deemed to prohibit a private person exercising lawful control over privately owned property, including property held open to the public for the purposes of a commercial enterprise, from excluding from such property persons seeking to engage in activity supporting or opposing initiative amendments.

History.—s. 15, ch. 79-365; s. 12, ch. 83-251; s. 30, ch. 84-302; s. 22, ch. 97-13; s. 9, ch. 2002-281; s. 3, ch. 2002-390; s. 3, ch. 2004-33; s. 28, ch. 2005-278; s. 4, ch. 2006-119; s. 25, ch. 2007-30; s. 1, ch. 2007-231; s. 14, ch. 2008-95; s. 23, ch. 2011-40.

Florida 2014 Ballot & Legislation

Proposed Constitutional Amendment on the 2014 Ballot

Petition Text

The following presents the text of the petition initiative “Use of Marijuana for Certain Medical Conditions” on the 2014 Ballot.

Florida Department of State
Division of Elections

Use of Marijuana for Certain Medical Conditions
13-02

Reference:

Article X, Section 29

Summary: View Full Text (pdf)

Allows the medical use of marijuana for individuals with debilitating diseases 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 authorize violations of federal law or any non-medical use, possession or production of marijuana.

Related Links:

Financial Impact
Financial Information
Additional Information

Sponsor:

People United for Medical Marijuana
20 North Orange Avenue
Suite 1600
Orlando, FL 32801-
(850) 845-0561

Contact: John Morgan, Chairperson
20 North Orange Avenue
Suite 1600
Orlando, FL 32801-0000

Signatures: **Verified Totals are UNOFFICIAL until the Initiative receives certification and a ballot number.

Required for review by Attorney General:	68,314
Required to have initiative on the ballot:	683,149
** Number currently valid:	786,368
(View By District by County)	

Status: ***Defeated***

Approval Date:	07/10/2013
Undue Burden:	

Made Review:	09/20/2013
Attorney General:	09/26/2013
Sent to Supreme Court:	10/24/2013
Supreme Court Ruling:	Constitutional
SC Ruling Date:	01/27/2014
Financial Impact Statement Date:	11/04/2013
SC Approval of Financial Impact Statement:	01/27/2014
Made Ballot:	01/27/2014
Ballot Number:	2
Election Date:	11/04/2014
Votes For:	3,370,761
Votes Against:	2,478,993

Florida 2014 Ballot & Legislation

Proposed Constitutional Amendment on the 2014 Ballot

Ballot Financial Summary

The following presents the 75-word financial impact statement developed by the FIEC in 2013 for the 2014 ballot.

INITIATIVE FINANCIAL INFORMATION STATEMENT FOR
USE OF MARIJUANA FOR CERTAIN MEDICAL CONDITIONS, #13-02

FINANCIAL IMPACT STATEMENT

Increased costs from this amendment to state and local governments cannot be determined. There will be additional regulatory and enforcement activities associated with the production and sale of medical marijuana. Fees will offset at least a portion of the regulatory costs. While sales tax may apply to purchases, changes in revenue cannot reasonably be determined since the extent to which medical marijuana will be exempt from taxation is unclear without legislative or state administrative action.

Florida 2014 Ballot & Legislation

Proposed Constitutional Amendment on the 2014 Ballot

One-Page Financial Summary

The following presents the SUMMARY OF INITIATIVE FINANCIAL INFORMATION STATEMENT from the 2013 FIEC for the 2014 ballot.

INITIATIVE FINANCIAL INFORMATION STATEMENT FOR
USE OF MARIJUANA FOR CERTAIN MEDICAL CONDITIONS

SUMMARY OF INITIATIVE FINANCIAL INFORMATION STATEMENT

The amendment allows the use of medical marijuana for certain specified medical conditions, as well as other conditions, for which a physician licensed in Florida believes the medical use of marijuana would likely outweigh the potential health risks for the patient. In addition, a process is established for the sale of medical marijuana to qualifying patients and designated caregivers. Based on the information provided through public workshops and staff research, the Financial Impact Estimating Conference expects that the proposed amendment will have the following financial effects:

- According to the final analysis provided by the Department of Health, the department will incur an estimated $1.1 million in costs each year to comply with the regulatory responsibilities assigned to it by the constitutional amendment. These costs will likely be offset through fees charged to the medical marijuana industry and users, but this may require further action by the Legislature.
- The Department of Business and Professional Regulation, the Agency for Health Care Administration, and the Department of Agriculture and Consumer Services do not expect the amendment's passage to produce a significant impact on their regulatory functions. To the extent regulatory impacts occur, they will likely be offset through fees charged to the affected industries.
- The Department of Highway Safety and Motor Vehicles, the Police Chiefs Association, and the Sheriffs Association expect additional law enforcement costs based on the experience from other states that have similar amendments or laws, but the magnitude could not be determined at this time.
- Other state and local agencies were unable to quantify the amendment's impact, if any, on the services they provide.
- The Conference has determined that the purchase of medical marijuana is subject to Florida sales and use tax since medical marijuana is tangible personal property for the purposes of Chapter 212, Florida Statutes, unless a specific exemption exists.
- After testimony from the Department of Revenue, the Conference determined that agricultural-related exemptions apply to sales of medical marijuana when the grower or cultivator sells or dispenses the product directly to the end-user or designated caregiver. However, if the grower or cultivator sells the product to a third-party retailer (a non-taxable transaction) which then sells or dispenses the product to the end-user or a caregiver, the agricultural exemption on the final sale is lost and that transaction becomes taxable. Since the sponsors indicated that the proposed amendment was drafted to allow various levels of industry integration, the potential for both taxable and exempt activities exists. In the case of a segmented market structure, the determination of whether medical marijuana is a common household remedy (and therefore exempt) becomes significant. Until this determination is made by the Department of Revenue and/or the Department of Business and Professional Regulation or by a future action of the Legislature, the tax treatment of a sale through a third-party to the end-user is uncertain.
- The magnitude of the impact on property taxes, either positive or negative, cannot be determined.

Florida 2014 Ballot & Legislation

Proposed Constitutional Amendment on the 2014 Ballot

Sixteen-Page Financial Summary

The following presents the complete financial information statement from the 2013 FIEC for the 2014 ballot.

INITIATIVE FINANCIAL INFORMATION STATEMENT FOR
USE OF MARIJUANA FOR CERTAIN MEDICAL CONDITIONS

SUMMARY OF INITIATIVE FINANCIAL INFORMATION STATEMENT

The amendment allows the use of medical marijuana for certain specified medical conditions, as well as other conditions, for which a physician licensed in Florida believes the medical use of marijuana would likely outweigh the potential health risks for the patient. In addition, a process is established for the sale of medical marijuana to qualifying patients and designated caregivers. Based on the information provided through public workshops and staff research, the Financial Impact Estimating Conference expects that the proposed amendment will have the following financial effects:

- According to the final analysis provided by the Department of Health, the department will incur an estimated $1.1 million in costs each year to comply with the regulatory responsibilities assigned to it by the constitutional amendment. These costs will likely be offset through fees charged to the medical marijuana industry and users, but this may require further action by the Legislature.
- The Department of Business and Professional Regulation, the Agency for Health Care Administration, and the Department of Agriculture and Consumer Services do not expect the amendment's passage to produce a significant impact on their regulatory functions. To the extent regulatory impacts occur, they will likely be offset through fees charged to the affected industries.
- The Department of Highway Safety and Motor Vehicles, the Police Chiefs Association, and the Sheriffs Association expect additional law enforcement costs based on the experience from other states that have similar amendments or laws, but the magnitude could not be determined at this time.
- Other state and local agencies were unable to quantify the amendment's impact, if any, on the services they provide.
- The Conference has determined that the purchase of medical marijuana is subject to Florida sales and use tax since medical marijuana is tangible personal property for the purposes of Chapter 212, Florida Statutes, unless a specific exemption exists.
- After testimony from the Department of Revenue, the Conference determined that agricultural-related exemptions apply to sales of medical marijuana when the grower or cultivator sells or dispenses the product directly to the end-user or designated caregiver. However, if the grower or cultivator sells the product to a third-party retailer (a non-taxable transaction) which then sells or dispenses the product to the end-user or a caregiver, the agricultural exemption on the final sale is lost and that transaction becomes taxable. Since the sponsors indicated that the proposed amendment was drafted to allow various levels of industry integration, the potential for both taxable and exempt activities exists. In the case of a segmented market structure, the determination of whether medical marijuana is a common household remedy (and therefore exempt) becomes significant. Until this determination is made by the Department of Revenue and/or the Department of Business and Professional Regulation or by a future action of the Legislature, the tax treatment of a sale through a third-party to the end-user is uncertain.
- The magnitude of 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 and enforcement activities associated with the production and sale of medical marijuana. Fees will offset at least a portion of the regulatory costs. While sales tax may apply to purchases, changes in revenue cannot reasonably be determined since the extent to which medical marijuana will be exempt from taxation is unclear without legislative or state administrative action.

I. SUBSTANTIVE ANALYSIS

A. Proposed Amendment

Ballot Title:

Use of Marijuana for Certain Medical Conditions.

Ballot Summary:

Allows the medical use of marijuana for individuals with debilitating diseases 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 authorize 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 personal caregiver is not subject to criminal or civil liability or sanctions under Florida law except as provided in this section.

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

(3) Actions and conduct by a medical marijuana treatment center registered with the Department, or its employees, as permitted by this section and in compliance with Department regulations, shall not be subject to criminal or civil liability or sanctions under Florida law except as provided in this section.

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

(1) "Debilitating Medical Condition" means cancer, glaucoma, positive status for human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, multiple sclerosis or other conditions 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 person who has a physician certification or a personal caregiver who is at least twenty-one (21) years old and has agreed to assist with a qualifying patient's medical use of marijuana.
(4) "Marijuana" has the meaning given cannabis in Section 893.02(3), Florida Statutes (2013).
(5) "Medical Marijuana Treatment Center" 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 personal caregivers and is registered by the Department.
(6) "Medical use" means the acquisition, possession, use, delivery, transfer, or administration of marijuana or related supplies by a qualifying patient or personal caregiver for use by a qualifying patient for the treatment of a debilitating medical condition.
(7) "Personal 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 a caregiver identification card issued by the Department. A personal caregiver may assist no more than five (5) qualifying patients at one time. An employee of a hospice provider, nursing, or medical facility may serve as a personal caregiver to more than five (5) qualifying patients as permitted by the Department. Personal caregivers are prohibited from consuming marijuana obtained for the personal, medical use by the qualifying patient.
(8) "Physician" means a physician who is licensed 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 potential benefits of the medical use of marijuana would likely outweigh the 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 of the patient and a full assessment of the patient's medical history.
(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 shall affect laws relating to non-medical use, possession, production or sale of marijuana.
(2) Nothing in this section authorizes the use of medical marijuana by anyone other than a qualifying patient.
(3) Nothing in this section allows the operation of a motor vehicle, boat, or aircraft while under the influence of marijuana.
(4) Nothing in this law section requires the violation of federal law or purports to give immunity under federal law.

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

(6) 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.

(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 of qualifying patient identification cards to people with physician certifications, and standards for the renewal of such identification cards.

b. Procedures for the issuance of personal caregiver identification cards to persons qualified to assist with a qualifying patient's medical use of marijuana, and standards for the renewal of such identification cards.

c. Procedures for the registration of Medical Marijuana Treatment Centers that include procedures for the issuance, renewal, suspension, and revocation of registration, and standards to ensure 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) Issuance of identification cards and registrations. The Department shall begin issuing qualifying patient and personal caregiver identification cards, as well as begin registering Medical Marijuana Treatment Centers no later than nine months (9) 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 Medical Marijuana Treatment Centers 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 provision.

(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 any 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. This amendment does not specify an effective date and will be effective as stated in Article XI, Section 5(e), of the Florida Constitution. However, the amendment delays implementation of certain provisions by allowing the Department of Health six months after the effective date to promulgate regulations and nine months after the effective date to 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 proponents chose not to provide a response to a request for overall input on the initiative. However, a representative responded to a specific request from staff regarding the market structure envisioned by the sponsors.

An opponent group, 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 status of marijuana as not approved by the federal Food and Drug Administration (FDA) and the resulting unregulated nature of the use of marijuana, emphasizing that "crude (smoked) marijuana does not meet the standards of modern medicine." The testimony also noted that "the approval of medicines and the protection of consumers are the responsibility of the FDA, not state legislators, not voters and not governors petitioning for marijuana to be rescheduled." The testimony also expressed concerns relating to: potential impacts on public safety, with an emphasis on drugged driving; environmental impacts of marijuana production, including water quality and water use, wildlife, and wildfires; and the fiscal impact of regulating and policing "pot shops."

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

[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.

$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]

The Necessity Defense in Florida

Despite the fact that the use, possession, and sale of marijuana is prohibited by state law, 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[7] 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 in Other States

Currently, 20 states and the District of Columbia[8] have some form of law that permits the use of marijuana for medicinal purposes. These 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.
  - 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

[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.
[7] 582 So. 2d 676
[8] These states include Alaska, Arizona, California, Colorado, Connecticut, Delaware, Hawaii, Illinois (effective 2014), Maine, Maryland, Massachusetts, Michigan, 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 Illinois was the most recent state to pass medical marijuana legislation in August of 2013. Illinois legislation does not become effective until 2014. See http://www.ncsl.org/issues-research/health/state-medical-marijuana-laws.aspx. Last visited on Oct. 17, 2013.

the list either by allowing a state agency or board to add medical conditions to the list or by including a "catch-all" phrase.[9] Most states require that the patient receive certification from at least one, but often 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 strictly 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.
- Provisions allowing a patient to either self-cultivate marijuana, creating regulated marijuana "dispensaries" where a patient may purchase marijuana, or both. The regulations governing such dispensaries, in states that allow them, vary widely.

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.[10] 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." [11] 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

[9] 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."

[10] 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. 17, 2013.

[11] See http://www.justice.gov/ag/smart-on-crime.pdf. Last visited on Oct. 17, 2013

kingpins." This announcement indicates the justice department's relative unwillingness to prosecute low-level drug cases leaving such prosecutions largely up to state authorities.

Proposed Florida Laws

Distinct from the petition initiative, Florida legislation was proposed to enact concepts similar to the subject of the amendment. During the 2013 legislative session, identical bills were introduced in the Senate and House of Representatives relating to medical cannabis. The bill established regulatory responsibilities and rulemaking authority for the Department of Health (DOH) and the Department of Business and Professional Regulation (DBPR), and provided rulemaking authority for the Department of Revenue (DOR) specific to taxation and reporting responsibility for specified entities. The bill:

- Authorized a qualifying patient and the patient's qualified caregiver to possess and administer medical cannabis to a qualifying patient, and to possess and use paraphernalia for specified purposes;
- Provided procedures and requirements for DOH administration;
- Authorized a physician to recommend use of medical cannabis under specified procedures and requirements;
- Required DBPR to regulate licensure of cultivation centers and dispensaries, under related procedures and requirements;
- Established a medical cannabis section within DBPR, including procedures and requirements to authorize a medical cannabis farm to possess, cultivate, and manufacture medical cannabis, medical cannabis-based products, and marijuana plants for wholesale in this state, including permitting and licensing procedures and fees, administrative fines, license suspension, and injunctive relief.
- Required rule adoption by specified dates;
- Provided that use of medical cannabis is a defense to certain offenses, and does not create defense to certain other offenses;
- Made conforming revisions to a variety of criminal provisions, including changes to the Offense Severity Ranking Chart;
- Included a severability clause; and
- Provided an effective date of July 1, 2013.

The bill stipulated that fees established by DOH must offset all expenses of implementing and administering the provisions of the bill, specified fee caps for DBPR permitting purposes, and indicated that fees collected by DOH, DBPR, and DOR be applied first to administering the responsibilities assigned under the provisions. Senate Bill (SB) 1250, introduced by Senator Clemens and one co-sponsor, was referred to four committees of reference. House Bill 1139, introduced by Representative Edwards and five co-sponsors, was referred to four committees of reference. A related public records exemption bill, SB 1214, was also filed by Senator Clemens. When the 2013 session ended, each bill died in its initial committee of reference, having not been heard.

Potential Users of Medical Marijuana

The Florida Legislature's 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, 2015. Approach I draws on the experience of other states. Approaches II – V attempt to capture eligible users with the specified medical conditions in the proposed ballot initiative, except "other conditions." It is not possible to precisely estimate the number of users that would qualify under "other conditions" as these conditions are currently unknown and 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, 2015
I. States with medical marijuana laws	452 to 417,252
II. Disease prevalence	1,295,922
III. Disease incidence	116,456
IV. Use by cancer patients	173,671
V. Deaths	46,903
VI. Self-reported marijuana use	1,052,692 to 1,619,217
Range	**452 to 1,619,217**

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 2015 projected population. Using the current experience of 16 other states, there may be an estimated 452 to 417,252 Floridians using medical marijuana in 2015. 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, hepatitis C, and HIV to determine the number of eligible patients with the conditions specified in the proposed ballot initiative. There will be an estimated 1,295,922 patients alive in 2015 that have been diagnosed with cancer, hepatitis C, or HIV during their lifetime. These patients represent the pool of eligible patients for medical use of marijuana. Prevalence data for the remaining conditions specified in the proposed ballot initiative were not available. In addition, there are unspecified "other conditions" 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) for cancer, hepatitis C, HIV, and amyotrophic lateral sclerosis (ALS) 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 116,456 patients newly diagnosed with cancer, hepatitis C, HIV, or ALS in 2015 in Florida. These patients represent the pool of eligible patients for medical use of marijuana. Incidence data for the remaining conditions specified in the proposed ballot initiative were not available. In addition, there are unspecified "other conditions" 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 by disease, specifically cancer, to estimate medical marijuana users in Florida. The number of Florida cancer patients that are likely to use medical marijuana in 2011 is calculated by applying the average penetration rate among cancer patients from seven other states to the Florida number of cancer patients. Assuming Florida will have the same average proportion of cancer patients in the total medical marijuana users as these seven states, the number of medical marijuana users with cancer is grown to represent total medical marijuana users with all conditions in Florida in 2011. The latter is then adjusted to produce 173,671 medical marijuana users with all conditions in 2015.

Approach V. Deaths

Approach V assumes that mostly terminally ill patients will use medical marijuana. Thus, it uses 2012 death rates by disease for the specified diseases, excluding glaucoma and ALS for which no data were available, in the proposed ballot initiative to estimate the number of users. Adjusting these rates to 2015 population projections produces 46,903 potential medical marijuana patients with the specified conditions. In addition, there are unspecified "other conditions" 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 2011 National Survey on Drug Use and Health. Adjusting 2011 survey results to the 2015 Florida population projections shows that there may be an estimated 1,619,217 self-reported recreational users of marijuana 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 1,052,692 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.

The Conference requested EDR to estimate 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 2011 National Survey on Drug Use and Health, it is estimated that there will be 676,099 pain reliever users for nonmedical reasons in 2015, 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 17,178 to 41,271 snowbirds may apply for ID cards.

For a variety of reasons, the estimates of pill mill and medical tourism were included to "color" the final estimate of the potential number of medical marijuana users and are not meant to be additive to approaches I – VI.

After careful consideration and review of all methods, the Conference determined that the likely number of potential users of medical marijuana upon full implementation of the amendment would be less than 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 1, 2015. The analysis further assumes the Florida Department of Health will: (1) promulgate rules by June 30, 2015, (2) issue qualified patient and personal caregiver identification cards prior to October 1, 2015, and (3) register Medical Marijuana Treatment Centers prior to October 1, 2015.

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, patient and caregiver identification cards, medical marijuana treatment centers, and the department's responsibilities.

The department estimates that when the program is fully implemented, the number of annual program participants to be: (1) 417,252 qualified patients, (2) 250,351 personal caregivers and (3) 1,789 registered Medical Marijuana Treatment Centers. These estimates were derived based on experience data for the states of Colorado and Oregon.

Program Components

The Florida Department of Health will establish a Florida Medical Marijuana Program which supports: (1) physician issuance of certification, (2) patient and caregiver identification cards, (3)

medical marijuana treatment center registration and regulation, and (4) 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 final analysis provided by the Department of Health, the department will incur an estimated $1.1 million in costs each year to comply with the regulatory responsibilities assigned to it by the constitutional amendment. Details regarding these costs are in the following table.

Cost Analysis

Cost of Implementation	Year 1 2015	Year 2 2016	Description
Program Staff State Health Office	$287,654	$238,181	**Year 1** Recurring FTE. Program Manager, $60,000 salary, fringe (35%) & expense package ($15,541). One-time contracted positions- Rule making support $20 hr/2080 hours plus fringe (35%) and contract overhead (4%). Educator $20.00 hr/1500 hours plus fringe (35%) and contract overhead (4%). Cost to disseminate materials to physicians ($7,000). **Year 2** Program Manager and 2.0 additional recurring FTEs to manage established program. Environmental Consultant ($82,587) and Senior Clerk ($37,993). Year 2 includes 750 hours of contracted time to refresh training materials.
Data system implementation and maintenance	$238,400	$32,000	**Year 1** Business Analysis for program and data system development $85 per hours for 1040 hours. One-time contractual. Cost to design, develop, test and data system based on business requirements. One-time contractual 1800 hours at $75.00 per hour ($135,000) and $15,000 for hardware. **Year 2** Annual cost of help desk and software maintenance 800 hours per year at $40 per hour. Recurring $32,000 after Year 1 implementation.
Treatment facility inspections, reinspections, and complaint investigations	$564,129	$790,755	**Year 1** 25% of Year 2 cost for services ($197,689). One-time cost for 10 state vehicles @ $35,000 each, 10 pentablets @ $1,500, and VPN connectivity service $48 per month for 3 months in year 1- $1,440. **Year 2** Cost for services for 12 months - 9,303 services @ $85.00 per service = $790,755. 1,789 treatment centers – 7,156 quarterly inspections, 1,789 reinspections (25% rate) and 358 complaint investigation (20% of centers). Funds 13.25 Environmental Specialist II's to conduct inspections & investigations. (Salary $37,357, Fringe $12,451 and Travel $9,606) for a total of $787,236. Interagency Agreement with DOACS for inspections of cultivators/processors = $2,500 per year. Miscellaneous cost of services=$1,019.
Total	**$1,090,183**	**$1,060,936**	

Requested Information from State Agencies

The following table reflects a summary of information gleaned from several agencies that were asked to appear before 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	10/21/2013 11/1/2013	Written preliminary and final analyses and testimony showing $1.1 million in ongoing annual costs, likely to be offset by regulatory fees (see preceding section).
Florida Department of Children and Families Substance Abuse and Mental Health Program	10/28/2013	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 these services are not an entitlement.
Florida Agency for Health Care Administration	10/28/2013	Discussed the possible impact regarding "personal care givers". 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	10/28/2013	The dispensaries 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	10/28/2013 10/31/2013	Whether medical marijuana is a 'common household remedy' is currently unknown. There may be costs associated with making this determination. The form of the substance does not greatly matter, unless it is a food or has been processed. DBPR would have little authority over related supplies or devices.
Florida Department of Agriculture and Consumer Services	10/28/2013	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.
Florida Department of Law Enforcement	10/22/2013	Deferred to the Attorney General's office, as per phone call with staff.
Florida Office of the Attorney General	10/24/2013	Referred the Conference to a letter that was submitted to the Chief Justice and Justices of the Florida Supreme Court detailing several concerns; among them the interaction of the amendment and current federal law.
Florida Department of Highway Safety and Motor Vehicles	10/31/2013	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	10/29/2013	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	10/30/2013	Responded via phone call to staff that they had no input at this time and referred the Conference to the Police Chiefs Association.
Florida Police Chiefs Association	10/25/2013	Email indicating 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 Sheriffs Association	10/21/2013 10/27/2013	Presentation and email indicating 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 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. Based on testimony provided by both departments that they are unclear whether the broad classes of remedies presently on the list encompass medical marijuana, the Conference is left with uncertainty regarding the applicability of the exemption. During the discussion, both agencies identified reasons that the exemption may not apply, emphasizing the restrictive nature of the certification process on potential users and the limitation on sales locations to registered Medical Marijuana Treatment Centers. Because this aspect of the discussion applies equally to a decision regarding the specific inclusion of medical marijuana on a future list, doubt is cast on this action as well. However, it is possible that some supplies related to the use of medical marijuana are already on the list so each item would have to be evaluated on a case-by-case basis even if the sale of medical marijuana itself is determined to be taxable.

The agricultural-related exemptions apply to sales of medical marijuana when the grower or cultivator sells or dispenses the product directly to the end-user or a personal caregiver as defined in the proposed amendment. If the grower or cultivator instead sells the product to a third-party retailer (a non-taxable transaction) who then sells or dispenses the product to the end-user or the caregiver, the agricultural exemption on the final sale is lost and that transaction

becomes taxable.[12] However, the determination of whether medical marijuana is a common household remedy becomes significant at this point. Since it is unclear whether medical marijuana will ultimately be deemed to be a common household remedy, the tax treatment of a sale through a third-party to the end-user is uncertain.

The only form of medical marijuana that appears especially problematic to the direct application of the above findings regarding taxability is its inclusion as a part of a food product. In this regard, if medical marijuana is determined to be transformed from its original form into a distinct food product, then the law and the Department of Revenue's rules regarding food will govern its taxability. The sale of each type of food product would have to be evaluated on a case-by-case basis.

Finally, the sales of items such as grow lights and hydroponic systems that might be used for the indoor cultivation of medical marijuana are generally taxable. However, there is an exemption from sales tax for "power farm equipment." According to the Florida Statutes, "power farm equipment" means "moving or stationary equipment that contains within itself the means for its own propulsion or power and moving or stationary equipment that is dependent upon an external power source to perform its functions." Therefore, grow lights and hydroponic systems that are sold as a component part of power farm equipment would likely be exempt.

In summary, the revenue impact to state and local government from the application of the sales and use tax to the sale of medical marijuana and related supplies would range from zero to positive indeterminate because critical details regarding the specific transactions are currently unknown and key decisions regarding the potential tax exemptions have yet to be made by the affected agencies under their current administration of the law. It is also possible that the Legislature would enact new legislation specific to these questions.

Potential Estimates Related to 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 states that have approved the use of medical marijuana, at least eight states and the District of Columbia have a sales tax structure that could encompass medical marijuana transactions.[13] Of these, at least three states and the District of Columbia have approved medical marijuana and also have a sales tax provision providing an exemption or partial exemption for over-the-counter health remedies. It appears that the exemption for common household remedies will apply to the sales of medical marijuana in at least Vermont. 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 the exemption. This leaves the experience of five states and the District of Columbia for comparison purposes. Within this grouping, California's collections

[12] According to Jon Mills who spoke via phone conversation on behalf of the initiative's sponsors, the proposed amendment was drafted to allow various levels of industry integration: both vertical integration of the complete supply chain through one owner and a segmented market structure with independent intermediaries at each stage. He also indicated that the Legislature or the Department of Health through its rule-making process would have the ability to further limit or define the permissible market structure arrangements.

[13] Arizona, California, Colorado, Illinois, Maine, New Jersey, Rhode Island, Vermont and the District of Columbia have sales taxes. Nevada reportedly has a 2% excise tax at the wholesale and retail levels.

were by far the highest with projected revenues from the 7.5% state sales tax rate ranging between $58 million and $105 million in 2012.

Temporarily suspending the confusion regarding Florida's final tax treatment of medical marijuana sales, the Legislative Office of Economic and Demographic Research used the information from other states to analyze the potential range of state sales tax revenues *in the extreme case where no sales tax exemptions apply*. 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 $8.3 million to a maximum of $338.0 million. Since the brackets at both ends assume *no exemptions apply*—and the Conference believes that at a minimum the exemption for agricultural products will apply in at least some instances—these numbers do not encompass a probable range and cannot be used for a purpose other than testing significance.

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	April 1, 2015 Users	Sales ($)		State Sales Tax Revenues ($)	
		$225/ oz	$450/ oz	$225/ oz	$450/ oz
Annual use of 3.53 oz (100 g)					
I. States with medical marijuana laws	417,252	331,402,401	662,804,802	19,884,144	39,768,288
IV. Use by cancer patients	173,671	137,938,192	275,876,384	8,276,292	16,552,583
Annual use of 30 oz (850 g)					
I. States with medical marijuana laws	417,252	2,816,451,000	5,632,902,000	168,987,060	337,974,120
IV. Use by cancer patients	173,671	1,172,279,250	2,344,558,500	70,336,755	140,673,510

NOTE: Additional detail can be found at EDR's website:
http://edr.state.fl.us/Content/constitutional-amendments/2014Ballot/UseofMarijuanaforCertainMedicalConditions/UseofMarijuanaAdditionalInformation.cfm,

Florida Property Tax Treatment of Medical Marijuana

Lands used for growing medical marijuana will likely qualify as agricultural property for property tax purposes. This means that the property would receive a classified use agricultural assessment. Because this treatment may increase or decrease the taxable value relative to its prior value, the impact on property taxes is indeterminate—both in terms of magnitude and direction.

2014 Legislative Session

This section contains:

- Bill text for CS for CS for SB 1030 (the “Compassionate Medical Cannabis Act of 2014”) from the 2014 legislative session became law on 6/17/2014.
- Bill text for SB 1700 (Exemption from Public Records related to CS for CS for SB 1030).

An act relating to cannabis; providing a short title; creating s. 381.986, F.S.; defining terms; authorizing specified physicians to order low-THC cannabis for use by specified patients; providing conditions; prohibiting specified acts by physicians or persons seeking low-THC cannabis; providing criminal penalties; requiring physician education; providing duties of the Department of Health; requiring the department to create a compassionate use registry; providing requirements for the registry; requiring the department to authorize a specified number of dispensing organizations; authorizing rulemaking; providing requirements and duties for a dispensing organization; providing exceptions to specified laws; creating s. 385.211, F.S.; defining the term "low-THC cannabis"; authorizing certain medical centers to conduct research on cannabidiol and low-THC cannabis; authorizing state or privately obtained research funds to be used to support such research; creating s. 385.212, F.S.; requiring the department to establish an Office of Compassionate Use; authorizing the office to engage in specified activities; authorizing rulemaking; amending s. 893.02, F.S.; revising the term "cannabis" as used in the Florida Comprehensive Drug Abuse Prevention and Control Act and as applicable to certain criminal offenses proscribing the sale, manufacture, delivery, possession, dispensing, distribution, or purchase of cannabis, to

which penalties apply; creating s. 1004.441, F.S.; defining the term "low-THC cannabis"; authorizing state universities with both medical and agricultural research programs to conduct specified research on cannabidiol and low-THC cannabis; authorizing state or privately obtained research funds to be used to support such research; providing an appropriation to the department for research of cannabidiol and its effect on intractable childhood epilepsy; specifying how biomedical research funding for research of cannabidiol and its effect on intractable childhood epilepsy shall be awarded; specifying who may apply for such funding; providing an effective date.

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

Section 1. This act may be cited as the "Compassionate Medical Cannabis Act of 2014."

Section 2. Section 381.986, Florida Statutes, is created to read:

381.986 Compassionate use of low-THC cannabis.—

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

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

(b) "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.

(c) "Medical use" means administration of the ordered amount of low-THC cannabis. The term does not include the possession, use, or administration by smoking. The term also does not include 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 on behalf of the qualified patient.

(d) "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 from a dispensing organization.

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

(2) PHYSICIAN ORDERING.—Effective January 1, 2015, a physician licensed under chapter 458 or chapter 459 who has examined and is treating a patient suffering from cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms may order for the patient's medical use low-THC cannabis to treat such disease, disorder, or condition or to alleviate symptoms of such disease, disorder, or condition, if no other satisfactory alternative treatment options exist for that patient and all of the following conditions apply:

(a) The patient is a permanent resident of this state.

(b) The physician determines that the risks of ordering

low-THC cannabis are reasonable in light of the potential benefit for that 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.

(c) The physician registers as the orderer of low-THC 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. The physician shall deactivate the patient's registration when treatment is discontinued.

(d) 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.

(e) The physician 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 on patients.

(f) 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.

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

(4) PHYSICIAN EDUCATION.—

(a) Before ordering low-THC cannabis for use by a patient in this state, the appropriate board shall require the ordering physician licensed under chapter 458 or chapter 459 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, the appropriate delivery mechanisms, the contraindications for such use, as well as the relevant state and federal laws governing the ordering, dispensing, and possessing of this substance. The first course and examination shall be presented by October 1, 2014, and shall be administered at least annually thereafter. 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 approved under subsection (5) to 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.

(c) Successful completion of the course and examination specified in paragraph (a) is required for every physician who orders low-THC cannabis 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 may be subject to disciplinary action under the applicable practice act and under s. 456.072(1)(k).

(5) DUTIES OF THE DEPARTMENT.—By January 1, 2015, the department shall:

(a) Create a secure, electronic, and online compassionate use registry for the registration of physicians and patients as provided under this section. The registry must be accessible to law enforcement agencies and to a dispensing organization in order to verify patient authorization for low-THC cannabis and record the low-THC cannabis 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 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.

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 who is a physician licensed under chapter 458 or chapter 459 to supervise the activities of the dispensing organization.

(c) Monitor physician registration and ordering of low-THC cannabis for ordering practices that could facilitate unlawful diversion or misuse of low-THC cannabis and take disciplinary action as indicated.

(d) Adopt rules necessary to implement this section.

(6) DISPENSING ORGANIZATION.—An approved dispensing organization shall maintain compliance with the criteria demonstrated for selection and approval as a dispensing organization under subsection (5) at all times. Before dispensing low-THC cannabis to a qualified patient, the dispensing organization shall verify that the patient has an active registration in the compassionate use registry, the order presented matches the order contents as recorded in the registry, and the order has not already been filled. Upon dispensing the low-THC cannabis, the dispensing organization shall record in the registry the date, time, quantity, and form of low-THC cannabis dispensed.

(7) 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 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. For purposes of this subsection, the terms "manufacture," "possession," "deliver," "distribute," and "dispense" have the same meanings as provided in s. 893.02.

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

Section 3. Section 385.211, Florida Statutes, is created to read:

385.211 Refractory and intractable epilepsy treatment and research at recognized medical centers.—

(1) As used in this section, the term "low-THC cannabis" means "low-THC cannabis" as defined in s. 381.986 that is dispensed only from a dispensing organization as defined in s. 381.986.

(2) Notwithstanding chapter 893, medical centers recognized

pursuant to s. 381.925 may conduct research on cannabidiol and low-THC cannabis. This research may include, but is not limited to, the agricultural development, production, clinical research, and use of liquid medical derivatives of cannabidiol and low-THC cannabis for the treatment for refractory or intractable epilepsy. The authority for recognized medical centers to conduct this research is derived from 21 C.F.R. parts 312 and 316. Current state or privately obtained research funds may be used to support the activities described in this section.

Section 4. Section 385.212, Florida Statutes, is created to read:

385.212 Powers and duties of the Department of Health; Office of Compassionate Use.—

(1) The Department of Health shall establish an Office of Compassionate Use under the direction of the Deputy State Health Officer.

(2) The Office of Compassionate Use may enhance access to investigational new drugs for Florida patients through approved clinical treatment plans or studies. The Office of Compassionate Use may:

(a) Create a network of state universities and medical centers recognized pursuant to s. 381.925.

(b) Make 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.

(c) Enter into any agreements necessary to facilitate enhanced access to compassionate use for Florida patients.

(3) The department may adopt rules necessary to implement

this section.

Section 5. Subsection (3) of section 893.02, Florida Statutes, is amended 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 "low-THC cannabis," as defined in s. 381.986, if manufactured, possessed, sold, purchased, delivered, distributed, or dispensed, in conformance with s. 381.986.

Section 6. Section 1004.441, Florida Statutes, is created to read:

1004.441 Refractory and intractable epilepsy treatment and research.—

(1) As used in this section, the term "low-THC cannabis" means "low-THC cannabis" as defined in s. 381.986 that is dispensed only from a dispensing organization as defined in s. 381.986.

(2) Notwithstanding chapter 893, state universities with both medical and agricultural research programs, including those that have satellite campuses or research agreements with other similar institutions, may conduct research on cannabidiol and low-THC cannabis. This research may include, but is not limited to, the agricultural development, production, clinical research, and use of liquid medical derivatives of cannabidiol and low-THC

cannabis for the treatment for refractory or intractable epilepsy. The authority for state universities to conduct this research is derived from 21 C.F.R. parts 312 and 316. Current state or privately obtained research funds may be used to support the activities authorized by this section.

Section 7. (1) As used in this section, the term "cannabidiol" means an extract from the cannabis plant that has less than 0.8 percent tetrahydrocannabinol and the chemical signature 2-[(1R,6R)-6-isopropenyl-3-methylcyclohex-2-en-1-yl]-5-pentylbenzene-1,3-diol, or a derivative thereof, as determined by the International Union of Pure and Applied Chemistry.

(2) For the 2014-2015 fiscal year, $1 million in nonrecurring general revenue is appropriated to the Department of Health for the James and Esther King Biomedical Research Program and shall be deposited into the Biomedical Research Trust Fund. These funds shall be reserved for research of cannabidiol and its effect on intractable childhood epilepsy.

(3) Biomedical research funding for research of cannabidiol and its effect on intractable childhood epilepsy shall be awarded pursuant to s. 215.5602, Florida Statutes. An application for such funding may be submitted by any research university in the state that has obtained approval from the United States Food and Drug Administration for an exploratory investigational new drug study of cannabidiol and its effect on intractable childhood epilepsy. For purposes of this section, the Biomedical Research Advisory Council created under s. 215.5602, Florida Statutes, shall advise the State Surgeon General as to the direction and scope of research of cannabidiol and its effect on intractable childhood epilepsy and the award

of research funding.

Section 8. This act shall take effect upon becoming a law.

An act relating to public records; creating s. 381.987, F.S.; exempting from public records requirements personal identifying information of patients and physicians held by the Department of Health in the compassionate use registry; exempting information related to ordering and dispensing low-THC cannabis; authorizing specified persons and entities access to the exempt information; requiring that information released from the registry remain confidential; providing a criminal penalty; providing for future legislative review and repeal; providing a statement of public necessity; providing a contingent effective date.

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

Section 1. Section 381.987, Florida Statutes, is created to read:

381.987 Public records exemption for personal identifying information in the compassionate use registry.—

(1) A patient's personal identifying information held by the department in the compassionate use registry established under s. 381.986, including, but not limited to, the patient's name, address, telephone number, and government-issued identification number, and all information pertaining to the physician's order for low-THC cannabis and the dispensing thereof are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(2) A physician's identifying information held by the department in the compassionate use registry established under s. 381.986, including, but not limited to, the physician's name, address, telephone number, government-issued identification number, and Drug Enforcement Administration number, and all information pertaining to the physician's order for low-THC cannabis and the dispensing thereof are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(3) The department shall allow access to the registry, including access to confidential and exempt information, to:

(a) A law enforcement agency that is investigating a violation of law regarding cannabis in which the subject of the investigation claims an exception established under s. 381.986.

(b) A dispensing organization approved by the department pursuant to s. 381.986 which is attempting to verify the authenticity of a physician's order for low-THC cannabis, including whether the order had been previously filled and whether the order was written for the person attempting to have it filled.

(c) A physician who has written an order for low-THC cannabis for the purpose of monitoring the patient's use of such cannabis or for the purpose of determining, before issuing an order for low-THC cannabis, whether another physician has ordered the patient's use of low-THC cannabis. The physician may access the confidential and exempt information only for the patient for whom he or she has ordered or is determining whether to order the use of low-THC cannabis pursuant to s. 381.986.

(d) An employee of the department for the purposes of

maintaining the registry and periodic reporting or disclosure of information that has been redacted to exclude personal identifying information.

(e) The department's relevant health care regulatory boards responsible for the licensure, regulation, or discipline of a physician if he or she is involved in a specific investigation of a violation of s. 381.986. If a health care regulatory board's investigation reveals potential criminal activity, the board may provide any relevant information to the appropriate law enforcement agency.

(f) A person engaged in bona fide research if the person agrees:

1. To submit a research plan to the department which specifies the exact nature of the information requested and the intended use of the information;

2. To maintain the confidentiality of the records or information if personal identifying information is made available to the researcher;

3. To destroy any confidential and exempt records or information obtained after the research is concluded; and

4. Not to contact, directly or indirectly, for any purpose, a patient or physician whose information is in the registry.

(4) All information released from the registry under subsection (3) remains confidential and exempt, and a person who receives access to such information must maintain the confidential and exempt status of the information received.

(5) A person who willfully and knowingly violates this section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(6) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2019, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. The Legislature finds that it is a public necessity that identifying information of patients and physicians held by the Department of Health in the compassionate use registry established under s. 381.986, Florida Statutes, be made confidential and exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. Specifically, the Legislature finds that it is a public necessity to make confidential and exempt from public records requirements the names, addresses, telephone numbers, and government-issued identification numbers of patients and physicians and any other information on or pertaining to a physician's order for low-THC cannabis written pursuant to s. 381.986, Florida Statutes, which are held in the registry. The choice made by a physician and his or her patient to use low-THC cannabis to treat that patient's medical condition or symptoms is a personal and private matter between those two parties. The availability of such information to the public could make the public aware of both the patient's use of low-THC cannabis and the patient's diseases or other medical conditions for which the patient is using low-THC cannabis. The knowledge of the patient's use of low-THC cannabis, the knowledge that the physician ordered the use of low-THC cannabis, and the knowledge of the patient's medical condition could be used to embarrass, humiliate, harass, or discriminate against the patient and the physician. This information could be used as a discriminatory

tool by an employer who disapproves of the patient's use of low-THC cannabis or of the physician's ordering such use. However, despite the potential hazards of collecting such information, maintaining the compassionate use registry established under s. 381.986, Florida Statutes, is necessary to prevent the diversion and nonmedical use of any low-THC cannabis as well as to aid and improve research done on the efficacy of low-THC cannabis. Thus, the Legislature finds that it is a public necessity to make confidential and exempt from public records requirements the identifying information of patients and physicians held by the Department of Health in the compassionate use registry established under s. 381.986, Florida Statutes.

Section 3. This act shall take effect on the same date that SB 1030, or similar legislation establishing an electronic system to record a physician's orders for, and a patient's use of, low-THC cannabis takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes a law.

Analysis of CS for CS for SB 1030 (2014 Legislative Session)

A summary of CS for CS for SB 1030 and its implementation to date.

Florida's Current Medical Cannabis Law Summary

Compassionate Medical Cannabis Act of 2014

Patient Treatment with Low-THC Cannabis

The Compassionate Medical Cannabis Act of 2014[1] (act) legalized a low tetrahydrocannabinol (THC) and high cannabidiol (CBD) form of cannabis (low-THC cannabis)[2] for the medical use[3] by patients suffering from cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms. The act provides that a Florida licensed allopathic or osteopathic physician who has completed the required training[4] 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;[5]
- The physician registers as the orderer of low-THC cannabis for the patient on the compassionate use registry (registry) maintained by the 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

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[1] *See* ch. 2014-157, L.O.F., and s. 381.986, F.S.

[2] 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).

[3] 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.

[4] 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

[5] 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.

patient's condition with low-THC cannabis, the medically acceptable alternatives, and the potential risks and side effects.

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[6] 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.[7]

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.[8] 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.[9]

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[6] *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.
[7] *See* s. 381.986(7)(c), F.S.
[8] *See* s. 381.986(5)(b), F.S.
[9] Id.

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.[10] 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 authority by the Administrative Law Judge on November 14, 2014.[11] 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.[12] 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.[13] 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.[14]

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.[15]

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:

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[10] Id.
[11] *See* https://www.doah.state.fl.us/ROS/2014/14004296.pdf (last accessed March 27, 2015).
[12] 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).
[13] 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).
[14] Phone conversation with Marco Paredes, Legislative Planning Director for the DOH, on Sep. 23, 2015.
[15] Conversation with Jennifer Tschetter, Chief of Staff (DOH) (March 20, 2015).

- 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.[16]
- 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.[17]

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;
- 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.

[16] *See* s. 381.925, F.S.
[17] *See* s. 385.212, F.S.

2015 Legislative Session

This section contains:

- HB 683 (Medical Use of Marijuana) – Died in Health Quality Subcommittee
- HB 1097 (Pub. Rec./Medical Marijuana Patient Registry) – Died in Criminal Justice Subcommittee
- HM 1179 (Medical Marijuana) – Died in Judiciary Committee
- SB 528 (Medical Use of Marijuana) – Died in Regulated Industries Committee
- SB 7066 (Low-THC Cannabis) – Died on Calendar

A bill to be entitled

An act relating to the medical use of marijuana; creating s. 381.99, F.S.; providing a short title; creating s. 381.991, F.S.; defining terms; creating s. 381.992, F.S.; allowing registered patients and designated caregivers to purchase, acquire, and possess medical-grade marijuana subject to specified requirements; allowing a cultivation and processing licensee, employee, or contractor to acquire, cultivate, transport, and sell marijuana under certain circumstances; allowing a retail licensee to purchase, receive, possess, store, dispense, and deliver marijuana under certain circumstances; allowing a licensed laboratory to receive marijuana for certification purposes; prohibiting certain actions regarding the acquisition, possession, transfer, use, and administration of marijuana; clarifying that a person is prohibited from driving under the influence of marijuana; creating s. 381.993, F.S.; specifying registration requirements for a patient identification card; allowing a qualified patient to designate a caregiver subject to certain requirements; requiring notification by the Department of Health of the denial of a designated caregiver's registration; requiring the department to create certain patient registration and certification forms for availability by a

specified date; requiring the department to update a patient registry and issue an identification card under certain circumstances within a specified timeframe; specifying the requirements of the identification card, including expiration and renewal requirements; providing notification and return requirements if the department removes the patient or caregiver from the registry; creating s. 381.994, F.S.; requiring the department to create an online patient registry by a specified date subject to certain requirements; creating s. 381.995, F.S.; requiring the department to establish standards and develop and accept licensure application forms for the cultivation, processing, and sale of marijuana by a specified date subject to certain requirements; providing for an initial application fee, a licensure fee, and a renewal fee for specified licenses; requiring the department to issue certain licenses by specified dates; specifying requirements for a cultivation and processing license, including expiration and renewal requirements; specifying facility requirements for a cultivation and processing licensee, including inspections and the issuance of cultivation and processing facility licenses; allowing a dispensing organization to use a contractor to cultivate and process marijuana subject to certain

requirements; directing a dispensing organization or contractor to destroy all marijuana byproducts under certain conditions within a specified timeframe; allowing a cultivation and processing licensee to sell, transport, and deliver marijuana products under certain circumstances; prohibiting the Department of Health from licensing retail facilities in a county unless the board of county commissioners for that county determines by ordinance the number and location of retail facilities subject to certain limitations; specifying the application requirements for a retail license; requiring the department to consider certain factors when issuing retail licenses to encourage a competitive marketplace; providing expiration and renewal requirements for a retail license; requiring inspection of a retail facility before dispensing marijuana; providing dispensing requirements; allowing retail licensees to contract with certain types of carriers to deliver marijuana under certain circumstances; prohibiting a licensee from advertising marijuana products; specifying inspection, license, and testing requirements for certain facilities; requiring the department to create standards and impose penalties for a dispensing organization subject to certain restrictions; requiring the department to maintain a public, online list of all licensed retail

facilities; creating s. 381.996, F.S.; providing patient certification requirements relating to qualified patients; requiring a physician to transfer an order and update the registry subject to certain requirements and time restraints; requiring physician education; creating s. 381.997, F.S.; requiring testing, certification, and reporting of results by an independent laboratory before distribution or sale of marijuana or marijuana products; providing package and label requirements; requiring the department to establish quality standards and testing procedures by a certain date; creating s. 381.998, F.S.; providing criminal penalties; creating s. 381.999, F.S.; establishing that this act does not require or restrict health insurance coverage for the purchase of medical-grade marijuana; creating s. 381.9991, F.S.; providing rulemaking authority; providing an effective date.

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

Section 1. Section 381.99, Florida Statutes, is created to read:

381.99 Short title.—Sections 381.99-381.9991 may be cited as "The Florida Medical Marijuana Act."

Section 2. Section 381.991, Florida Statutes, is created

to read:

381.991 Definitions.—As used in ss. 381.991-381.9991 the term:

(1) "Allowed amount of medical-grade marijuana" means the amount of medical-grade marijuana, or the equivalent amount in processed form, which a physician may determine is necessary to treat a registered patient's qualifying condition for 30 days.

(2) "Batch" means a specifically identified quantity of processed marijuana that is uniform in strain; cultivated using the same herbicides, pesticides, and fungicides; and harvested at the same time from a single licensed cultivation and processing facility.

(3) "Cultivation and processing facility" means a facility licensed by the department for the cultivation of marijuana, the processing of marijuana, or both.

(4) "Cultivation and processing license" means a license issued by the department which authorizes the licensee to cultivate or process, or to both cultivate and process, marijuana at one or more cultivation and processing facilities.

(5) "Department" means the Department of Health.

(6) "Designated caregiver" means a person who is registered with the department as the caregiver for one or more registered patients.

(7) "Dispense" means the transfer or sale at a retail facility of the allowed amount of medical-grade marijuana from a dispensing organization to a registered patient or the patient's

designated caregiver.

(8) "Dispensing organization" means an organization that holds a cultivation and processing license, a retail license, or both.

(9) "Identification card" means a card issued by the department only to registered patients and designated caregivers.

(10) "Marijuana" has the same meaning as the term "cannabis" in s. 893.02.

(11) "Medical-grade marijuana" means marijuana that has been tested in accordance with s. 381.997; meets the standards established by the department for sale to registered patients; and is packaged, labeled, and ready to be dispensed.

(12) "Medical marijuana patient registry" means an online electronic registry created and maintained by the department to store identifying information for all registered patients and designated caregivers.

(13) "Medical use" means the acquisition, possession, transportation, use, and administration of the allowed amount of medical-grade marijuana. The term does not include the use or administration of medical-grade marijuana by, or possession of medical-grade marijuana for, smoking.

(14) "Physician" means a physician who is licensed under chapter 458 or chapter 459, has an effective federal Drug Enforcement Administration Registration number, and meets the requirements of s. 381.996(4).

(15) "Qualified patient" means a resident of this state who has been certified by a physician and diagnosed as suffering from:

(a) Cancer;

(b) Positive status for human immunodeficiency virus (HIV);

(c) Acquired immune deficiency syndrome (AIDS);

(d) Epilepsy;

(e) Amyotrophic lateral sclerosis (ALS);

(f) Multiple sclerosis;

(g) Crohn's disease;

(h) Parkinson's disease; or

(i) A terminal illness.

(16) "Registered patient" means a qualified patient who has registered with the department and has been issued a medical marijuana registry identification card.

(17) "Retail facility" means a facility licensed by the department to dispense medical-grade marijuana to registered patients and caregivers.

(18) "Retail license" means a license issued by the department which authorizes the licensee to dispense medical-grade marijuana to registered patients and caregivers from a retail facility.

(19) "Terminal illness" means a medical prognosis, as determined by a physician, with a life expectancy of 1 year or less if the illness runs its normal course.

Section 3. Section 381.992, Florida Statutes, is created to read:

381.992 Medical-grade marijuana.—

(1) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other law, but subject to the requirements in ss. 381.991-381.9991, a registered patient or his or her designated caregiver may purchase, acquire, and possess up to the allowed amount of medical-grade marijuana, including paraphernalia, for that patient's medical use. In order to maintain the protections under this section, a registered patient or his or her designated caregiver must demonstrate that:

(a) He or she is legally in possession of the medical-grade marijuana, by producing his or her medical marijuana identification card; and

(b) Any marijuana in his or her possession is within the registered patient's allowed amount of marijuana, by producing a receipt from the dispensing organization.

(2) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other law, but subject to the requirements in ss. 381.991-381.9991, a cultivation and processing licensee and an employee or contractor of a cultivation and processing licensee may acquire, cultivate, and possess marijuana while on the property of a cultivation and processing facility; may transport marijuana between licensed facilities owned by the licensee; may transport marijuana to independent laboratories for certification as medical-grade marijuana; and may transport and

sell medical-grade marijuana to retail facilities.

(3) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other law, but subject to the requirements in ss. 381.991-381.9991, a retail licensee and an employee of a retail licensee may purchase and receive medical-grade marijuana from a cultivation and processing licensee or its employee or contractor; may possess, store, and hold medical-grade marijuana for retail sale; and may dispense the allowed amount of medical-grade marijuana to a registered patient or designated caregiver at a retail facility. A retail licensee and an employee or contractor of a retail licensee may deliver medical-grade marijuana to the residence of a registered patient.

(4) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other law, but subject to the requirements in ss. 381.991-381.9991, a licensed laboratory and an employee of an independent testing laboratory may receive and possess marijuana for the sole purpose of testing the marijuana for certification as medical-grade marijuana.

(5) This section does not authorize:

(a) The acquisition, purchase, transportation, use, possession, or administration of any type of marijuana other than medical-grade marijuana by a registered patient or designated caregiver.

(b) The use of medical-grade marijuana by anyone other than the registered patient for whom the medical-grade marijuana was ordered.

(c) The transfer or administration of medical-grade marijuana to anyone other than the registered patient for whom the medical-grade marijuana was ordered.

(d) The acquisition or purchase of medical-grade marijuana by a registered patient or designated caregiver from an entity other than a dispensing organization that has a retail license.

(e) A registered patient or designated caregiver to transfer medical-grade marijuana to a person other than the patient for whom the medical-grade marijuana was ordered or to any entity except for the purpose of returning unused medical-grade marijuana to a dispensing organization.

(f) The recommendation of medical-grade marijuana to a minor without the written consent of a parent or guardian.

(g) The use or administration of medical-grade marijuana:

1. On any form of public transportation.

2. In any public place.

3. In a registered patient's place of work, if restricted by his or her employer.

(h) The possession, use, or administration of medical-grade marijuana:

1. In a state correctional institution, as defined in s. 944.02(8), or a correctional institution, as defined in s. 944.241(2)(a);

2. On the grounds of any preschool, primary school, or secondary school; or

3. On a school bus.

(6) This section does not exempt any person from the prohibition against driving under the influence provided in s. 316.193.

Section 4. Section 381.993, Florida Statutes, is created to read:

381.993 Medical marijuana patient and designated caregiver registration.—

(1) In order to register for an identification card, a qualified patient must submit to the department:

(a) A patient registration form;

(b) Proof of Florida residency; and

(c) A passport-style photograph taken within the previous 90 days.

(2) For a qualified patient to be registered and to receive an identification card, a physician must submit a patient-certification form directly to the department which includes certification by the physician that the patient suffers from one or more qualifying conditions specified in s. 381.991(15).

(3) If a qualified patient is under 21 years of age, a second physician must also submit a patient-certification form that meets the requirements of subsection (2).

(4) The patient-certification form may be submitted through the department website.

(5) A qualified patient may, at initial registration or while a registered patient, designate a caregiver to assist him

or her with the medical use of medical-grade marijuana. A designated caregiver must be at least 21 years of age and must meet the background screening requirements in s. 408.809 unless the caregiver is assisting only his or her own spouse, parents, children, or siblings. A designated caregiver may not be registered to assist more than one patient at any given time unless:

(a) All of the caregiver's registered patients are the caregiver's parents, siblings, or children;

(b) All of the caregiver's registered patients are first degree relations to each other who share a residence; and

(c) All of the caregiver's registered patients reside in an assisted living facility, nursing home, or other such facility and the caregiver is an employee of that facility.

(6) If the department determines, for any reason, that a caregiver designated by a registered patient may not assist that patient, the department must notify that patient of the denial of the designated caregiver's registration.

(7) The department must create a registration form and a patient-certification form and make the forms available to the public by January 1, 2016. The registration form must require the patient to include, at a minimum, the information required to be on the patient's identification card and on his or her designated caregiver's identification card if the patient is designating a caregiver.

(8) Beginning on July 1, 2016, when the department

receives a registration form, the supporting patient-certification form, and proof of the patient's residency, the department must, within 14 days:

(a) Enter the qualified patient's and his or her designated caregiver's information into the medical marijuana patient registry; and

(b) Issue an identification card to the qualified patient and to that patient's designated caregiver, if applicable. The department is not required to issue an additional identification card to a designated caregiver who already possesses a valid identification card when that caregiver becomes registered as the caregiver for additional registered patients unless the required information has changed. The expiration date for a designated caregiver's identification card must coincide with the last occurring expiration date on the identification card of the patient the caregiver is registered to assist.

(9) Identification cards issued to registered patients and designated caregivers must be resistant to counterfeiting and include, but not be limited to, all of the following information:

(a) The person's full legal name.

(b) The person's photograph.

(c) A randomly assigned identification number.

(d) The expiration date of the identification card.

(10) Except as provided in paragraph (8)(b), patient and caregiver identification cards expire 1 year after the date they

are issued. In order to renew an identification card, a qualified patient must submit proof of continued residency and a physician must certify to the department:

(a) That he or she has examined the patient during the course of the patient's treatment with medical-grade marijuana.

(b) That the patient suffers from one or more qualifying conditions.

(c) That, in the physician's good faith medical judgment, the use of medical-grade marijuana gives the patient some relief from the symptoms of the qualifying condition.

(d) The allowed amount of medical-grade marijuana that the physician orders for the patient's use.

(11) Should the department become aware of information that would disqualify a patient or caregiver from being registered, the department must notify that person of the change in his or her status as follows:

(a) For registered patients, the department must give notice at least 30 days before removing that patient from the registry. The patient must return all medical-grade marijuana, medical-grade marijuana products, and his or her identification card to a retail facility within 30 days after receiving such notice. A dispensing organization must notify the department within 24 hours after it has received such a return. Such notification may be submitted electronically.

(b) For designated caregivers, the department must give notice to the registered patient and the designated caregiver at

least 15 days before removing a caregiver from the registry. The caregiver must return his or her identification card to a retail facility within 15 days after receiving such notice. A dispensing organization must notify the department within 24 hours after it has received such a return. Such notification may be submitted electronically.

Section 5. Section 381.994, Florida Statutes, is created to read:

381.994 Electronic medical marijuana patient registry.—

(1) By July 1, 2016, the department must create a secure, online, electronic medical marijuana patient registry containing a file for each registered patient and caregiver and for each certifying physician consisting of, but not limited to, all of the following:

(a) For patients and caregivers:

1. His or her full legal name;

2. His or her photograph;

3. The randomly assigned identification number on his or her identification card; and

4. The expiration date of the identification card.

(b) For physicians, the physician's full legal name and license number.

(c) For a registered patient:

1. The full legal name of his or her designated caregiver, if any;

2. His or her allowed amount of medical-grade marijuana;

and

3. The concentration ranges of specified cannabinoids, if any, ordered by the patient's certifying physician.

(d) For a designated caregiver:

1. The full legal name or names of all registered patients whom the caregiver is registered to assist;

2. The allowed amount of medical-grade marijuana for each patient the caregiver is registered to assist; and

3. The concentration ranges of specified cannabinoids, if any, ordered by the certifying physician for each respective patient the caregiver is registered to assist.

(e) The date and time of dispensing, and the allowed amount of medical-grade marijuana dispensed, for each of that registered patient's or caregiver's transactions with the dispensing organization.

(2) The registry must be able to:

(a) Be accessed by a retail licensee or employee to verify the authenticity of a patient identification card, to verify the allowed amount and any specified type of medical-grade marijuana ordered by his or her physician, and to determine the prior dates on which and times at which medical-grade marijuana was dispensed to the patient and the amount dispensed on each occasion;

(b) Accept in real time the original and updated orders for medical-grade marijuana from certifying physicians;

(c) Be accessed by law enforcement agencies in order to

verify patient or caregiver authorization for possession of an allowed amount of medical-grade marijuana; and

(d) Accept and post initial and updated information to each registered patient's file from the dispensing organization that shows the date, time, and amount of medical-grade marijuana dispensed to that patient at the point of sale.

Section 6. Section 381.995, Florida Statutes, is created to read:

381.995 Dispensing organizations.—

(1) By January 1, 2016, the department shall establish operating standards for the cultivation, processing, packaging, and labeling of marijuana, establish standards for the sale of medical-grade marijuana, develop licensure application forms for cultivation and processing licenses and retail licenses, make such forms available to the public, establish procedures and requirements for cultivation facility licenses and renewals and processing facility licenses and renewals, and begin accepting applications for licensure. The department may charge an initial application fee of up to $100,000 for cultivation and processing licenses and up to $10,000 for retail licenses, a licensure fee, and a license renewal fee as necessary to pay for all expenses incurred by the department in administering this section.

(2) The department must begin issuing cultivation and processing licenses by March 1, 2016, and retail licenses by July 1, 2016.

(3) The department may issue a cultivation and processing

license to an applicant who provides:

(a) A completed cultivation and processing license application form;

(b) The initial application fee;

(c) The legal name of the applicant;

(d) The physical address of each location where marijuana will be cultivated and processed;

(e) The name, address, and date of birth of each principal officer and board member, if applicable;

(f) The name, address, and date of birth of each of the applicant's current employees who will participate in the operations of the dispensing organization;

(g) Proof that all principals and employees of the applicant have passed a level 2 background screening pursuant to chapter 435 within the prior year;

(h) Proof of an established infrastructure or the ability to establish an infrastructure in a reasonable amount of time designed to cultivate, process, test, package, and label marijuana and to deliver medical-grade marijuana to retail facilities throughout the state;

(i) Proof that the applicant possesses the technical and technological ability to cultivate and process medical-grade marijuana;

(j) Proof of operating procedures designed to secure and maintain accountability for all marijuana and marijuana-related byproducts it may possess;

(k) Proof of the financial ability to maintain operations for the duration of the license;

(l) Proof of at least $1 million of hazard and liability insurance for each cultivation and processing facility; and

(m) A $5 million performance and compliance bond, to be forfeited if the licensee fails to maintain its license for the duration of the licensure period or fails to comply with the substantive requirements of this subsection and applicable agency rules for the duration of the licensure period.

(4) A cultivation and processing license expires 2 years after the date it is issued. The licensee must apply for a renewed license before the expiration date. In order to receive a renewed license, a cultivation and processing licensee must demonstrate continued compliance with the requirements in subsection (3) and have no outstanding substantial violations of the standards established by the department for the cultivation, processing, packaging, and labeling of marijuana and medical-grade marijuana.

(5) A cultivation and processing licensee may cultivate marijuana at one or more facilities only if each facility used for cultivation has been inspected by the department and issued a cultivation facility license. A cultivation and processing licensee may process marijuana at one or more processing facilities only if each facility used for processing has been inspected by the department and issued a processing facility license. A cultivation and processing licensee may cultivate and

process marijuana at the same facility only if that facility has been inspected by the department and issued both a cultivation facility license and a processing facility license. Each cultivation and processing facility must be secure and closed to the public and may not be located within 1,000 feet of an existing public or private elementary or secondary school, a child care facility licensed under s. 402.302, or a licensed service provider offering substance abuse services. The department may establish by rule additional security and zoning requirements for cultivation and processing facilities. All matters regarding the licensure and regulation of cultivation and processing facilities, including the location of such facilities, are preempted to the state.

(6) Before beginning cultivation or processing at a facility, that facility must be inspected and licensed as a cultivation facility, a processing facility, or both by the department. A cultivation and processing licensee may cultivate and process marijuana only for the purpose of producing medical-grade marijuana and may do so only at a licensed cultivation and processing facility. Such processing may include, but is not limited to, processing marijuana into medical-grade marijuana and processing medical-grade marijuana into various forms including, but not limited to, topical applications, oils, and food products for a registered patient's use. A dispensing organization may use a contractor to cultivate the marijuana, to process marijuana into medical-grade marijuana, or to process

the medical-grade marijuana into other forms, but the dispensing organization is responsible for all of the operations performed by each contractor relating to the cultivation and processing of marijuana and the physical possession of all marijuana and medical-grade marijuana. All work done by a contractor must be performed at a licensed cultivation and processing facility. All marijuana byproducts that are unable to be processed or reprocessed into medical-grade marijuana must be destroyed by the dispensing organization or its contractor within 48 hours after processing is completed.

(7) A cultivation and processing licensee may transport, or contract to have transported, marijuana and marijuana products to independent testing laboratories to be tested and certified as medical-grade marijuana.

(8) A cultivation and processing licensee may sell, transport, and deliver medical-grade marijuana and medical-grade marijuana products to retail licensees throughout the state.

(9) The department may not license any retail facilities in a county unless the board of county commissioners for that county determines by ordinance the number and location of any retail facilities that may be located within that county. A retail facility may not be located on the same property as a facility licensed for cultivation or processing of marijuana or within 1,000 feet of an existing public or private elementary or secondary school, a child care facility licensed under s. 402.302, or a licensed service provider that offers substance

abuse services.

(10) An applicant for a retail license must provide the department with at least all of the following:

(a) A completed retail license application form.

(b) The initial application fee.

(c) The full legal name of the applicant.

(d) The physical address of the retail facility where marijuana will be dispensed.

(e) Identifying information for all other current or previous retail licenses held by the applicant.

(f) The name, address, and date of birth for each of the applicant's principal officers and board members.

(g) The name, address, and date of birth of each of the applicant's current employees who will participate in the operations of the dispensing organization.

(h) Proof that all principals and employees of the applicant have passed a level 2 background screening pursuant to chapter 435 within the prior year.

(i) Proof of an established infrastructure or the ability to establish an infrastructure in a reasonable amount of time which is designed to receive medical-grade marijuana from cultivation and processing facilities, the ability to maintain the security of the retail facility to prevent theft or diversion of any medical marijuana product received, the ability to correctly dispense the allowed amount and specified type of medical-grade marijuana to a registered patient or his or her

designated caregiver pursuant to a physician's order, the ability to check the medical marijuana patient registry, and the ability to electronically update the medical marijuana patient registry with dispensing information.

(j) Proof of operating procedures designed to secure and maintain accountability for all medical-grade marijuana and products that it may receive and possess.

(k) Proof of the financial ability to maintain operations for the duration of the license.

(l) Proof of at least $500,000 of hazard and liability insurance for each license.

(m) A $1 million performance and compliance bond, for each license, to be forfeited if the licensee fails to maintain the license for the duration of the licensure period or fails to comply with the requirements of this subsection for the duration of the licensure period.

(11) The department may issue multiple retail licenses to a single qualified entity; however, to encourage a competitive marketplace, when multiple entities have applied for a license in the same county, in addition to the qualifications of each applicant, the department shall consider the number of retail licenses currently held by each applicant and the number of separate entities that hold retail licenses within the same geographic area.

(12) A retail license expires 2 years after the date it is issued. The retail licensee must reapply for renewed licensure

before the expiration date. In order to qualify for a renewed license, a retail licensee must meet all the requirements for initial licensure and have no outstanding substantial violations of the applicable standards established by the department.

(13) Before beginning to dispense, each retail facility must be inspected by the department. Retail licensees may dispense the allowed amount of medical-grade marijuana to a registered patient or the patient's designated caregiver only if the dispensing organization's employee:

(a) Verifies the authenticity of the patient's or caregiver's identification card with the medical marijuana patient registry;

(b) Verifies the physician's order for medical-grade marijuana with the medical marijuana patient registry;

(c) Determines that the registered patient has not been dispensed the allowed amount of marijuana within the previous 30 days;

(d) Issues the registered patient or the patient's caregiver a receipt that details the date and time of dispensing, the amount of medical-grade marijuana dispensed, and the person to whom the medical-grade marijuana was dispensed; and

(e) Updates the medical marijuana patient registry with the date and time of dispensing and the amount and type of medical-grade marijuana being dispensed to the registered patient before dispensing to that patient or that patient's

designated caregiver.

(14) Retail licensees may contract with licensed and bonded carriers to transport medical-grade marijuana and medical-grade marijuana products between properties owned by the licensee and to deliver it to the residence of a registered patient.

(15) A licensee under the Florida Medical Marijuana Act may not advertise its marijuana products.

(16) The department must inspect and license each dispensing organization's cultivation and processing facilities and retail facilities before those facilities begin operations. The department must also inspect each licensed facility at least once every 2 years. The department may also conduct additional announced or unannounced inspections at reasonable hours in order to ensure that such facilities meet the standards set by the department. The department may test any marijuana, marijuana product, medical-grade marijuana, or medical-grade marijuana product in order to ensure that such marijuana, marijuana product, medical-grade marijuana, or medical-grade marijuana product meets the standards established by the department. The department may, by interagency agreement with the Department of Business and Professional Regulation or with the Department of Agriculture and Consumer Services, perform joint inspections of such facilities with those agencies.

(17) The department must create a schedule of violations in rule in order to impose reasonable fines not to exceed

$10,000 on a dispensing organization. In determining the amount of the fine to be levied for a violation, the department shall consider:

(a) The severity of the violation;

(b) Any actions taken by the dispensing organization to correct the violation or to remedy complaints; and

(c) Any previous violations.

(18) The department may suspend, revoke, or refuse to renew the license of a dispensing organization or of an individual facility for violations of the standards established by the department.

(19) The department shall maintain a publicly available, easily accessible list on its website of all licensed retail facilities.

Section 7. Section 381.996, Florida Statutes, is created to read:

381.996 Patient certification.—

(1) A physician may certify a patient to the department as a qualified patient if:

(a) The physician has seen the patient on a regular basis to treat a qualifying condition for a period of at least 3 months immediately preceding the patient's submission of a patient registration form to the department.

(b) The physician believes, in his or her good faith medical judgment, the patient suffers from one or more of the qualifying conditions.

(2) After certifying a patient, the physician must electronically transfer an original order for medical-grade marijuana for that patient to the medical marijuana patient registry. Such order must include, at a minimum, the allowed amount of medical-grade marijuana and the concentration ranges for individual cannabinoids, if any. The physician must also update the registry with any changes in the specifications of his or her order for that patient within 7 days.

(3) If the physician becomes aware that the patient no longer suffers from his or her qualifying condition or if the physician's order for the allowed amount of medical marijuana changes for that patient, the physician must update the registry with the new information within 7 days.

(4) In order to qualify to issue patient certifications for medical-grade marijuana, and before ordering medical-grade marijuana for any patient, a physician must successfully complete an 8-hour course and subsequent examination offered by the Florida Medical Association or the Florida Osteopathic Medical Association, as appropriate, which encompasses the clinical indications for the appropriate use of medical-grade marijuana, the appropriate delivery mechanisms, the contraindications of the use of medical-grade marijuana, and the relevant state and federal laws governing ordering, dispensing, and possession. The appropriate boards shall offer the first course and examination by October 1, 2015, and shall administer them at least annually thereafter. Successful completion of the

course may be used by a physician to satisfy 8 hours of the continuing medical education requirements imposed by his or her respective board for licensure renewal. This course may be offered in a distance-learning format. Successful completion of the course and examination is required for every physician who orders medical-grade marijuana each time such physician renews his or her license.

Section 8. Section 381.997, Florida Statutes, is created to read:

381.997 Medical-grade marijuana testing and labeling.—

(1) A cultivation and processing licensee may not distribute or sell medical-grade marijuana or product to a retail licensee unless the batch of origin of that marijuana or product has been tested by an independent testing laboratory and the cultivation and processing licensee has received test results from that laboratory which certify that the batch meets the quality standards established by the department.

(2) When testing a batch of marijuana or product a testing laboratory must, at a minimum, test for unsafe contaminants and for presence and concentration of individual cannabinoids.

(3) Each testing laboratory must report its findings for each batch tested to the cultivation and processing licensee from which the batch originated and to the department. Such findings must include, at a minimum, the license number or numbers of the processing and cultivation facility from which the batch originated, the size and batch number of the batch

tested, the types of tests performed on the batch, and the results of each test.

(4) Before distribution or sale to a retail licensee, any medical-grade marijuana that meets department testing standards must be packaged in a child-resistant container and labeled with at least the name and license number of the cultivation and processing licensee, the license number of the facility or facilities where the batch was harvested and processed, the harvest or production batch number, the concentration range of each individual cannabinoid present at testing, and any other labeling requirements established in Florida or federal law or rules for that form of the product. For the purposes of this subsection, any oil-based extraction meant for direct consumption in small quantities as a supplement need not be labeled as a food product.

(5) Before sale to a registered patient or caregiver, a retail licensee must affix an additional label to each product that includes the licensee's name and license number.

(6) By January 1, 2016, the department must establish standards for quality and testing procedures and for maximum levels of unsafe contaminants. The department must also create a list of individual cannabinoids that must be tested for, concentrations that are considered significant for those cannabinoids, and varying ranges of concentrations for each cannabinoid upon which a physician may base his or her order for a patient's use of a specific strain of medical-grade marijuana.

Section 9. Section 381.998, Florida Statutes, is created to read:

381.998 Penalties.—

(1) A physician commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, if he or she orders medical-grade marijuana for a patient without a reasonable belief that the patient is suffering from a condition listed in s. 381.991(15).

(2) A person who fraudulently represents that he or she has a medical condition listed in s. 381.991(15) for the purpose of being ordered medical-grade marijuana by such physician commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

Section 10. Section 381.999, Florida Statutes, is created to read:

381.999 Insurance.—The Florida Medical Marijuana Act does not require a governmental, private, or other health insurance provider or health care services plan to cover a claim for reimbursement for the purchase of medical-grade marijuana nor does it restrict such coverage.

Section 11. Section 381.9991, Florida Statutes, is created to read:

381.9991 Rulemaking.-The department may adopt rules related to health, safety, and welfare as necessary to implement this act.

Section 12. This act shall take effect July 1, 2015.

A bill to be entitled

An act relating to public records; creating s. 381.9941, F.S.; exempting from public records requirements personal identifying information of patients and physicians held by the Department of Health in the electronic medical marijuana patient registry; exempting information related to ordering and dispensing medical marijuana; authorizing specified persons and entities access to the exempt information; requiring that information released from the registry remain confidential; providing a criminal penalty; providing for future legislative review and repeal; providing a statement of public necessity; providing a contingent effective date.

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

Section 1. Section 381.9941, Florida Statutes, is created to read:

381.9941 Public records exemption for personal identifying information in the electronic medical marijuana patient registry.—

(1) A patient's personal identifying information held by the department in the electronic medical marijuana patient registry established under s. 381.994, including, but not limited to, the patient's name, address, telephone number, and

government-issued identification number, and all information pertaining to the physician's order for medical marijuana and the dispensing thereof are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(2) A physician's identifying information held by the department in the electronic medical marijuana patient registry established under s. 381.994, including, but not limited to, the physician's name, address, telephone number, government-issued identification number, and Drug Enforcement Administration number, and all information pertaining to the physician's order for medical marijuana and the dispensing thereof are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(3) The department shall allow access to the registry, including access to confidential and exempt information, to:

(a) A law enforcement agency that is investigating a violation of law regarding cannabis in which the subject of the investigation claims an exception established under s. 381.994.

(b) A retail facility or employee approved by the department that is attempting to verify the authenticity of a physician's order for medical marijuana, including whether the order had been previously filled and whether the order was written for the person attempting to have it filled.

(c) A physician who has written an order for medical marijuana for the purpose of monitoring the patient's use of such cannabis or for the purpose of determining, before issuing

an order for medical marijuana, whether another physician has ordered the patient's use of medical marijuana. The physician may access the confidential and exempt information only for the patient for whom he or she has ordered or is determining whether to order the use of medical marijuana pursuant to ss. 381.991-381.9991.

(d) An employee of the department for the purposes of maintaining the registry and periodic reporting or disclosure of information that has been redacted to exclude personal identifying information.

(e) The department's relevant health care regulatory boards responsible for the licensure, regulation, or discipline of a physician if he or she is involved in a specific investigation of a violation of ss. 381.991-381.9991. If a health care regulatory board's investigation reveals potential criminal activity, the board may provide any relevant information to the appropriate law enforcement agency.

(4) All information released from the registry under subsection (3) remains confidential and exempt, and a person who receives access to such information must maintain the confidential and exempt status of the information received.

(5) A person who willfully and knowingly violates this section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(6) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed

on October 2, 2020, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. The Legislature finds that it is a public necessity that identifying information of patients and physicians held by the Department of Health in the electronic medical marijuana patient registry established under s. 381.994, Florida Statutes, be made confidential and exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. Specifically, the Legislature finds that it is a public necessity to make confidential and exempt from public records requirements the names, addresses, telephone numbers, and government-issued identification numbers of patients and physicians and any other information on or pertaining to a physician's order for medical marijuana written pursuant to s. 381.994, Florida Statutes, which are held in the registry. The choice made by a physician and his or her patient to use medical marijuana to treat that patient's medical condition or symptoms is a personal and private matter between those two parties. The availability of such information to the public could make the public aware of both the patient's use of medical marijuana and the patient's diseases or other medical conditions for which the patient is using medical marijuana. The knowledge of the patient's use of medical marijuana, the knowledge that the physician ordered the use of medical marijuana, and the knowledge of the patient's medical condition could be used to embarrass, humiliate, harass, or discriminate

against the patient and the physician. This information could be used as a discriminatory tool by an employer who disapproves of the patient's use of medical marijuana or of the physician's ordering such use. However, despite the potential hazards of collecting such information, maintaining the electronic medical marijuana patient registry established under s. 381.994, Florida Statutes, is necessary to prevent the diversion and nonmedical use of any medical marijuana. Thus, the Legislature finds that it is a public necessity to make confidential and exempt from public records requirements the identifying information of patients and physicians held by the Department of Health in the electronic medical marijuana patient registry established under s. 381.994, Florida Statutes.

Section 3. This act shall take effect on the same date that HB 683, or similar legislation establishing an electronic system to record a physician's orders for, and a patient's use of, medical marijuana takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes a law.

House Memorial

A memorial to the Congress of the United States, urging Congress to remove marijuana from the Schedule I drug list and allow it to be researched and used for medical purposes.

WHEREAS, marijuana is currently listed under the Controlled Substances Act as a Schedule I drug and, under the act, such drugs are considered to have a high potential for abuse and have no currently accepted medical use, and

WHEREAS, the District of Columbia and twenty-three states recognize the medical value of marijuana in treating multiple diseases and medical conditions, and

WHEREAS, due to the Federal Government's resistance in allowing marijuana to be used for medical purposes, clinical studies cannot be conducted, or are severely stunted, in attempting to discover the full potential of this plant and its healing abilities, and

WHEREAS, the few studies that have been done were conducted despite the researcher's fears of being shut down or even prosecuted, and

WHEREAS, the studies and results on patients have proven that marijuana has healing properties for many debilitating and painful diseases, cancer, and other ailments that currently plague our citizens, and

WHEREAS, if federal laws were supportive of this plant as a medicine, further studies could be conducted to learn of all the possibilities that this plant holds, and

WHEREAS, with the support of the Federal Government, highly organized and supervised production facilities, as well as a means of distribution, could be established, NOW, THEREFORE,

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

That the Legislature of the State of Florida, with all due respect, does hereby urge the United States Congress to remove marijuana from the Schedule I drug list and allow marijuana to be researched and used for medical purposes.

BE IT FURTHER RESOLVED that copies of this memorial be dispatched to the President of the United States, to the President of the United States Senate, to the Speaker of the United States House of Representatives, and to each member of the Florida delegation to the United States Congress.

By Senator Brandes

22-00645A-15 2015528__

A bill to be entitled

An act relating to the medical use of marijuana; creating s. 381.99, F.S.; providing a short title; creating s. 381.991, F.S.; defining terms; creating s. 381.992, F.S.; allowing registered patients and designated caregivers to purchase, acquire, and possess medical-grade marijuana subject to specified requirements; allowing a cultivation and processing licensee, employee, or contractor to acquire, cultivate, transport, and sell marijuana under certain circumstances; allowing a retail licensee to purchase, receive, possess, store, dispense, and deliver marijuana under certain circumstances; allowing a licensed laboratory to receive marijuana for certification purposes; prohibiting certain actions regarding the acquisition, possession, transfer, use, and administration of marijuana; clarifying that a person is prohibited from driving under the influence of marijuana; creating s. 381.993, F.S.; specifying registration requirements for a patient identification card; allowing a qualified patient to designate a caregiver subject to certain requirements; requiring notification by the Department of Health of the denial of a designated caregiver's registration; requiring the department to create certain patient registration and certification forms for availability by a specified date; requiring the department to update a patient registry and issue an identification card under certain circumstances within a specified

timeframe; specifying the requirements of the identification card, including expiration and renewal requirements; providing notification and return requirements if the department removes the patient or caregiver from the registry; creating s. 381.994, F.S.; requiring the department to create an online patient registry by a specified date subject to certain requirements; creating s. 381.995, F.S.; requiring the department to establish standards and develop and accept licensure application forms for the cultivation, processing, and sale of marijuana by a specified date subject to certain requirements; providing for an initial application fee, a licensure fee, and a renewal fee for specified licenses; requiring the department to issue certain licenses by specified dates; specifying requirements for a cultivation and processing license, including expiration and renewal requirements; specifying facility requirements for a cultivation and processing licensee, including inspections and the issuance of cultivation and processing facility licenses; allowing a dispensing organization to use a contractor to cultivate and process marijuana subject to certain requirements; directing a dispensing organization or contractor to destroy all marijuana byproducts under certain conditions within a specified timeframe; allowing a cultivation and processing licensee to sell, transport, and deliver marijuana products under certain circumstances; prohibiting the Department of

Health from licensing retail facilities in a county unless the board of county commissioners for that county determines by ordinance the number and location of retail facilities subject to certain limitations; specifying the application requirements for a retail license; requiring the department to consider certain factors when issuing retail licenses to encourage a competitive marketplace; providing expiration and renewal requirements for a retail license; requiring inspection of a retail facility before dispensing marijuana; providing dispensing requirements; allowing retail licensees to contract with certain types of carriers to deliver marijuana under certain circumstances; prohibiting a licensee from advertising marijuana products; specifying inspection, license, and testing requirements for certain facilities; requiring the department to create standards and impose penalties for a dispensing organization subject to certain restrictions; requiring the department to maintain a public, online list of all licensed retail facilities; creating s. 381.996, F.S.; providing patient certification requirements relating to qualified patients; requiring a physician to transfer an order and update the registry subject to certain requirements and time restraints; requiring physician education; creating s. 381.997, F.S.; requiring testing, certification, and reporting of results by an independent laboratory before distribution or sale of marijuana or marijuana products; providing package and

label requirements; requiring the department to establish quality standards and testing procedures by a certain date; creating s. 381.998, F.S.; providing criminal penalties; creating s. 381.999, F.S.; establishing that this act does not require or restrict health insurance coverage for the purchase of medical-grade marijuana; creating s. 381.9991, F.S.; providing rulemaking authority; providing an effective date.

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

Section 1. Section 381.99, Florida Statutes, is created to read:

381.99 Short title.—Sections 381.99-381.9991 may be cited as "The Florida Medical Marijuana Act."

Section 2. Section 381.991, Florida Statutes, is created to read:

381.991 Definitions.—As used in ss. 381.991-381.9991 the term:

(1) "Allowed amount of medical-grade marijuana" means the amount of medical-grade marijuana, or the equivalent amount in processed form, which a physician may determine is necessary to treat a registered patient's qualifying condition or qualifying symptom or symptoms for 30 days.

(2) "Batch" means a specifically identified quantity of processed marijuana that is uniform in strain; cultivated using the same herbicides, pesticides, and fungicides; and harvested at the same time from a single licensed cultivation and

processing facility.

(3) "Cultivation and processing facility" means a facility licensed by the department for the cultivation of marijuana, the processing of marijuana, or both.

(4) "Cultivation and processing license" means a license issued by the department which authorizes the licensee to cultivate or process, or to both cultivate and process, marijuana at one or more cultivation and processing facilities.

(5) "Department" means the Department of Health.

(6) "Designated caregiver" means a person who is registered with the department as the caregiver for one or more registered patients.

(7) "Dispense" means the transfer or sale at a retail facility of the allowed amount of medical-grade marijuana from a dispensing organization to a registered patient or the patient's designated caregiver.

(8) "Dispensing organization" means an organization that holds a cultivation and processing license, a retail license, or both.

(9) "Identification card" means a card issued by the department only to registered patients and designated caregivers.

(10) "Marijuana" has the same meaning as the term "cannabis" in s. 893.02.

(11) "Medical-grade marijuana" means marijuana that has been tested in accordance with s. 381.997; meets the standards established by the department for sale to registered patients; and is packaged, labeled, and ready to be dispensed.

(12) "Medical marijuana patient registry" means an online

electronic registry created and maintained by the department to store identifying information for all registered patients and designated caregivers.

(13) "Medical use" means the acquisition, possession, transportation, use, and administration of the allowed amount of medical-grade marijuana.

(14) "Physician" means a physician who is licensed under chapter 458 or chapter 459 and meets the requirements of s. 381.996(4).

(15) "Qualified patient" means a resident of this state who has been certified by a physician and diagnosed as suffering from:

(a) Cancer;

(b) Positive status for human immunodeficiency virus (HIV);

(c) Acquired immune deficiency syndrome (AIDS);

(d) Epilepsy;

(e) Amyotrophic lateral sclerosis (ALS);

(f) Multiple sclerosis;

(g) Crohn's disease;

(h) Parkinson's disease; or

(i) Any physical medical condition or treatment for a medical condition that chronically produces one or more qualifying symptoms.

(16) "Qualifying symptom" means:

(a) Cachexia or wasting syndrome;

(b) Severe and persistent pain;

(c) Severe and persistent nausea;

(d) Persistent seizures; or

(e) Severe and persistent muscle spasms.

(17) "Registered patient" means a qualified patient who has registered with the department and has been issued a medical marijuana registry identification card.

(18) "Retail facility" means a facility licensed by the department to dispense medical-grade marijuana to registered patients and caregivers.

(19) "Retail license" means a license issued by the department which authorizes the licensee to dispense medical-grade marijuana to registered patients and caregivers from a retail facility.

Section 3. Section 381.992, Florida Statutes, is created to read:

381.992 Medical-grade marijuana.—

(1) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other law, but subject to the requirements in ss. 381.991-381.9991, a registered patient or his or her designated caregiver may purchase, acquire, and possess up to the allowed amount of medical-grade marijuana, including paraphernalia, for that patient's medical use. In order to maintain the protections under this section, a registered patient or his or her designated caregiver must demonstrate that:

(a) He or she is legally in possession of the medical-grade marijuana, by producing his or her medical marijuana identification card; and

(b) Any marijuana in his or her possession is within the registered patient's allowed amount of marijuana, by producing a receipt from the dispensing organization.

(2) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other law, but subject to the requirements in ss. 381.991-

381.9991, a cultivation and processing licensee and an employee or contractor of a cultivation and processing licensee may acquire, cultivate, and possess marijuana while on the property of a cultivation and processing facility; may transport marijuana between licensed facilities owned by the licensee; may transport marijuana to independent laboratories for certification as medical-grade marijuana; and may transport and sell medical-grade marijuana to retail facilities.

(3) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other law, but subject to the requirements in ss. 381.991-381.9991, a retail licensee and an employee of a retail licensee may purchase and receive medical-grade marijuana from a cultivation and processing licensee or its employee or contractor; may possess, store, and hold medical-grade marijuana for retail sale; and may dispense the allowed amount of medical-grade marijuana to a registered patient or designated caregiver at a retail facility. A retail licensee and an employee or contractor of a retail licensee may deliver medical-grade marijuana to the residence of a registered patient.

(4) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other law, but subject to the requirements in ss. 381.991-381.9991, a licensed laboratory and an employee of an independent testing laboratory may receive and possess marijuana for the sole purpose of testing the marijuana for certification as medical-grade marijuana.

(5) This section does not authorize:

(a) The acquisition, purchase, transportation, use, possession, or administration of any type of marijuana other than medical-grade marijuana by a registered patient or

designated caregiver.

(b) The use of medical-grade marijuana by anyone other than the registered patient for whom the medical-grade marijuana was ordered.

(c) The transfer or administration of medical-grade marijuana to anyone other than the registered patient for whom the medical-grade marijuana was ordered.

(d) The acquisition or purchase of medical-grade marijuana by a registered patient or designated caregiver from an entity other than a dispensing organization that has a retail license.

(e) A registered patient or designated caregiver to transfer medical-grade marijuana to a person other than the patient for whom the medical-grade marijuana was ordered or to any entity except for the purpose of returning unused medical-grade marijuana to a dispensing organization.

(f) The use or administration of medical-grade marijuana:

1. On any form of public transportation.

2. In any public place.

3. In a registered patient's place of work, if restricted by his or her employer.

(g) The possession, use, or administration of medical-grade marijuana:

1. In a correctional facility;

2. On the grounds of any preschool, primary school, or secondary school; or

3. On a school bus.

(6) This section does not exempt any person from the prohibition against driving under the influence provided in s. 316.193.

Section 4. Section 381.993, Florida Statutes, is created to read:

381.993 Medical marijuana patient and designated caregiver registration.—

(1) In order to register for an identification card, a qualified patient must submit to the department:

(a) A patient registration form;

(b) Proof of Florida residency; and

(c) A passport-style photograph taken within the previous 90 days.

(2) For a qualified patient to be registered and to receive an identification card, a physician must submit a patient-certification form directly to the department which includes:

(a) Certification by the physician that the patient suffers from one or more qualifying conditions or symptoms specified in s. 381.991(15); and

(b) Unless the patient suffers from a condition listed in s. 381.991(15)(a)-(i), certification that in that physician's good faith medical judgment the patient has exhausted all other reasonable medical treatments for those symptoms.

(3) If a qualified patient is under 21 years of age, a second physician must also submit a patient-certification form that meets the requirements of paragraphs (2)(a) and 2(b).

(4) The patient-certification form may be submitted through the department website.

(5) A qualified patient may, at initial registration or while a registered patient, designate a caregiver to assist him or her with the medical use of medical-grade marijuana. A designated caregiver must be at least 21 years of age and must

meet the background screening requirements in s. 408.809 unless the caregiver is assisting only his or her own spouse, parents, children, or siblings. A designated caregiver may not be registered to assist more than one patient at any given time unless:

(a) All of the caregiver's registered patients are the caregiver's parents, siblings, or children;

(b) All of the caregiver's registered patients are first degree relations to each other who share a residence; and

(c) All of the caregiver's registered patients reside in an assisted living facility, nursing home, or other such facility and the caregiver is an employee of that facility.

(6) If the department determines, for any reason, that a caregiver designated by a registered patient may not assist that patient, the department must notify that patient of the denial of the designated caregiver's registration.

(7) The department must create a registration form and a patient-certification form and make the forms available to the public by January 1, 2016. The registration form must require the patient to include, at a minimum, the information required to be on the patient's identification card and on his or her designated caregiver's identification card if the patient is designating a caregiver.

(8) Beginning on July 1, 2016, when the department receives a registration form, the supporting patient-certification form, and proof of the patient's residency, the department must, within 14 days:

(a) Enter the qualified patient's and his or her designated caregiver's information into the medical marijuana patient

registry; and

(b) Issue an identification card to the qualified patient and to that patient's designated caregiver, if applicable. The department is not required to issue an additional identification card to a designated caregiver who already possesses a valid identification card when that caregiver becomes registered as the caregiver for additional registered patients unless the required information has changed. The expiration date for a designated caregiver's identification card must coincide with the last occurring expiration date on the identification card of the patient the caregiver is registered to assist.

(9) Identification cards issued to registered patients and designated caregivers must be resistant to counterfeiting and include, but not be limited to, all of the following information:

(a) The person's full legal name.

(b) The person's photograph.

(c) A randomly assigned identification number.

(d) The expiration date of the identification card.

(10) Except as provided in paragraph (8)(b), patient and caregiver identification cards expire 1 year after the date they are issued. In order to renew an identification card, a qualified patient must submit proof of continued residency and a physician must certify to the department:

(a) That he or she has examined the patient during the course of the patient's treatment with medical-grade marijuana;

(b) That the patient suffers from one or more qualifying symptoms or conditions;

(c) That, except for patients suffering from the conditions

listed in s. 381.991(15)(a)-(i), in the physician's good faith medical judgment, there are no reasonable alternative medical options for the relief of such symptom or symptoms;

(d) That, in the physician's good faith medical judgment, the use of medical-grade marijuana gives the patient some relief from his or her symptoms; and

(e) The allowed amount of medical-grade marijuana that the physician orders for the patient's use.

(11) Should the department become aware of information that would disqualify a patient or caregiver from being registered, the department must notify that person of the change in his or her status as follows:

(a) For registered patients, the department must give notice at least 30 days before removing that patient from the registry. The patient must return all medical-grade marijuana, medical-grade marijuana products, and his or her identification card to a retail facility within 30 days after receiving such notice. A dispensing organization must notify the department within 24 hours after it has received such a return. Such notification may be submitted electronically.

(b) For designated caregivers, the department must give notice to the registered patient and the designated caregiver at least 15 days before removing a caregiver from the registry. The caregiver must return his or her identification card to a retail facility within 15 days after receiving such notice. A dispensing organization must notify the department within 24 hours after it has received such a return. Such notification may be submitted electronically.

Section 5. Section 381.994, Florida Statutes, is created to

read:

381.994 Electronic medical marijuana patient registry.—

(1) By July 1, 2016, the department must create a secure, online, electronic medical marijuana patient registry containing a file for each registered patient and caregiver and for each certifying physician consisting of, but not limited to, all of the following:

(a) For patients and caregivers:

1. His or her full legal name;

2. His or her photograph;

3. The randomly assigned identification number on his or her identification card; and

4. The expiration date of the identification card.

(b) For physicians, the physician's full legal name and license number.

(c) For a registered patient:

1. The full legal name of his or her designated caregiver, if any;

2. His or her allowed amount of medical-grade marijuana; and

3. The concentration ranges of specified cannabinoids, if any, ordered by the patient's certifying physician.

(d) For a designated caregiver:

1. The full legal name or names of all registered patients whom the caregiver is registered to assist;

2. The allowed amount of medical-grade marijuana for each patient the caregiver is registered to assist; and

3. The concentration ranges of specified cannabinoids, if any, ordered by the certifying physician for each respective

patient the caregiver is registered to assist.

(e) The date and time of dispensing, and the allowed amount of medical-grade marijuana dispensed, for each of that registered patient's or caregiver's transactions with the dispensing organization.

(2) The registry must be able to:

(a) Be accessed by a retail licensee or employee to verify the authenticity of a patient identification card, to verify the allowed amount and any specified type of medical-grade marijuana ordered by his or her physician, and to determine the prior dates on which and times at which medical-grade marijuana was dispensed to the patient and the amount dispensed on each occasion;

(b) Accept in real time the original and updated orders for medical-grade marijuana from certifying physicians;

(c) Be accessed by law enforcement agencies in order to verify patient or caregiver authorization for possession of an allowed amount of medical-grade marijuana; and

(d) Accept and post initial and updated information to each registered patient's file from the dispensing organization that shows the date, time, and amount of medical-grade marijuana dispensed to that patient at the point of sale.

Section 6. Section 381.995, Florida Statutes, is created to read:

381.995 Dispensing organizations.—

(1) By January 1, 2016, the department shall establish operating standards for the cultivation, processing, packaging, and labeling of marijuana, establish standards for the sale of medical-grade marijuana, develop licensure application forms for

cultivation and processing licenses and retail licenses, make such forms available to the public, establish procedures and requirements for cultivation facility licenses and renewals and processing facility licenses and renewals, and begin accepting applications for licensure. The department may charge an initial application fee of up to $100,000 for cultivation and processing licenses and up to $10,000 for retail licenses, a licensure fee, and a license renewal fee as necessary to pay for all expenses incurred by the department in administering this section.

(2) The department must begin issuing cultivation and processing licenses by March 1, 2016, and retail licenses by July 1, 2016.

(3) The department may issue a cultivation and processing license to an applicant who provides:

(a) A completed cultivation and processing license application form;

(b) The initial application fee;

(c) The legal name of the applicant;

(d) The physical address of each location where marijuana will be cultivated and processed;

(e) The name, address, and date of birth of each principal officer and board member, if applicable;

(f) The name, address, and date of birth of each of the applicant’s current employees who will participate in the operations of the dispensing organization;

(g) Proof that all principals and employees of the applicant have passed a level 2 background screening pursuant to chapter 435 within the prior year;

(h) Proof of an established infrastructure or the ability

to establish an infrastructure in a reasonable amount of time designed to cultivate, process, test, package, and label marijuana and to deliver medical-grade marijuana to retail facilities throughout the state;

(i) Proof that the applicant possesses the technical and technological ability to cultivate and process medical-grade marijuana;

(j) Proof of operating procedures designed to secure and maintain accountability for all marijuana and marijuana-related byproducts it may possess;

(k) Proof of the financial ability to maintain operations for the duration of the license;

(l) Proof of at least $1 million of hazard and liability insurance for each cultivation and processing facility; and

(m) A $5 million performance and compliance bond, to be forfeited if the licensee fails to maintain its license for the duration of the licensure period or fails to comply with the substantive requirements of this subsection and applicable agency rules for the duration of the licensure period.

(4) A cultivation and processing license expires 2 years after the date it is issued. The licensee must apply for a renewed license before the expiration date. In order to receive a renewed license, a cultivation and processing licensee must demonstrate continued compliance with the requirements in subsection (3) and have no outstanding substantial violations of the standards established by the department for the cultivation, processing, packaging, and labeling of marijuana and medical-grade marijuana.

(5) A cultivation and processing licensee may cultivate

marijuana at one or more facilities only if each facility used for cultivation has been inspected by the department and issued a cultivation facility license. A cultivation and processing licensee may process marijuana at one or more processing facilities only if each facility used for processing has been inspected by the department and issued a processing facility license. A cultivation and processing licensee may cultivate and process marijuana at the same facility only if that facility has been inspected by the department and issued both a cultivation facility license and a processing facility license. Each cultivation and processing facility must be secure and closed to the public and may not be located within 1,000 feet of an existing public or private elementary or secondary school, a child care facility licensed under s. 402.302, or a licensed service provider offering substance abuse services. The department may establish by rule additional security and zoning requirements for cultivation and processing facilities. All matters regarding the licensure and regulation of cultivation and processing facilities, including the location of such facilities, are preempted to the state.

(6) Before beginning cultivation or processing at a facility, that facility must be inspected and licensed as a cultivation facility, a processing facility, or both by the department. A cultivation and processing licensee may cultivate and process marijuana only for the purpose of producing medical-grade marijuana and may do so only at a licensed cultivation and processing facility. Such processing may include, but is not limited to, processing marijuana into medical-grade marijuana and processing medical-grade marijuana into various forms

including, but not limited to, topical applications, oils, and food products for a registered patient's use. A dispensing organization may use a contractor to cultivate the marijuana, to process marijuana into medical-grade marijuana, or to process the medical-grade marijuana into other forms, but the dispensing organization is responsible for all of the operations performed by each contractor relating to the cultivation and processing of marijuana and the physical possession of all marijuana and medical-grade marijuana. All work done by a contractor must be performed at a licensed cultivation and processing facility. All marijuana byproducts that are unable to be processed or reprocessed into medical-grade marijuana must be destroyed by the dispensing organization or its contractor within 48 hours after processing is completed.

(7) A cultivation and processing licensee may transport, or contract to have transported, marijuana and marijuana products to independent testing laboratories to be tested and certified as medical-grade marijuana.

(8) A cultivation and processing licensee may sell, transport, and deliver medical-grade marijuana and medical-grade marijuana products to retail licensees throughout the state.

(9) The department may not license any retail facilities in a county unless the board of county commissioners for that county determines by ordinance the number and location of any retail facilities that may be located within that county. A retail facility may not be located on the same property as a facility licensed for cultivation or processing of marijuana or within 1,000 feet of an existing public or private elementary or secondary school, a child care facility licensed under s.

402.302, or a licensed service provider that offers substance abuse services.

(10) An applicant for a retail license must provide the department with at least all of the following:

(a) A completed retail license application form.

(b) The initial application fee.

(c) The full legal name of the applicant.

(d) The physical address of the retail facility where marijuana will be dispensed.

(e) Identifying information for all other current or previous retail licenses held by the applicant.

(f) The name, address, and date of birth for each of the applicant's principal officers and board members.

(g) The name, address, and date of birth of each of the applicant's current employees who will participate in the operations of the dispensing organization.

(h) Proof that all principals and employees of the applicant have passed a level 2 background screening pursuant to chapter 435 within the prior year.

(i) Proof of an established infrastructure or the ability to establish an infrastructure in a reasonable amount of time which is designed to receive medical-grade marijuana from cultivation and processing facilities, the ability to maintain the security of the retail facility to prevent theft or diversion of any medical marijuana product received, the ability to correctly dispense the allowed amount and specified type of medical-grade marijuana to a registered patient or his or her designated caregiver pursuant to a physician's order, the ability to check the medical marijuana patient registry, and the

ability to electronically update the medical marijuana patient registry with dispensing information.

(j) Proof of operating procedures designed to secure and maintain accountability for all medical-grade marijuana and products that it may receive and possess.

(k) Proof of the financial ability to maintain operations for the duration of the license.

(l) Proof of at least $500,000 of hazard and liability insurance for each license.

(m) A $1 million performance and compliance bond, for each license, to be forfeited if the licensee fails to maintain the license for the duration of the licensure period or fails to comply with the requirements of this subsection for the duration of the licensure period.

(11) The department may issue multiple retail licenses to a single qualified entity; however, to encourage a competitive marketplace, when multiple entities have applied for a license in the same county, in addition to the qualifications of each applicant, the department shall consider the number of retail licenses currently held by each applicant and the number of separate entities that hold retail licenses within the same geographic area.

(12) A retail license expires 2 years after the date it is issued. The retail licensee must reapply for renewed licensure before the expiration date. In order to qualify for a renewed license, a retail licensee must meet all the requirements for initial licensure and have no outstanding substantial violations of the applicable standards established by the department.

(13) Before beginning to dispense, each retail facility

must be inspected by the department. Retail licensees may dispense the allowed amount of medical-grade marijuana to a registered patient or the patient's designated caregiver only if the dispensing organization's employee:

(a) Verifies the authenticity of the patient's or caregiver's identification card with the medical marijuana patient registry;

(b) Verifies the physician's order for medical-grade marijuana with the medical marijuana patient registry;

(c) Determines that the registered patient has not been dispensed the allowed amount of marijuana within the previous 30 days;

(d) Issues the registered patient or the patient's caregiver a receipt that details the date and time of dispensing, the amount of medical-grade marijuana dispensed, and the person to whom the medical-grade marijuana was dispensed; and

(e) Updates the medical marijuana patient registry with the date and time of dispensing and the amount and type of medical-grade marijuana being dispensed to the registered patient before dispensing to that patient or that patient's designated caregiver.

(14) Retail licensees may contract with licensed and bonded carriers to transport medical-grade marijuana and medical-grade marijuana products between properties owned by the licensee and to deliver it to the residence of a registered patient.

(15) A licensee under the Florida Medical Marijuana Act may not advertise its marijuana products.

(16) The department must inspect and license each

dispensing organization's cultivation and processing facilities and retail facilities before those facilities begin operations. The department must also inspect each licensed facility at least once every 2 years. The department may also conduct additional announced or unannounced inspections at reasonable hours in order to ensure that such facilities meet the standards set by the department. The department may test any marijuana, marijuana product, medical-grade marijuana, or medical-grade marijuana product in order to ensure that such marijuana, marijuana product, medical-grade marijuana, or medical-grade marijuana product meets the standards established by the department. The department may, by interagency agreement with the Department of Business and Professional Regulation or with the Department of Agriculture and Consumer Services, perform joint inspections of such facilities with those agencies.

(17) The department must create a schedule of violations in rule in order to impose reasonable fines not to exceed $10,000 on a dispensing organization. In determining the amount of the fine to be levied for a violation, the department shall consider:

(a) The severity of the violation;

(b) Any actions taken by the dispensing organization to correct the violation or to remedy complaints; and

(c) Any previous violations.

(18) The department may suspend, revoke, or refuse to renew the license of a dispensing organization or of an individual facility for violations of the standards established by the department.

(19) The department shall maintain a publicly available,

easily accessible list on its website of all licensed retail facilities.

Section 7. Section 381.996, Florida Statutes, is created to read:

381.996 Patient certification.—

(1) A physician may certify a patient to the department as a qualified patient if:

(a) The physician has seen the patient on a regular basis for a period of at least 3 months;

(b) The physician certifies that, in his or her good faith medical judgment, the patient chronically suffers from one or more of the qualifying conditions or symptoms; and

(c) For patients who do not suffer from a condition listed in s. 381.991(15)(a)-(i), the physician certifies that in his or her good faith medical judgment the patient has exhausted all other reasonably available medical treatments for any of the patient's qualifying symptoms.

(2) After certifying a patient, the physician must electronically transfer an original order for medical-grade marijuana for that patient to the medical marijuana patient registry. Such order must include, at a minimum, the allowed amount of medical-grade marijuana and the concentration ranges for individual cannabinoids, if any. The physician must also update the registry with any changes in the specifications of his or her order for that patient within 7 days.

(3) If the physician becomes aware that alternative treatments are available, that the patient no longer suffers from his or her qualifying condition or symptom, or if the physician's order for the allowed amount of medical marijuana

changes for that patient, the physician must update the registry with the new information within 7 days.

(4) In order to qualify to issue patient certifications for medical-grade marijuana, and before ordering medical-grade marijuana for any patient, a physician must successfully complete an 8-hour course and subsequent examination offered by the Florida Medical Association or the Florida Osteopathic Medical Association, as appropriate, which encompasses the clinical indications for the appropriate use of medical-grade marijuana, the appropriate delivery mechanisms, the contraindications of the use of medical-grade marijuana, and the relevant state and federal laws governing ordering, dispensing, and possession. The appropriate boards shall offer the first course and examination by October 1, 2015, and shall administer them at least annually thereafter. Successful completion of the course may be used by a physician to satisfy 8 hours of the continuing medical education requirements imposed by his or her respective board for licensure renewal. This course may be offered in a distance-learning format. Successful completion of the course and examination is required for every physician who orders medical-grade marijuana each time such physician renews his or her license.

Section 8. Section 381.997, Florida Statutes, is created to read:

381.997 Medical-grade marijuana testing and labeling.—

(1) A cultivation and processing licensee may not distribute or sell medical-grade marijuana or product to a retail licensee unless the batch of origin of that marijuana or product has been tested by an independent testing laboratory and

the cultivation and processing licensee has received test results from that laboratory which certify that the batch meets the quality standards established by the department.

(2) When testing a batch of marijuana or product a testing laboratory must, at a minimum, test for unsafe contaminants and for presence and concentration of individual cannabinoids.

(3) Each testing laboratory must report its findings for each batch tested to the cultivation and processing licensee from which the batch originated and to the department. Such findings must include, at a minimum, the license number or numbers of the processing and cultivation facility from which the batch originated, the size and batch number of the batch tested, the types of tests performed on the batch, and the results of each test.

(4) Before distribution or sale to a retail licensee, any medical-grade marijuana that meets department testing standards must be packaged in a child-resistant container and labeled with at least the name and license number of the cultivation and processing licensee, the license number of the facility or facilities where the batch was harvested and processed, the harvest or production batch number, the concentration range of each individual cannabinoid present at testing, and any other labeling requirements established in Florida or federal law or rules for that form of the product. For the purposes of this subsection, any oil-based extraction meant for direct consumption in small quantities as a supplement need not be labeled as a food product.

(5) Before sale to a registered patient or caregiver, a retail licensee must affix an additional label to each product

that includes the licensee's name and license number.

(6) By January 1, 2016, the department must establish standards for quality and testing procedures and for maximum levels of unsafe contaminants. The department must also create a list of individual cannabinoids that must be tested for, concentrations that are considered significant for those cannabinoids, and varying ranges of concentrations for each cannabinoid upon which a physician may base his or her order for a patient's use of a specific strain of medical-grade marijuana.

Section 9. Section 381.998, Florida Statutes, is created to read:

381.998 Penalties.—

(1) A physician commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, if he or she orders medical-grade marijuana for a patient without a reasonable belief that the patient is suffering from a condition or symptom listed in s. 381.991(15) or s. 381.991(16).

(2) A person who fraudulently represents that he or she has a medical condition or symptom listed in s. 381.991(15) or s. 381.991(16) for the purpose of being ordered medical-grade marijuana by such physician commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

Section 10. Section 381.999, Florida Statutes, is created to read:

381.999 Insurance.—The Florida Medical Marijuana Act does not require a governmental, private, or other health insurance provider or health care services plan to cover a claim for reimbursement for the purchase of medical-grade marijuana nor does it restrict such coverage.

Section 11. Section 381.9991, Florida Statutes, is created to read:

381.9991 Rulemaking Authority.-The department may adopt rules related to health, safety, and welfare as necessary to implement this act.

Section 12. This act shall take effect July 1, 2015.

By the Committees on Rules; Health Policy; and Regulated Industries

595-03805-15 20157066c2

A bill to be entitled

An act relating to low-THC cannabis; amending s. 381.986, F.S.; defining terms; revising the illnesses and symptoms for which a physician may order a patient the medical use of low-THC cannabis in certain circumstances; providing that a physician who improperly orders low-THC cannabis is subject to specified disciplinary action; revising the duties of the Department of Health; requiring the department to create a secure, electronic, and online compassionate use registry; requiring the department to begin to accept applications for licensure as a dispensing organization according to a specified application process; requiring the department to review all applications, notify applicants of deficient applications, and request any additional information within a specified period; requiring an application for licensure to be filed and complete by specified dates; requiring the department to select two applicants in specified regions for licensure as a dispensing organization; requiring the department to issue 10 additional licenses to qualified applicants by lottery; authorizing applicants to operate in any region of the state; prohibiting a dispensing organization from having cultivation or processing facilities outside the region in which it is licensed; requiring the department to select by lottery another applicant in certain circumstances; requiring the department to conduct a new lottery after the

revocation or the denial of renewal of a license; requiring the department to conduct a lottery at specified intervals if there are available dispensing organization licenses; providing an exemption for the application process; requiring the department to use an application form that requires specified information from the applicant; requiring the department to impose specified application fees; requiring the department to inspect each dispensing organization's properties, cultivation facilities, processing facilities, and retail facilities before those facilities may operate; authorizing followup inspections at reasonable hours; providing that licensure constitutes permission for the department to enter and inspect the premises and facilities of any dispensing organization; authorizing the department to inspect any licensed dispensing organization; requiring dispensing organizations to make all facility premises, equipment, documents, low-THC cannabis, and low-THC cannabis products available to the department upon inspection; authorizing the department to test low-THC cannabis or low-THC cannabis products; authorizing the department to suspend or revoke a license, deny or refuse to renew a license, or impose a maximum administrative penalty for specified acts or omissions; requiring the department to create a permitting process for vehicles used for the transportation of low-THC cannabis or low-THC cannabis products; authorizing the department

to adopt rules as necessary for implementation of specified provisions and procedures, and to provide specified guidance; providing procedures and requirements for an applicant seeking licensure as a dispensing organization or the renewal of its license; requiring the dispensing organization to verify specified information of specified persons in certain circumstances; authorizing a dispensing organization to have cultivation facilities, processing facilities, and retail facilities; authorizing a retail facility to be established in a municipality only after such an ordinance has been created; authorizing a retail facility to be established in the unincorporated areas of a county only after such an ordinance has been created; requiring retail facilities to have all utilities and resources necessary to store and dispense low-THC and low-THC cannabis products; requiring retail facilities to be secured with specified theft-prevention systems; requiring a dispensing organization to provide the department with specified updated information within a specified period; authorizing a dispensing organization to transport low-THC cannabis or low-THC cannabis products in vehicles in certain circumstances; requiring such vehicles to be operated by specified persons in certain circumstances; requiring a fee for a vehicle permit; requiring the signature of the designated driver with a vehicle permit application; providing for expiration of the permit in certain

circumstances; requiring the department to cancel a vehicle permit upon the request of specified persons; providing that the licensee authorizes the inspection and search of his or her vehicle without a search warrant by specified persons; requiring all low-THC cannabis and low-THC cannabis products to be tested by an independent testing laboratory before the dispensing organization may dispense it; requiring the independent testing laboratory to provide the lab results to the dispensing organization for a specified determination; requiring all low-THC cannabis and low-THC cannabis products to be labeled with specified information before dispensing; requiring the University of Florida College of Pharmacy to establish and maintain a specified safety and efficacy research program; providing program requirements; requiring the department to provide information from the prescription drug monitoring program to the University of Florida as needed; requiring the Agency for Health Care Administration to provide access to specified patient records under certain circumstances; prohibiting persons who have direct or indirect interest in a dispensing organization and the dispensing organization’s managers, employees, and contractors who directly interact with low-THC cannabis and low-THC cannabis products from making recommendations, offering prescriptions, or providing medical advice to qualified patients; providing that the act does not provide an exception to the

prohibition against driving under the influence; authorizing specified individuals to manufacture, possess, sell, deliver, distribute, dispense, and lawfully dispose of reasonable quantities of low-THC cannabis; authorizing a licensed laboratory and its employees to receive and possess low-THC cannabis in certain circumstances; providing that specified rules adopted by the department are exempt from the requirement to be ratified by the Legislature; amending s. 381.987, F.S.; requiring the department to allow specified persons engaged in research to access the compassionate use registry; amending s. 893.055, F.S.; providing that persons engaged in research at the University of Florida shall have access to specified information; amending s. 893.0551, F.S.; providing a specified public records exemption for persons engaged in research at the University of Florida; providing an effective date.

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

Section 1. Section 381.986, Florida Statutes, is amended to read:

381.986 Compassionate use of low-THC cannabis.—

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

(a) “Applicant” means a person that has submitted an application to the department for licensure or renewal as a dispensing organization.

(b) “Batch” means a specific quantity of low-THC cannabis

product that is intended to have uniform character and quality, within specified limits, and is produced at the same time from one or more harvests.

(c) "Dispensing organization" means an applicant licensed ~~organization approved~~ by the department to cultivate, process, and dispense low-THC cannabis pursuant to this section.

(d) "Harvest" means a specifically identified and numbered quantity of low-THC cannabis cultivated using the same herbicides, pesticides, and fungicides and harvested at the same time from a single facility.

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

(f)~~(b)~~ "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.

(g) "Low-THC cannabis product" means any product derived from low-THC cannabis, including 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 which is dispensed from a dispensing organization. Low-THC cannabis products include, but are not limited to, oils, tinctures, creams, encapsulations, and food products. Low-THC cannabis food products may not include candy or similar

confectionary products that appeal to children. All low-THC cannabis products must maintain concentrations, weight for weight, of 0.8 percent or less of tetrahydrocannabinol and more than 10 percent of cannabidiol.

(h)~~(c)~~ “Medical use” means administration of the ordered amount of low-THC cannabis. The term does not include:

1. The possession, use, or administration by smoking.

2. ~~The term also does not include~~ 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 who is registered in the compassionate use registry on behalf of the qualified patient.

3. The use or administration of low-THC cannabis or low-THC cannabis products:

a. On any form of public transportation.

b. In any public place.

c. In a registered qualified patient’s place of work, if restricted by his or her employer.

d. In a correctional facility.

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

f. On a school bus.

(i)~~(d)~~ “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 from a dispensing organization.

(j)~~(e)~~ “Smoking” means burning or igniting a substance and inhaling the smoke. Smoking does not include the use of a vaporizer.

(2) PHYSICIAN ORDERING.—

(a) ~~Effective January 1, 2015,~~ A physician licensed under chapter 458 or chapter 459 who has examined and is treating a patient suffering from cancer, human immunodeficiency virus, acquired immune deficiency syndrome, epilepsy, amyotrophic lateral sclerosis, autism, multiple sclerosis, Crohn's disease, Parkinson's disease, paraplegia, quadriplegia, or terminal illness ~~a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms~~ may order for the patient's medical use low-THC cannabis to treat such disease, disorder, or condition; ~~or~~ to alleviate symptoms of such disease, disorder, or condition; or to alleviate symptoms caused by a treatment for such disease, disorder, or condition~~,~~ if no other satisfactory alternative treatment options exist for that patient and all of the following ~~conditions~~ apply:

1.~~(a)~~ The patient is a permanent resident of this state.

2.~~(b)~~ The physician determines that the risks of ordering low-THC cannabis are reasonable in light of the potential benefit for that 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.

3.~~(c)~~ The physician registers the patient, the patient's legal representative if requested by the patient, and himself or herself as the orderer of low-THC 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. If the patient is a minor, the physician must register a legal

representative on the compassionate use registry. The physician shall deactivate the patient's registration when treatment is discontinued.

4.~~(d)~~ 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.

5.~~(e)~~ The physician submits the patient treatment plan, as well as any other requested medical records, quarterly to the University of Florida College of Pharmacy for research on the safety and efficacy of low-THC cannabis on patients pursuant to subsection (8).

6.~~(f)~~ 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 conditions or symptoms ~~condition~~ with low-THC cannabis, the medically acceptable alternatives, and the potential risks and side effects.

(b) A physician who improperly orders low-THC cannabis is subject to disciplinary action under the applicable practice act and under s. 456.072(1)(k).

(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 at least one of the conditions listed in subsection (2).~~:~~

~~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) Any person who fraudulently represents that he or she has at least one condition listed in subsection (2) ~~cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms~~ to a physician for the purpose of being ordered low-THC cannabis by such physician commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(4) PHYSICIAN EDUCATION.—

(a) Before ordering low-THC cannabis for use by a patient in this state, the appropriate board shall require the ordering physician licensed under chapter 458 or chapter 459 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, the appropriate delivery mechanisms, the contraindications for such use, as well as the relevant state and federal laws governing the ordering, dispensing, and possessing of this substance. The first course and examination shall be presented by October 1, 2014, and shall be administered at least annually thereafter. 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 approved under subsection (5) to 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.

(c) Successful completion of the course and examination specified in paragraph (a) is required for every physician who orders low-THC cannabis 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 may be subject to disciplinary action under the applicable practice act and under s. 456.072(1)(k).

(5) DUTIES AND POWERS OF THE DEPARTMENT. ~~By January 1, 2015, The department shall:~~

(a) The department shall create a secure, electronic, and online compassionate use registry for the registration of physicians and patients as provided under this section. The registry must be accessible to law enforcement agencies and to a dispensing organization in order to verify patient authorization for low-THC cannabis and record the low-THC cannabis dispensed. The registry must prevent an active registration of a patient by

multiple physicians.

(b)1. Beginning 7 days after the effective date of this act, the department shall accept applications for licensure as a dispensing organization. The department shall review each application to determine whether the applicant meets the criteria in subsection (6) and qualifies for licensure.

2. Within 10 days after receiving an application for licensure, the department shall examine the application, notify the applicant of any apparent errors or omissions, and request any additional information the department is allowed by law to require. An application for licensure must be filed with the department no later than 5 p.m. on the 30th day after the effective date of this act, and all applications must be complete no later than 5 p.m. on the 60th day after the effective date of this act.

3. Prior to the 75th day after the effective date of this act, the department shall select by lottery two applicants who meet the criteria in subsection (6) in each of the following regions:

a. Northwest Florida, consisting of Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Santa Rosa, Okaloosa, Taylor, Wakulla, Walton, and Washington Counties.

b. Northeast Florida, consisting of Alachua, Baker, Bradford, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Suwannee, and Union Counties.

c. Central Florida, consisting of Brevard, Citrus, Hardee, Hernando, Hillsborough, Indian River, Lake, Orange, Osceola,

Pasco, Pinellas, Polk, Seminole, St. Lucie, Sumter, and Volusia Counties.

d. Southwest Florida, consisting of Charlotte, Collier, DeSoto, Glades, Hendry, Highlands, Lee, Manatee, Okeechobee, and Sarasota Counties.

e. Southeast Florida, consisting of Broward, Miami-Dade, Martin, Monroe, and Palm Beach Counties.

4. After the department has selected by lottery the 10 dispensing organizations pursuant to subparagraph 3., the department shall select by lottery 10 more applicants who meet the criteria in subsection (6) for licensure. Once licensed, those applicants are authorized to operate in any region in the state, but a dispensing organization may not have cultivation or processing facilities outside the region in which it is licensed.

5. The department shall license an applicant selected pursuant to subparagraph 3. or subparagraph 4. unless the applicant fails to pay the licensure fee within 10 days of selection. If a selected applicant fails to timely pay the licensure fee, the department shall select by lottery another applicant from the existing pool of eligible applicants.

6. If the department revokes a license or denies the renewal of a license pursuant to paragraph (f), the department shall conduct a new lottery using the selection process outlined in this paragraph. The selection process must begin 24 hours after such revocation or denial.

7. If the department does not have a sufficient pool of qualified applicants to issue 2 licenses in each region, or to license 10 dispensing organizations pursuant to subparagraph 4.,

the department shall conduct a lottery using the process in this paragraph every 6 months until each region has 2 licensed dispensing organizations and 10 additional dispensing organizations are licensed, totaling 20 licensed dispensing organizations in this state.

8. This section is exempt from s. 120.60(1) ~~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 under this section, one in each of the following regions: northwest Florida, northeast Florida, central Florida, southeast Florida, and southwest Florida~~.

(c) The department shall use ~~develop~~ an application form that requires the applicant to state:

1. Whether the application is for initial licensure or renewal licensure;

2. The name, the physical address, the mailing address, the address listed on the Department of Agriculture and Consumer Services certificate required in paragraph (6)(b), and the contact information for the applicant and for the nursery that holds the Department of Agriculture and Consumer Services certificate, if different from the applicant;

3. The name, address, and contact information for the operating nurseryman of the organization that holds the Department of Agriculture and Consumer Services certificate;

4. The name, address, license number, and contact information for the applicant’s medical director; and

5. All information required to be included by subsection (6).

(d) The department shall ~~and~~ impose an initial application fee of $50,000, an initial licensure fee of $125,000, and a biennial renewal fee of $125,000 ~~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.~~

~~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 who is a physician licensed under chapter 458 or chapter 459 to supervise the activities of the dispensing organization.~~

(e) The department shall inspect each dispensing organization's properties, cultivation facilities, processing facilities, and retail facilities before they begin operations and at least once every 2 years thereafter. The department may conduct additional announced or unannounced inspections, including followup inspections, at reasonable hours in order to ensure that such property and facilities maintain compliance with all applicable requirements in subsections (6) and (7) and to ensure that the dispensing organization has not committed any other act that would endanger the health, safety, or security of a qualified patient, dispensing organization staff, or the community in which the dispensing organization is located. Licensure under this section constitutes permission for the department to enter and inspect the premises and facilities of any dispensing organization. The department may inspect any licensed dispensing organization, and a dispensing organization must make all facility premises, equipment, documents, low-THC cannabis, and low-THC cannabis products available to the department upon inspection. The department may test any low-THC cannabis or low-THC cannabis product in order to ensure that it is safe for human consumption and that it meets the requirements in this section.

(f) The department may suspend or revoke a license, deny or refuse to renew a license, or impose an administrative penalty not to exceed $10,000 for the following acts or omissions:

1. A violation of this section or department rule.

2. Failing to maintain qualifications for licensure.

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 a license by bribery or fraudulent misrepresentation.

6. Being convicted or found guilty of, or entering a plea of 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 licensee knows to be false.

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

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 revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of any jurisdiction,

including its agencies or subdivisions, for a violation that would constitute a violation under state law. A licensing authority's acceptance of a relinquishment of licensure or a stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of charges against the license, shall be construed as an action against the license.

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 shall create a permitting process for all dispensing organization vehicles used for the transportation of low-THC cannabis or low-THC cannabis products.

(h)~~(c)~~ The department shall monitor physician registration and ordering of low-THC cannabis for ordering practices that could facilitate unlawful diversion or misuse of low-THC cannabis and take disciplinary action as indicated.

(i)~~(d)~~ The department shall adopt rules as necessary to implement this section.

(6) DISPENSING ORGANIZATION.—

(a) An applicant seeking licensure as a dispensing organization, or the renewal of its license, must submit an application to the department. The department must review all applications for completeness, including an appropriate inspection of the applicant's property and facilities to verify the authenticity of the information provided in, or in connection with, the application. An applicant authorizes the department to inspect his or her property and facilities for licensure by applying under this subsection.

(b) In order to receive or maintain licensure as a dispensing organization, an applicant must provide proof that:

1. The applicant, or a separate entity that is owned solely by the same persons or entities in the same ratio as the applicant, possesses a valid certificate of registration issued by the Department of Agriculture and Consumer Services pursuant to s. 581.131 for the cultivation of more than 400,000 plants, is operated by a nurseryman as defined in s. 581.011, and has been operated as a registered nursery in this state for at least 30 continuous years.

2. The personnel on staff or under contract for the applicant have experience cultivating and introducing multiple varieties of plants in this state, including plants that are not native to Florida; experience with propagating plants; and experience with genetic modification or breeding of plants.

3. The personnel on staff or under contract for the applicant include at least one person who:

a. Has at least 5 years' experience with United States Department of Agriculture Good Agricultural Practices and Good Handling Practices;

b. Has at least 5 years' experience with United States Food and Drug Administration Good Manufacturing Practices for food production;

c. Has a doctorate degree in organic chemistry or microbiology;

d. Has at least 5 years' of experience with laboratory procedures which includes analytical laboratory quality control measures, chain of custody procedures, and analytical laboratory methods;

e. Has experience with cannabis cultivation and processing, including cannabis extraction techniques and producing cannabis products;

f. Has experience and qualifications in chain of custody or other tracking mechanisms;

g. Works solely on inventory control; and

h. Works solely for security purposes.

4. The persons who have a direct or indirect interest in the dispensing organization and the applicant's managers, employees, and contractors who directly interact with low-THC cannabis or low-THC cannabis products have been fingerprinted and have successfully passed a level 2 background screening pursuant to s. 435.04.

5. The applicant owns, or has at least a 2-year lease of, all properties, facilities, and equipment necessary for the cultivation and processing of low-THC cannabis. The applicant must provide a detailed description of each facility and its equipment, a cultivation and processing plan, and a detailed floor plan. The description must include proof that:

a. The applicant is capable of sufficient cultivation and processing to serve at least 15,000 patients with an assumed daily use of 1,000 mg per patient per day of low-THC cannabis or low-THC cannabis product;

b. The applicant has arranged for access to all utilities and resources necessary to cultivate or process low-THC cannabis at each listed facility; and

c. Each facility is secured and has theft-prevention systems including an alarm system, cameras, and 24-hour security personnel.

6. The applicant has diversion and tracking prevention procedures, including:

a. A system for tracking low-THC material through cultivation, processing, and dispensing, including the use of batch and harvest numbers;

b. An inventory control system for low-THC cannabis and low-THC cannabis products;

c. A vehicle tracking and security system; and

d. A cannabis waste-disposal plan.

7. The applicant has recordkeeping policies and procedures in place.

8. The applicant has a facility emergency management plan.

9. The applicant has a plan for dispensing low-THC cannabis throughout the state. This plan must include planned retail facilities and a delivery plan for providing low-THC cannabis and low-THC cannabis products to qualified patients who cannot travel to a retail facility.

10. The applicant has financial documentation, including:

a. Documentation that demonstrates the applicant’s financial ability to operate. If the applicant’s assets, credit, and projected revenues meet or exceed projected liabilities and expenses and the applicant provides independent evidence that the funds necessary for startup costs, working capital, and contingency financing exist and are available as needed, the applicant has demonstrated the financial ability to operate. Financial ability to operate must be documented by:

I. The applicant’s audited financial statements. If the applicant is a newly formed entity and does not have a financial history of business upon which audited financial statements may

be submitted, the applicant must provide audited financial statements for the separate entity that is owned solely by the same persons or entities in the same ratio as the applicant that possesses the valid certificate of registration issued by the Department of Agriculture and Consumer Services;

II. The applicant's projected financial statements, including a balance sheet, an income and expense statement, and a statement of cash flow for the first 2 years of operation, which provides evidence that the applicant has sufficient assets, credit, and projected revenues to cover liabilities and expenses; and

III. A statement of the applicant's estimated startup costs and sources of funds, including a break-even projection and documentation demonstrating that the applicant has the ability to fund all startup costs, working capital costs, and contingency financing requirements.

All documents required under this sub-subparagraph shall be prepared in accordance with generally accepted accounting principles and signed by a certified public accountant. The statements required by sub-sub-subparagraphs II. and III. may be presented as a compilation.

b. A list of all subsidiaries of the applicant;

c. A list of all lawsuits pending and completed within the past 7 years of which the applicant was a party; and

d. Proof of a $1 million performance and compliance bond, or other equivalent means of security deemed equivalent by the department, such as an irrevocable letter of credit or a deposit in a trust account or financial institution, payable to the

department, which must be posted once the applicant is approved as a dispensing organization. The purpose of the bond is to secure payment of any administrative penalties imposed by the department and any fees and costs incurred by the department regarding the dispensing organization license, such as the dispensing organization failing to pay 30 days after the fine or costs become final. The department may make a claim against such bond or security until 1 year after the dispensing organization's license ceases to be valid or until 60 days after any administrative or legal proceeding authorized in this section involving the dispensing organization concludes, including any appeal, whichever occurs later.

11. The employment of a medical director who is a physician licensed under chapter 458 or chapter 459 to supervise the activities of the dispensing organization.

(c) An approved dispensing organization shall maintain compliance with the criteria in paragraphs (b), (d), and (e) and subsection (7) ~~demonstrated for selection and approval as a dispensing organization under subsection (5)~~ at all times. Before dispensing low-THC cannabis or low-THC cannabis products to a qualified patient or to the qualified patient's legal representative, the dispensing organization shall verify the identity of the qualified patient or the qualified patient's legal representative by requiring the qualified patient or the qualified patient's legal representative to produce a government-issued identification card and shall verify that the qualified patient and the qualified patient's legal representative have ~~has~~ an active registration in the compassionate use registry, that the order presented matches the

order contents as recorded in the registry, and that the order has not already been filled. Upon dispensing the low-THC cannabis, the dispensing organization shall record in the registry the date, time, quantity, and form of low-THC cannabis dispensed.

(d) A dispensing organization may have cultivation facilities, processing facilities, and retail facilities.

1. All matters regarding the location of cultivation facilities and processing facilities are preempted to the state. Cultivation facilities and processing facilities must be closed to the public, and low-THC cannabis may not be dispensed on the premises of such facilities.

2. A municipality must determine by ordinance the criteria for the number and location of, and other permitting requirements for, all retail facilities located within its municipal boundaries. A retail facility may be established in a municipality only after such an ordinance has been created. A county must determine by ordinance the criteria for the number, location, and other permitting requirements for all retail facilities located within the unincorporated areas of that county. A retail facility may be established in the unincorporated areas of a county only after such an ordinance has been created. Retail facilities must have all utilities and resources necessary to store and dispense low-THC cannabis and low-THC cannabis products. Retail facilities must be secured and have theft-prevention systems, including an alarm system, cameras, and 24-hour security personnel. Retail facilities may not sell, or contract for the sale of, anything other than low-THC cannabis or low-THC cannabis products on the property of the

retail facility. Before a retail facility may dispense low-THC cannabis or a low-THC cannabis product, the dispensing organization must have a computer network compliant with the federal Health Insurance Portability and Accountability Act of 1996 which is able to access and upload data to the compassionate use registry and which shall be used by all retail facilities.

(e) Within 15 days after such information becoming available, a dispensing organization must provide the department with updated information, as applicable, including:

1. The location and a detailed description of any new or proposed facilities.

2. The updated contact information, including electronic and voice communication, for all dispensing organization facilities.

3. The registration information for any vehicles used for the transportation of low-THC cannabis and low-THC cannabis products, including confirmation that all such vehicles have tracking and security systems.

4. A plan for the recall of any or all low-THC cannabis or low-THC cannabis products.

(f)1. A dispensing organization may transport low-THC cannabis or low-THC cannabis products in vehicles departing from their places of business only in vehicles that are owned or leased by the licensee or by a person designated by the dispensing organization, and for which a valid vehicle permit has been issued for such vehicle by the department.

2. A vehicle owned or leased by the dispensing organization or a person designated by the dispensing organization and

approved by the department must be operated by such person when transporting low-THC cannabis or low-THC products from the licensee's place of business.

3. A vehicle permit may be obtained by a dispensing organization upon application and payment of a fee of $5 per vehicle to the department. The signature of the person designated by the dispensing organization to drive the vehicle must be included on the vehicle permit application. Such permit remains valid and does not expire unless the licensee or any person designated by the dispensing organization disposes of his or her vehicle, or the licensee's license is transferred, canceled, not renewed, or is revoked by the department, whichever occurs first. The department shall cancel a vehicle permit upon request of the licensee or owner of the vehicle.

4. By acceptance of a license issued under this section, the licensee agrees that the licensed vehicle is, at all times it is being used to transport low-THC cannabis or low-THC cannabis products, subject to inspection and search without a search warrant by authorized employees of the department, sheriffs, deputy sheriffs, police officers, or other law enforcement officers to determine that the licensee is transporting such products in compliance with this section.

(7) TESTING AND LABELING OF LOW-THC CANNABIS.—

(a) All low-THC cannabis and low-THC cannabis products must be tested by an independent testing laboratory before the dispensing organization may dispense them. The independent testing laboratory shall provide the dispensing organization with lab results. Before dispensing, the dispensing organization must determine that the lab results indicate that the low-THC

cannabis or low-THC cannabis product meets the definition of low-THC cannabis or low-THC cannabis product, is safe for human consumption, and is free from harmful contaminants.

(b) All low-THC cannabis and low-THC cannabis products must be labeled before dispensing. The label must include, at a minimum:

1. A statement that the low-THC cannabis or low-THC cannabis product meets the requirements in paragraph (a);

2. The name of the independent testing laboratory that tested the low-THC cannabis or low-THC cannabis product;

3. The name of the cultivation and processing facility where the low-THC cannabis or low-THC cannabis product originates; and

4. The batch number and harvest number from which the low-THC cannabis or low-THC cannabis product originates.

(8) SAFETY AND EFFICACY RESEARCH FOR LOW-THC CANNABIS.—The University of Florida College of Pharmacy shall establish and maintain a safety and efficacy research program for the use of low-THC cannabis or low-THC cannabis products to treat qualifying conditions and symptoms. The program must include a fully integrated electronic information system for the broad monitoring of health outcomes and safety signal detection. The electronic information system must include information from the compassionate use registry; provider reports, including treatment plans, adverse event reports, and treatment discontinuation reports; patient reports of adverse impacts; event-triggered interviews and medical chart reviews performed by University of Florida clinical research staff; information from external databases, including Medicaid billing reports and

information in the prescription drug monitoring database for registered patients; and all other medical reports required by the University of Florida to conduct the research required by this subsection. The department must provide access to information from the compassionate use registry and the prescription drug monitoring database, established in s. 893.055, as needed by the University of Florida to conduct research under this subsection. The Agency for Health Care Administration must provide access to registered patient Medicaid records, to the extent allowed under federal law, as needed by the University of Florida to conduct research under this subsection.

(9) The persons who have direct or indirect interest in the dispensing organization and the dispensing organization's managers, employees, and contractors who directly interact with low-THC cannabis or low-THC cannabis products are prohibited from making recommendations, offering prescriptions, or providing medical advice to qualified patients.

(10)~~(7)~~ 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 who is registered with the department on the compassionate use registry may purchase and possess for the patient's medical use up to the amount of low-THC cannabis ordered for the patient. Nothing in this section exempts any person from the prohibition against driving under the influence provided in s. 316.193.

(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 and the owners, managers, and employees of contractors who have direct contact with low-THC cannabis or low-THC cannabis product may manufacture, possess, sell, deliver, distribute, dispense, and lawfully dispose of reasonable quantities, as established by department rule, of low-THC cannabis. For purposes of this subsection, the terms “manufacture,” “possession,” “deliver,” “distribute,” and “dispense” have the same meanings as provided in s. 893.02.

(c) 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.

(d) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other law, but subject to the requirements of this section, a licensed laboratory and its employees may receive and possess low-THC cannabis for the sole purpose of testing the low-THC cannabis to ensure compliance with this section.

(11) Rules adopted by the department under this section are exempt from the requirement that they be ratified by the Legislature pursuant to s. 120.541(3).

Section 2. Paragraph (g) is added to subsection (3) of section 381.987, Florida Statutes, to read:

381.987 Public records exemption for personal identifying information in the compassionate use registry.—

(3) The department shall allow access to the registry,

including access to confidential and exempt information, to:

(g) Persons engaged in research at the University of Florida pursuant to s. 381.986(8).

Section 3. Paragraph (b) of subsection (7) of section 893.055, Florida Statutes, is amended to read:

893.055 Prescription drug monitoring program.—

(7)

(b) A pharmacy, prescriber, or dispenser shall have access to information in the prescription drug monitoring program's database which relates to a patient of that pharmacy, prescriber, or dispenser in a manner established by the department as needed for the purpose of reviewing the patient's controlled substance prescription history. Persons engaged in research at the University of Florida pursuant to s. 381.986(8) shall have access to information in the prescription drug monitoring program's database which relates to qualified patients as defined in s. 381.986(1) for the purpose of conducting such research. Other access to the program's database shall be limited to the program's manager and to the designated program and support staff, who may act only at the direction of the program manager or, in the absence of the program manager, as authorized. Access by the program manager or such designated staff is for prescription drug program management only or for management of the program's database and its system in support of the requirements of this section and in furtherance of the prescription drug monitoring program. Confidential and exempt information in the database shall be released only as provided in paragraph (c) and s. 893.0551. The program manager, designated program and support staff who act at the direction of

or in the absence of the program manager, and any individual who has similar access regarding the management of the database from the prescription drug monitoring program shall submit fingerprints to the department for background screening. The department shall follow the procedure established by the Department of Law Enforcement to request a statewide criminal history record check and to request that the Department of Law Enforcement forward the fingerprints to the Federal Bureau of Investigation for a national criminal history record check.

Section 4. Paragraph (h) is added to subsection (3) of section 893.0551, Florida Statutes, to read:

893.0551 Public records exemption for the prescription drug monitoring program.—

(3) The department shall disclose such confidential and exempt information to the following persons or entities upon request and after using a verification process to ensure the legitimacy of the request as provided in s. 893.055:

(h) Persons engaged in research at the University of Florida pursuant to s. 381.986(8).

Section 5. This act shall take effect upon becoming a law.

Department of Revenue

The Florida Department of Revenue's Nontaxable Medical Items and General Grocery List.

FLORIDA
DEPARTMENT OF REVENUE

Nontaxable Medical Items and General Grocery List

DR-46NT
R. 07/10

Rule 12A-1.097
Florida Administrative Code
Effective 07/10

Chemical Compounds and Test Kits

Chemical compounds and test kits used for the diagnosis or treatment of disease, illness, or injury, dispensed according to an individual prescription or prescriptions written by a licensed practitioner authorized by Florida law to prescribe medicinal drugs are EXEMPT. In addition, the following chemical compounds and test kits (including replacement parts) for HUMAN USE are EXEMPT, with or without a prescription.

- Allergy test kits that use human blood to test for the most common allergens
- Anemia meters and test kits
- Antibodies to Hepatitis C test kits
- Bilirubin test kits (blood or urine)
- Blood analyzers, blood collection tubes, lancets, capillaries, test strips, tubes containing chemical compounds, and test kits to test human blood for levels of albumin, cholesterol, HDL, LDL, triglycerides, glucose, ketones, or other detectors of illness, disease, or injury
- Blood sugar (glucose) test kits, reagent strips, test tapes, and other test kit refills
- Blood pressure monitors, kits, and parts
- Breast self-exam kits
- Fecal occult blood tests (colorectal tests)
- Hemoglobin test kits
- Human Immunodeficiency Virus (HIV) test kits and systems
- Influenza AB test kits
- Middle ear monitors
- Prostate Specific Antigen (PSA) test kits
- Prothrombin (clotting factor) test kits
- Thermometers, for human use
- Thyroid Stimulating Hormone (TSH) test kits
- Urinalysis test kits, reagent strips, tablets, and test tapes to test levels, such as albumin, blood, glucose, leukocytes, nitrite, pH, or protein levels, in human urine as detectors of illness, disease, or injury
- Urinary tract infection test kits
- Vaginal acidity (pH) test kits

Chemical compounds and test kits used for the diagnosis or treatment of animals' disease, illness, or injury are TAXABLE.

Common Household Remedies

Tax is not imposed on any common household remedy dispensed according to an individual prescription or prescriptions written by a licensed practitioner authorized by Florida law to prescribe medicinal drugs. In addition, the following common household remedies are specifically EXEMPT with or without a prescription.

- Adhesive tape
- Alcohol, alcohol wipes, and alcohol swabs containing ethyl or isopropyl alcohol
- Allergy relief products
- Ammonia inhalants/smelling salts
- Analgesics (pain relievers)
- Antacids
- Antifungal treatment drugs
- Antiseptics
- Asthma preparations
- Astringents, except cosmetic
- Band-aids
- Bandages and bandaging materials
- Boric acid ointments
- Bronchial inhalation solutions
- Bronchial inhalers
- Burn ointments and lotions, including sunburn ointments generally sold for use in treatment of sunburn
- Calamine lotion
- Camphor
- Castor oil
- Cod liver oil
- Cold capsules and remedies
- Cold sore and canker remedies
- Cough and cold items, such as cough drops and cough syrups
- Denture adhesive products
- Diarrhea aids and remedies
- Digestive aids
- Disinfectants, for use on humans
- Diuretics
- Earache products and ear wax removal products
- Enema preparations
- Epsom salts
- External analgesic patch, plaster, and poultice
- Eye bandage, patch, and occlusor
- Eye drops, lotions, ointments and washes, contact lens lubricating and rewetting solutions (Contact lens cleaning solutions and disinfectants are TAXABLE.)
- First aid kits

Common Household Remedies - continued

- Foot products (bunion pads, medicated callus pads and removers, corn pads or plasters, ingrown toenail preparations, and athlete's foot treatments)
- Gargles, intended for medical use
- Gauze
- Glucose for treatment or diagnosis of diabetes
- Glycerin products, intended for medical use
- Hay fever aid products
- Headache relief aid products
- Hot or cold disposable packs for medical purposes
- Hydrogen peroxide
- Insect bite and sting preparations
- Insulin
- Ipecac
- Itch and rash relievers, including feminine anti-itch creams
- Laxatives and cathartics
- Lice treatments (pediculicides), including shampoos, combs, and sprays
- Liniments
- Lip balms, ices, and salves
- Lotions, medicated
- Menstrual cramp relievers
- Mercurochrome
- Milk of Magnesia
- Mineral oil
- Minoxidil for hair regrowth
- Motion sickness remedies
- Nasal drops and sprays
- Nicotine replacement therapies, including nicotine patches, gums, and lozenges
- Ointments, medicated
- Pain relievers, oral or topical
- Petroleum jelly and gauze
- Poison ivy and oak relief preparations
- Rectal preparations (hemorrhoid and rash)
- Sinus relievers
- Sitz bath solutions
- Skin medications
- Sleep aids (inducers)
- Styptic pencils
- Suppositories, except contraceptives
- Teething lotions and powders
- Throat lozenges
- Toothache relievers
- Wart removers
- Witch hazel
- Worming treatments (anthelmintics), for human use

Cosmetics and Toilet Articles

Cosmetics and toilet articles **ARE TAXABLE**, even when the cosmetic or toilet article contains medicinal ingredients. Examples of cosmetics are cold cream, suntan lotion, makeup, body lotion, soap, toothpaste, hair spray, shaving products, cologne, perfume, shampoo, deodorant, and mouthwash. Cosmetics and toilet articles are EXEMPT only when dispensed according to an individual prescription or prescriptions written by a licensed practitioner authorized by Florida law to prescribe medicinal drugs.

Prosthetic Appliances or Orthopedic Appliances

Prosthetic or orthopedic appliances dispensed according to an individual prescription written by a licensed practitioner (a physician, osteopathic physician, chiropractic physician, podiatric physician, or dentist duly licensed under Florida law) are EXEMPT.

In addition, the following prosthetic and orthopedic appliances are specifically EXEMPT under Florida law or have been certified by the Department of Health as EXEMPT without a prescription.

- Abdominal belts
- Arch, foot, and heel supports; gels, insoles, and cushions, excluding shoe reliners and pads
- Artificial eyes
- Artificial limbs
- Artificial noses and ears
- Back braces
- Batteries, for use in prosthetic and orthopedic appliances
- Braces and supports worn on the body to correct or alleviate a physical incapacity or injury
- Canes (all)
- Crutches, crutch tips, and pads
- Dentures, denture repair kits, and cushions
- Dialysis machines and artificial kidney machines, parts, and accessories
- Fluidic breathing assistors; portable resuscitators
- Hearing aids (repair parts, batteries, wires, condensers)
- Heart stimulators and external defibrillators
- Mastectomy pads
- Ostomy pouch and accessories
- Patient safety vests
- Rupture belts

Prosthetic Appliances or Orthopedic Appliances - continued

- Suspensories
- Trusses
- Urine collectors and accessories
- Walkers, including walker chairs
- Walking bars
- Wheelchairs, including powered models, their parts, and repairs

Other Exempt Medical Items

- Hypodermic needles and syringes
- Lithotripters

Medical products and supplies used in the cure, mitigation, alleviation, prevention, or treatment of injury, disease, or incapacity that are temporarily or permanently incorporated into a patient or client or an animal by a licensed practitioner or a licensed veterinarian are EXEMPT. Examples are dental bridges and crowns.

Medical products, supplies, or devices are EXEMPT when they are:

1. dispensed under federal or state law only by the prescription or order of a licensed practitioner, e.g., “Rx only” or “CAUTION: Federal law restricts this device to sale by or on the order of a [designation of a licensed health care practitioner authorized to use or order the use of the device]”; and
2. intended for use on a single patient and are not intended to be reusable.

Some examples of items that would meet these requirements are:

- Artificial arteries, heart valves, and larynxes
- Bone cement, nails, pins, plates, screws, and wax
- Catheters
- Eyelid load prosthesis
- Pacemakers

Unless listed as a specifically tax-exempt item, sales of medical equipment to physicians, dentists, hospitals, clinics, and like establishments are TAXABLE, even though the equipment may be used in connection with medical treatment.

Optical Goods

Prescription eyeglasses, lenses, and contact lenses, including items that become a part thereof, are EXEMPT. Standard or stock eyeglasses and other parts sold without a prescription are TAXABLE.

General Groceries

The following general classifications of grocery products are EXEMPT from tax. However, food products prepared and sold for immediate consumption (except food products prepared off the seller’s premises and sold in the original container or sliced into smaller portions), sold as part of a prepared meal (whether hot or cold), or sold for immediate consumption within a place where the entrance is subject to an admission charge are TAXABLE. Sandwiches sold ready for immediate consumption are TAXABLE.

- Baked goods and baking mixes
- Baking and cooking items advertised and normally sold for use in cooking or baking, such as chocolate morsels, flavored frostings, glazed or candied fruits, marshmallows, powdered sugar, or food items intended for decorating baked goods
- Bread or flour products
- Breakfast bars, cereal bars, granola bars, and other nutritional food bars, including those that are candy-coated or chocolate-coated
- Butter
- Canned foods
- Cereal and cereal products
- Cheese and cheese products
- Cocoa
- Coffee and coffee substitutes
- Condiments and relishes, including seasoning sauces and spreads, such as mayonnaise, ketchup, or mustard
- Cookies, including chocolate-coated or cream-filled
- Crackers
- Dairy products
- Dairy substitutes
- Dietary substitutes (including herbal supplements)
- Drinking water, including water enhanced by the addition of minerals (except when carbonation or flavorings have been added to the water in the manufacturing process)

General Groceries - continued

Eggs and egg products
Fish, shellfish, and other fish products
Food coloring
Food supplements
Frozen foods
Fruit (including fruit sliced, chunked, or otherwise cut by the retailer)
Fruit snacks, fruit roll-ups, and dried fruit, including those sweetened with sugar or other sweeteners
Gelatins, puddings, and fillings, including flavored gelatin desserts, puddings, custards, parfaits, pie fillings, and gelatin base salads
Grain products and pastas, including macaroni and noodle products, rice and rice dishes
Honey
Ice cream, frozen yogurt, sherbet, and similar frozen dairy or nondairy products sold in units larger than one pint (Ice cream, frozen yogurt, and similar frozen dairy or nondairy products in cones, small cups, or pints, and popsicles, frozen fruit bars, or other novelty items, whether sold separately or in multiple units are TAXABLE.)
Jams, jellies, and preserves
Margarine
Marshmallows
Meal replacement powders and drinks, including liquid food supplements
Meat and meat products
Meat substitutes
Milk and milk products, including products intended to be mixed with milk
Natural fruit juices containing 100 percent fruit juices (Fruit drinks labeled ades, beverages, cocktails, drink or fruit or vegetable flavor, flavored, or flavorings are TAXABLE.)
Peanut butter
Poultry and poultry products
Salad dressings and dressing mixes
Salt, salt tablets, pepper, spices, seeds, herbs, seasonings, blends, extracts, and flavorings, whether natural or artificial
Sandwich spreads
Sauces and gravies
Seafood and seafood products

General Groceries - continued

Snack foods, including chips, corn chips, potato chips, cheese puffs and curls, cereal bars, cracker jacks, granola bars, nuts and edible seeds, pork rinds, and pretzels, including those that are chocolate-coated, honey-coated, or candy-coated (Candy and like items regarded and advertised as candy, as indicated on the label, are TAXABLE.)
Spreads, except those cooked or prepared on the seller's premises
Sugar, sugar products, and substitutes
Tea (including herbal tea), unless sold in liquid form
Vegetables and vegetable products, including natural vegetable products that include natural vegetable juices
Vegetable juices, natural (except those labeled as ades, beverages, cocktails, drink, or fruit or vegetable flavor, flavored, or flavorings)
Vegetable oils, lard, olive oil, shortenings, and oleomargarine
Vegetable salads, fresh (except those sold cooked with eating utensils)
Vitamins and minerals

Bakeries, Pastry Shops, or Similar Establishments

Bakery products sold by bakeries, pastry shops, or similar establishments that do not have eating facilities are EXEMPT.

Bakery products sold by bakeries, pastry shops, or similar establishments that have eating facilities are TAXABLE, except when sold for consumption off premises. Bakery products sold in quantities of five (5) or fewer are presumed to be TAXABLE. Bakery products, regardless of the quantity, that are not packaged with an intention by the customer to consume the products off the premises are also presumed to be TAXABLE.

Exempt Infant Supplies

Baby food
Baby formulas, liquid or powder
Baby teething lotion
Baby teething powder
Oral electrolyte solutions for infants and children

Exempt Miscellaneous Items

Bibles, hymn books, and prayer books
Flags, United States or official state flag of Florida

Seeds and Fertilizers

Fertilizers, including peat, topsoil, and manure[1 and 2]
Seeds, including field, garden, and flower (no exemption certificate required)
Fungicides[1 and 2]
Herbicides[1 and 2]
Insecticides[1 and 2]
Pesticides[1 and 2]
Seedlings, cuttings, plants, and fruit or nut trees used to produce food for humans[2]
Weed killers[1 and 2]

[1] Exempt if used for application on or in cultivation of crops, groves, and home vegetable gardens or by commercial nurserymen.
[2] The purchaser **must** furnish the seller a certificate stating that the item is used exclusively for exempt purposes.

Federal Reports & Letters

U.S. Department of Justice

This section contains:

- Memorandum from U.S. Attorney General

A memorandum from James M. Cole, Deputy Attorney General, U.S. Department of Justice, dated August 29, 2013 to all United States Attorneys, with the subject - Guidance Regarding Marijuana Enforcement

- Smart on Crime Report

A report from the U.S. Department of Justice, entitled “Smart on Crime; Reforming the Criminal Justice System for the 21st Century”, released August 2013

U.S. Department of Justice

Office of the Deputy Attorney General

The Deputy Attorney General

Washington, D.C. 20530

August 29, 2013

MEMORANDUM FOR ALL UNITED STATES ATTORNEYS

FROM: James M. Cole
Deputy Attorney General

SUBJECT: Guidance Regarding Marijuana Enforcement

In October 2009 and June 2011, the Department issued guidance to federal prosecutors concerning marijuana enforcement under the Controlled Substances Act (CSA). This memorandum updates that guidance in light of state ballot initiatives that legalize under state law the possession of small amounts of marijuana and provide for the regulation of marijuana production, processing, and sale. The guidance set forth herein applies to all federal enforcement activity, including civil enforcement and criminal investigations and prosecutions, concerning marijuana in all states.

As the Department noted in its previous guidance, Congress has determined 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. The Department of Justice is committed to enforcement of the CSA consistent with those determinations. The Department is also committed to using its limited investigative and prosecutorial resources to address the most significant threats in the most effective, consistent, and rational way. In furtherance of those objectives, as several states enacted laws relating to the use of marijuana for medical purposes, the Department in recent years has focused its efforts on certain enforcement priorities that are particularly important to the federal government:

- Preventing the distribution of marijuana to minors;
- Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs, and cartels;
- Preventing the diversion of marijuana from states where it is legal under state law in some form to other states;
- 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 violence and the use of firearms in the cultivation and distribution of marijuana;
- Preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use;
- Preventing the growing of marijuana on public lands and the attendant public safety and environmental dangers posed by marijuana production on public lands; and
- Preventing marijuana possession or use on federal property.

These priorities will continue to guide the Department's enforcement of the CSA against marijuana-related conduct. Thus, this memorandum serves as guidance to Department attorneys and law enforcement to focus their enforcement resources and efforts, including prosecution, on persons or organizations whose conduct interferes with any one or more of these priorities, regardless of state law.[1]

Outside of these enforcement priorities, the federal government has traditionally relied on states and local law enforcement agencies to address marijuana activity through enforcement of their own narcotics laws. For example, the Department of Justice 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. Instead, the Department has left such lower-level or localized activity to state and local authorities and has stepped in to enforce the CSA only when the use, possession, cultivation, or distribution of marijuana has threatened to cause one of the harms identified above.

The enactment of state laws that endeavor to authorize marijuana production, distribution, and possession by establishing a regulatory scheme for these purposes affects this traditional joint federal-state approach to narcotics enforcement. The Department's guidance in this memorandum rests on its expectation that states and local governments that have enacted laws authorizing marijuana-related conduct will implement strong and effective regulatory and enforcement systems that will address the threat those state laws could pose to public safety, public health, and other law enforcement interests. A system adequate to that task must not only contain robust controls and procedures on paper; it must also be effective in practice. Jurisdictions that have implemented systems that provide for regulation of marijuana activity

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[1] These enforcement priorities are listed in general terms; each encompasses a variety of conduct that may merit civil or criminal enforcement of the CSA. By way of example only, the Department's interest in preventing the distribution of marijuana to minors would call for enforcement not just when an individual or entity sells or transfers marijuana to a minor, but also when marijuana trafficking takes place near an area associated with minors; when marijuana or marijuana-infused products are marketed in a manner to appeal to minors; or when marijuana is being diverted, directly or indirectly, and purposefully or otherwise, to minors.

must provide the necessary resources and demonstrate the willingness to enforce their laws and regulations in a manner that ensures they do not undermine federal enforcement priorities.

In jurisdictions that have enacted laws legalizing marijuana in some form and that have also 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 priorities set forth above. Indeed, a robust system may affirmatively address those priorities by, for example, implementing effective measures to prevent diversion of marijuana outside of the regulated system and to other states, prohibiting access to marijuana by minors, and replacing an illicit marijuana trade that funds criminal enterprises with a tightly regulated market in which revenues are tracked and accounted for. In those circumstances, consistent with the traditional allocation of federal-state efforts in this area, enforcement of state law by state and local law enforcement and regulatory bodies should remain the primary means of addressing marijuana-related activity. If state enforcement efforts are not sufficiently robust to protect against the harms set forth above, the federal government may seek to challenge the regulatory structure itself in addition to continuing to bring individual enforcement actions, including criminal prosecutions, focused on those harms.

The Department's previous memoranda specifically addressed the exercise of prosecutorial discretion in states with laws authorizing marijuana cultivation and distribution for medical use. In those contexts, the Department advised that it likely was not an efficient use of federal resources to focus enforcement efforts on seriously ill individuals, or on their individual caregivers. In doing so, the previous guidance drew a distinction between the seriously ill and their caregivers, on the one hand, and large-scale, for-profit commercial enterprises, on the other, and advised that the latter continued to be appropriate targets for federal enforcement and prosecution. In drawing this distinction, the Department relied on the common-sense judgment that the size of a marijuana operation was a reasonable proxy for assessing whether marijuana trafficking implicates the federal enforcement priorities set forth above.

As explained above, however, both the existence of a strong and effective state regulatory system, and an operation's compliance with such a system, may allay the threat that an operation's size poses to federal enforcement interests. Accordingly, in exercising prosecutorial discretion, prosecutors should not consider the size or commercial nature of a marijuana operation alone as a proxy for assessing whether marijuana trafficking implicates the Department's enforcement priorities listed above. Rather, prosecutors should continue to review marijuana cases on a case-by-case basis and weigh all available information and evidence, including, but not limited to, whether the operation is demonstrably in compliance with a strong and effective state regulatory system. A marijuana operation's large scale or for-profit nature may be a relevant consideration for assessing the extent to which it undermines a particular federal enforcement priority. The primary question in all cases – and in all jurisdictions – should be whether the conduct at issue implicates one or more of the enforcement priorities listed above.

As with the Department's previous statements on this subject, this memorandum is intended solely as a guide to the exercise of investigative and prosecutorial discretion. This memorandum does not alter in any way the Department's authority to enforce federal law, including federal laws relating to marijuana, regardless of state law. Neither the guidance herein nor any state or local law provides a legal defense to a violation of federal law, including any civil or criminal violation of the CSA. Even in jurisdictions with strong and effective regulatory systems, evidence that particular conduct threatens federal priorities will subject that person or entity to federal enforcement action, based on the circumstances. This memorandum 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. It applies prospectively to the exercise of prosecutorial discretion in future cases and does not provide defendants or subjects of enforcement action with a basis for reconsideration of any pending civil action or criminal prosecution. Finally, nothing herein precludes investigation or prosecution, even in the absence of any one of the factors listed above, in particular circumstances where investigation and prosecution otherwise serves an important federal interest.

cc: Mythili Raman
Acting Assistant Attorney General, Criminal Division

Loretta E. Lynch
United States Attorney
Eastern District of New York
Chair, Attorney General's Advisory Committee

Michele M. Leonhart
Administrator
Drug Enforcement Administration

H. Marshall Jarrett
Director
Executive Office for United States Attorneys

Ronald T. Hosko
Assistant Director
Criminal Investigative Division
Federal Bureau of Investigation

SMART on CRIME

Reforming The Criminal Justice System for the 21st Century

August 2013

"By targeting the most serious offenses, prosecuting the most dangerous criminals, directing assistance to crime 'hot spots,' and pursuing new ways to promote public safety, deterrence, efficiency, and fairness – we can become both smarter *and* tougher on crime."

—Attorney General Eric Holder
Remarks to American Bar Association's Annual Convention in San Francisco, CA
August 12, 2013

INTRODUCTION

At the direction of the Attorney General, in early 2013 the Justice Department launched a comprehensive review of the criminal justice system in order to identify reforms that would ensure federal laws are enforced more fairly and—in an era of reduced budgets—more efficiently. Specifically, this project identified five goals:

- To ensure finite resources are devoted to the most important law enforcement priorities;
- To promote fairer enforcement of the laws and alleviate disparate impacts of the criminal justice system;
- To ensure just punishments for low-level, nonviolent convictions;
- To bolster prevention and reentry efforts to deter crime and reduce recidivism;
- To strengthen protections for vulnerable populations.

As part of its review, the Department studied all phases of the criminal justice system—including charging, sentencing, incarceration and reentry—to examine which practices are most successful at deterring crime and protecting the public, and which aren't. The review also considered demographic disparities that have provoked questions about the fundamental fairness of the criminal justice system.

The preliminary results of this review suggest a need for a significant change in our approach to enforcing the nation's laws. Today, a vicious cycle of poverty, criminality, and incarceration traps too many Americans and weakens too many communities. However, many aspects of our criminal justice system may actually exacerbate this problem, rather than alleviate it.

The reality is, while the aggressive enforcement of federal criminal statutes remains necessary, we cannot prosecute our way to becoming a safer nation. To be effective, federal efforts must also focus on prevention and reentry. In addition, it is time to rethink the nation's system of mass imprisonment. The United States today has the highest rate of incarceration of any nation in the world, and the nationwide cost to state and federal budgets was $80 billion in 2010 alone. This pattern of incarceration is disruptive to families, expensive to the taxpayer, and may not serve the goal of reducing recidivism. We must marshal resources, and use evidence-based strategies, to curb the disturbing rates of recidivism by those reentering our communities.

These findings align with a growing movement at the state level to scrutinize the cost-effectiveness of our corrections system. In recent years, states such as Texas and Arkansas have reduced their prison populations by pioneering approaches that seek alternatives to incarceration for people convicted of low-level, nonviolent drug offenses.

It is time to apply some of the lessons learned from these states at the federal level. By shifting away from our over-reliance on incarceration, we can focus resources on the most important law enforcement priorities, such as violence prevention and protection of vulnerable populations.

The initial package of reforms described below—dubbed the Justice Department's "Smart on Crime" initiative—is only the beginning of an ongoing effort to modernize the criminal justice system. In the months ahead, the Department will continue to hone an approach that is not only more efficient, and not only more effective at deterring crime and reducing recidivism, but also more consistent with our nation's commitment to treating all Americans as equal under the law.

We of course must remain tough on crime. But we must also be smart on crime.

FIVE PRINCIPLES OF "SMART ON CRIME"

I. PRIORITIZE PROSECUTIONS TO FOCUS ON MOST SERIOUS CASES

Given scarce resources, federal law enforcement efforts should focus on the most serious cases that implicate clear, substantial federal interests. Currently, the Department's interests are:

1. Protecting Americans from national security threats
2. Protecting Americans from violent crime
3. Protecting Americans from financial fraud
4. Protecting the most vulnerable members of society

Based on these federal priorities, the Attorney General is, for the first time, requiring the development of district-specific guidelines for determining when federal prosecutions should be brought. This necessarily will mean focusing resources on fewer but the most significant cases, as opposed to fixating on the sheer volume of cases.

The Attorney General's call for the creation of district-specific guidelines recognizes that each U.S. Attorney is in the best position to articulate the priorities that make sense for that area. A particular district's priorities will often depend on local criminal threats and needs.

In the coming months, the U.S. Attorneys' Manual will be updated to reflect the requirement that U.S. Attorneys develop district-specific guidelines for the prioritization of cases.

II. REFORM SENTENCING TO ELIMINATE UNFAIR DISPARITIES AND REDUCE OVERBURDENED PRISONS.

Our prisons are over-capacity and the rising cost of maintaining them imposes a heavy burden on taxpayers and communities. At the state level, costs for running corrections facilities have roughly tripled in the last three decades, making it the second-fastest rising

expense after Medicaid. At the federal level, the Bureau of Prisons comprises one-third of the Justice Department's budget.

This requires a top-to-bottom look at our system of incarceration. For many non-violent, low-level offenses, prison may not be the most sensible method of punishment. But even for those defendants who do require incarceration, it is important to ensure a sentence length commensurate with the crime committed. Our policies must also seek to eliminate unfair sentencing disparities.

It is time for meaningful sentencing reform. As a start, the Attorney General is 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. Reserving the most severe penalties for serious, high-level, or violent drug traffickers will better promote public safety, deterrence, and rehabilitation – while making our expenditures smarter and more productive.

The Attorney General also plans to work with Congress to pass legislation that would reform mandatory minimum laws. A number of bipartisan proposals – including bills by Senators Dick Durbin (D-IL) and Mike Lee (R-UT), as well as Senators Patrick Leahy (D-VT) and Rand Paul (R-KY) – show the emerging consensus in favor of addressing this issue.

Sentencing reform also entails considering reductions in sentence for inmates facing extraordinary and compelling circumstances – and who pose no threat to public safety. In late April, the Bureau of Prisons (BOP) expanded the medical criteria that will be considered for inmates seeking compassionate release. In a new step, the Attorney General is announcing revised criteria for other categories of inmates seeking reduced sentences. This includes elderly inmates and certain inmates who are the only possible caregiver for their dependents. In both cases, under the revised policy, BOP would generally consider inmates who did not commit violent crimes and have served significant portions of their sentences. The sentencing judge would ultimately decide whether to reduce the sentence.

III. PURSUE ALTERNATIVES TO INCARCERATION FOR LOW-LEVEL, NON-VIOLENT CRIMES.

Incarceration is not the answer in every criminal case. Across the nation, no fewer than 17 states have shifted resources away from prison construction in favor of treatment and supervision as a better means of reducing recidivism. In Kentucky, new legislation has reserved prison beds for the most serious offenders and re-focused resources on community supervision and evidence-based programs. As a result, the state is projected to reduce its prison population by more than 3,000 over the next 10 years – saving more than $400 million.

Federal law enforcement should encourage this approach. In appropriate instances involving non-violent offenses, prosecutors ought to consider alternatives to incarceration, such as drug courts, specialty courts, or other diversion programs. Accordingly, the Department will issue a "best practices" memorandum to U.S. Attorney Offices encouraging more widespread adoption of these diversion policies when appropriate.

In its memorandum, the Department will endorse certain existing diversion programs as models. In the Central District of California, the USAO, the court, the Federal Public Defender, and the Pretrial Services Agency (PSA) have together created a two-track specialty court/post-plea diversion program, known as the Conviction and Sentence Alternatives (CASA) program. Selection for the program is not made solely by the USAO, but by the program team, comprised of the USAO, the Public Defender, PSA, and the court. Track one is for candidates with minimal criminal histories whose criminal conduct appears to be an aberration that could appropriately be addressed by supervision, restitution and community service. Examples of potential defendants include those charged with felony, though relatively minor, credit card or benefit fraud, mail theft, and narcotics offenses. Track two is for those defendants with somewhat more serious criminal histories whose conduct appears motivated by substance abuse issues. Supervision in these cases includes intensive drug treatment. Examples of eligible defendants are those charged with non-violent bank robberies, or mail and credit card theft designed to support a drug habit.

The Department will also recommend the use of specialty courts and programs to deal with unique populations. Examples include a treatment court for veterans charged with misdemeanors in the Western District of Virginia, and the Federal/Tribal Pretrial Diversion program in the District of South Dakota, which is designed specifically for juvenile offenders in Indian country.

IV. IMPROVE REENTRY TO CURB REPEAT OFFENSES AND RE-VICTIMIZATION.

After prison, recidivism rates are high. A reduction in the recidivism rate of even one or two percentage points could create long-lasting benefits for formerly incarcerated individuals and their communities.

To lead these efforts on a local level, the Department is calling for U.S. Attorneys to designate a prevention and reentry coordinator within each of their offices to focus on prevention and reentry efforts. As part of this enhanced commitment, Assistant U.S. Attorneys will be newly encouraged to devote time to reentry issues in addition to casework. The Executive Office of U.S. Attorneys will report periodically on the progress made in USAOs on the reentry front.

Other efforts to aid reentry are also being launched. It is well documented that the consequences of a criminal conviction can remain long after someone has served his or her sentence. Rules and regulations pertaining to formerly incarcerated people can limit employment and travel opportunities, making a proper transition back into society difficult. Currently, the Justice Department is working with the American Bar Association to publish a catalogue of these collateral consequences imposed at the state and federal level. To address these barriers to reentry, the Attorney General will issue a new memorandum to Department of Justice components, requiring them to factor these collateral consequences into their rulemaking. If the rules imposing collateral consequences are found to be unduly burdensome and not serving a public safety purpose, they should be narrowly tailored or eliminated.

The Attorney General's Reentry Council has published helpful materials on reentry efforts related to employment, housing, and parental rights. In an update to these materials, the Department will publish new fact sheets on ways to reduce unnecessary barriers to reentry in two areas: (1) to connect the reentering population with legal services to address obstacles such as fines and criminal records expungement when appropriate; and (2) to highlight efforts to reduce or eliminate fines at the local level.

V. 'SURGE' RESOURCES TO VIOLENCE PREVENTION AND PROTECTING MOST VULNERABLE POPULATIONS.

Even as crime levels have fallen, many of our communities still suffer from alarming rates of homicides, shootings and aggravated assaults. Confronting this problem and its root causes with a holistic approach remains a priority for the Department of Justice.

By exploring cost-effective reforms to our prison system, it will allow law enforcement to redirect scarce federal resources towards the priority of violence prevention.

Under a new memorandum issued by the Deputy Attorney General, U.S. Attorneys will put in place updated anti-violence strategies that are specific to their district. As an initial step, they will be urged to lead anti-violence forums to include Special Agents-in-Charge,

Assistant Special Agents-in-Charge, U.S. Marshals and Chief Deputy Marshals, and State and Local Police Chiefs, Commanders, and Captains. With multiple federal, state, and local agencies involved in the fight against violent crime, strong relationships and robust information sharing are critical to achieve common goals and to avoid the unnecessary duplication of competing resources and efforts.

To monitor the success of these district-based anti-violence strategies, the Department will, in the coming months, implement new information-sharing techniques to share data from high-crime communities across Justice Department components.

The Department will also stress efforts to reduce and respond to violence, particularly violence against women and youth violence.

Within the Department, the Office of Community Oriented Policing Services (COPS), the Office of Victims of Crimes (OVC), and the Office of Violence Against Women (OVW) have partnered together to provide law enforcement agencies with the resources, technical assistance, and support they need to combat gender bias and sexual assault.

In April, the Department issued a revised Sexual Assault Forensic Examinations (SAFE) Protocol to standardize up-to-date approaches to victim-centered forensic medical examinations. In a new step, OVW will release a companion document that applies the protocol's recommendations for use in correctional facilities. A similar document will be released in the coming weeks for tribal communities.

In the coming months, the Department will also work with the Federal Bureau of Investigation to support states' implementation of the revised Uniform Crime Report definition of "rape."

In the effort to further protect children, the Department envisions several new steps:

- As part of the Attorney General's Defending Childhood Initiative:
    - This fall, the Department will launch a public awareness and community action campaign to stem youth violence.
    - The Department will establish a Task Force on American Indian/Alaska Native Children Exposed to Violence.
    - The Department will partner with select states to form "State Commissions" that will implement model public policy initiatives at the state and local level to reduce the impact of children's exposure to violence, including the adaptation and implementation of recommendations of the Attorney General's Task Force on Children Exposed to Violence.
- The Department will prioritize School Resource Officer requests in its COPS Hiring grant awards this year.

- The Department and the Department of Education will jointly issue guidance to public elementary and secondary schools on their federal civil rights obligations to administer student discipline without discrimination on the basis of race, color, or national origin, and the Department will continue to vigorously enforce civil rights laws to ensure that school discipline is fair and equitable.

- In September, the Department will host the National Forum Youth Violence Prevention Summit, which, for the first time, will convene stakeholders from the Forum, Defending Childhood, Community-Based Grant Programs, and youth violence prevention initiatives at other federal agencies to collaborate on innovative strategies and comprehensive solutions to end youth violence, protect the children that are exposed to it, and create safer and healthier communities.

In addition to these violence prevention efforts, the Department also remains focused on serving victims of crime. In June, the Justice Department issued the *Vision 21* report that offers an unprecedented snapshot of the current state of victim services and calls for sweeping, evidence-based changes to bring these services into the 21st century. It will empower survivors by closing research gaps and developing new ways to reach those who need our assistance the most.

Government Accountability Office Report

A review of early experiences in four states (Alaska, California, Hawaii, and Oregon) with medical marijuana laws, released November 2002.

United States General Accounting Office

GAO

Report to the Chairman, Subcommittee on Criminal Justice, Drug Policy and Human Resources, Committee on Government Reform, U.S. House of Representatives

November 2002

MARIJUANA

Early Experiences with Four States' Laws That Allow Use for Medical Purposes

GAO-03-189

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Figures

Abbreviations

CSA	Controlled Substances Act of 1970
DEA	Drug Enforcement Administration
FBI	Federal Bureau of Investigation
HHS	Department of Health and Human Services
UCR	Uniform Crime Reports

GAO
Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

November 1, 2002

The Honorable Mark Souder
Chairman, Subcommittee on Criminal Justice,
Drug Policy and Human Resources
Committee on Government Reform
House of Representatives

Dear Mr. Chairman:

A number of states have adopted laws that allow medical use of marijuana. Federal law, however, does not recognize any accepted medical use for marijuana and individuals remain subject to federal prosecution for marijuana possession. Debate continues over the medical effectiveness of marijuana, and over government policies surrounding medical use. A bill introduced in the House of Representatives in July 2001 would modify the federal classification of marijuana and allow doctors, in states with medical marijuana laws, to recommend or prescribe marijuana.[1] As the debate continues, so has interest in how state medical marijuana programs are operating, and in the issues faced by federal and state law enforcement officials in enforcing criminal marijuana provisions.[2]

This report responds to your request that we examine the implementation of medical marijuana laws in selected states. We did not examine the effectiveness of states' or local jurisdictions efforts to administer their programs and did not judge the validity of their approaches for implementing states' laws. As agreed with your staff, we selected Oregon, Alaska, Hawaii, and California because they had medical marijuana laws in effect for at least 6 months and, according to our preliminary work, some

[1]States' Rights to Medical Marijuana Act, H.R. 2592, 107th Cong. (2001). Status as of August 5, 2002: Referred to House Energy and Commerce, Subcommittee on Health on July 31, 2001.

[2]Throughout this report, we use the phrase medical marijuana to describe marijuana use that qualifies for a medical use exception under state law.

data was available on patient and physician participation.[3] For these states, we are reporting on (1) their approach to implementing their medical marijuana laws and how these approaches compare, and the results of any state audits or reviews; (2) the number, age, gender, and medical conditions of patients that have had doctors recommend marijuana for medical use in each state; (3) how many doctors are known to have recommended marijuana in each state, and what guidance is available for making these recommendations; and (4) the perceptions of federal and state law enforcement officials, and whether data are available to show how the enforcement of state marijuana laws has been affected by the introduction of these states' medical marijuana laws.

In conducting our work, we examined applicable federal and state laws and regulations and spoke with responsible program officials in Oregon, Alaska, Hawaii, and California. In the four states, we obtained and analyzed available information on program implementation, program audits, and program participation by patients and doctors. We also met with various federal, state, and local law enforcement officials—including officials with the Drug Enforcement Administration (DEA) and U.S. Attorneys offices in Washington, D.C., and the four selected states—to discuss data on arrests and prosecutions and views on the impact of the state's medical marijuana laws on their law enforcement efforts.

Results from our review of these states cannot be generalized to other states with state medical marijuana laws, nor are they generalizable across the states selected for review. Similarly, in California, the information from the local jurisdictions we reviewed cannot be generalized to all local jurisdictions in California. We conducted our review between September 2001 and June 2002 in accordance with generally accepted government auditing standards. (Appendix I describes our scope and methodology in greater detail.)

[3]According to *United States v. Oakland Cannabis Buyers' Cooperative*, 532 U.S. 483, 502 n.4 (2001), eight states have enacted medical marijuana laws. We selected four of those states based on the length of time the laws had been in place and the availability of data. Two of the eight states, Nevada and Colorado, were not selected because their laws had not been in place for at least 6 months when our review began. Also, at the time of our review, two other states, Maine and Washington, did not have state registries to obtain information on program registrants. Alaska, Oregon, and Hawaii have state registries and had laws in place for at least 6 months. California's law was enacted in1996. California does not have a participant registry, but based on our preliminary work, some local registry information was available.

Results in Brief

State laws in Oregon, Alaska, Hawaii, and California allow medical use of marijuana under specified conditions. All four states require a patient to have a physician's recommendation to be eligible for medical marijuana use. Alaska, Hawaii, and Oregon have established state-run registries for patients and caregivers to document their eligibility to engage in medical marijuana use; these states require physician documentation of a person's debilitating condition to register. Laws in these three states also establish maximum allowable amounts of marijuana for medical purposes. California's law does not establish a state-run registry or establish maximum allowable amounts of marijuana. Some local California jurisdictions have developed their own guidelines and voluntary registries. Oregon has changed some verification practices and administrative procedures as a result of a review of their medical marijuana program.

Relatively few people had registered to use marijuana for medical purposes in Oregon, Hawaii, and Alaska. As of Spring 2002, about 2,450 people, or about 0.05 percent of the total population of the three states combined, had registered as medical marijuana users. Statewide figures for California are unknown. In Oregon, Alaska, and Hawaii, over 70 percent of registrants were over 40 years of age or older, and in Hawaii and Oregon, the two states where gender information is collected, about 70 percent of registrants were men. Data from Hawaii and Oregon also showed that about 75 percent and more than 80 percent respectively, of the physician recommendations were for severe pain and conditions associated with muscle spasms, such as multiple sclerosis. Statewide figures on gender and medical conditions were not available for Alaska or California.

Hawaii and Oregon were the only two states that had data on the number of physicians recommending marijuana. As of February 2002, less than one percent of the approximately 5,700 physicians in Hawaii and three percent of Oregon's physicians out of about 12,900 had recommended marijuana to their patients. Oregon also was the only state that maintained data on the number of times individual physicians recommended marijuana—as of February 2002, about 62 percent of the Oregon physicians recommending marijuana made one recommendation. Professional medical associations in all four states provided some guidance to physicians. The associations caution physicians about the legal issues facing them, or give advice on practices to follow and avoid. Most state medical board officials said they would only become involved with physicians recommending marijuana in cases where a complaint was filed against a physician for violating state medical practice standards. California's medical board provides informal guidelines on making marijuana recommendations to their patients.

Data were not readily available to measure how marijuana-related law enforcement has been affected by the introduction of medical marijuana laws. To assess the relationship between trends in marijuana-related law enforcement activities and the passage of medical marijuana laws would require a statistical analysis over time that included measures of law enforcement activities, such as arrests, as well as data on other factors that are not easily measured, such as changes in perceptions about marijuana and shifts in law enforcement priorities. Officials from over half of the 37 selected federal, state, and local law enforcement organizations we interviewed in the four states said that the introduction of medical marijuana laws had not greatly affected their law enforcement activities. These officials indicated that they had not encountered situations involving a medical marijuana defense or they had other drug priorities. However, officials with some of the organizations told us that the laws in their states had made it more difficult to prosecute marijuana cases where medical use might be claimed; there was confusion over how to handle seized marijuana; and that, in their view, the laws had softened public attitudes toward marijuana.

In commenting on a draft of this report, the Department of Justice (DOJ) said that we fully described the current status of the programs in the states reviewed. However, DOJ stated that we failed to adequately address some of the serious difficulties associated with such programs. Specifically, DOJ commented that the report did not adequately address issues related to the (1) inherent conflict between state laws permitting the use of marijuana and federal laws that do not; (2) potential for facilitating illegal trafficking; (3) impact of such laws on cooperation among federal, state, and local law enforcement; and (4) lack of data on the medicinal value of marijuana. DOJ further stated that our use of the phrase "medical marijuana" implicitly accepts a premise that is contrary to existing federal law.

We disagree. We believe the report adequately addresses the issues within the scope of our review. With respect to DOJ's first issue, our report describes how laws in the selected states and federal law treat the use of marijuana—the opening paragraph of our report specifically states that federal law does not recognize any accepted medical use of marijuana and individuals remain subject to federal prosecution for marijuana possession regardless of state medical marijuana laws. With regard to the second and third issues raised by DOJ concerning the potential for facilitating illegal trafficking and the impact on cooperation between federal, state, and local law enforcement officials, respectively, we interviewed federal, state, and local law enforcement officials about their perceptions concerning the impact of state medical marijuana laws on their activities and our report

conveys the views and opinions of those officials. However, based on comments from law enforcement officials on a draft section of this report, we modified our report to discuss some of the issues law enforcement faces when dealing with medical marijuana laws and seized marijuana. Concerning the fourth issue—the lack of data on marijuana's medical value--our report discusses that a continuing debate exists over the medical value of marijuana, but an analysis of the scientific aspects of this debate was beyond the scope of our review.

Finally, we disagree with DOJ's comment that our use of the phrase medical marijuana accepts a premise contrary to federal law. The introduction to our report specifically states that, throughout the report, we use the phrase medical marijuana to describe marijuana use that qualifies for a medical use exception under state law. Our detailed response to DOJ's comments is provided on pages 35 to 38 and we have reprinted a copy of DOJ's comments in appendix V.

Background

The cannabis plant, commonly known as marijuana, is the most widely used illicit drug in the United States. According to recent national survey figures, over 75 percent of the 14 million illicit drug users 12 years or older are estimated to have used marijuana alone or with other drugs in the month prior to the survey.[4] Marijuana can be consumed in food or drinks, but most commonly dried portions of the leaves and flowers are smoked. Marijuana is widely used and the only major drug of abuse grown within the United States borders, according to the Drug Enforcement Administration.

Marijuana is a controlled substance under federal law and is classified in the most restrictive of categories of drugs by the federal government. The federal Controlled Substances Act of 1970 (CSA)[5] places all federally controlled substances into one of five "schedules," depending on the drug's likelihood for abuse or dependence, and whether the drug has an accepted medical use.[6] Marijuana is classified under Schedule I,[7] the classification reserved for drugs that have been found by the federal

[4]U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), *National Household Survey on Drug Abuse 2000*. Hashish is included by SAMHSA in the statistic for marijuana use.

[5]21 U.S.C. §§ 801 to 971.

[6]*Id.* § 812(a), (b).

[7]*Id.* § 812(c), Schedule I (c)(10).

government to have a high abuse potential, a lack of accepted safety under medical supervision, and no currently accepted medical use.[8] 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.[9] The CSA does not allow Schedule I drugs to be dispensed upon a prescription, unlike drugs in the other schedules.[10] In particular, the CSA provides federal sanctions for possession, manufacture, distribution or dispensing of Schedule I substances, including marijuana, except in the context of a government-approved research project.[11]

The potential medical value of marijuana has been a continuing debate. For example, beginning in 1978, the federal government allowed the first patient to use marijuana as medicine under the "Single Patient Investigational New Drug" procedure, which allows treatment for individual patients using drugs that have not been approved by the Food and Drug Administration. An additional 12 patients were approved under the procedure between 1978 and 1992. When the volume of applicants tripled, the Secretary of the Department of Health and Human Services (HHS) decided not to supply marijuana to any more patients. According to *Kuromiya v. United States*, HHS concluded that the use of the single patient Investigational New Drug procedure would not yield useful data to resolve the remaining safety and effectiveness issues.[12]

[8]Schedule I includes drugs such as heroin, lysergic acid diethylamide (LSD) and other hallucinogenic substances. 21 C.F.R. 1308.11(c), (d).

[9]*Id.* § 812(b)(2)-(5).

[10]*Id.* § 829. DEA rejected petitions in 1992 and 2001 to reschedule marijuana to schedule II. See Notice of Denial of Petition, 66 Fed. Reg. 20038 (2001); Marijuana Scheduling Petition; Denial of Petition; Remand, 57 Fed. Reg. 10499 (1992) (final order affirming the 1989 denial after remand); Marijuana Scheduling Petition; Denial of Petition, 54 Fed. Reg. 53767 (1989).

[11]*Id.* § 823(f), 841(a)(1), 844.

[12]*See* 78 F. Supp. 2d 367 (E.D.Pa.1999). In the *Kuromiya* case, a group of approximately 160 plaintiffs raised an equal protection challenge to the administration of the "Single Patient Investigational New Drug" program. The plaintiffs contended that they were similarly situated to patients currently receiving marijuana under the program and that the government acted unconstitutionally in denying them access to the same program. The court concluded that the government had a rational basis for its decision not to supply marijuana to the plaintiffs through this program and granted the government's motion for summary judgment.

In 1999, an Institute of Medicine study[13] commissioned by the White House Office of National Drug Control Policy recognized both a potential therapeutic value and potential harmful effects, particularly the harmful effects from smoked marijuana. The study called for more research on the physiological and psychological effects of marijuana and on better delivery systems. A 2001 report by the American Medical Association's Council on Scientific Affairs also summarized the medical and scientific research in this area, similarly calling for more research.[14]

In May 1999, HHS released procedures allowing researchers not funded by the National Institute of Health to obtain research-grade marijuana for approved clinical studies. Sixteen proposals have been submitted for research under these procedures, and seven of the proposals had been approved as of May 2002.

Some states have passed laws that create a medical use exception to otherwise applicable state marijuana sanctions. California was the first state to pass such a law in 1996 when California voters passed a ballot initiative, Proposition 215 (The Compassionate Use Act of 1996) that removed certain state criminal penalties for the medical use of marijuana.[15] Since then, voters in Oregon, Alaska, Colorado, Maine, Washington and Nevada have passed medical marijuana initiatives, and Hawaii has enacted a medical marijuana measure through its legislature. While state criminal penalties do not apply to medical marijuana users defined by the state's statute, federal penalties remain, as determined by the Supreme Court in *United States v. Oakland Cannabis Buyers' Cooperative*.[16] (Appendix II provides more information on the Supreme Court's decision.)

In California, Alaska, and Oregon, where voters passed medical marijuana laws through ballot initiatives, each state provided an official ballot pamphlet, which included the text of the proposed law and arguments

[13]National Academy of Sciences, Institute of Medicine, "Marijuana and Medicine: Assessing the Science Base." 1999.

[14]American Medical Association, Council on Scientific Affairs Report: *Medical Marijuana (A-01)*, June, 2001.

[15]The medical use exception in the states we reviewed allows growing or possessing marijuana for the purpose of the patient's personal medical use, and does not extend to other state marijuana prohibitions such as distribution outside the patient-caregiver relationship or any sale of marijuana.

[16]532 U.S. 483 (2001).

from proponents and opponents. Opponents of the initiatives referred to federal marijuana prohibitions, legal marijuana alternatives, and evidence of the dangers of smoked marijuana. Proponents referred to supportive studies and positive statements from medical personnel. In Hawaii, where the state legislature enacted the medical marijuana measure, law enforcement officials, advocacy groups, and medical professionals made similar arguments for or against the proposed law during the legislative process.

Implementation in Oregon, Alaska, Hawaii, and California

Oregon, Alaska, Hawaii, and California laws allow medical use of marijuana under certain conditions.[17] All four states require a patient to have a physician's recommendation to be eligible for medical marijuana. Consistent with their laws, Oregon, Alaska, and Hawaii also have designated a state agency to administer patient registries—which document a patient's eligibility to use medical marijuana based on the written certification of a licensed physician—and issue cards to identify certified registrants. Also, laws in Oregon, Alaska, and Hawaii establish limits on the amounts of marijuana a patient is allowed to possess for medical purposes. California does not provide for state implementation of its law. In particular, California has not delegated authority to a state agency or established a statewide patient registry. In addition, California law does not prescribe a specific amount of marijuana that can be possessed for medical purposes. In the absence of specific statutory language, some local California jurisdictions have established their own registries, physician certification requirements, and guidelines for allowable marijuana amounts for medical purposes. Only Oregon has reviewed its medical marijuana program, and as a result of that review, has changed some of its procedures and practices, including verifying all doctor recommendations.

States and Some Local California Jurisdictions Maintain Medical Marijuana Registries

To document their eligibility to engage in medical marijuana use, applicants in Oregon, Alaska, and Hawaii must register with state agencies charged with implementing provisions of the medical marijuana laws in those states (hereinafter referred to as registry states). In Oregon, the Department of Human Services is responsible, and in Alaska, the

[17]The states' medical marijuana laws appear at Alaska Stat. Ann. 11.71.090, 17.37.010 to 17.37.080; Cal. Health & Safety Code Ann. 11362.5; Haw. Rev. Stat. 329-121 to 329-128; and Ore. Rev. Stat. 475.300 to 475.346. Alaska's Hawaii's and Oregon's administrative regulations appear at Alaska Admin. Code, tit. 7, ch. 34; Haw. Admin. R., tit. 23, ch. 202; and Ore. Admin. R., ch. 333, div. 8. There are no regulations under California's law.

Department of Health and Social Services. In Hawaii, the Narcotics Enforcement Division within the Department of Public Safety is responsible for the state's medical marijuana registry. Applicants meeting state requirements are entered into a registry maintained by each state. In California, a number of counties have established voluntary registries to certify eligibility under the state' s medical marijuana law.[18]

The three registry states, Oregon, Alaska and Hawaii, have similar registry requirements. Potential registrants must supply written documentation by a physician licensed in that state certifying that the person suffers from a debilitating medical condition (as defined by the state statute) and in the physician's opinion would benefit from the use of marijuana. They also must provide information on the name, address, and birth date of the applicant (and of their caregiver, where one is specified) along with identification to verify the personal information. In each state, registry agencies must verify the information in the application based on procedures set in that state's statutes or regulations before issuing the applicant a medical marijuana identification card. All three states allow law enforcement officers to rely upon registry applications in lieu of registry cards to determine whether a medical use exception applies. Figure 1 provides an example of the registry card issued by Oregon. (Appendix III provides examples of registry cards from Alaska and Hawaii.)

[18]Under Alaska's and Hawaii's statutes, patients and caregivers must strictly comply with the registration requirement in order to receive legal protection; unregistered persons may not present a medical use defense to a marijuana prosecution in these states. *See* Alaska Stat. Ann. 11.71.090; Haw. Rev. Stat. 329-125. Under Oregon's statute, unregistered patients who have substantially complied with the act may raise such a defense to a marijuana prosecution, while registered persons are excepted from criminal charges, so long as they meet the act's quantity and use restrictions. *See* Ore. Rev. Stat. 475.306, 475.316, 475.319, 475.342. Because California's law does not establish a state-run registry, a medical use defense may be established by any individual meeting the act's substantive requirements, that is, patients whose doctors have recommended marijuana to treat an allowed medical condition and their primary caregivers. *See* Cal. Health & Safety Code Ann. 11362.5; *see also People v. Mower*, No. S094490, 2002 Cal. Lexis 4520 (July 18, 2002), in which the California Supreme Court interprets California's medical marijuana act.

Figure 1: Example of Oregon's Medical Marijuana Registry Card

Source: Oregon Department of Human Services.

Hawaii's Department of Public Safety requires that doctors submit the completed registry application to the state agency, and if approved, the medical use certification is returned to the doctor for issuance to their patient. By contrast, registry agencies in Oregon and Alaska require that the registry card applicant submit the physician statement as part of the application, and issue the card directly to the patient. Alaska allows registry cards to be revoked if the registrant commits an offense involving a controlled substance of any type, whereas Oregon and Hawaii allow registry cards to be revoked only for marijuana-related offenses, such as sale. Table 1 summarizes registry requirements and verification procedures of the responsible agencies in each registry state as of July 2002.

Table 1: Registry Requirements and Verification Procedures in Oregon, Alaska and Hawaii, as of July 2002

Registry requirements	Oregon	Alaska	Hawaii
Completed application form	x[a] (submitted by applicant)	x (submitted by applicant)	x (submitted by physician)
Written physician documentation	x [b]	x [c]	x [d]
Applicant name, address and date of birth. Must include a copy of a current photographic identification card, such as license, or ID card number	x	x	x
Primary caregiver name, address and date of birth. Must include a copy of a current photographic identification card, such as license, or ID card number	x	x	x
Sworn caregiver statement on department form regarding lack of felony drug conviction, not on probation or parole, and over 21		x	
Address of site where marijuana will be produced	x		x
Annual renewal for registry card	x	x	x
Minors: parents declaration form and agreement to serve as minor's caregiver	x (must be notarized)	x	x
Registration fee	$150	$25 first time $20 renewal	$25
Registry Verification Procedures			
Doctor has a valid license in state	x	x	x
Verification call or letter sent to doctor re: recommendation	x	x[e]	x
Patient contacted to validate application information	x	x[e]	x
Caregiver contacted to validate application information	x[e]	x[e]	x[e]
Registry checked to assure caregiver only serves one patient		x	

[a]A legible written statement with all the form information included will be accepted.

[b]Attending physician completes a state declaration form that the person has been diagnosed with a debilitating medical condition and that the medical use of marijuana may mitigate the symptoms or effects of the patient's condition, or applicant provides medical records of debilitating condition signed by physician that contains all information required on physician form.

[c]Signed physician statement that the patient was examined within bona fide relationship and is diagnosed with a debilitating medical condition, other medications were considered and that patient might benefit from marijuana.

[d]Signed statement that in the physician's opinion, the qualifying patient has a debilitating medical condition and the potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient, OR medical records with same information.

[e]Agency officials verify when they believe it is appropriate.

Source: Oregon, Alaska, and Hawaii medical marijuana state statutes, administrative rules and program officials.

California's statute does not establish a state registry or require that a person or caregiver be registered to qualify for a medical use exception. California's law requires that medical use has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana for certain symptoms or conditions. The exception applies based "upon the written or oral recommendation or approval of a

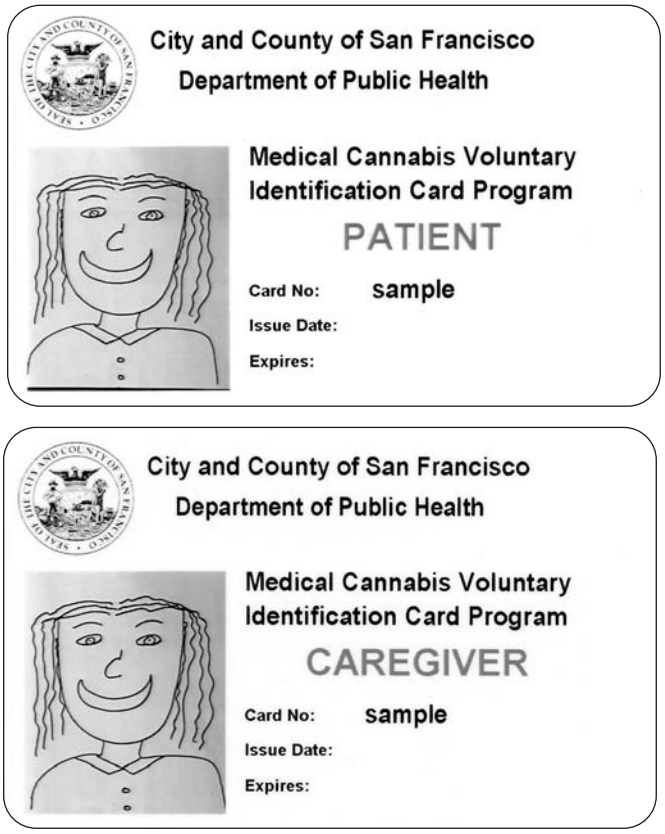
physician." After the medical marijuana law was passed, the California Attorney General assembled a task force to discuss implementation issues in light of the "ambiguities and significant omissions in the language of the initiative." The task force recommended a statewide registry be created and administered by the Department of Health Services, among other things, to clarify California's law.[19] However, a bill incorporating many of the ideas agreed upon by the task force was not enacted by the California legislature.[20]

Some California communities have created voluntary local registries to provide medical marijuana users with registry cards to document that the cardholder has met certain medical use requirements. Figure 2 provides examples of patient and caregiver registry cards issued by San Francisco's Department of Public Health. (See the following section for a discussion of caregivers.)

[19]Office of the Attorney General, State of California, Department of Justice, *Medical Marijuana Task Force* (July 12, 1999). Other recommendations included requiring that the patient's personal physician make the marijuana recommendation, and allowing cooperative marijuana cultivation.

[20]California Senate Bill 187, 2001-2002 Reg. Sess. The bill was introduced by California Senator Vasconcellos on February 7, 2001.

Figure 2: Example of San Francisco's Medical Marijuana Registry Cards



Source: San Francisco Department of Public Health.

According to a September 2000 letter by the California Attorney General, medical marijuana policies have been created in some counties. Local registries have been created in Humboldt, Mendocino, San Francisco, and Sonoma counties. A medical marijuana registry in the city of Arcata, located in Humboldt County, was discontinued, however, the Arcata police department accepts registry cards from Humboldt County. A more recent list of medical marijuana registries operated by a county or city was not available, an official with the Attorney General's office said, because there is no requirement for counties or cities to report on provisions they adopt regarding medical use of marijuana. At least two counties have since approved development of county medical marijuana registries, in San Diego in November 2001, and in Del Norte, in April 2002. Several cannabis buyers' clubs, or cannabis cooperatives may have also established voluntary registries of their members.

(Appendix III provides additional discussion on state registry procedures in Oregon, Alaska, and Hawaii, procedures in selected California county registries, and examples of registry cards.)

Medical Marijuana Patient Primary Caregivers

Laws in Oregon, Alaska, Hawaii, and California allow medical marijuana users to designate a primary caregiver. To qualify as a caregiver in the registry states, persons must be part of the state registry and be issued medical marijuana cards. Registered caregivers may assist registrants in their medical use of marijuana without violating state criminal laws for possession or cultivation of marijuana, within the allowed medical use amounts. Alaska allows registrants to designate a primary and alternate caregiver. Both must submit a sworn statement that they are at least 21 years old, have not been convicted of a felony drug offense, and are not currently on probation or parole. In Hawaii and Alaska, caregivers can serve only one patient at a time. Alaska, however, allows exceptions for patients related to the caregiver by blood or marriage, or with agency approval, such as circumstances where a patient resides in a licensed hospice program. Oregon does not specify a limit to the number of patients one caregiver may serve. Table 2 provides information on definitions and caregiver provisions in Oregon, Alaska, and Hawaii.

Table 2: Definition and Provisions Regarding Caregivers in Oregon, Alaska and Hawaii

	Oregon	Alaska	Hawaii
Definition of Caregiver	"Designated primary caregiver" means an individual eighteen years of age or older who has significant responsibility for managing the well-being of a person who has been diagnosed with a debilitating medical condition and who is designated as such on that person's application for a registry identification card or in other written notification to the division. Designated primary caregiver does not include the person's attending physician.	"Primary caregiver" means a person listed as a primary caregiver (in the state medical use registry) and in physical possession of a caregiver registry identification card: "primary caregiver" also includes an alternate caregiver when the alternate caregiver is in physical possession of the caregiver registry identification card. "Alternate caregiver" means a person who is listed as an alternate caregiver (in the state medical use registry).	"Primary caregiver" means a person, other than the qualifying patient and the qualifying patient's physician, who is eighteen years of age or older, and who has agreed to undertake responsibility for managing the well-being of the qualifying patient with respect to the medical use of marijuana.
Limit to number of caregivers per patient	1	2 (a primary and an alternate)	1
Limit to number of patients per caregiver	Not specified	1 (exceptions may be granted by state agency)	1
Criminal record restriction on serving as caregiver	Not specified	Yes	Not specified

Source: Oregon, Alaska, and Hawaii medical marijuana statutes and administrative rules.

California's statute also allows qualified medical marijuana users to designate a primary caregiver. The statue defines "primary caregiver" to mean "the individual designated by the person exempted under this section who has consistently assumed responsibility for the housing, health or safety of that person." There is no requirement that the patient–caregiver relationship be registered or otherwise documented, nor is there a specified limit to the number of patients that can designate a particular caregiver.

Physician Recommendation Requirements

In all four states, patients must obtain a physician's diagnosis that he or she suffers from a medical condition eligible for marijuana use under that state's statute, and a physician recommendation for the use of marijuana. California does not have a requirement that the diagnosis or recommendation be documented, as the other states do. In the registry states, patients must supply written documentation of their physician's medical determination and marijuana recommendation in their registry applications. This documentation must conform with program requirements, reflecting that the physician made his or her

recommendation in the context of a bona fide physician-patient relationship.

California's law does not require patients to submit documentation of a physician's determination or recommendation to any state entity, nor does it specify particular examination requirements. According to California's law, marijuana may be used for medical purposes "where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana" in treating certain medical conditions; such recommendations may be oral or written.

The physician certification form adopted by Hawaii's Department of Public Safety calls for doctors recommending marijuana to a patient to certify that "I have primary responsibility for the care and treatment of the named patient and based on my professional opinion and having completed a medical examination and/or full assessment of my patient's medical history and current medical condition in the course of a bona fide physician-patient relationship have issued this written certificate." Similarly in Alaska, the recommending physician signs a statement that they personally examined the patient on a specific date, and that the examination took place in the context of a bona fide physician-patient relationship.

Under Oregon's medical marijuana law, the patient's attending physician must supply physician documentation. Oregon's administrative rules defining "attending physician" were amended in March 2002 to more fully describe the conditions for meeting the definition. To qualify, the physician must have established a physician-patient relationship with the patient and must diagnose the patient with a debilitating condition in the context of that relationship.[21] Agency officials stated that they changed the definition of an attending physician in light of information that one doctor responsible for many medical marijuana recommendations had not

[21]As provided in Ore. Admin. R. 333-008-0010, an attending physician is "a physician who has established a physician/patient relationship with the patient, is licensed under ORS chapter 677, and who, with respect to a patient diagnosed with a debilitating medical condition: (a) Is primarily responsible for the care and treatment of the patient; (b) Is primarily responsible for recognized, medical specialty care and treatment of the patient; (c) Has been asked to consult and treat the patient by the patient's primary care physician; or (d) Has reviewed a patient's medical records at the patient's request, has conducted a thorough physical examination of the patient, has provided a treatment plan and/or follow-up care, and has documented these activities in a patient file. "

followed standard physician-patient practices, such as keeping written patient records. (See physician section.) Under its regulations, the Department of Human Services will contact each physician making a medical marijuana recommendation to assure that the physician is an "attending physician" and, with patient approval, the department may review the physician's patient file in connection with this inquiry.

Qualifying State Conditions for Use of Medical Marijuana

The laws in all four states we reviewed identify medical conditions[22] for which marijuana may be used for medical purposes. Table 3 displays the allowed medical conditions for which marijuana may be used in each state. (See appendix IV for descriptions from general medical sources of the allowable conditions identified by the state laws.)

Table 3: Allowable Conditions for Medical Marijuana Use in Four States

Conditions[a]	Oregon	Alaska	Hawaii	California
Cancer	x	x	x	x
Glaucoma	x	x	x	x
HIV positive status	x	x	x	
AIDS	x	x	x	x
Cachexia	x	x	x	
Wasting syndrome			x	
Anorexia				x
Epilepsy and other seizure disorders	x	x	x	
Multiple sclerosis and other disorders characterized by persistent muscle spasticity	x	x	x	x
Crohn's disease			x	
Alzheimer's disease	x			
Arthritis				x
Migraine				x
Severe pain	x	x	x	
Chronic pain				x
Severe nausea	x	x	x	
Any other illness for which marijuana provides relief[b]				x

[a]Oregon's, Alaska's, and Hawaii's medical marijuana statutes use the term "debilitating medical condition" to encompass the conditions eligible for medical marijuana use. California's statute does not use this term, but simply lists the eligible conditions.

[b]California's statute does not define "any other illness for which marijuana provides relief."

[22]For simplicity, we use the general term medical "condition" to encompass, diseases, symptoms, and medical conditions.

Source: California, Oregon, Alaska and Hawaii medical marijuana statutes and Oregon administrative rules.

Allowable Amounts of Marijuana for Medical Use

Statutes in Oregon, Alaska, and Hawaii define the maximum amount of marijuana and the number of plants that an individual registrant and their caregiver may possess under medical marijuana laws, while California's statute does not provide such definitions. Oregon and Hawaii regulations also provide definitions of marijuana plant maturity. Table 4 provides the definitions of quantity and maturity for each registry state.

Table 4: Permissible Amounts of Medical Marijuana and Plant Maturity in Oregon, Alaska, and Hawaii

	Oregon	Alaska	Hawaii
Allowable amount	A patient and a designated primary caregiver may not individually or collectively possess more than three mature plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant, if present at a location at which marijuana is produced, including any residence associated with that location. If not at a location where marijuana is produced, including any residence associated with that location, the allowable amount is one ounce of usable marijuana.[a]	A patient, primary caregiver or alternate caregiver may not possess in the aggregate more than one ounce of marijuana in usable form; and six marijuana plants, with no more than three mature and flowering plants producing usable marijuana at any one time.	"Adequate Supply" means an amount of marijuana jointly possessed between the qualifying patient and the primary caregiver that is not more than is reasonably necessary to assure the uninterrupted availability of marijuana for the express purpose of alleviating the symptoms or effects of a qualifying patient's debilitating medical condition; provided that the "adequate supply" jointly possessed by the qualifying patient and the primary caregiver not exceed three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant.
Plant maturity	"Mature plant" means the following: A marijuana plant shall be considered mature when male or female flower buds are readily observed on the plant by unaided visual examination. Until this sexual differentiation has taken place, a marijuana plant will be considered immature.	Not specified	"Immature marijuana plant" means a marijuana plant, whether male or female, that has not yet flowered and which does not yet have buds that are readily observed by unaided visual examination. "Mature plant" means a marijuana plant, whether male or female, that has flowered and which has buds that are readily observed by unaided visual examination.

[a]Registered patients and caregivers in Oregon who exceed the act's quantity restrictions are not immune from prosecution, but may establish an "affirmative defense" in a marijuana prosecution that the greater amount is medically necessary to mitigate the symptoms or effects of the patient's debilitating medical condition. Ore. Rev. Stat. 475.306(2).

Source: Oregon, Alaska, and Hawaii medical marijuana statutes and administrative rules.

California's statute does not specify an amount of marijuana allowable under medical use provisions; however, some local jurisdictions have established their own guidelines. The statute's criminal exemption is for "personal medical purposes" but does not define an amount appropriate

for personal medical purposes. The California Attorney General's medical marijuana task force debated establishing an allowable amount but could not come to a consensus on this issue, proposing that the Department of Health Services determine an appropriate amount. Participants did agree that the amount of marijuana a patient may possess might well depend on the type and severity of illness. They concluded that an appropriate amount of marijuana was ultimately a medical issue, better analyzed and decided by medical professionals. In the absence of state specified amounts, a number of the state's 58 counties and some cities have informally established maximum allowable amounts of marijuana for medical purposes. According to the September 2000 summary by the California Attorney General's office, the amount of marijuana an individual patient and their caregiver were allowed to have varied, with a two-plant limit in one area, and a 48 plant (indoors, with mature flowers) limit in another area. In May 2002, Del Norte County raised their limit from 6 plants to 99 plants per individual patient.

Safety and Public Use Restrictions

California, Oregon, Alaska, and Hawaii prohibit medical marijuana use in specific situations relating to safety or public use. Patients or caregivers who violate these prohibitions are subject to state marijuana sanctions and, in the registry states, may also forfeit their registry cards.[23] Table 5 reflects the various states' safety or public use restrictions.

[23]Alaska's statute provides a one-year suspension from using or obtaining a registry card; Oregon's statute provides up to a 6-month suspension from using or obtaining a registry card; Hawaii's rules provide for revocation of the registry certificate for an indefinite time.

Table 5: Safety and Public Use Restrictions in Oregon, Alaska, Hawaii and California

	Oregon	Alaska	Hawaii	California
Safety restrictions	Oregon's medical marijuana statute prohibits driving under the influence of marijuana.	Alaska's medical marijuana statute prohibits medical use of marijuana that endangers the health or well-being of any person.	Hawaii's medical marijuana statute prohibits medical use of marijuana that endangers the health or well-being of another person.	California's medical marijuana statute provides that, "Nothing in this section shall be construed to supersede legislation prohibiting persons from engaging in conduct that endangers others, nor to condone the diversion of marijuana for nonmedical purposes."
Public use restrictions	Oregon's medical marijuana statute prohibits patients and caregivers from engaging in the medical use of marijuana in public places as defined in Ore. Rev. Stat. 161.015,[a] or in public view or in a correctional facility as defined in Ore. Rev. Stat. 162.135(2) or youth correction facility as defined in Ore. Rev. Stat 162.135(6).	Alaska's medical marijuana law prohibits the medical use of marijuana in plain view of, or in a place open to, the general public. The law also states that medical marijuana use need not be accommodated in any place of employment; in any correctional facility, medical facility, or facility monitored by the Alaska Department of Administration; on or within 500 feet of school grounds; at or within 500 feet of a recreation or youth center; or on a school bus.	Hawaii's medical marijuana statute prohibits the medical use of marijuana in a school bus, public bus, or any moving vehicle; in the workplace of one's employment; on any school grounds; at any public park, public beach, public recreation center, recreation or youth center; or other place open to the public.	(not specified)

[a]As defined in Ore. Rev. Stat. 161.015, a public place means a place to which the general public has access including, but not limited to, hallways, lobbies and other parts of apartment houses and hotels not constituting rooms or apartments designed for actual residence, and highways, streets, schools, places of amusement, parks, playgrounds and premises used in connection with public passenger transportation.

Source: California, Oregon, Alaska and Hawaii state statutes.

Management Review Results in Oregon Program Changes

Oregon was the only state of the four we reviewed to have conducted a management review of their state's medical marijuana program.[24] The Oregon Department of Human Services conducted the review after concerns arose that a doctor's signature for marijuana recommendations had been forged. The review team reported a number of program areas needing improvement, and proposed a corrective plan of action. Most of

[24]"Oregon's Medical Marijuana Program: A Management Review" Oregon Department of Human Services, June 11, 2001.

the actions had been completed, as of May 2002. Lack of verification of physician signature was a key problem identified by the team. All physician signatures are now verified. A number of other team findings had to do with program management and staffing. The Program Manager was replaced, additional staff was added, and their roles were clarified, according to officials. Another area of recommendation was the processing of applications and database management, such as how to handle incomplete applications, handling of voided applications, edit checks for data entry, and reducing the application backlog. As of May 2002, some action items were still open, such as computer "flags" for problem patient numbers or database checks on patients and caregivers at the same address.

Few Registrants, Most with Severe Pain or Muscle Spasms

A relatively small number of people are registered as medical marijuana users in Oregon, Hawaii, and Alaska. In those states, most registrants were over 40 years old. Severe pain and muscle spasms (spasticity) were the most common medical conditions for which marijuana was recommended in the states where data was gathered.

Small Number of Medical Marijuana Registrants

Relatively few people are registered as medical marijuana users in Alaska, Hawaii and Oregon. In these states, registry data showed that the number of participants registered was below 0.05 percent or less of the total population of each respective state. Data doesn't exist to identify the total population of people with medical conditions that might qualify for marijuana use because not all the conditions specified in the state's laws are diseases for which population data is available. For example, a debilitating condition of "severe pain" may be a symptom for a number of specific medical conditions, such as a back injury, however not all patients with back injury suffer severe pain. Table 6 shows the number of patients registered in Oregon, Hawaii, and Alaska, at the time of our review as compared to the total population from the U.S. Census Bureau population projections for 2002.

Table 6: Medical Marijuana Registrants in Oregon, Hawaii, and Alaska, by Projected 2002 State Population

State	State population	Number of registrants	Percent of registrants by state population
Oregon	3,488,000	1,691	0.05
Hawaii	1,289,000	573	0.04
Alaska	672,000	190	0.03
Totals	**5,449,000**	**2,454**	**0.05**

Note: Oregon data as of February 2002, Alaska and Hawaii data as of April 2002.

Source: Oregon, Hawaii, and Alaska state medical marijuana registries and U.S. Bureau of the Census population projections for 2002.

There is no statewide data on participants in California because the medical marijuana law does not provide for a state registry. We obtained information from four county registries in San Francisco, Humboldt, Mendocino and Sonoma counties.[25] In each of these registries, participation was 0.5 percent or less than the respective county's population. However, because the local registries are voluntary it is unknown how many people in those jurisdictions have received medical recommendations from their doctors for marijuana but have not registered.

Table 7 shows the number of patients registered in four California counties and as a percent of the population for those counties, since each registry was established.

[25]Sonoma County does not maintain a "registry" of approved medical marijuana users, but is included because it does have records of county patients whose doctors have recommended marijuana using Sonoma County Medical Association peer review process.

Table 7: Registrants in Four California Counties by County Population

Registrant source	County population	Number of registrants	Percent of registrants by county population
San Francisco Department of Public Health	793,729	3551	0.44
Sonoma County Medical Association	468,754	435	0.09
Humboldt County Department of Public Health	127,754	182	0.14
Mendocino County	87,273	430	0.49

Note: San Francisco and Sonoma county data as of July 2002, Humboldt county data as of January 2002, and Mendocino county data as of April 2002.

Sources: California State Association of Counties (as of January 2002), and California medical marijuana county registries.

Medical Marijuana Registrant Demographics

Most medical marijuana registrants in Hawaii and Oregon—the states where both gender and age data were available—were males over 40 years old. Hawaii and Oregon were the only states that provided gender information; in both cases approximately 70 percent of registrants were men. In Alaska, Hawaii, and Oregon state records showed that over 70 percent of all registrants in each state were 40 years of age or older. Only in one state was there a person under the age of 18 registered as a medical marijuana user. Table 8 shows the distribution of registrants by age in the registry states.

Table 8: Registrant Age in Alaska, Hawaii and Oregon

(Percent in each age category)			
Age	**Alaska**	**Hawaii**	**Oregon**
Under 18	1 (1%)	0	0
19-29	10 (5%)	16 (3%)	145 (9%)
30-39	42 (22%)	70 (12%)	247 (15%)
40-49	84 (44%)	197 (34%)	613 (36%)
50-59	42 (22%)	216 (38%)	550 (33%)
Over 60	11 (6%)	74 (13%)	136 (8%)
Total	**190**	**573**	**1691**

Note: Oregon data as of February 2002, Alaska and Hawaii data as of April 2002.

Source: Medical Marijuana registries in Alaska, Hawaii and Oregon.

In California, none of the local jurisdictions we met with kept information on participants' gender, and only Sonoma County Medical Association provided information on their registrants' age. The age of medical association registrants was similar to participants in the state registries, only slightly younger. Over 60 percent of participants that have had their records reviewed by medical associations were 40 years or older.

Medical Marijuana Registrant Conditions

Most medical marijuana recommendations in states where data are collected have been made for applicants with severe pain or muscle spasticity as their medical condition. Conditions allowed by the states' medical marijuana laws ranged from illnesses such as cancer and AIDS, to symptoms, such as severe pain. Information is not collected on the conditions for which marijuana has been recommended in Alaska or California. However, data from Hawaii's registry showed that the majority of recommendations have been made for the condition of severe pain or the condition of muscle spasticity. Likewise, data from Oregon's registry showed that, 84 percent of recommendations were for the condition of severe pain or for muscle spasticity. Table 9 shows the number and percentage of patients registered by types of conditions in Oregon and Hawaii.

Table 9: Registrant Conditions in Oregon and Hawaii

	Oregon		Hawaii	
	Number of recommendations per condition	Percent with condition	Number of recommendations per condition	Percent with condition
Cancer	43	3	9	2
Glaucoma	31	2	10	2
HIV positive status or AIDS	47	3	66	12
Cachexia	18	1	-	-
Cachexia or wasting syndrome	-	-	9	2
Epilepsy and other seizure disorders	43	3	5	1
Multiple Sclerosis and other disorders characterized by persistent muscle spasms, or spasticity	459	28	240	43
Alzheimer's disease	1	Under 1	-	-
Severe pain	915	56	172	31
Severe nausea	83	5	12	2
Severe nausea/severe pain	-	-	31	6
Total	**1640**[a]		**554**[b]	

Note: Oregon data as of February 2002, Hawaii data as of March 2002.

[a]Information on 51 cases not available.

[b]The number of registrants for Hawaii differs in tables 8 and 9 due to differences in the reporting dates.

Source: Oregon and Hawaii medical marijuana registries.

On the basis of records from the Oregon registry, we reviewed the information provided by doctors for additional insight into the conditions for which registrants use marijuana. The Oregon registry keeps track of secondary conditions in cases where the recommending doctor specified more than one condition. We examined the pool of secondary conditions associated with severe pain[26] and muscle spasms,[27] the two largest condition categories. About 40 percent of those with severe pain reported muscle spasms, migraines, arthritis, or nausea as a secondary medical condition. The most common secondary conditions reported by those with

[26]Of the 915 registrants that reported severe pain as their primary condition, over half reported only one secondary condition, some included up to five secondary conditions. The percentages reported here include those with only one secondary condition.

[27]Of the 459 registrants that reported spasms as a primary condition over 40 percent reported only one secondary condition, some included up to four secondary conditions. The percentages reported here include those with only one secondary condition.

spasms were pain, multiple sclerosis, and fibromyalgia,[28] accounting for 37 percent of the secondary conditions for spasms. A variety of other secondary conditions were identified in the Oregon data, such as acid reflux, asthma, chronic fatigue syndrome, hepatitis C, and lupus.

Few Physicians Make Marijuana Recommendations; Some Guidance Available

In the two states, Hawaii and Oregon, where data on physicians is maintained, few physicians have made medical marijuana recommendations. Of the pool of recommending physicians in Oregon, most physicians made only one to two recommendations. Over half of the medical organizations we contacted provide written guidance for physicians considering recommending marijuana.

Low Physician Participation

Only a small percentage of physicians in Hawaii and Oregon were identified by state registries as having made recommendations for their patients to use marijuana as medicine. These two states maintain information on recommending physicians in their registry records. No information was available on physician participation in California and Alaska. In Hawaii, at the time of our review, there were 5,673 physicians licensed by the state's medical board. Of that number, 44 (0.78 percent) physicians had recommended marijuana to at least one of their patients since the legislation was passed in June 2000. In Oregon, at the time of our review, 435 (3 percent) of the 12,926 licensed physicians in the state had participated in the medical marijuana program since May 1999.

Both Hawaii and Oregon's medical marijuana registration programs are relatively new, which may account for the low level of participation by physicians in both states. Oregon's program has operated for a year longer than Hawaii's, however physician participation overall is low in both states. A Hawaii medical association official told us that he believes physicians consider a number of factors when deciding whether to recommend marijuana as medicine, such as the legal implications of recommending marijuana, lack of conclusive research results on the drug's medical efficacy, and a doctor's own philosophical stance on the use of marijuana as medicine.

[28]Fibromyalgia: Chronic pain, stiffness, and tenderness of muscles, tendons, and joints without detectable inflammation. Fatigue and sleep disorders are common in fibromyalgia patients.

The lower federal courts are divided in terms of whether doctors can make medical marijuana recommendations without facing federal enforcement action, including the revocation of doctors' DEA registrations that allow them to write prescriptions for federally controlled substances. In one case, the district court for the Northern District of California held that the federal government could not revoke doctors' registrations, stating that the de-registration policy raised "grave constitutional doubts" concerning doctors' exercise of free speech rights in making medical marijuana recommendations.[29] In the other case considering this issue, the district court for the District of Columbia ruled that the federal government could revoke doctors' registrations, stating that "[e]ven though state law may allow for the prescription or recommendation of medicinal marijuana within its borders, to do so is still a violation of federal law under the CSA," and "there are no First Amendment protections for speech that is used 'as an integral part of conduct in violation of a valid criminal statute."[30]

Oregon is the only state we reviewed which has registry records that identify recommendations by doctor. Few Oregon physicians made recommendations to use medical marijuana to more than two patients. According to registry data, 82 percent of the participating physicians made one or two recommendations, and 18 percent made three or more recommendations. Table 10 shows a breakdown of the frequency by which physicians made marijuana recommendations.

[29]*See Conant v. McCaffrey*, No. C-97-00139, 2000 U.S. Dist. LEXIS 13024 at *19 (N.D. Cal. Sept. 7, 2000) (permanent injunction granted); *see also Conant v. McCaffrey*, 172 F.R.D. 681 (N.D. Cal. 1997) (preliminary injunction granted). On October 29, 2002, the Ninth Circuit Court of Appeals affirmed, finding that the district court convincingly explained how the government's professed enforcement policy threatened to interfere with doctors' First Amendment rights. *See Conant v. Walters*, No. 00-17222, 2002 U.S. App. LEXIS 22942 at *2 (9th Cir. Oct. 29, 2002)

[30]*See Pearson v. McCaffrey*, 139 F. Supp. 2d 113, 121 (D.D.C. 2001).

Table 10: Number of Marijuana Recommendations Made by Oregon Physicians, as of February 2002

Number of recommendations	Number of physicians making recommendations	Percentage of recommending physicians
1	269	61.8
2	87	20.0
3	33	7.6
4	22	5.1
5	8	1.8
6	2	0.5
7	2	0.5
9	2	0.5
10	1	0.2
11	1	0.2
12	1	0.2
13	2	0.5
14	1	0.2
18	1	0.2
23	1	0.2
38	1	0.2
823	1	0.2

Source: Oregon Department of Human Services.

State or law enforcement officials in Oregon, California, and Hawaii indicated that they were each aware of a particular physician in their state that had recommended marijuana to many patients.[31] In Alaska, a state official knew of no physician that had made many recommendations. In Oregon and California the state medical boards have had formal complaints filed against these physicians for alleged violations of the states' Medical Practices Acts, which establish physician standards for medical care. The complaints charge the physicians with unprofessional conduct violations such as failure to conduct a medical examination, failure to maintain adequate and accurate records, and failure to confer with other medical care providers. In Oregon, the physician

[31]Program officials in the registry states verify that a physician recommendation has been made in accordance with program requirements, and that the physician is licensed; they are not authorized to determine whether a doctor's recommendation is medically appropriate.

recommending marijuana to over 800 patients was disciplined.[32] The California case was still pending. At the time of our review, there was no medical practice complaint filed against the Hawaiian doctor known to have made many marijuana recommendations.

Physician Guidance for Making Medical Marijuana Recommendations

In all four states, professional medical associations provide some guidance for physicians in regards to recommending marijuana to patients. State medical boards, in general, have limited involvement in providing this type of guidance. Table 11 indicates the type of guidance available from these medical organizations in each state.

Table 11: Doctor Guidance Provided by Selected State Medical Organizations

State Medical Organizations	Guidance provided	Description
Oregon State Board of Medical Examiners	No	
Oregon Medical Association	Yes	The association has a document informing members of the legal issues facing doctors and advising them on doctor-patient discussions and documentation concerning the use of marijuana for medicine, and actions to avoid.
Alaska State Medical Board	No	
Alaska Medical Association	Yes	Those inquiring about recommending marijuana are directed to seek legal counsel.
Hawaii State Board of Medical Examiners	No	
Hawaii Medical Association	Yes	Those inquiring about recommending marijuana are informed of the association's official position against medical marijuana and advised of the legal implications involved.
Medical State Board of California	Yes	The board has a document that describes the standards physicians recommending marijuana should apply to their practice and advises them on how to best protect themselves.
California Medical Association	Yes	The association provides a document covering the legal issues facing doctors, doctor-patient discussions and documentation concerning the use of marijuana for medicine, actions to avoid, and other topics under the law that may be of concern to physicians.

Note: Guidance provided as of the time of our review.

Source: State Medical Boards and Medical Associations in Oregon, Alaska, Hawaii, and Oregon.

The guidance to physicians considering recommending marijuana to a patient in Oregon, for example, includes avoiding engaging in any

[32]The April 2002 order by the Oregon Board of Medical Examiners reprimanded the physician, fined him $5,000, suspended his license for 90 days, and specified conditions under which any future marijuana recommendations would be made, and other disciplinary actions.

discussions with a patient on how to obtain marijuana, and to avoid providing a patient with any written documentation other than that in the patient's medical records. The medical association also advises physicians to clearly document in a patient's medical records conversations that take place between the physician and patient about the use of marijuana as medicine. Oregon's medical association notes that until the federal government advises whether it considers a physician's medical marijuana recommendation in a patient chart to violate federal law, no physician is fully protected from federal enforcement action.

Most of the state medical board officials we contacted stated that the medical boards do not provide guidance for physicians on recommending marijuana to patients. The medical boards do become involved with physicians making marijuana recommendations if a complaint for violating state medical practices is filed against them. Once a complaint is filed, the boards investigate a physician's practice. Any subsequent action occurs if the allegations against a doctor included violations of the statutes regulating physician conduct.

California medical board's informal guidance states that physicians recommending marijuana to their patients should apply the accepted standards of medical responsibility such as the physical examination of the patient, development of a treatment plan, and discussion of side effects. In addition, the board warns physicians that their best legal protection is by documenting how they arrived at their decision to recommend marijuana as well as any actions taken for the patient.

Difficult to Measure the Impact of State Medical Marijuana Laws on Law Enforcement Activities

Data are not readily available to show whether the introduction of medical marijuana laws have affected marijuana-related law enforcement activities. Assessing such a relationship would require a statistical analysis over time that included measures of law enforcement activities, such as arrests, as well as other measures that may influence law enforcement activities. It may be difficult to identify the relevant measures because crime is a sociological phenomena influenced by a variety of factors.[33] Local law enforcement officials we spoke with about trends in marijuana law enforcement noted several factors, other than medical marijuana laws, important in assessing trends. These factors included changes in general perceptions about marijuana, shifts in funding for various law

[33]According to the FBI introduction to users of Uniform Crime Report data.

enforcement activities, shifts in local law enforcement priorities from one drug to another, or changes in emphasis from drugs to other areas, such as terrorism. Demographics might also be a factor.

The limited availability of data on marijuana-related law enforcement activity illustrates some of the difficulties in doing a statistically valid trend analysis. To fully assess the relationship between the passage of state's medical marijuana laws and law enforcement, one would need data on marijuana related arrests or prosecutions over some period of time, and preferably an extended period of time. Although state-by-state data on marijuana-related arrests is available from the FBI Uniform Crime Reports (UCR), at the time of our review, only data up to the year 2000 was available. Yearly data would be insufficient for analytic purposes since the passage of the medical marijuana initiatives or law in three of the states—Oregon (November 1998), Alaska (November 1998), and Hawaii (June 2000)—is too recent to permit a rigorous appraisal of trends in arrests and changes in them.[34] Furthermore, although California's law took effect during 1996 providing a longer period of data, it is also important to note that the FBI cautions about UCR data comparisons between time periods because of variations in year-to-year reporting by agencies.[35]

Similar data limitations would occur using marijuana prosecutions as a measure of trends in law enforcement activity. Data on marijuana prosecutions are not collected or aggregated at the federal level by state. At the state level, for the four states we reviewed, the format for collecting the data, or time period covered also had limitations. For example in California, the state maintains "disposition" data that includes prosecutions, but reflects only the most serious offenses, so that marijuana possession that was classified as a misdemeanor would not be captured if the defendant was also charged with possession of other drugs, or was involved with theft or other non-misdemeanor crimes. Further, the data is grouped by the year of final disposition, not when the offense

[34]Programs to implement the laws in Oregon, Alaska and Hawaii were developed somewhat later. Alaska's registry was established in June 1999, Oregon's program began operating in May 1999, and Hawaii issued its first card in January 2001.

[35]As described in the methodology section of UCR's annual publication, *Crime in the United States* (2000) UCR excludes trend statistics if the reporting units have not provided comparable data for the periods under consideration, or when it is ascertained that unusual fluctuations, such as improved record keeping or annexations are involved. Although most law enforcement agencies submit crime reports to the UCR program, data are sometimes not received for complete annual periods. If data on other factors was available for California to analyze the relationship of its medical marijuana law and arrests, one would also need to assess the comparability of arrest data from different time periods.

occurred. Hawaii does not have statewide prosecution data. At the time of our review, prosecution data from Oregon's statewide Law Enforcement Data System was only available for 1999 and 2000.

Perceptions of Officials with Selected Law Enforcement Organizations Regarding the Impact of Medical Marijuana Laws

We interviewed officials from 37 selected federal, state, and local law enforcement organizations in the four states to obtain their views on the effect, if any, state medical marijuana laws had on their law enforcement activities. Officials representing 21 of the organizations we contacted indicated that medical marijuana laws had had little impact on their law enforcement activities for a variety of reasons, including very few or no encounters involving medical marijuana registry cards or claims of a medical marijuana defense. For example:

- The police department on one Hawaiian island had never been presented a medical marijuana registry card, and only 15 registrants lived on the island.
- In Alaska, a top official for the State Troopers Drug Unit had never encountered a medical marijuana registry card in support of claimed medical use.
- In Oregon, one district attorney reported having less than 10 cases since the law was passed where the defendant presented a medical marijuana defense.[36]
- In Los Angeles County, an official in the District Attorney's office stated that only three medical marijuana cases have been filed in the last two years in the Central Branch office, two of the cases involving the same person.

Some of the federal law enforcement officials we interviewed indicated that the introduction of medical marijuana laws has had little impact on their operations. Senior Department of Justice officials said that the Department's overall policy is to enforce all laws regarding controlled substances, however they do have limited resources. Further, the federal process of using a case-by-case review of potential marijuana prosecutions has not changed as a consequence of the states' medical marijuana laws. These officials said that U.S. Attorneys have their own criteria or guidelines for which cases to prosecute that are based on the Department's overall strategies and objectives.

[36]The District Attorney noted that they had won these cases because the defendants were not operating within the parameters of the state medical marijuana law.

Law enforcement officials in the selected states also told us that, given the range of drug issues, other illicit drug concerns, such as rampant methamphetamine abuse or large-scale marijuana production are higher priorities than concerns about abuse of medical marijuana. In at least one instance, this emphasis was said to reflect community concerns—in Hawaii, one prosecuting attorney estimated that one-third to one-half of the murders and most hostage situations in the county involved methamphetamines. He said businesses ask why law enforcement is bothering with marijuana when they have methamphetamines to deal with.

Although many of the officials with other organizations we contacted did not clearly indicate whether medical marijuana laws had, or had not, had major impact on their activities, officials with two organizations said that medical marijuana laws had become a problem from their perspective. Specifically, an official with the Oregon State Police Drug Enforcement Section said that during 2000 and 2001, there were 14 cases in which the suspects had substantial quantities of processed or growing marijuana and were arrested for distribution of marijuana for profit, yet were able to obtain medical marijuana registry cards after their arrests. Because the same two defense attorneys represented all the suspects, the police official expressed his view that the suspects might have been referred to the same doctor, causing the official to speculate about the validity of the recommendations. In Northern California—an area where substantial amounts of marijuana are grown[37]—officials with the Humboldt County Drug Task Force[38] told us that they have encountered growers claiming to be caregivers for multiple medical marijuana patients. With a limit of 10 plants per person established by the Humboldt County District Attorney, growers can have hundreds of plants officials said, and no documentation to support their medical use claims is required.[39]

Over one-third of officials from the 37 law enforcement organizations told us that they believe that the introduction of medical marijuana laws have, or could make it, more difficult to pursue or prosecute some marijuana

[37]According to the senior DEA official for the area, three northern counties are the source region for much of the domestically produced marijuana in the United States, and this production is a major contributor to the local economies.

[38]Headed by a Commander from the California Bureau of Narcotics and staffed by officers from local law enforcement.

[39]The 10 plant limit can be exceeded if the grower claims to grow 10 plants for patient A, 10 plants for patient B, and so on. Documentation of caregiver status is not required under the state's law.

cases. In California, some local law enforcement officials said that their state's medical marijuana law makes them question whether it is worth pursuing some criminal marijuana cases because of concerns about whether they can effectively prosecute (e.g., with no statutory limit on the number of marijuana plants allowed for medical use, the amount consistent with a patient's personal medical purposes is open to interpretation). In Oregon, Hawaii, and Alaska where specific plant limits have been established, some law enforcement officials and district attorneys said that they were less likely to pursue marijuana cases that could be argued as falling under medical use provisions. For example, one Oregon District Attorney stated that because they have limited resources the District Attorneys might not prosecute a case where someone is sick, has an amount of marijuana within the medical use limit, and would probably be approved for a card if they did apply. Officers in Hawaii reported reluctance of a judge to issue a search warrant until detectives were certain that cultivated marijuana was not being grown for medical use, or that the growth was over the 25-plant limit qualifying for felony charges.

Less concrete, but of concern to law enforcement officials were the more subtle consequences attributed to the passage of state medical marijuana laws. Officials in over one-fourth of the 37 law enforcement organizations we interviewed indicated they believe there has been a general softening in public attitude toward marijuana, or public perception that marijuana is no longer illegal. For example, state troopers in Alaska said that they believe that the law has desensitized the public to the issue of marijuana, reflected in fewer calls to report illegal marijuana activities than they once received. Hawaiian officers stated that it is their view that Hawaii's law may send the wrong message because people may believe that the drug is safe or legal.

Several law enforcement officials in California and Oregon cited the inconsistency between federal and state law as a significant problem, particularly regarding how seized marijuana is handled. According to a California Attorney General official, state and local law enforcement officials are frequently faced with this issue if the court or prosecutor concludes that marijuana seized during an arrest was legally possessed under California law, and law enforcement is ordered to return the marijuana. To return it puts officials in violation of federal law for dispensing a Schedule I narcotic, according to the California State Sheriffs' Association, and in direct violation of the court order if they don't return it. The same issue has arisen in Portland, Oregon, officials said, when the Portland police seized 2.5 grams of marijuana from an individual. After the state dismissed charges, the court ordered the return of the marijuana to

the individual, who was a registered medical marijuana user. The city of Portland appealed the court order on grounds that its police officers could not return the seized marijuana without violating federal law, but the Oregon court of appeals rejected this argument in *Oregon v. Kama*.[40] Oregon officials said that DEA then obtained a federal court order to seize the marijuana from the Portland police department. The Department of Justice stated in comments on a draft of this report that they believe conflicts between federal and non-federal law enforcement over the handling of seized marijuana has been and will continue to be a problem.

Law enforcement officials in all four states identified areas of their medical marijuana laws that can hamper their marijuana enforcement activities because the law could be clearer or provide better control. In California, key issues were lack of a definable amount of marijuana for medical use, and no systematic way to identify who qualifies for the exemption. In Oregon, officers were concerned about individuals registering as medical marijuana users after they have been arrested, and timely law enforcement access to the registry information. Officials with about one-fourth of the law enforcement organizations in Hawaii, California and Oregon shared the concern about the degree of latitude given to physicians in qualifying patients for medical use.

Agency Comments and Our Evaluation

We provided a copy of a draft of this report to the Department of Justice for review and comment. In a September 27, 2002 letter, DOJ's Acting United States Assistant Attorney General for Administration commented on the draft. DOJ's comments are summarized below and presented in their entirety in appendix V.

In its comments, DOJ noted that the report fully described the current status of the programs in the states reviewed. However, DOJ stated that the report failed to adequately address some of the serious difficulties associated with such programs. Specifically, according to DOJ, the report

[40]39 P.3d 866 (Or. Ct. App. 2002); *rev. den.*, 47 P.3d 484 (Or. S. Ct. 2002). In *Kama*, the city argued that, because marijuana is a Schedule I controlled substance, its police officers would commit the federal crime of delivering a controlled substance if they returned seized marijuana. The court of appeals disagreed, reasoning that the federal Controlled Substances Act, 21 U.S.C. 885(d), confers immunity on state or local law enforcement officials "lawfully engaged in the enforcement of any law or municipal ordinance relating to controlled substances." The court concluded that, because the officers were required to return the seized marijuana under Oregon's medical marijuana act, Or. Rev. Stat. 475.323(2), federal law granted them immunity for doing so.

does not adequately address, through any considered analysis, issues related to the (1) inherent conflict between state laws permitting the use of marijuana and federal laws that do not; (2) potential for facilitating illegal trafficking; (3) impact of such laws on cooperation among federal, state, and local law enforcement; and (4) lack of data on the medicinal value of marijuana. DOJ further stated that our use of the phrase "medical marijuana" implicitly accepts a premise that is contrary to existing federal law.

In regard to the first issue—state laws that permit the use of marijuana and federal laws that do not—DOJ pointed out that the most fundamental problem with the report is that it failed to emphasize that there is no federally recognized medicinal use of marijuana and thus possession or use of this substance is a federal crime. We disagree, and believe that we have clearly described federal law on the use of marijuana. On page 1 of our report, we specifically state that federal law does not recognize any accepted medical use for marijuana and individuals remain subject to federal prosecution for marijuana possession regardless of state medical marijuana laws.

In other comments about state and federal laws, DOJ also pointed out that our report failed to mention that state medical marijuana laws undermine (1) the closed system of distribution for controlled substances under the Controlled Substances Act and (2) the federal government's obligations under international drug control treaties which, according to DOJ, prohibit the cultivation of marijuana except by persons licensed by, and under the direct supervision of, the federal government. As discussed in our report, the legal framework for our work was the Supreme Court's opinion in *United States v. Oakland Cannabis Buyers Cooperative*, 532 U.S. 483 (2001) which held that the federal government can enforce marijuana prohibitions without regard to a medical necessity defense, even in states with medical marijuana laws. During our review, we saw no reason to expand our analysis beyond that set forth in the Supreme Court's decision. This is especially true since the scope of our work was to examine how the selected states were implementing their medical marijuana laws—not the issues raised in DOJ comments.

Regarding the second issue concerning the potential for illegal trafficking, DOJ commented that our report did not mention that state medical marijuana laws are routinely being abused to facilitate traditional illegal trafficking. DOJ also highlighted the lack of guidance provided by the California state government to implement its medical marijuana law as contributing to the problem in California. Our report discusses the views

of law enforcement officials representing 37 organizations in the four states—including federal officials—regarding the impact of state medical marijuana laws on their law enforcement efforts. Our report presented the views they conveyed to us. Thus, in those instances where law enforcement officials, including representatives of DEA and U.S. Attorneys' offices, discussed what they considered instances of abuse or potential abuse, we discussed it in our report. During our review, none of the federal officials we spoke with provided information to support a statement that abuse of medical marijuana laws was routinely occurring in any of the states, including California. DOJ further asserted that we should include information on the "underlying criminal arena," on homicides related to marijuana cultivation, and on illegal marijuana production and diversion. These issues were beyond the scope of our work.

In regard to its third comment pertaining to cooperation among federal, state, and local law enforcement officials, DOJ stated that our report did not reflect DEA's experience—a worsening of relations between federal, state, and local law enforcement. DOJ's comments provided specific examples of incidents involving conflicts between DEA and non-federal law enforcement officials, but these examples were not provided to us during our fieldwork. In comments on a summary of law enforcement opinions, some of the non-federal law enforcement officials we interviewed also stated we should discuss the conflict between state medical marijuana laws and federal laws as it related to seized marijuana.[41] We modified our draft to include a discussion of these concerns, and have likewise included DOJ's comment. It is also important to note, however, that contrary to DOJ's suggestion, our report included a discussion about the concerns of the law enforcement officials regarding a "softening" of the public perception about marijuana. Finally, DOJ's point that Oregon's medical marijuana law negatively impacts federal seized asset sharing was an issue outside the scope of our review.

In regard to the fourth issue—lack of data on the medicinal value of marijuana—DOJ stated that our discussion of the debate over the medical value of marijuana is inadequate and does not present an accurate picture. We believe our report adequately discusses that a continuing debate exists. The overall objective of our review was to examine the implementation of state medical marijuana laws, and an analysis of the

[41]A summary of law enforcement opinions was sent to those we spoke with for their comments.

scientific aspects of the medical marijuana debate was beyond the scope of our work. We do, however, footnote various studies so that readers can access additional information on the studies if they desire.

Finally, we disagree with DOJ's comment that our use of the term medical marijuana accepts a premise contrary to federal law, given that we specifically defined the term in relation to state, not federal, law. As mentioned earlier, our report specifically states that federal law does not recognize any accepted medical use for marijuana and individuals remain subject to federal prosecution for marijuana possession regardless of state medical marijuana laws. Furthermore, the introduction to the report clearly points out that, throughout the report, we use the phrase medical marijuana to describe marijuana use that qualifies for a medical use exception under state law.

DOJ also provided technical comments, which we have included in this report, where appropriate. In addition, as mentioned earlier, some of the representatives of state law enforcement organizations provided comments on the section of the report dealing with their perceptions, and we have made changes to the report, where appropriate.

As agreed with your office, 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 of this report to the Ranking Minority Member, Subcommittee on Criminal Justice, Drug Policy and Human Resources, and the Chairman and Ranking Minority Member, House Committee on Government Reform; the Chairman and Ranking Minority Member of the House Judiciary Committee; the Chairman and Ranking Minority Member of the Senate Judiciary Committee; the Attorney General; and the Director, Office of Management and Budget. We will also make copies available to others on request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have any questions on this report, please contact me or John Mortin on (202) 512 –8777. Key contributors are acknowledged in appendix V.

Sincerely yours,

Paul Jones
Director, Justice Issues

Appendix I: Objectives, Scope, and Methodology

Objectives

Our overall objectives were to provide fact-based information on how selected states implement laws that create a medical use exception to specified state marijuana prohibitions, and to document the impact of those laws on law enforcement efforts. Specifically, for selected states, our objectives were to provide information on (1) their approach to implementing their medical marijuana laws and how they compare, and the results of any state audits or reviews, (2) the number of patients that have had doctors recommend marijuana for medical use in each state, for what medical conditions, and by age and gender characteristics, (3) how many doctors are known to have recommended marijuana in each, and what guidance is available for making these recommendations, and (4) perceptions of federal and state law enforcement officials, and whether data are available to show how law enforcement activities have been affected by the exceptions provided by these states' medical marijuana laws.

We conducted our review between September 2001 and June 2002 in accordance with generally accepted government auditing standards.

Scope and Methodology: State Selection and Data

Eight states have enacted medical marijuana statutes.[1] We selected four of those states based on the length of time the laws had been in place, the availability of data, and congressional interest. Two of the eight states, Nevada and Colorado, were not selected because their laws had not been in place for at least 6 months when our review began. Another two states, Maine and Washington, were not selected because they do not have state registries to obtain information on program registrants. Alaska, Oregon and Hawaii do have state registries and had laws in place for at least 6 months. California's law was enacted in 1996; however, the state does not have a participant registry. We included it because some local registry information was available, and the requestor specifically requested information on California and Oregon. Our sample consists of these four states: California, Oregon, Alaska, and Hawaii.

We conducted on-site data collection and interviews with senior officials at state registries in Oregon and Hawaii, county offices in selected California counties, and the senior official in Alaska by phone and email. We examined applicable federal and state laws and regulations and

[1]These eight states were identified in the Supreme Court's decision in *United States v. Oakland Cannabis Buyers' Cooperative*, 532 U.S. 483, 502 n.4 (2001).

obtained and analyzed available information on program implementation, program audits, and program participation by patients and doctors.

Data Reliability

State and California county officials voluntarily supplied data on medical marijuana program registrants and some provided data on physician participation. Officials did not provide names to protect participants' confidentiality. We reviewed the data for reasonableness and followed up with appropriate individuals about any questions concerning the data. Given the confidentiality of the information, we could not check the data back to source documents. We also interviewed knowledgeable state and county officials to learn how the data was collected and processed, and to gain a full understanding of the data. We determined the data was reliable enough for the limited purposes of this report. However, the data only reflects those that have registered with state and county programs. No estimate is available on the number of medical marijuana users that have not registered with a program. Additionally, data from the three state registries are not representative of participation in other states for which we did not collect data. Similarly, data from select California counties only reflect each county, not other counties where we did not conduct audit work.

Scope and Methodology: Law Enforcement Opinions

We used a nonprobability sample to select law enforcement representatives to provide examples of the policies, procedures, experiences, and opinions of law enforcement regarding state medical marijuana laws. Our selection of these law enforcement representatives was not designed to enable us to project their responses to others, in this case, other law enforcement officials. Feedback was requested from officials at law enforcement organizations we visited, and incorporated where appropriate.

We discussed state medical marijuana laws with federal, state and local law enforcement officials in the states of California, Hawaii, Oregon and Alaska. On-site interviews were conducted in all but Alaska.[2] Federal officials in each state included representatives from the office of the U.S. Attorney and the Drug Enforcement Administration (DEA). The specific

[2]As a result of phone discussions with law enforcement officials in Alaska, and the low number of registrants in Alaska's medical marijuana program, we decided that interviews could be conducted by email and phone.

U.S. Attorney and DEA office and officials we met with were selected by the Department of Justice as the most knowledgeable on the subject. For a statewide perspective, we interviewed representatives from the Attorney General's office and at least one statewide association in California and Oregon representing law enforcement officials. This included representatives from the following:

Oregon Attorney General
Oregon Association of Chiefs of Police
California Attorney General
California District Attorney Association
California State Sheriff's Association
Hawaii Attorney General
Hawaii Department of Public Safety
Alaska Attorney General
Alaska State Troopers

For a local law enforcement perspective, we interviewed district attorney and local police department officials. Selection was judgmental and based on a number of factors, including: suggestions by federal or state officials, jurisdictions where trips were planned to interview state medical marijuana registry program officials or state officials, or large portions of the state population were covered by the department. Local law enforcement representatives included the following:

Marion County Oregon District Attorney
Portland Oregon District Attorney
Portland Oregon Bureau of Police
Oregon State Police
Oregon Association of Chiefs of Police (Dallas Oregon Police Chief participated)
Clackamus County Oregon Sheriff's Office
Los Angeles California District Attorney
Los Angeles California Police Department
San Bernardino California Police Department
Orange California Police Department
Eureka California Police Department/ Humboldt (state) Drug Task Force
Arcata California Police Department
San Francisco California Police Department
Hawaii County Hawaii Prosecuting Attorney
Honolulu County Hawaii Prosecuting Attorney
Hawaii County Hawaii Police Department
Honolulu Hawaii Police Department

Maui Hawaii Police Department
Anchorage Alaska District Attorney
Anchorage Alaska Police Department
Juneau Alaska Police Department

We requested comments from DOJ on a draft of this report in August 2002. The comments are discussed near the end of the letter and are reprinted as appendix V. DOJ also provided technical comments on the draft of this report and we incorporated DOJ's comments where appropriate. In addition, we requested comments from the law enforcement officials we interviewed pertaining to the section of this report dealing with their perceptions and included their comments where appropriate. Finally, we verified the information we obtained on the implementation of state medical marijuana laws with the officials we contacted during our review.

Appendix II: The Supreme Court's Decision in *United States v. Oakland Cannabis Buyers' Cooperative*

Under the federal Controlled Substances Act of 1970 (CSA), marijuana is classified as a Schedule I controlled substance, a classification reserved for drugs found by the federal government to have no currently accepted medical use. 21 U.S.C. 812(c), Schedule I (c)(10).

Consistent with this classification system, the CSA does not allow Schedule I drugs to be dispensed upon a prescription, unlike drugs in the less restrictive drug schedules. *Id.* 829. In particular, the CSA prohibits all possession, manufacture, distribution or dispensing of Schedule I substances, including marijuana, except in the context of a government-approved research project. *Id.* 823(f), 841(a)(1), 844.

Some states have passed laws that create a medical use exception to otherwise applicable state marijuana sanctions. California was the first state to pass such a law, when, in 1996, California voters passed a ballot initiative, Proposition 215, which removed certain state criminal penalties for the medical use of marijuana.

In the wake of Proposition 215, various cannabis clubs formed in California to provide marijuana to patients whose physicians had recommended such treatment. In 1998, the United States sued to enjoin one of these clubs, the Oakland Cannabis Buyers' Cooperative, from cultivating and distributing marijuana. The United States argued that, whether or not the Cooperative's actions were legal under California law, they violated the CSA. Following lower court proceedings, the U.S. Supreme Court granted the government's petition for a writ of certiorari to review whether the CSA permitted the distribution of marijuana to patients who could establish "medical necessity." *United States v. Oakland Cannabis Buyers' Cooperative*, 532 U.S. 483 (2001).

Although the tension between California's Proposition 215 and the broad federal prohibition on marijuana was the backdrop for the *Oakland Cannabis* case, the legal issue addressed by the Supreme Court did not involve the constitutionality of either the federal or state statute. Rather, the Court confined its analysis to an interpretation of the CSA and whether there was a medical necessity defense to the Act's marijuana prohibitions. The Court held that there was not. While observing that the CSA did not expressly abolish the defense, the Court stated that the statutory scheme left no doubt that the defense was unavailable for marijuana. Because marijuana appeared in Schedule I, it reflected a determination that marijuana had no currently accepted medical use for purposes of the CSA. The Court concluded that a medical necessity defense could not apply under the CSA to a drug determined to have no medical use.

The *Oakland Cannabis* case upheld the federal government's power to enforce federal marijuana prohibitions without regard to a claim of medical necessity. Thus, while California (and other states) exempt certain medical marijuana users and their designated caregivers from state sanctions, these individuals remain subject to federal sanctions for marijuana use.

Appendix III: Medical Marijuana Registries in Oregon, Alaska, Hawaii, and Select California Counties

How states implemented registry requirements in the three registry states, such as which agency administers the registry or the number of staff to manage it, varied in some ways and were similar in other ways. Similarly, the county-based registries in California had some differences and commonalities.

Oregon

In Oregon, the Department of Human Services is designated to maintain the state medical marijuana registry. A staff of six is responsible for reviewing and verifying incoming applications and renewals, including following up on those that are incomplete, and input and update of the database. Recommending physicians are sent, and must respond to a verification letter for the application to be approved. By statute in Oregon, an applicant can be denied a card for only two reasons—submitting incomplete or false information. According to the State Public Health Officer, the scope of the Department of Human Services responsibility is to see to that there is a written determination of the patient's condition by a legitimate doctor, and includes an attending physician recommendation that the patient might benefit from using marijuana. He stated that the staff does not question a doctor's recommendation for medical marijuana use. The law is clear, he said. It is up to the physician to decide what is best.

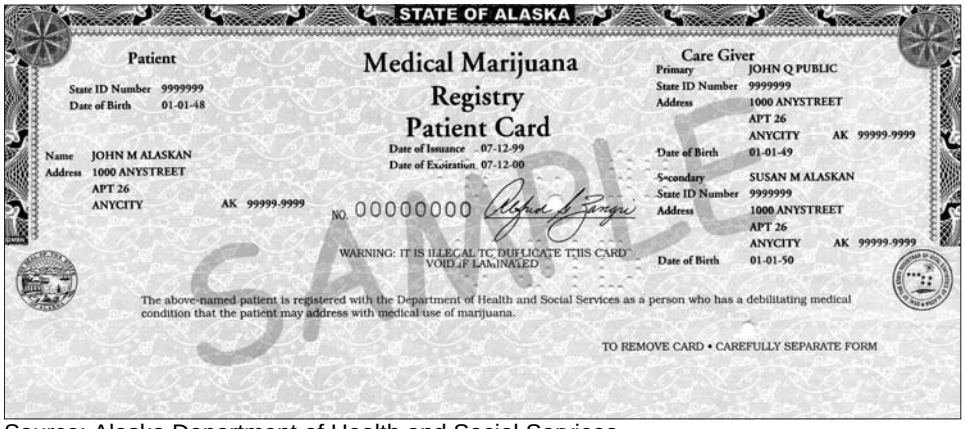
The Oregon Department of Human Services also considers the addition of new conditions to the list of those acceptable for medical use of marijuana, as authorized by Oregon's medical marijuana statute. At the time of our review, only one of the eight petitions that had been reviewed by the Department had been approved—agitation due to Alzheimer's disease. Most of the petitioned conditions have had a psychological basis, the State Public Health Officer said.

Alaska

Alaska's statute designates the Department of Health and Social Services to manage the state medical marijuana registry. The full time equivalent of one half-time person is responsible for registry duties, including checking applications for accuracy and completeness and entering the information into the registry. The physician's license is checked for approval to practice in Alaska, and if a caregiver is designated the registry is checked to assure they are only listed as a caregiver for one person unless otherwise approved by the Department. Patients, physicians and caregivers are also contacted to verify information as appropriate. If all Alaska statutory requirements are met, a medical marijuana registry identification card is issued (see fig. 4). Registry cards are denied in Alaska

if the application is not complete, the patient is not otherwise qualified to be registered, or if the information in the application is found to be false.

Figure 3: Example of Alaska's Medical Marijuana Certification Card



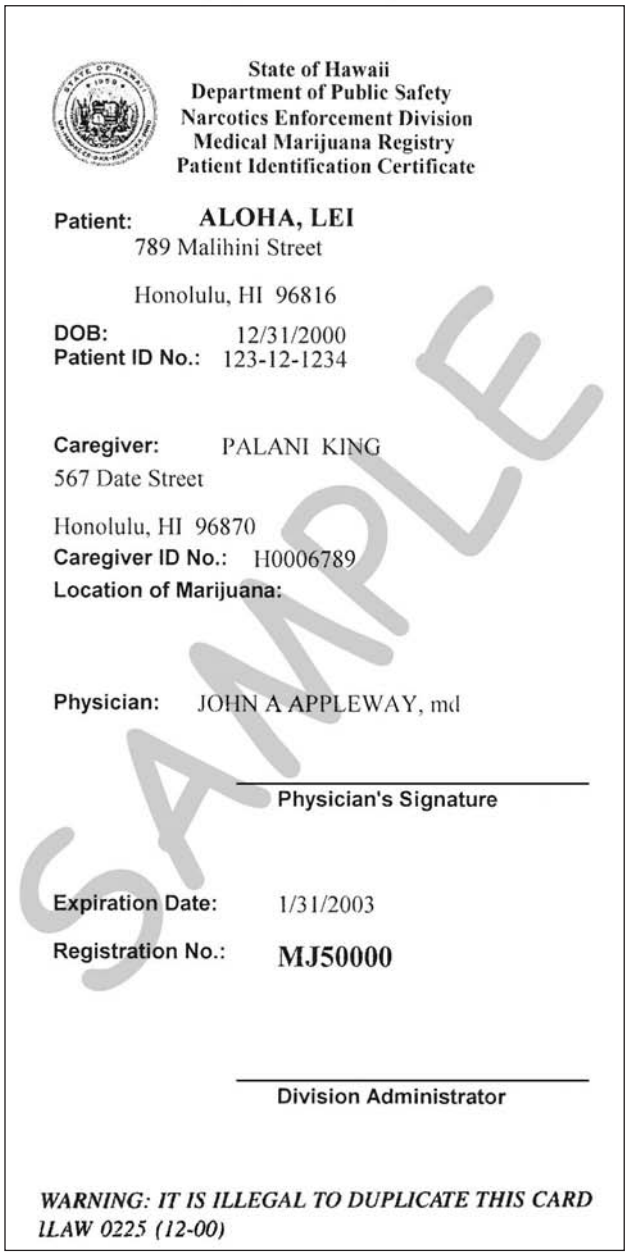
Source: Alaska Department of Health and Social Services.

Alaska's statute allows the Department to add debilitating medical conditions to the approved list for use of marijuana. A procedure for requesting new conditions is outlined in state regulations. To date, there have been no requests to consider new conditions and none have been added.

Hawaii

The medical marijuana law passed by the Hawaiian legislature designates the state Department of Public Safety to administer the Hawaiian medical marijuana registry. One person within Public Safety's Narcotics Enforcement Division staffs the registry. This person is responsible for reviewing and approving applications and renewals as complete, inputting applicant information into the database, and responding to any law enforcement inquiries. Verification procedures in Hawaii are similar to those followed in other states. See figure 4 for an example of Hawaii's registry card.

Figure 4: Example of Hawaii's Medical Marijuana Registry Card



Source: State of Hawaii Department of Public Safety.

California

Registration application requirements and procedures for the voluntary California registries we reviewed were unique to each county, but shared some procedures with the programs established in the registry states.

In Humboldt County, the patient must submit an application and physician recommendation to the county Department of Health and Human Services, with a $40.00 fee. Applicants are interviewed, photographed, and their county residency documents are checked during an in-person interview. To protect the confidentiality of doctors, after the physician recommendation has been verified, the physician portion of the application is detached and shredded. Applications are denied if the patient is not a county resident, the physician is not licensed in California, or there is not a therapeutic relationship between the patient and physician.

The San Francisco Medical Cannabis ID Card Program applications are made available through the city's Department of Public Health, where the registry is maintained, and also from clinics, doctor's offices and medical cannabis organizations that have requested them. Applicants must bring a physician's statement form, or form documenting that an oral recommendation was received, medical records release form, proof of identification and residence in San Francisco and the fee. For an applicant the fee is $25.00, plus $25.00 for each primary caregiver, up to a maximum of three caregivers. Registry cards are valid for up to 2 years, based on a physician's recommendation. After verifying the application documents to its satisfaction, the Department returns the entire application package to the applicant, and issues cards to the applicant and caregivers. The department does not copy the materials, or keep the name of registrants. Information kept on file is limited to the serial number of the cards issued, the serial number of the identification card submitted, the date the registry card was issued, and when it expires.

The Mendocino County Public Heath Department and the Sheriff's office jointly run the County Pre-identification Program for county residents. The Health Department accepts the applicant's Medical Marijuana Authorization forms, which includes patient and caregiver information, and a section for the physician to complete. The physician section requires checking "yes" or "no" to a recommendation, and the expiration length for the recommendation in months, years or for the patient's lifetime. No condition information is requested. After verifying the physician recommendation, that section is destroyed, and the approved authorization sheet is sent to the Sheriff's office. The Sheriff's office interviews registrants and caregivers, requiring that they sign a declaration

as to the caregiver's role in patient care. Program identification cards with photographs of patients and caregivers are issued by the Sheriff's office.

In Sonoma County, the Sonoma County Medical Association, in conjunction with the Sonoma County District Attorney, developed a voluntary process for the medical association to provide peer review of individuals' medical records and physician recommendations for medical use of marijuana. Based on the review, the patient's physician is sent a determination regarding whether the patient's case met criteria established regarding the patient-physician relationship, whether marijuana was approved of, and whether the condition is within the California state code allowing medical marijuana use. Upon receiving the determination from their doctor, patients decide whether to voluntarily submit the results to the District Attorney for distribution to the appropriate police department or to the sheriff's office. According to the medical association director, some patients will go through the process but prefer to keep the letter themselves rather than have their name in a law enforcement database.

Appendix IV: Descriptions of Allowable Conditions under State Medical Marijuana Laws

Medical marijuana laws in California, Oregon, Hawaii and Alaska identify medical conditions or symptoms eligible for medical marijuana use, but do not specifically define the conditions or symptoms. The following descriptions are based on definitions in the Merriam Webster Medical Dictionary and selected other sources.

Alzheimer's Disease: Alzheimer's is a brain disease that usually starts in late middle or old age. It is characterized as a memory loss for recent events spreading to memories for more distant events and progressing over the course of five to ten years to a profound intellectual decline characterized by impaired thought and speech and finally complete helplessness.

Anorexia: Anorexia is a lack, or severe loss of appetite, especially when prolonged. Many patients develop anorexia as a secondary condition to other diseases.

AIDS: Acquired Immune Deficiency Syndrome is a severe disorder caused by the human immunodeficiency virus, resulting in a defect in the cells responsible for immune response that is manifested by increased susceptibility to infections and to certain rare cancers.

Arthritis: Arthritis refers to the inflammation of joints, usually accompanied by pain, swelling, and stiffness.

Cachexia: Cachexia is a general physical wasting and malnutrition usually associated with chronic disease, such as AIDS or cancer.

Cancer: Cancer is an abnormal growth that tends to grow uncontrolled and spread to other areas of the body. It can involve any tissue of the body and can have many different forms in each body area. Cancer is a group of more than 100 different diseases. Most cancers are named for the type of cell or the organ in which they begin.

Crohn's Disease: Crohn's disease is a serious inflammatory disease of the gastrointestinal tract, it predominates in parts of the small and large intestine causing diarrhea, abdominal pain, nausea, fever, and at times loss of appetite and subsequent weight loss.

Epilepsy: Epilepsy is a disorder marked by disturbed electrical rhythms of the central nervous system and typically manifested by convulsive attacks, usually with clouding of consciousness.

Glaucoma: Glaucoma is a disease of the eye marked by increased pressure within the eyeball that can result in damage to the part of the eye referred to as the blind spot and if untreated leads to gradual loss of vision.

HIV: Human Immunodeficiency Virus is a virus that reduces the number of the cells in the immune system that helps the body fight infection and certain rare cancers, and causes acquired immune deficiency syndrome (AIDS).

Migraine: A migraine is a severe recurring headache, usually affecting only one side of the head, characterized by sharp pain and often accompanied by nausea, vomiting, and visual disturbances.

Multiple Sclerosis: Multiple Sclerosis is a disease of the central nervous system marked by patches of hardened tissue in the brain or the spinal cord causing muscular weakness, loss of coordination, speech and visual disturbances, and associated with partial or complete paralysis and jerking muscle tremor.

Nausea: Nausea refers to a stomach distress with distaste for food and an urge to vomit. Severe Nausea refers to nausea of a great degree.

Pain: Pain refers to an unpleasant sensation that can range from mild, localized discomfort to agony. Pain has both physical and emotional components. The physical part of pain results from nerve stimulation. Pain may be contained to a discrete area, as in an injury, or it can be more diffuse, as in disorders that are characterized as causing pain, stiffness, and tenderness of the muscles, tendons, and joints. Severe pain refers to pain causing great discomfort or distress. Chronic pain is often described as pain that lasts six months or more and marked by slowly progressing seriousness.

Spasticity: Spasticity is a condition in which certain muscles are continuously contracted. This contraction causes stiffness or tightness of the muscles and may interfere with gait, movement, and speech. Symptoms may include increased muscle tone, a series of rapid muscle contractions, exaggerated deep tendon reflexes, muscle spasms, involuntary crossing of the legs, and fixed joints. The degree of spasticity varies from mild muscle stiffness to severe, painful, and uncontrollable muscle spasms.

Wasting Syndrome: A condition characterized by loss of ten percent of normal weight without obvious cause. The weight loss is largely the result of depletion of the protein in lean body mass and represents a metabolic derangement frequent during AIDS.

Appendix V: Comments from the Department of Justice

U.S. Department of Justice

Washington, D.C. 20530

SEP 27 2002

Mr. Paul Jones
Director
Justice Issues
U.S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Jones:

On August 26, 2002, the General Accounting Office (GAO) provided the Department of Justice (DOJ) copies of its draft report entitled "MEDICAL MARIJUANA: Early Experiences With Four States' Laws." While we note that the report fully describes the current status of the programs in the states reviewed, we are concerned that it fails to adequately address some of the serious difficulties associated with such programs. The DOJ believes the report does not adequately address, through any considered analysis, issues related to the 1) inherent conflict between state laws permitting the use of marijuana and federal laws that do not; 2) potential for facilitating illegal trafficking; 3) impact of such laws on cooperation among federal, state, and local law enforcement; and 4) lack of data on the medicinal value of marijuana. Further, the GAO's continued use of the term "medical marijuana" implicitly accepts the fact that there is a 1) proven medicinal value to marijuana and 2) legitimate exception to federal law for this use. Neither of these premises are true. Finally, we note that the GAO fails to consider what the existence of state "medical marijuana" laws communicates. We believe such laws send society the wrong message.

Conflict Between Laws

The most fundamental problem with the draft GAO report is that it fails to emphasize the fact that there is no federally recognized medicinal use of marijuana and thus possession or use of this substance is a federal crime. Further, the GAO fails to even mention that state laws purporting to approve marijuana for medical use undermine the closed system of distribution for controlled substances established by the Controlled Substances Act (CSA). The time-proven safeguards that have made the medical drug supply in the United States the safest in the world are lacking. State medical marijuana legislation does not and could not require the cultivators and distributors of marijuana to comply with the federal requirement that all manufacturers and distributors of Schedule I controlled Substances be registered with the Drug Enforcement Administration (DEA). The registration process and record-keeping requirements established by federal law and administered by DEA are critical components of DEA's

effort to restrict abuse of marijuana and other controlled substances. In this regard, there is no analysis nor comparison of state controls of marijuana subject to state "medical marijuana" laws with federal and state controls of other prescribed medicines covered by the CSA. The regulation of the production and distribution of prescribed medicines is a critical component in preventing the diversion of controlled substances that are properly prescribed for medical use. A comparison of DEA's controls of other legitimately prescribed controlled substances would highlight the lack of proper oversight of marijuana as a "medicine."

The registration process is also an important aspect of the United States Government's implementation of international drug control treaties. These treaties obligate the federal government to prohibit the cultivation of marijuana except by persons licensed by, and under the direct supervision of, the federal government. The treaties also obligate the federal government to control the distribution of marijuana. This is required even if the federal government determines that marijuana has an accepted medical use. Any state legislation purporting to authorize medical use of marijuana is inconsistent with the CSA as none of these state laws require the cultivation of marijuana that is federally licensed and supervised by the federal government. These state laws undermine the ability of the federal government to meet its obligations under international law. The GAO Draft Report makes no mention of this critical issue.

Abuse of State Laws to facilitate Illegal Drug Trafficking

The GAO Draft Report does not mention that state "medical marijuana" laws are routinely being abused to facilitate traditional illegal marijuana trafficking and use. Information acquired by DEA during its investigations of cannabis clubs would provide specific examples of this abuse. The report focuses exclusively on so-called medical use of marijuana and omits any mention of the abuse of state "medical marijuana" laws. The report fails to reflect the underlying criminal arena in which marijuana is produced and consumed and the significant profitability that drives the marijuana market. Because of that factor, there is a blurred line between medical and illegal commercial markets. Further, some U.S. Attorney's Offices have indicated that in their district violent crimes associated with marijuana cultivation (such as homicides) create significant law enforcement and social issues. Without addressing the illegal production and diversion of marijuana, the GAO Draft Report provides an incomplete analysis of the impact of the "medical" marijuana laws on the enforcement of drug control laws.

The passage of Proposition 215 in California and similar legislation in other states has created unfortunate circumstances for state and local law enforcement officers. The state initiatives also have provided legal loopholes for drug dealers and marijuana cultivators to avoid arrest and prosecution. This is due in part to California state government's lack of guidance as to the implementation of the law and their seeming unwillingness to enforce state drug laws against traffickers who claim to be involved with marijuana under the state "medical marijuana" law. Further, those counties that have taken a public position on proposition 215 have contributed to the dilemma now being experienced by state and local law enforcement. The vague guidelines established throughout the counties in California sends a message to many that anyone who has a "recommendation" from a doctor is permitted to grow and possess certain (varying) amounts of marijuana.

Impact on Law Enforcement Operations and Cooperation

The GAO Draft Report states that "[s]ome of the federal law enforcement officials we interviewed indicated that the introduction of state "medical marijuana" laws has had little impact on their operations." This statement does not accurately reflect DEA's experience in addressing state "medical marijuana" laws. One of the major effects of the states legislation is the worsening of relations between federal, state, and local law enforcement.

As a result of these circumstances the most significant issue that now appears to be occurring is the recognizable rift that the laws have created between state and local law enforcement and federal drug agents, who are mandated to enforce the federal law. There have been and undoubtedly will continue to be instances that occur in the affected states where local officers working joint investigations with DEA have been ordered or instructed not to seize contraband plants and/or marijuana by their district attorney or state's attorney office. In some cases, DEA has been required to obtain Federal warrants to seize marijuana being held by local police agencies to prevent the return of the marijuana to persons pursuant to State court orders. This conflict has lead to several heated incidences on the West Coast.

For example, in one recent case, where federal agents were cooperating with local officers to serve a state search warrant at a residence, the District Attorney of Butte County, California, advised a Butte County detective to arrest a DEA Special Agent if the agent confiscated six marijuana plants that were found during the operation. The District Attorney asserted that under California's "medical marijuana" law the plants were lawfully possessed; however, such possession violates federal law. The plants were seized and submitted to the DEA laboratory for destruction without incident only after negotiations between the U.S. Attorney, the District Attorney, and DEA representatives to resolve the issue. In another instance, the Oakland Police Department referred to the DEA a shooting incident involving the theft of a pound of marijuana because the city of Oakland prohibits its officers from pursuing any investigation of marijuana that may be claimed to be subject to the state "medical marijuana" law. In this instance the "victim" of the robbery was a marijuana recipient under the state "medical marijuana" law who was attempting to sell the marijuana he had to his robbers. Such conflicts over individual mandates have required frequent intervention by DEA's Office of Chief Counsel and the DOJ due to the clear lack of a coordinated drug law enforcement policy.

Because state and local law enforcement cannot work on certain marijuana cases under these laws, federal seized asset sharing has been negatively impacted. In the state of Oregon, the state legislation prevents the federal government from sharing seized assets directly with state/local law enforcement entities in cases involving asset seizure without criminal prosecution initiated following marijuana grow seizures.

It is much more difficult for federal and state officials to prosecute marijuana cases where medicinal use can be claimed. There is growing local sentiment that because of these laws, federal law enforcement resources should not be devoted to marijuana prosecutions. This sentiment also manifests itself in jury

trials where prosecutors have jury nullification concerns (as a result of softened public attitudes towards marijuana).

In these states, the perception that marijuana is accepted by the public has significantly impacted law enforcement. According to Oregon State Police authorities, outlaw motorcycle gang members are now applying for marijuana caregiver status, believing that this will officially authorize their marijuana grow operations. Marijuana grow operations have always presented problems to law enforcement, and marijuana potentially subject to state "medical marijuana" laws only serve to further confuse the general public on this drug. Public perception on this issue appears to be further softened as a result of strong marketing strategies by pro-legalization/medicinal use advocates. Groups supporting the legalization of marijuana in Alaska are now preparing new proposals to legalize all marijuana. The public confusion on this issue can be demonstrated by the fact that the voters in these states approved the medical use of marijuana but *do not allow use* in *public places* (Oregon) or in *medical facilities*, or nearby school grounds, recreation centers or youth centers (Alaska). This sends a mixed message to the public as no other medicines are restricted in this way.

Marijuana As Medicine

The GAO Draft Report's discussion of the debate over the medical value of marijuana is inadequate and does not present an accurate picture. The draft states that "[t]he potential medical value of marijuana has been a continuing debate." It fails to mention, however, that smoked marijuana has never been approved as medicine by the Food and Drug Administration (FDA) and has never been proven safe and effective in sound scientific studies. Further, at its 2001 Annual Meeting, the American Medical Association (AMA)adopted the following as its policy on the medicinal use of marijuana:

> "The AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease; (2) The AMA recommends that marijuana be retained in Schedule I of the Controlled Substances Act pending the outcome of such studies. (3) The AMA urges the National Institutes of Health (NIH) to implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research into the medical utility of marijuana. . . . (4) The AMA believes that the NIH should use its resources and influence to support the development of a smoke-free inhaled delivery system for marijuana or delta-9-tetrahydrocannabinol (THC) to reduce the health hazards associated with the combustion and inhalation of marijuana."

We also believe the GAO Draft Report should at least reference DEA final orders concerning petitions to reschedule marijuana published in 1992 and 2001. These reports contain a comprehensive explanation of the scientific and legal bases for keeping marijuana in Schedule 1.

In addition, the GAO Draft Report fails to mention that medical "marijuana" is legally available in the prescription drug Marinol. A pharmaceutical product, Marinol is widely available by prescription. It comes in the form of a pill and is also being studied by researchers for suitability via other delivery methods, such as an inhaler or patch, The active ingredient in Marinol is synthetic THC, which has been found to relieve the nausea and vomiting associated with chemotherapy for cancer patients and to assist with loss of appetite with AIDS patients. Unlike smoked marijuana–which contains more than 400 different chemicals, including most of the hazardous chemicals found in tobacco smoke–Marinol has been studied and approved by the medical community and the FDA. Information about Marinol is necessary to understand the debate over medical use of marijuana.

There is no mention in the report on the prescription of Marinol in these states, or more specifically the doctors identified in the study, as compared to doctors not prescribing marijuana under state "medical marijuana" laws versus their prescriptions authored for Marinol, if any. Although the information concerning the prescription of Marinol may not yet be available, it would be available through a longer term study by DEA Office of Diversion Control. It would be informative to determine if Marinol is sold in any quantity to pharmacies in these states by distributors for the manufacturer, both before and after state "medical marijuana" legislation was passed.

As noted by the above comments, we believe that the report falls short by not adequately addressing these significant issues. I urge you will consider our concerns in preparing the final GAO report on this important subject. If you have any questions regarding the Department's comments, you may contact Vickie L. Sloan, Director, Audit Liaison Office, on (202) 514-0469.

Sincerely,

Robert F. Diegelman
Acting Assistant Attorney General
for Administration

Appendix VI: GAO Contacts and Staff Acknowledgments

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Tanya Cruz, Christine Davis, Francisco Enriquez, Evan Gilman, and Monica Kelly made key contributions to this report.

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Congressional Research Service Report on States

A review of federal and state policies related to medical marijuana for states with medical marijuana laws, released April 2, 2010.

Medical Marijuana: Review and Analysis of Federal and State Policies

Mark Eddy
Specialist in Social Policy

April 2, 2010

Congressional Research Service
7-5700
www.crs.gov
RL33211

CRS Report for Congress
Prepared for Members and Committees of Congress

Summary

The issue before Congress is whether to continue the federal prosecution of medical marijuana patients and their providers, in accordance with the federal Controlled Substances Act (CSA), or whether to relax federal marijuana prohibition enough to permit the medicinal use of botanical cannabis products when recommended by a physician, especially where permitted under state law.

Fourteen states, mostly in the West, have enacted laws allowing the use of marijuana for medical purposes, and many thousands of patients are seeking relief from a variety of serious illnesses by smoking marijuana or using other herbal cannabis preparations.

Two bills relating to the therapeutic use of cannabis have been introduced in the 111th Congress. The Medical Marijuana Patient Protection Act (H.R. 2835), which would allow the medical use of marijuana in states that permit its use with a doctor's recommendation, was introduced on June 11, 2009, by Representative Barney Frank. The bill would move marijuana from Schedule I to Schedule II of the CSA and exempt from federal prosecution authorized patients and medical marijuana providers who are acting in accordance with state laws. Also, the Truth in Trials Act (H.R. 3939), a bill that would make it possible for defendants in federal court to reveal to juries that their marijuana activity was medically related and legal under state law, was introduced on October 27, 2009, by Representative Sam Farr.

For the first time since District of Columbia residents approved a medical marijuana ballot initiative in 1998, a rider blocking implementation of the initiative was not attached to the D.C. appropriations act for FY2010 (P.L. 111-117), clearing the way for the creation of a medical marijuana program for seriously ill patients in the nation's capital.

The Obama Administration Department of Justice, in October 2009, announced an end to federal raids by the Drug Enforcement Administration of medical marijuana dispensaries that are operating in "clear and unambiguous compliance with existing state laws." This move fulfills a pledge to end such raids that was made by candidate Obama during the presidential campaign.

Claims and counterclaims about medical marijuana—much debated by journalists and academics, policymakers at all levels of government, and interested citizens—include the following: Marijuana is harmful and has no medical value; marijuana effectively treats the symptoms of certain diseases; smoking is an improper route of drug administration; marijuana should be rescheduled to permit medical use; state medical marijuana laws send the wrong message and lead to increased illicit drug use; the medical marijuana movement undermines the war on drugs; patients should not be arrested for using medical marijuana; the federal government should allow the states to experiment and should not interfere with state medical marijuana programs; medical marijuana laws harm the federal drug approval process; the medical cannabis movement is a cynical ploy to legalize marijuana and other drugs. With strong opinions being expressed on all sides of this complex issue, the debate over medical marijuana does not appear to be approaching resolution.

This report will be updated as legislative activity and other developments occur.

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Introduction: The Issue Before Congress

The issue before Congress is whether to continue the federal prosecution of medical marijuana[1] patients and their providers, in accordance with marijuana's status as a Schedule I drug under the Controlled Substances Act, or whether to relax federal marijuana prohibition enough to permit the medicinal use of botanical cannabis[2] products when recommended by a physician, especially in those states that have created medical marijuana programs under state law.

Two bills, versions of which have been introduced in prior Congresses, have been proposed again in the 111th Congress. The Medical Marijuana Patient Protection Act (H.R. 2835), which would allow the medical use of marijuana in states that permit its use with a doctor's recommendation, was introduced on June 11, 2009, by Representative Barney Frank. The bill would also move marijuana from Schedule I to Schedule II of the CSA and exempt from federal prosecution authorized patients and medical marijuana providers who are acting in accordance with state laws. The second bill, the Truth in Trials Act (H.R. 3939), introduced by Representative Sam Farr on October 27, 2009, would make it possible for medical marijuana users and providers who are being tried in federal court to reveal to juries that their marijuana activity was medically related and legal under state law.

Background: Medical Marijuana Prior to 1937

The Cannabis sativa plant has been used for healing purposes throughout history. According to written records from China and India, the use of marijuana to treat a wide range of ailments goes back more than 2,000 years. Ancient texts from Africa, the Middle East, classical Greece, and the Roman Empire also describe the use of cannabis to treat disease.

For most of American history, growing and using marijuana was legal under both federal law and the laws of the individual states. By the 1840s, marijuana's therapeutic potential began to be recognized by some U.S. physicians. From 1850 to 1941 cannabis was included in the *United States Pharmacopoeia* as a recognized medicinal.[3] By the end of 1936, however, all 48 states had enacted laws to regulate marijuana.[4] Its decline in medicine was hastened by the development of aspirin, morphine, and then other opium-derived drugs, all of which helped to replace marijuana in the treatment of pain and other medical conditions in Western medicine.[5]

[1] The terms *medical marijuana* and *medical cannabis* are used interchangeably in this report to refer to marijuana (scientific name: Cannabis sativa) and to marijuana use that qualifies for a medical use exception under the laws of certain states and under the federal Investigational New Drug Compassionate Access Program.

[2] The terms *botanical cannabis*, *herbal cannabis*, *botanical marijuana*, and *crude marijuana*, used interchangeably in this report, signify the whole or parts of the natural marijuana plant and therapeutic products derived therefrom, as opposed to drugs produced synthetically in the laboratory that replicate molecules found in the marijuana plant.

[3] Gregg A. Bliz, "The Medical Use of Marijuana: The Politics of Medicine," *Hamline Journal of Public Law and Policy*, vol. 13, spring 1992, p. 118.

[4] Oakley Ray and Charles Ksir, *Drugs, Society, and Human Behavior*, 10th ed. (New York: McGraw-Hill, 2004), p. 456.

[5] Bill Zimmerman, *Is Marijuana the Right Medicine for You? A Factual Guide to Medical Uses of Marijuana* (New Canaan, CT: Keats Publishing, 1998), p. 19.

Federal Medical Marijuana Policy

All three branches of the federal government play an important role in formulating federal policy on medical marijuana. Significant actions of each branch are highlighted here, beginning with the legislative branch.

Congressional Actions

The Marihuana Tax Act of 1937[6]

Spurred by spectacular accounts of marijuana's harmful effects on its users, by the drug's alleged connection to violent crime, and by a perception that state and local efforts to bring use of the drug under control were not working, Congress enacted the Marihuana Tax Act of 1937.[7] Promoted by Harry Anslinger, Commissioner of the recently established Federal Bureau of Narcotics, the act imposed registration and reporting requirements and a tax on the growers, sellers, and buyers of marijuana. Although the act did not prohibit marijuana outright, its effect was the same. (Because marijuana was not included in the Harrison Narcotics Act in 1914,[8] the Marihuana Tax Act was the federal government's first attempt to regulate marijuana.)

Dr. William C. Woodward, legislative counsel of the American Medical Association (AMA), opposed the measure. In oral testimony before the House Ways and Means Committee, he stated that "there are evidently potentialities in the drug that should not be shut off by adverse legislation. The medical profession and pharmacologists should be left to develop the use of this drug as they see fit."[9] Two months later, in a letter to the Senate Finance Committee, he again argued against the act:

> There is no evidence, however, that the medicinal use of these drugs ["cannabis and its preparations and derivatives"] has caused or is causing cannabis addiction. As remedial agents they are used to an inconsiderable extent, and the obvious purpose and effect of this bill is to impose so many restrictions on their medicinal use as to prevent such use altogether. Since the medicinal use of cannabis has not caused and is not causing addiction, the prevention of the use of the drug for medicinal purposes can accomplish no good end whatsoever. How far it may serve to deprive the public of the benefits of a drug that on further research may prove to be of substantial value, it is impossible to foresee.[10]

Despite the AMA's opposition, the Marihuana Tax Act was approved, causing all medicinal products containing marijuana to be withdrawn from the market and leading to marijuana's

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[6] In Spanish, the letter "j" carries the sound of "h" in English. This alternative spelling of marijuana (with an "h") was formerly used by the federal government and is still used by some writers today.

[7] P.L. 75-238, 50 Stat. 551, August 2, 1937. In *Leary* v. *United States* (395 U.S. 6 (1968)), the Supreme Court ruled the Marihuana Tax Act unconstitutional because it compelled self-incrimination, in violation of the Fifth Amendment.

[8] P.L. 63-223, December 17, 1914, 38 Stat. 785. This law was passed to implement the Hague Convention of 1912 and created a federal tax on opium and coca leaves and their derivatives.

[9] U.S. Congress, House Committee on Ways and Means, *Taxation of Marihuana*, hearings on H.R. 6385, 75th Cong., 1st sess., May 4, 1937 (Washington: GPO, 1937), p. 114.

[10] U.S. Congress, Senate Committee on Finance, Taxation of Marihuana, hearing on H.R. 6906, 75th Cong., 1st sess., July 12, 1937 (Washington: GPO, 1937), p. 33.

removal, in 1941, from *The National Formulary* and the *United States Pharmacopoeia*, in which it had been listed for almost a century.

Controlled Substances Act (1970)

With increasing use of marijuana and other street drugs during the 1960s, notably by college and high school students, federal drug-control laws came under scrutiny. In July 1969, President Nixon asked Congress to enact legislation to combat rising levels of drug use.[11] Hearings were held, different proposals were considered, and House and Senate conferees filed a conference report in October 1970.[12] The report was quickly adopted by voice vote in both chambers and was signed into law as the Comprehensive Drug Abuse Prevention and Control Act of 1970 (P.L. 91-513).

Included in the new law was the Controlled Substances Act (CSA),[13] which placed marijuana and its derivatives in Schedule I, the most restrictive of five categories. Schedule I substances have "a high potential for abuse," "no currently accepted medical use in treatment in the United States," and "a lack of accepted safety [standards] for use of the drug ... under medical supervision."[14] Other drugs used recreationally at the time also became Schedule I substances. These included heroin, LSD, mescaline, peyote, and psilocybin. Drugs of abuse with recognized medical uses—such as opium, cocaine, and amphetamine—were assigned to Schedules II through V, depending on their potential for abuse.[15] Despite its placement in Schedule I, marijuana use increased, as did the number of health-care professionals and their patients who believed in the plant's therapeutic value.

The CSA does not distinguish between the medical and recreational use of marijuana. Under federal statute, simple possession of marijuana for personal use, a misdemeanor, can bring up to one year in federal prison and up to a $100,000 fine for a first offense.[16] Growing marijuana is considered *manufacturing* a controlled substance, a felony.[17] A single plant can bring an individual up to five years in federal prison and up to a $250,000 fine for a first offense.[18]

The CSA is not preempted by state medical marijuana laws, under the federal system of government, nor are state medical marijuana laws preempted by the CSA. States can statutorily create a medical use exception for botanical cannabis and its derivatives under their own, state-level controlled substance laws. At the same time, federal agents can investigate, arrest, and prosecute medical marijuana patients, caregivers, and providers in accordance with the federal

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[11] U.S. President, 1969-1974 (Nixon), "Special Message to the Congress on Control of Narcotics and Dangerous Drugs," July 14, 1969, *Public Papers of the Presidents of the United States 1969* (Washington: GPO, 1971), pp. 513-518.

[12] U.S. Congress, Conference Committees, *Comprehensive Drug Abuse Prevention and Control Act of 1970*, conference report to accompany H.R. 18583, 91st Cong., 2nd sess., H.Rept. 91-1603 (Washington: GPO, 1970).

[13] Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, P.L. 91-513, October 27, 1970, 84 Stat. 1242, 21 U.S.C. §801, *et seq*.

[14] Ibid., Sec. 202(b)(1), 84 Stat. 1247, 21 U.S.C. §812(b)(1).

[15] Ibid., Sec. 202(c), 84 Stat. 1248.

[16] Ibid., Sec. 404 (21 U.S.C. §844) and 18 U.S.C. §3571. Sec. 404 also calls for a minimum fine of $1,000, and Sec. 405 (21 U.S.C. §844a) permits a civil penalty of up to $10,000.

[17] Sec. 102(15), (22) of the CSA (21 U.S.C. §802(15), (22)).

[18] Sec. 401(b)(1)(D) of the CSA (21 U.S.C. §841(b)(1)(D)).

Controlled Substances Act, even in those states where medical marijuana programs operate in accordance with state law.

Anti-Medical Marijuana Legislation in the 105th Congress (1998)

In September 1998, the House debated and passed a resolution (H.J.Res. 117) declaring that Congress supports the existing federal drug approval process for determining whether any drug, including marijuana, is safe and effective and opposes efforts to circumvent this process by legalizing marijuana, or any other Schedule I drug, for medicinal use without valid scientific evidence and without approval of the Food and Drug Administration (FDA). With the Senate not acting on the resolution and adjournment approaching, this language was incorporated into the FY1999 omnibus appropriations act under the heading "Not Legalizing Marijuana for Medicinal Use."[19]

In a separate amendment to the same act, Congress prevented the District of Columbia government from counting ballots of a 1998 voter-approved initiative that would have allowed the medical use of marijuana by persons suffering from serious diseases, including cancer and HIV infection.[20] The amendment was challenged and overturned in District Court, the ballots were counted, and the measure passed 69% to 31%. Nevertheless, despite further court challenges, Congress continued to prohibit implementation of the initiative until the rider known as the Barr Amendment[21] was dropped from the FY2010 D.C. appropriations act (H.R. 3288) in the 111th Congress.

The Hinchey-Rohrabacher Amendment (2003-2007) [22]

In the first session of the 108th Congress, in response to federal Drug Enforcement Administration (DEA) raids on medical cannabis users and providers in California and other states that had approved the medical use of marijuana if recommended by a physician, Representatives Hinchey and Rohrabacher offered a bipartisan amendment to the FY2004 Commerce, Justice, State appropriations bill (H.R. 2799). The amendment would have prevented the Justice Department from using appropriated funds to interfere with the implementation of medical cannabis laws in the nine states that had approved such use. The amendment was debated on the floor of the House

[19] Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999, P.L. 105-277, October 21, 1998, 112 Stat. 2681-760.

[20] Ibid., District of Columbia Appropriations Act, 1999, Sec. 171, 112 Stat. 2681-150.

[21] "The Legalization of Marijuana for Medical Treatment Initiative of 1998, also known as Initiative 59, approved by the electors of the District of Columbia on November 3, 1998, shall not take effect." (District of Columbia Appropriations Act, 2006 (Division B of P.L. 109-115, Sec. 128 (b); 119 Stat. 2521.) This recurring provision of D.C. appropriations acts is known as the Barr Amendment because it was originally offered by Rep. Bob Barr. Since leaving Congress in 2003, Barr changed his position and worked for a period of time in support of medical marijuana as a lobbyist for the Marijuana Policy Project. See his website http://www.bobbarr.org.

[22] When last considered in July 2007, the amendment stated: "None of the funds made available in this Act to the Department of Justice may be used, with respect to the States of Alaska, California, Colorado, Hawaii, Maine, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont, and Washington, to prevent such States from implementing their own State laws that authorize the use, distribution, possession, or cultivation of medical marijuana." The wording of previous versions of the amendment was similar.

on July 22, 2003. When brought to a vote on the following day, it was defeated 152 to 273 (61 votes short of passage).[23]

The amendment was offered again in the second session of the 108th Congress. It was debated on the House floor on July 7, 2004, during consideration of H.R. 4754, the Commerce, Justice, State appropriations bill for FY2005. This time it would have applied to 10 states, with the recent addition of Vermont to the list of states that had approved the use of medical cannabis. It was again defeated by a similar margin, 148 to 268 (61 votes short of passage).[24]

The amendment was voted on again in the first session of the 109th Congress and was again defeated, 161-264 (52 votes short of passage), on June 15, 2005. During floor debate on H.R. 2862, the FY2006 Science, State, Justice, Commerce appropriations bill, a Member stated in support of the amendment that her now-deceased mother had used marijuana to treat her glaucoma. Opponents of the amendment argued, among other things, that its passage would undermine efforts to convince young people that marijuana is a dangerous drug.[25]

Despite an extensive pre-vote lobbying effort by supporters, the amendment gained only two votes in its favor over the previous year when it was debated and defeated, 163 to 259 (49 votes short of passage), on June 28, 2006.[26] The bill under consideration this time was H.R. 5672, the FY2007 Science, State, Justice, Commerce appropriations bill.

In the first session of the 110th Congress, on July 25, 2007, the amendment was proposed to H.R. 3093, the Commerce, Justice, Science appropriations bill for FY2008. It was debated on the House floor for the fifth time in as many years and was again rejected, 165 to 262 (49 votes short of passage). The amendment's supporters framed it as a states' rights issue:

> A vote "yes" on Hinchey-Rohrabacher is a vote to respect the intent of our Founding Fathers and respect the rights of our people at the State level to make the criminal law under which they and their families will live. It reinforces rules surrounding the patient-doctor relationship, and it is in contrast to emotional posturing and Federal power grabs and bureaucratic arrogance, which is really at the heart of the opposition.[27]

Opponents argued that smoked marijuana is not a safe and effective medicine and that its approval would send the wrong message to young people.

Legislative Activity in the 110th Congress

The first action on medical marijuana in the 110th Congress occurred during consideration of legislation to reauthorize existing FDA programs and expand the agency's authority to ensure the safety of prescription drugs, medical devices, and biologics. On April 18, 2007, at markup of the

[23] "Amendment No. 1 offered by Mr. Hinchey," *Congressional Record*, daily edition, vol. 149 (July 22, 2003), pp. H 7302-H7311 and vol. 149 (July 23, 2003), pp. H7354-H7355.

[24] "Amendment No. 6 Offered by Mr. Farr," *Congressional Record*, daily edition, vol. 150 (July 7, 2004), pp. H5300-H 5306, H5320.

[25] "Amendment Offered by Mr. Hinchey," *Congressional Record*, daily edition, vol. 151 (July 15, 2005), pp. H4519-H 4524, H4529.

[26] "Amendment Offered by Mr. Hinchey," *Congressional Record*, daily edition, vol. 152 (June 28, 2006), pp. H4735-H 4739.

[27] "Amendment Offered by Mr. Hinchey," *Congressional Record*, daily edition, vol. 153 (July 25, 2007), p. H8484.

Prescription Drug User Fee Act (S. 1082), the Senate Committee on Health, Education, Labor, and Pensions adopted, in an 11-9 vote, an amendment offered by Senator Coburn designed to shut down state medical marijuana programs. The amendment stated:

> The Secretary of Health and Human Services shall require that State-legalized medical marijuana be subject to the full regulatory requirements of the Food and Drug Administration, including a risk evaluation and mitigation strategy and all other requirements of the Federal Food, Drug, and Cosmetic Act regarding safe and effective reviews, approval, sale, marketing, and use of pharmaceuticals.

Herbal cannabis products are not, in fact, being marketed in the United States as pharmaceuticals, nor are they being developed as investigational new drugs due largely to federal restrictions on marijuana research. Because of this and other possibly complicating factors, the validity and actual effect of this amendment, if it had been signed into law, would have been unclear and would have been subject to legal interpretation and judicial review.[28] The bill, as amended, cleared the Senate and was sent to the House on May 9. The Coburn Amendment, however, was not included in the version of the FDA amendments act (H.R. 2900) that was approved by Congress and enacted into law (P.L. 110-85) on September 27, 2007.

In another action on medical marijuana, the House Judiciary Subcommittee on Crime, Terrorism, and Homeland Security held an oversight hearing on DEA's regulation of medicine on July 12, 2007. A DEA official testified that his agency would "continue to enforce the law as it stands and to investigate, indict, and arrest those who use the color of state law to possess and sell marijuana." A California medicinal cannabis patient and provider stated, "The well-being of thousands of seriously ill Americans backed by the opinion of the vast majority of their countrymen demands that medical marijuana be freed from federal interference." In his introduction of the patient, the subcommittee chairman observed, "Even if the law technically gives DEA the authority to investigate medical marijuana users, it is worth questioning whether targeting gravely ill people is the best use of federal resources."

Two weeks later, on July 25, the whole House decided to continue to use federal resources against medical marijuana users when it rejected the Hinchey-Rohrabacher amendment, 165-262, as described above.

In the second session of the 110th Congress, on April 17, 2008, Representative Frank introduced H.R. 5842, the Medical Marijuana Patient Protection Act, to provide for the medical use of marijuana in accordance with the laws of the various states. Introduced with four original co-sponsors—Representatives Farr, Hinchey, Paul, and Rohrabacher—the bill would have moved marijuana from schedule I to schedule II of the CSA and would have, within states with medical marijuana programs, permitted

- a physician to prescribe or recommend marijuana for medical use;
- an authorized patient to obtain, possess, transport, manufacture, or use marijuana;
- an authorized individual to obtain, possess, transport, or manufacture marijuana for an authorized patient; and

[28] For a legal analysis of the amendment, see CRS Congressional Distribution Memorandum, "Possible Legal Effects of the Medical Marijuana Amendment to S. 1082," by Vanessa Burrows and Brian Yeh.

- a pharmacy or other authorized entity to distribute medical marijuana to authorized patients.

No provision of the Controlled Substances Act or the Federal Food, Drug, and Cosmetic Act would have been allowed to prohibit or otherwise restrict these activities in states that have adopted medical marijuana programs. Also, the bill would not have affected any federal, state, or local law regulating or prohibiting smoking in public. In his introductory statement, Representative Frank said, "When doctors recommend the use of marijuana for their patients and states are willing to permit it, I think it's wrong for the federal government to subject either the doctors or the patients to criminal prosecution."[29] Although differently worded, H.R. 5842 had the same intent as the States' Rights to Medical Marijuana Act, versions of which had been introduced in every Congress since the 105th in 1997. The bill was referred to the House Committee on Energy and Commerce and saw no further action.

Medical Marijuana Measures in the 111th Congress

Bills have been introduced in recent Congresses to allow patients who appear to benefit from medical cannabis to use it in accordance with the various regulatory schemes that have been approved, since 1996, by the voters or legislatures of 14 states. This legislative activity continues in the 111th Congress with the reintroduction of two bills that would serve to relax somewhat the federal prohibition against the medical use of marijuana.

The Medical Marijuana Patient Protection Act (H.R. 2835), which would allow the medical use of marijuana in states that permit its use with a doctor's recommendation, was introduced on June 11, 2009, by Representative Barney Frank with 13 original cosponsors. The bill would move marijuana from Schedule I to Schedule II of the CSA and exempt from federal prosecution authorized patients and medical marijuana providers who are acting in accordance with state laws. Its wording is identical to H.R. 5842 as introduced in the 110th Congress, and its provisions are described more fully above. H.R. 2835 was referred to the House Committee on Energy and Commerce, where it awaits further action. (Versions of this bill have been introduced in every Congress since 1997 but have not seen action beyond the committee referral process.)

The second bill, the Truth in Trials Act (H.R. 3939), was introduced by Representative Sam Farr on October 27, 2009. It would make it possible for medical marijuana users and providers who are being tried in federal court to reveal to juries that their marijuana activity was medically related and legal under state law. After the 2001 Supreme Court decision *U.S.* v. *Oakland Buyers' Cooperative* (discussed below), it was no longer permissible for medical marijuana defendants in federal court to introduce evidence showing that their marijuana-related activities were undertaken for a valid medical purpose under state law.[30] H.R. 3939 would amend the Controlled Substances Act to make an affirmative defense possible for persons who provide or use marijuana in accordance with state medical marijuana laws. The bill also would limit the authority of federal agents to seize marijuana authorized for medical use under state law and would provide for the

[29] "Frank Introduces Legislation to Remove Federal Penalties on Personal Marijuana Use," press release from the office of Rep. Barney Frank, April 17, 2008.

[30] When it was first introduced in the 108th Congress, the bill was called the Steve McWilliams Truth in Trials Act. It was named after a Californian who took his own life while awaiting federal sentencing for marijuana trafficking. At his trial, it was impermissible to inform the jury that he was actually providing marijuana to seriously ill patients in San Diego in compliance with state law.

retention and return of seized plants pending resolution of a case involving medical marijuana. Introduced with nine original co-sponsors, the bill was referred to the Committee on the Judiciary and also to the Committee on Energy and Commerce.

For the first time since District of Columbia residents approved a medical marijuana ballot initiative in 1998, a rider blocking implementation of the initiative was not attached to the D.C. appropriations act for FY2010 (H.R. 3288), signed into law on December 16, 2009 (P.L. 111-117), clearing the way for the creation of a medical marijuana program for seriously ill patients in the nation's capital.

Executive Branch Actions and Policies

IND Compassionate Access Program (1978)

In 1975, a Washington, DC, resident was arrested for growing marijuana to treat his glaucoma. He won his case by using the medical necessity defense,[31] forcing the government to find a way to provide him with his medicine. In 1978, FDA created the Investigational New Drug (IND) Compassionate Access Program,[32] allowing patients whose serious medical conditions could be relieved only by marijuana to apply for and receive marijuana from the federal government. Over the next 14 years, other patients, less than 100 in total, were admitted to the program for conditions including chemotherapy-induced nausea and vomiting (emesis), glaucoma, spasticity, and weight loss. Then, in 1992, in response to a large number of applications from AIDS patients who sought to use medical cannabis to increase appetite and reverse wasting disease, the George H.W. Bush Administration closed the program to all new applicants. Several previously approved patients remain in the program today and continue to receive their monthly supply of government-grown medical marijuana.

Approval of Marinol (1985)

Made by Unimed, Marinol is the trade name for dronabinol, a synthetic form of delta-9-tetrahydrocannabinol (THC), one of the principal psychoactive components of botanical marijuana. It was approved in May 1985 for nausea and vomiting associated with cancer chemotherapy in patients who fail to respond to conventional antiemetic treatments. In December 1992, it was approved by FDA for the treatment of anorexia associated with weight loss in patients with AIDS. Marketed as a capsule, Marinol was originally placed in Schedule II.[33] In July 1999, in response to a rescheduling petition from Unimed, it was moved administratively by DEA to Schedule III to make it more widely available to patients.[34] The rescheduling was granted

[31] The Common Law *Doctrine of Necessity* argues that the illegal act committed (in this case, growing marijuana) was necessary to avert a greater harm (blindness).

[32] Despite the program's name, it was not a clinical trial to test the drug for eventual approval, but a means for the government to provide medical marijuana to patients demonstrating necessity. Some have criticized the government for its failure to study the safety and efficacy of the medical-grade marijuana it grew and distributed to this patient population.

[33] U.S. Dept. of Justice, Drug Enforcement Administration, "Schedules of Controlled Substances: Rescheduling of Synthetic Dronobinol in Sesame Oil and Encapsulation in Soft Gelatin Capsules From Schedule I to Schedule II; Statement of Policy," 51 *Federal Register* 17476, May 13, 1986.

[34] Ibid., "Schedules of Controlled Substances: Rescheduling of the Food and Drug Administration Approved Product Containing Synthetic Dronabinol [(-)-delta nine-(trans)-Tetrahydrocannabinol] in Sesame Oil and Encapsulated in Soft (continued...)

after a review by DEA and the Department of Health and Human Services found little evidence of illicit abuse of the drug. In Schedule III, Marinol is now subject to fewer regulatory controls and lesser criminal sanctions for illicit use.

Administrative Law Judge Ruling to Reschedule Marijuana (1988)

Congressional passage of the Controlled Substances Act in 1970 and its placement of marijuana in Schedule I provoked controversy at the time because it strengthened the federal policy of marijuana prohibition and forced medical marijuana users to buy marijuana of uncertain quality on the black market at inflated prices, subjecting them to fines, arrest, court costs, property forfeiture, incarceration, probation, and criminal records. The new bureaucratic controls on Schedule I substances were also criticized because they would impede research on marijuana's therapeutic potential, thereby making its evaluation and rescheduling through the normal drug approval process unlikely.

These concerns prompted a citizens' petition to the Bureau of Narcotics and Dangerous Drugs (BNDD) in 1972 to reschedule marijuana and make it available by prescription. The petition was summarily rejected.[35] This led to a long succession of appeals, hearing requests, and various court proceedings. Finally, in 1988, after extensive public hearings on marijuana's medicinal value, Francis L. Young, the chief administrative law judge of the Drug Enforcement Administration (the BNDD's successor agency), ruled on the petition, stating that "Marijuana, in its natural form, is one of the safest therapeutically active substances known to man."[36] Judge Young also wrote:

> The evidence in this record clearly shows that marijuana has been accepted as capable of relieving the distress of great numbers of very ill people, and doing so with safety under medical supervision. It would be unreasonable, arbitrary and capricious for DEA to continue to stand between those sufferers and the benefits of this substance in light of the evidence in this record.

Judge Young found that "the provisions of the [Controlled Substances] Act permit and require the transfer of marijuana from schedule I to schedule II," which would recognize its medicinal value and permit doctors to prescribe it. The judge's nonbinding findings and recommendation were soon rejected by the DEA Administrator because "marijuana has not been demonstrated as suitable for use as a medicine."[37] Subsequent rescheduling petitions also have been rejected, and marijuana remains a Schedule I substance.

(...continued)

Gelatin Capsules From Schedule II to Schedule III," 64 *Federal Register* 35928, July 2, 1999.

[35] Ibid., Bureau of Narcotics and Dangerous Drugs, "Schedule of Controlled Substances: Petition to Remove Marijuana or in the Alternative to Control Marijuana in Schedule V of the Controlled Substances Act," 37 *Federal Register* 18097, September 7, 1972.

[36] Ibid., Drug Enforcement Administration, "In the Matter of Marijuana Rescheduling Petition, Docket No. 86-22, Opinion and Recommended Ruling, Findings of Fact, Conclusions of Law and Decision of Administrative Law Judge," Francis L. Young, Administrative Law Judge, September 6, 1988. This quote and the following two quotes are at pp. 58-59, 68, and 67, respectively. This opinion is online at http://www.druglibrary.net/olsen/MEDICAL/YOUNG/young.html.

[37] Ibid., "Marijuana Scheduling Petition; Denial of Petition," 54 *Federal Register* 53767 at 53768, December 29, 1989. The petition denial was appealed, eventually resulting in yet another DEA denial to reschedule. See Ibid., "Marijuana Scheduling Petition; Denial of Petition; Remand," 57 *Federal Register* 10499, March 26, 1992.

NIH-Sponsored Workshop (1997)

NIH convened a scientific panel on medical marijuana composed of eight nonfederal experts in fields such as cancer treatment, infectious diseases, neurology, and ophthalmology. Over a two-day period in February, they analyzed available scientific information on the medical uses of marijuana and concluded that "in order to evaluate various hypotheses concerning the potential utility of marijuana in various therapeutic areas, more and better studies would be needed." Research would be justified, according to the panel, into certain conditions or diseases such as pain, neurological and movement disorders, nausea of patients undergoing chemotherapy for cancer, loss of appetite and weight related to AIDS, and glaucoma.[38]

Institute of Medicine Report (1999)

In January 1997, shortly after passage of the California and Arizona medical marijuana initiatives, the Director of the Office of National Drug Control Policy (the federal drug czar) commissioned the Institute of Medicine (IOM) of the National Academy of Sciences to review the scientific evidence on the potential health benefits and risks of marijuana and its constituent cannabinoids. Begun in August 1997, IOM's 257-page report, *Marijuana and Medicine: Assessing the Science Base*, was released in March 1999.[39] A review of all existing studies of the therapeutic value of cannabis, the IOM Report was also based on public hearings and consultations held around the country with biomedical and social scientists and concerned citizens.

For the most part, the IOM Report straddled the fence and provided sound bites for both sides of the medical marijuana debate. For example, "Until a nonsmoked rapid-onset cannabinoid drug delivery system becomes available, we acknowledge that there is no clear alternative for people suffering from *chronic* conditions that might be relieved by smoking marijuana, such as pain or AIDS-wasting" (p. 179) and "Smoked marijuana is unlikely to be a safe medication for any chronic medical condition" (p. 126). For another example, "There is no conclusive evidence that marijuana causes cancer in humans, including cancers usually related to tobacco use" (p. 119) and "Numerous studies suggest that marijuana smoke is an important risk factor in the development of respiratory disease" (p. 127).

The IOM Report did find more potential promise in synthetic cannabinoid drugs than in smoked marijuana (p. 177):

> The accumulated data suggest a variety of indications, particularly for pain relief, antiemesis, and appetite stimulation. For patients such as those with AIDS or who are undergoing chemotherapy, and who suffer simultaneously from severe pain, nausea, and appetite loss, cannabinoid drugs might offer broad-spectrum relief not found in any other single medication.

In general, the report emphasized the need for well-formulated, scientific research into the therapeutic effects of marijuana and its cannabinoid components on patients with specific disease

[38] National Institutes of Health. The Ad Hoc Group of Experts. *Workshop on the Medical Utility of Marijuana: Report to the Director,* August 1997. (Hereafter cited as NIH Workshop.)

[39] Janet E. Joy, Stanley J. Watson, Jr., and John A. Benson, Jr., eds., *Marijuana and Medicine: Assessing the Science Base* (Washington: National Academy Press, 1999). (Hereafter cited as the IOM Report.) http://www.nap.edu/books/0309071550/html/

conditions. To this end, the report recommended that clinical trials be conducted with the goal of developing safe delivery systems.

Denial of Petition to Reschedule Marijuana (2001)

In response to a citizen's petition to reschedule marijuana submitted to the DEA in 1995, DEA asked the Department of Health and Human Services (HHS) for a scientific and medical evaluation of the abuse potential of marijuana and a scheduling recommendation. HHS concluded that marijuana has 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. HHS therefore recommended that marijuana remain in Schedule I. In a letter to the petitioner dated March 20, 2001, DEA denied the petition.[40]

FDA Statement That Smoked Marijuana Is Not Medicine (2006)

On April 20, 2006, the FDA issued an interagency advisory restating the federal government's position that "smoked marijuana is harmful" and has not been approved "for any condition or disease indication." The one-page announcement did not refer to new research findings. Instead, it was based on a "past evaluation" by several agencies within HHS that "concluded that no sound scientific studies supported medical use of marijuana for treatment in the United States, and no animal or human data supported the safety or efficacy of marijuana for general medical use."[41]

Media reaction to this pronouncement was largely negative, asserting that the FDA position on medical marijuana was motivated by politics, not science, and ignored the findings of the 1999 Institute of Medicine Report.[42] In Congress, 24 House Members, led by Representative Hinchey, sent a letter to the FDA acting commissioner requesting the scientific evidence behind the agency's evaluation of the medical efficacy of marijuana and citing the FDA's IND Compassionate Access Program as "an example of how the FDA could allow for the legal use of a drug, such as medical marijuana, without going through the 'well-controlled' series of steps that other drugs have to go through if there is a compassionate need."[43]

Administrative Law Judge Ruling to Grow Research Marijuana (2007-2009)

Since 1968, the only source of marijuana available for scientific research in the United States has been tightly controlled by the federal government. Grown at the University of Mississippi under a contract administered by the National Institute on Drug Abuse, the marijuana is difficult to obtain even by scientists whose research protocols have been approved by the FDA. Not only is the

[40] U.S. Dept. of Justice, Drug Enforcement Administration, "Notice of Denial of Petition," 65 *Federal Register* 20038, April 18, 2001.

[41] U.S. Food and Drug Administration, "Inter-Agency Advisory Regarding Claims That Smoked Marijuana Is a Medicine," press release, April 20, 2006, p. 1. Although not cited in the press release, the "past evaluation" referred to is apparently the 2001 denial of the petition to reschedule marijuana discussed above.

[42] See, for example, "The Politics of Pot," editorial, *New York Times*, April 22, 2006, p. A26, which calls the FDA statement "disingenuous" and concludes: "It's obviously easier and safer to issue a brief, dismissive statement than to back research that might undermine the administration's inflexible opposition to the medical use of marijuana."

[43] "Hinchey Leads Bipartisan House Coalition In Calling For FDA To Explain Baseless Anti-Medical Marijuana Policy," press release, April 27, 2006. (The press release, which includes the full text of the letter, is available on Rep. Hinchey's website at http://www.house.gov/hinchey/newsroom/press_2006/042706medmarijuanafdaletter.html.)

federal supply of marijuana largely inaccessible, but researchers also complain that it does not meet the needs of research due to its inferior quality and lack of multiple strains.[44] Other Schedule I substances—such as LSD, heroin, and MDMA (Ecstasy)—can be provided legally by private U.S. laboratories or imported from abroad for research purposes, with federal permission. Only marijuana is limited to a single, federally-controlled provider.

In response to this situation, Dr. Lyle Craker, a professor of plant biology and director of the medicinal plant program at the University of Massachusetts at Amherst, applied in 2001 for a DEA license to cultivate research-grade marijuana. The application was filed in association with the Multidisciplinary Association for Psychedelic Studies (MAPS), a nonprofit drug research organization headed by Dr. Rick Doblin, whose stated goal is

> to break the government's monopoly on the supply of marijuana that can be used in FDA-approved research, thereby creating the proper conditions for a $5 million, 5 year drug development effort designed to transform smoked and/or vaporized marijuana into an FDA-approved prescription medicine.[45]

After being sued for "unreasonable delay" in the DC Circuit Court of Appeals, the DEA rejected the Craker/MAPS application in December 2004 as not consistent with the public interest. Upon appeal, nine days of hearings were held over a five-month period in 2005, at which researchers testified that their requests for marijuana had been rejected, making it impossible to conduct their FDA-approved research. On February 12, 2007, DEA's Administrative Law Judge Mary Ellen Bittner found that "an inadequate supply" of marijuana is available for research and ruled that it "would be in the public interest" to allow Dr. Craker to create the proposed marijuana production facility.[46]

Rulings by administrative law judges, however, are nonbinding and may be rejected by agency heads, which happened in this case. In the closing days of the Bush Administration, on January 7, 2009, the DEA Deputy Administrator signed an order denying Dr. Craker's application for a DEA certificate of registration as a manufacturer of marijuana.[47] In response, Dr. Craker submitted to DEA a Motion to Reconsider, which, if rejected, would trigger an appeal that has been docketed by the U.S. Court of Appeals for the First Circuit in Boston.[48]

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[44] Jessica Winter, "Weed Control: Research on the Medicinal Benefits of Marijuana May Depend on Good Gardening—and Some Say Uncle Sam, the Country's Only Legal Grower of the Cannabis Plant, Isn't Much of a Green Thumb," *Boston Globe*, May 28, 2006.

[45] "The UMass Amherst MMJ Production Facility Project," on the MAPS website at http://www.maps.org/mmj/mmjfacility.html. See the entry for February 8, 2005. (Numerous documents related to the Craker/MAPS application are linked here.)

[46] U.S. Dept. of Justice, Drug Enforcement Administration, "In the Matter Lyle E. Craker, Ph.D., Docket No. 05-16, Opinion and Recommended Ruling, Findings of Fact, Conclusions of Law, and Decision of Administrative Law Judge," Mary Ellen Bittner, Administrative Law Judge, February 12, 2007, p. 87. This opinion is online at http://www.maps.org/mmj/DEAlawsuit.html.

[47] Department of Justice, "Lyle E. Craker; Denial of Application," 74 *Federal Register* 2101-2133, January 14, 2009.

[48] The documents in this case, including the ones cited here, can be found at http://www.maps.org/mmj/DEAlawsuit.html.

DEA Enforcement Actions Against Medical Marijuana Providers

Most arrests in the United States for marijuana possession are made by state and local police, not the DEA. This means that patients and their caregivers in the states that permit medical marijuana mostly go unprosecuted, because their own state's marijuana prohibition laws do not apply to them and because federal law is not usually enforced against them.

Federal agents have, however, moved against medical cannabis growers and distributors in states with medical marijuana programs. In recent years, especially during the George W. Bush Administration, DEA agents conducted many raids of medical marijuana dispensaries, especially in California, where the law states that marijuana providers can receive "reasonable compensation" on a nonprofit basis. The DEA does not provide statistics on its moves against medical marijuana outlets because the agency does not distinguish between criminal, non-medical marijuana trafficking organizations and locally licensed storefront dispensaries that are legal under state law. They are all felony criminal operations under the federal Controlled Substances Act. As a practical matter, however, the DEA reportedly was targeting larger, for-profit medical marijuana providers who were engaged in "nothing more than high-stakes drug dealing, complete with the same high-rolling lifestyles."[49] A few high-profile medical marijuana patients were also being prosecuted under federal law.[50]

In July 2007, DEA's Los Angeles Field Division Office introduced a new enforcement tactic against medical marijuana dispensaries in the city when it sent letters to the owners and managers of buildings in which medical marijuana facilities were operating. The letters threatened the property owners and managers with up to 20 years in federal prison for violating the so-called "crack house statute," a provision of the CSA enacted in 1986 that made it a federal offense to "knowingly and intentionally rent, lease, or make available for use, with or without compensation, [a] building, room, or enclosure for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance."[51] The DEA letters also threatened the landlords with seizure of their property under the CSA's asset forfeiture provisions.[52]

In response, L.A. City Council members wrote a letter to DEA Administrator Karen Tandy in Washington urging her to abandon this tactic and allow them to continue work on an ordinance to regulate medical cannabis facilities "without federal interference." They also unanimously approved a resolution endorsing the Hinchey-Rohrabacher amendment, which would prohibit

[49] Rone Tempest, "DEA Targets Larger Marijuana Providers," *Los Angeles Times*, January 1, 2007.

[50] These include medical marijuana activist and author Ed Rosenthal, whose first federal jury, in 2003, renounced its guilty verdict when it learned after the trial that he was legally helping patients under state law. He was retried and reconvicted in 2007 but not re-sentenced because he had already served his sentence of one day. See "'Guru of Ganja' Convicted on Marijuana Charges," *Associated Press*, May 30, 2007.

[51] Sec. 416 of the Controlled Substances Act (21 U.S.C. § 856) as amended by P.L. 99-570, Title I, sec. 1841(a), October 27, 1986; 100 Stat. 3207-52. Actually, the crack house statute was amended in 2003 by the "rave act" (§ 608 of P.L. 108-21, May 1, 2003; 117 Stat. 691), which broadened the language of the crack house statute to include outdoor venues and other possible places where raves could be held by striking the words "building, room, or enclosure" (which appear in the DEA letter) and replacing them with "place." This and other subtle but significant changes in the language of the law were designed to penalize rave promoters and the owners and managers of the venues where raves (all-night music festivals) occur at which Ecstasy (MDMA) and other club drugs might be used. The July 2007 DEA letter cites the language of the pre-2003 version of the crack house statute rather than the provision of law currently in force. This section of the CSA has also been used by the DEA against fund-raising events put on by drug law reform organizations.

[52] 21 U.S.C. § 881(a)(7).

such DEA actions and which was about to be debated in the House, as discussed above. An editorial in the *Los Angeles Times* called the DEA threats to landlords a "deplorable new bullying tactic."[53]

In subsequent months, DEA expanded this enforcement mechanism to other parts of California, including the Bay Area. In one lawsuit challenging the right of landlords to evict marijuana dispensaries, a Los Angeles County Superior Court judge ruled, in April 2008, that federal law preempts California's Compassionate Use Act. If the ruling is affirmed on appeal, it would threaten the future of medical marijuana in California and elsewhere.

DEA's actions against medical marijuana growing and distribution operations have provoked other lawsuits. In April 2003, for example, the city and county of Santa Cruz, CA, along with seven medical marijuana patients, filed a lawsuit in San Jose federal district court in response to DEA's earlier raid on the Wo/Men's Alliance for Medical Marijuana (WAMM). The court granted the plaintiffs' motion for a preliminary injunction, thereby allowing WAMM to resume growing and producing marijuana medications for its approximately 250 member-patients with serious illnesses, pending the final outcome of the case.[54] The suit is said to be the first court challenge brought by a local government against the federal war on drugs.

The Obama Administration and Medical Marijuana

During the presidential campaign, candidate Barack Obama stated several times his position that moving against medical marijuana dispensaries that were operating in compliance with state laws would not be a priority of his administration. Nevertheless, the continuation of such raids during the early days of the Obama Administration created confusion regarding the medical marijuana policies of the new government.[55] In mid-March, Attorney General Eric H. Holder, Jr., stated that such raids would cease.[56]

The new policy was finally formalized in a Justice Department memorandum to U.S. Attorneys dated October 19, 2009.[57] Noting that "Congress has determined that marijuana is a dangerous drug, and the illegal distribution and sale of marijuana is a serious crime," the memo directs the U.S. Attorneys in states with medical marijuana programs not to focus their investigative and prosecutorial resources "on individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana." The memo does not free medical marijuana providers from federal scrutiny, especially in cases where "state law is being invoked as a pretext for the production or distribution of marijuana for purposes not authorized by state law." The memo specifically states that "prosecution of commercial enterprises that unlawfully market and sell marijuana for profit continues to be an enforcement priority of the Department." The new directive, however, can be expected to result in fewer federal operations against medical marijuana providers than were conducted by the previous administration.

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[53] "New Challenges for Medical Marijuana," *Los Angeles Times* editorial, July 19, 2007.

[54] *County of Santa Cruz* v. *Ashcroft*, 314 F.Supp.2d 1000 (N.D.Cal. 2004); the decision, however, rests on the 9th Circuit's ruling in *Raich*, subsequently reversed by the Supreme Court, as described below.

[55] Stephen Dinan and Ben Conery, "DEA Continues Pot Raids Obama Opposes," *Washington Times*, February 5, 2009.

[56] David Johnston and Neil A. Lewis, "Obama Administration to Stop Raids on Medical Marijuana Dispensers," *New York Times*, March 19, 2009.

[57] The memorandum is available at http://blogs.usdoj.gov/blog/archives/192.

Medical Cannabis in the Courts: Major Cases

Because Congress and the executive branch have not acted to permit seriously ill Americans to use botanical marijuana medicinally, the issue has been considered by the judicial branch, with mixed results. Three significant cases have been decided so far, and other court challenges are moving through the judicial pipeline.[58]

U.S. v. *Oakland Cannabis Buyers' Cooperative* (2001)

The U.S. Department of Justice filed a civil suit in January 1998 to close six medical marijuana distribution centers in northern California. A U.S. district court judge issued a temporary injunction to close the centers, pending the outcome of the case. The Oakland Cannabis Buyers' Cooperative fought the injunction but was eventually forced to cease operations and appealed to the Ninth Circuit Court of Appeals. At issue was whether a medical marijuana distributor can use a medical necessity defense against federal marijuana distribution charges.[59]

The Ninth Circuit's decision in September 1999 found, 3-0, that medical necessity is a valid defense against federal marijuana trafficking charges if a trial court finds that the patients to whom the marijuana was distributed are seriously ill, face imminent harm without marijuana, and have no effective legal alternatives.[60] The Justice Department appealed to the Supreme Court.

The Supreme Court held, 8-0, that "a medical necessity exception for marijuana is at odds with the terms of the Controlled Substances Act" because "its provisions leave no doubt that the defense is unavailable."[61] This decision had no effect on state medical marijuana laws, which continued to protect patients and primary caregivers from arrest by state and local law enforcement agents in the states with medical marijuana programs.

Conant v. *Walters* (2002)

After the 1996 passage of California's medical marijuana initiative, the Clinton Administration threatened to investigate doctors and revoke their licenses to prescribe controlled substances and participate in Medicaid and Medicare if they recommended medical marijuana to patients under the new state law. A group of California physicians and patients filed suit in federal court, early in 1997, claiming a constitutional free-speech right, in the context of the doctor-patient relationship, to discuss the potential risks and benefits of the medical use of cannabis. A preliminary injunction, issued in April 1997, prohibited federal officials from threatening or punishing physicians for recommending marijuana to patients suffering from HIV/AIDS, cancer, glaucoma, or seizures or muscle spasms associated with a chronic, debilitating condition.[62] The court subsequently made the injunction permanent in an unpublished opinion.

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[58] For a legal analysis of the three Supreme Court cases mentioned here, see CRS Report RL31100, *Marijuana for Medical Purposes: The Supreme Court's Decision in United States v. Oakland Cannabis Buyers' Cooperative and Related Legal Issues*, by Charles Doyle.

[59] The necessity defense argues that the illegal act committed (distribution of marijuana in this instance) was necessary to avert a greater harm (withholding a helpful drug from seriously ill patients).

[60] 190 F.3d 1109.

[61] 532 U.S. 483 (2001) at 494 n. 7.

[62] *Conant* v. *McCaffrey*, 172 F.R.D. 681 (N.D. Cal. 1997).

On appeal, the Ninth Circuit affirmed, in a 3-0 decision, the district court's order entering a permanent injunction. The federal government, the opinion states, "may not initiate an investigation of a physician solely on the basis of a recommendation of marijuana within a bona fide doctor-patient relationship, unless the government in good faith believes that it has substantial evidence of criminal conduct."[63] The Bush Administration appealed, but the Supreme Court refused to take the case.

Gonzales v. *Raich* (2005)

In response to DEA agents' destruction of their medical marijuana plants, two patients and two caregivers in California brought suit. They argued that applying the Controlled Substances Act to a situation in which medical marijuana was being grown and consumed locally for no remuneration in accordance with state law exceeded Congress's constitutional authority under the Commerce Clause, which allows the federal government to regulate interstate commerce. In December 2003, the Ninth Circuit Court of Appeals in San Francisco agreed, ruling 2-1 that states are free to adopt medical marijuana laws so long as the marijuana is not sold, transported across state lines, or used for nonmedical purposes.[64] Federal appeal sent the case to the Supreme Court.

The issue before the Supreme Court was whether the Controlled Substances Act, when applied to the *intra*state cultivation and possession of marijuana for personal use under state law, exceeds Congress's power under the Commerce Clause. The Supreme Court, in June 2005, reversed the Ninth Circuit's decision and held, in a 6-3 decision, that Congress's power to regulate commerce extends to purely local activities that are "part of an economic class of activities that have a substantial effect on interstate commerce."[65]

Raich does not invalidate state medical marijuana laws. The decision does mean, however, that DEA may continue to enforce the CSA against medical marijuana patients and their caregivers, even in states with medical marijuana programs.

Although *Raich* was not about the efficacy of medical marijuana or its listing in Schedule I, the majority opinion stated in a footnote: "We acknowledge that evidence proffered by respondents in this case regarding the effective medical uses for marijuana, if found credible after trial, would cast serious doubt on the accuracy of the findings that require marijuana to be listed in Schedule I."[66] The majority opinion, in closing, notes that in the absence of judicial relief for medical marijuana users there remains "the democratic process, in which the voices of voters allied with these respondents may one day be heard in the halls of Congress."[67]

Thus, the Supreme Court reminds that Congress has the power to reschedule marijuana, thereby recognizing that it has accepted medical use in treatment in the United States. Congress, however, does not appear likely to do so. Neither does the executive branch, which could reschedule marijuana through regulatory procedures authorized by the Controlled Substances Act. In the

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[63] *Conant* v. *Walters*, 309 F.3d 629, 636 (9th Cir. 2002); the parties agreed that "a doctor who actually prescribes or dispenses marijuana violates federal law," ibid. at 634.

[64] *Raich* v. *Ashcroft*, 352 F.3d 1222 (9th Cir. 2003).

[65] *Gonzales* v. *Raich*, 125 S.Ct. 2195, 2205 (2005).

[66] Ibid. at 2211 n. 37. For a legal analysis of this case, see CRS Report RS22167, *Gonzales v. Raich: Congress's Power Under the Commerce Clause to Regulate Medical Marijuana*, by Todd B. Tatelman.

[67] Ibid. at 2215.

meantime, actions taken by state and local governments continue to raise the issue, as discussed below.

Americans for Safe Access (ASA) Lawsuit Against HHS

The federal Data Quality Act of 2001 (DQA) requires the issuance of guidelines "for ensuring and maximizing the quality, objectivity, utility, and integrity of information (including statistical information) disseminated by Federal agencies" and allows "affected persons to seek and obtain correction of information maintained and disseminated by the agency that does not comply with the guidelines."[68]

In October 2004, Americans for Safe Access (ASA), a California-based patient advocacy group, formally petitioned HHS, under the DQA, to correct four erroneous statements about medical marijuana made by HHS in its 2001 denial of the marijuana rescheduling petition discussed above. Specifically, ASA requested that "there have been no studies that have scientifically assessed the efficacy of marijuana for any medical condition" be replaced with "[a]dequate and well-recognized studies show the efficacy of marijuana in the treatment of nausea, loss of appetite, pain and spasticity"; that "it is clear that there is not a consensus of medical opinion concerning medical applications of marijuana" be replaced with "[t]here is substantial consensus among experts in the relevant disciplines that marijuana is effective in treating nausea, loss of appetite, pain and spasticity. It is accepted as medicine by qualified experts"; that "complete scientific analysis of all the chemical components found in marijuana has not been conducted" be replaced with "[t]he chemistry of marijuana is known and reproducible"; and that "marijuana has no currently accepted medical use in treatment in the United States" be replaced with "[m]arijuana has a currently accepted use in treatment in the United States." The petition claimed that "HHS's statements about the lack of medical usefulness of marijuana harms these individuals [ill persons across the United States] in that it contributes to denying them access to medicine which will alleviate their suffering."[69]

Were HHS to accept the ASA petition, the revised statements would set the preconditions for placing marijuana in a schedule other than I. HHS denied the petition in 2005 and rejected ASA's subsequent appeal in 2006 on just those grounds: that HHS is already in the process of reviewing a rescheduling petition submitted to DEA in October 2002 and will be evaluating all of the publicly available peer-reviewed literature on the medicinal efficacy of marijuana in that context. In response, in February 2007, ASA filed suit in U.S. District Court for the Northern District of California to force HHS to change the four statements, which the organization believes are not science-based. The case is pending.

State and Local Referenda and Legislation

In the face of federal intransigence on the issue, advocates of medical marijuana have turned to the states in a largely successful effort, wherever it has been attempted, to enact laws that enable

[68] P.L. 106-554, 114 Stat. 2763A-153, 44 U.S.C. § 3516 note. For background on the DQA see CRS Report RL32532, *The Information Quality Act: OMB's Guidance and Initial Implementation*, by Curtis W. Copeland.

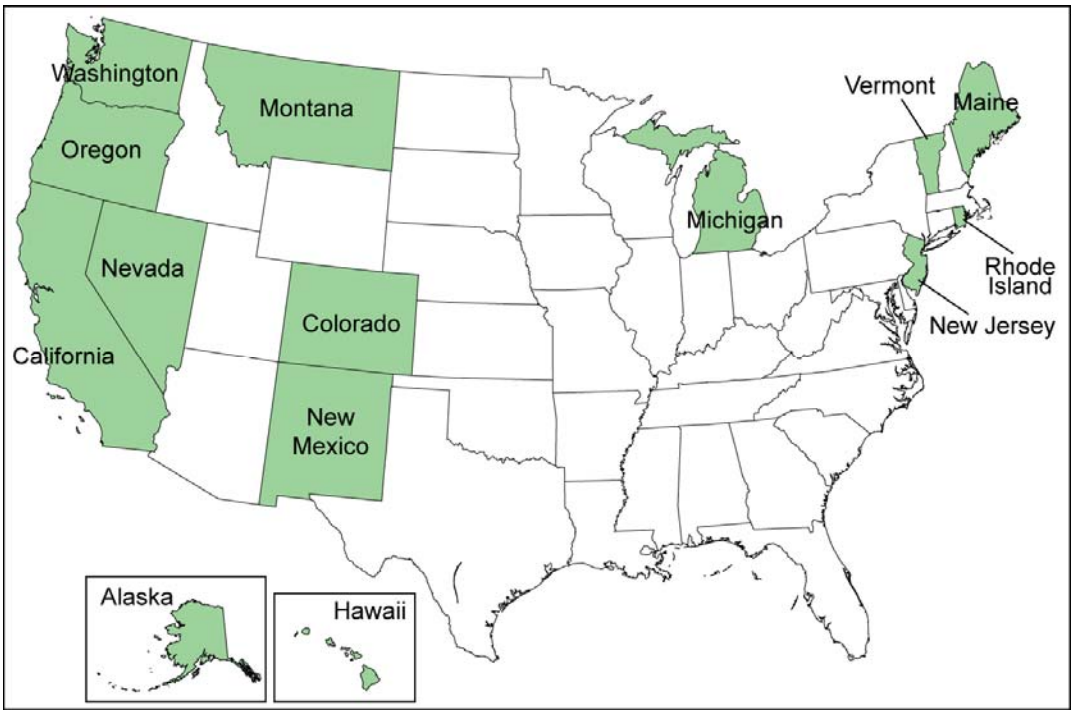
[69] The original petition and all subsequent documents relating to the case can be found at http://www.safeaccessnow.org/article.php?id=4401. See also Carolyn Marshall, "U.S. Is Sued Over Position on Marijuana," *New York Times*, February 22, 2007.

patients to obtain and use botanical marijuana therapeutically in a legal and regulated manner, even though such activity remains illegal under federal law.

States Allowing Use of Medical Marijuana[70]

Fourteen states, covering about 27% of the U.S. population, have enacted laws to allow the use of cannabis for medical purposes.[71] These states have removed state-level criminal penalties for the cultivation, possession, and use of medical marijuana, if such use has been recommended by a medical doctor. All of these states have in place, or are developing, programs to regulate the use of medical marijuana by approved patients. Physicians in these states are immune from liability and prosecution for discussing or recommending medical cannabis to their patients in accordance with state law. Patients in state programs (except for New Mexico and New Jersey) may be assisted by caregivers—persons who are authorized to help patients grow, acquire, and use the drug.

Figure 1. States With Medical Marijuana Programs



Source: Map Resources. Adapted by CRS.

[70] The information in this and the following section is drawn largely from *State-By-State Medical Marijuana Laws: How to Remove the Threat of Arrest*, Marijuana Policy Project, 2008, available at http://www.mpp.org/legislation/state-by-state-medical-marijuana-laws.html. More recent information is from press reports.

[71] Alaska (Stat. §11.71.090); California (Cal.Health & Safety Code Ann. §11362.5 and §§11362.7 to 11362.83); Colorado (Colo.Const. Art. XVIII §14); Hawaii (Rev.Stat. §§329-121 to 329-128); Maine (Me.Rev.Stat.Ann. tit.22 §1102 or 2382-B(5)); Michigan (MCL §§333.26421 to 26430); Montana (Mont.Code Ann. §§50-46-101 to 50-46-210); Nevada (Nev.Rev.Stat.Ann. §§453A.010 to 453A.400); New Jersey (N.J. Stat. §24:6I); New Mexico (N.M. Stat. Ann. §26-2B-1); Oregon (Ore.Rev.Stat. §§475.300 to 475.346); Rhode Island (RI ST §§21 to 28.6-1); Vermont (Vt.Stat.Ann. tit. 18, §§4472 to 4474d); Washington (Wash.Rev.Code Ann. §§69.51A.005 to 69.51A.902).

Nine of the 14 states that have legalized medical marijuana are in the West: Alaska, California, Colorado, Hawaii, Montana, Nevada, New Mexico, Oregon, and Washington. Of the 37 states outside the West, Michigan plus four other states, all in the Northeast—Maine, New Jersey, Rhode Island, and Vermont—have adopted medical cannabis statutes. Hawaii, New Jersey, New Mexico, Rhode Island, and Vermont have the only programs created by acts of their state legislatures. The medical marijuana programs in the other nine states were approved by the voters in statewide referenda or ballot initiatives, beginning in 1996 with California. Since then, voters have approved medical marijuana initiatives in every state where they have appeared on the ballot with the exception of South Dakota, where a medical marijuana initiative was defeated in 2006 by 52% of the voters. Bills to create medical marijuana programs have been introduced in the legislatures of additional states—Alabama, Arizona, Connecticut, Illinois, Maryland, Minnesota, and New Hampshire, among others—and have received varying levels of consideration but have so far not been enacted.

Effective state medical marijuana laws do not attempt to overturn or otherwise violate federal laws that prohibit doctors from writing prescriptions for marijuana and pharmacies from distributing it. In the 14 states with medical marijuana programs, doctors do not actually prescribe marijuana, and the marijuana products used by patients are not distributed through pharmacies. Rather, doctors *recommend* marijuana to their patients, and the cannabis products are grown by patients or their caregivers, or they are obtained from cooperatives or other alternative dispensaries. The state medical marijuana programs do, however, contravene the federal prohibition of marijuana. Medical marijuana patients, their caregivers, and other marijuana providers can, therefore, be arrested by federal law enforcement agents, and they can be prosecuted under federal law.

Statistics on Medical Marijuana Users

Determining exactly how many patients use medical marijuana with state approval is difficult, but the limited data available suggest the number is rising rapidly. According to a 2002 study published in the *Journal of Cannabis Therapeutics*, an estimated 30,000 California patients and another 5,000 patients in eight other states possessed a physician's recommendations to use cannabis medically.[72] The *New England Journal of Medicine* reported in August 2005 that an estimated 115,000 people had obtained marijuana recommendations from doctors in the states with programs.[73]

Although 115,000 people might have been approved medical marijuana users in 2005, the number of patients who had actually registered was much lower. A July 2005 CRS telephone survey of the state programs revealed a total of 14,758 registered medical marijuana users in eight states.[74] (Maine and Washington do not maintain state registries, and Rhode Island, New Mexico, Michigan, and New Jersey had not yet passed their laws.) This number vastly understated the actual number of medical marijuana users, however, because California's state registry was in pilot status, with only 70 patients so far registered.

[72] Dale Gieringer, "The Acceptance of Medical Marijuana in the U.S.," *Journal of Cannabis Therapeutics*, vol. 3, no. 1 (2003), pp. 53-67. The author later estimated that there were more than 100,000 medical marijuana patients in California alone (personal communication dated April 30, 2004).

[73] Susan Okie, "Medical Marijuana and the Supreme Court," *New England Journal of Medicine*, vol. 353, no. 7 (August 18, 2005), p. 649.

[74] The telephone survey was conducted for this report by CRS summer intern Broocks Andrew Meade.

More recently, an estimate published by *Newsweek* early in 2010 found a total of 369,634 users in the 13 states with established programs, with California's estimated patient population of 253,800 alone accounting for 69% of the total.[75] (It remains necessary to estimate California's number because registration is voluntary at both the state and county levels, and only a small fraction of patients choose to register. There were fewer than 33,000 registered patients as of March 2010, according to the state's medical marijuana program website.[76])

A brief description of each state's medical marijuana program follows. The programs are discussed in the order in which they were approved by voters or became law by actions of the state legislatures.

California (1996)

Proposition 215, approved by 56% of the voters in November, removed the state's criminal penalties for medical marijuana use, possession, and cultivation by patients with the "written or oral recommendation or approval of a physician" who has determined that the patient's "health would benefit from medical marijuana." Called the Compassionate Use Act, it legalized cannabis for "the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief." The law permits possession of an amount sufficient for the patient's "personal medical purposes." A second statute (Senate bill 420), passed in 2003, allows "reasonable compensation" for medical marijuana caregivers and states that the drug should be distributed on a nonprofit basis.

Oregon (1998)

Voters in November removed the state's criminal penalties for use, possession, and cultivation of marijuana by patients whose physicians advise that marijuana "may mitigate the symptoms or effects" of a debilitating condition. The law, approved by 55% of Oregon voters, does not provide for distribution of cannabis but allows up to seven plants per patient (changed to 24 plants by act of the state legislature in 2005). The state registry program is supported by patient fees. (In the November 2004 election, 58% of Oregon voters rejected a measure that would have expanded the state's existing program.)

Alaska (1998)

Voters in November approved a ballot measure to remove state-level criminal penalties for patients diagnosed by a physician as having a debilitating medical condition for which other approved medications were considered. The measure was approved by 58% of the voters. In 1999, the state legislature created a mandatory state registry for medical cannabis users and limited the amount a patient can legally possess to 1 ounce and six plants.

[75] Ian Yarett, "Back Story: How High Are You?," *Newsweek*, February 15, 2010, p. 56.

[76] The California Department of Public Health Medical Marijuana Program homepage is available on the Web at http://www.cdph.ca.gov/programs/MMP.

Washington (1998)

Approved in November by 59% of the voters, the ballot initiative exempts from prosecution patients who meet all qualifying criteria, possess no more marijuana than is necessary for their own personal medical use (but no more than a 60-day supply), and present valid documentation to investigating law enforcement officers. The state does not issue identification cards to patients.

Maine (1999)

Maine's ballot initiative, passed in November by 61% of the voters, puts the burden on the state to prove that a patient's medical use or possession is not authorized by statute. Patients with a qualifying condition, authenticated by a physician, who have been "advised" by the physician that they "might benefit" from medical cannabis, are permitted 1¼ ounces and six plants. There is no state registry of patients.

Hawaii (2000)

In June, the Hawaii legislature approved a bill removing state-level criminal penalties for medical cannabis use, possession, and cultivation of up to seven plants. A physician must certify that the patient has a debilitating condition for which "the potential benefits of the medical use of marijuana would likely outweigh the health risks." This was the first state law permitting medical cannabis use that was enacted by a legislature instead of by ballot initiative.

Colorado (2000)

A ballot initiative to amend the state constitution was approved by 54% of the voters in November. The amendment provides that lawful medical cannabis users must be diagnosed by a physician as having a debilitating condition and be "advised" by the physician that the patient "might benefit" from using the drug. A patient and the patient's caregiver may possess 2 usable ounces and six plants.

Nevada (2000)

To amend the state constitution by ballot initiative, a proposed amendment must be approved by the voters in two separate elections. In November, 65% of Nevada voters passed for the second time an amendment to exempt medical cannabis users from prosecution. Patients who have "written documentation" from their physicians that marijuana may alleviate their health condition may register with the state Department of Agriculture and receive an identification card that exempts them from state prosecution for using medical marijuana.

Vermont (2004)

In May, Vermont became the second state to legalize medical cannabis by legislative action instead of ballot initiative. Vermont patients are allowed to grow up to three marijuana plants in a locked room and to possess 2 ounces of manicured marijuana under the supervision of the Department of Public Safety, which maintains a patient registry. The law went into effect without the signature of the governor, who declined to sign it but also refused to veto it, despite pressure

from Washington. A 2007 legislative act expanded eligibility for the program and increased to nine the number of plants participants may grow.

Montana (2004)

In November, 62% of state voters passed Initiative 148, allowing qualifying patients to use marijuana under medical supervision. Eligible medical conditions include cancer, glaucoma, HIV/AIDS, wasting syndrome, seizures, and severe or chronic pain. A doctor must certify that the patient has a debilitating medical condition and that the benefits of using marijuana would likely outweigh the risks. The patient may grow up to six plants and possess 1 ounce of dried marijuana. The state public health department registers patients and caregivers.

Rhode Island (2006)

In January, the state legislature overrode the governor's veto of a medical marijuana bill, allowing patients to possess up to 12 plants or 2½ ounces to treat cancer, HIV/AIDS, and other chronic ailments. The law included a sunset provision and was set to expire on July 1, 2007, unless renewed by the legislature. The law was made permanent on June 21, 2007, after legislators voted again to override the governor's veto by a wide margin.

New Mexico (2007)

Passed by the legislature and signed into law by the governor in April, the Lynn and Erin Compassionate Use Medical Marijuana Act went into effect on July 1, 2007. It requires the state's Department of Health to set rules governing the distribution of medical cannabis to state-authorized patients. Unlike most other state programs, patients and their caregivers cannot grow their own marijuana; rather, it will be provided by state-licensed "cannabis production facilities."

Michigan (2008)

Approved by 63% of Michigan voters in the November 2008 presidential election, Proposal 1 permits physicians to approve marijuana use by registered patients with debilitating medical conditions, including cancer, HIV/AIDS, hepatitis C, multiple sclerosis, glaucoma, and other conditions approved by the state's Department of Community Health. Up to 12 plants can be cultivated in an indoor, locked facility by the patient or a designated caregiver.

New Jersey (2010)

A bill passed by the legislature and signed by the governor allows for the regulated distribution of marijuana by state-monitored dispensaries. Doctors may recommend up to 2 ounces monthly to registered patients, who are not allowed to grow their own. Considered the most restrictive of the state programs approved to date, the law restricts usage to a specific set of diseases including cancer, AIDS, glaucoma, muscular dystrophy, multiple sclerosis, and other diseases involving severe and chronic pain, severe nausea, seizures, or severe and persistent muscle spasms.

Other State and Local Medical Marijuana Laws

Arizona (1996)

Arizona's law,[77] approved by 65% of the voters in November, permits marijuana prescriptions, but there is no active program in the state because federal law prohibits doctors from *prescribing* marijuana. Patients cannot, therefore, obtain a valid prescription. (Other states' laws allow doctors to "recommend" rather than "prescribe.")

Maryland (2003)

Maryland's General Assembly became the second state legislature, after Hawaii, to protect medical cannabis patients from the threat of jail when it approved a bill, later signed by the governor, providing that patients using marijuana preparations to treat the symptoms of illnesses such as cancer, AIDS, and Crohn's disease would be subject to no more than a $100 fine.[78] The law falls short of full legalization and does not create a medical marijuana program, but it allows for a medical necessity defense for people who use marijuana on their own for medical purposes. If patients arrested for possession in Maryland can prove in court that they use cannabis for legitimate medical needs, they escape the maximum penalty of one year in jail and a $1,000 fine.

Other State Laws

Laws favorable to medical marijuana have been enacted in 36 states since 1978.[79] Except for the state laws mentioned above, however, these laws do not currently protect medical marijuana users from state prosecution. Some laws, for example, allow patients to acquire and use cannabis through therapeutic research programs, although none of these programs has been operational since 1985, due in large part to federal opposition. Other state laws allow doctors to prescribe marijuana or allow patients to possess marijuana if it has been obtained through a prescription, but the federal Controlled Substances Act prevents these laws from being implemented. Several states have placed marijuana in a controlled drug schedule that recognizes its medical value. State legislatures continue to consider medical marijuana bills, some favorable to its use by patients, others not. In Michigan, a medical marijuana initiative will be presented to the voters on the November 2008 ballot.

District of Columbia (1998)

In the nation's capital, 69% of voters approved a medical cannabis initiative to allow patients a "sufficient quantity" of marijuana to treat illness and to permit nonprofit marijuana suppliers. In every year since then, however, Congress attached a rider to the D.C. appropriations act blocking the Initiative 59 from taking effect, until Congress eliminated the ban in the FY2010 DC appropriations act (H.R. 3288, which was signed into law in December 2009 (P.L. 111-117). More than 11 years after DC voters approved the medical marijuana measure, city officials were free to

[77] Ariz.Rev.Stat.Ann. §13-3412.01(A).

[78] Md. Crim.Code Ann. §5-601.

[79] *State-By-State Medical Marijuana Laws: How to Remove the Threat of Arrest*, Marijuana Policy Project, 2008, p. 2 and Appendix A. The laws in some of these states have expired or been repealed.

begin drafting legislation to create a medical marijuana program in the nation's capital.[80] Any law passed by the DC Council and signed into law by the mayor would be subject to congressional approval.

Local Measures

Medical cannabis measures have been adopted in several localities throughout the country. San Diego is the country's largest city to do so. One day after the Supreme Court's anti-marijuana ruling in *Gonzales* v. *Raich* was issued, Alameda County in California approved an ordinance to regulate medical marijuana dispensaries, becoming the 17th locality in the state to do so. Localities in nonmedical marijuana states have also acted. In November 2004, for example, voters in Columbia, MO, and Ann Arbor, MI, approved medical cannabis measures. Since then, four other Michigan cities, including Detroit, have done the same. Although largely symbolic, such local laws can influence the priorities of local law enforcement officers and prosecutors.

Public Opinion on Medical Marijuana

Majorities of voters in nine states have now approved medical marijuana initiatives to protect patients from arrest under state law. More broadly, national public opinion polls have consistently favored access to medical marijuana by seriously ill patients. ProCon.org, a nonprofit and nonpartisan public education foundation, has identified 23 national public opinion polls that asked questions about medical marijuana from 1995 to the present. Respondents in every poll were in favor of medical marijuana by substantial margins, ranging from 60% to 85%.[81]

Among recent opinion surveys, a January 2010 ABC News/Washington Post poll found that more than 8 in 10 Americans (81%) supported efforts to make marijuana legal for medical use, up from 69% in 1997. Given three choices as to who should be allowed to use it where it is legal, 56% of respondents chose the most lenient position of prescribing it "for any patient the doctor thinks it could help." Its use would be restricted to "patients who have serious but not fatal illnesses" by 21%, and another 21% would limit the drug "to patients who are terminally ill and near death." According to the pollsters' analysis,

> Medical marijuana … receives majority support across the political and ideological spectrum, from 68 percent of conservatives and 72 percent of Republicans as well as 85 percent of Democrats and independents and about nine in 10 liberals and moderates. Support slips to 69 percent among seniors, vs. 83 percent among all adults under age 65.[82]

The *Journal of the American Medical Association* analyzed public opinion on the War on Drugs in a 1998 article. The authors' observations concerning public attitudes toward medical marijuana remain true today:

> While opposing the use or legalization of marijuana for recreational purposes, the public apparently does not want to deny very ill patients access to a potentially helpful drug therapy

[80] Tim Craig, "D.C. Council Proposes Legalization of Medical Marijuana," *Washington Post*, January 20, 2010, p. B1.

[81] The questions asked and the results obtained can be viewed at http://medicalmarijuana.procon.org/view.additional-resource.php?resourceID=151.

[82] Gary Langer, "High Support for Medical Marijuana," ABC News/Washington Post Poll, January 18, 2010.

> if prescribed by their physicians. The public's support of marijuana for medical purposes is conditioned by their belief that marijuana would be used only in the treatment of serious medical conditions.[83]

In public opinion polls, then, the majority of Americans appear to hold that seriously ill or terminal patients should be able to use marijuana if recommended by their doctors. Fourteen state governments have created medical marijuana programs, either through ballot initiatives or the legislative process. Many other state governments, however, along with the federal government, remain opposed to the national majority in favor of medical marijuana.

Analysis of Arguments For and Against Medical Marijuana

In the ongoing debate over cannabis as medicine, certain arguments are frequently made on both sides of the issue. These arguments are briefly stated below and are analyzed in turn. CRS takes no position on the claims or counterclaims in this debate.

What follows is an attempt to analyze objectively the claims frequently made about the role that herbal cannabis might or might not play in the treatment of certain diseases and about the possible societal consequences should its role in the practice of modern medicine be expanded beyond the places where it is now permitted under state laws.

For those interested in learning more about medical marijuana research findings, the Internet offers two useful websites. The International Association for Cannabis as Medicine (IACM), based in Germany, provides abundant information on the results of controlled clinical trials at http://www.cannabis-med.org. Information on peer-reviewed, double-blind studies on both animals and human subjects conducted since 1990 has been compiled by ProCon.org and is available at http://www.medicalmarijuanaprocon.org.

Marijuana Is Harmful and Has No Medical Value

> *Suitable and superior medicines are currently available for treatment of all symptoms alleged to be treatable by crude marijuana.*
> —Brief of the Drug Free America Foundation, et al., 2004[84]

The federal government—along with many state governments and private antidrug organizations—staunchly maintains that botanical marijuana is a dangerous drug without any legitimate medical use. Marijuana intoxication can impair a person's coordination and decision-making skills and alter behavior. Chronic marijuana smoking can adversely affect the lungs, the cardiovascular system, and possibly the immune and reproductive systems.[85]

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[83] Robert J. Blend on and John T. Young, "The Public and the War on Illicit Drugs," *Journal of the American Medical Association*, vol. 279, no. 11 (March 18, 1998), p. 831.

[84] Brief for the Drug Free America Foundation, Inc. et al. as Amici Curiae Supporting Petitioners at 13, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454). The amici curiae briefs filed in *Raich* contain a wealth of information and arguments on both sides of the medical marijuana debate. They are available online at http://www.angeljustice.org.

[85] See, for example, "Exposing the Myth of Medical Marijuana," on the DEA website at http://www.usdoj.gov/dea/ (continued...)

Of course, FDA's 1985 approval of Marinol proves that the principal psychoactive ingredient of marijuana—THC—has therapeutic value. But that is not the issue in the medical marijuana debate. Botanical marijuana remains a plant substance, an herb, and its opponents say it cannot substitute for legitimate pharmaceuticals. Just because certain molecules found in marijuana might have become approved medicines, they argue, does not make the unpollinated bud of the female Cannabis sativa plant a safe and effective medicine. The Drug Free America Foundation calls the medical use of crude marijuana "a step backward to the times of potions and herbal remedies."[86]

The federal government's argument that marijuana has no medical value is straightforward. A drug, in order to meet the standard of the Controlled Substances Act as having a "currently accepted medical use in treatment in the United States," must meet a five-part test:

> (1) The drug's chemistry must be known and reproducible,
> (2) there must be adequate safety studies,
> (3) there must be adequate and well-controlled studies proving efficacy,
> (4) the drug must be accepted by qualified experts, and
> (5) the scientific evidence must be widely available.[87]

According to the DEA, botanical marijuana meets none of these requirements. First, marijuana's chemistry is neither fully known nor reproducible. Second, adequate safety studies have not been done. Third, there are no adequate, well-controlled scientific studies proving marijuana is effective for any medical condition. Fourth, marijuana is not accepted by even a significant minority of experts qualified to evaluate drugs. Fifth, published scientific evidence concluding that marijuana is safe and effective for use in humans does not exist.[88]

The same DEA Final Order that set forth the five requirements for currently accepted medical use also outlined scientific evidence that would be considered irrelevant by the DEA in establishing currently accepted medical use. These include individual case reports, clinical data collected by practitioners, studies conducted by persons not qualified by scientific training and experience to evaluate the safety and effectiveness of the substance at issue, and studies or reports so lacking in detail as to preclude responsible scientific evaluation. Such information is inadequate for experts to conclude responsibly and fairly that marijuana is safe and effective for use as medicine.[89] The DEA and other federal drug control agencies can thereby disregard medical literature and opinion that claim to show the therapeutic value of marijuana because they do not meet the government's standards of proof.

The official view of medical marijuana is complicated by the wider War on Drugs. It is difficult to disentangle the medical use of locally grown marijuana for personal use from the overall policy of marijuana prohibition, as the Supreme Court made clear in *Raich*. To make an exemption for medical marijuana, the Court decided, "would undermine the orderly enforcement of the entire

(...continued)

ongoing/marijuanap.html.

[86] Ibid., at 25.

[87] This test was first formulated by the DEA in 1992 in response to a marijuana rescheduling petition. See U.S. Department of Justice, Drug Enforcement Administration, "Marijuana Scheduling Petition; Denial of Petition; Remand," 57 *Federal Register* 10499, March 26, 1992, at 10506.

[88] Ibid., p. 10507.

[89] Ibid., pp. 10506-10507.

regulatory scheme ... The notion that California law has surgically excised a discrete activity that is hermetically sealed off from the larger interstate marijuana market is a dubious proposition.... „[90]

It remains the position of the federal government, then, that the Schedule I substance marijuana is harmful—not beneficial—to human health. Its use for any reason, including medicinal, should continue to be prohibited and punished. Despite signs of a more tolerant public attitude toward medical marijuana, its therapeutic benefits, if any, will continue to be officially unacknowledged and largely unrealized in the United States so long as this position prevails at the federal level.

Marijuana Effectively Treats the Symptoms of Some Diseases

> *[I]t cannot seriously be contested that there exists a small but significant class of individuals who suffer from painful chronic, degenerative, and terminal conditions, for whom marijuana provides uniquely effective relief.*
> —Brief of the Leukemia & Lymphoma Society, et al., 2004[91]

Proponents of medical marijuana point to a large body of studies from around the world that support the therapeutic value of marijuana in treating a variety of disease-related problems, including

- relieving nausea,
- increasing appetite,
- reducing muscle spasms and spasticity,
- relieving chronic pain,
- reducing intraocular pressure, and
- relieving anxiety.[92]

Given these properties, marijuana has been used successfully to treat the debilitating symptoms of cancer and cancer chemotherapy,[93] AIDS, multiple sclerosis, epilepsy, glaucoma, anxiety, and other serious illnesses.[94] As opponents of medical marijuana assert, existing FDA-approved pharmaceuticals for these conditions are generally more effective than marijuana. Nevertheless, as the IOM Report acknowledged, the approved medicines do not work for everyone.[95] Many medical marijuana users report trying cannabis only reluctantly and as a last resort after

[90] *Gonzales* v. *Raich*, 125 S.Ct. 2195, at 2212 and 2213 (2005).

[91] Brief for the Leukemia & Lymphoma Society, et al. as Amici Curiae Supporting Respondents at 4, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454).

[92] Ibid., at 1-2.

[93] A 1990 survey of oncologists found that 54% of those with an opinion on medical marijuana favored the controlled medical availability of marijuana and 44% had already broken the law by suggesting at least once that a patient obtain marijuana illegally. R. Doblin and M. Kleiman, "Marijuana as Antiemetic Medicine," *Journal of Clinical Oncology*, vol. 9 (1991), pp. 1314-1319.

[94] There is evidence that marijuana might also be useful in treating arthritis, migraine, menstrual cramps, alcohol and opiate addiction, and depression and other mood disorders.

[95] IOM Report, pp. 3-4: "The effects of cannabinoids on the symptoms studied are generally modest, and in most cases there are more effective medications. However, people vary in their responses to medications, and there will likely always be a subpopulation of patients who do not respond well to other medications."

exhausting all other treatment modalities. A distinct subpopulation of patients now relies on whole cannabis for a degree of relief that FDA-approved synthetic drugs do not provide.

Medical cannabis proponents claim that single-cannabinoid, synthetic pharmaceuticals like Marinol are poor substitutes for the whole marijuana plant, which contains more than 400 known chemical compounds, including about 60 active cannabinoids in addition to THC. They say that scientists are a long way from knowing for sure which ones, singly or in combination, provide which therapeutic effects. Many patients have found that they benefit more from the whole plant than from any synthetically produced chemical derivative.[96] Furthermore, the natural plant can be grown easily and inexpensively, whereas Marinol and any other cannabis-based pharmaceuticals that might be developed in the future will likely be expensive—prohibitively so for some patients.[97]

In recognition of the therapeutic benefits of botanical marijuana products, various associations of health professionals have passed resolutions in support of medical cannabis. These include the American Public Health Association, the American Nurses Association, and the California Pharmacists Association. The *New England Journal of Medicine* has editorialized in favor of patient access to marijuana.[98] Other groups, such as the American Medical Association, are more cautious. Their position is that not enough is known about botanical marijuana and that more research is needed.

The recent discovery of cannabinoid receptors in the human brain and immune system provides a biological explanation for the claimed effectiveness of marijuana in relieving multiple disease symptoms. The human body produces its own cannabis-like compounds, called endocannabinoids, that react with the body's cannabinoid receptors. Like the better known opiate receptors, the cannabinoid receptors in the brain stem and spinal cord play a role in pain control. Cannabinoid receptors, which are abundant in various parts of the human brain, also play a role in controlling the vomiting reflex, appetite, emotional responses, motor skills, and memory formation. It is the presence of these natural, endogenous cannabinoids in the human nervous and immune systems that provides the basis for the therapeutic value of marijuana and that holds the key, some scientists believe, to many promising drugs of the future.[99]

The federal government's own IND Compassionate Access Program, which has provided government-grown medical marijuana to a select group of patients since 1978, provides important evidence that marijuana has medicinal value and can be used safely. A scientist and organizer of the California medical marijuana initiative, along with two medical-doctor colleagues, has written:

> Nothing reveals the contradictions in federal policy toward marijuana more clearly than the fact that there are still eight patients in the United States who receive a tin of marijuana 'joints' (cigarettes) every month from the federal government.... These eight people can

[96] Brief for the Leukemia & Lymphoma Society et al. as Amici Curiae Supporting Respondents at 18, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454).

[97] Marinol currently sells at retail for about $17 per pill.

[98] "Federal Foolishness and Marijuana," *New England Journal of Medicine*, vol. 336, no. 5 (January 30, 1997), pp. 366-367.

[99] For a summary of the growing body of research on endocannabinoids, see Roger A. Nicoll and Bradley N. Alger, "The Brain's Own Marijuana," Scientific American, December 2004, pp. 68-75, and Jean Marx, "Drugs Inspired by a Drug," Science, January 20, 2006, pp. 322-325.

> legally possess and use marijuana, at government expense and with government permission. Yet hundreds of thousands of other patients can be fined and jailed under federal law for doing exactly the same thing.[100]

Smoking Is an Improper Route of Drug Administration

> *Can you think of any other untested, home-made, mind-altering medicine that you self-dose, and that uses a burning carcinogen as a delivery vehicle?*
> —General Barry McCaffrey, U.S. Drug Czar, 1996-2000[101]

That medical marijuana is smoked is probably the biggest obstacle preventing its wider acceptance. Opponents of medical marijuana argue that smoking is a poor way to take a drug, that inhaling smoke is an unprecedented drug delivery system, even though many approved medications are marketed as inhalants. DEA Administrator Karen Tandy writes:

> The scientific and medical communities have determined that smoked marijuana is a health danger, not a cure. There is no medical evidence that smoking marijuana helps patients. In fact, the Food and Drug Administration (FDA) has approved no medications that are smoked, primarily because smoking is a poor way to deliver medicine. Morphine, for example has proven to be a medically valuable drug, but the FDA does not endorse smoking opium or heroin.[102]

Medical marijuana opponents argue that chronic marijuana smoking is harmful to the lungs, the cardiovascular system, and possibly the immune and reproductive systems. These claims may be overstated to help preserve marijuana prohibition. For example, neither epidemiological nor aggregate clinical data show higher rates of lung cancer in people who smoke marijuana.[103] The other alleged harms also remain unproven. Even if smoking marijuana is proven harmful, however, the immediate benefits of smoked marijuana could still outweigh the potential long-term harms—especially for terminally ill patients.[104]

The therapeutic value of *smoked* marijuana is supported by existing research and experience. For example, the following statements appeared in the American Medical Association's "Council on Scientific Affairs Report 10—Medicinal Marijuana,"[105] adopted by the AMA House of delegates on December 9, 1997:

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[100] Bill Zimmerman, *Is Marijuana the Right Medicine For You? A Factual Guide to Medical Uses of Marijuana* (Keats Publishing, New Canaan, CT: 1998), p. 25.

[101] Barry R. McCaffrey, "We're on a Perilous Path," *Newsweek*, February 3, 1997, p. 27.

[102] Karen Tandy, "Marijuana: The Myths Are Killing Us," *Police Chief Magazine*, March 2005, available at http://www.usdoj.gov/dea/pubs/pressrel/pr042605p.html.

[103] Lynn Zimmer and John P. Morgan, *Marijuana Myths Marijuana Facts* (New York: Lindesmith Center, 1997), p. 115.

[104] Medicines do not have to be completely safe to be approved. In fact, no medicine is completely safe; every drug has toxicity concerns. All pharmaceuticals have potentially harmful side effects, and it would be startling, indeed, if botanical marijuana were found to be an exception. The IOM Report states that "except for the harms associated with smoking, the adverse effects of marijuana use are within the range of effects tolerated for other medications." (p. 5)

[105] American Medical Association, Council on Scientific Affairs Report: *Medical Marijuana (A-01)*, June 2001. An unpaginated version of this document can be found on the Web at http://www.mfiles.org/Marijuana/medicinal_use/b2_ama_csa_report.html.

- "Smoked marijuana was comparable to or more effective than oral THC [Marinol], and considerably more effective than prochlorperazine or other previous antiemetics in reducing nausea and emesis." (p. 10)
- "Anecdotal, survey, and clinical data support the view that smoked marijuana and oral THC provide symptomatic relief in some patients with spasticity associated with multiple sclerosis (MS) or trauma." (p. 13)
- "Smoked marijuana may benefit individual patients suffering from intermittent or chronic pain." (p. 15)

The IOM Report expressed concerns about smoking (p. 126): "Smoked marijuana is unlikely to be a safe medication for any chronic medical condition." Despite this concern, the IOM Report's authors were willing to recommend smoked marijuana under certain limited circumstances. For example, the report states (p. 154):

> Until the development of rapid-onset antiemetic drug delivery systems, there will likely remain a subpopulation of patients for whom standard antiemetic therapy is ineffective and who suffer from debilitating emesis. It is possible that the harmful effects of smoking marijuana for a limited period of time might be outweighed by the antiemetic benefits of marijuana, at least for patients for whom standard antiemetic therapy is ineffective and who suffer from debilitating emesis. Such patients should be evaluated on a case-by-case basis and treated under close medical supervision.

The IOM Report makes another exception for terminal cancer patients (p. 159):

> Terminal cancer patients pose different issues. For those patients the medical harm associated with smoking is of little consequence. For terminal patients suffering debilitating pain or nausea and for whom all indicated medications have failed to provide relief, the medical benefits of smoked marijuana might outweigh the harm.

Smoking can actually be a preferred drug delivery system for patients whose nausea prevents them from taking anything orally. Such patients *need* to inhale their antiemitic drug. Other patients *prefer* inhaling because the drug is absorbed much more quickly through the lungs, so that the beneficial effects of the drug are felt almost at once. This rapid onset also gives patients more control over dosage. For a certain patient subpopulation, then, these advantages of inhalation may prevail over both edible marijuana preparations and pharmaceutical drugs in pill form, such as Marinol.

Moreover, medical marijuana advocates argue that there are ways to lessen the risks of smoking. Any potential problems associated with smoking, they argue, can be reduced by using higher potency marijuana, which means that less has to be inhaled to achieve the desired therapeutic effect. Furthermore, marijuana does not have to be smoked to be used as medicine. It can be cooked in various ways and eaten.[106] Like Marinol, however, taking marijuana orally can be difficult for patients suffering from nausea. Many patients are turning to vaporizers, which offer the benefits of smoking—rapid action, ease of dose titration—without having to inhale smoke. Vaporizers are devices that take advantage of the fact that cannabinoids vaporize at a lower temperature than that required for marijuana to burn. Vaporizers heat the plant matter enough for the cannabinoids to be released as vapor without having to burn the marijuana preparation.

[106] Cannabis preparations are also used topically as oils and balms to soothe muscles, tendons, and joints.

Patients can thereby inhale the beneficial cannabinoids without also having to inhale the potentially harmful by-products of marijuana combustion.[107]

Marijuana Should Be Rescheduled To Permit Medical Use

> *[T]he administrative law judge concludes that the provisions of the [Controlled Substances] Act permit and require the transfer of marijuana from Schedule I to Schedule II. The Judge realizes that strong emotions are aroused on both sides of any discussion concerning the use of marijuana. Nonetheless it is essential for this Agency [DEA], and its Administrator, calmly and dispassionately to review the evidence of record, correctly apply the law, and act accordingly.*
> —Francis L. Young, DEA Administrative Law Judge, 1988[108]

Proponents of medical marijuana believe its placement in Schedule I of the CSA was an error from the beginning. Cannabis is one of the safest therapeutically active substances known.[109] No one has ever died of an overdose.[110] Petitions to reschedule marijuana have been received by the federal government, and rejected, ever since the original passage of the Controlled Substances Act in 1970.

Rescheduling can be accomplished administratively or it can be done by an act of Congress. Administratively, the federal Department of Health and Human Services (HHS) could find that marijuana meets sufficient standards of safety and efficacy to warrant rescheduling. Even though THC, the most prevalent cannabinoid in marijuana, was administratively moved to Schedule III in 1999, no signs exist that botanical marijuana will similarly be rescheduled by federal agency ruling anytime soon.

An act of Congress to reschedule marijuana is only slightly less likely, although such legislation has been introduced in recent Congresses including the 111th.[111] The Medical Marijuana Patient Protection Act (H.R. 2835/Frank), which would move marijuana from Schedule I to Schedule II of the Controlled Substances Act, has seen no action beyond committee referral.[112]

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[107] Several companies offer vaporizers for sale in the United States, but their marketing is complicated by marijuana prohibition and by laws prohibiting drug paraphernalia. The advantages of the vaporizer were brought to the attention of the IOM panel. The IOM Report, however, devoted only one sentence to such devices, despite its recommendation for research into safe delivery systems. The IOM Report said, "Vaporization devices that permit inhalation of plant cannabinoids without the carcinogenic combustion products found in smoke are under development by several groups; such devices would also require regulatory review by the FDA." (p. 216)

[108] U.S. Dept. of Justice, Drug Enforcement Administration, "In the Matter of Marijuana Rescheduling Petition, Docket No. 86-22, Opinion and Recommended Ruling, Findings of Fact, Conclusions of Law and Decision of Administrative Law Judge," Francis L. Young, Administrative Law Judge, September 6, 1988, p. 67. This opinion is online at http://www.druglibrary.net/olsen/MEDICAL/YOUNG/young.html.

[109] Ibid., pp. 58-59.

[110] Ibid., p. 56.

[111] When Congress directly schedules a drug, as it did marijuana in 1970, it is not bound by the criteria in section 202(b) of the CSA (21 U.S.C. 812(b)).

[112] Congress could also follow the lead of some states that have a dual scheduling scheme for botanical marijuana whereby its recreational use is prohibited (Schedule I) but it is permitted when used for medicinal purposes (Schedules II or III). Congress could achieve the same effect by leaving marijuana in Schedule I but removing criminal penalties for the medical use of marijuana, commonly called *decriminalization*. Congress could also opt for *legalization* by removing marijuana from the CSA entirely and subjecting it to federal and state controls based on the tobacco or alcohol regulatory models or by devising a regulatory scheme unique to marijuana. None of these options seem likely (continued...)

Schedule II substances have a high potential for abuse and may lead to severe psychological or physical dependence but have a currently accepted medical use in treatment in the United States. Cocaine, methamphetamine, morphine, and methadone are classified as Schedule II substances. Many drug policy experts and laypersons alike believe that marijuana should also reside in Schedule II.

Others think marijuana should be properly classified as a Schedule III substance, along with THC and its synthetic version, Marinol. Substances in Schedule III have less potential for abuse than the drugs in Schedules I and II, their abuse may lead to moderate or low physical dependence or high psychological dependence, and they have a currently accepted medical use in treatment in the United States.

Rescheduling seems to be supported by public opinion. A nationwide Gallup Poll conducted in March 1999 found that 73% of American adults favored "making marijuana legally available for doctors to prescribe in order to reduce pain and suffering." An AARP poll of American adults age 45 and older conducted in mid-November 2004 found that 72% agreed that adults should be allowed to legally use marijuana for medical purposes if recommended by a physician. A January 2010 ABC News/Washington Post poll found that more than 8 in 10 Americans (81%) supported efforts to make marijuana legal for medical use.[113]

Few Members of Congress, however, publicly support the rescheduling option. The Medical Marijuana Patient Protection Act (H.R. 2835), which would move marijuana from Schedule I to Schedule II of the Controlled Substances Act, as mentioned above, currently has 30 cosponsors.

State Medical Marijuana Laws Increase Illicit Drug Use

> *The natural extension of this myth [that marijuana is good medicine] is that, if marijuana is medicine, it must also be safe for recreational use.*
> —Karen P. Tandy, DEA Administrator, 2005[114]

It is the position of the federal government that to permit the use of medical marijuana affords the drug a degree of legitimacy it does not deserve. America's youth are especially vulnerable, it is said, and state medical marijuana programs send the wrong message to our youth, many of whom do not recognize the very real dangers of marijuana.

Studies show that the use of an illicit drug is inversely proportional to the perceived harm of that drug. That is, the more harmful a drug is perceived to be, the fewer the number of people who will try it.[115] Opponents of medical marijuana argue that "surveys show that perception of harm

(...continued)

given the current political climate in which both political parties support continued marijuana prohibition.

[113] These and other poll results can be consulted at http://medicalmarijuana.procon.org/view.resource.php?resourceID=000148. This website states: "Because the majority (98% or more) of the voter initiatives and polls we located were favorable towards the medical use of marijuana, we contacted several organizations decidedly 'con' to medical marijuana—two of which were federal government agencies—and none knew of any voter initiatives or polls that were 'con' to medical marijuana."

[114] Karen Tandy, "Marijuana: The Myths Are Killing Us," *Police Chief Magazine*, March 2005, available at http://www.usdoj.gov/dea/pubs/pressrel/pr042605p.html.

[115] See, for example, J.G. Bachman et al., "Explaining Recent Increases in Students' Marijuana Use: Impacts of Perceived Risks and Disapproval, 1976 through 1996," *American Journal of Public Health*, vol. 88 (1998), pp. 887-
(continued...)

with respect to marijuana has been dropping off annually since the renewal of the drive to legalize marijuana as medicine, which began in the early 1990s when legalization advocates first gained a significant increase in funding and began planning the state ballot initiative drive to legalize crude marijuana as medicine."[116] They point to the 1999 National Household Survey on Drug Abuse (NHSDA), which "reveals that those states which have passed medical marijuana laws have among the highest levels of past-month marijuana use, of past-month other drug use, of drug addiction, and of drug and alcohol addiction."[117]

Indeed, all 11 states that have passed medical marijuana laws ranked above the national average in the percentage of persons 12 or older reporting past-month use of marijuana in 1999, as shown in **Table 2**. It is at least possible, however, that this analysis confuses cause with effect. It is logical to assume that the states with the highest prevalence of marijuana usage would be more likely to approve medical marijuana programs, because the populations of those states would be more knowledgeable of marijuana's effects and more tolerant of its use.

It is also the case that California, the state with the largest and longest-running medical marijuana program, ranked 34th in the percentage of persons age 12-17 reporting marijuana use in the past month during the period 2002-2003, as shown in **Table 1**. In fact, between 1999 and 2002-2003, of the 10 states with active medical marijuana programs, five states (AK, HI, ME, MT, VT) rose in the state rankings of past-month marijuana use by 12- to 17-year-olds and five states fell (CA, CO, NV, OR, WA).[118] Of the five states that had approved medical marijuana laws before 1999 (AK, AZ, CA, OR, WA), only Alaska's ranking rose between 1999 and 2002-2003, from 7th to 4th, with 11.08% of youth reporting past-month marijuana use in 2002-2003 compared with 10.4% in 1999. No clear patterns are apparent in the state-level data. Clearly, more important factors are at work in determining a state's prevalence of recreational marijuana use than whether the state has a medical marijuana program.

The IOM Report found no evidence for the supposition that state medical marijuana programs lead to increased use of marijuana or other drugs (pp. 6-7):

> Finally, there is a broad social concern that sanctioning the medical use of marijuana might increase its use among the general population. At this point there are no convincing data to support this concern. The existing data are consistent with the idea that this would not be a problem if the medical use of marijuana were as closely regulated as other medications with abuse potential.... [T]his question is beyond the issues normally considered for medical uses of drugs and should not be a factor in evaluating the therapeutic potential of marijuana or cannabinoids.

(...continued)

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[116] Brief for the Drug Free America Foundation, Inc. et al. as Amici Curiae Supporting Petitioners at 26, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454).

[117] Ibid., at 27. The 1999 NHSDA was the first to include state-level estimates for various measures of drug use. Unfortunately, comprehensive state-level data prior to 1999 are not available from other sources.

[118] Care should be taken in comparing NHSDA data for 1999 with NSDUH data for 2002 and after, due to changes in survey methodology made in 2002. The trend observations drawn here from these data should therefore be considered suggestive rather than definitive.

Table 1. States Ranked by Percentage of Youth Age 12-17 Reporting Past-Month Marijuana Use, 1999 and 2002-2003

1999			2002-2003		
Rank	**State**	**%**	**Rank**	**State**	**%**
1	Delaware	13.9	1	**Vermont**	13.32
2	Massachusetts	11.9	2	**Montana**	12.07
3	**Nevada**	11.6	3	New Hampshire	11.79
4	**Montana**	11.4	4	**Alaska**	11.08
5	Rhode Island	10.8	5	Rhode Island	10.86
6	New Hampshire	10.7	6	**Maine**	10.56
7	**Alaska**	10.4	7	Massachusetts	10.53
8	**Colorado**	10.3	8	New Mexico	10.35
9	Minnesota	9.9	9	**Hawaii**	10.23
9	**Washington**	9.9	10	**Colorado**	9.82
11	**Oregon**	9.6	11	**Nevada**	9.58
	District of Columbia	9.6	12	South Dakota	9.57
12	Illinois	9.2	13	Delaware	9.41
12	New Mexico	9.2	14	**Oregon**	9.31
14	Maryland	8.8	15	Michigan	9.23
15	Indiana	8.7	16	Connecticut	9.22
16	Connecticut	8.6	17	Nebraska	9.13
17	**Vermont**	8.4	18	**Washington**	9.11
18	**Hawaii**	8.3	19	Minnesota	8.92
18	Wisconsin	8.3	20	New York	8.76
20	Michigan	7.8	21	Ohio	8.74
20	Wyoming	7.8	22	West Virginia	8.62
22	**California**	7.7	23	Florida	8.52
23	North Dakota	7.6	24	North Carolina	8.44
	National	7.4	25	Virginia	8.43
24	South Carolina	7.4	26	Pennsylvania	8.18
27	**Arizona**	7.3	27	Kentucky	8.16
27	Arkansas	7.3	28	Oklahoma	8.13
27	New Jersey	7.3		*National*	8.03
28	**Maine**	7.2	29	Arkansas	7.97
29	West Virginia	7.1	30	Idaho	7.92
31	Ohio	6.9	31	Maryland	7.87
31	South Dakota	6.9	32	**Arizona**	7.74
33	New York	6.8	33	Wisconsin	7.71
33	North Carolina	6.8	34	**California**	7.66
34	Mississippi	6.7	35	Illinois	7.61
37	Kansas	6.6	36	North Dakota	7.58
37	Louisiana	6.6	37	Missouri	7.43
37	Missouri	6.6		District of Columbia	7.43
38	Georgia	6.4	38	Kansas	7.39
40	Oklahoma	6.3	39	Indiana	7.37
40	Pennsylvania	6.3	40	New Jersey	7.33
41	Florida	6.2	41	South Carolina	7.25

1999			2002-2003		
Rank	**State**	**%**	**Rank**	**State**	**%**
43	Nebraska	6.1	42	Wyoming	7.14
43	Utah	6.1	43	Iowa	7.10
45	Idaho	5.9	44	Louisiana	6.92
45	Virginia	5.9	45	Georgia	6.87
46	Texas	5.7	46	Texas	6.38
47	Alabama	5.6	47	Alabama	6.37
48	Kentucky	5.3	47	Tennessee	6.37
50	Iowa	5.2	49	Mississippi	6.04
50	Tennessee	5.2	50	Utah	5.30

Sources: SAMHSA, Office of Applied Studies, National Household Survey on Drug Abuse, 1999, Table 3B, at http://www.oas.samhsa.gov/ NHSDA/99StateTabs/tables2.htm. Rankings calculated by CRS. SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002 and 2003, Table B.3, at http://www.oas.samhsa.gov/2k3State/appB.htm#tabB.3. Rankings calculated by CRS.

Table 2. States Ranked by Percentage of Persons 12 or Older Reporting Past-Month Marijuana Use, 1999 and 2003-2004

1999			2003-2004		
Rank	**State**	**%**	**Rank**	**State**	**%**
1	Maryland	7.9	1	New Hampshire	10.23
2	**Colorado**	7.7	2	**Alaska**	9.78
3	Massachusetts	7.5	3	**Vermont**	9.77
4	Rhode Island	7.4		District of Columbia	9.60
5	**Alaska**	7.1	4	Rhode Island	9.56
	District of Columbia	7.1	5	**Montana**	9.17
6	**Washington**	6.8	6	**Oregon**	8.88
7	**Oregon**	6.6	7	**Colorado**	8.49
8	Delaware	6.5	8	**Maine**	7.95
8	New Mexico	6.5	9	Massachusetts	7.80
10	**California**	6.0	10	**Nevada**	7.62
11	**Montana**	5.9	11	**Washington**	7.41
11	New Hampshire	5.9	12	New Mexico	7.37
13	**Hawaii**	5.8	13	New York	7.34
13	**Maine**	5.8	14	Michigan	7.20
15	**Nevada**	5.6	15	**Hawaii**	6.95
15	Wyoming	5.6	16	Connecticut	9.94
17	**Vermont**	5.4	17	Delaware	6.89
18	Michigan	5.3	18	Missouri	6.76
18	Minnesota	5.3	19	Florida	6.58
20	**Arizona**	5.2	20	**California**	6.50
21	Wisconsin	5.1	21	Ohio	6.49
22	Connecticut	5.0	22	Minnesota	6.37
22	Florida	5.0		*National*	6.18
22	New Jersey	5.0	23	Indiana	6.12
25	New York	4.9	24	Nebraska	5.97

1999			2003-2004		
Rank	**State**	**%**	**Rank**	**State**	**%**
25	Utah	4.9	25	Virginia	5.96
	National	4.9	26	North Carolina	5.89
27	Illinois	4.8	27	Louisiana	5.77
29	Missouri	4.7	28	Maryland	5.73
29	North Carolina	4.7	29	**Arizona**	5.68
30	Indiana	4.6	30	South Carolina	5.65
31	Pennsylvania	4.5	31	Pennsylvania	5.64
32	Ohio	4.3	32	Arkansas	5.63
34	Georgia	4.2	33	Kentucky	5.62
34	Idaho	4.2	34	Illinois	5.60
35	South Dakota	4.1	35	Oklahoma	5.58
36	Virginia	4.0	36	Wyoming	5.45
38	Nebraska	3.9	37	Wisconsin	5.40
38	North Dakota	3.9	38	North Dakota	5.35
39	South Carolina	3.8	39	South Dakota	5.24
40	Kansas	3.7	40	West Virginia	5.12
43	Kentucky	3.6	41	Idaho	5.09
43	Tennessee	3.6	42	New Jersey	5.05
43	West Virginia	3.6	43	Georgia	4.93
47	Arkansas	3.5	44	Kansas	4.91
47	Louisiana	3.5	45	Iowa	4.90
47	Oklahoma	3.5	46	Texas	4.79
47	Texas	3.5	47	Mississippi	4.64
50	Alabama	3.3	48	Tennessee	4.59
50	Iowa	3.3	49	Alabama	4.32
50	Mississippi	3.3	50	Utah	4.00

Sources: SAMHSA, Office of Applied Studies, National Household Survey on Drug Abuse, 1999, Table 3B, at http://www.oas.samhsa.gov/NHSDA/99StateTabs/tables2.htm. Rankings calculated by CRS. SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002 and 2003, Table B.3, at http://www.oas.samhsa.gov/2k3State/appB.htm#tabB.3. Rankings calculated by CRS.

The IOM Report further states (p. 126):

> Even if there were evidence that the medical use of marijuana would decrease the perception that it can be a harmful substance, this is beyond the scope of laws regulating the approval of therapeutic drugs. Those laws concern scientific data related to the safety and efficacy of drugs for individual use; they do not address perceptions or beliefs of the general population.

The IOM Report also found (p. 102): "No evidence suggests that the use of opiates or cocaine for medical purposes has increased the perception that their illicit use is safe or acceptable." Doctors can prescribe cocaine, morphine, amphetamine, and methamphetamine, but this is not seen as weakening the War on Drugs. Why would doctors recommending medical marijuana to their patients be any different?

The so-called "Gateway Theory" of marijuana use is also cited to explain how medical marijuana could increase illicit drug use. With respect to the rationale behind the argument that marijuana serves as a "gateway" drug, the IOM Report offered the following (p. 6):

> In the sense that marijuana use typically precedes rather than follows initiation of other illicit drug use, it is indeed a "gateway" drug. But because underage smoking and alcohol use typically precede marijuana use, marijuana is not the most common, and is rarely the first, "gateway" to illicit drug use. There is no conclusive evidence that the drug effects of marijuana are causally linked to the subsequent abuse of other illicit drugs.

A statistical analysis of marijuana use by emergency room patients and arrestees in four states with medical marijuana programs—California, Colorado, Oregon, and Washington—found no statistically significant increase in recreational marijuana use among these two population subgroups after medical marijuana was approved for use.[119] Another study looked at adolescent marijuana use and found decreases in youth usage in every state with a medical marijuana law. Declines exceeding 50% were found in some age groups.[120]

These studies are consistent with the findings of a 2002 report by the Government Accountability Office that concluded that state medical marijuana laws were operating as voters and legislators intended and did not encourage drug use among the wider population.[121] Concerns that medical cannabis laws send the wrong message to vulnerable groups such as adolescents seem to be unfounded.

Medical Marijuana Undermines the War on Drugs

> *The DEA and its local and state counterparts routinely report that large-scale drug traffickers hide behind and invoke Proposition 215, even when there is no evidence of any medical claim. In fact, many large-scale marijuana cultivators and traffickers escape state prosecution because of bogus medical marijuana claims. Prosecutors are reluctant to charge these individuals because of the state of confusion that exists in California. Therefore, high-level traffickers posing as 'care-givers' are able to sell illegal drugs with impunity.*
> —"California Medical Marijuana Information," DEA Web page[122]

It is argued by many that state medical marijuana laws weaken the fight against drug abuse by making the work of police officers more difficult. This undermining of law enforcement can occur in at least three ways: by diverting medical marijuana into the recreational drug market, by causing state and local law enforcement priorities to diverge from federal priorities, and by complicating the job of law enforcement by forcing officers to distinguish medical users from recreational users.

Diversion

Marijuana grown for medical purposes, according to DEA and other federal drug control agencies, can be diverted into the larger, illegal marijuana market, thereby undermining law

[119] Dennis M. Gorman and J. Charles Huber, Jr., "Do Medical Cannabis Laws Encourage Cannabis Use?" *International Journal of Drug Policy*, vol. 18, no. 3 (May 2007), pp. 160-167.

[120] Karen O'Keefe, et al., "Marijuana Use by Young People: The Impact of State Medical Marijuana Laws," updated June 2008, available at http://www.mpp.org/research/teen-use-report.html. (New Mexico was excluded from the study because it passed its law too recently.)

[121] U.S. General Accounting Office, *Marijuana: Early Experiences with Four States' Laws That Allow Use for Medical Purposes*, GAO-03-189, November 2002.

[122] Available at http://www.usdoj.gov/dea/ongoing/calimarijuanap.html.

enforcement efforts to eliminate the marijuana market altogether. This point was emphasized by the Department of Justice (DOJ) in its prepublication review of a report by the Government Accountability Office (GAO) on medical marijuana. DOJ criticized the GAO draft report on the grounds that the "report did not mention that state medical marijuana laws are routinely abused to facilitate traditional illegal trafficking."[123]

GAO responded that in their interviews with federal officials regarding the impact of state medical marijuana laws on their law enforcement efforts, "none of the federal officials we spoke with provided information that abuse of medical marijuana laws was routinely occurring in any of the states, including California."[124] The government also failed to establish this in the *Raich* case. (It is of course possible that significant diversion is taking place yet remains undetected.)

Just as with many pharmaceuticals, some diversion is inevitable. Some would view this as an acceptable cost of implementing a medical marijuana program. Every public policy has its costs and benefits. Depriving seriously ill patients of their medical marijuana is seen by some as a small price to pay if doing so will help to protect America's youth from marijuana. Others balance the harms and benefits of medical marijuana in the opposite direction. Legal analyst Stuart Taylor Jr. recently wrote, "As a matter of policy, Congress as well as the states should legalize medical marijuana, with strict regulatory controls. The proven benefits to some suffering patients outweigh the potential costs of marijuana being diverted to illicit uses."[125]

Changed State and Local Law Enforcement Priorities

Following the passage of the California and Arizona medical marijuana initiatives in 1996, federal officials expressed concern that the measures would seriously affect the federal government's drug enforcement effort because federal drug policies rely heavily on the state's enforcement of their own drug laws to achieve federal objectives. For instance, in hearings before the Senate Judiciary Committee, the head of the Drug Enforcement Administration stated:

> I have always felt ... that the federalization of crime is very difficult to carry out; that crime, just in essence, is for the most part a local problem and addressed very well locally, in my experience. We now have a situation where local law enforcement is unsure.... The numbers of investigations that you would talk about that might be presently being conducted by the [Arizona state police] at the gram level would be beyond our capacity to conduct those types of individual investigations without abandoning the major organized crime investigations.[126]

State medical marijuana laws arguably feed into the deprioritization movement, by which drug reform advocates seek to influence state and local law enforcement to give a low priority to the enforcement of marijuana laws. This movement to make simple marijuana possession the lowest law enforcement priority has made inroads in such cities as San Francisco, Seattle, and Oakland, but it extends beyond the medical marijuana states to college towns such as Ann Arbor, MI,

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[123] U.S. General Accounting Office, *Marijuana: Early Experiences with Four States' Laws That Allow Use for Medical Purposes*, GAO-03-189, November 2002, p. 36.

[124] Ibid., p. 37.

[125] Stuart Taylor, Jr., "Liberal Drug Warriors! Conservative Pot-Coddlers!," *National Journal*, June 11, 2005, p. 1738.

[126] Testimony of Thomas A. Constantine in U.S. Congress, Senate Committee on the Judiciary, *Prescription for Addiction? The Arizona and California Medical Drug Use Initiatives*, hearing, 104th Cong., 2nd sess., December 2, 1996 (Washington: GPO, 1997), pp. 42-43, 45.

Madison, WI, Columbia, MO, and Lawrence, KS.[127] Federal officials fear that jurisdictions that "opt out" of marijuana enforcement "will quickly become a haven for drug traffickers."[128]

Distinguishing Between Legal and Illegal Providers and Users

Police officers in medical marijuana states have complained about the difficulty of distinguishing between legitimate patients and recreational marijuana smokers. According to the DEA:

> Local and state law enforcement counterparts cannot distinguish between illegal marijuana grows and grows that qualify as medical exemptions. Many self-designated medical marijuana growers are, in fact, growing marijuana for illegal, "recreational" use.[129]

This reasoning is echoed in the *Raich* amici brief of Community Rights Counsel (p. 12):

> Creating an exception for medical use [of marijuana] could undermine enforcement efforts by imposing an often difficult burden on prosecutors of establishing the violator's subjective motivation and intent beyond a reasonable doubt. Given that marijuana used in response to medical ailments is not readily distinguishable from marijuana used for other reasons, Congress rationally concluded that the control of all use is necessary to address the national market for controlled substances.

Patients and caregivers, on the other hand, have complained that their marijuana that is lawful under state statute has been seized by police and not returned. In some cases, patients and caregivers have been unexpectedly arrested by state or local police officers. A November 2002 GAO report on medical marijuana stated that "Several law enforcement officials in California and Oregon cited the inconsistency between federal and state law as a significant problem, particularly regarding how seized marijuana is handled."[130]

The failure of state and local law enforcement officers to observe state medical marijuana laws has especially been a problem in California. The California Highway Patrol (CHP) has, on numerous occasions, arrested patients or confiscated their medical marijuana during routine traffic stops. "Although voters legalized medical marijuana in California nearly nine years ago," reports the *Los Angeles Times*, "police statewide have wrangled with activists over how to enforce the law."[131]

As a result of a lawsuit brought against the CHP by a patient advocacy group, CHP officers will no longer seize patients' marijuana as long as they possess no more than 8 ounces and can show a certified-user identification card or their physician's written recommendation. The CHP's new

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[127] "Marijuana: Lawrence, Kansas, Ponders City Marijuana Ordinance—Impact of HEA Cited," available at http://stopthedrugwar.org/chronicle/401/lawrence.shtml.

[128] Brief for U.S. Representative Mark E. Souder et al. as Amici Curiae Supporting Petitioners at 20, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454).

[129] "California Medical Marijuana Information," available on DEA's website at http://www.usdoj.gov/dea/ongoing/calimarijuanap.html.

[130] U.S. General Accounting Office, *Marijuana: Early Experiences with Four States' Laws That Allow Use for Medical Purposes*, GAO-03-189, November 2002, p. 64. GAO interviewed 37 law enforcement agencies and found that the majority indicated that "medical-marijuana laws had not greatly affected their law enforcement activities." (p. 4)

[131] Eric Bailey, "CHP Revises Policy on Pot Seizures," *Los Angeles Times* (national edition), August 28, 2005, p. A12.

policy, announced in August 2005, will likely influence the behavior of other California law enforcement agencies.

The Committee on Drugs and the Law of the Bar of the City of New York concluded its 1997 report "Marijuana Should be Medically Available" with this statement: "The government can effectively differentiate medical marijuana and recreational marijuana, as it has done with cocaine. The image of the Federal authorities suppressing a valuable medicine to maintain the rationale of the war on drugs only serves to discredit the government's effort."[132]

Patients Should Not Be Arrested for Using Medical Marijuana

> *Centuries of Anglo-American law stand against the imposition of criminal liability on individuals for pursuing their own lifesaving pain relief and treatment.... Because the experience of pain can be so subversive of dignity—and even of the will to live—ethics and legal tradition recognize that individuals pursuing pain relief have special claims to non-interference.*
> —Brief of the Leukemia & Lymphoma Society, et al., 2004[133]

Medical marijuana advocates believe that seriously ill people should not be punished for acting in accordance with the opinion of their physicians in a bona fide attempt to relieve their suffering, especially when acting in accordance with state law. Even if marijuana were proven to be more harmful than now appears, prison for severely ill patients is believed to be a worse alternative. Patients have enough problems without having to fear the emotional and financial cost of arrest, legal fees, prosecution, and a possible prison sentence.

The American public appears to agree. The Institute of Medicine found that "public support for patient access to marijuana for medical use appears substantial; public opinion polls taken during 1997 and 1998 generally reported 60-70 percent of respondents in favor of allowing medical uses of marijuana."[134]

The federal penalty for possessing one marijuana cigarette—even for medical use—is up to one year in prison and up to a $100,000 fine,[135] and the penalty for growing a cannabis plant is up to five years and up to a $250,000 fine.[136] That patients are willing to risk these severe penalties to obtain the relief that marijuana provides appears to present strong evidence for the substance's therapeutic effectiveness.

Although the Supreme Court ruled differently in *Raich*, the argument persists that medical marijuana providers and patients are engaging in a class of activity totally different from those persons trafficking in marijuana for recreational use and that patients should not be arrested for using medical marijuana in accordance with the laws of the states in which they reside.

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[132] Committee on Drugs and the Law, "Marijuana Should be Medically Available," *Record of the Association of the Bar of the City of New York*, vol. 52, no. 2 (March 1997), p. 238.

[133] Brief for the Leukemia & Lymphoma Society et al. as Amici Curiae Supporting Respondents at 1,2, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454).

[134] IOM Report, p. 18.

[135] 21 U.S.C. §844 and 18 U.S.C. §3571. 21 U.S.C. §844 also calls for a minimum fine of $1,000, and 21 U.S.C. §844a permits a civil penalty of up to $10,000.

[136] 21 U.S.C. §841(b)(1)(D).

With its position affirmed by *Raich*, however, DEA continues to investigate—and sometimes raid and shut down—medical marijuana distribution operations in California and other medical marijuana states. DEA's position is that:

> [F]ederal law does not distinguish between crimes involving marijuana for claimed "medical" purposes and crimes involving marijuana for any other purpose. DEA likewise does not so distinguish in carrying out its duty to enforce the CSA and investigate possible violations of the Act. Rather, consistent with the agency's mandate, DEA focuses on large-scale trafficking organizations and other criminal enterprises that warrant federal scrutiny. If investigating CSA violations in this manner leads the agency to encounter persons engaged in criminal activities involving marijuana, DEA does not alter its approach if such persons claim at some point their crimes are "medically" justified. To do so would be to give legal effect to an excuse considered by the text of federal law and the United States Supreme Court to be of no moment.[137]

Because nearly all arrests and prosecutions for marijuana possession are handled by state and local law enforcement officers, patients and caregivers in the medical marijuana states can, as a practical matter, possess medical marijuana without fear of arrest and imprisonment. DEA enforcement actions against medical marijuana dispensaries—as occurred in San Francisco shortly after the *Raich* decision was announced[138]—can, however, make it more difficult for patients to obtain the drug. The situation that Grinspoon and Bakalar described in 1995 in the *Journal of the American Medical Association* persists a decade later: "At present, the greatest danger in medical use of marihuana is its illegality, which imposes much anxiety and expense on suffering people, forces them to bargain with illicit drug dealers, and exposes them to the threat of criminal prosecution."[139]

The States Should Be Allowed to Experiment

> *Doctors, not the federal government, know what's best for their patients. If a state decides to allow doctors to recommend proven treatments for their patients, then the federal government has no rightful place in the doctor's office.*
> —Attorney Randy Barnett, 2004[140]

Three States—California, Maryland, and Washington—filed an amici curiae brief supporting the right of states to institute medical marijuana programs. Their brief argued, "In our federal system States often serve as democracy's laboratories, trying out new, or innovative solutions to society's ills."[141]

The *Raich* case shows that the federal government has zero tolerance for state medical marijuana programs. The Bush Administration appealed the decision of the Ninth Circuit Court of Appeals

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[137] Communication from DEA Congressional Affairs to author dated September 27, 2005.

[138] Stacy Finz, "19 Named in Medicinal Pot Indictment, More than 9,300 Plants Were Seized in Raids," *San Francisco Chronicle*, June 24, 2005, p. B4.

[139] Lester Grinspoon and James B. Bakalar, "Marihuana as Medicine: A Plea for Reconsideration," *Journal of the American Medical Association*, vol. 273, no. 23 (June 21, 1995), p. 1876.

[140] Angel Wings Patient OutReach press release, November 29, 2004. Barnett represented Raich et al. in Supreme Court oral argument on this date.

[141] Brief for the States of California, Maryland, and Washington et al. as Amici Curiae Supporting Respondents at 3, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454).

to the Supreme Court, which reversed the Ninth Circuit and upheld the federal position against the states. Framed as a Commerce Clause issue, the case became a battle for states' rights against the federal government.

The *Raich* case created unusual political alliances. Three southern states that are strongly opposed to any marijuana use, medical or otherwise—Alabama, Louisiana, and Mississippi—filed an amici curiae brief supporting California's medical marijuana users on the grounds of states' rights. Their brief argued

> As Justice Brandeis famously remarked, "[i]t is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."[142] Whether California and the other compassionate-use States are "courageous—or instead profoundly misguided—is not the point. The point is that, as a sovereign member of the federal union, California is entitled to make for itself the tough policy choices that affect its citizens.[143]

States' rights advocates argue that authority to define criminal law and the power to make and enforce laws protecting the health, safety, welfare, and morals reside at the state level and that a state has the right to set these policies free of congressional interference.

For Justice O'Connor, the *Raich* case exemplified "the role of States as laboratories."[144] She wrote in her dissenting opinion:

> If I were a California citizen, I would not have voted for the medical marijuana ballot initiative; if I were a California legislator I would not have supported the Compassionate Use Act. But whatever the wisdom of California's experiment with medical marijuana, the federalism principles that have driven our Commerce Clause cases require that room for experiment be protected in this case.[145]

Medical Marijuana Laws Harm the Drug Approval Process

> *The current efforts to gain legal status of marijuana through ballot initiatives seriously threaten the Food and Drug Administration statutorily authorized process of proving safety and efficacy.*
> —Brief of the Drug Free America Foundation, et al., 2004[146]

Although the individual states regulate the practice of medicine, the federal government has taken primary responsibility for the regulation of medical products, especially those containing controlled substances. Pharmaceutical drugs must be approved for use in the United States by the Food and Drug Administration, an agency of the Department of Health and Human Services. The Federal Food, Drug, and Cosmetics Act gives HHS and FDA the responsibility for determining

[142] *New State Ice Co.* v. *Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

[143] Brief for the States of Alabama, Louisiana, and Mississippi et al. as Amici Curiae Supporting Respondents at 3, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454).

[144] *Gonzales* v. *Raich*, 125 S.Ct. 2195, 2220 (2005) (O'Connor, J., dissenting).

[145] Ibid. at 2229.

[146] Brief for the Drug Free America Foundation, Inc. et al. as Amici Curiae Supporting Petitioners at 12, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454).

that drugs are safe and effective, a requirement that all medicines must meet before they can enter interstate commerce and be made available for general medical use.[147] Clinical evaluation is required regardless of whether the drug is synthetically produced or originates from a natural botanical or animal source.

Opponents of medical marijuana say that the FDA's drug approval process should not be circumvented. To permit states to decide which medical products can be made available for therapeutic use, they say, would undercut this regulatory system. State medical marijuana initiatives are seen as inconsistent with the federal government's responsibility to protect the public from unsafe, ineffective drugs.

The Bush Administration argued in its brief in the *Raich* case that "excepting drug activity for personal use or free distribution from the sweep of [federal drug laws] would discourage the consumption of lawful controlled substances and would undermine Congress's intent to regulate the drug market comprehensively to protect public health and safety."[148]

Three prominent drug abuse experts argued in their amici brief:

> This action by the state of California did not create a "novel social and economic experiment," but rather chaos in the scientific and medical communities. Furthermore, under Court of Appeals ruling, such informal State systems could be replicated, and even expanded, in a manner that puts at risk the critical protections so carefully crafted under the national food and drug legislation of the 20th century.[149]

The Food and Drug Administration itself has stated that

> FDA is the sole Federal agency that approves drug products as safe and effective for intended indications.... FDA's drug approval process requires well-controlled clinical trials that provide the necessary scientific data upon which FDA makes its approval and labeling decisions.... Efforts that seek to bypass the FDA drug approval process would not serve the interests of public health because they might expose patients to unsafe and ineffective drug products. FDA has not approved smoked marijuana for any condition or disease indication.[150]

The Drug Free America *Raich* brief elaborates further (pp. 12-13):

> The ballot initiative-led laws create an atmosphere of medicine by popular vote, rather than the rigorous scientific and medical process that all medicines must undergo. Before the development of modern pharmaceutical science, the field of medicine was fraught with potions and herbal remedies. Many of those were absolutely useless, or conversely were harmful to unsuspecting subjects. Thus evolved our current Food and Drug Administration and drug scheduling processes, which Congress has authorized in order to create a uniform and reliable system of drug approval and regulation. This system is being intentionally undermined by the legalization proponents through use of medical marijuana initiatives.

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[147] 21 U.S.C. §351-360

[148] Brief for Petitioners at 11, Gonzales v. Raich, 125 S.Ct. 2195 (2002) (No. 03-1454).

[149] Brief for Robert L. DuPont, M.D. et al. as Amici Curiae Supporting Petitioners at 19, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454).

[150] U.S. Food and Drug Administration, "Inter-Agency Advisory Regarding Claims That Smoked Marijuana Is a Medicine," press release, April 20, 2006, p. 1.

The organizers of the medical marijuana state initiatives deny that it was their intent to undermine the federal drug approval process. Rather, in their view, it became necessary for them to *bypass* the FDA and go to the states because of the federal government's resistance to marijuana research requests and rescheduling petitions.

As for the charge that politics should not play a role in the drug approval and controlled substance scheduling processes, medical marijuana supporters point out that marijuana's original listing as a Schedule I substance in 1970 was itself a political act on the part of Congress.

Scientists on both sides of the issue say more research needs to be done, yet some researchers charge that the federal government has all but shut down marijuana clinical trials for reasons based on politics and ideology rather than science.[151]

In any case, as the IOM Report pointed out, "although a drug is normally approved for medical use only on proof of its 'safety and efficacy,' patients with life-threatening conditions are sometimes (under protocols for 'compassionate use') allowed access to unapproved drugs whose benefits and risks are uncertain."[152] This was the case with the FDA's IND Compassionate Access Program under which a limited number of patients are provided government-grown medical marijuana to treat their serious medical conditions.

Some observers believe the pharmaceutical industry and some politicians oppose medical marijuana to protect pharmaceutical industry profits. Because the whole marijuana plant cannot be patented, research efforts must be focused on the development of *synthetic* cannabinoids such as Marinol. But even if additional cannabinoid drugs are developed and marketed, some believe that doctors and patients should still not be criminalized for recommending and using the natural substance.

The *New England Journal of Medicine* has editorialized that

> [A] federal policy that prohibits physicians from alleviating suffering by prescribing marijuana for seriously ill patients is misguided, heavy-handed, and inhumane. Marijuana may have long-term adverse effects and its use may presage serious addictions, but neither long-term side effects nor addiction is a relevant issue in such patients. It is also hypocritical to forbid physicians to prescribe marijuana while permitting them to use morphine and meperidine to relieve extreme dyspnea and pain. With both of these drugs the difference between the dose that relieves symptoms and the dose that hastens death is very narrow; by contrast, there is no risk of death from smoking marijuana. To demand evidence of therapeutic efficacy is equally hypocritical. The noxious sensations that patients experience are extremely difficult to quantify in controlled experiments. What really counts for a therapy with this kind of safety margin is whether a seriously ill patient feels relief as a result of the intervention, not whether a controlled trial "proves" its efficacy.[153]

Some observers suggest that until the federal government relents and becomes more hospitable to marijuana research proposals and more willing to consider moving marijuana to a less restrictive schedule, the medical marijuana issue will continue to be fought at state and local levels of governance. As one patient advocate has stated, "As the months tick away, it will become more

[151] See, for example, Lila Guterman, "The Dope on Medical Marijuana," *Chronicle of Higher Education*, June 2, 2000, p. A21.

[152] IOM Report, p. 14.

[153] "Federal Foolishness and Marijuana," *New England Journal of Medicine*, vol. 336, no. 5 (January 30, 1997), p. 366.

and more obvious that we need to continue changing state laws until the federal government has no choice but to change its inhumane medicinal marijuana laws."[154]

The Medical Marijuana Movement Is Politically Inspired

> *Advocates have tried to legalize marijuana in one form or another for three decades, and the "medical marijuana" concept is a Trojan Horse tactic towards the goal of legalization.*
> —Brief of the Drug Free America Foundation, et al., 2004[155]

Medical marijuana opponents see the movement to promote the use of medical marijuana as a cynical attempt to subvert the Controlled Substances Act and legalize the recreational use of marijuana for all. They see it as a devious tactic in the more than 30-year effort by marijuana proponents to bring an end to marijuana prohibition in the United States and elsewhere.

They point out that between 1972 and 1978, the National Organization for the Reform of Marijuana Laws (NORML) successfully lobbied 11 state legislatures to decriminalize the drug, reducing penalties for possession in most cases to that of a traffic ticket. Also, in 1972, NORML began the first of several unsuccessful attempts to petition DEA to reschedule marijuana from Schedule I to Schedule II on the grounds that crude marijuana had use in medicine.[156]

Later, beginning with California in 1996, "drug legalizers" pushed successfully for passage of medical marijuana voter initiatives in several states, prompting then-Drug Czar Barry McCaffrey, writing in *Newsweek*, to warn that "We're on a Perilous Path." "I think it's clear," he wrote, "that a lot of the people arguing for the California proposition and others like it are pushing the legalization of drugs, plain and simple."[157]

Is it cynical or smart for NORML and other drug reform organizations to simultaneously pursue the separate goals of marijuana decriminalization for all, on the one hand, and marijuana rescheduling for the seriously ill, on the other? It is not unusual for political activists tactically to press for—and accept—half-measures in pursuit of a larger strategic goal. Pro-life activists work to prohibit partial-birth abortions and to pass parental notification laws. Gay rights activists seek limited domestic partner benefits as a stepping stone to full marriage equality. Thus is the tactic used on both sides of the cultural divide in America, to the alarm of those opposed.

It is certainly true that the medical cannabis movement is an offshoot of the marijuana legalization movement. Many individuals and organizations that support medical marijuana also support a broader program of drug law reform. It is also true, however, that many health

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[154] Chuck Thomas, quoted in "National Drug War Leaders Disregard Science in Medicinal Marijuana Debate," Marijuana Policy Project press release dated April 20, 1999, available at http://www.mpp.org/news/press-releases/national-drug-war-leaders-disregard-science-in-medicinal-marijua.html.

[155] Brief for the Drug Free America Foundation, Inc. et al. as Amici Curiae Supporting Petitioners at 9, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454).

[156] For example, the amici curiae brief of the Drug Free America Foundation et al. reveals this history to discredit the medical marijuana movement (pp. 9-11). Actually, NORML and some other drug reform organizations are open in acknowledging that they support patient access to marijuana as a first step toward decriminalizing or legalizing marijuana for use by adults in general. See, for example, Joab Jackson, "Medical Marijuana: From the Fringe to the Forefront," *Baltimore City Paper*, March 28, 2002, available at http://www.alternet.org/drugreporter/12714.

[157] Barry R. McCaffrey, "We're on a Perilous Path," *Newsweek*, February 3, 1997, p. 27.

professionals and other individuals who advocate medical access to marijuana do not support any other changes in U.S. drug control policy. In the same way, not everyone in favor of parental notification laws supports banning abortions for everyone. And not every supporter of domestic partner benefits believes in same-sex marriage.

In these hot-button issues, ideology and emotion often rule. Marijuana users in general, and medical marijuana users in particular, are demonized by some elements of American society. The ideology of the "Drug Warriors" intrudes on the science of medical marijuana, as pointed out by Grinspoon and Bakalar in the *Journal of the American Medical Association*:

> Advocates of medical use of marihuana are sometimes charged with using medicine as a wedge to open a way for "recreational" use. The accusation is false as applied to its target, but expresses in a distorted form a truth about some opponents of medical marihuana: they will not admit that it can be a safe and effective medicine largely because they are stubbornly committed to exaggerating its dangers when used for nonmedical purposes.[158]

The authors of the IOM Report were aware of the possibility that larger ideological positions could influence one's stand on the specific issue of patient access to medical marijuana when they wrote that

> [I]t is not relevant to scientific validity whether an argument is put forth by someone who believes that all marijuana use should be legal or by someone who believes that any marijuana use is highly damaging to individual users and to society as a whole. (p. 14)

In other words, it is widely believed that science should rule when it comes to medical issues. Both sides in the medical marijuana debate claim adherence to this principle. The House Government Reform Committee's April 2004 hearing on medical marijuana was titled "Marijuana and Medicine: The Need for a Science-Based Approach." And medical marijuana advocates plead with the federal government to permit scientific research on medical marijuana to proceed.

Rescheduling marijuana and making it available for medical use and research is not necessarily a step toward legalizing its recreational use. Such a move would put it on a par with cocaine, methamphetamine, morphine, and methadone, all of which are Schedule II substances that are not close to becoming legal for recreational use. Proponents of medical marijuana ask why marijuana should be considered differently than these other scheduled substances.

It is also arguable that marijuana should indeed be considered differently than cocaine, methamphetamine, morphine, and methadone. Scientists note that marijuana is less harmful and less addictive than these Schedule II substances. Acceptance of medical marijuana could in fact pave the way for its more generalized use. Ethan Nadelmann, head of the Drug Policy Alliance, has observed, "As medical marijuana becomes more regulated and institutionalized in the West, that may provide a model for how we ultimately make marijuana legal for all adults."[159] Medical marijuana opponents have trumpeted his candor as proof of the hypocrisy of those on the other side of the issue. Others note, however, that his comment may be less hypocritical than astute.

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[158] Lester Grinspoon and James B. Bakalar, "Marihuana as Medicine: A Plea for Reconsideration," *Journal of the American Medical Association*, vol. 273, no. 23 (June 21, 1995), p. 1876.

[159] Quoted in MSNBC.com story, "Western States Back Medical Marijuana," November 4, 2004, available at http://msnbc.msn.com/id/6406453.

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Congressional Research Service Report on Taxing

A review of issues surrounding a potential federal marijuana tax, released November 13, 2014.

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Federal Proposals to Tax Marijuana: An Economic Analysis

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CRS REPORT
Prepared for Members and
Committees of Congress

Summary

The combination of state policy and general public opinion favoring the legalizing of marijuana has led some in Congress to advocate for legalization and taxation of marijuana at the federal level. The Marijuana Tax Equity Act of 2013 (H.R. 501) would impose a federal excise tax of 50% on the producer and importer price of marijuana. The National Commission on Federal Marijuana Policy Act of 2013 (H.R. 1635) proposes establishing a National Commission on Federal Marijuana Policy that would review the potential revenue generated by taxing marijuana, among other things.

This report focuses solely on issues surrounding a potential federal marijuana tax. First, it provides a brief overview of marijuana production. Second, it presents possible justifications for taxes and, in some cases, estimates the level of tax suggested by that rationale. Third, it analyzes possible marijuana tax designs. The report also discusses various tax administration and enforcement issues, such as labeling and tracking.

Economic theory suggests the efficient level of taxation is equal to marijuana's external cost to society. Studies conducted in the United Kingdom (UK) and Canada suggest that the costs of individual marijuana consumption to society are between 12% and 28% of the costs of an individual alcohol user, and total social costs are even lower after accounting for the smaller number of marijuana users in society. Based on an economic estimate of $30 billion of net external costs for alcohol, the result is an external cost of $0.5 billion to $1.6 billion annually for marijuana. These calculations imply that an upper limit to the economically efficient tax rate could be $0.30 per marijuana cigarette (containing an average of one half of a gram of marijuana) or $16.80 per ounce. An increased number of users in a legal market would raise total costs, but not necessarily costs per unit.

Some could also view excise taxes as a means to curtail demand, particularly as the price of marijuana can be expected to drop from current retail prices of up $200-$300 per ounce to prices closer to the cost of production at $5-$18 per ounce, if broadly legalized. The demand for marijuana is estimated to be relatively price inelastic, meaning that consumer demand is relatively insensitive to price changes. Although previous studies of marijuana demand largely examine consumers willing to engage in illegal activities, it appears that higher tax rates would have a minor effect on reducing demand. With this said, tax policy, coupled with adequate law enforcement, could be an effective tool to limit marijuana consumption among youth, as empirical studies indicate that their demand is more sensitive to price than non-youth.

Excise taxes on marijuana could also be levied primarily to raise revenue, as has been historically the case with tobacco and alcohol. As an illustration, assuming a total market size of $40 billion, a federal tax of $50 per ounce is estimated to raise about $6.8 billion annually, after accounting for behavioral effects associated with price decreases following legalization.

The choices in administrative design could affect consumer behavior, production methods, evasion rates, or the tax base of a federal marijuana excise tax. Some of the more significant choices include whether to exempt medicinal uses or homegrown marijuana from tax.

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Introduction

The cultivation, distribution, and possession of marijuana are prohibited for any reason other than to engage in federally approved research under the federal Controlled Substances Act of 1970 (CSA; P.L. 91-513). Yet, 23 states, the District of Columbia, and Guam have passed legislation or initiatives legalizing qualified sale, possession, manufacture, and distribution of medical marijuana, and 17 states and the District of Columbia have decriminalized the possession of marijuana.[1] In addition, in November 2012, Colorado and Washington became the first states to legalize, regulate, and tax small amounts of marijuana for non-medicinal use (so-called recreational) by individuals 21 and older. Commercial sales of recreational marijuana became legal in the state of Colorado beginning on January 1, 2014—the first jurisdiction in the world to do so. Washington's commercial marijuana market opened on July 7, 2014. On November 4, 2014, Alaska and Oregon became the third and fourth states to approve ballot initiatives to legalize, regulate, and tax marijuana for recreational purposes.[2] That same day, the District Columbia approved further measures to legalize the cultivation, possession, and exchange (but not the commercial sales) of marijuana.[3]

In addition to state and local movements to decriminalize or legalize the production, sales, or use of marijuana, there has been a general shift in popular sentiment toward marijuana policy. According to polls conducted by Rassmussen, the Pew Research Center, and Gallup, a majority of Americans favor legalizing marijuana.[4]

The combination of state policies and general sentiment has led to heightened debate over the merits of marijuana legalization at the federal level. For example, in the 113th Congress, bills have

[1] For a list of jurisdictions that have legalized medical marijuana, see National Conference on State Legislatures, "State Medical Marijuana Laws," at http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx. For a list of jurisdictions that have decriminalized marijuana possession for personal consumption, see National Organization for the Reform of Marijuana Laws (NORML), "States that Have Decriminalized," at http://norml.org/aboutmarijuana/item/states-that-have-decriminalized.

[2] For a summary of the marijuana-related ballot initiatives approved on November 4, 2014, see Paul Armentano, "State, Local Marijuana Legalization Measures Win Big On Election Day," November 5, 2014, at http://blog.norml.org/2014/11/05/state-local-marijuana-legalization-measures-win-big-on-election-day/.

[3] Under the District of Columbia Home Rule Act of 1973 (P.L. 93-198), DC officials must transmit the legalization bill to Congress. Then, Congress has 60 legislative days to review certain changes to DC's criminal code and 30 legislative days to review other legislative measures. See Council of the District of Columbia, "How a Bill Becomes a Law," at http://dccouncil.us/pages/how-a-bill-becomes-a-law.

[4] See "56% Favor Legalizing, Regulating Marijuana," *Rasmussen Reports*, May 17, 2012, at http://www.rasmussenreports.com/public_content/lifestyle/general_lifestyle/may_2012/56_favor_legalizing_regulating_marijuana; Pew Research Center for the People and the Press, *Majority Now Supports Legalizing Marijuana*, April 4, 2013, at http://www.people-press.org/2013/04/04/majority-now-supports-legalizing-marijuana/; and Art Swift, *For First Time, Americans Favor Legalizing Marijuana*, Gallup, October 22, 2013, at http://www.gallup.com/poll/165539/first-time-americans-favor-legalizing-marijuana.aspx. According to the polls, disagreements exist along ideological lines though, with a majority of Democrats and Independents in favor of legalization but a majority of Republicans are against legalization. A majority of poll respondents, regardless of ideology, agree that government efforts to enforce marijuana laws cost more than they are worth. See Pew Research Center, *Partisans Disagree on Legalization of Marijuana, but Agree on Law Enforcement Policies*, April 30, 2013, at http://www.pewresearch.org/daily-number/partisans-disagree-on-legalization-of-marijuana-but-agree-on-law-enforcement-policies/. For analysis on select public opinion polls on marijuana, see E.J. Dionne, Jr. and William Galston, *The New Politics of Marijuana Legalization:*, The Brookings Institution, May 2013, at http://www.brookings.edu/research/interactives/2013/politics-of-marijuana-legalization.

been introduced that would remove marijuana from the list of Schedule I drugs prohibited by the Controlled Substances Act and impose a federal excise tax on the production and importation of marijuana.[5] Another bill proposes the establishment of a National Commission on Federal Marijuana Policy that would review the potential revenue generated by taxing marijuana, among other things.[6] Overall, the debate concerning marijuana legalization is complex, as it spans across issues ranging from criminal justice to public health and safety. The revenue-raising potential of a marijuana tax could become a contributing factor in the desirability of legalizing marijuana.

This report focuses solely on one aspect of the economic debate over federal marijuana legalization: imposing an excise tax on legalized marijuana.[7] First, it provides a brief overview of marijuana production. Second, it presents possible arguments for taxes and, in some cases, estimates the level of tax suggested by that rationale. Third, possible marijuana tax designs are analyzed.[8]

A Brief Overview of Marijuana Production

Marijuana is a preparation of the plant, *Cannabis sativa*, generally used as a recreational drug or medicine primarily for its psychoactive and physiological effects.[9] The term *marijuana* refers to the dried leaves and flowers of the cannabis plant. The main psychoactive ingredient in marijuana is delta-9-tetrahydrocannabinol (THC). THC is the primary cannabinoid responsible for the "high" that users experience when consuming the drug. Still, THC is only one of many "cannabinoid" chemical compounds in marijuana that contribute to the effects of the psychoactive effects of marijuana (in terms of strength, onset, duration, etc.). Consumers could desire different strains of marijuana for the contents of other cannabinoids that do not produce a psychoactive effect. For example, marijuana strains high in cannabidiol (CBD) are often sought to provide relief from anxiety.[10]

Depending on its preparation, the potency, or relative concentration, of a particular product derived from marijuana can vary. The stalks and stems of a marijuana plant have almost no

[5] These bills are, respectively, the Ending Federal Marijuana Prohibition Act of 2013 (H.R. 499) and the Marijuana Tax Equity Act of 2013 (H.R. 501). Specifically, H.R. 501 would impose a 50% tax on the price sold.

[6] See the National Commission on Federal Marijuana Policy Act of 2013 (H.R. 1635).

[7] The current federal tax treatment of marijuana (as a Schedule I drug) is detailed in **Appendix B**.

[8] This report also assumes some familiarity with the general principles and analysis of excise taxes. For an introduction to excise tax issues, see CRS Report R43189, *Federal Excise Taxes: An Introduction and General Analysis* , by Sean Lowry. Also, it does not consider legal or regulatory issues, except as they relate to excise tax issues. For further information on these issues, see CRS Report R43034, *State Legalization of Recreational Marijuana: Selected Legal Issues*, by Todd Garvey and Brian T. Yeh; CRS Report R43435, *Marijuana: Medical and Retail—Selected Legal Issues*, by Todd Garvey and Charles Doyle; and Rosalie Liccardo Pacula et al., "Developing Public Health Regulations for Marijuana: Lessons From Alcohol and Tobacco," *American Journal of Public Health*, April 17, 2014.

[9] The two major strains of cannabis are indica and sativa; some plants are hybrids. Industrial hemp is a different variety of Cannabis sativa and is the same plant species of marijuana. However, hemp is genetically different and is distinguished by its use and chemical makeup (e.g., containing a THC concentration level of less than 1%), as well as by different cultivation practices in its production. For more information on industrial hemp, see CRS Report RL32725, *Hemp as an Agricultural Commodity*, by Renée Johnson.

[10] For lists of common cannabinoids and their claimed effects, see SC Labs, "Cannabinoids," at http://sclabs.com/learn/learn-cannabinoids.html; CannLabs, "Cannabinoids," at http://www.cannlabs.com/the-science/cannabinoids/; or Steep Hill Labs, "Cannabinoid and Terpenoid Reference Guide," at http://steephilllab.com/resources/cannabinoid-and-terpenoid-reference-guide/.

psychoactive content, whereas the leaves and flowers (buds) of the plant have increasing concentrations of THC. The hair-like trichomes on the buds are coated with a translucent resin that contains the highest concentration of THC on the plant. Marijuana plants are also either male or female. If female plants are grown in controlled environments, separate from pollination of male plants, then the female plants are capable of growing buds that produce more resin. This process is used to grow *sinsemilla* (Spanish for without seed) varieties of marijuana, which typically contain 10%-18% THC content (about three times the level of conventional, commercial-grade marijuana derived from pollinated plants).[11]

Marijuana consumption methods vary. Marijuana is generally consumed by smoking the dried plant matter. A "joint" is made by rolling marijuana in cigarette paper whereas a "blunt" is made by hollowing some or all of the tobacco from a cigar and replacing it with marijuana. Although smoking habits vary by user, a typical joint contains less than half a gram of marijuana, and each "hit" or drag on the joint contains approximately one-twentieth of a gram of marijuana.[12] Numerous other devices for consuming marijuana exist, ranging from glass pipes to vaporizers (which heat the chemicals in marijuana, but avoid creating the smoke irritants associated with combustion).

Cannabis can also be processed into a number of different products, all with their own THC concentration levels and typical methods of consumption. For example, hashish or "hash" is made by pressing trichomes together into a brick-shaped product with more than 40% THC content.[13] THC is also capable of being dissolved in fats, oils, and alcohol for use in the creation of "edibles," such as candy or baked goods.[14]

Why a Federal Excise Tax on Marijuana?

Economic analysis as a general rule suggests that excise taxes are less desirable than more general taxes (such as income or broad based sales taxes) because they distort prices of different commodities. This section discusses several possible reasons for imposing an excise tax on marijuana: (1) reflect external, or spillover, costs to society; (2) discourage use, particularly for youth; (3) prevent too rapid a fall in price; (4) fund related programs; and (5) raise revenue.

Taxes to Reflect External Costs

Economic efficiency occurs when the price of a commodity (at the margin) equals its costs. If consumption of marijuana imposes costs on others, then the consumer cost is too small and economic efficiency could be achieved by imposing a tax equal to consumption cost. This rationale has often been used for similar commodities, such as alcohol and tobacco.[15]

[11] Jonathan Caulkins et al., *Marijuana Legalization: What Everyone Needs to Know* (Oxford: Oxford UP, 2012), p. 8.

[12] Ibid., p. 22.

[13] Ibid., p. 8.

[14] For definitions of terms relating to marijuana, see Leafly Glossary of Cannabis Terms, at http://www.leafly.com/knowledge-center/cannabis-101/glossary-of-cannabis-terms; and "Marijuana 101 – The Ultimate Weed Glossary" at http://www.marijuana.com/news/2012/05/marijuana-101-the-ultimate-weed-glossary/.

[15] The external cost cannot account for these taxes, however. Tobacco taxes appear to be imposed at rates well above their external costs to society, whereas alcohol taxes are imposed well below their external costs. After increasing an (continued...)

In considering this justification and the level of tax economic analysis suggests, the external costs should be separate from the costs the user bears. For example, if a substance causes early death, the value of the lost years of life and the individual's own costs in treating illness falls on the individual. Society bears the loss of tax revenue from those lost earnings and some of the costs of treating illness that fall on private or social health insurance. However, society also receives gains from the early death in the amount of smaller health costs and transfer payments (such as Social Security) in the future. These future costs should be discounted. At least in studies of other substances, these external costs are typically much smaller than the total costs.[16] A 1991 study by Manning et al. used this method to estimate the external costs of alcohol and tobacco.[17] Adjusting these estimates for price changes, those results imply a cost of $30 billion for alcohol, which will be used to estimate the cost for marijuana, for which no study of this nature exists.[18] As with the case of tobacco, these external costs are typically much smaller than the total costs.

Although no U.S. study of marijuana of this nature could be located, it is possible to investigate the likely magnitude of a tax necessary to correct for externalities of marijuana use by examining studies that compare the costs of cannabis use to alcohol.

A British study ranked different drugs by harm on a scale of 1 to 100.[19] Overall, alcohol ranked 72, whereas cannabis ranked 20, or 28% of alcohol. Considering just the external harm, alcohol ranked 47 and cannabis ranked 9, or 19% of alcohol. A Canadian study found an even smaller ratio of health costs per user, about 12%.[20] It is also likely that the non-health costs of marijuana are lower than for alcohol. For example, part of the spillover effect of alcohol is in the effect of traffic accidents, but studies tend to find that marijuana impairs driving ability less than alcohol.[21]

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estimate from a 1994 study by inflation, the external cost per pack of cigarettes is estimated to be around $0.42. See CRS Report 94-214, *Cigarette Taxes to Fund Health Care Reform: An Economic Analysis*, by Jane G. Gravelle and Dennis Zimmerman. After the latest increase in federal cigarette taxes to $1.01 a pack in 2009, the total taxes were estimated at $2.32 (including state and local taxes and the tobacco settlement, which functions as an excise tax). See CRS Report RS22681, *The Cigarette Tax Increase to Finance SCHIP*, by Jane G. Gravelle. The external cost of alcohol is estimated at 97 cents per ounce, compared with combined federal and state taxes of 26 cents per ounce. See CRS Report R43350, *Alcohol Excise Taxes: Current Law and Economic Analysis*, by Sean Lowry.

[16] For example, one study of alcohol places the total costs of U.S. alcohol consumption (additional health costs, loss of productivity, and other costs such as criminal justice) at $223 billion annually. The study identifies 58.5% of those costs as falling on others, which indicates that these costs are $130 billion. Ellen E. Bouchery et al., "Economic Costs of Excessive Alcohol Consumption in the U.S., 2006," *American Journal of Preventive Medicine*, vol. 41, no. 5, November 2011, pp. 516-524, at http://www.ajpmonline.org/article/S0749-3797(11)00538-1/pdf. As noted in the text, estimates adjusting for lifetime costs are $30 billion.

[17] Willard G. Manning et al., *The Costs of Poor Health Habits* (Cambridge, MA: Harvard University Press, 1991).

[18] These calculations are based on data on external cost per ounce compared with tax collection per ounce and tax revenues. See CRS Report R43350, *Alcohol Excise Taxes: Current Law and Economic Analysis*, by Sean Lowry.

[19] David J. Nutt, Leslie A. King, and Lawrence D. Phillips (on Behalf of the Independent Scientific Committee on Drugs), "Drug harms in the UK: a Multicriteria Decision Analysis," *Lancet*, November 2010, vol. 376, pp. 1558-1565.

[20] Gerald Thomas, and Christopher G. Davis, "Cannabis, Tobacco and Alcohol Use in Canada: Comparing risks of Harm and Costs to Society," Reprinted from "Cannabis" issue of *Visions Journal*, 2009, 5 (4), p. 11, at http://www.heretohelp.bc.ca/visions/cannabis-vol5/cannabis-tobacco-and-alcohol-use-in-canada and Comparing the Perceived Seriousness and Actual Costs of Substance Abuse in Canada, Canadian Centre on Substance Abuse, March 2007, at http://ccsa.ca/Resource%20Library/ccsa-011350-2007.pdf#search=rehm.

[21] Mark D. Anderson, Benjamin Hansen, and Daniel I. Rees, "Medical Marijuana Laws, Traffic Fatalities, and Alcohol Consumption," *Journal of Law and Economics*, vol.56, no. 2 (2013), pp. 333-369.This study reports that medical marijuana legalization was associated with decreased traffic fatalities. The study also noted that cannabis impairs functions such as reaction times in laboratory studies, but does not appear to impair driving in actual studies (which are summarized) because drivers engage in compensatory behavior. Under the influence of alcohol, drivers take more risks.

Evidence also suggests that smoking marijuana is inversely related to domestic violence.[22] The Canadian study found larger enforcement costs for marijuana, but that effect is probably due to marijuana's illicit status. (For additional discussion of some of the various social effects of marijuana, see **Appendix A**.)

In addition to indications that the externalities of marijuana are smaller per user than alcohol, the prevalence of marijuana use is smaller. According to the National Survey of Drug Use and Health (NSDUH), alcohol usage in 2013 for the population 12 and older was 66.3% in the past year and 52.2% in the past month, whereas marijuana usage was 12.6% and 7.5% respectively.[23] Thus marijuana usage is 19% (based on use in the past year) and 14% (based on use in the past month) as common as alcohol usage. These numbers suggest that the external costs of marijuana range from $0.5 billion to $1.7 billion.[24]

To translate this amount into a tax per ounce requires an estimate of the total market size and the price. A 2014 report issued by the White House Office of National Drug Control Policy (ONDCP) provides estimates of the unit price, total expenditure, and total consumption weight of marijuana in the United States.[25] The calculations extrapolate from two sets of data: (1) the NSDUH, which is a self-reported survey of drug use habits; and (2) survey data from drug-offense arrestees in a limited number of areas designated as Arrestee Drug Abuse Monitoring (ADAM) jurisdictions.[26] The report finds that from 2002 to 2010, the amount of marijuana consumed in the United States likely increased by about 40%.[27] The ONDCP report also provides estimates of $30 billion, $41 billion, and $60 billion (given various assumptions) for total U.S. expenditures on marijuana in 2010.[28] Additionally, the report indicates that THC levels in marijuana increased from 2000 to 2010.[29]

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[22] A new study is not available, but a news article describes it. See Christopher Ingraham, "Study: Couples Who Smoke Marijuana are Less Likely to Engage in Domestic Violence," *Washington Post*, August 26, 2014. An abstract of the study, to be published in the Psychology of Addictive Behavior, can be found at http://www.ncbi.nlm.nih.gov/pubmed/25134048.

[23] National Institute of Health, National Institute of Drug Abuse, at http://www.drugabuse.gov/national-survey-drug-use-health. This usage reflects the current illicit market.

[24] The smaller number is the smallest relative harm (12%) multiplied by the smaller usage rate (14%) times $30 billion. The larger number uses the largest relative harm (28%) multiplied by the larger usage rate (19%) times $30 billion. This cost could rise with legalization and lower prices, but the subsequent calculations made in this section are per unit (per ounce) and do not depend on the size of the market. If the market expands to include more casual users, the external effect per unit could decline. This estimate does not take into account the net external benefits of marijuana consumption. There are few studies that have quantified the social benefits of marijuana production (e.g., through medicinal or therapeutic methods).

[25] White House Office of National Drug Control Policy, *What America's Users Spend on Illegal Drugs: 2000-2010*, February 2014, at http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/wausid_results_report.pdf. A detailed explanation of the limitations (such as underreported drug use of survey participants) of each of the data sources used in the report's analyses begins on p. 46.

[26] Most of the ADAM jurisdictions are medium to large cities within a region. See White House Office of National Drug Control Policy, *What America's Users Spend on Illegal Drugs: 2000-2010 Technical Report*, February 2014, at http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/wausid_technical_report.pdf.

[27] White House Office of National Drug Control Policy, *What America's Users Spend on Illegal Drugs: 2000-2010*, February 2014, p. 3, at http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/wausid_results_report.pdf.

[28] These are estimates based on specific assumptions and are not the same as a range or confidence interval of the estimated size of the U.S. marijuana market. The estimates are based on total consumption, and make no distinction between underground marijuana consumption and medical marijuana that is "legal" under certain state laws. White House Office of National Drug Control Policy, *What America's Users Spend on Illegal Drugs: 2000-2010*, February (continued...)

Using the ONDCP estimates of the market cited above ($30 billion to $60 billion), the estimates of external cost imply a tax of 0.8% to 5.3% of current price.

The White House's 2014 ONDCP report provides estimates of the price per gram of marijuana from 2000 to 2010. The nominal price of marijuana is roughly constant over the period, implying the inflation-adjusted price of marijuana was likely decreasing over time. In 2010, the White House report estimates that the price per gram of marijuana was $7.11 per gram ($199.08 per ounce), not accounting for differences in quality.

In addition, there are anecdotal prices recorded through anonymous sources and informal interviews with consumers or dealers in the underground market. Other researchers have used different techniques and newer data sources to estimate the price of marijuana across a wider range of locations. One website, priceofweed.com, contains anonymous, volunteer-submitted data on individual transactions across a variety of global locations, down to the level of particular towns or cities. Using data from priceofweed.com, the price of marijuana can be estimated as $317 per ounce, after weighting the observations for the quality of marijuana reported.[30] However, it is unclear if data submitted to priceofweed.com are representative. Anecdotal reports in the media indicate that high-quality marijuana can be obtained in some areas, such as Washington State, for $28 per eighth of an ounce ($224 per ounce, but presumably less if bought in bulk).[31] Another source suggests that consumers would have to pay at least $10 per gram, or $238 per ounce.[32]

Tax rates ranging from 0.8% to 5.3% of the price might seem small to some, but marijuana prices are currently much higher than the production cost because of the illicit nature of the market. In a legal market, prices would be lower. These estimates of external cost range from $1.60 to $16.80

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2014, pp. 58-59, at http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/wausid_results_report.pdf.

[29] Private studies of the marijuana market find both smaller and larger effects. Jeffrey Miron and Katherine Waldock, *The Budgetary Impact of Ending Drug Prohibition*, Cato Institute, September 27, 2010, at http://www.cato.org/publications/white-paper/budgetary-impact-ending-drug-prohibition, estimate the market at $13 billion although they acknowledge their estimates are small. Jon Gettman, "Marijuana Production in the United States," *The Bulletin of Cannabis Reform*, December 2006, http://www.drugscience.org/Archive/bcr2/MJCropReport_2006.pdf, estimates the quantity rather than market value. At $200 to $300 per ounce, his estimates suggest a market of $106 billion to $158 billion. See also Jon Gettman, "The Supply of Marijuana to the United States," for a discussion of the method of estimating the market, at http://www.drugscience.org/Archive/bcr4/5Supply.html.

[30] CRS analysis of data from Matthew Zook, Mark Graham, and Monica Stephens, *Data Shadows of an Underground Economy: Volunteered Geographic Information and the Economic Geographies of Marijuana*, Floating Sheep Working Paper Series (FSWP001), August 30, 2011. Zook et al. reported per ounce prices for high, medium, and low quality of $377.02, $245.14, and $138.12, respectively. Observations in each category were 9,955; 5,353; and 1,194, respectively. Zook et al. removed some price-based entries from the raw data to reduce the risk of user-entry error. The data were collected across 11,860 U.S. cities. An "ounce" is equivalent to 28 grams, as some drug dealers in the underground economy use the convention of the 28 gram-ounce, instead of the precise 28.35 gram-ounce, for simplicity. Priceofweed.com does not ask users whether the marijuana was purchased through state-licensed dispensaries or through underground transactions Zook et al. also report the distribution of prices for high-quality marijuana by state. Oregon had the lowest average state price for high-quality marijuana ($256 per ounce) and Delaware had the highest ($450 per ounce).

[31] See the story of Ben Jammin, a long-time marijuana dealer, in Patrick Radden Keffe, "Buzzkill," *The New Yorker*, November 18, 2013, at http://www.newyorker.com/reporting/2013/11/18/131118fa_fact_keefe?currentPage=all.

[32] Steven Easton, "Legalize Marijuana for Tax Revenue," Opinion in the Business Week Debateroom, *Bloomberg Business Week*, 2009, at http://www.businessweek.com/debateroom/archives/2010/03/legalize_marijuana_for_tax_revenue.html.

per ounce. The smaller estimate assumes a 0.8% tax and a $200 price; and the larger estimate assumes a 5.3% tax and a $317 price. Estimates discussed in subsequent sections suggest the price in a fully competitive market could be as low as $5 per ounce, so that the tax would be greater relative to price.

If a typical joint contains a half of a gram of marijuana, then the largest estimate is the equivalent of $0.30 per joint. For comparison, the federal tax on cigarettes is $0.05 for each cigarette whereas taxes on alcoholic drinks range from $0.04 for a five ounce glass of wine, $0.05 for a 12 ounce beer, and $0.13 for a 1.5 ounce shot of distilled spirits.[33] Thus, the tax on a joint would be about the same as the tax on a six-pack of beer. States (and sometimes localities) also impose taxes on alcohol and tobacco, and they presumably would also tax marijuana as Colorado and Washington have.[34] These state taxes are probably already in excess of the external costs of marijuana.

Although clearly many uncertainties surround attempts to measure the external costs of marijuana (as reflected in the range of estimates), the information that is available suggests a relatively small tax compared with current prices.

Discouraging Use, Including Among Youth

An argument can be made for imposing a tax to discourage marijuana users because these potential consumers underestimate long-term health costs and possible dependence when they begin to use the substance. This argument may be particularly important to underage use of marijuana.

Some disagree that marijuana is physically addictive, although it may result in dependence. A recent study found that about 9% of marijuana users become dependent.[35] Another study found that medical marijuana laws in the United States increase the probability of marijuana abuse or dependency by 15%-27% among adults aged 21 or older.[36]

Information on the risks of marijuana could be improved with more research and dissemination of the results of that research. In the case of the risk of addiction or dependence, economists disagree on whether the behavior of users is suboptimal, at least in the case of adults. “Rational addiction” theories indicate that as long as consumers are informed they are making desirable choices.[37]

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[33] The cigarette tax is $1.01 per pack of 20. For tax rates on alcohol, see CRS Report R43350, *Alcohol Excise Taxes: Current Law and Economic Analysis*, by Sean Lowry.

[34] Colorado imposes a 15% excise tax on cultivator, a 10% special sales tax, and the 2.9% standard sales tax. Washington imposes a tax on 25% at each sale point: from grower to processor, from processor to marketer, and at retail. The grower to processor tax does not apply if the grower and processor are the same.

[35] For the 9% estimate, see National Institute of Drug Abuse, “Is Marijuana Addictive?” at http://www.drugabuse.gov/publications/research-reports/marijuana/marijuana-addictive. For an accessible discussion with differing viewpoints see, Dr. Sanjay Gupta, “Why I Changed My Mind on Weed,” *CNN*, August 8, 2013, at http://www.cnn.com/2013/08/08/health/gupta-changed-mind-marijuana/; and the post of Dr. Robert Dupont at “Is Marijuana Addictive (Debate),” *Huffington Post*, September 12, 2013, at http://www.huffingtonpost.com/2012/09/04/is-marijuana-addictive_n_1851564.html.

[36] See Hefei Wen, Jason M. Hockenberry, and Janet R. Cummings, *The Effect of Medical Marijuana Laws on Marijuana, Alcohol, and Hard Drug Use*, National Bureau of Economic Research, NBER Working Paper No. 20085, May 2014, at http://www.nber.org/papers/w20085.

[37] See Gary Becker and Kevin Murphy, “A Theory of Rational Addiction,” *Journal of Political Economy*, vol. 96, no.4, (continued...)

Other economists argue that individuals can be engaged in hyperbolic discounting, in which they make time-inconsistent choices in the present that their future selves would not prefer.[38]

An important issue in determining a tax that is intended for the best interests of the potential user is that the tax would also reduce income. If the purpose of the tax is to increase the user's welfare, that benefit must be offset by the reduced income. Individuals that typically consume multiple joints per day consume a disproportionate share of the marijuana used in the United States (a trend similar to alcohol use) and in heavier doses. Researchers have estimated that 20% of marijuana users constitute about 80% of consumption.[39] Like taxes on alcohol and tobacco, the majority of the burden of a marijuana tax would fall primarily on the heaviest users.[40]

A tax on marijuana, like most excise taxes, is likely to be regressive, and this outcome might be considered undesirable (although current users are likely to benefit from a decline in price from making marijuana legal).

Evaluating the potential benefit to users of imposing taxes to discourage consumption depends on how users' participation in the market and the quantity purchased respond to the tax. It is assumed that the tax is passed on in price.[41] Responses to price changes are generally expressed as elasticities by economists: the percentage change in quantity divided by the percentage change in price. For example, if the elasticity is -0.5, a 10% increase in price leads to a 5% decrease in quantity consumed. If the price elasticity is low, the tax alters behavior very little, while imposing a significant tax burden, and users are harmed by the tax although their small change in consumption may be closer to the optimal choice (i.e., the choice they would make fully accounting for the costs).

Gallet (2014) examines a combination of 42 studies on the demand for various illicit drugs, 13 of which measure the price elasticity demand of marijuana.[42] After controlling for various factors related to the studies, Gallet's model predicts elasticities of demand for marijuana ranging

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1988, pp. 675-700.

[38] David Laibson, "Golden Eggs and Hyperbolic Discounting," *Quarterly Journal of Economics*, vol. 112, no. 2, May 1997, pp. 443-477. Hyperbolic discounting means that the value of future effects falls sharply initially and then settles to a slow decline, unlike exponential discounting in which the value falls by the same proportion in every period.

[39] Jonathan Caulkins et al., *Marijuana Legalization: What Everyone Needs to Know* (Oxford: Oxford UP, 2012), p. 27. This analysis is based on the 2009 National Survey on Drug Use and Health (NSDUH).

[40] Survey evidence suggests that a marijuana tax would be regressive (like most excise taxes), because lower-income individuals are more likely to be heavier consumers of marijuana. See Figure 4.6, Beau Kilmer et al., *Before the Grand Opening: Measuring Washington State's Marijuana Market in the Last Year Before Legalized Commercial Sales*, RAND Corporation, December 2013, p. 36, at http://www.rand.org/pubs/research_reports/RR466.html.

[41] In a competitive market, where firms do not earn profits above the amount needed to pay capital suppliers, the tax must be passed on because price must cover all costs. Even in imperfect markets, both theory and empirical evidence (such as that derived from the alcohol and tobacco markets) indicate the tax is likely to be passed forward. This issue of the pass through of excise taxes to price and references to the empirical literature are presented in in detail in CRS Report R43342, *The Medical Device Excise Tax: Economic Analysis*, by Jane G. Gravelle and Sean Lowry.

[42] Craig A. Gallet, "Can Price Get the Monkey Off Our Back? A Meta-Analysis of Illicit Drug Demand," *Health Economics*, vol. 23 (2014), pp. 55-68. See also *Altered State? Assessing How Marijuana Legalization in California Could Influence Marijuana Consumption and Public Budgets*, RAND Corporation, 2010, at http://www.rand.org/content/dam/rand/pubs/occasional_papers/2010/RAND_OP315.pdf; Kenneth W. Clements and Mert Daryal, *The Economics of Marijuana Consumption*, Economic Research Centre, Department of Economics - The University of Western Australia, September 1999, p. 42, at http://www.drugpolicy.org/docUploads/Mari.pdf; and Henry Saffer and Frank Chaloupka, "The Demand for Illicit Drugs," *Economic Inquiry*, vol. 37, no. 3 (July 1999), pp. 401-411.

between -0.15 and -0.31. In other words, a 1% increase in the price of marijuana results in a 0.15% to 0.31% decrease in the demand for marijuana. Consumer demand is relatively unresponsive to changes in price.[43] Thus, it is more likely that users would be harmed overall by a tax imposed for their own benefit, because gains in moving to more optimal consumption may be more than offset by lost income from the tax.[44]

Government policy is often focused on limiting use of drugs (whether legal or illegal) by minors. Current, state marijuana legalization laws disallow purchases by those under 21 years old, but, as with other commodities, youth may still obtain them in various ways. Estimates of the price elasticity for minors tend to be larger. One study had an overall estimate of -0.44 but an estimate of -1.01 for ages 12-17 years old.[45] Thus taxes may be more effective in reducing usage among youth (assuming these youth are not purchasing marijuana through illegal markets or acquiring legally produced marijuana through informal, secondary channels without cost).

The policy question then may be how much of a tax burden should be placed on non-responsive adult users to limit consumption of youth. (A similar issue arises with taxation of tobacco.) This question has no quantifiable answer, but one objective that might be considered is to set the tax so that the price of marijuana does not fall substantially with legalization and expanded demand, especially among minors who are more responsive to price. The next section discusses the potential level of such a tax.

Capturing the Current Differential Between Cost and Price

The characteristics of a legalized, and low-cost, marijuana market, as well as the concerns discussed above about youth consumption, may suggest a tax to keep these prices from falling precipitously until the consequences of a legal market can be determined. Depending on those consequences, a relatively high tax may be retained, or the tax may be reduced.

After legalization, it is estimated that the cost of marijuana will decrease significantly because more will be produced and the implicit costs of evading law enforcement will decline. Many producers are currently confined to smaller-scale or indoor operations that lack economies of scale. Workers in the illicit trade of marijuana must also be compensated more than comparable workers in industries that are not subject to law enforcement risk (e.g., laborers harvesting fruits or vegetables). Although a legalized market for marijuana could develop in such a way that some firms are able to attain market power and charge higher prices for their particular brands of marijuana compared with generic brands, the market for marijuana could become more competitive. In a competitive market, firms earn no profit above the normal return necessary to attract capital (if they did, other firms would enter to exploit it).[46] Prices would, therefore, fall to reflect lower production costs.

[43] Following legalization, the elasticities of demand for marijuana could increase (become more price sensitive) as more casual users become part of the consumer base. However, it can be expected that the majority of demand will still be driven by heavy users, who would likely be less responsive to price changes because they may be dependent on marijuana.

[44] Overall welfare could be increased, depending on the use of the tax revenue.

[45] David Ruggeri, "Marijuana Price Estimates and the Price Elasticity of Demand," *International Journal of Trends in Economics, Management, & Technology (IJTEMT)*, vol. 2, no. 3 (June 2013), pp. 2321-5518.

[46] Because these firms are price-takers, and are not influential enough to affect prices prevailing in the market, higher profits could signal firms to enter the industry. As quantity increases, the price will decline. Profits will converge (continued...)

The difference between the projected cost in a legal competitive market and current prices (which largely reflect illicit production) provides a range within which a federal tax rate might be considered, at least initially. The tax should not be set too high (including any state and local taxes) to encourage illicit productions, so that this approach might be aimed at offsetting only part of the price reduction expected from the legalization of marijuana.

Caulkins (2010) estimates the costs of producing and processing legalized marijuana, under a number of methods and scenarios.[47] As shown in **Table 1**, Caulkins estimates that the production cost *per pound* of high-quality marijuana would be roughly equivalent to the current retail price *per ounce*. Outdoor production of marijuana is estimated to cost substantially less, per pound of output. However, marijuana cultivated outdoors is less likely to contain the higher levels of THC found in plants grown indoors in controlled growing environments. The estimated production costs in **Table 1** do not include processing costs, which are estimated to add an additional $20 to $35 per pound.

Table 1. Estimated Production Costs of Legalized Marijuana

Production Method	Estimated Cost per Pound
Indoor Production	
-Five foot by five foot "hobbyist"	$225 + an in-kind compensation for the hobbyist's time
-1,500 square foot residential house	$200 to $400
-One acre 50% covered with greenhouses	$70 to $215
Outdoor Production	
-Commercial-grade, low estimate	$1
-Commercial-grade, mid estimate	$8
-Commercial-grade, high estimate	$10
-High-quality, *sinsemilla*-equivalent resin	$265

Source: Jonathan P. Caulkins, *Estimated Cost of Production for Legalized Cannabis*, RAND Corporation, July 2010, at http://www.rand.org/pubs/working_papers/WR764.html.

Notes: See Caulkins (2010) for details on methodology. Indoor production costs include consumable materials (e.g., soil, water), lighting, labor, and structure/rent. Outdoor production estimates vary based on estimated yield, density of plantings, and labor costs. Calculations assume all output is commercial grade, but the THC-levels across all methods of production are not assumed to be equal. Production costs do not include processing costs, which Caulkins (2010) estimates could add $20 to $35 per pound.

Producing high-quality marijuana in greenhouses appears to cost, at the upper limit, $215 plus $35 per pound for processing, or around $15 per ounce. Using outdoor production, of $10 plus $35 a pound, the cost is about $2.80 per ounce. These products vary by THC concentration; as noted earlier, *sinsemilla* contains 10% -18% THC, or about three times the potency conventional commercial-grade marijuana that is pollinated.

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toward normal levels, and the entry of new firms will cease.

[47] Jonathan P. Caulkins, *Estimated Cost of Production for Legalized Cannabis*, RAND Corporation, July 2010, at http://www.rand.org/pubs/working_papers/WR764.html.

In a different estimate, Easton (2009) indicates that government-sponsored marijuana in Canada can be produced at 33 cents per gram ($9 per ounce or $144 per pound).[48] He also suggests that, based on tobacco sales, the cost per gram of going to a retail market is about 10 cents per gram, or $2.80 per ounce ($44.80 per pound). Adding this amount to estimated costs leads to a cost (and expected price) of $5-$18 per ounce ($80-$288 per pound).

In jurisdictions where marijuana has become quasi-legal, prices tend to be lower than the street price in most cases but higher than these cost estimates. In an article indicating an increased price for medical marijuana in Canada, the price was listed as $1.80-$5 per gram to the final consumer, $50-$140 per ounce. In that same article, a lawyer representing numerous suppliers said his clients could supply for $1-$4 per gram, or $28-$110 per ounce.[49] The street price was listed as $10-$15 per gram, or $280-$420 per ounce. Of course, the price could be discounted if bought in larger quantities. These street prices are high compared with the averages in priceofweed.com. Beginning in April 2014, the Canadian government set the price of medical marijuana at $7.60 (CAD) per gram, which is higher than the current average and closer to the street price.[50] Small growers and homegrown marijuana will no longer be permitted under the new law. These prices are higher than the costs discussed above but also apparently do not reflect an unfettered and mature competitive market.

Actual prices can also be observed in Colorado marijuana shops through online websites, such as Leafly.com. Leafly is a website and mobile phone application that helps users find marijuana shops, medical marijuana dispensaries, and doctors that prescribe medical marijuana located in their areas.[51] Like the consumer website and application, Yelp (which is used to review restaurants, stores, and other sites of interest), Leafly provides consumer reviews of each location and various strands of marijuana and provides "menu" prices of products available at each shop. According to an examination by the authors of some of the most-reviewed marijuana shops in Denver, a gram of marijuana is priced around $9 to $15, an eighth of an ounce of marijuana can be priced around $29 to $40, and an ounce can be priced around $190 to $350.[52] Some of the higher prices listed on Leafly include tax, but it is unclear from the "menu prices" whether some of the prices are before or after tax (although they are most likely before tax, unless noted).

Submissions to priceofweed.com report that marijuana prices in Colorado are lower than the national prices reported earlier, with high quality at $238 per ounce and medium quality at $197 per ounce (compared with $377 and $245 reported for the United States overall). These prices still reflect a mix of the illicit and legal markets but would presumably include taxes on any legal purchases.[53]

Colorado prices provide some indication of falling prices with legalization, but prices appear not close to the cost of production. The prices in Colorado, however, may not reflect those in a fully

[48] Steven Easton, "Legalize Marijuana for Tax Revenue," Opinion in the Business Week Debateroom, *Bloomberg Business Week*, 2009, at http://www.businessweek.com/debateroom/archives/2010/03/legalize_marijuana_for_tax_revenue.html.

[49] Brian Hutchinson, "Medical Marijuana Production in Canada Set for Dramatic Change," *National Post*, January 17, 2014, at http://news.nationalpost.com/2014/01/17/medical-marijuana-production-in-canada-set-for-dramatic-change/.

[50] Ibid.

[51] Leafly has reviews of locations wherever recreational or medical marijuana is available (not just Colorado).

[52] CRS review of prices listed for various Denver-based marijuana shops on Leafly.com was on July 23, 2014.

[53] Data for Colorado, http://www.priceofweed.com/prices/United%20States/Colorado.html, visited October 27, 2014.

legal market because they are still in a quasi-legal status. Because the federal government does not recognize the legality of these operations, media reports indicate that these producers may have trouble getting banking assistance, including deposit accounts, much less business loans.[54] These operations are potentially subject to very large federal income taxes, which can be imposed without allowing for deductions because they remain illegal. These taxes can be the equivalent of excise taxes at the federal rate and can apply at each stage of production. (See discussion in **Appendix B**.) And marijuana businesses are still subject to the threat of potential enforcement from federal authorities.

In a 2010 study of the possible effects of legalization in California, researchers from the RAND Corporation estimate that the pretax retail price of marijuana would likely decrease by more than 80%,[55] suggesting a price of $40-$60 per ounce. Miron and Waldock, however, estimate a 50% price reduction, based on a comparison of prices in the United States and the Netherlands (sold in coffee shops).[56] This price reduction would suggest a price of $100-$150 per ounce on average. The Netherlands, however, is, like Colorado, not an instance of a fully legalized market because the Netherlands bans imports and has anti-drug laws on the books.

Although the range of projected prices in a fully legal market is wide, from a few dollars to $100 per ounce, street prices of $200-$300 per ounce suggest that there could be a wide scope for a tax rate designed to align legalized marijuana prices close to current street prices of illegal marijuana. For example, if the eventual competitive price is $50 per ounce and the average street price is $250 per ounce, there is scope for taxes up to $200 tax per ounce.

There are several caveats to this point. The first is state and local governments will likely collect a tax that will absorb some of the differential. The second is a tax that is set too high would encourage the illicit market, and one of the advantages of legalizing marijuana is to largely eliminate the illicit market, reducing law enforcement costs. Moreover, the potential scope of the difference is uncertain, but lowering tax and observing market conditions may be the best initial strategy.

Funding Marijuana Research and Information Programs

Some or all of the yield from a marijuana tax could be used to fund marijuana research. Medical marijuana, as noted, has been approved by 23 states and the District of Columbia. Research on the effects of medical marijuana, which would be helpful in providing guidance to patients and doctors, could be funded in part by the tax.[57] A recent report by the American College of

[54] See Eric Gorski, "Reluctance of Banks Leaves Pot Shops Looking for Secure Practices," *The Denver Post*, June 15, 2014; and Alex Altman, "Colorado's New Pot Banking Law Won't Solve Cash Problems," *TIME*, June 6, 2014.

[55] Beau Kilmer et al., *Altered State? Assessing How Marijuana Legalization in California Could Influence Marijuana Consumption and Public Budgets*, RAND Corporation, 2010, p. 53, at http://www.rand.org/content/dam/rand/pubs/occasional_papers/2010/RAND_OP315.pdf.

[56] Jeffrey A. Miron and Katherine Waldock, The Budgetary Impact of Ending Drug Prohibition, CATO Institute, 2010, at http://www.cato.org/pubs/wtpapers/DrugProhibitionWP.pdf. Note that only retail sales are licensed and taxed in coffee shops, as production is still illegal.

[57] See Mary Wilson, "In Medical Marijuana Debate, Arguments Return to Lack of Research, Transforming Health," January 29, 2014, at http://www.transforminghealth.org/stories/2014/01/in-medical-marijuana-debate-arguments-return-to-lack-of-research.php; and Ryan Jaslow, "Medical Marijuana: More States Legalizing, but Scientific Evidence Lacking," *CBS News*, December 13, 2013, at http://www.cbsnews.com/news/medical-marijuana-more-states-legalizing-but-scientific-evidence-lacking/.

Physicians noted that limitations on marijuana research are caused, in part, by barriers encountered for federal approval, the lack of high-grade, research-quality marijuana, and the general classification of marijuana as a Schedule I illegal drug.[58] The report discusses a wide range of conditions that marijuana may be beneficial for and urges study of the efficacy and side effects of marijuana.

With legalization it would also be more feasible to study a wide array of issues (as discussed in this report), such as externalities, addictive properties, and health effects on recreational as well as medical users. Revenue could also be used to finance information programs on both the risks of marijuana use and to discourage consumption by minors.

Raising Revenue

Historically, the primary purposes of excise taxes in the United States have been to raise revenue, including revenues for emergency spending.[59] Cigarette taxes have been used to offset higher spending levels on health care, such as the Children's Health Insurance Program (CHIP), in recent years.[60]

Given assumptions about price and demand, an excise tax on marijuana can be designed in such a way to achieve a certain revenue target. This section provides some illustrations of how much revenue might be raised from an excise tax were marijuana to become legal. These revenue consequences are quite uncertain given the broad uncertainty about potential price and quantity in the market.

In addition, casual consumers may enter the marijuana market and increase revenue. These consumers may purchase marijuana because concerns about punishment are no longer present or because of a distaste for participating in illegal activities in general. These effects are not necessarily captured in the existing price elasticity estimates (which mostly reflect consumers that are determined enough to defy law enforcement to consume marijuana), and the legal market, even setting price aside, could be much larger than the current market for this reason.

The pace of legalization and taxation of marijuana at the state level could also affect potential revenue collected from a federal excise tax. If more states tend to legalize marijuana, and try to set their excise tax rates to roughly equalize the price of legal (under state laws) marijuana with illicit marijuana, then federal lawmakers could be more constrained in their ability to levy excise taxes on marijuana without encouraging production in the illicit market.[61]

Some analysts have tried to estimate the potential revenue that could be raised from nationwide legalization of marijuana using various economic models, and may in some cases include excise

[58] American College of Physicians, *Supporting Research into the Therapeutic Role of Marijuana*, 2008, at http://www.acponline.org/acp_policy/policies/supporting_medmarijuana_2008.pdf.

[59] For general historical context of U.S. excise tax policy, see CRS Report R43189, *Federal Excise Taxes: An Introduction and General Analysis* , by Sean Lowry.

[60] See CRS Report R40226, *P.L. 111-3: The Children's Health Insurance Program Reauthorization Act of 2009*, by Evelyne P. Baumrucker, Elicia J. Herz, and Jane G. Gravelle; and CRS Report RS22681, *The Cigarette Tax Increase to Finance SCHIP*, by Jane G. Gravelle.

[61] Assuming that the federal tax rate more than offsets any decline in price due to the effects of legalization.

taxes.[62] (Legalization itself would presumably increase revenues by moving more of national income into legal sectors subject to income, such as sales and business taxes, even without an excise tax.)

Miron and Waldock of the Cato Institute estimate that a federal excise tax could raise $5.8 billion (in 2008 dollars) annually in excise taxes if marijuana is taxed at a rate equal to 50% of its price to consumers.[63] Their calculations assume the national market for marijuana at $13.13 billion (in 2008), a 50% fall in price after legalization, and a 25% increase in consumption. They also estimate $3.3 billion in annual savings in expenditures from law enforcement. Miron and Waldock do not report price and quantity separately, but they are probably estimating a tax of around $50-$75 per ounce. Miron and Waldock note that their market size estimates, which are extrapolated from survey data, are small by comparison with other estimates. At the same time, they appear to be assuming a greater response from consumers than that suggested by the literature review.

A Sample Calculation

This calculation outlines how to estimate revenues from an excise tax, using the example of a $50 per ounce tax. It takes into account the effects on aggregate consumption and interactions with income taxes. The results depend on the specific assumptions about market conditions as well as state and proposed federal taxes.

To estimate revenue yield, data on price and quantity are needed. As noted earlier, data on the value of the market ranged from $30 billion to $60 billion according to ONDCP. The current price was estimated at between $200 and $300 per ounce. For this example, assume intermediate values of a $40 billion market and a $250 current price.

To illustrate the potential effect on revenue assume a fully legalized industry nationwide, assume a pretax price of $50 per ounce, a state tax of $50 per ounce, and the consequences of a federal tax of $50 per ounce. The taxes and costs bring the total price to $150 per ounce.

The federal excise tax collection, therefore, is $50 multiplied by the quantity (in ounces). In the current market, quantity would be determined by dividing $40 billion by $250. If quantity did not change the federal excise tax revenue would be $50 multiplied by $40 billion divided by $250, or $8 billion. Collections, however, would be somewhat larger because the fall in price from legalization would increase consumption. Using a constant elastic formula, the ratio of the new quantity to the old is (P*/P)^E, P* is the new price, P is the old price, and E is the price elasticity (which is negative). Assuming a price elasticity of -0.25, the effect of legalization alone, which is assumed to reduce the price to $50 per ounce, would lead to a 50% increase in quantity. With federal, state, and local taxes, the price is $150 and the increase in quantity is 14%, leading to a projected excise tax collection of $9.1 billion. By comparison, the tax on alcoholic beverages is $10 billion, a much lower tax applied to a much larger market.[64]

[62] Most models of the potential revenue effects of a federal marijuana tax do not take into account potential exports and imports, as marijuana is still largely illegal in most overseas markets. If exports and imports were allowed, the standard tax treatment would be to tax imports of marijuana and exempt exports.

[63] Jeffrey Miron and Katherine Waldock, *The Budgetary Impact of Ending Drug Prohibition*, Cato Institute, September 27, 2010, at http://www.cato.org/publications/white-paper/budgetary-impact-ending-drug-prohibition.

[64] See CRS Report R43350, *Alcohol Excise Taxes: Current Law and Economic Analysis*, by Sean Lowry, for data.

The actual revenue gained is, according to standard estimating conventions, reduced by 25% to account for the loss of income and wage taxes because excise taxes produce a wedge between output and income.[65] Thus the projected revenue gain is $6.8 billion.[66] As a reminder, this estimate is based on a series of assumptions, changes to which would alter the revenue estimate.

The yield will also depend on how widespread the movement for legalization is and whether medical marijuana is covered. Currently only Colorado and Washington allow recreational marijuana, and they represent less than 4% of the population, so the short-term yield might be less than $300 million. More revenue would be gained if medical marijuana in other states were taxed.

Using Data from Colorado to Estimate Market Size

As previously mentioned, calculations based on data from the illicit market for marijuana might not be representative of a fully commercialized market. Given the scale of policy changes at the state level, tax collection data from Colorado and Washington could serve as early indicators of the potential tax base of a national legalized market.

Marijuana sales are subject to several layers of taxation at the state and local level. In Colorado, recreational marijuana sales are subject to three different state taxes: (1) a 15% marijuana excise tax on the unprocessed product, (2) a 10% retail marijuana excise tax, and (3) a 2.9% general sales tax. The approximate effective tax rate on marijuana products is between 15% and 25%, before the imposition of the state's 2.9% general sales tax.[67] Medical marijuana in Colorado is subject to the 2.9% general sales tax. Local taxes, such as the Denver city sales tax, can also apply on top of the state taxes.

From January 2014 to September 2014, Colorado has collected more than $37.0 million in sales taxes, excise taxes, and retail license fees on recreational marijuana (in addition to $13.7 million collected from medical marijuana sales taxes and license fees).[68]

By extrapolating from the actual tax revenue data from Colorado, the national market for marijuana could be estimated. These calculations are detailed in **Appendix C**. After adjusting the September 2014 tax data from Colorado to control for usage rates in different states, it can be estimated that the national sales tax base for recreational marijuana could be between $15.9 billion and $17.0 billion per year (assuming market conditions currently in Colorado prevail nationally).[69] It is difficult to extrapolate medical marijuana data in Colorado to the general U.S.

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[65] U.S. Congress, Joint Committee on Taxation, New Income and Payroll Tax Offsets to Changes in Excise Tax Revenues for 2013-2023, committee print, 113th Cong., 1st sess., February 12, 2013, JCX-5-13 (Washington: GPO, 2013).

[66] Again, this is the gain only from the excise tax, conditional on a legal market, and not from making marijuana legal, in which income taxes would increase.

[67] John Walsh, *Q&A: Legal Marijuana in Colorado and Washington*, The Brookings Institution, May 21, 2013, at http://www.brookings.edu/research/papers/2013/05/21-legal-marijuana-colorado-washington.

[68] Calculated from monthly reports at Colorado Department of Revenue, "Colorado Marijuana Tax Data," at http://www.colorado.gov/cs/Satellite/Revenue-Main/XRM/1251633259746.

[69] These estimates are based on different assumptions, and should not be considered as a range or confidence interval for what the projected national sales tax base of marijuana could be. The lower and higher estimates are based on different reported usage rates, based on age, from the NSDUH survey data. The higher estimate is based on the usage rates of 18-25 year olds and the lower estimate is based on the usage rates of those aged 26 and older. Surveys of drug habits tend to understate actual usage rates. See **Appendix C** for details.

population due to incomplete data in some states, but the tax collections data from Colorado indicate that medical marijuana consumption could roughly double that consumption base.[70]

The combined medical and recreational marijuana sales in Colorado roughly extrapolated to the United States suggest a market of at least $30 billion, which is small compared with most estimates considering that the price should be smaller than in the illicit markets. It may be that the Colorado market is insufficiently developed, and substantial levels of illicit sales are continuing (either due to lower prices on the illicit market or preexisting relationships between buyers and sellers in the black market). However, consumption in Colorado could be overstated due to non-resident sales (also known as "pot tourism").

The estimates do, however, suggest that the issue of whether to exempt medical marijuana and how to enforce any medical exemption that might develop are potentially important issues.

Design Issues for a Federal Marijuana Excise Tax

Aside from the general level of the tax, there are a number of design issues for an excise tax discussed in this section.

Choosing the Stage of Production to Levy an Excise Tax

In general, an excise tax that is levied at earlier stages of production has lower administrative costs and fewer opportunities for tax evasion. In most situations, consumers vastly outnumber producers. Trying to implement an excise tax at the consumer retail outlet often results in a duplication of processes and increases the risk of tax evasion.[71] As a result, federal excise taxes are generally levied on manufacturers and imports (with an exemption for exports).

Choosing the Excise Tax Base

In general, marijuana can be taxed based on a per unit measurement or the product price. Each tax base has its own advantages and disadvantages, and multiple tax bases could be combined.

Weight

A tax by weight is similar to the federal excise tax regime for tobacco because regulations limit the per unit size of cigarettes, cigars, etc. A tax by weight is relatively easy to administer (after accounting for moisture content). The tax could be levied based on the "wet" weight, right after

[70] This is not to say that the ratio of medical marijuana users to recreational users is always 1:1. Based on recent tax data, it appears that the recreational and medical marijuana sales bases (before state taxes are applied) are converging. See **Appendix C** for tax revenue data from Colorado on retail and medical marijuana. Given the lower tax rates on medical marijuana, those who already have a medical marijuana registration card have little economic incentive to purchase recreational marijuana.

[71] For example, some retailers could offer "free" marijuana in combination with other goods and services. Products also tend to be more prone to theft at the retail level. In both of these situations, no tax would be paid. See Pat Oglesby, "State May Be Stuck with Second-Best Marijuana Taxes," *State Tax Notes*, June 2, 2014, pp. 539-544.

the leaves and flowers are picked, or the weight after drying.[72] A weight-based tax would need to be administered at the manufacturing level, as a retail-based weight tax could create significant issues for different types of products.[73] However, a weight-based tax could encourage the production of more potent marijuana.

Potency

Most potency-based tax proposals are based on the per-ounce THC content. In comparison to a weight-based tax, a potency-based tax could be more complicated and costly to enforce and administer. The largest administrative hurdle to a potency-based tax is ensuring that lab testing of marijuana strains is accurate and reliable. Regulations defining the number and weight of any samples that producers need to submit for testing would be required. According to one lab in Oakland, CA, samples of two grams can be used to evaluate the potency of up to two pounds of marijuana. Costs of these lab tests can be much as $100-$120 per sample, and as low as $60-$75 per test with a bulk discount. If marijuana is legalized, it can be expected that more labs that perform similar services will enter the market, and possibly reduce the price of testing. More competition in testing could encourage the development of more reliable technology, but it could also lead growers to pick a lab that tends to understate the amount of THC in a product.[74]

Ultimately, it could be difficult to measure final THC content with any degree of reliability, given the nature of some marijuana products. Another disadvantage to a tax based on THC potency is that it could encourage more consumption of less-potent marijuana. If the public health costs of smoking marijuana outweigh the health costs of consuming more potent marijuana, then the effects of this option might be undesirable.[75]

An alternative potency calculation could be based on the ratio of THC to cannabidiol (CBD). Such a tax base could encourage consumers to purchase marijuana with more sedative effects.

Price

A tax could be levied as a percentage (ad valorem) of the manufacturers or retail sales price of marijuana. Ad valorem taxes have several advantages: they (1) automatically adjust for changes in price, and (2) can be easily applied to a wide variety of products that might otherwise be difficult to quantify in a per unit manner. Both the tax regimes in Colorado and Washington use some form of an ad valorem tax on wholesalers as one method to tax marijuana, and H.R. 501, the Marijuana Tax Equity Act of 2013, proposes a 50% tax on the producer or importer price. The main disadvantage of an ad valorem tax is the required regulations to specify the taxable price the taxes apply to.

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[72] The "wet" weight of a marijuana harvest is approximately four to five times its dry weight. See Jonathan P. Caulkins, *Estimated Cost of Production for Legalized Cannabis*, RAND Corporation, July 2010, p. 24, at http://www.rand.org/content/dam/rand/pubs/working_papers/2010/RAND_WR764.pdf.

[73] For example, a tax on the "final weight" of a large, THC-infused baked good could be more than a tax based on the final weight of an individual, THC-infused lozenge, even if both products contained the same amount of THC. See Jonathan P. Caulkins et al., "High Tax States: Options for Gleaning Revenue from Legal Cannabis," *Oregon Law Review*, vol. 91 (2013), pp. 1041-1068.

[74] Pat Oglesby, "State May Be Stuck with Second-Best Marijuana Taxes," *State Tax Notes*, June 2, 2014, pp. 539-544.

[75] Jonathan P. Caulkins et al., "High Tax States: Options for Gleaning Revenue from Legal Cannabis," *Oregon Law Review*, vol. 91 (2013), pp. 1041-1068.

A manufacturers tax (i.e., imposed after the plant is first grown and harvested) is the most simple form of administration because there are generally fewer firms involved in manufacturing than retailing. Most federal excise taxes are imposed at the manufacturer stage (e.g., tobacco, alcohol, firearms). For vertically integrated firms that are both manufacturers and retailers (or some other sort of intermediate firm, such as a wholesaler), regulations need to identify how to construct a manufacturers price if no market transaction takes place.

In contrast, a retail tax regime, resembling a sales tax, could be created to capture any price markup due to the type of product or any "market power" of firms with branding or advertising advantages. The price of a product containing marijuana or THC could be determined by a number of characteristics other than its intoxication potential.[76]

Special Considerations

In the case of a per unit tax (e.g., weight or potency), the tax rate can be indexed for inflation using some sort of measure of price changes, such as increases in the Consumer Price Index (CPI). Most other federal excise taxes are unindexed (e.g., alcohol, tobacco, gasoline), and, as a result, have declined in real value over time, absent legislative increases in statutory tax rates.[77]

Given the uncertainty over prices and demand after legalization, sunset provisions for the tax could be incorporated into any initial authorizing language of a marijuana tax. Sunset provisions could encourage legislators to revisit marijuana tax laws to better reflect the evolving conditions of the nascent, legalized industry. For example, the initial tax rate for legalized marijuana could be set low enough to undermine the illicit market, but then increased gradually to set the tax rate high enough to limit consumption. Alternatively, legislation could delegate authority to the Secretary of the Treasury (or a similar official) to adjust tax rates according to certain criteria.

Other Options

Various methods of taxation could also be combined. For example, a general tax on marijuana could be levied based on price or weight, with either a surcharge for higher-THC products or differential rates for various products, such as edibles. Differential tax rates could help shape consumption in such a way that it could reduce some of the negative social costs of marijuana. But, different tax rates could add complexity and unequal tax burdens across various marijuana consumers.

By comparison, alcohol is taxed by potency (i.e., alcohol content) as well as category, with taxes per alcohol content lower for beer and wine than for distilled spirits. Cigarettes are taxed on a per unit basis. Cigars are subject to an ad valorem tax with a high ceiling, although the tax is imposed at the manufacturers' level.

[76] For example, appearance or smell might affect price of dried marijuana. For baked edibles, the cost of flour, eggs, or sugar might affect the price of the final product.

[77] This is particularly the case with alcohol taxes, which have not been increased since 1993. See CRS Report R43350, *Alcohol Excise Taxes: Current Law and Economic Analysis*, by Sean Lowry.

Tax Treatment of Existing Plant and Product Inventories

The initiation of a federal marijuana tax could also raise the question of whether to integrate existing stocks of marijuana into the tax base.[78] Lawmakers would have to address the taxation of marijuana plants and any consumer goods sold in jurisdictions that have legalized medical and recreational sales. Integrating more preexisting marijuana plants and products into the tax base could enable producers and retailers to better meet the initial demand for marijuana (at prices potentially low enough to undercut the illegal market), reduce complexity between federal and local tax regulations, and increase initial federal tax revenue. However, some preexisting marijuana plants and products might not comply with new federal regulations or purity standards that are likely to accompany any federal tax regime.

An alternative option could include ample lead time between the enactment of such a tax and the effective date of the first legalized sales, giving producers sufficient time to comply with any federal regulations. Although this might help legal producers and retailers compete with the underground market, it would add complexity to the multiple layers of taxation of marijuana in some jurisdictions.

Colorado and Washington have taken slightly different approaches to this issue. In Colorado, retail licenses were initially issued to existing medical marijuana dispensaries (some of which were already growing their own plants).[79] In Washington, current plants grown indoors or outdoors can be converted to legal stocks if the owner has a producer license and the growing space meets all of the state's guidelines.[80]

In general, when federal excise taxes are increased, untaxed floor stocks are subject to tax (sometimes with exemptions for small retail operations). The purpose is to prevent building up inventories in advance of the effective date of the tax.

Restrictions, Exemptions, and Special Tax Treatment

Several issues could arise concerning restrictions, exemptions, and special treatment under a federal tax on marijuana. Policy makers could choose to implement such regulations at the federal level or allow the states to make their own laws pertaining to each of these issues. Any of these differential tax treatments, however, would make the tax more complicated.

Age Restrictions

State laws in Colorado and Washington limit recreational marijuana purchases to individuals aged 21 or older. Age restrictions could have a limiting effect on the tax base, as surveys indicate that younger individuals use marijuana at higher rates than those over 26 years old.[81] However, this

[78] For more information, see the discussion of transition issues and floor stocks taxes in CRS Report R43189, *Federal Excise Taxes: An Introduction and General Analysis* , by Sean Lowry

[79] See Colorado Department of Revenue, "Retail Marijuana Licensing Information," at http://www.colorado.gov/cs/Satellite/Rev-MMJ/CBON/1251646187389.

[80] See Washington State Liquor Control Board, "FAQs on I-502," at http://lcb.wa.gov/marijuana/faqs_i-502.

[81] In the SAMSHA surveys, these respondents are divided into two age-based categories: 12-17 year olds and 18-25 year olds. According to surveys taken from 2011 to 2012, the national average of marijuana use in the past month was 7.55% for 12-17 year olds, and 18.89% for 18-25 year olds. By comparison, the national average for individuals aged (continued...)

trend could change post-legalization as the stigma among adult use lessens and the exotic appeal of an illicit drug lessens among youth. In any case, excluding these consumers from the legal tax base could support some underground production activity (which would be untaxed), or indirect sales of legally purchased marijuana through of-age connections (which could still be preferable to direct transactions with illicit dealers).

Customer Purchasing or Possession Limits

Under state law, Colorado residents are allowed to possess up to one ounce of marijuana and make as many transactions as desired as long as they do not exceed the one ounce limit. Non-Colorado residents are restricted to purchasing one quarter of an ounce (7 grams) in a single transaction. The restriction on non-residents is primarily intended to reduce the risks for larger-scale diversion or export. It has yet to be seen if this restriction has had a significant effect on diversion. More restrictive purchasing limits (by weight) coupled with an ad valorem tax rate can also serve to increase the effective tax rate on heavy users, who are more likely to benefit from a bulk discount.

Production Limits

Production limits could be enacted based on the total market size or per grower. Washington has a target of 80 metric tons (half for dried marijuana and half for marijuana-extract based products, such as edibles and lotions) for the maximum size of its marijuana market. The primary rationales behind this policy are to monitor possible diversion of sales to other states and guide the number of licenses issued.[82] Colorado has no target. Similarly, concerns could be raised about the diversion of underground exports from the United States to countries where marijuana is still illegal. A tax administered closer to the beginning of the production chain might be more capable of monitoring such diversion. Mark Kleiman, Professor of Public Policy at UCLA and former marijuana policy consultant to the state of Washington, has been quoted as saying that a production limit could also reduce the power of larger producers who, if left unregulated, could increase the negative social consequences of marijuana consumption in pursuit of maximizing profit.[83]

(...continued)

26 and older was 5.05%. See Table 3 in http://www.samhsa.gov/data/NSDUH/2k12State/Tables/NSDUHsaeTOC2012.htm. Whole numbers are reported in: http://www.samhsa.gov/data/NSDUH/2k12State/NSDUHsae2012/NSDUHsaeStateTabs2012.htm#tab1. Some researchers have found that survey data on marijuana use understates actual use, in the range of 20% -40%, particularly among adolescents and young adults. See Jonathan P. Caulkins et al., *Marijuana Legalization: What Everyone Needs to Know* (Oxford University Press, 2012), p. 17.

[82] Eliza Gray, "New Laws Chart Course for Marijuana Legalization," *Time*, October 19, 2013, at http://nation.time.com/2013/10/19/new-laws-chart-course-for-marijuana-legalization/.

[83] See Patrick Radden Keffe, "Buzzkill," *The New Yorker*, November 18, 2013, at http://www.newyorker.com/reporting/2013/11/18/131118fa_fact_keefe?currentPage=all. One small scale study of underground cannabis growers in Norway found that there are several financial and cultural mechanisms that tend to prevent marijuana growers from growing from small-scale to large-scale operations. Some of these mechanisms would likely not hold in a largely unregulated, commercialized market. See Eirik Hammersvik, Sveinung Sandberg, and Willy Pedersen, "Why Small-Scale Cannabis Growers Stay Small: Five Mechanisms that Prevent Small-Scale Growers from Going Large Scale," *International Journal of Drug Policy*, vol. 23 (2012), pp. 458-464.

In general, production limits generate inefficiency and can contribute to windfall profits for firms already in the market. Production limits have never been considered for any other commodity by the federal government and are unlikely to work for states and a national legal market.

Exemption or Inclusion of Medical Marijuana

The tax treatment of medical marijuana varies in the jurisdictions that have legalized medical marijuana. Each jurisdiction applies its general sales tax or a special gross receipts or revenue tax on medical marijuana. For example, medical marijuana sold in Colorado is subject to the 2.9% general, state sales tax but is not subject to the 10% retail marijuana state sales tax or the 15% retail marijuana excise tax.

Medical marijuana, and the extent to which users are in medical need, is an issue that is contentious. This use might be more attractive to consumers who hesitate or dislike participating in an illicit market. Evidence suggests a negative correlation between medical marijuana and prescription drugs because deaths from prescription drug overdoses have declined in states with medical marijuana.[84]

Although there is a possible justification for exempting this medical use, differences in the after-tax price of recreational and medical marijuana could also provide incentives for users to seek out medical prescriptions. As indicated by the analysis of tax data in Colorado, exempting medical marijuana from a federal tax could also significantly limit the tax base if strict standards for medical prescriptions are not enforced. Preventing such abuse, however, could significantly increase the cost of tax administration.

If medical marijuana is exempt, and the tax is imposed at the production level, producers would have to know the end use of the product. Thus, a segregation of sales of medical marijuana and a marking or stamping device would likely be necessary.

Exemption for Home Production

Rules vary across different products that are subject to excise taxation.[85] Colorado allows individuals to grow up to six plants for recreational use, and households can grow up to 12 plants. Washington does not allow home growing of marijuana for recreational use.[86] In comparison, in federal law, no home distilling of alcohol is legal, whereas wine and beer can be made in limited amounts, and tobacco can be grown without limit.

If home production is allowed and exempt from taxation, another issue is whether a quantity limit should apply and if so what that limit might be. Pat Oglesby, former chief tax counsel of the Senate Finance Committee and noted expert on state marijuana taxes, indicates that a single plant can yield 448 grams (or approximately a pound of marijuana) and the average user consumes

[84] Causation between the increase in medical marijuana consumption and decrease in prescription drug overdoses has yet to be determined. See Niraj Chokshi, "Medical Marijuana States See Fewer Drug Deaths," Washington Post, p. A2, August 26, 2014.

[85] Among states where marijuana is legal for recreational or medical use, home-grow allowance laws vary based on weight or number of plants. See the National Organization for the Reform of Marijuana Laws (NORML), "State Laws," at http://norml.org/laws.

[86] See Washington State Liquor Control Board, "FAQs on I-502," at http://lcb.wa.gov/marijuana/faqs_i-502.

about 100 grams (less than four ounces) per year, so any home-growing limit would probably be seen as high.[87] At the same time, Oglesby (2011) argues that production for home use is not likely to be much of a threat to the tax because even with high illicit prices, even where homegrown is legal, users participated in the illicit market rather than growing their own. However, Caulkins et al., suggest that home production would seriously undermine enforcement because anyone in possession of nontaxed product could claim home production.[88] Banning home production could also increase the revenue generated from a marijuana tax.

Special Tax Rates for Small Producers

Small wine and beer producers are eligible for lower tax rates, so there is some precedent for tax reductions for small producers. This exemption or lower rate would be linked to a point of collection at the packaging and distribution level. The value of a lower tax for small producers is not clear. In general, however, it is more efficient to collect the tax from a few larger producers, and a benefit for small firms would act against that objective. Additionally, a small businesses exemption could encourage larger forms of evasion, because processing and distribution may be easier on a small scale.

Special Tax Rates for More Energy Efficient Production

Another possibility is to apply a lower tax to marijuana grown outdoors, which uses less energy than indoor growing. One study indicates that legalization could reduce the price of marijuana, and lead to less costly cultivation practices outdoors rather than indoors.[89] In contrast, concerns exist that outdoor marijuana cultivation could divert land and bodies of water, thereby generating another set of negative environmental effects.[90] Incentives to produce higher-potency marijuana (e.g., a tax rate based on weight) could encourage indoor production, where growing conditions can be better managed.

Occupational Taxes

Another federal tax option is levying a special occupational tax (SOT) on any business involved in the production, distribution, or sales of marijuana. SOTs are not licensing fees. Generally,

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[87] See Pat Oglesby, "Laws to Tax Marijuana," *State Tax Notes*, January 24, 2011, pp. 251-269. Although more sophisticated, indoor plant operations are known to achieve higher yields, the point still stands that a single plant can typically supply more marijuana than a typical user consumes. Oglesby quotes estimates of annual consumption from Beau Kilmer et al., *Altered State? Assessing How Marijuana Legalization in California Could Influence Marijuana Consumption and Public Budgets*, RAND Corporation, 2010, p. 18, at http://www.rand.org/content/dam/rand/pubs/occasional_papers/2010/RAND_OP315.pdf.

[88] Jonathan Caulkins, et al., "Design Considerations for Legalizing Cannabis: Lessons Inspired by Analysis of California's Proposition 19," *Addiction*, Society for the Study of Addiction, 2011.

[89] Evan Mills, "The Carbon Footprint of Indoor Cannabis Production," *Energy Policy*, vol. 46 (July 2012), pp. 58-67.

[90] This issue has been covered in some media outlets, such as Matt Ferner, "California County Bans Outdoor Medical Marijuana Grows," *Huffington Post*, June 4, 2014, at http://www.huffingtonpost.com/2014/06/04/lake-county-medical-marijuana_n_5441027.html. This diversion could be the result of the high price of illicit marijuana attracting growers to enter the market, though. One study found that the amount of land needed to grow enough marijuana to roughly meet current demand levels would require a relatively insignificant share of U.S. farmland (<0.01%), assuming economies of scale using outdoor production techniques. See Jonathan P. Caulkins, *Estimated Cost of Production for Legalized Cannabis*, RAND Corporation, July 2010, p.25, at http://www.rand.org/content/dam/rand/pubs/working_papers/2010/RAND_WR764.pdf.

SOTs are levied as a flat fee annually on each firm and comprise a small amount of revenue relative to excise taxes. Currently, federal SOTs are collected on certain businesses in the tobacco or firearms industry. Segments of the alcohol trade were also subject to SOTs until they were repealed in 2008.[91]

The Marijuana Tax Equity Act of 2013 (H.R. 501) would impose an occupational tax of $1,000 per year on each marijuana producer, importer, or manufacturer, and a $500 per year tax for any other person engaged in a marijuana enterprise.

Tax Administration, Enforcement, and Other Regulations

History suggests that the role of enforcement and administrative efforts could be the difference between a sustainable and unsustainable federal tax regime on marijuana. The illicit trade and importation of bootleg spirits in the United States continued after Prohibition ended in 1934 until cuts in tariff rates on spirit imports were negotiated with trading partners (thereby lowering the price of legal spirits), and until the Department of the Treasury hired or assigned more than 1,000 agents to work on enforcing alcohol-related laws during the late 1930s.[92]

Today, marijuana enforcement efforts would have to deter regular consumers from engaging in illicit transactions with dealers they have presumably built a relationship of trust with in terms of secrecy and product integrity. Additionally, enforcement would have to compel producers to obtain licenses and pay taxes. Without increasing resources for tax-enforcement authorities commensurate with federal-policy change, legalizing and taxing marijuana would likely undermine the long-term viability of any federal tax base.

Tracking the Production of Legal Marijuana

Some tax experts have noted that marijuana smuggling might be more prevalent compared with illegal alcohol production because marijuana is more compact and easier to transport than alcohol.[93] However, marijuana is more pungent than packaged alcohol.

Collecting a tax closer to the point of production, rather than point of sales, could reduce the number of taxable entities and increase the scale of tax units that would need to be monitored (e.g., greenhouses compared to joints). If the tax is applied early in the stage of production, some marker or evidence that the tax has been paid would be needed. As with the case of alcohol and tobacco, tax stamps could be used, or seals on packages (although packages can be opened and refilled, so this method is not completely foolproof). If sold as joints, individual marks could be put on each paper cylinder. Another possibility is the use of dye. New technological developments

[91] For more information, see CRS Report R43350, *Alcohol Excise Taxes: Current Law and Economic Analysis*, by Sean Lowry.

[92] Tun-Yuan Hu, *The Liquor Tax in the United States, 1791-1947* (New York, NY: Columbia University Graduate School of Business, 1950), pp. 90-96.

[93] Pat Oglesby, "Laws to Tax Marijuana," *State Tax Notes*, January 24, 2011, pp. 251-269.

are also discussed by Oglesby, such as genetic markers or tracking systems that would monitor production from seed to final sale.[94]

Colorado developed several planks for its enforcement system. It tracks marijuana plants from "seed to sale" using radio frequency identification (RFID) tags attached to each plant.[95] When the plant is harvested, the leaves and buds are given a new RFID tag and a label printed with the plant's authorized source.[96] Marijuana enterprises are required to report their inventory to the Colorado Department of Revenue's Marijuana Enforcement Division through a linked-computer system called Marijuana Inventory Tracking Solutions (MITS). These systems are meant to complement traditional forms of enforcement, such as physical surveillance.

Labeling and Measurement

Regulations that would standardize weights and potency measurements would most likely need to accompany a marijuana tax regime. Such a regime would contribute to consumer safety and more accurate dosing. Additionally, the U.S. Department of the Treasury could develop marketing standards on the issues related to labeling and branding of different strains of marijuana.[97] These marketing standards are currently negotiated with industry representatives as a means to inform consumers and prevent competition from domestic and imported products that do not meet the same standards. For example, regulations could define what can be labeled "indica," "sativa," or certain types of hybrid strands.

Strict Enforcement of Medical Marijuana Prescription Standards

As previously mentioned, different tax rates in medical and recreational marijuana could create significant arbitrage opportunities for consumers. This is particularly the case for heavy users, who stand the most to gain from evading a significant excise tax burden.[98] Medical marijuana dispensaries are typically organized as nonprofit organizations. Thus, enforcement of regulations will also be important for proper collection of income taxes if these nonprofits are allowed to organize as Section 501(c) entities.

Distinguishing Marijuana from Industrial Hemp

Hemp has no commercial value as a psychoactive due to its low concentrations of THC. The 113th Congress made changes to U.S. policies regarding industrial hemp during the omnibus farm bill debate. The Agricultural Act of 2014 (H.R. 2642; commonly known as the "farm bill") includes a provision that would allow certain research institutions and also state departments of agriculture

[94] Ibid.

[95] For visual examples of the RFID tagging system, see David Rosenberg, "Inside a Colorado Marijuana Dispensary," *Slate*, June 30, 2014, at http://www.slate.com/blogs/behold/2014/06/30/theo_stroomer_a_look_at_medicine_man_one_of_colorado_s_largest_marijuana.html.

[96] Claire Swedberg, "Colorado Readies System for Monitoring Marijuana," *RFID Journal*, December 16, 2013, at http://www.rfidjournal.com/articles/view?11283.

[97] In the domain of alcohol, for example, Treasury has issued regulations that specify exactly what kind of spirits can be labeled as "whisky." See 27 CFR 5.22.

[98] Jonathan P. Caulkins et al., "High Tax States: Options for Gleaning Revenue from Legal Cannabis," *Oregon Law Review*, vol. 91 (2013), pp. 1041-1068.

to grow industrial hemp, if allowed under state laws where the institution or state department of agriculture is located.[99] Because hemp is a useful agricultural plant, some might also think that it would be reasonable to legalize hemp for industrial production (and exempt it from taxation) if marijuana is legalized for commercial production.

For tax purposes, hemp could be distinguished from marijuana for purposes of taxes by its THC quantity. Oglesby notes that proposed legislation in the United States used a THC content of less than ½ of 1% and less than 1% by weight to distinguish hemp from marijuana. Europe and Canada currently allow hemp to be grown and require less than 0.3% THC by weight to distinguish legal hemp from illegal marijuana.

An argument made by Oglesby (and others) is that marijuana can be hidden in hemp fields, one reason that hemp is illegal. This claim is likely overstated, as cross-pollination would weaken the effectiveness of the marijuana plants.[100] As previously mentioned, higher-quality strains of marijuana require controlled climates isolated from pollination in order to reach peak THC potency.

Effects of Federal Marijuana Laws on State Tax and Regulatory Regimes

Some experts have also noted that the decision, or delay, of legalization at the federal level could have significant effects on the development of marijuana tax policy at the state level. As long as marijuana remains illegal at the federal level, states with marijuana legalization laws could rely on a system of licensing private businesses to grow and sell marijuana, instead of systems in which a state-based monopoly regulates the sale of marijuana (i.e., as some states currently have over liquor retail sales).[101] Proponents of state-based monopolies see them as a tool to regulate consumption (e.g., state-approved retail locations, restricted marketing), while opponents of state-based monopolies see them as susceptible to corruption, and driven mostly for purposes of raising revenue (a common critique of many state-run lottery commissions).[102] Although the differences in the level of revenue extracted from a licensing scheme versus a state monopoly scheme might be difficult to predict or even negligible, the dominance of licensing systems across states could make it difficult for lawmakers to roll back such systems and encourage state monopolies (for whatever reasons) in the future.[103]

[99] For more information on hemp, see CRS Report RL32725, *Hemp as an Agricultural Commodity*, by Renée Johnson.

[100] For more comparisons on the production of hemp versus marijuana, see CRS Report RL32725, *Hemp as an Agricultural Commodity*, by Renée Johnson.

[101] The reasoning behind this prediction is that state monopolies for marijuana production or distribution cannot occur while it is still illegal at the federal level because state governments cannot force the employees of such hypothetical operations to engage in the marketing of a drug that is illegal at the federal level. See Pat Oglesby, "States May Be Stuck with Second-Best Marijuana Taxes," *State Tax Notes*, June 2, 2014, pp. 539-544.

[102] For more analysis of the option for state-run monopolies on marijuana production or retail sales, see Pat Oglesby, "States May Be Stuck with Second-Best Marijuana Taxes," *State Tax Notes*, June 2, 2014, pp. 539-544; and Jonathan P. Caulkins et al., "High Tax States: Options for Gleaning Revenue from Legal Cannabis," *Oregon Law Review*, vol. 91 (2013), pp. 1041-1068.

[103] See Vice, "Mark Kleiman on Regulating Weed: VICE Podcast 022," November 1, 2013, approximately 31:00-33:00, YouTube.

Conclusion

The uncertainty over many aspects of marijuana creates difficulties in arriving at conclusions about the possible effects of a legalized and taxed marijuana market.

These uncertainties include the post-legalization price of marijuana (and even the current illicit price), the size of the market, and the response of consumers to price changes. These aspects make the projection of revenues for a particular tax uncertain. The uncertainty about prices as well as the spillover and health effects of marijuana makes the setting of the level of the tax difficult. Even choosing how to impose the tax is limited by uncertainties as to differential consumer response to potency and price and the compliance costs of taxing for potency.

In terms of revenue-raising potential, it appears that the tax base for legalized marijuana sales is much more limited compared with alcohol or tobacco, at least in the short term. This outcome is particularly the case if medical marijuana sales are exempt from a federal marijuana tax.

Appendix A. Some Additional Social Costs and Benefits of Marijuana

The discussion in the text reported some broader information on the magnitude of the social costs and benefits of marijuana. This appendix discusses some of the components of those social costs.

Relationship Between Marijuana and Alcohol Consumption

One of the potential determinants of social costs of marijuana legalization is the relationship between marijuana consumption and alcohol consumption. Social costs of alcohol consumption have been well documented in academic studies.[104] If marijuana is a *substitute* for alcohol, then arguably marijuana has some positive spillover effects on society because marijuana consumption has fewer social costs than alcohol consumption.[105] However, if marijuana is consumed with alcohol, then arguably marijuana results in some negative spillover effects on society.

Researchers have not reached a consensus on this issue.[106] Many economic studies that measure the relationship between marijuana and other substances (i.e., cross-price elasticity of demand) do not capture long-term effects, could be measuring spurious relationships, or examine individuals who might not be representative of the national population.[107] Marijuana research is highly regulated in the United States. The National Institute on Drug Abuse, the agency primarily responsible for policy research, has been quoted in media sources that it "does not fund research focused on the potential beneficial medical effects of marijuana."[108] Additionally, no study captures the effects of commercial and recreational legalization on the scale of Colorado or Washington because no other jurisdiction in the world has pursued such policies.

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[104] In this report, see "Taxes to Reflect External Costs" and the section titled "Spillover Effects from Alcohol Consumption" in CRS Report R43350, *Alcohol Excise Taxes: Current Law and Economic Analysis*, by Sean Lowry.

[105] See Ruth Weissenborn and David Nutt, "Popular Intoxicants: What Lessons Can be Learned from the Last 40 Years of Alcohol and Cannabis Regulation?," *Journal of Psychopharmacology*, vol. 26, no. 2 (February 2012), pp. 213-220; Gerald Thomas and Chris Davis, "Cannabis, Tobacco and Alcohol Use in Canada: Comparing Risks of Harm and Costs to Society," *Visions*, vol. 5, no. 4 (2009), p. 11; and Wayne Hall, Robin Room, and Susan Bondy, *A Comparative Appraisal of the Health and Psychological Consequences of Alcohol, Cannabis, Nicotine and Opiate Use*, World Health Organization (WHO) Project on Health Implications of Cannabis Use, August 1995, at http://www.druglibrary.org/schaffer/hemp/general/who-index.htm. For a comparison of the social costs of alcohol and tobacco see Willard G. Manning et al., *The Costs of Poor Health Habits* (Cambridge, MA: Harvard University Press, 1991).

[106] For a summary of some of these studies, most of which analyze trends in youth consumption, see Table 15 in Kenneth W. Clements and Mert Daryal, *The Economics of Marijuana Consumption*, Economic Research Centre, Department of Economics - The University of Western Australia, September 1999, p. 42, at http://www.drugpolicy.org/docUploads/Mari.pdf. For a study on the effects of U.S. medical marijuana laws (MMLs) on alcohol consumption, see Hefei Wen, Jason M. Hockenberry, and Janet R. Cummings, *The Effect of Medical Marijuana Laws on Marijuana, Alcohol, and Hard Drug Use*, National Bureau of Economic Reseach, NBER Working Paper No. 20085, May 2014, at http://www.nber.org/papers/w20085. Wen et al. find that among those aged 21 and older, MMLs increased the frequency of binge drinking by 6%-9%, but MMLs did not affect drinking behavior among those 12-20 years old.

[107] For a more detailed discussion of the general shortcomings of this body of research, see Jonathan P. Caulkins et al., *Marijuana Legalization: What Everyone Needs to Know* (Oxford University Press, 2012), pp. 133-135.

[108] Gardiner Harris, "Researchers Find Study of Medical Marijuana Discouraged," *New York Times*, January 18, 2010, at http://www.nytimes.com/2010/01/19/health/policy/19marijuana.html.

This uncertainty surrounding the relationship between alcohol and marijuana use is important because it limits the plausibility that a marijuana tax could be initially levied based on the external costs to society. For example, marijuana legalization could impose significant external costs or savings on society, even if marijuana consumption has a minor effect on the demand for alcohol due to the relatively large external costs of alcohol consumption.[109] Initiatives at the state levels in Colorado and Washington could provide researchers with an opportunity to better understand the effects of broader legalization policies.

Polydrug Use

In addition, the social costs of marijuana legalization could vary based on the relationship between the consumption of marijuana and other illicit drugs (commonly referred to as "polydrug use"). Studies indicate that marijuana has a lower risk of addiction and abuse than cocaine, crack, or heroin.[110] Some claim that marijuana is a "gateway drug" to further illicit drug use. In survey data, about 10% of infrequent marijuana users in the past year report using other illegal drugs whereas the rate for "heavy" marijuana users (21-30 days per month) is slightly more than 25%.[111]

Driving Under the Influence

Current research on the effects of marijuana use on traffic fatalities is limited by methodological and technological shortcomings. As noted earlier, some researchers have used controlled experiments to measure the effects of marijuana use on standard driving measurements, such as ability to track driving lanes.[112] Other researchers have studied the extent to which marijuana use has been linked to actual driving fatalities. Among non-alcohol drugs, marijuana is the most frequently detected substance in the general driver population as well as in drivers being involved in crashes.[113] However, this is not the same as saying that there is a causal link between marijuana use and traffic fatalities. Studies using data from actual crash sites typically measure the driver's blood, urine, or saliva for alcohol and metabolites released by the body in reaction to

[109] Most researchers argue that alcohol excise tax rates are set below the economically efficient level to compensate for social costs. One estimate finds the combined federal, state, and local taxes between 25 cents and 27 cents (in 2011 dollars) per ounce of pure alcohol compared with the external cost of 97 cents per ounce. See CRS Report R43350, *Alcohol Excise Taxes: Current Law and Economic Analysis*, by Sean Lowry.

[110] Caulkins et al. (2012), pp. 131-132. Also see Hefei Wen, Jason M. Hockenberry, and Janet R. Cummings, *The Effect of Medical Marijuana Laws on Marijuana, Alcohol, and Hard Drug Use*, National Bureau of Economic Reseach, NBER Working Paper No. 20085, May 2014, at http://www.nber.org/papers/w20085. Wen et al. find that MMLs had no discernible impact on hard drug use in either youth or adults in U.S. states that legalized marijuana for medical purposes.

[111] See Figure 4.7 in Beau Kilmer et al., *Before the Grand Opening: Measuring Washington State's Marijuana Market in the Last Year Before Legalized Commercial Sales*, RAND Corporation, December 2013, p. 37, at http://www.rand.org/pubs/research_reports/RR466.html.

[112] Giovanni Battistella et al., "Weed or Wheel! fMRI, Behavioural, and Toxicological Investigations of How Cannabis Smoking Affects Skills Necessary for Driving," *PLoS ONE*, vol. 8, no. 1 (2013); and Rebecca L. Hartman and Marilyn A. Huestis, "Cannabis Effects on Driving Skills," *Clinical Chemistry*, vol. 59, no. 3 (December 2012), pp. 478-492.

[113] Guohua Li, Joanne E. Brady, and Qixuan Chen, "Drug Use and Fatal Motor Vehicle Crashes: A Case-Control Study," *Accident Analysis and Prevention*, vol. 60 (2013), pp. 205-210. For data analysis, see Joanne E. Brady and Guohua Li, "Prevalence of Alcohol and Other Drugs in Fatally Injured Drivers," *Addiction*, vol. 108, no. 1 (January 2013), pp. 104-114; and Amelia M. Arria et al., "Substance-Related Traffic-Risk Behaviors among College Students," *Drug and Alcohol Dependence*, vol. 118, no. 2-3 (November 2011), pp. 306-312.

consumption of various types of drugs (including marijuana). Marijuana testing technology is currently limited in its ability to detect the level of marijuana intoxication at a given time. In the words of one study, "it is possible for a driver to test positive for cannabinol in the blood up to one week after use. Thus, the prevalence of nonalcoholic drugs ... should be interpreted as an indicator of use, not necessarily a measure of drug impairment."[114] For example, more advanced metabolite tests or mouth swabs would need to be developed to distinguish between a positive driving under the influence (DUI) test of a recent user and a chronic medical marijuana patient that has not been under the psychoactive effects of marijuana.

Criminal Incarcerations

Some claim that marijuana legalization could lead to savings in criminal justice spending at the federal, state, and local levels. Some of the estimates cited in media sources have been quite large. For example, Jeffrey Miron, a researcher at Harvard University, estimated in 2005 that legalizing marijuana would save $7.7 billion per year in total enforcement costs at state and federal levels.[115]

However, subsequent research suggests that estimates could be much smaller.[116] Sevigny and Caulkins (2004) estimated that 8% of state and federal prison inmates serving sentences for drug law violations were marijuana-only offenders.[117] Some prisoners caught trafficking other drugs could have also possessed marijuana, but these individuals would have been incarcerated even if marijuana were legal.

According to the U.S. Sentencing Commission, 31.2% of offenders in FY2013 were sentenced to a federal prison for a primary offense related to drugs.[118] The vast majority of these sentences are for drug trafficking.[119] Of these drug-related offenses, 28.4% of the sentences were related to marijuana (the highest share among drug-related categories).[120] Federal legalization of marijuana would likely not affect federal inmates already serving sentences for marijuana-related charges. It is unclear how federal legalization of marijuana might impact the future federal prison population.[121]

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[114] Joanne E. Brady and Guohua Li, "Trends in Alcohol and Other Drugs Detected in Fatally Injured Drivers in the United States, 1999-2010," *American Journal of Epidemiology*, vol. 179, no. 6 (2014), pp. 692-699.

[115] Jeffrey A. Miron, *The Budgetary Implications of Marijuana Prohibition*, Marijuana Policy Project, June 2005, at http://www.prohibitioncosts.org/mironreport/.

[116] For specific critiques of Miron's study, see Jonathan P. Caulkins et al., "What are the Pros and Cons of Legalization Generally?" in *Marijuana Legalization: What Everyone Needs to Know* (Oxford: Oxford University Press, 2012), pp. 129-130.

[117] Eric L. Sevigny and Jonathan P. Caulkins, "Kingpins or Mules: An Analysis of Drug Offenders Incarcerated in Federal and State Prisons," *Criminology and Public Policy*, vol. 3, no. 3 (July 2004), pp. 401-434. Other convictions that involved marijuana possession and another offense (e.g., robbery) could still result in prison time.

[118] See Figure A in U.S. Sentencing Commission, *2013 Sourcebook of Federal Sentencing Statistics*, http://www.ussc.gov/research-and-publications/annual-reports-sourcebooks/2013/sourcebook-2013; and CRS Report R42937, *The Federal Prison Population Buildup: Overview, Policy Changes, Issues, and Options*, by Nathan James.

[119] According to Department of Justice data, nearly 99% of sentenced drug offenders are sent to federal prison for trafficking offenses. For analysis of the most recent data, see CRS Report R42937, *The Federal Prison Population Buildup: Overview, Policy Changes, Issues, and Options*, by Nathan James.

[120] See Figure A in U.S. Sentencing Commission, *2013 Sourcebook of Federal Sentencing Statistics*, http://www.ussc.gov/research-and-publications/annual-reports-sourcebooks/2013/sourcebook-2013.

[121] Another factor that could affect federal prison populations is any changes to federal sentencing guidelines for drug (continued...)

In state and local jails, drug violations account for about one-fifth of incarcerations and marijuana-only violations account for less than 10% of those charges.[122] According to these estimates, legalizing marijuana could lead to 2% fewer prisoners in jails over time. Federal legalization would likely not affect state and local inmates already serving sentences for marijuana-related charges, and would not affect future state and local incarcerations in jurisdictions that do not choose to legalize it.

These benefits, large or small, would be related to legalizing marijuana, not taxing it. If taxes or regulations are so large or onerous that they encourage a continuation of the illicit market, some of these gains would be lost.

Marijuana-Related Crime, Violence, and Corruption

The majority of costs associated with the black market for illicit drugs are related to illegal stimulants and opiates, not marijuana. This is because the price per pound of these other drugs is typically more than marijuana. Many marijuana exchanges take place indoors among parties (such as friends and family) where there is less risk for conflict, whereas many other drug transactions take place outdoors among strangers or in public.[123]

(...continued)

trafficking. For more information, see CRS Report WSLG814, *Lower Drug Trafficking Penalties, Sentencing Commission Proposes*, by Charles Doyle.

[122] Jonathan P. Caulkins et al., "What are the Pros and Cons of Legalization Generally?" in *Marijuana Legalization: What Everyone Needs to Know* (Oxford: Oxford University Press, 2012), pp. 129-130.

[123] Caulkins et al. (2012), p. 131.

Appendix B. Current Treatment of the Deductibility of Expenses for Marijuana-Related Businesses

Marijuana producers and retailers may not deduct the costs of selling their product (e.g., payroll, rent, and advertising) for the purposes of the federal tax filings.[124] The Internal Revenue Code (IRC) Section 280E states that

> No deduction or credit shall be allowed for any amount paid or incurred during the taxable year in carrying on any trade or business if such trade or business (or the activities which comprise such trade or business) consists of trafficking in controlled substances (within the meaning of schedule I and II of the Controlled Substances Act) which is prohibited by Federal law or the law of any State in which such trade or business is conducted.

Media reports indicate that the Internal Revenue Service (IRS) has enforced this provision in audits of marijuana-related businesses by refusing to accept these business deductions.[125] Effectively this constitutes an implicit tax on marijuana-related businesses equal to the value of the tax benefit of such deductions if firms engaged in an industry that was legal under federal law.

Some businesses have challenged the IRS's practices through the courts. For example, Sacramento-based, Canna Care marijuana dispensary is challenging IRS tax penalties of more than $800,000 in a case before the U.S. tax court in San Francisco, CA. Media reports indicate that the IRS refused to accept $2.6 million in business deductions for employee salaries, rent, and other costs over three years (although the IRS allowed Canna Care to deduct the cost of the marijuana itself).[126]

The discrepancies between federal and state and local tax treatments of marijuana-related businesses create economic incentives to engage in the underground economy. In addition to the uncertainty of federal tax enforcement procedures (and costs of any related legal assistance), the inability of marijuana businesses to deduct their business expenses is effectively an implicit tax up to 39.6% (if organized as sole-proprietor or partnership) or 35% (if organized as a corporation) of the cost of these expenses.[127] These implicit taxes are paid in addition to state and local sales and special excise taxes.[128]

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[124] For more legal analysis, see CRS Report WSLG1101, *Federal Taxation of Marijuana Sellers*, by Erika K. Lunder.

[125] Katy Steinmetz, "Christian Pot Dispensary Takes on IRS," *TIME*, February 19, 2014, at http://time.com/8764/medical-marijuana-legalization-pot-christian-canna-care-lanette-davies/.

[126] "Medical Marijuana Dispensary Takes on IRS over What It Calls 'Punitive' Taxes," *Washington Post*, February 23, 2014, at http://www.washingtonpost.com/politics/medical-marijuana-dispensary-takes-on-irs-over-what-it-calls-punitive-taxes/2014/02/23/25fa6458-9cd3-11e3-ad71-e03637a299c0_story.html.

[127] With 35% being the top, marginal tax bracket for corporations and 39.6% being the top, marginal tax bracket for individuals under the federal income tax code.

[128] Colorado imposes a sales tax of 10% and an excise tax of 15% on retail marijuana sales, in addition to a general 2.9% state sales tax and any local sales taxes. See State of Colorado Department of Revenue, "Retail Marijuana Return Filing Overview," January 29-31, 2014, at http://www.colorado.gov/cms/forms/dor-tax/RetailMarijuanaReturnFilingOverviewJan2014.pdf. The state of Washington, which will allow recreational marijuana sales later in 2014, will impose an excise tax of 25% on the sales price of marijuana within an established, state-distribution system.

The status quo administration of federal tax laws creates an economic advantage for illicit marijuana sellers, who are not subject to direct taxation of their sales.

In the 113th Congress, the Small Business Tax Equity Act of 2013 (H.R. 2240) would exempt a business that conducts marijuana sales in compliance with state law from the IRC Section 280E prohibition against allowing business-related tax credits or deductions for expenditures in connection with trafficking in controlled substances.

Appendix C. Technical Calculations for the Estimate of a National Marijuana Tax Base from Colorado Data

An estimate of the total sales volume of a national sales base can be calculated by extrapolating tax collection data from Colorado or Washington. Data from both states likely underrepresent total demand because licenses for more production and retail businesses are pending. Additionally, it is unknown if the underground market for marijuana significantly declined from the opening of state-licensed stores.

For the purposes of this report, the most recent tax revenue data from Colorado are used to calculate an estimate of the state's marijuana tax base (dollar amount of total sales). The recreational tax base can be calculated using tax collections data from the 10% retail marijuana sales tax or the 2.9% general sales tax (which provide two measures to derive the total tax base), where tax base is equal to tax collections divided by the tax rate.[129] Because each of the two taxes yields slightly different tax bases, the two calculations are averaged to determine a monthly aggregate tax base for recreational sales.

For example, the Colorado Department of Revenue reported that the 10% retail marijuana sales tax collected $2.9 million[130] and the 2.9% sales tax collected $886,915 (on retail, non-medical marijuana) in September 2014.[131] Using the methodology above, this would lead to tax base calculations of $29.4 million and $30.6 million, respectively.[132] Averaging these two numbers leads to an estimate of $30.0 million in recreational marijuana sales in the state of Colorado in September 2014. [133]

The data from Colorado can then be extrapolated for each state and the District of Columbia to calculate an estimate of the national sales tax base. The recreational sales tax base averaged from the two data points in Colorado can be multiplied by each state's or district's population (indexed, relative to Colorado) and then multiplied by the marijuana usage rates (indexed, relative to Colorado) as reported by the National Survey of Drug Use and Health (NSDUH). In other words, this simple calculation assumes the primary sources of variation in consumption in each state or district are based on population and usage rates and does not assume major changes in price (e.g., the large-scale production of relatively cheap, unbranded marijuana; or variations in state tax rates) that could lead to further supply and demand effects. Using the August 2014 data from Colorado, it can be estimated that the national sales tax base for recreational marijuana could be $14.5 billion or $15.4 billion per year.[134] These estimates could be subject to revision, as recreational tax revenue in Colorado has been generally increasing since January 2014.

[129] It is more difficult to calculate the state tax base using collections data from 15% retail medical tax because this tax is calculated on state-set average prices for various categories of marijuana.

[130] The exact figure is $2,940,346.

[131] Colorado Department of Revenue, "Colorado Marijuana Tax Data," at https://www.colorado.gov/pacific/revenue/colorado-marijuana-tax-data.

[132] The exact calculations result in tax base calculations of $29,403,460 and $30,583,276, respectively.

[133] The exact calculation is $29,993,368.

[134] The lower and higher estimates are based on different reported usage rates, based on age, from the NSDUH survey (continued...)

A similar process can be used to calculate the medical marijuana tax base in Colorado, although there is only one tax levied on medical marijuana in Colorado (the 2.9% general sales tax). Based on September 2014 data, medical marijuana sales in Colorado were $31.3 million.[135] From January to September 2014, monthly medical marijuana sales in Colorado have ranged between approximately $31 million and $35 million. In FY2013 (ending June 30, 2013), before the legalization of recreational marijuana, state sales tax collections data from the Colorado Department of Revenue imply an annual medical marijuana tax base of $314.2 million in sales.[136] It is too early to conclude whether the opening of the recreational marijuana market has affected the demand for medical marijuana in Colorado.

However, it is difficult to extrapolate medical marijuana data in Colorado to the general U.S. population because of incomplete data in some states.[137] Additionally, the medical marijuana patient data could have a self-selection bias, as some individuals could have been willing to relocate to states permitting medical marijuana use, if they felt that they had few other options to alleviate their condition. Based on Colorado's tax collections data, medical marijuana consumption could double marijuana consumption total amounts, if not more. Even if medical marijuana regulations were more tightly enforced, post-legalization, users denied for a medical card could purchase marijuana for recreational purposes.

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data. The higher estimate is based on the usage rates of 18-25 year olds and the lower estimate is based on the usage rates of 26+ year olds. Surveys of drug habits tend to understate actual usage rates. These estimates are based on different assumptions, and they should not be considered as a range or confidence interval for what the projected national sales tax base of marijuana could be.

[135] This calculation is based on $886,915 collected In September 2014 from the 2.9% general sales tax. See Colorado Department of Revenue, "Colorado Marijuana Tax Data," at https://www.colorado.gov/pacific/revenue/colorado-marijuana-tax-data.

[136] Calculations based on $9.1 million in reported tax collections during FY2013. See Colorado Department of Revenue, "Colorado Medical Marijuana Dispensaries, Retail Sales and State Tax by County, Fourth Quarter, FY2012-13," at http://www.colorado.gov/cs/Satellite?c=Document_C&childpagename=Revenue-Main%2FDocument_C%2FXRMAddLink&cid=1251647950747&pagename=XRMWrapper.

[137] Medical marijuana patient data is available at Marijuana Policy Project, "Medical Marijuana Patient Numbers," at http://www.mpp.org/states/medical-marijuana-patient.html. Some states do not disclose their number of medical marijuana patients, doctors, or caregivers.

Congressional Research Service Report on Federal Law Enforcement

A review of the implications of state marijuana legalization activities for federal law enforcement, released December 4, 2014.

State Marijuana Legalization Initiatives: Implications for Federal Law Enforcement

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Prepared for Members and Committees of Congress

Summary

Marijuana is the most commonly used illicit drug in the United States. In 2013, an estimated 19.8 million individuals in the United States aged 12 or older (7.5% of this population) had used marijuana in the past month. While reported marijuana use is similar to that in 2012, it has generally increased since 2007 when 5.8% of individuals aged 12 or older were current users of marijuana. Mirroring this increase in use, marijuana availability in the United States has also increased. This growth has been linked to factors such as rising marijuana production in Mexico, and increasing marijuana cultivation in the United States led by criminal networks including Mexican drug trafficking organizations.

Along with the uptick in the availability and use of marijuana in the United States, there has been a general shift in public attitudes toward the substance. In 1969, 12% of the surveyed population supported legalizing marijuana; today, more than half (52%) of surveyed adults have expressed opinions that marijuana should be legalized. And, 60% indicate that the federal government should not enforce its marijuana laws in states that allow the use of marijuana.

The federal government—through the Controlled Substances Act (CSA; P.L. 91-513; 21 U.S.C. §801 et. seq.)—prohibits the manufacture, distribution, dispensation, and possession of marijuana. Over the last few decades, some states have deviated from an across-the-board prohibition of marijuana. Evolving state-level positions on marijuana include decriminalization initiatives, legal exceptions for medical use, and legalization of certain quantities for recreational use. Notably, in the November 2012 elections, voters in Washington State and Colorado voted to legalize, regulate, and tax the recreational use of small amounts of marijuana. In the November 2014 elections, legalization initiatives passed in Alaska, Oregon, and the District of Columbia, further spreading the discrepancy between federal and state marijuana laws in the United States. These latest moves have spurred a number of questions regarding their potential implications for related federal law enforcement activities and for the nation's drug policies on the whole. Among these questions is whether or to what extent state initiatives to decriminalize or legalize the use of marijuana conflict with federal law.

In general, federal law enforcement has tailored its efforts to target criminal networks rather than individual criminals; its stance regarding marijuana offenders appears consistent with this position. While drug-related investigations and prosecutions remain a priority for federal law enforcement, the Obama Administration has suggested that efforts will be harnessed against large-scale trafficking organizations rather than on recreational users of marijuana. In an August 2013 memorandum, Deputy Attorney General Cole stated that while marijuana remains an illegal substance under the Controlled Substances Act, the Department of Justice would focus its resources on the "most significant threats in the most effective, consistent, and rational way." The memo outlined eight enforcement priorities including preventing the distribution of marijuana to minors and preventing the diversion of marijuana from states where it is legal under state law into other states. It is unclear whether or how the Department of Justice is tracking activity to ensure that federal enforcement priorities are being followed in states that have legalized marijuana.

Some may question whether state-level laws and regulations regarding marijuana prohibition—in particular those that clash with federal laws—may adversely impact collaborative law enforcement efforts and relationships. Currently, there is no evidence to suggest that the operation of these collaborative bodies has been impacted by current state-level marijuana decriminalization or legalization initiatives. Data from the U.S. Sentencing Commission seem to

indicate a federal law enforcement focus on trafficking as opposed to possession offenses. Of the federal drug cases with marijuana listed as the primary drug type (21.6% of total drug cases sentenced), over 98% involved a sentence for drug *trafficking* in FY2013.

A number of criminal networks rely heavily on profits generated from the sale of illegal drugs—including marijuana—in the United States. As such, scholars and policymakers have questioned whether or how any changes in state or federal marijuana policy in the United States might impact organized crime proceeds and levels of drug trafficking-related violence, particularly in Mexico. In short, there are no definitive answers to these questions; without clear understanding of (1) actual proceeds generated by the sale of illicit drugs in the United States, (2) the proportion of total proceeds attributable to the sale of marijuana, and (3) the proportion of marijuana sales controlled by criminal organizations and affiliated gangs, any estimates of how marijuana legalization might impact the drug trafficking organizations are purely speculative.

Given the differences between federal marijuana policies and those of states that have authorized use of marijuana in some capacity, Congress may choose to address state legalization initiatives in a number of ways, or choose to take no action. Among the host of options, policymakers may choose to amend or affirm federal marijuana policy, exercise oversight over federal law enforcement activities, or incentivize state policies through the provision or denial of certain funds.

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Introduction

Marijuana is the most commonly used illicit drug in the United States. In 2013, an estimated 19.8 million individuals in the United States aged 12 or older (7.5% of this population) were current (past month) users of marijuana.[1] While reported marijuana use is similar to that in 2012, it has generally increased since 2007 when 5.8% of individuals aged 12 or older were current users of marijuana.[2] The past decade has seen a decline in youth perceptions of risk tied to smoking marijuana; however, the rate of past-month marijuana use among youth declined between 2011 and 2013 (7.1%).[3] Youth also perceive that obtaining marijuana—if they desire it—is relatively easy.[4] Indeed, marijuana availability in the United States has increased, according to the Drug Enforcement Administration (DEA). This increase has been linked to factors such as rising marijuana production in Mexico and increasing marijuana cultivation in the United States led by criminal networks including Mexican drug trafficking organizations.[5]

The uptick in availability and use of marijuana in the United States is coupled with a general shift in public attitudes toward the substance. In 1969, 12% of the surveyed population supported legalizing marijuana; today, more than half (52%) of surveyed adults feel that marijuana should be legalized.[6] In addition, 60% indicate that the federal government should not enforce federal laws prohibiting marijuana use in those states that allow for its use.[7]

Marijuana is currently listed as a Schedule I controlled substance under the Controlled Substances Act (CSA).[8] This indicates that the federal government has determined that

> (A) The drug or other substance has a high potential for abuse.
>
> (B) The drug or other substance has no currently accepted medical use in treatment in the United States.
>
> (C) There is a lack of accepted safety for use of the drug or other substance under medical supervision.[9]

[1] Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*, September 2014, p. 16. Hereinafter, Results from 2013 NSDUH.

[2] Between 2007 and 2013, the proportion of individuals aged 12 or older who were "current" users of marijuana ranged from 5.8%-7.5% of this population. See Results from 2013 NSDUH, p. 17.

[3] Results from 2013 NSDUH, p. 73. For this study, "youth" are individuals 12 to 17 years of age.

[4] Ibid., p. 75. Nearly half of surveyed youth indicated that obtaining marijuana would be "fairly easy" or "very easy" to obtain if desired.

[5] U.S. Drug Enforcement Administration, *2013 National Drug Threat Assessment Summary*, DEA-NWW-DIR-017-13, November 2013. Hereinafter, *NDTA, 2013.*

[6] Pew Research Center for the People & the Press, *As Midterms Near, GOP Leads on Key Issues, Democrats Have a More Positive Image*, October 23, 2014.

[7] Pew Research Center for the People & the Press, *Majority of Americans Say Government Should Not Force Federal Marijuana Laws on States*, August 30, 2013 (Based on poll data from March 2013).

[8] For more information on the CSA, see the text box below.

[9] 21 U.S.C. §812(b)(1).

Controlled Substances Act (CSA)

The CSA was enacted as Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970.[10] It regulates the manufacture, possession, use, importation, and distribution of certain drugs, substances, and precursor chemicals. Under the CSA, there are five schedules under which substances may be classified—Schedule I being the most restrictive.[11] Substances placed onto one of the five schedules are evaluated on

- actual or relative potential for abuse;
- known scientific evidence of pharmacological effects;
- current scientific knowledge of the substance;
- history and current pattern of abuse;
- scope, duration, and significance of abuse;
- risk to public health;
- psychic or physiological dependence liability; and
- whether the substance is an immediate precursor of an already-scheduled substance.

U.S. federal drug control policies—and specifically those positions relating to marijuana—continue to generate debates among policymakers, law enforcement officials, scholars, and the public. Even prior to the federal government's move in 1970 to criminalize the manufacture, distribution, dispensation, and possession of marijuana,[12] there were significant discussions over marijuana's place in American society.

While the federal government maintains marijuana's current place as a Schedule I controlled substance, states have established a range of views and policies regarding its medical and recreational use. As of November 2014, over half of all states and the District of Columbia allowed for the *medical use* of marijuana in some capacity.[13] In the November 2012 elections, voters in Washington State and Colorado voted to legalize, regulate, and tax small amounts of marijuana for *recreational use*. In the November 2014 elections, voters in the District of Columbia, Oregon, and Alaska also passed recreational legalization initiatives. These moves have spurred a number of questions regarding their potential implications for related federal law enforcement activities and for the nation's drug policies on the whole.

This report provides a background on federal marijuana policy as well as an overview of state trends with respect to marijuana decriminalization and legalization—for both medical and

[10] P.L. 91-513; 21 U.S.C. §801 et. seq. For more information on the CSA, see CRS Report RL34635, *The Controlled Substances Act: Regulatory Requirements*, by Brian T. Yeh, and CRS Report RL30722, *Drug Offenses: Maximum Fines and Terms of Imprisonment for Violation of the Federal Controlled Substances Act and Related Laws*, by Brian T. Yeh.

[11] Federal rulemaking proceedings to add, delete, or change the schedule of a drug or substance may be initiated by the Attorney General (through the Drug Enforcement Administration), the Secretary of Health and Human Services, or by petition by any interested person. 21 U.S.C. §811(a). Congress may also change the scheduling status of a drug or substance through legislation.

[12] 21 U.S.C. §812 and §841. For more information, see the section, "Background on Federal Marijuana Policy."

[13] National Conference of State Legislatures, *State Medical Marijuana Laws*, November 2014, http://www.ncsl.org/issues-research/health/state-medical-marijuana-laws.aspx. Some states allow broad access to medical marijuana while others have more narrow conditions under which access is granted. For example, in Alabama medical marijuana may only be dispensed by the University of Alabama and only to treat a person with an epileptic condition under certain conditions.

recreational uses. It then analyzes relevant issues for U.S. federal law enforcement as well as for the criminal organizations involved in producing, distributing, and profiting from the black market sale of marijuana. This report also outlines a number of related policy questions that Congress may confront. Of note, it does not discuss the legal issues associated with state-level initiatives to legalize marijuana for recreational use.[14]

Background on Federal Marijuana Policy

Until 1937, the growth and use of marijuana was legal under federal law.[15] The federal government *unofficially* banned marijuana under the Marihuana Tax Act of 1937 (MTA; P.L. 75-238).[16] The MTA imposed a strict regulation requiring a high-cost transfer tax stamp for every sale of marijuana, and these stamps were rarely issued by the federal government.[17] Shortly after passage of the MTA, all states made the possession of marijuana illegal.[18]

The Controlled Substances Act (CSA), enacted as Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 (P.L. 91-513), placed the control of marijuana and other plant, drug, and chemical substances under federal jurisdiction regardless of state regulations and laws. In designating marijuana as a Schedule I controlled substance, this legislation *officially* prohibited the manufacture, distribution, dispensation, and possession of marijuana.[19]

As part of the CSA, the National Commission on Marihuana and Drug Abuse, also known as the Shafer Commission, was established to study marijuana in the United States.[20] Specifically, this commission was charged with examining issues such as

> (A) the extent of use of marihuana in the United States to include its various sources of users, number of arrests, number of convictions, amount of marihuana seized, type of user, nature of use;
>
> (B) an evaluation of the efficacy of existing marihuana laws;
>
> (C) a study of the pharmacology of marihuana and its immediate and long-term effects, both physiological and psychological;
>
> (D) the relationship of marihuana use to aggressive behavior and crime;

[14] For information on legal issues surrounding the Colorado and Washington laws regarding recreational marijuana, see CRS Report R43034, *State Legalization of Recreational Marijuana: Selected Legal Issues*, by Todd Garvey and Brian T. Yeh.

[15] States regulated marijuana but did not begin to ban it until after 1937.

[16] Congressional testimony indicated that marijuana, while it was a problem in the Southwest United States starting in the mid-1920s, became a national menace in the mid-1930s (1935-1937). See statement by H. J. Anslinger, Commissioner of Narcotics, Bureau of Narcotics, Department of the Treasury, before the U.S. Congress, House Committee on Ways and Means, *Taxation of Marihuana*, 75th Cong., 1st sess., April 27, 1937.

[17] Charles F. Levinthal, *Drugs, Society, and Criminal Justice*, 3rd ed. (New York: Prentice Hall, 2012), p. 58.

[18] In *Leary v. United States* (395 U.S. 6 (1968)), the MTA was overturned by the U.S. Supreme Court as a violation of the Fifth Amendment's privilege against compelled self-incrimination.

[19] 21 U.S.C. §812 and §841. Of note, growing a marijuana plant is considered *manufacturing* marijuana.

[20] The commission was composed of two Members of the Senate, two Members of the House, and nine members appointed by the President of the United States. President Nixon appointed Raymond Shafer as the Commissioner.

> (E) the relationship between marihuana and the use of other drugs; and
>
> (F) the international control of marihuana.[21]

The Shafer Commission, in concluding its review, produced two reports: (1) *Marihuana: A Signal of Misunderstanding*, and (2) *Drug Use in America: Problem in Perspective*.[22]

In its first report, the Shafer Commission discussed the perception of marijuana as a major social problem and how it came to be viewed as such.[23] It made a number of recommendations, including the development of a "social control policy seeking to discourage marihuana use, while concentrating primarily on the prevention of heavy and very heavy use."[24] In this first report, the Shafer Commission also called the application of the criminal law in cases of personal use of marijuana "constitutionally suspect" and declared that "total prohibition is functionally inappropriate."[25] Of note, federal criminalization and prohibition of marijuana was never altered, either administratively or legislatively, to comply with the recommendations of the Shafer Commission.

In its second report, the Shafer Commission reviewed the use of all drugs in the United States, not solely marijuana. It examined the origins of the drug problem in the United States, including the social costs of drug use, and once again made specific recommendations regarding social policy. Among other conclusions regarding marijuana, the Shafer Commission indicated that aggressive behavior generally cannot be attributed to marijuana use.[26] The Shafer Commission also reaffirmed its previous findings and recommendations regarding marijuana and added the following statement:

> The risk potential of marihuana is quite low compared to the potent psychoactive substances, and even its widespread consumption does not involve social cost now associated with most of the stimulants and depressants (Jones, 1973; Tinklenberg, 1971). Nonetheless, the Commission remains persuaded that availability of this drug should not be institutionalized at this time.[27]

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[21] P.L. 91-513, §601(d).

[22] National Commission on Marihuana and Drug Abuse, *Marihuana: A Signal of Misunderstanding*, First Report of the National Commission on Marihuana and Drug Abuse, Washington, DC, March 1972. Hereinafter, First Report of the Shafer Commission; and National Commission on Marihuana and Drug Abuse, *Drug Use in America: Problem in Perspective*, Second Report of the National Commission on Marihuana and Drug Abuse, Washington, DC, March 1973. Hereinafter, Second Report of the Shafer Commission.

[23] The commission stated that three factors contributed to the perception of marijuana as a major national problem including "[1] the illegal behavior is highly visible to all segments of our society, [2] use of the drug is perceived to threaten the health and morality not only of the individual but of society itself, and [3] most important, the drug has evolved in the late sixties and early seventies as a symbol of wider social conflicts and public issues." First Report of the Shafer Commission, p. 6.

[24] First Report of the Shafer Commission, p. 134.

[25] Ibid., pp. 142-143.

[26] Second Report of the Shafer Commission, p. 158.

[27] Ibid, p. 224. In this statement, the Shafer Commission cites the following studies: R.T. Jones, *Mental Illness and Drugs: Pre-Existing Psychopathology and Response to Psychoactive Drugs*, Paper Prepared for the National Commission on Marihuana and Drug Abuse, 1973 and J.R. Tinklenberg, *Marihuana and Crime*, Paper Prepared for the National Commission on Marihuana and Drug Abuse, Unpublished, October 1971.

At the conclusion of the second report, the Shafer Commission recommended that Congress launch a subsequent commission to reexamine the broad issues surrounding drug use and societal response.[28] While a number of congressionally directed commissions regarding drugs have since been established,[29] no such commission has been directed to review the comprehensive issues of drug use, abuse, and response in the United States. Going forward, policymakers may debate the utility of a complete re-examination of federal drug policy or, more narrowly, federal marijuana policy.

Trends in States

Over the past few decades, some states have deviated from an across-the-board prohibition of marijuana. Evolving state-level positions on marijuana include decriminalization initiatives, legal exceptions for medical use, and legalization of certain quantities for recreational use.

Decriminalization

Marijuana *decriminalization* differs markedly from *legalization*. A state decriminalizes conduct by removing the accompanying criminal penalties; however, civil penalties remain. If, for instance, a state decriminalizes the possession of marijuana in small amounts,[30] possession of marijuana still violates state law; however, possession of marijuana within the specified *small amount* is considered a civil offense and subject to a civil penalty, not criminal prosecution. By decriminalizing possession of marijuana in small amounts, states are *not legalizing* its possession. In addition, as these initiatives generally relate to the *possession* (rather than the manufacture or distribution) of *small* amounts of marijuana, decriminalization initiatives do not conflict with federal law enforcement's priority of targeting high-level drug offenders, or so-called "big fish."

Decriminalization initiatives by the states do not appear at odds with the CSA because both maintain that possessing marijuana is in violation of the law. For example, individuals in possession of small amounts of marijuana in Massachusetts—a state that has decriminalized possession in small amounts—are in violation of both the CSA and Massachusetts state law. The difference lies in the associated penalties for these federal and state violations. Under the CSA, a person convicted of simple possession (1st offense) of marijuana may be punished with up to one year imprisonment and/or fined not less than $1,000.[31] Under Massachusetts state law, a person in possession of an ounce or less of marijuana is subject to a civil penalty of $100.[32]

In recent years, several states have decriminalized the possession of small amounts of marijuana; however, some of these states, such as New York, continue to treat possession of small amounts of marijuana as a criminal offense under specific circumstances. In New York, the possession of small amounts of marijuana is still considered a crime when it is "open to public view." In 2010,

[28] Second Report of the Shafer Commission, pp. 410-411.

[29] See, for example, the President's Media Commission on Alcohol and Drug Abuse Prevention and the National Commission on Drug-Free Schools.

[30] Typically one ounce or less, but the amount varies from state to state.

[31] 21 U.S.C. §844.

[32] MGL c.94C, s.32L; and MGL c.40, s.21D. This is a civil penalty for offenders 18 years of age or older. An offender under the age of eighteen must also complete a drug awareness program.

nearly 55,000 individuals in New York State were arrested for criminal possession of marijuana in the fifth degree,[33] a misdemeanor in New York State.[34] In November 2014, New York City (NYC) Mayor de Blasio and NYC Police Commissioner Bratton announced a change in marijuana enforcement policy; individuals found to be in possession of marijuana (25 grams or less) *may* be eligible to receive a summons instead of being arrested.[35]

Medical Marijuana Exceptions

In 1996, California became the first state to amend its drug laws to allow for the medicinal use of marijuana. As of November 2014, over half of all states and the District of Columbia allow for medicinal use of marijuana, but do so in various ways.[36] For example, while some states exempt qualified users of medical marijuana from state prosecution, others specifically authorize and regulate medical marijuana.[37]

The CSA does not distinguish between the medical and recreational use of marijuana. Under the CSA, marijuana has "no currently accepted medical use in treatment in the United States,"[38] and states' allowance of its use for medical purposes appears to be at odds with the federal position. Federal law enforcement has investigated, arrested, and prosecuted individuals for medical marijuana-related offenses regardless of whether they are in compliance with state law. However, as discussed in the section on "Enforcement Priorities," federal law enforcement emphasizes the investigation and prosecution of growers and dispensers over the individual users of medical marijuana.

Recreational Legalization

In contrast to marijuana *decriminalization* initiatives wherein civil penalties remain for violations involving marijuana possession, marijuana *legalization* measures remove all state-imposed penalties for specified activities involving marijuana. Until 2012, the recreational use of marijuana had not been legal in any U.S. state since prior to the passage of the CSA in 1970. The CSA explicitly prohibits the cultivation, distribution, and possession of marijuana for *any* purpose other than to conduct federally approved research. In November 2012, citizens of Colorado and Washington voted to legalize, regulate, and tax small amounts of marijuana for recreational use.[39] In the November 2014 elections, legalization initiatives also passed in Alaska, Oregon, and the

[33] NY Pen. Law. §221.10.

[34] Memo (in Lieu of Testimony) of Harry G. Levine, Queens College, CUNY, "Regarding Marijuana Possession Arrests in New York, 1977-2010," June 15, 2011.

[35] City of New York, *Transcript: Mayor de Blasio, Police Commissioner Bratton Announce Change in Marijuana Policy*, November 10, 2014, http://www1.nyc.gov/office-of-the-mayor/news/511-14/transcript-mayor-de-blasio-police-commissioner-bratton-change-marijuana-policy.

[36] National Conference of State Legislatures, *State Medical Marijuana Laws*, November 2014, http://www.ncsl.org/issues-research/health/state-medical-marijuana-laws.aspx.

[37] For a broader discussion of state medical marijuana laws, see CRS Report R42398, *Medical Marijuana: The Supremacy Clause, Federalism, and the Interplay Between State and Federal Laws*, by Todd Garvey.

[38] 21 U.S.C. §812(b)(1).

[39] For more detail regarding both Washington Initiative 502 and Colorado Amendment 64, see CRS Report R43034, *State Legalization of Recreational Marijuana: Selected Legal Issues* , by Todd Garvey and Brian T. Yeh

District of Columbia (DC), further expanding the disparities between federal and state marijuana laws in the United States.

These recreational legalization initiatives all legalize the possession of specific quantities of marijuana by individuals aged 21 and over and, with the exception of DC, set up state-administered regulatory schemes for the sale of marijuana;[40] however, the initiatives also vary. For example, Colorado, Alaska, Oregon, and DC allow for individuals to grow their own marijuana plants while Washington Initiative 502 did not allow for private citizen cultivation. These legalization initiatives also specify that many actions involving marijuana remain crimes. For example, Washington Initiative 502 specifies that the operation of a motor vehicle while under the influence of marijuana remains a crime.[41] Colorado's Amendment 64 allows any individual over the age of 21 to grow small amounts of marijuana for personal use, but specifies that marijuana may not be consumed "openly and publicly or in a manner that endangers others."[42]

Legalization initiatives in the states reflect growing public support for the legalization of marijuana. As noted, just prior to passage of the CSA in 1970, 12% of surveyed individuals aged 18 and older felt that marijuana should be made legal. In 2014, more than half (52%) of surveyed U.S. adults expressed that marijuana should be legalized.[43]

Enforcement Priorities: A Focus on Traffickers

Federal law enforcement has generally tailored its efforts to target criminal networks rather than individual criminals;[44] its stance regarding drug (particularly marijuana) offenders appears consistent with this position. In the years since the enactment of the CSA and the establishment of the U.S. Drug Enforcement Administration (DEA), federal counter-drug efforts have largely been focused toward traffickers and distributors of illicit drugs, rather than the low-level users of illicit substances.[45]

After some states began to legalize the medical use of marijuana, the Department of Justice (DOJ) reaffirmed that marijuana growth, possession, and trafficking remain crimes under federal law

[40] Regulatory schemes include restrictions and requirements for licensing the production, processing, and retail of marijuana, and procedures for the issuance of licenses.

[41] Washington Initiative 502, http://sos.wa.gov/_assets/elections/initiatives/i502.pdf.

[42] Colorado Amendment 64, http://www.leg.state.co.us/LCS/Initiative%20Referendum/1112initrefr.nsf/c63bddd6b9678de787257799006bd391/cfa3bae60c8b4949872579c7006fa7ee/$FILE/Amendment%2064%20-%20Use%20&%20Regulation%20of%20Marijuana.pdf. For information on the Colorado regulatory system, see the website of the Colorado Department of Revenue, Marijuana Enforcement Division: https://www.colorado.gov/pacific/enforcement/marijuanaenforcement.

[43] Pew Research Center for the People & the Press, *As Midterms Near, GOP Leads on Key Issues, Democrats Have a More Positive Image*, October 23, 2014.

[44] Congressional testimony has indicated that DOJ is enhancing its focus on drug trafficking and transnational organized crime, among other national security and criminal priorities. See Statement of Eric H. Holder, Jr., Attorney General, before the U.S. Congress, House Committee on the Judiciary, *Oversight of the U.S. Department of Justice*, 113th Cong., 1st sess., May 15, 2013.

[45] Arrests for marijuana possession offenses are largely made by state and local police. For a broader discussion of drug enforcement in the United States, see CRS Report R43749, *Drug Enforcement in the United States: History, Policy, and Trends*, by Lisa N. Sacco.

irrespective of how individual states may change their laws and positions on marijuana.[46] DOJ has continued to enforce the CSA in those states, and federal agents and U.S. Attorneys have arrested and prosecuted medical marijuana producers (growers) and distributors for violations of federal drug laws regardless of their compliance with state laws.

DOJ has clarified federal marijuana policy through several memos providing direction for U.S. Attorneys in states that allow the medical use of marijuana. In the so-called Ogden Memo of 2009, Deputy Attorney General David Ogden reiterated that combating major drug traffickers remains a central priority and stated:

> [t]he prosecution of significant traffickers of illegal drugs, including marijuana, and the disruption of illegal drug manufacturing and trafficking networks continues to be a core priority in the [Justice] Department's efforts against narcotics and dangerous drugs, and the Department's investigative and prosecutorial resources should be directed towards these objectives. As a general matter, pursuit of these priorities should not focus federal resources in your States on individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana.[47]

In a follow-up memorandum to U.S. Attorneys, Deputy Attorney General James Cole restated that enforcing the CSA remained a core priority of DOJ, even in states that had legalized medical marijuana. He clarified that "the Ogden Memorandum was never intended to shield such activities from federal enforcement action and prosecution, even where those activities purport to comply with state law."[48]

In his memo, Deputy Attorney General Cole warned those who might assist medical marijuana dispensaries in any way. He stated that "persons who are in the business of cultivating, selling or distributing marijuana, *and those who knowingly facilitate such activities* [emphasis added], are in violation of the Controlled Substances Act, regardless of state law."[49] This has been interpreted by some to mean, for example, that building owners and managers are in violation of the CSA by allowing medical marijuana dispensaries to operate in their buildings.[50] Deputy Attorney General Cole further warned that "those who engage in transactions involving the proceeds of such activity [cultivating, selling, or distributing of marijuana] may be in violation of federal money laundering statutes and other federal financial laws."[51] This warning may be one reason why medical marijuana dispensaries have had difficulty accessing bank services.[52]

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[46] United States Attorney's Office, "Statement From U.S. Attorney's Office on Initiative 502," press release, December 5, 2012.

[47] Deputy Attorney General David W. Ogden, *Memorandum for Selected United States Attorneys*, U.S. Department of Justice, Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana, Washington, D.C., October 19, 2009.

[48] Deputy Attorney General James M. Cole, *Memorandum for United States Attorneys*, U.S. Department of Justice, Guidance Regarding the Ogden Memo in Jurisdictions Seeking to Authorize Marijuana for Medical Use, Washington, DC, June 29, 2011. Hereinafter *Cole Memo*.

[49] Ibid.

[50] Jennifer Medina, "U.S. Attorneys in California Set Crackdown on Marijuana," *New York Times*, October 8, 2011, p. 10.

[51] *Cole Memo*.

[52] John Ingold, "Last Bank Shuts Doors on Colorado Pot Dispensaries," *The Denver Post*, October 1, 2011; Jonathan Martin, "Medical-Marijuana Dispensaries Run Into Trouble at the Bank," *The Seattle Times*, April 29, 2012.

In an August 2013 memorandum, Deputy Attorney General Cole stated that while marijuana remains an illegal substance under the Controlled Substances Act, the Department of Justice would focus its resources on the "most significant threats in the most effective, consistent, and rational way."[53] The memo outlined eight enforcement priorities for the Department of Justice:

> Preventing the distribution of marijuana to minors;
>
> Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs, and cartels;
>
> Preventing the diversion of marijuana from states where it is legal under state law in some form to other states;
>
> 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 violence and the use of firearms in the cultivation and distribution of marijuana;
>
> Preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use;
>
> Preventing the growing of marijuana on public lands and the attendant public safety and environmental dangers posed by marijuana production on public lands; and
>
> Preventing marijuana possession or use on federal property.[54]

These priorities are to guide U.S. Attorneys and federal law enforcement to focus their resources and efforts on those who interfere with any of these priorities, regardless of state law.[55] In an interview with ABC News, President Obama noted that "[it] would not make sense from a prioritization point of view for us to focus on recreational drug users in a state that has already said that under state law that's legal."[56]

Of note, under the Supremacy Clause of the U.S. Constitution,[57] state laws that conflict with federal law are generally preempted and therefore are void;[58] however, courts have generally not viewed the relationship between state and federal marijuana laws in such a manner.[59] Further, Congress did not intend that the CSA should displace all state laws associated with controlled substances.[60]

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[53] James M. Cole, *Memorandum for all United States Attorneys*, U.S. Department of Justice, Guidance Regarding Marijuana Enforcement, Washington, DC, August 29, 2013, http://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf. p. 1.

[54] Ibid., pp. 1-2.

[55] Ibid., p. 2.

[56] "Marijuana Not High Obama Priority," *ABC Nightline*, December 14, 2012.

[57] U.S. Const., Art. VI, cl. 2.

[58] See, for example, *Wickard v. Filburn*, 317 U.S. 111, 124 (1942)("[N]o form of state activity can constitutionally thwart the regulatory power granted by the commerce clause to Congress").

[59] For a full discussion of federal preemption of state law in the context of drug laws, see CRS Report R43034, *State Legalization of Recreational Marijuana: Selected Legal Issues* , by Todd Garvey and Brian T. Yeh

[60] 21 U.S.C. §903 (limiting the preemptive scope of the CSA to only those state laws that create a "positive conflict" with federal law). For more information, see CRS Report R42398, *Medical Marijuana: The Supremacy Clause*, (continued...)

It is unclear whether or how the Department of Justice is tracking activity to ensure that standards are being met in states that have legalized marijuana. At minimum, it appears that the DEA discusses trafficking issues with state and local law enforcement. According to DEA Administrator Michele Leonhart, there has been increased marijuana trafficking in states surrounding Colorado since Colorado legalized for recreational use.[61]

Selected Counter-Drug Trafficking Efforts

As the Department of Justice (DOJ) has continued to focus its counterdrug efforts on large production and trafficking organizations, this section provides snapshots of selected federal law enforcement efforts to counter drug trafficking and associated criminal networks. The majority of these programs and initiatives are not drug type-specific, but rather focus on countering the manufacturing (including growth), transportation, and sale of illegal drugs in the United States. In addition, many federal counter-drug law enforcement efforts—including those discussed in this section—involve collaborations or partnerships with state and local law enforcement and include efforts to combat a vast range of illicit activities carried out by criminal networks.

High Intensity Drug Trafficking Areas (HIDTA) Program

The HIDTA program provides assistance to law enforcement agencies—at the federal, state, local, and tribal levels—that are operating in regions of the United States that have been deemed as critical drug trafficking regions.[62] The program aims to reduce drug production and trafficking through four means: (1) promoting coordination and information sharing between federal, state, local, and tribal law enforcement; (2) bolstering intelligence sharing between federal, state, local, and tribal law enforcement; (3) providing reliable intelligence to law enforcement agencies such that they may be better equipped to design effective enforcement operations and strategies; and (4) promoting coordinated law enforcement strategies that rely upon available resources to reduce illegal drug supplies not only in a given area, but throughout the country.[63] There are 28 designated HIDTAs in the United States and its territories. On the whole, the HIDTA program is administered by the Office of National Drug Control Policy (ONDCP) within the White House. However, each of the HIDTA regions is governed by its own Executive Board. Notably, "a central feature of the HIDTA program is the discretion granted to the Executive Boards to design and implement initiatives that confront the drug trafficking threat in each HIDTA region."[64] Of note,

(...continued)

Federalism, and the Interplay Between State and Federal Laws, by Todd Garvey.

[61] U.S. Congress, Senate Committee on the Judiciary, *Hearing on Oversight of the Drug Enforcement Administration*, Testimony of Administrator Michele M. Leonhart [transcript], 113th Cong., 2nd sess., April 30, 2014. Administrator Leonhart further stated, "Take for instance, Kansas, and we've talked to our partners in Kansas and they've already been seeing a 61 percent increase in marijuana seizures coming from Colorado."

[62] Congress created the HIDTA program through the Anti-Drug Abuse Act of 1988 (P.L. 100-690, §1005(c)). For more information on the program, see Office of National Drug Control Policy (ONDCP), *High Intensity Drug Trafficking Areas (HIDTA) Program*, http://www.whitehouse.gov/ondcp/high-intensity-drug-trafficking-areas-program. The HIDTA program provides support for 733 initiatives nationwide. They range from enforcement initiatives involving multi-agency investigation and prosecution activities to drug use prevention and treatment initiatives.

[63] 21 U.S.C. §1706(a)(2).

[64] Office of National Drug Control Policy, *Fiscal Year 2015 Congressional Budget Submission*, p. 40.

"[m]ultiple HIDTA task forces may make up an overarching HIDTA enforcement or investigative initiative."[65]

- In May 2013, 21 individuals were arrested for their alleged roles in two overlapping drug trafficking rings—one distributing marijuana and the other, powder and crack cocaine. This case was investigated by the FBI, Madison-Morgan County (AL) HIDTA Task Force, as well as other federal, state, and local law enforcement agencies.[66]

Organized Crime Drug Enforcement Task Force (OCDETF) Program

The OCDETF program targets—with the intent to disrupt and dismantle—major drug trafficking and money laundering organizations. Federal agencies that participate in the OCDETF program include the Drug Enforcement Administration (DEA); Federal Bureau of Investigation (FBI); Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF); U.S. Marshals; Internal Revenue Service (IRS); U.S. Immigration and Customs Enforcement (ICE); U.S. Coast Guard (USCG); the 94 U.S. Attorneys Offices; and DOJ's Criminal Division. These federal agencies also collaborate with state and local law enforcement on the task forces. There are 11 OCDETF strike forces around the country as well as an OCDETF Fusion Center.[67] The OCDETFs target those organizations that have been identified on the Consolidated Priority Organization Targets (CPOT) List, which is the "most wanted" list for leaders of drug trafficking and money laundering organizations. For FY2013, 16% (822 cases) of active OCDETF investigations were linked to valid CPOTs, and an additional 5% (275 cases) were also linked to Regional Priority Organization Targets (RPOTs).[68]

- In January 2013, an OCDETF operation in the Dallas-Fort Worth, TX, area resulted in the indictment of 20 individuals for their alleged roles in a marijuana trafficking conspiracy. The conspiracy reportedly involved distributing and selling drugs as well as laundering the monetary proceeds. The OCDETF investigation led to the seizure of over 600 marijuana plants, 25 pounds of hydroponic marijuana, 10 vehicles, and 5 firearms.[69] The leader of the marijuana distribution conspiracy was sentenced to federal prison in April 2014.[70]

Domestic Cannabis Eradication/Suppression Program (DCE/SP)

The DEA has indicated that "[m]arijuana is the only major drug of abuse grown within the U.S. borders." As one of its efforts to stop the growth of this illegal substance, the DEA funds the DCE/SP—a nationwide law enforcement program targeting the cultivation of marijuana by drug

[65] Office of National Drug Control Policy, *High Intensity Drug Trafficking Areas Program Report to Congress*, June 2011, p. 169.

[66] U.S. Attorney's Office, "Twenty-One People Arrested in Huntsville-based Drug-Trafficking Conspiracy," press release, May 23, 2013.

[67] U.S. Department of Justice, *FY2015 Interagency Crime and Drug Enforcement, Congressional Budget Submission*.

[68] Ibid., p. 23.

[69] United States Attorney's Office, "Federal Grand Jury Indicts 20 in Marijuana Trafficking Conspiracy," press release, January 18, 2013.

[70] U.S. Department of Justice, "Dallas Man Who Ran a Marijuana Distribution Conspiracy is Sentenced to More Than 17 Years in Federal Prison," press release, April 21, 2014.

trafficking organizations.[71] The DCE/SP was involved in the eradication of 4,033,513 cannabis plants that had been cultivated at 6,376 outdoor grow sites and 361,727 plants that had been cultivated at 2,754 indoor sites in 2013.[72] Of note, there are no concrete data to delineate the proportion of domestically grown marijuana cultivated by drug trafficking organizations—separately from gangs or lone growers—nor are there reliable data on the amount cultivated by specific criminal networks.

- In October 2012, the DEA (through the DCE/SP) and Arizona Department of Public Safety eradicated over 4,500 marijuana plants across four separate grow sites in Arizona. Each of these grow sites "had its own irrigation system powered by a pump that emitted water through an underground watering drip system."[73]

Border Enforcement Security Task Force (BEST): Tunnel Task Force

The Border Enforcement Security Task Force (BEST) initiative,[74] led by ICE within the Department of Homeland Security (DHS), is a series of multi-agency investigative task forces that aim to identify, disrupt, and dismantle criminal organizations posing significant threats to border security along the northern border with Canada and the Southwest border with Mexico as well as within Mexico.[75] While the BEST initiative broadly targets criminal networks, tailored task forces have been established to target specific threats; in order to focus efforts on criminal networks exploiting the U.S.-Mexican border via underground tunnels (which have been primarily used to smuggle marijuana), ICE established the first tunnel task force in San Diego in 2003.[76] The task force was created as a partnership between ICE, DEA, and the U.S. Border Patrol, along with state law enforcement and Mexican counterparts. The tunnel task force was incorporated into ICE's BEST initiative in 2006 in order to further enhance multilateral law enforcement intelligence and information sharing. Since 1990, over 150 tunneling attempts have been discovered along the U.S.-Mexican border.[77]

- In April 2014, the San Diego tunnel task force, along with Mexican counterparts, uncovered two sophisticated cross-border tunnels connecting commercial buildings in Otay Mesa, CA, with warehouses in Tijuana, Mexico. The tunnels were about 600 and 700 yards long, respectively, and were equipped with

[71] For more information, see http://www.justice.gov/dea/ops/cannabis.shtml.

[72] Drug Enforcement Administration, *2013 Domestic Cannabis Eradication/Suppression Statistical Report*.

[73] Drug Enforcement Administration, "Over 4500 Marijuana Plants Eradicated near Wenden, Arizona: Four Separate Grows Discovered," press release, October 3, 2012.

[74] Department of Homeland Security, U.S. Immigration and Customs Enforcement (ICE), *Border Enforcement Security Task Force (BEST)*, http://www.ice.gov/best/.

[75] Other agency participants include U.S. Customs and Border Protection, Drug Enforcement Administration, ATF, FBI, USCG, and the U.S. Attorneys Offices, and state and local law enforcement. The Mexican law enforcement agency Secretaría de Seguridad Pública and the Colombian National Police were partners along the Southwest border. Canadian law enforcement agencies are also active partners on the Northern border. There are 35 BEST units located in the United States, including its territories.

[76] Department of Homeland Security, "Testimony of Executive Associate Director James A. Dinkins, Immigration and Customs Enforcement, Before the Senate Caucus on International Narcotics Control, "Illegal Tunnels on the Southwest Border"," press release, June 15, 2011. In March 2012, a tunnel task force was established in Nogales, Arizona, to respond to an increasing number of tunnels detected in that area.

[77] Ibid.

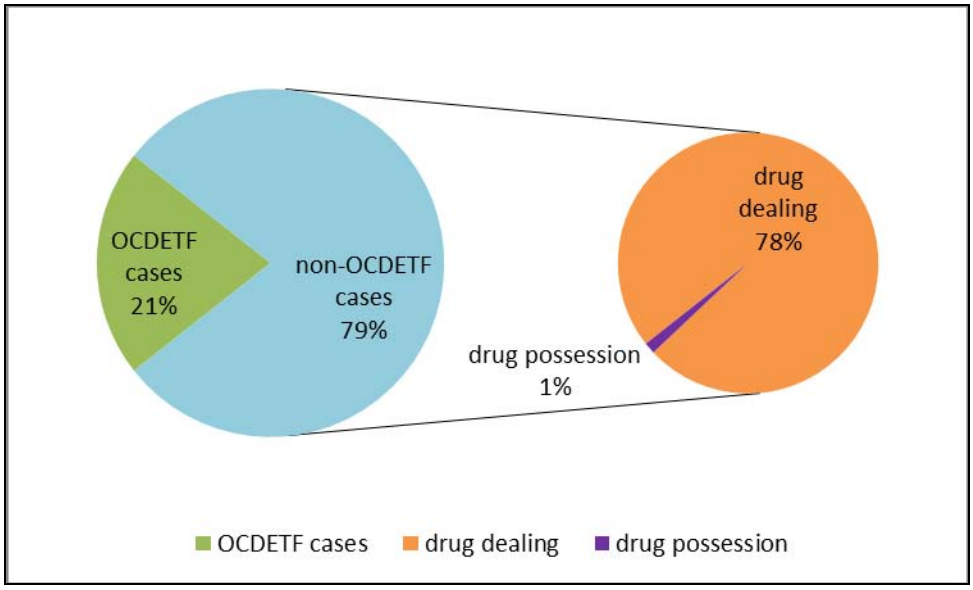
lighting, ventilation, and electric rail cars. They were two of seven underground, cross-border tunnels revealed in the San Diego area in fewer than four years.[78]

Prosecutions and Convictions Data

In its drug-related investigations and prosecutions, federal law enforcement has focused more efforts on investigations of criminal networks and drug traffickers and has generally placed less emphasis on going after individuals for simple drug possession.[79] Data from the U.S. Attorneys' case filings follow these patterns. As illustrated in **Figure 1**, of the 13,383 drug cases filed in FY2013 with the U.S. Attorneys, 21% (2,841) were OCDETF cases.[80] The remaining 10,542 non-OCDETF drug cases can be broken down between what the U.S. Attorneys categorize as drug dealing and drug possession cases; of these non-OCDETF cases, 99% (10,394) of cases filed were for *allegations* of drug dealing rather than drug possession.[81] While these data suggest a general prioritization of drug trafficking cases over cases of possession, they do not detail trends in investigations and prosecutions of cases involving specific drug *types* such as marijuana.

Figure 1. Drug Cases Filed with U.S. Attorneys

FY2013



Source: CRS presentation of data from the Executive Office of the United States Attorneys, *United States Attorneys' Annual Statistical Report: Fiscal Year 2013*, p. 57.

Note: OCDETF cases involve drug trafficking. The U.S. Attorneys categorize the non-OCDETF cases as either "drug dealing" or "drug possession." There is no available information, however, on the specific statutory offenses included in each of these two categories.

[78] U.S. Immigration and Customs Enforcement, "ICE-Led Task Force Shutters 2 San Diego-Area Smuggling Tunnels," press release, April 4, 2014.

[79] Simple possession is defined, and its penalties are outlined, in 21 U.S.C. §844.

[80] Executive Office of the United States Attorneys, *United States Attorneys' Annual Statistical Report: Fiscal Year 2013*, p. 57.

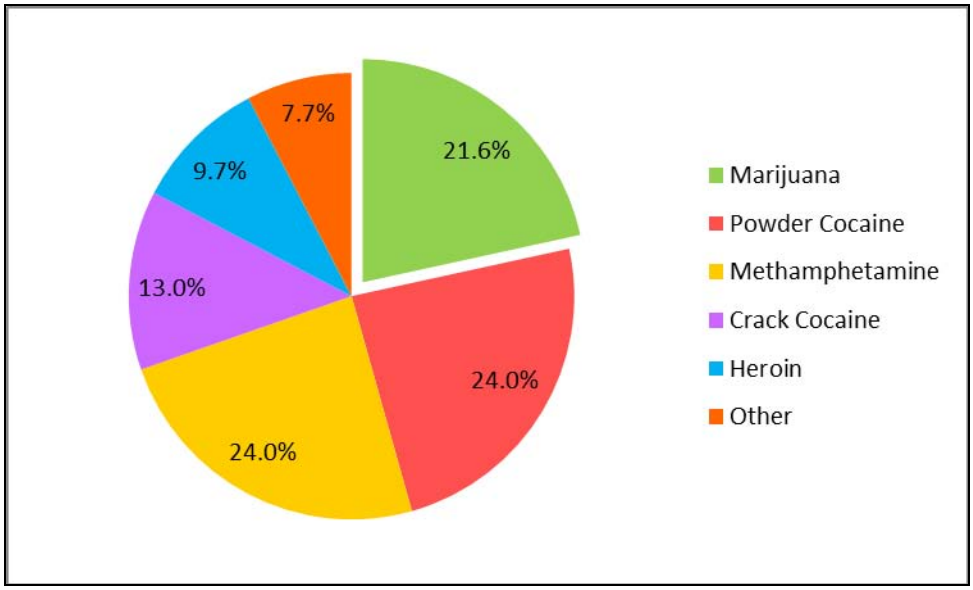
[81] Ibid.

The U.S. Sentencing Commission[82] data provide more nuanced information relating to federal drug prosecutions resulting in convictions and sentences, including for those cases involving marijuana-related offenses.[83] Of note, these data only reflect information on the *primary offense* for which any given offender was sentenced.

- Of the 72,180 cases from FY2013 with sufficient information for Sentencing Commission analysis, 32% of the cases (23,179) were determined to be drug cases. Moreover, the vast majority (93%) of these drug cases were drug trafficking cases.[84]
- As illustrated in **Figure 2**, of the drug cases for which information on primary drug type was available, 4,942 cases (almost 22%) involved marijuana as the primary drug in FY2013.
- Of the drug cases with marijuana as the primary drug type in FY2013, nearly 98% involved a drug trafficking sentence.[85]

Figure 2. Drug Cases Sentenced in Federal Court, FY2013

By Primary Drug Type



Source: CRS presentation of U.S. Sentencing Commission data provided in U.S. Sentencing Commission, *2013 Sourcebook of Federal Sentencing Statistics*, Table 33.

Notes: "Other" drug types include Oxycodone/Oxycontin, MDMA/Ecstasy/MDA, Hydrocodone, PCP, and steroids, among others.

[82] The Sentencing Commission is an independent body charged with promulgating guidelines for federal sentencing. For more information on the guidelines, see archived CRS Report RL32766, *Federal Sentencing Guidelines: Background, Legal Analysis, and Policy Options*, by Lisa Seghetti and Alison M. Smith.

[83] The Sentencing Commission has data on 80,035 cases in which an offender was sentenced in federal court in FY2013. Of these cases, 72,180 had sufficient information available for the Sentencing Commission to analyze. U.S. Sentencing Commission, *2013 Sourcebook of Federal Sentencing Statistics*, Figure I.

[84] The other 2% of drug cases included offenses described as "protected locations," "continuing criminal enterprise," "listed chemicals," "simple possession," "acquiring by deception," and "other."

[85] U.S. Sentencing Commission, *2013 Sourcebook of Federal Sentencing Statistics*, Table 33.

Implications for Federal Law Enforcement

Federal, State, and Local Cooperation

As experts have noted, "[t]he federal government maintains the power to enforce federal law; however, it cannot compel states to assist in enforcing that law, and the states have no obligation to forbid the same drugs that the federal government forbids."[86] As such, some policymakers may question whether the disparity between federal drug laws and those in states that have passed or enacted recreational legalization initiatives may pose challenges for the operation of collaborative law enforcement efforts and relationships—such as task forces and intelligence fusion centers in which federal, state, and local law enforcement all participate.[87]

If, in a task force setting for example, state and local law enforcement prioritize going after marijuana users over traffickers and other members of criminal networks, there could be reasonable concerns regarding a lack of alignment between the drug enforcement priorities of the participating federal, state, and local agencies. However, most drug-related task forces with federal involvement appear to devote greater energy to identifying and apprehending individuals involved in criminal networks producing, transporting, and selling large quantities of drugs. As such, there is no evidence to suggest that the operation of these collaborative bodies will be impacted by the recreational legalization initiatives in the states.

Examining how task forces have responded to medical marijuana legalization initiatives may provide some insight into how they may operate with respect to recreational marijuana legalization initiatives. Consistent with the Administration's indication that federal law enforcement prioritizes the investigation and prosecution of drug trafficking organizations and criminal networks over low-level drug users, it appears that investigations and arrests relating to medical marijuana follow similar trends. Federal law enforcement press releases suggest that investigations relating to medical marijuana generally target individuals "who are in the commercial business of cultivating, selling, or distributing marijuana, and those who knowingly facilitate such activities ... and will not focus enforcement efforts on individuals with cancer or other serious illnesses who use marijuana as part of a recommended medical treatment regimen consistent with applicable state law, or their caregivers."[88]

- In January 2013, the owner of two medical marijuana dispensaries in San Diego, CA, was sentenced for his role in distributing marijuana and laundering the proceeds. The investigation, conducted by the San Diego DEA's Narcotics Task

[86] John Walsh, *Q&A: Legal Marijuana in Colorado and Washington*, Washington Office on Latin America & Brookings, May 2013, p. 3. For more information on the interplay between state and federal marijuana laws, see CRS Report R42398, *Medical Marijuana: The Supremacy Clause, Federalism, and the Interplay Between State and Federal Laws*, by Todd Garvey.

[87] Task forces and fusion centers are primary means for federal law enforcement to coordinate and share information with state and local law enforcement. For more information on such cross-cutting efforts, see CRS Report R41927, *The Interplay of Borders, Turf, Cyberspace, and Jurisdiction: Issues Confronting U.S. Law Enforcement*, by Kristin Finklea and CRS Report R43583, *Domestic Federal Law Enforcement Coordination: Through the Lens of the Southwest Border*, by Jerome P. Bjelopera and Kristin Finklea.

[88] Drug Enforcement Administration, "Local, State, and Federal Agents Shut Down Two Commercial Marijuana Grow Operations," press release, June 30, 2011.

Force and Internal Revenue Service (IRS), revealed that these dispensaries were grossing about $3.5 million each year.[89]

- In May 2013, the owner of a medical marijuana dispensary in Sacramento, CA, was sentenced for his role in growing marijuana and operating the dispensary. The case was investigated by local law enforcement with assistance from the Sacramento HIDTA Task Force.[90]

If federal law enforcement priorities relating to recreational marijuana in states that have passed such initiatives follow the enforcement priorities regarding medical marijuana in states such as California, observers may see a focus on investigating marijuana growers and commercial sellers and less emphasis on the individual users of recreational marijuana.

Synthetic Alternatives[91]

Officials began to see synthetic cannabinoids marketed as "legal alternatives to marijuana" in 2008.[92] Synthetic cannabinoids are substances chemically produced to mimic tetrahydrocannabinol (THC), the active ingredient in marijuana. When these substances are sprayed onto dried herbs and then consumed through smoking or oral ingestion, they can produce psychoactive effects similar to those of marijuana.[93] They are often sold as herbal incense, and common brand names under which synthetic cannabinoids are marketed are "Spice" and "K2."

At least 41 states and Puerto Rico have legislatively banned chemical substances contained in synthetic cannabinoids.[94] In June 2012, Congress passed legislation (the Synthetic Drug Abuse Prevention Act of 2012—Subtitle D of Title XI of the Food and Drug Administration Safety and Innovation Act (P.L. 112-144)) that, among other things, permanently added "cannabimimetic agents" to Schedule I of the CSA.[95]

The American Association of Poison Control Centers (AAPCC) noted that poison control centers around the country received 2,663 calls about synthetic cannabinoid substances in 2013. In the first 10 months of 2014, AAPCC logged 2,996 calls to poison control centers regarding these substances.[96]

[89] Drug Enforcement Administration, "San Diego Man is Sentenced to 100 Months for Running Marijuana Dispensary and Money Laundering," press release, January 24, 2013.

[90] United States Attorneys' Office, "Sacramento Marijuana Dispensary Operator Sentenced," press release, May 24, 2013.

[91] For more information on synthetic cannabinoids and other substances, see CRS Report R42066, *Synthetic Drugs: Overview and Issues for Congress*, by Lisa N. Sacco and Kristin Finklea.

[92] NDTA, 2011, p. 36.

[93] National Conference of State Legislatures, Synthetic Cannabinoids (K2), November 28, 2012.

[94] Ibid. In addition to the NCSL data, the Maryland General Assembly passed a bill that bans "cannabimimetic agents" and specific compounds; this bill took effect on October 1, 2013. See State of Maryland, General Assembly, Chapter 442 (Senate Bill 109), Approved by the Governor, May 16, 2013.

[95] Under this act, a cannabimimetic agent is defined as one of five structural classes of synthetic cannabinoids (and their analogues). The act also provided 15 examples of cannabimimetic substances.

[96] American Association of Poison Control Centers, *Synthetic Marijuana Data*, (As of October 31, 2014), http://www.aapcc.org/alerts/synthetic-marijuana/.

It is currently unclear whether synthetic alternatives will continue to be developed and consumed in an attempt to circumvent federal and state marijuana laws. Policymakers may be interested in following the trends in sales, arrests, calls to poison control centers, and emergency department visits related to synthetic cannabinoids in states that have legalized small quantities of marijuana for recreational use. It is currently unclear what kind of impact—if any—state decriminalization and legalization initiatives may have on the use of synthetic substances.

Legalization Impact on Criminal Networks

A number of criminal networks rely on profits generated from the sale of illegal drugs—including marijuana—in the United States. Mexican drug trafficking organizations control more of the wholesale distribution of marijuana than other major drug trafficking organizations in the United States.[97] One estimate has placed the proportion of U.S.-consumed marijuana that was imported from Mexico at somewhere between 40% and 67%.[98] While the Mexican criminal networks control the wholesale marijuana distribution of illicit drugs in the United States, they "are not generally directly involved in retail distribution of illicit drugs."[99] In order to facilitate the distribution and sale of drugs in the United States, Mexican drug traffickers have formed relationships with U.S. street gangs, prison gangs, and outlaw motorcycle gangs.[100] Although these gangs have historically been involved with retail-level drug distribution, their ties to the Mexican criminal networks have allowed them to become increasingly involved at the wholesale level as well.[101] These gangs facilitate the movement of illicit drugs to urban, suburban, and rural areas of the United States. Not only do these domestic gangs distribute and sell the drugs, but they also "provide warehousing, security, and/or transportation services as well."[102]

- Barrio Azteca is a prominent U.S. prison gang with ties to Mexican drug trafficking organizations. Barrio Azteca primarily generates money from smuggling marijuana, heroin, and cocaine across the Southwest border for the drug trafficking organizations—namely, the Juárez cartel—but they are also involved in other crimes, such as extortion, kidnapping, and alien smuggling.[103]

A number of organizations have assessed the potential profits generated from illicit drug sales, both worldwide and in the United States, but "[e]stimates of marijuana ... revenues suffer

[97] NDTA, 2011, p. 2.

[98] Beau Kilmer, Jonathan P. Caulkins, and Brittany M. Bond, et al., *Reducing Drug Trafficking Revenues and Violence in Mexico: Would Legalizing Marijuana in California Help?*, RAND International Programs and Drug Policy Research Center, 2010.

[99] Organization of American States, *The Drug Problem in the Americas: Studies: The Economics of Drug Trafficking*, p. 18.

[100] NDTA, 2011, p. 11.

[101] Wholesale refers to the sale of goods to retailers for resale to consumers rather than selling goods directly to consumers. Retailers, on the other hand, sell goods directly to consumers. Wholesalers tend to sell larger quantities of goods to retailers, who then sell smaller quantities to consumers.

[102] NDTA, 2011, p. 12. See also, National Gang Intelligence Center, *2011 National Gang Threat Assessment: Emerging Trends*, http://www.fbi.gov/stats-services/publications/2011-national-gang-threat-assessment/2011-national-gang-threat-assessment-emerging-trends.

[103] National Gang Intelligence Center, *2011 National Gang Threat Assessment: Emerging Trends.* See also the U.S. Department of Justice website at http://www.usdoj.gov/criminal/gangunit/gangs/prison.html.

particularly high rates of uncertainty."[104] The former National Drug Intelligence Center (NDIC), for instance, estimated that the sale of illicit drugs in the United States generates between $18 billion and $39 billion in U.S. wholesale drug proceeds for the Colombian and Mexican drug trafficking organizations annually.[105] The proportion that is attributable to marijuana sales, however, is unknown.[106] Without a clear understanding of (1) actual proceeds generated by the sale of illicit drugs in the United States, (2) the proportion of total proceeds attributable to the sale of marijuana, and (3) the proportion of marijuana sales controlled by criminal organizations and affiliated gangs, any estimates of how marijuana legalization might impact the drug trafficking organizations are purely speculative.

Marijuana proceeds are generated at many points along the supply chain, including production, transportation, and distribution. Experts have debated which aspects of this chain—and the related proceeds—would be most heavily impacted by marijuana legalization. In addition, the potential impact of marijuana legalization in four of the 50 U.S. states and the District of Colombia (complicated by varying legal frameworks and regulatory regimes) may be more difficult to model than the impact of federal marijuana legalization. For instance, in evaluating the potential fiscal impact of the 2012 Washington and Colorado legalization initiatives on the profits of Mexican drug trafficking organizations, the Organization of American States (OAS) hypothesized that "[a]t the extreme, Mexican drug trafficking organizations could lose some 20 to 25 percent of their drug export income, and a smaller, though difficult to estimate, percentage of their total revenues."[107]

Other scholars have, in estimating the potential financial impact of marijuana legalization, based their estimates on a hypothetical federal legalization of marijuana. Under this scenario, small scale growers at the start of the marijuana production-to-consumption chain might be put out of business by professional farmers, a few dozen of which "could produce enough marijuana to meet U.S. consumption at prices small-scale producers couldn't possibly match."[108] Large drug trafficking organizations generate a majority of their marijuana-related income (which some estimates place at between $1.1 billion to $2.0 billion) from exporting the drug to the United States and selling it to wholesalers on the U.S. side of the border.[109] This revenue could be

[104] Organization of American States, *The Drug Problem in the Americas: Studies: The Economics of Drug Trafficking*, 2013, p. 7.

[105] U.S. Department of Justice, National Drug Intelligence Center, *National Drug Threat Assessment 2009*, Product No. 2008-Q0317-005, December 2008, p.49, http://www.usdoj.gov/ndic/pubs31/31379/31379p.pdf. Hereinafter, NDTA, 2009.

[106] A 2006 Office of National Drug Control Policy figure estimated that over 60% of Mexican drug trafficking organizations' revenue could be attributed to marijuana sales. However, a number of researchers and experts have questioned the accuracy of this number and provided other estimates of marijuana proceeds. See, for example, Beau Kilmer, *Debunking the Mythical Numbers about Marijuana Production in Mexico and the United States*, RAND Drug Policy Research Center. See also U.S. Government Accountability Office, *Drug Control: U.S. Assistance has Helped Mexican Counternarcotics Efforts, but Tons of Illicit Drugs Continue to Flow into the United States*, GAO-07-1018, August 2007. Another estimate has placed the proportion of Mexican DTO export revenues attributable to marijuana at between 15% and 26% of total drug revenues. See Beau Kilmer, Jonathan P. Caulkins, and Brittany M. Bond, et al., *Reducing Drug Trafficking Revenues and Violence in Mexico: Would Legalizing Marijuana in California Help?*, RAND International Programs and Drug Policy Research Center, 2010.

[107] Organization of American States, *The Drug Problem in the Americas: Studies: The Economics of Drug Trafficking*, p. 41.

[108] Jonathan P. Caulkins, Angela Howken, and Beau Kilmer, "How Would Marijuana Legalization Affect Me Personally?" in *Marijuana Legalization: What Everyone Needs to Know* (Oxford University Press, 2012).

[109] Beau Kilmer, Jonathan P. Caulkins, and Brittany M. Bond, et al., *Reducing Drug Trafficking Revenues and Violence in Mexico: Would Legalizing Marijuana in California Help?*, RAND International Programs and Drug Policy Research (continued...)

jeopardized if the United States were to legalize the production and consumption of recreational marijuana.

Aside from the fiscal impact of U.S. marijuana legalization on drug revenues generated by the criminal networks in Mexico, some have also questioned whether there might be an impact on the levels of drug trafficking-related violence in Mexico. In short, there is no definitive answer to this question, and arguments have been presented to support both the stance that marijuana legalization in the United States could drive violence higher (because of increased competition for the scarce revenues that would be generated from an expected dwindling market of Mexican-produced marijuana) and the position that such legalization could help in reducing drug trafficking-related violence (because the profit motive for entering and dominating the drug trade might be reduced). Either way, "[a]ny changes in cannabis markets will take time to develop and may occur simultaneously with other changes that also affect violence rates in Mexico."[110]

The diversification of drug trafficking organizations' illicit activities could also mitigate the impacts they might feel from various levels of marijuana legalization in the United States. While these criminal networks might generate a substantial portion of their proceeds from the growth, production, transportation, and sale of marijuana, they have enhanced their dominance over the market of other illicit substances. Mexican drug trafficking organizations control more of the wholesale cocaine, heroin, and methamphetamine distribution than any other major drug trafficking organizations in the United States.[111] In addition to their drug-related illegal activities, Mexican criminal networks have diversified their operations, adding to their portfolio crimes ranging from kidnapping and extortion to human trafficking and intellectual property rights violations.[112] Profits from these enterprises may help supplement their drug trafficking-related income.

Going Forward: Congressional Options

Given the differences in marijuana policies of the federal government and those of Alaska, Colorado, Oregon, Washington, and the District of Columbia, Congress may choose to address state legalization initiatives in a number of ways, or not at all. There are a host of options available to policymakers should they choose to address state-level legalization of marijuana, including affirming federal marijuana policy, exercising oversight over federal law enforcement activities, or incentivizing state policies through the provision or denial of certain funds. Alternatively, Congress may opt *not* to address the policy conflict with state legalization of marijuana.

(...continued)

Center, 2010.

[110] Organization of American States, *The Drug Problem in the Americas: Studies: The Economics of Drug Trafficking*, p. 43.

[111] NDTA, 2011, p. 8.

[112] Grace Wyler, "The Mexican Drug Cartels Are A National Security Issue," *Borderland Beat,* June 14, 2011, http://www.borderlandbeat.com/2011/06/mexican-drug-cartels-are-national.html.

Federal Marijuana Policy—The Controlled Substances Act

For over 40 years, the federal government's official position, as implied by sustaining marijuana's position as a Schedule I controlled substance under the CSA, has been that marijuana is a dangerous drug with no accepted medical use and a high potential for abuse. Since passing the CSA, Congress has not altered marijuana's status as a Schedule I drug.

In addressing states' most recent legalization efforts, Congress could take one of two general routes. On one hand, Congress could elect to take no action, thereby upholding the federal government's current marijuana policy. On the other hand, Congress could choose to reevaluate marijuana's placement as a Schedule I controlled substance. On this path, Congress could consider a variety of actions. For one, it could once again exercise its authority to establish a policy commission to examine marijuana, its impacts, and the efficacy of current marijuana laws in the United States, just as it did in establishing the Shafer Commission.[113] Additionally, Congress could direct the Secretary of Health and Human Services (HHS) and/or the Attorney General to reevaluate marijuana and its position within the schedules of controlled substances. Of note, the Attorney General—through the DEA, and in consultation with the Secretary of HHS—may reschedule a substance or remove a substance altogether from control.[114]

In addition to establishing commissions and directing additional research, congressional options include legislatively amending the CSA. This could involve keeping—with caveats—marijuana as a Schedule I substance, moving it to a different schedule, or removing it from the schedule altogether. Without altering marijuana's position as a Schedule I controlled substance on the whole, one option might be to build additional flexibility into existing law. For example, policymakers could amend the CSA to make certain criminal liability exceptions for individuals operating in compliance with state marijuana laws.[115]

Upon reevaluation, should Congress determine that marijuana no longer meets the criteria to be a Schedule I substance,[116] it could take legislative action to remove marijuana from Schedule I of the CSA. In doing so, Congress may (1) place marijuana on one of the other Schedules (II, III, IV, or V) of controlled substances or (2) remove marijuana as a controlled substance altogether;[117]

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[113] In the 113th Congress, H.R. 1635, the National Commission on Federal Marijuana Policy Act of 2013 was introduced in the House. This bill would establish a commission similar in nature to the National Commission on Marihuana and Drug Abuse, also known as the Shafer Commission, in order to "undertake a comprehensive review of the state and efficacy of current policies of the Federal Government toward marijuana in light of the growing number of States in which marijuana is legal for medicinal or personal use." For more information on congressional commissions, see CRS Report R40076, *Congressional Commissions: Overview, Structure, and Legislative Considerations*, by Matthew E. Glassman and Jacob R. Straus.

[114] 21 U.S.C. §811. In the 113th Congress, H.R. 689, the States' Medical Marijuana Patient Protection Act, would, among other things, require the Secretary of HHS and DEA Administrator to recommend removing marijuana from Schedule I and relist it.

[115] In the 113th Congress, H.R. 1523, the Respect State Marijuana Laws Act of 2013, was introduced in the House. This bill would amend the CSA so that certain provisions related to marijuana (under 21 U.S.C. §801 et seq.) would not apply to "any person acting in compliance with State laws relating to the production, possession, distribution, dispensation, administration, or delivery of marihuana." Similar provisions are also proposed in H.R. 689.

[116] The criteria are (1) the drug or other substance has a high potential for abuse; (2) the drug or other substance has no currently accepted medical use in treatment in the United States; and (3) there is a lack of accepted safety for the use of the drug or other substance under medical supervision (21 U.S.C. §812(b)(1)).

[117] In the 113th Congress, H.R. 499, the Ending Federal Marijuana Prohibition Act of 2013, was introduced in the House. This bill would remove marijuana in any form from all schedules under §202(c) of the CSA among other things (continued...)

however, if marijuana *remains* a controlled substance under the CSA under any Schedule, then this would not eliminate the existing policy conflict with those states that have legalized to allow recreational use. If Congress chooses to remove marijuana as a controlled substance, it could alternatively seek to regulate and tax marijuana. If Congress were to take this route of legalizing and regulating marijuana, and given agencies' current authorities over controlled and legal substances, one path may then be to transfer jurisdiction over marijuana from the DEA to the ATF for regulation.[118]

Oversight of Federal Law Enforcement Activities

Review of Agency Missions

In exercising its oversight authorities, Congress may choose to examine the extent to which the carrying out of federal law enforcement missions might be impacted by state initiatives to decriminalize or legalize—either for medical or recreational purposes—marijuana. For instance, policymakers may elect to review the mission of each federal law enforcement agency involved in enforcing the CSA and examine how its drug-related investigations may be influenced by the varying state-level policies regarding marijuana. As noted, federal law enforcement has generally prioritized the investigation of drug traffickers and dealers over that of low-level drug users. Policymakers may question whether these priorities are consistent across states with different forms of drug policies regarding marijuana. Policymakers may question whether federal law enforcement priorities have shifted in states that have altered their marijuana laws and regulations.

Cooperation with State and Local Law Enforcement

With respect to the coordination of federal, state, and local efforts to combat drug trafficking networks and other drug offenders, one issue policymakers may debate is whether or how to incentivize task forces, fusion centers, and other coordinating bodies charged with combating drug-related crimes. Before determining whether to increase, decrease, or maintain funding for coordinated efforts such as task forces, policymakers may consider whether state and local counterparts are able to effectively achieve task force goals if the respective state marijuana policy is not in agreement with federal marijuana policy. Policymakers may choose to evaluate whether certain drug task forces are sustainable in states that have established policies that are either inconsistent—such as in states that have decriminalized small amounts of marijuana possession—or are in direct conflict—including states that have legalized either medical or recreational marijuana—with federal drug policy. For instance, might there be any internal conflicts that prevent task force partners from collaborating effectively to carry out their investigations?

(...continued)

in order to "decriminalize marijuana at the Federal level, [and] to leave to the States a power to regulate marijuana that is similar to the power they have to regulate alcohol, and for other purposes."

[118] Ibid.

Oversight of Federal Enforcement Priorities

As noted, in responding to states with recreational legalization initiatives, the Department of Justice (DOJ) issued federal enforcement priorities for states with legal marijuana. It is unclear whether or how DOJ is tracking activity in these states to ensure that these priorities are being emphasized. The metrics to evaluate these priorities, whether in place or not, are also unknown. For example, one of the eight enforcement priorities listed by Deputy Attorney General Cole was to prevent the diversion of marijuana to other states. While it seems the DEA is aware of increased marijuana trafficking from Colorado to Kansas, it is unclear what level of increased trafficking might trigger action by the federal government against state marijuana laws. Congress may choose to exercise oversight over DOJ's enforcement priorities and metrics for tracking illicit activity in the states. Congress may also request research or investigation of this issue outside of actions by the Obama Administration.

Policy-Linked Funding for States

Congress has long used the provision of monies as a carrot to influence states' policies. If policymakers are interested in affecting states' drug policies, one means may be through some form of policy-contingent funding. For instance, Congress could consider compliance with federal marijuana policy as an eligibility requirement to receive certain federal grant funds. In the past, Congress has exercised its authority to withhold federal grant funds to states in order to achieve agreement with federal policy. For example, under the Sex Offender Registration and Notification Act (SORNA; P.L. 109-248),[119] Congress established a set of minimum standards for sex offender registration and notification for all 50 states, the District of Columbia, territories, and federally recognized American Indian tribes. To assure compliance with these standards, SORNA mandated a 10% reduction in annual formula funding under the Edward Byrne Memorial Justice Assistance Grant (JAG) Program[120] for the states, territories, and District of Columbia if these jurisdictions did not substantially implement SORNA by July 27, 2009.[121] Congress may choose to establish similar financial penalties to influence states' drug policies or ensure consistency between state-level laws and those outlined under the CSA.

Whether or not linking funding to state-level compliance with federal drug policy standards might produce the desired outcomes is unknown. One question that remains is whether Congress could withhold sufficient money from programs such as JAG to provide a true incentive for states to acquiesce to federal drug policy requirements. Might states that legalize and tax marijuana generate enough revenue to offset any losses from grant program funding that Congress might impose? In addition, could states see some savings in criminal justice expenditures from not

[119] Title I of the Adam Walsh Child Protection and Safety Act of 2006.

[120] For more information on the JAG Program, see CRS Report RS22416, *Edward Byrne Memorial Justice Assistance Grant (JAG) Program*, by Nathan James.

[121] Two extensions were provided, and a final deadline of July 27, 2011 was established. For relevant statutory guidelines and deadlines, see 42 U.S.C. §16924 and §16925. According to the U.S. Department of Justice, Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking (SMART Office), sixteen states, three territories, and 47 tribal jurisdictions have substantially implemented SORNA. For more information regarding SORNA compliance, see the SMART Office website: http://www.ojp.usdoj.gov/smart/sorna.htm. For more information regarding the JAG Program, see the Office of Justice Programs, Bureau of Justice Assistance website, http://www.ojp.usdoj.gov/smart/sorna.htm.

investigating, prosecuting, and incarcerating low-level marijuana offenders? These savings could also compensate for any losses from congressionally imposed financial penalties.[122]

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[122] A number of other savings or expenditures, such as those in the public health arena, may arise from any possible changes in federal marijuana policy; however, they are beyond the scope of this report.

U.S. Department of the Treasury

A guidance from the U.S. Department of the Treasury to financial institutions on marijuana businesses, dated February 14, 2014.

Financial Crimes Enforcement Network
A bureau of the U.S. Department of the Treasury

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FinCEN Issues Guidance to Financial Institutions on Marijuana Businesses

Guidance Clarifies Expectations of Financial Institutions Serving Marijuana Businesses

WASHINGTON, DC – The Financial Crimes Enforcement Network (FinCEN), in coordination with the U.S. Department of Justice (DOJ), today issued guidance that clarifies customer due diligence expectations and reporting requirements for financial institutions seeking to provide services to marijuana businesses. The guidance provides that financial institutions can provide services to marijuana-related businesses in a manner consistent with their obligations to know their customers and to report possible criminal activity.

Providing clarity in this context should enhance the availability of financial services for marijuana businesses. This would promote greater financial transparency in the marijuana industry and mitigate the dangers associated with conducting an all-cash business. The guidance also helps financial institutions file reports that contain information important to law enforcement. Law enforcement will now have greater insight into marijuana business activity generally, and will be able to focus on activity that presents high-priority concerns.

"Now that some states have elected to legalize and regulate the marijuana trade, FinCEN seeks to move from the shadows the historically covert financial operations of marijuana businesses," noted FinCEN Director Jennifer Shasky Calvery. "Our guidance provides financial institutions with clarity on what they must do if they are going to provide financial services to marijuana businesses and what reporting will assist law enforcement."

FinCEN writes the rules and regulations that U.S. financial institutions, like banks, credit unions, and money services businesses, must follow to help protect the U.S. financial system from money laundering and terrorist finance. FinCEN also has the civil power to enforce these rules and penalize offenders. To satisfy their regulatory obligations in this area, FinCEN expects

financial institutions to perform thorough customer due diligence on marijuana businesses and file reports that highlight information that is particularly valuable to law enforcement.

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FinCEN's mission is to safeguard the financial system from illicit use and combat money laundering and promote national security through the collection, analysis, and dissemination of financial intelligence and strategic use of financial authorities.

Department of the Treasury
Financial Crimes Enforcement Network

Guidance

FIN-2014-G001
Issued: February 14, 2014
Subject: BSA Expectations Regarding Marijuana-Related Businesses

The Financial Crimes Enforcement Network ("FinCEN") is issuing guidance to clarify Bank Secrecy Act ("BSA") expectations for financial institutions seeking to provide services to marijuana-related businesses. FinCEN is issuing this guidance in light of recent state initiatives to legalize certain marijuana-related activity and related guidance by the U.S. Department of Justice ("DOJ") concerning marijuana-related enforcement priorities. This FinCEN guidance clarifies how financial institutions can provide services to marijuana-related businesses consistent with their BSA obligations, and aligns the information provided by financial institutions in BSA reports with federal and state law enforcement priorities. This FinCEN guidance should enhance the availability of financial services for, and the financial transparency of, marijuana-related businesses.

Marijuana Laws and Law Enforcement Priorities

The Controlled Substances Act ("CSA") makes it illegal under federal law to manufacture, distribute, or dispense marijuana.[1] Many states impose and enforce similar prohibitions. Notwithstanding the federal ban, as of the date of this guidance, 20 states and the District of Columbia have legalized certain marijuana-related activity. In light of these developments, U.S. Department of Justice Deputy Attorney General James M. Cole issued a memorandum (the "Cole Memo") to all United States Attorneys providing updated guidance to federal prosecutors concerning marijuana enforcement under the CSA.[2] The Cole Memo guidance applies to all of DOJ's federal enforcement activity, including civil enforcement and criminal investigations and prosecutions, concerning marijuana in all states.

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. The Cole Memo notes that DOJ is committed to enforcement of the CSA consistent with those determinations. It also notes that DOJ is committed to using its investigative and prosecutorial resources to address the most

[1] Controlled Substances Act, 21 U.S.C. § 801, *et seq*.
[2] James M. Cole, Deputy Attorney General, U.S. Department of Justice, *Memorandum for All United States Attorneys: Guidance Regarding Marijuana Enforcement* (August 29, 2013), *available at* http://www.justice.gov/iso/opa/resources/305201382913275685746 7.pdf.

significant threats in the most effective, consistent, and rational way. In furtherance of those objectives, the Cole Memo provides guidance to DOJ attorneys and law enforcement to focus their enforcement resources on persons or organizations whose conduct interferes with any one or more of the following important priorities (the "Cole Memo priorities"):[3]

- Preventing the distribution of marijuana to minors;
- Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs, and cartels;
- Preventing the diversion of marijuana from states where it is legal under state law in some form to other states;
- 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 violence and the use of firearms in the cultivation and distribution of marijuana;
- Preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use;
- Preventing the growing of marijuana on public lands and the attendant public safety and environmental dangers posed by marijuana production on public lands; and
- Preventing marijuana possession or use on federal property.

Concurrently with this FinCEN guidance, Deputy Attorney General Cole is issuing supplemental guidance directing that prosecutors also consider these enforcement priorities with respect to federal money laundering, unlicensed money transmitter, and BSA offenses predicated on marijuana-related violations of the CSA.[4]

Providing Financial Services to Marijuana-Related Businesses

This FinCEN guidance clarifies how financial institutions can provide services to marijuana-related businesses consistent with their BSA obligations. In general, the decision to open, close, or refuse any particular account or relationship should be made by each financial institution based on a number of factors specific to that institution. These factors may include its particular business objectives, an evaluation of the risks associated with offering a particular product or service, and its capacity to manage those risks effectively. Thorough customer due diligence is a critical aspect of making this assessment.

In assessing the risk of providing services to a marijuana-related business, a financial institution should conduct customer due diligence that includes: (i) verifying with the appropriate state authorities whether the business is duly licensed and registered; (ii) reviewing the license application (and related documentation) submitted by the business for obtaining a state license to operate its marijuana-related business; (iii) requesting from state licensing and enforcement authorities available information about the business and related parties; (iv) developing an understanding of the normal and expected activity for the business, including the types of

[3] The Cole Memo notes that these enforcement priorities are listed in general terms; each encompasses a variety of conduct that may merit civil or criminal enforcement of the CSA.

[4] 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).

products to be sold and the type of customers to be served (e.g., medical versus recreational customers); (v) ongoing monitoring of publicly available sources for adverse information about the business and related parties; (vi) ongoing monitoring for suspicious activity, including for any of the red flags described in this guidance; and (vii) refreshing information obtained as part of customer due diligence on a periodic basis and commensurate with the risk. With respect to information regarding state licensure obtained in connection with such customer due diligence, a financial institution may reasonably rely on the accuracy of information provided by state licensing authorities, where states make such information available.

As part of its customer due diligence, a financial institution should consider whether a marijuana-related business implicates one of the Cole Memo priorities or violates state law. This is a particularly important factor for a financial institution to consider when assessing the risk of providing financial services to a marijuana-related business. Considering this factor also enables the financial institution to provide information in BSA reports pertinent to law enforcement's priorities. A financial institution that decides to provide financial services to a marijuana-related business would be required to file suspicious activity reports ("SARs") as described below.

Filing Suspicious Activity Reports on Marijuana-Related Businesses

The obligation to file a SAR is unaffected by any state law that legalizes marijuana-related activity. A financial institution is required to file a SAR if, consistent with FinCEN regulations, the financial institution knows, suspects, or has reason to suspect that a transaction conducted or attempted by, at, or through the financial institution: (i) involves funds derived from illegal activity or is an attempt to disguise funds derived from illegal activity; (ii) is designed to evade regulations promulgated under the BSA, or (iii) lacks a business or apparent lawful purpose.[5] Because federal law prohibits the distribution and sale of marijuana, financial transactions involving a marijuana-related business would generally involve funds derived from illegal activity. Therefore, a financial institution is required to file a SAR on activity involving a marijuana-related business (including those duly licensed under state law), in accordance with this guidance and FinCEN's suspicious activity reporting requirements and related thresholds.

One of the BSA's purposes is to require financial institutions to file reports that are highly useful in criminal investigations and proceedings. The guidance below furthers this objective by assisting financial institutions in determining how to file a SAR that facilitates law enforcement's access to information pertinent to a priority.

"Marijuana Limited" SAR Filings

A financial institution providing financial services to a marijuana-related business that it reasonably believes, based on its customer due diligence, does not implicate one of the Cole Memo priorities or violate state law should file a "Marijuana Limited" SAR. The content of this

[5] *See, e.g.*, 31 CFR § 1020.320. Financial institutions shall file with FinCEN, to the extent and in the manner required, a report of any suspicious transaction relevant to a possible violation of law or regulation. A financial institution may also file with FinCEN a SAR with respect to any suspicious transaction that it believes is relevant to the possible violation of any law or regulation but whose reporting is not required by FinCEN regulations.

SAR should be limited to the following information: (i) identifying information of the subject and related parties; (ii) addresses of the subject and related parties; (iii) the fact that the filing institution is filing the SAR solely because the subject is engaged in a marijuana-related business; and (iv) the fact that no additional suspicious activity has been identified. Financial institutions should use the term "MARIJUANA LIMITED" in the narrative section.

A financial institution should follow FinCEN's existing guidance on the timing of filing continuing activity reports for the same activity initially reported on a "Marijuana Limited" SAR.[6] The continuing activity report may contain the same limited content as the initial SAR, plus details about the amount of deposits, withdrawals, and transfers in the account since the last SAR. However, if, in the course of conducting customer due diligence (including ongoing monitoring for red flags), the financial institution detects changes in activity that potentially implicate one of the Cole Memo priorities or violate state law, the financial institution should file a "Marijuana Priority" SAR.

"Marijuana Priority" SAR Filings

A financial institution filing a SAR on a marijuana-related business that it reasonably believes, based on its customer due diligence, implicates one of the Cole Memo priorities or violates state law should file a "Marijuana Priority" SAR. The content of this SAR should include comprehensive detail in accordance with existing regulations and guidance. Details particularly relevant to law enforcement in this context include: (i) identifying information of the subject and related parties; (ii) addresses of the subject and related parties; (iii) details regarding the enforcement priorities the financial institution believes have been implicated; and (iv) dates, amounts, and other relevant details of financial transactions involved in the suspicious activity. Financial institutions should use the term "MARIJUANA PRIORITY" in the narrative section to help law enforcement distinguish these SARs.[7]

"Marijuana Termination" SAR Filings

If a financial institution deems it necessary to terminate a relationship with a marijuana-related business in order to maintain an effective anti-money laundering compliance program, it should

[6] Frequently Asked Questions Regarding the FinCEN Suspicious Activity Report (Question #16), *available at:* http://fincen.gov/whatsnew/html/sar_faqs.html (providing guidance on the filing timeframe for submitting a continuing activity report).

[7] FinCEN recognizes that a financial institution filing a SAR on a marijuana-related business may not always be well-positioned to determine whether the business implicates one of the Cole Memo priorities or violates state law, and thus which terms would be most appropriate to include (i.e., "Marijuana Limited" or "Marijuana Priority"). For example, a financial institution could be providing services to another domestic financial institution that, in turn, provides financial services to a marijuana-related business. Similarly, a financial institution could be providing services to a non-financial customer that provides goods or services to a marijuana-related business (e.g., a commercial landlord that leases property to a marijuana-related business). In such circumstances where services are being provided indirectly, the financial institution may file SARs based on existing regulations and guidance without distinguishing between "Marijuana Limited" and "Marijuana Priority." Whether the financial institution decides to provide indirect services to a marijuana-related business is a risk-based decision that depends on a number of factors specific to that institution and the relevant circumstances. In making this decision, the institution should consider the Cole Memo priorities, to the extent applicable.

file a SAR and note in the narrative the basis for the termination. Financial institutions should use the term "MARIJUANA TERMINATION" in the narrative section. To the extent the financial institution becomes aware that the marijuana-related business seeks to move to a second financial institution, FinCEN urges the first institution to use Section 314(b) voluntary information sharing (if it qualifies) to alert the second financial institution of potential illegal activity. See *Section 314(b) Fact Sheet* for more information.[8]

Red Flags to Distinguish Priority SARs

The following red flags indicate that a marijuana-related business may be engaged in activity that implicates one of the Cole Memo priorities or violates state law. These red flags indicate only possible signs of such activity, and also do not constitute an exhaustive list. It is thus important to view any red flag(s) in the context of other indicators and facts, such as the financial institution's knowledge about the underlying parties obtained through its customer due diligence. Further, the presence of any of these red flags in a given transaction or business arrangement may indicate a need for additional due diligence, which could include seeking information from other involved financial institutions under Section 314(b). These red flags are based primarily upon schemes and typologies described in SARs or identified by our law enforcement and regulatory partners, and may be updated in future guidance.

- A customer appears to be using a state-licensed marijuana-related business as a front or pretext to launder money derived from other criminal activity (i.e., not related to marijuana) or derived from marijuana-related activity not permitted under state law. Relevant indicia could include:
    - The business receives substantially more revenue than may reasonably be expected given the relevant limitations imposed by the state in which it operates.
    - The business receives substantially more revenue than its local competitors or than might be expected given the population demographics.
    - The business is depositing more cash than is commensurate with the amount of marijuana-related revenue it is reporting for federal and state tax purposes.
    - The business is unable to demonstrate that its revenue is derived exclusively from the sale of marijuana in compliance with state law, as opposed to revenue derived from (i) the sale of other illicit drugs, (ii) the sale of marijuana not in compliance with state law, or (iii) other illegal activity.
    - The business makes cash deposits or withdrawals over a short period of time that are excessive relative to local competitors or the expected activity of the business.

[8] Information Sharing Between Financial Institutions: Section 314(b) Fact Sheet, *available at: http://fincen.gov/statutes_regs/patriot/pdf/314bfactsheet.pdf.*

- Deposits apparently structured to avoid Currency Transaction Report ("CTR") requirements.

- Rapid movement of funds, such as cash deposits followed by immediate cash withdrawals.

- Deposits by third parties with no apparent connection to the accountholder.

- Excessive commingling of funds with the personal account of the business's owner(s) or manager(s), or with accounts of seemingly unrelated businesses.

- Individuals conducting transactions for the business appear to be acting on behalf of other, undisclosed parties of interest.

- Financial statements provided by the business to the financial institution are inconsistent with actual account activity.

- A surge in activity by third parties offering goods or services to marijuana-related businesses, such as equipment suppliers or shipping servicers.

- The business is unable to produce satisfactory documentation or evidence to demonstrate that it is duly licensed and operating consistently with state law.

- The business is unable to demonstrate the legitimate source of significant outside investments.

- A customer seeks to conceal or disguise involvement in marijuana-related business activity. For example, the customer may be using a business with a non-descript name (e.g., a "consulting," "holding," or "management" company) that purports to engage in commercial activity unrelated to marijuana, but is depositing cash that smells like marijuana.

- Review of publicly available sources and databases about the business, its owner(s), manager(s), or other related parties, reveal negative information, such as a criminal record, involvement in the illegal purchase or sale of drugs, violence, or other potential connections to illicit activity.

- The business, its owner(s), manager(s), or other related parties are, or have been, subject to an enforcement action by the state or local authorities responsible for administering or enforcing marijuana-related laws or regulations.

- A marijuana-related business engages in international or interstate activity, including by receiving cash deposits from locations outside the state in which the business operates, making or receiving frequent or large interstate transfers, or otherwise transacting with persons or entities located in different states or countries.

- The owner(s) or manager(s) of a marijuana-related business reside outside the state in which the business is located.

- A marijuana-related business is located on federal property or the marijuana sold by the business was grown on federal property.

- A marijuana-related business's proximity to a school is not compliant with state law.

- A marijuana-related business purporting to be a "non-profit" is engaged in commercial activity inconsistent with that classification, or is making excessive payments to its manager(s) or employee(s).

Currency Transaction Reports and Form 8300's

Financial institutions and other persons subject to FinCEN's regulations must report currency transactions in connection with marijuana-related businesses the same as they would in any other context, consistent with existing regulations and with the same thresholds that apply. For example, banks and money services businesses would need to file CTRs on the receipt or withdrawal by any person of more than $10,000 in cash per day. Similarly, any person or entity engaged in a non-financial trade or business would need to report transactions in which they receive more than $10,000 in cash and other monetary instruments for the purchase of goods or services on FinCEN Form 8300 (Report of Cash Payments Over $10,000 Received in a Trade or Business). A business engaged in marijuana-related activity may not be treated as a non-listed business under 31 C.F.R. § 1020.315(e)(8), and therefore, is not eligible for consideration for an exemption with respect to a bank's CTR obligations under 31 C.F.R. § 1020.315(b)(6).

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FinCEN's enforcement priorities in connection with this guidance will focus on matters of systemic or significant failures, and not isolated lapses in technical compliance. Financial institutions with questions about this guidance are encouraged to contact FinCEN's Resource Center at (800) 767-2825, where industry questions can be addressed and monitored for the purpose of providing any necessary additional guidance.

States with Medical Marijuana Laws

Registrant Characteristics by State

Analysis of California Registrants

An article published in the Journal of Drug Policy Analysis that analyzed the medical conditions of medical marijuana users in California in 2006, released January 2011.

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An Analysis of Applicants Presenting to a Medical Marijuana Specialty Practice in California

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An Analysis of Applicants Presenting to a Medical Marijuana Specialty Practice in California

Helen Nunberg, Beau Kilmer, Rosalie Liccardo Pacula, and James R. Burgdorf

Abstract

While 15 states and the District of Columbia provide allowances for medical marijuana, little is known about the individuals who seek a physician's recommendation to use marijuana. This study provides descriptive information about 1,655 applicants in California who sought a physician's recommendation for medical marijuana, the conditions for which they sought treatment, and the diagnoses made by the physicians. It presents a systematic analysis of physician records and questionnaires obtained from consecutive applicants seen during a three-month period at nine medical marijuana specialty practices operating throughout the state. The analysis yields insights that may be useful for future research on medical marijuana and marijuana policy, including: 1) very few of those who sought a recommendation had cancer, HIV/AIDS, glaucoma, or multiple sclerosis; 2) most applicants presented with chronic pain, mental health conditions, or insomnia; and 3) half of the applicants reported using marijuana as a substitute for prescription drugs.

KEYWORDS: medical marijuana, California, ballot, drug policy

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I. INTRODUCTION

As of December 2010, 15 states and the District of Columbia provide allowances for medical marijuana (National Conference of State Legislatures, 2010).[1] There is a small literature about whether these laws influence the overall demand for marijuana (Gorman and Charles, 2007; Pacula et al., 2010), and a tremendous amount of discussion about how medicinal marijuana is distributed, especially in California (see e.g., Hoeffel, 2010a; 2010b). What remains largely missing from the literature and policy discussions is a good understanding of the individuals who seek a medical allowance for marijuana.

This paper helps fill this gap by systematically evaluating the characteristics, ailments, and medical histories of a large group of applicants who sought a medicinal marijuana recommendation. Data were collected from medical charts and doctor interviews with 1,655 individuals seen in June, July and August of 2006 from nine medical marijuana specialty practices dispersed throughout California. The results provide some interesting insights as to the characteristics of those seeking medicinal allowances nearly a decade after the policy was introduced in California.

The remainder of this paper is organized as follows. In Section 2 we briefly review the literature on the therapeutic value of cannabinoids, provide details of the specific allowances provided for within California state law, and review previously published surveys of populations of medical marijuana users. In Section 3 we discuss the methods that were used in the current study, including our data collection procedures, and in Section 4 we present our results. A general discussion of these findings and the limitations of our study are presented in Section 5.

II. BACKGROUND AND LITERATURE REVIEW

Research on the Therapeutic Value of Cannabinoids

Cannabinoids are compounds found in the cannabis plant (phytocannabinoids), in animals (endocannabinoids), and synthesized in laboratories (e.g., THC analogues, cannabinoid receptor agonists) (Pertwee, 2006). Cannabinoid receptors are found in all animals; in humans, cannabinoid receptors are concentrated in the brain but are also found in other parts of the body.

The use of cannabis as a medicine originated thousands of years ago. After being introduced to the West in the mid-nineteenth century, cannabis-based

[1] This excludes Maryland. While Maryland does allow those arrested for marijuana possession to use a medical necessity defense, those found to be using for medical purposes are still convicted and can be fined up to $100.

medicines were popular through the early decades of the twentieth century (Grinspoon, 2005; Zuardi, 2006). The virtual disappearance of cannabis-based medicines by the mid-1900s was due to the introduction of new pharmaceuticals (e.g., aspirin, chloral hydrate, barbiturates) for the same conditions, such as pain, migraines, menstrual cramps, and sedation, as well as the legal restrictions associated with the 1937 Marihuana Tax Act (Fankhauser, 2002; Grinspoon, 2005).

The Institute of Medicine's (IOM) 1999 report *Marijuana and Medicine: Assessing the Science Base*, concluded: "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" (4). The report further noted that, "For the most part, the logical categories for the medical use of marijuana are not based on particular diseases but on symptoms…[that] can be caused by various diseases or even by treatments for diseases" (IOM, 1999; pp. 137-138). Based on these findings, the panel recommended that "clinical trials of cannabinoid drugs for symptom management should be conducted with the goal of developing rapid-onset, reliable, and safe delivery systems" (4). In addition to focusing on pain relief, control of nausea and vomiting, and appetite stimulation, the IOM report also recommended that clinical trials focus on the suitability of cannabinoid drugs to address anxiety reduction and sedation.

Reviews published since the IOM report also highlight the potential therapeutic value of cannabinoid drugs; however, few of the studies focus on inhaled marijuana. A review of 72 randomized, double-blind, placebo-controlled studies from 1975 to 2004 that evaluated the therapeutic effects of cannabinoids concludes: "Cannabinoids present an interesting therapeutic potential as antiemetics, appetite stimulants in debilitating diseases (cancer and AIDS), analgesics, and in the treatment of multiple sclerosis, spinal cord injuries, Tourette's syndrome, epilepsy and glaucoma" (Ben Amar, 2006). A more recent review focusing on clinical studies published from 2005 to 2009 (Hazekamp and Grotenhermen, 2010) concluded that cannabinoids have "therapeutic potential mainly as analgesics in chronic neuropathic pain, appetite stimulants in debilitating diseases (cancer and AIDS), as well as in the treatment of multiple sclerosis." For both reviews, a minority of the trials evaluated inhaled marijuana (six and eight studies, respectively). The others used a synthetic THC isomer or analog for oral administration, or plant extract in oral or sublingual preparations.[2]

[2] Hazekamp and Grotenhermen included recent studies of nabilone, a prescription drug that is a THC analog. Skrabek et al. (2008) performed a randomized, controlled trial to assess the benefit of nabilone on pain reduction and quality of life improvement in patients with fibromyalgia. They found significant decreases in pain and anxiety. Similarly, Ware et al. (2010) concluded that nabilone "is effective in improving sleep in patients with fibromyalgia and is well tolerated."

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In February 2010, the Center for Medicinal Cannabis Research (CMCR) at the University of California San Diego submitted a report to the Legislature and Governor of California describing five completed clinical trials with inhaled marijuana (Grant et al., 2010). Four demonstrated pain relief effects in conditions secondary to injury or disease of the nervous system (Abrams et al., 2007; Wallace et al., 2007; Wilsey et al., 2008; Ellis et al., 2009), and one suggested a reduction of spasticity in multiple sclerosis (Corey-Bloom et al., 2008).

Medicinal Marijuana in California

In California, patients with a physician's recommendation, along with their designated caregivers and recommending physicians, are exempted from state criminal laws against marijuana. Although provision and use remain illegal under federal law, U.S. Attorney General Eric Holder made a statement in March 2009 suggesting that the federal government would not target those who complied with state medical marijuana laws. This was made more official in an October 2009 memo to U.S. Attorneys which noted: "As a general matter, pursuit of these priorities should not focus federal resources in your States on individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana."

The California medical marijuana law, passed through voter referendum (Proposition 215) in 1996, permits the use of marijuana for "cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief." California Senate Bill 420, signed into law on October 12, 2003, named additional ailments such as severe nausea, cachexia, seizures, and persistent muscle spasms (regardless of whether they are associated with multiple sclerosis). In an effort to provide better guidance to law enforcement agencies, SB 420 allowed patients and primary caregivers to possess up to six mature plants (or 12 immature plants) and eight ounces of marijuana; however, it granted local governments the authority to establish larger maximum quantities.

Many of the early studies about medicinal marijuana users in California focused on individuals with HIV or AIDS (e.g., Harris et al., 2000; Sidney, 2001; de Jong et al., 2005; Prentiss et al., 2004). Based on analyses of several unpublished surveys of clients entering cannabis buyer clubs in the San Francisco Bay Area, Gieringer (2002) found that the share of clients that were AIDS and cancer patients declined after the passage of Proposition 215. More recent research in California shows that medicinal marijuana patients are largely men

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Finally, in a more recent observational study (Bestard and Toth, 2010), nabilone was found to be as effective as gabapentin, a first line medication for peripheral neuropathy, in measures of pain, sleep, depression and anxiety.

who present with pain and/or emotional/mental health concerns (O'Connell and Bou-Matar, 2007; Reiman, 2007; Reiman, 2009). An informal survey of several California medical marijuana specialty physicians revealed that more than 95% of the patients of each physician were already "self-medicating" prior to the receipt of their recommendation, leading Mikuriya et al. (2007) to conclude that the physicians were really "approving" the medical use of marijuana as opposed to "recommending" it.

III. DATA AND METHODS

The data used in this study come from medical records of 1,745 applicants consecutively presenting to nine MediCann clinics located in large and small cities throughout California.[3] The sample is based on visits in June, July, and August 2006, roughly ten years after the original law was enacted. Medical charts were reviewed and data entered within a few weeks of the visit. Our final sample excludes 90 individuals who are either missing diagnosis information (N=35) or did not report using marijuana before seeking a recommendation (N=55).[4] There are no statistically significant differences in terms of age, race/ethnicity, and gender between those included and excluded in the analysis sample.

We drew on consecutive visits from all nine clinics in hopes of approximating a representative sample of applicants seeking recommendations at these medical marijuana specialty practices. The sample is not generalizable to all individuals applying for a medical marijuana recommendation as it only represents those individuals selecting this particular network of physicians.

In general, the MediCann policy was to provide a 12-month recommendation to those with an acceptable medical condition who had supporting medical record documentation.[5] Those without medical record documentation received a provisional three-month recommendation conditional upon them providing the MediCann physician with a copy of the relevant supporting medical record, or, if not currently under the care of a medical professional, seeking care and providing those records. Applicants were only denied if they did not report having an eligible medical condition or if they

[3] Since 2006, MediCann has expanded to 21 locations throughout California.

[4] While in many ways the applicants who report not using marijuana prior to seeking this recommendation are perhaps the most interesting, there are an insufficient number of these individuals in our sample for robust comparisons.

[5] Qualifying patients would be given a recommendation and would be reassessed periodically to review the course of treatment and any new information about their health, as well as to monitor response to treatment as indicated by a decrease in symptoms, an increase in level of function, or an improvement in quality of life.

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refused to be under the care of a medical professional. For our sample the denial rate was less than 2%.

MediCann's medical records include two standard forms specifically created for MediCann. One form is filled out by the applicant and includes demographic information, medical history, and marijuana use history. The second form is filled out by the evaluating physician and contains clinical information related to the health problem and symptoms for which the applicant is seeking help. Clinic physicians relied on medical histories, physical exams, and the supporting medical documents when they assigned diagnoses. The supporting medical documents included laboratory and radiological evaluations to validate applicant claims of use of marijuana for relief of symptoms due to a medical condition. Over two-thirds of applicants (67.8%) brought medical record documentation with them at the time of the visits analyzed in our study.

In light of the limited information on this population of interest, we examine simple means or sample proportions for several variables of interest, including patient characteristics and stated therapeutic needs, physician diagnoses, and medical history. Results are provided for the entire sample and then broken down by gender.

IV. RESULTS

Applicant Characteristics

Applicant demographic information is shown in Table 1 both for the full sample and by gender, since almost 73% of the applicants seeking a recommendation were male. This is not much different than the share of those in the 2006 National Household Survey on Drug Use and Health who reported purchasing marijuana in the previous month (70%). Female applicants seeking recommendations were, on average, older and more likely than men to be African American, have some college education, have Medicaid (Medi-Cal) health insurance, or to be unemployed and disabled (19.5% of women reported being unemployed due to disability). In general, those seeking recommendations were insured (73.0% currently insured, of whom 24.2% were covered through Medicare or Medicaid), have at least a high school degree (only 8.8% had less than a high school degree), and were generally employed (68.7%).

As for the age distribution, at least half of the population that sought medical recommendations through this physician group was over the age of 35. For comparison, the median age category for those 18 and older in the 2006 NSDUH who reported purchasing marijuana in the previous month was 26-29 years.

Table 1. Characteristics of applicants seeking physician recommendations for medical marijuana

	All	**Females**	**Males**	**P-value**
	N=1655	N=452	N=1203	
Male	72.7%	--	--	--
White	58.5%	60.0%	58.0%	0.477
Hispanic	14.5%	13.1%	15.0%	0.305
Black	10.9%	14.2%	9.7%	*0.010*
Native American/Asian	6.9%	5.3%	7.6%	0.108
Mixed race or other	8.9%	8.0%	9.3%	0.393
12-18 years old	0.2%	0.0%	0.2%	0.288
18-24 years old	17.8%	12.6%	19.8%	*0.001*
25-34years old	27.9%	26.8%	28.3%	0.546
35-44 years old	21.8%	19.9%	22.5%	0.251
45-54 years old	19.3%	26.1%	16.8%	*0.000*
55+ years old	13.0%	14.6%	12.4%	0.232
Not a high school graduate	8.8%	8.6%	8.9%	0.866
High school graduate	42.5%	35.7%	45.1%	*0.001*
Some college	27.1%	31.0%	25.6%	*0.031*
College graduate	21.6%	24.7%	20.4%	0.064
Employed	68.7%	60.4%	71.8%	*0.000*
Disabled	15.5%	19.5%	14%	*0.006*
Previous military service	10.5%	2.1%	13.6%	*0.000*
Currently insured	73.0%	78.2%	71.1%	*0.004*
Workers' compensation	3.5%	2.9%	3.7%	0.394
Medicare	9.2%	11.9%	8.2%	*0.020*
Medi-Cal	15.0%	21.7%	12.6%	*0.000*
Private	42.4%	41.4%	42.7%	0.619
Veterans Administration	3.2%	2.0%	3.7%	0.086

Notes: Missing employment/disability data for 3 applicants, insurance information for 13 applicants, education information for 51 applicants, and military information for 86 applicants. Education variables denote highest level obtained. P-values below 0.05 are printed in italics.

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Table 2. Self report of therapeutic benefits of medical marijuana

	All	Females	Males	P-value
	N=1655	N=452	N=1203	
To relieve:				
Pain	82.6%	82.7%	82.5%	0.924
Spasms	41.3%	44.2%	40.1%	0.132
Headache	40.8%	49.3%	37.6%	*0.000*
Anxiety	38.1%	51.1%	33.3%	*0.000*
Nausea	27.7%	44.9%	21.3%	*0.000*
Depression	26.1%	35.4%	22.6%	*0.000*
Cramps	19.0%	33.4%	13.5%	*0.000*
Panic	16.9%	27.2%	13.1%	*0.000*
Diarrhea	4.8%	4.9%	4.7%	0.913
Itching	2.7%	1.1%	3.3%	*0.013*
To improve:				
Sleep	70.6%	69.0%	71.2%	0.397
Relaxation	55.6%	60.2%	53.9%	*0.023*
Appetite	38.0%	35.0%	39.2%	0.117
Focus	23.3%	19.7%	24.6%	*0.035*
Energy	15.5%	17.7%	14.7%	0.135
To prevent:				
Anger	22.7%	21.9%	22.9%	0.653
Medication side effects	22.6%	27.0%	20.9%	*0.009*
Involuntary movements	6.2%	7.3%	5.8%	0.266
Seizure	3.0%	3.8%	2.7%	0.239
As a substitute for:				
Prescription medicine	50.8%	51.1%	50.7%	0.885
Alcohol	13.2%	11.3%	13.9%	0.164

Note: P-values below 0.05 are printed in italics.

Applicants' Self Reports of the Therapeutic Benefits of Marijuana

In light of the IOM's argument that "the logical categories for the medical use of marijuana are not based on particular diseases but on symptoms" (IOM; pp. 137-138), we examined the self-reported therapeutic benefit received from marijuana and the symptoms it helped relieve. Applicants were asked: "Which of the following best describe the therapeutic benefit you receive from medicinal cannabis? (Check the most important reasons you use cannabis.)" The results are presented in Table 2.

Applicants most frequently reported using medical marijuana for pain relief (82.6%), improved sleep (70.6%), and relaxation (55.6%). The next most frequently reported benefits included relief of muscle spasms (41.3%), headache (40.8%), relief of anxiety (38.1%), improved appetite (38.0%), relief of nausea and vomiting (27.7%), and relief of depression (26.1%). Half the applicants (50.8%) reported using marijuana as a substitute for prescription medication and 13.2% reported using marijuana as a substitute for alcohol.

Interestingly, women were statistically more likely than men to report that they used marijuana to relieve most of the indications listed, including headaches, anxiety, nausea, depression, panic, and medication side-effects. The only indication for which men were more likely than women to report use of marijuana was to help with focus (24.6% and 19.7%, respectively).

Physician Diagnoses

Table 3 presents the highest frequency diagnoses made by MediCann physicians and the diagnoses specifically listed in the Compassionate Use Act. Recall that treating physicians make their diagnoses based on a review of the applicant's history, the medical records from treating physicians (in two-thirds of the cases), and on their own physical examination. Evaluating physicians were then asked to "circle only diagnoses related to patient's medicinal marijuana use" from a list of 162 diagnoses.

In general, chronic pain disorders were the most common diagnoses made by physicians, with nearly 60 percent (58.2%) of applicants being diagnosed with some sort of musculoskeletal or neuropathic chronic pain condition. Low back pain was diagnosed for over one quarter (26.2%) of patients seen during this three month period, with lumbar and cervical degenerative disc disease (together 21.8%) and arthritis (18%) the next most common diagnoses in the chronic pain group. Mental health disorders were the next largest group of diagnoses made (22.9%), followed closely by sleep disorders (21.3%). Diagnoses in the grouping "neurological disorders," including migraine and other headache, were made in

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16.6% of applicants. Only 3% of the applicants were diagnosed with either cancer or HIV/AIDS.

Table 3. High frequency diagnoses and diagnoses listed in Proposition 215 and SB 420

	All	Females	Males	P-value
	N= 1655	N= 452	N= 1203	
Musculoskeletal and neuropathic chronic pain				
Low back pain	26.2%	20.4%	28.4%	*0.001*
Arthritis	18.0%	17.0%	18.4%	0.529
Lumbar degenerative disc disease	15.6%	16.6%	15.3%	0.518
Muscle spasm	11.7%	9.5%	12.5%	0.095
Cervicalgia	8.9%	11.7%	7.9%	*0.015*
Cervical degenerative disc disease	6.2%	6.2%	6.2%	0.976
Peripheral neuropathy	5.8%	8.8%	4.7%	*0.001*
Fibromyalgia	1.6%	4.0%	0.7%	*0.000*
Spasticity	0.2%	0.0%	0.2%	0.288
Any of these chronic pain ICDs	58.2%	57.3%	58.5%	0.654
Mental disorders				
Anxiety disorders	18.7%	28.5%	15.0%	*0.000*
Depression	9.3%	14.2%	7.5%	*0.000*
Bipolar disorder	2.5%	4.9%	1.7%	*0.000*
Attention deficit disorder	3.1%	2.0%	3.6%	0.100
Any of these mental disorder ICDs	22.9%	33.6%	18.9%	*0.000*
Sleep disorders				
Persistent insomnia	13.5%	13.9%	13.4%	0.769
Insomnia due to pain	8.0%	8.4%	7.9%	0.734
Any of these sleep disorder ICDs	21.3%	21.9%	21.1%	0.727
Gastrointestinal disorders				
Nausea and vomiting	7.4%	9.5%	6.6%	*0.041*
Anorexia	4.6%	4.4%	4.7%	0.842
Abdominal pain	2.9%	4.9%	2.2%	*0.004*
Gastritis and GERD	2.5%	4.0%	1.9%	*0.016*
Irritable bowel syndrome	1.1%	0.4%	1.3%	0.121
Any of these gastrointestinal disorder ICDs	13.3%	16.6%	12.1%	*0.015*
Neurologic disorders				
Migraine headache	9.2%	16.2%	6.7%	*0.000*
Other headache	6.5%	6.6%	6.5%	0.910
Seizure	1.4%	1.5%	1.3%	0.735
Multiple sclerosis	0.6%	1.1%	0.4%	0.106
Any of these neurologic disorder ICDs	16.6%	24.8%	13.5%	*0.000*

Gynecologic disorders				
Dysmenorrhea		7.7%		
Endometriosis		1.8%		
Any of these gynecologic disorder ICDs		9.3%		
Other				
HIV/AIDS	1.6%	0.9%	1.9%	0.142
Cancer	1.5%	2.4%	1.1%	*0.040*
Glaucoma	1.3%	1.1%	1.3%	0.717

Note: Does not include all ICD9s, and excludes those that were written in. P-values below 0.05 are printed in italics.

Previous Treatments Reported by Applicants

Because self-reported information was collected from applicants and most provided medical documentation from their treating physician, it was possible to consider the extent to which previous therapies had been used to cope with or treat the primary symptoms for which they were seeking a medical allowance. In Table 4 we provide a list of therapies or approaches that were previously tried or currently being used. Almost half of the applicants (47.6%) reported taking prescription medication at the time of their evaluation, and nearly 4 out of 5 (79.5%) reported having taken prescription medication in the past for their problems. As chronic pain was the leading diagnosis for which marijuana was being recommended, we were curious to see what percent of applicants had used opioids or opiate medication to deal with their problem. On the physician evaluation form, evaluating physicians were asked to check yes or no if the applicant was currently using or had used in the past opioids or opiate medication prescribed by another physician for their chronic pain. Evaluating physicians determined that almost half of all applicants (48.0%) experiencing chronic pain either currently or in the past had been prescribed opioids or opiate medication.

Non-prescription therapies tried by applicants seeking medicinal marijuana allowances included physical therapy (48.6%), chiropractic services (37.2%), surgery (21.9%), psychological counseling (20.7%), and acupuncture (19.6%). Thus, these data do not suggest that applicants immediately seek marijuana recommendations as the first strategy to deal with their symptoms. In many cases, these individuals tried more traditional forms of medicine first.

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Table 4. Previous treatments and physician recommendations for additional treatment

	All	Females	Males	P-value
	N=1655	N=452	N=1203	
Other treatment modalities applicants tried for medical conditions				
Current prescription medication	47.6%	57.1%	44.2%	*0.000*
1-2 prescriptions	36.7%	36.1%	37.0%	0.727
3-5 prescriptions	4.4%	9.1%	2.7%	*0.000*
6+ prescriptions	6.5%	11.9%	4.5%	*0.000*
Previous prescription medication	79.5%	86.5%	76.8%	*0.000*
Past or current Rx for opioids for pain	48.0%	52.3%	46.4%	*0.040*
Physical therapy	48.6%	54.4%	46.5%	*0.004*
Chiropractic	37.2%	42.3%	35.2%	*0.009*
Surgery	21.9%	22.3%	21.8%	0.804
Psychological counseling	20.7%	33.4%	16.0%	*0.000*
Acupuncture	19.6%	26.8%	16.9%	*0.000*
Therapeutic injection	15.0%	21.5%	12.6%	*0.000*
Other types of treatment	8.6%	11.1%	7.7%	*0.032*
Referrals for further evaluation and treatment				
Primary care provider	22.4%	22.6%	22.3%	0.900
Medical specialist	16.2%	16.2%	16.2%	0.977
Physical therapy	8.2%	7.1%	8.6%	0.327
Chiropractor	6.5%	3.8%	7.5%	*0.006*
Psychological counseling	5.6%	7.1%	5.0%	0.098
Acupuncture	1.8%	2.2%	1.6%	0.382
Homeopathy	0.2%	0.2%	0.2%	0.815
Biofeedback	0.1%	0.0%	0.1%	0.540

Note: P-values below 0.05 are printed in italics.

V. DISCUSSION

This study provides descriptive information from 1,655 applicants who sought to obtain a physician's recommendation for medical marijuana in California, the conditions for which they sought treatment, and the diagnoses made by the physicians. The most common diagnoses reported were for chronic pain, mental health conditions (primarily anxiety and depression), and sleep disorders

(insomnia). For physicians who make medical marijuana recommendations, the risk of being deceived is not dissimilar to the risk of deception faced by those who prescribe oxycodone and other painkillers; however, those prescribing the latter can limit the number of pills and refills.[6] For medical marijuana, existing laws and policies only allow physicians to make recommendations, they cannot control the number of purchases, what is purchased (e.g., % THC or other cannabinoid content), where it is purchased, or the route of administration (e.g., inhale smoke or vapor, ingest an edible, apply topically).

The majority of applicants reported that they tried other therapies, including prescription drugs, to manage their symptoms prior to seeking the medicinal allowance. Fifty percent of the sample reported that they used marijuana as a substitute for prescription medicine. This is consistent with other studies (e.g., Reiman, 2007; 2009) and raises important questions about the specific drugs they are replacing. Future research with this population should focus on previous and concurrent prescription medication use to examine claims that marijuana enables people to reduce or eliminate their use of prescription medications. These data could also be useful for understanding whether there could be cost-savings or quality of life gains associated with substituting certain prescription medicines with marijuana.

This also raises the issue about whether the legalization of marijuana for non-medicinal purposes would influence the consumption of prescription drugs. Not only would full-scale legalization increase the availability and reduce the price of marijuana (Kilmer et al., 2010), but the reduced stigma may increase the likelihood that some individuals try it for medicinal purposes. It could also be the case that doctors may be more willing to discuss marijuana use with patients if it was not prohibited.

Less than 5% of the applicants in our sample were diagnosed with HIV/AIDS, cancer, or glaucoma. While these were not the only diseases and conditions discussed when Proposition 215 was on the ballot, they did receive a lot of attention. This low figure is not surprising; we would expect the number of applicants presenting with HIV/AIDS, cancer, or glaucoma to be relatively low compared to the number presenting with pain, anxiety, and insomnia, due to the relative prevalence of these conditions in the general population. However, it is also important to note that many of those receiving recommendations did so for conditions other than those listed by the IOM.

Finally, the age profile observed in the sample of applicants is intriguing, especially when compared with those who report purchasing marijuana in the previous month in the 2006 NSDUH. One should not assume the larger median age for these applicants is statistically meaningful given sampling differences and

[6] However, doctors prescribing oxycodone cannot prevent patients from crushing the pill to deactivate the time-release functionality and then snorting or injecting it.

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the fact that our sample is drawn exclusively from California. However, if these age differences appear in future studies, it could offer important insight about age-related risk aversion and/or age-specific access to distribution networks—each with different policy implications. Thus, future work should explore the robustness of these differences and consider their implications for policy.

We conclude by reminding readers that we did not examine a randomly-selected representative sample of all individuals in California seeking a medical recommendation for the use of marijuana. We were merely able to collect data from a sample of individuals who presented themselves within a three month window to a group of doctors that they most likely expected would be willing to provide them with a recommendation. The applicants receiving recommendations from these doctors may differ from those in the general population in important ways that we are unable to know. As applicants receiving physician recommendations are not required by law to register with county or state health officials, we have no way of knowing the extent to which the population served by this particular physician group might differ from that served by other medical marijuana specialists or by primary care physicians. Knowledge about the number and type of individuals that receive recommendations from other specialists or from primary care physicians would improve our understanding of medical marijuana users in California.

Since California law allows for medical marijuana use for any "illness for which marijuana provides relief," we have an enormous opportunity to further our understanding of the risks and benefits of marijuana with careful questioning of some of the thousands of patients willing to discuss their use of marijuana. Detailed information about the doses, frequency, methods, and forms of marijuana consumed, as well as information about past and present alcohol, illicit drug, and prescription medication consumption would be of great interest.

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Summary by Condition by State

A summary of medical marijuana registrants and conditions by state by the New York City Comptroller's Office published in August 2013. The full report is available at: http://comptroller.nyc.gov/wp-content/uploads/2013/08/RegMarij_Summary_8-29b.pdf

APPENDIX: METHODOLOGY

There are approximately 1,030,887 registered medical marijuana patients (MMP) in the U.S. We arrived at this number using a combination of state-reported MMP registry data and estimates when those were unavailable. The Comptroller's office located 2012 or 2013 registry data that was reported by state agencies in eight states: Arizona, Colorado, Hawaii, Michigan, Montana, Nevada, Oregon, and Rhode Island. California and Washington do not have registries, and so these numbers were estimated by ProCon.org, a non-partisan nonprofit research group that attempts to present balanced information on controversial issues. For the remaining states, we were unable to find state-reported data and relied upon ProCon.org for numbers of medical marijuana patients, which were current as of December 2012.[49]

STATES THAT LEGALIZED MEDICAL MARIJUANA			
State	**Year**	**Population**	**Registered Patients**
California	1996	38,041,430	553,684
Alaska	1998	731,449	1,246
Oregon	1998	3,899,353	55,937
Washington	1998	6,897,012	99,943
Maine	1999	1,329,192	16,444
Colorado	2000	5,187,582	106,817
Hawaii	2000	1,392,313	11,183
Nevada	2000	2,758,931	4,173
Montana	2004	1,005,141	7,099
Vermont	2004	626,011	559
Rhode Island	2006	1,050,292	4,849
New Mexico	2007	2,085,538	8,188
Michigan	2008	9,883,360	124,131
Arizona	2010	6,553,255	36,634
Subtotal		**81,440,859**	**1,030,887**
DC	2010	632,323	N/A
New Jersey	2010	8,864,590	N/A
Delaware	2011	917,092	N/A
Connecticut	2012	3,590,347	N/A
Massachusetts	2012	6,646,144	N/A
Illinois	2013	12,875,255	N/A
New Hampshire	2013	1,320,718	N/A
20 States + D.C. TOTALS		**116,287,328**	**1,030,887**

Source: Census Bureau; ProCon.org; Arizona Medical Marijuana Act, Monthly Report, 2013; Colorado Department of Health; Hawaii Department of Public Safety, Annual 2012 Report; Michigan Department of Health; Montana Marijuana Program May 2013 Registry Information; Nevada Health Division, Medical Marijuana Program; Oregon Health Authority; and Rhode Island Department of Health.

49 ProCon.org, "Medical Marijuana, How Many People in the United States Use Medical Marijuana," last updated December 2012, http://medicalmarijuana.procon.org/view.answers.php?questionID=001199, accessed on August 20, 2013.

Although medical marijuana legislation has passed in 20 states and the District of Columbia, our analysis includes only 14 states. We excluded D.C., New Hampshire, Illinois, Connecticut, Massachusetts, Delaware, and New Jersey, largely because they are new programs that have few or no patients. Delaware and New Jersey, which ProCon.org reports have 21 and 239 MMP respectively, are excluded because, as previously noted, their programs have experienced significant hurdles, greatly limiting the number of people who can access medical marijuana. New Hampshire and Illinois just passed medical marijuana in 2013. Connecticut and Massachusetts passed their laws in 2012. D.C. legalized medical marijuana in 2010, but its first medical marijuana patient just received the drug in July 2013.[50]

According to the Census Bureau 2012 population estimates, there are 81,440,859 people living in the 14 states we examined. To estimate the MMP population in NYC if medical marijuana were to be legalized, we created a ratio of MMPs to the general population in those 14 states: 1,030,887/81,440,859 = 1.27 percent. Applying this rate to the City's estimated 8,336,697 residents yields 105,527 New Yorkers that would likely register for medical marijuana today.

ESTIMATING NYC'S POTENTIAL MEDICAL MARIJUANA PATIENTS (MMPS)	
14 states	
Total Population	81,440,859
MMPs	1,030,887
Rate	1.27%
NYC	
Total Population	8,336,697
MMP Estimate	**105,527**

Certain states provide detailed reporting of registered medical marijuana patients by condition. The table below presents the number of patients registered to receive medical marijuana for each recognized condition in Arizona, Colorado, Hawaii, Michigan, Montana, Nevada, Oregon, and Rhode Island. For each state, we include each condition's share of that state's registered MMPs. For instance, in Colorado, 93.7 percent of MMPs are registered for chronic pain. The eight states generally report the same categories, although Montana lumps all cancer, glaucoma, and HIV/AIDS patients into single category.

50 DeBonis, Mike, "D.C. Records its First Pot Deal in at least 75 Years," *D.C. Politics*, July 29, 2013. http://www.washingtonpost.com/local/dc-politics/dc-records-its-first-legal-pot-deal-in-at-least-75-years/2013/07/29/17521b42-f889-11e2-b018-5b8251f0c56e_story.html, accessed on August 21, 2013.

NUMBER OF REGISTERED MEDICAL MARIJUANA PATIENTS FOR REPORTED CONDITIONS AND SHARE OF STATE'S PATIENTS REPORTING EACH CONDITION																	ESTIMATES	
	Arizona		Colorado		Hawaii		Michigan		Montana		Nevada		Oregon		Rhode Island		Ave. share	NYC
Chronic or severe pain	26,039	89.5%	100,112	93.7%	6,817	90.7%	79,313	66.0%	4,503	63.4%	3,808	91.3%	54,342	97.1%	3,504	72.3%	83.0%	87,594
Muscle spasms (including MS*)	543	1.5%	15,664	14.7%	156	2.1%	22,250	18.5%	118	1.7%	924	22.1%	14,990	26.8%	1,393	28.7%	14.5%	15,311
Severe Nausea	357	1.0%	11,216	10.5%	132	1.8%	9,084	7.6%	908	12.8%	719	17.2%	8,310	14.9%	858	17.7%	10.4%	10,996
Cancer	696	1.9%	2,843	2.7%	152	2.0%	2,526	2.1%			143	3.4%	2,332	4.2%	354	7.3%	3.4%	3,555
Seizures/epilepsy	255	0.7%	1,824	1.7%	48	0.6%	1,414	1.2%	207	2.9%	100	2.4%	1,362	2.4%	125	2.6%	1.8%	1,919
Wasting Syndrome (Cachexia)	40	0.1%	1,137	1.1%	46	0.6%	1,273	1.1%	405	5.7%	145	3.5%	1,063	1.9%	265	5.5%	2.4%	2,558
HIV/AIDS	186	0.5%	638	0.6%	72	1.0%	556	0.5%			57	1.4%	690	1.2%	146	3.0%	1.2%	1,227
Glaucoma	324	0.9%	1,070	1.0%	92	1.2%	1,112	0.9%			77	1.8%	911	1.6%	85	1.8%	1.3%	1,396
Hepatitis C	655	1.8%					1,617	1.3%							291	6.0%	3.0%	3,213
Other**	7,539		0		3,649		2,593		1,858				56		1,023	21.1%		
TOTAL PATIENTS	36,634		106,817		11,183		124,131		7,099		4,173		55,937		4,849		105,527	

Sources: Arizona Medical Marijuana Act, Monthly Report, 2013; Colorado Department of Health; Hawaii Department of Public Safety, Annual 2012 Report; Michigan Department of Health; Montana Marijuana Program May 2013 Registry Information; Nevada Health Division, Medical Marijuana Program; Oregon Health Authority; and Rhode Island Department of Health.

** "MS" means multiple sclerosis*

*** "Other" includes illnesses that were not reported in all states, such as Alzheimer's, Crohn's Disease, painful peripheral neuropathy, Central Nervous System disorder with pain, Admittance to hospice, ALS, Nail Patela, and a category for "Two or More Conditions." For Rhode Island, "other" also includes diagnoses that were not entered in the license system.*

ADDITONAL NOTES: Michigan's total number of patients in FY2012 was not reported outright. The report shows that adding patients by county yields 124,131 non-minor patients, but adding patients by condition yields 120,121. We use the lower count to calculate percentages in the table, but present the 124,131 as the total number of patients in this table and to calculate total MMPs in the 14 states. Similarly, in Hawaii, the reported total of 11,183 is higher than the sum of the reported conditions (11,164). The Annual Report that presents this information makes no attempt to explain the difference.

Some reporting differences among state are worth noting. Arizona and Hawaii report the number of people registered with multiple conditions (7,338 and 3,648, respectively), but do not distribute them among the different categories. Therefore, we calculated the share of MMPs registered for each condition without including the patients with two or more conditions. For instance, in Arizona, 88.9 percent of registered patients for which conditions are reported have chronic pain, or 26,039 divided by 29,095, which is the sum of patients in each category listed. Colorado, Montana, Nevada, Oregon, and Rhode Island do not separate out the number of patients registered for multiple conditions, so we were able to determine the share of patients for each condition by dividing by the total number of patients. These states count each patient under multiple conditions if they are registered for more than one, so the total number of patients is less than the sum of all conditions. Michigan only appears to report each patient once.

On the right side of the table we present an average across the eight states for the share that each condition comprises of the MMP population. We then apply these average rates to our estimate of patients who would register for medical marijuana in NYC: 105,527. These rough estimates suggest that more than 87,000 New Yorkers suffering from chronic pain and more than 15,000 New Yorkers with muscle spasms, including multiple sclerosis, could benefit from medical marijuana.

Summaries by State from Various Organizations

A listing of states with medical marijuana laws from the National Conference of State Legislatures.

A listing of states with medical marijuana laws from the National Conference of State Legislatures (NCSL), updated September 2015.

STATE MEDICAL MARIJUANA LAWS

8/11/2015

In 1996, California voters passed Proposition 215, making the Golden State the first in the union to allow for the medical use of marijuana. Since then, 22 more states, the District of Columbia and Guam have enacted similar laws.

A total of 23 states, the District of Columbia and Guam now allow for comprehensive public medical marijuana and cannabis programs. Recently approved efforts in 17 states allow use of "low THC, high cannabidiol (CBD)" products for medical reasons in limited situations or as a legal defense. Those programs are not counted as comprehensive medical marijuana programs but are listed in Table 2. NCSL uses criteria similar to other organizations to determine if a program is "comprehensive":

1. Protection from criminal penalties for using marijuana for a medical purpose;
2. Access to marijuana through home cultivation, dispensaries or some other system that is likely to be implemented;
3. It allows a variety of strains, including those more than "low THC;" and
4. It allows either smoking or vaporization of some kind of marijuana products, plant material or extract.

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Medical Uses of Marijuana

In response to California's Prop 215, the Institute of Medicine issued a report that examined potential therapeutic uses for marijuana. 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.[1]

State vs Federal Perspective

At the federal level, marijuana 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 marijuana a federal offense. In October of 2009, the Obama Administration sent a memo to federal prosecutors encouraging them not to prosecute people who distribute marijuana 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 reads that while marijuana 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.

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 marijuana. Since marijuana is still a Schedule I substance, federal law prohibits its prescription, making the initiative invalid. Medical marijuana

NAVIGATE

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"prescriptions" are more often called "recommendations" or "referrals" because of the federal prescription prohibition.

States with medical marijuana laws generally have some form of patient registry, which may provide some protection against arrest for possession up to a certain amount of marijuana for personal medicinal use.

Some of the most common policy questions regarding medical marijuana include how to regulate its recommendation, dispensing, and registration of approved patients. Some states and localities without dispensary regulation are experiencing a boom in new businesses, in hopes of being approved before presumably stricter regulations are made. Medical marijuana growers or dispensaries are often called "caregivers" and may be limited to a certain number of plants or products 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	Statutory Language (year)	Patient Registry or ID cards	Allows Dispensaries	Specifies Conditions	Recognizes Patients from other states	State Allows for Retail Sales/Adult Use
Alaska	Measure 8 (1998) SB 94 (1999) Statute Title 17, Chapter 37	Yes	No	Yes		Ballot Measure 2 (2014) Not yet operational
Arizona	Proposition 203 (2010)	Yes	Yes	Yes	Yes	
California	Proposition 215 (1996) SB 420 (2003)	Yes	Yes (cooperatives and collectives)	No		
Colorado Medical program info Adult-use info	Amendment 20 (2000)	Yes	Yes	Yes	No	Amendment 64 (2012) Task Force Implementation Recommendations (2013) Analysis of CO Amendment 64 (2013) Colorado Marijuana Sales and Tax Reports 2014 "Edibles" regulation measure
Connecticut	HB 5387 (2012)	Yes	Yes	Yes		
Delaware	SB 17 (2011)	Yes	Yes	Yes	Yes	
District of Columbia	Initiative 59 (1998) L18-0210 (2010)	Yes	Yes	Yes		Initiative 71 (2014) Pending Congressional review and not yet operational
Guam	Proposal 14A Approved in Nov. 2014, not yet operational.	Yes	Yes	Yes	No	
Hawaii	SB 862 (2000)	Yes	No	Yes		
Illinois	HB 1 (2013) *Eff. 1/1/2014* Proposed rules as of April, 2014	Yes	Yes	Yes	No	
Maine	Question 2 (1999) LD 611 (2002) Question 5 (2009) LD 1811 (2010) LD 1296 (2011)	Yes	Yes	Yes	Yes	
Maryland	HB 702 (2003) SB 308 (2011) HB 180/SB 580 (2013) HB 1101-	Yes	Yes	Yes		

	Chapter 403 (2013) SB 923 (signed 4/14/14) HB 881- similar to SB 923					
Massachusetts	Question 3 (2012) Regulations (2013)	Yes	Yes	Yes		
Michigan	Proposal 1 (2008)	Yes	Not in state law, but localities may create ordinances to allow them and regulate them.	Yes	Yes	
Minnesota	SF 2471, Chapter 311 (2014)	Yes	Yes, limited, liquid extract products only	Yes		
Montana	Initiative 148 (2004) SB 423 (2011)	Yes	No**	Yes	No	
Nevada	Question 9 (2000) NRS 453A NAC 453A	Yes	No	Yes		
New Hampshire	HB 573 (2013)	Yes	Yes	Yes	Yes, with a note from their home state, but they cannot purchase or grow their own in NH.	
New Jersey	SB 119 (2009) Program information	Yes	Yes	Yes		
New Mexico	SB 523 (2007) Medical Cannabis Program	Yes	Yes	Yes		
New York	A6357 (2014) Signed by governor 7/5/14	Yes	Ingested doses may not contain more than 10 mg of THC, product may not be combusted (smoked).	Yes		
Oregon	Oregon Medical Marijuana Act (1998) SB 161 (2007)	Yes	No	Yes		Measure 91 (2014) Not yet operational
Rhode Island	SB 791 (2007) SB 185 (2009)	Yes	Yes	Yes	Yes	
Vermont	SB 76 (2004) SB 7 (2007) SB 17 (2011)	Yes	Yes	Yes		
Washington	Initiative 692(1998) SB 5798 (2010) SB 5073 (2011)	No	Yes, approved as of Nov. 2012, stores opened in July, 2014.	Yes		Initiative 502 (2012) WAC Marijuana rules: Chapter 314-55 WAC

*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.

** While Montana's revised medical marijuana law limits caregivers to three patients, caregivers may serve an unlimited number of patients due to an injunction issued on January 16, 2013.

TABLE 2. LIMITED ACCESS MARIJUANA 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	Defintion of Products Allowed	Allows for Legal Defense	Allowed for Minors
Alabama	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. **Not operational as of April, 2015.**		Only the Univ. Alabama Birmingham is allowed to dispense FDA-approved trial products with the proper permissions.	Yes, debilitating epileptic conditions or life-threatening seizures.	No	Extracts that are low THC= below 3% THC	Yes	Yes
Florida	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 clinical research program that meets FDA trial compliance.	Yes, end stage cancer, ALS, MS, seizure disorders, Crohn's, mitochondrial disease, Parkinson's, Sickle Cell disease	No	Cannabis oils with low THC= below 5% THC and at least an equal amount of CDB.	Yes	Yes
Iowa	SF 2360, Medical Cannabidiol Act of 2014 (Effective 7/1/14)	Yes	Doesn't define or provide in-state methods of access or production.	Yes, intractable epilepsy	No	"Cannabidiol- a non-psychoactive cannabinoid" that contains below 3% THC, no more than 32 oz, and essentially free from plant material.	Yes	Yes
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, fibroymyalgia, 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
Kentucky	SB 124 (2014) Clara Madeline Gilliam Act Exempt cannabidiol from the definition of marijuana and allows it to be administerd by a public university or school of medicine in Kentucky for clinical	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".		

	trial or expanded access program approved by the FDA.							
Louisiana	SB 143 The "Alison Neustrom Act"		Louisiana State Univ. and the Southern Univ. Agricultural Center have the right of first refusal to be the licensed production facility. If they pass, it opens up to a competitive bid process.	Yes	No	"THC shall be reduced to the lowest acceptable therapeutic levels available through scientifically acceptable methods."	Yes	Yes
Mississippi	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 an authorized patient or guardian	Yes
Missouri	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 Treatment Act- Pilot Study	Yes	University research studies with a hemp extract registration card from the state DHHS or obtained from another jurisdiction that allows removal of the products from the state.	Yes, intractable epilepsy	No	"Hemp extracts" with less than three-tenths of one percent (0.3%) tetrahydrocannabinol (THC) by weight. Is composed of at least ten percent (10%) cannabidiol by weight. Contains no other psychoactive substance.	Yes	Yes
Oklahoma	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 allow patients and caregivers 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 least 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

			produce their own products.					
Tennessee	SB 2531 (2014) Creates a four-year study of high CBD/low THC marijuana at TN Tech Univ. HB 197 (2015)	Researchers need to track patient information and outcomes No	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. Allows for legal defense for having the product as long as it was obtained legally in the US or other medical marijuana state.	Yes, intractable seizure conditions. Yes, intractable seizure conditions.	No No	"Cannabis oil" with less than .9% THC as part of a clinical research study Same as above.	Yes	Yes
Texas	SB 339 (2015) Texas Compassionate Use Act	Yes	Yes, licensed by the Department of Public Safety.	Yes, intractable epilepsy.	No	"Low-THC Cannabis" with not more than 0.5 percent by weight of tetrahydrocannabinols; and not less than 10 percent by weight of cannabidiol	Yes	Yes
Utah	HB 105 (2014) Hemp Extract Registration Act	Yes	Not completely clear, however it may allows higher education institution to grow or cultivate industrial hemp	Yes, intractable epilepsy that hasn't responded to three or more treatment options suggested by 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	HB 1445	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 marijuana 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.*

Additional Resources

Comparisons of programs

Comparison of all state medical marijuana programs with contact information. Prepared by the Network for Public Health Law as of June 2014

"State-by-State Medical Marijuana Laws" Marijuana Policy Project, 2014

Finances/Tax information

"State Medical Marijuana Programs' Financial Information," Marijuana Policy Project, July 2013

Colorado Marijuana Sales and Tax Reports (updated monthly)

Washington State Sales and Tax Information (updated weekly)

"Taxing Marijuana: The Washington and Colorado Experience," Tax Foundation, August 2014

Law enforcement/crime information

"What Law Enforcement Can Learn from Marijuana Legalization in Colorado," Prepared by American Military University, March, 2015

Statement by ONDCP Director Gil Kerlikowske regarding Federal guidelines for medical marijuana prosecution

Medical marijuana research and reports

"Marijuana and Medicine: Assessing the Science Base," Institute of Medicine, 1999

Treatment Research Institute's (TRI) policy position statement regarding medical marijuana

ProCon.org's resources on medical marijuana. Medical Marijuana ProCon.org presents laws, studies, statistics, surveys, government reports, and pro and con statements on questions related to marijuana as medicine.

"Exposing the Myth of Smoked Medical Marijuana," U.S. Drug Enforcement Administration

"State-by-State Medical Marijuana Laws" Marijuana Policy Project, 2014

"Becoming a State-Authorized Patient," Americans for Safe Access

DEA: Pharmaceutical products already exist; they are called Marinol and Cesamet

Retail/Adult Use information and news

"State Legalization of **Recreational** Marijuana: Selected Legal Issues." Congressional Research Service, April 2013

Analysis of CO Amendment 64 (rec use initiative) by Colorado State University, April 2013

Colorado Marijuana Sales and Tax Reports

Colorado Marijuana Enforcement Division Annual Update, February 2015

Public Health Law Research Law Atlas: Recreational Marijuana Laws - Interactive Map

Brookings Institution: Colorado's Rollout of Legal Marijuana Is Succeeding

Public health and youth information

Marijuana Joins Smoke-Free Laws, *State Legislatures*, March 2013

Regulating Recreational Use of Marijuana and the Role of Public Health Law Prepared by the Network for Public Health Law

Marijuana Impact on Public Health and Safety in Colorado: conference by CO Association of Chiefs of Police, January 14-16, 2015

Smart Colorado: Protecting youth from marijuana

Interest groups and position statements

SAM: Smart Approaches to Marijuana

Smart Colorado: Protecting youth from marijuana

Treatment Research Institute's (TRI) policy position statement regarding medical marijuana

National Families in Action: Marijuana Studies Program "Marijuana Report"

Marijuana Majority

"State-by-State Medical Marijuana Laws" Marijuana Policy Project, 2014

Key Aspects of State and DC Medical Marijuana Laws, Marijuana Policy Project, 2013

"Becoming a State-Authorized Patient," Americans for Safe Access

Summaries by State from Various Organizations

A listing of states with medical marijuana laws from ProCon.org.

A listing of states with medical marijuana laws from ProCon.org, updated September 2015.

Medical Marijuana
ProCon.org

Last updated on: 7/1/2015 4:32:52 PM PST

23 Legal Medical Marijuana States and DC

Laws, Fees, and Possession Limits

I. Summary Chart II. Details by State III. Sources

I. Summary Chart: 23 states and DC have enacted laws to legalize medical marijuana

State	Year Passed	How Passed (Yes Vote)	Possession Limit
1. Alaska	1998	Ballot Measure 8 (58%)	1 oz usable; 6 plants (3 mature, 3 immature)
2. Arizona	2010	Proposition 203 (50.13%)	2.5 oz usable; 0-12 plants
3. California	1996	Proposition 215 (56%)	8 oz usable; 6 mature or 12 immature plants
4. Colorado	2000	Ballot Amendment 20 (54%)	2 oz usable; 6 plants (3 mature, 3 immature)
5. Connecticut	2012	House Bill 5389 (96-51 H, 21-13 S)	One-month supply (exact amount to be determined)
6. DC	2010	Amendment Act B18-622 (13-0 vote)	2 oz dried; limits on other forms to be determined
7. Delaware	2011	Senate Bill 17 (27-14 H, 17-4 S)	6 oz usable
8. Hawaii	2000	Senate Bill 862 (32-18 H; 13-12 S)	3 oz usable; 7 plants (3 mature, 4 immature)
9. Illinois	2013	House Bill 1 (61-57 H; 35-21 S)	2.5 ounces of usable cannabis during a period of 14 days
10. Maine	1999	Ballot Question 2 (61%)	2.5 oz usable; 6 plants
11. Maryland	2014	House Bill 881 (125-11 H; 44-2 S)	30-day supply, amount to be determined
12. Massachusetts	2012	Ballot Question 3 (63%)	60-day supply for personal medical use
13. Michigan	2008	Proposal 1 (63%)	2.5 oz usable; 12 plants
14. Minnesota	2014	Senate Bill 2470 (46-16 S; 89-40 H)	30-day supply of non-smokable marijuana
15. Montana	2004	Initiative 148 (62%)	1 oz usable; 4 plants (mature); 12 seedlings
16. Nevada	2000	Ballot Question 9 (65%)	1 oz usable; 7 plants (3 mature, 4 immature)
17. New Hampshire	2013	House Bill 573 (284-66 H; 18-6 S)	Two ounces of usable cannabis during a 10-day period
18. New Jersey	2010	Senate Bill 119 (48-14 H; 25-13 S)	2 oz usable
19. New Mexico	2007	Senate Bill 523 (36-31 H; 32-3 S)	6 oz usable; 16 plants (4 mature, 12 immature)
20. New York	2014	Assembly Bill 6357 (117-13 A; 49-10 S)	30-day supply non-smokable marijuana
21. Oregon	1998	Ballot Measure 67 (55%)	24 oz usable; 24 plants (6 mature, 18 immature)
22. Rhode Island	2006	Senate Bill 0710 (52-10 H; 33-1 S)	2.5 oz usable; 12 plants
23. Vermont	2004	Senate Bill 76 (22-7) HB 645 (82-59)	2 oz usable; 9 plants (2 mature, 7 immature)
24. Washington	1998	Initiative 692 (59%)	24 oz usable; 15 plants

Notes: (click to expand)

a. Residency Requirement

b. Home Cultivation

c. Patient Registration: Mandatory vs. Voluntary

d. Cannabidiol (CBD) Bills (Alabama, Delaware, Florida, Georgia, Iowa, Kentucky, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Utah, Virginia, Wisconsin)

e. Maryland Laws Prior to Legalization

f. United States Attorneys' Letters to Legal States

g. Symbolic Medical Marijuana Laws, 1979-1991 and 2015

II. Details by State: 23 states and DC that have enacted laws to legalize medical marijuana	
State and Relevant Medical Marijuana Laws	**Contact and Program Details**
1. Alaska **Ballot Measure 8** (100 KB) -- Approved Nov. 3, 1998 by 58% of voters **Effective:** Mar. 4, 1999 Removed state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess written documentation from their physician advising that they "might benefit from the medical use of marijuana." **Approved Conditions:** Cachexia, cancer, chronic pain, epilepsy and other disorders characterized by seizures, glaucoma, HIV or AIDS, multiple sclerosis and other disorders characterized by muscle spasticity, and nausea. Other conditions are subject to approval by the Alaska Department of Health and Social Services. **Possession/Cultivation:** Patients (or their primary caregivers) may legally possess no more than one ounce of usable marijuana, and may cultivate no more than six marijuana plants, of which no more than three may be mature. The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients. **Amended**: **Senate Bill 94** (40 KB) **Effective:** June 2, 1999 Mandates all patients seeking legal protection under this act to enroll in the state patient registry and possess a valid identification card. Patients not enrolled in the registry will no longer be able to argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges. **Update:** Alaska Statute Title 17 Chapter 37 (36 KB) Creates a confidential statewide registry of medical marijuana patients and caregivers and establishes identification card.	**Alaska Bureau of Vital Statistics** Marijuana Registry P.O. Box 110699 Juneau, AK 99811-0699 Phone: 907-465-5423 BVSSpecialServices@health.state.ak.us **Website:** AK Marijuana Registry Online **Information provided by the state on sources for medical marijuana:** No information is provided **Patient Registry Fee:** $25 new application/$20 renewal **Accepts other states' registry ID cards?** No **Registration:** Mandatory
2. Arizona **Ballot Proposition 203** (300 KB) "Arizona Medical Marijuana Act" -- Approved Nov. 2, 2010 by 50.13% of voters Allows registered qualifying patients (who must have a physician's written certification that they have been diagnosed with a debilitating condition and that they would likely receive benefit from marijuana) to obtain marijuana from a registered nonprofit dispensary, and to possess and use medical marijuana to treat the condition.	**Arizona Department of Health Services (ADHS)** Medical Marijuana Program 150 North 18th Avenue Phoenix, Arizona 85007 Phone: 602-542-1025 **Website:** Arizona Medical Marijuana Program **Information provided by the state on sources for medical marijuana:** "Qualifying patients can obtain medical marijuana from a

Requires the Arizona Department of Health Services to establish a registration and renewal application system for patients and nonprofit dispensaries. Requires a web-based verification system for law enforcement and dispensaries to verify registry identification cards. Allows certification of a number of dispensaries not to exceed 10% of the number of pharmacies in the state (which would cap the number of dispensaries around 124).

Specifies that a registered patient's use of medical marijuana is to be considered equivalent to the use of any other medication under the direction of a physician and does not disqualify a patient from medical care, including organ transplants.

Specifies that employers may not discriminate against registered patients unless that employer would lose money or licensing under federal law. Employers also may not penalize registered patients solely for testing positive for marijuana in drug tests, although the law does not authorize patients to use, possess, or be impaired by marijuana on the employment premises or during the hours of employment.

Approved Conditions: Cancer, glaucoma, HIV/AIDS, Hepatitis C, ALS, Crohn's disease, Alzheimer's disease, cachexia or wasting syndrome, severe and chronic pain, severe nausea, seizures (including epilepsy), severe or persistent muscle spasms (including multiple sclerosis). Starting Jan.1, 2015, PTSD will be added to the list.

Possession/Cultivation: Qualified patients or their registered designated caregivers may obtain up to 2.5 ounces of marijuana in a 14-day period from a registered nonprofit medical marijuana dispensary.If the patient lives more than 25 miles from the nearest dispensary, the patient or caregiver may cultivate up to 12 marijuana plants in an enclosed, locked facility.

Amended: Senate Bill 1443 (20 KB)
Effective: Signed by Governor Jan Brewer on May 7, 2013
"Specifies the prohibition to possess or use marijuana on a postsecondary educational institution campus does not apply to medical research projects involving marijuana that are conducted on the campus, as authorized by applicable federal approvals and on approval of the applicable university institutional review board."

[**Editor's Note:** On Apr. 11, 2012, the Arizona Department of Health Services (ADHS) announced the revised rules (1.1 MB) for regulating medical marijuana and set the application dates for May 14 through May 25.

On Nov. 15, 2012, the first dispensary was awarded "approval to operate." ADHS Director Will Humble stated on his blog that, "[W]e'll be declining new 'requests to cultivate' among new cardholders in most of the metro area… because self-grow (12 plants) is only allowed when the patient lives more than 25 miles from the nearest dispensary. The vast majority of the Valley is within 25 miles of this new dispensary."

On Dec. 6, 2012, the state's first dispensary, Arizona Organix, opened in Glendale.]

dispensary, the qualifying patient's designated caregiver, another qualifying patient, or, if authorized to cultivate, from home cultivation. When a qualifying patient obtains or renews a registry identification card, the Department will provide a list of all operating dispensaries to the qualifying patient."
ADHS, "Qualifying Patients FAQs," (150 KB) Mar. 25, 2010

Patient Registry Fee:
$150 / $75 for Supplemental Nutrition Assistance Program participants

Accepts other states' registry ID cards?
Yes, but does not permit visiting patients to obtain marijuana from an Arizona dispensary

Registration:
Mandatory

3. California

Ballot Proposition 215 (45 KB) -- Approved Nov. 5, 1996 by 56% of voters
Effective: Nov. 6, 1996

California Department of Public Health
Public Health Policy and Research Branch
Attention: Medical Marijuana Program Unit
MS 5202
P.O. Box 997377

Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess a "written or oral recommendation" from their physician that he or she "would benefit from medical marijuana." Patients diagnosed with any debilitating illness where the medical use of marijuana has been "deemed appropriate and has been recommended by a physician" are afforded legal protection under this act.

Approved Conditions: AIDS, anorexia, arthritis, cachexia, cancer, chronic pain, glaucoma, migraine, persistent muscle spasms, including spasms associated with multiple sclerosis, seizures, including seizures associated with epilepsy, severe nausea; Other chronic or persistent medical symptoms.

Amended: Senate Bill 420 (70 KB)
Effective: Jan. 1, 2004

Imposes statewide guidelines outlining how much medicinal marijuana patients may grow and possess.

Possession/Cultivation: Qualified patients and their primary caregivers may possess no more than eight ounces of dried marijuana and/or six mature (or 12 immature) marijuana plants. However, S.B. 420 allows patients to possess larger amounts of marijuana when recommended by a physician. The legislation also allows counties and municipalities to approve and/or maintain local ordinances permitting patients to possess larger quantities of medicinal pot than allowed under the new state guidelines.

S.B. 420 also grants implied legal protection to the state's medicinal marijuana dispensaries, stating, "Qualified patients, persons with valid identification cards, and the designated primary caregivers of qualified patients ... who associate within the state of California in order collectively or cooperatively to cultivate marijuana for medical purposes, shall not solely on the basis of that fact be subject to state criminal sanctions."

Challenge to Possession Limits: On Jan. 21, 2010, the California Supreme Court affirmed (S164830 (300 KB)) the May 22, 2008 Second District Court of Appeals ruling (50 KB) in the Kelly Case that the possession limits set by SB 420 violate the California constitution because the voter-approved Prop. 215 can only be amended by the voters.

ProCon.org contacted the California Medical Marijuana Program (MMP) on Dec. 6, 2010 to ask 1) how the ruling affected the implementation of the program, and 2) what instructions are given to patients regarding possession limits. A California Department of Public Health (CDPH) Office of Public Affairs representative wrote the following in a Dec. 7, 2010 email to ProCon.org: "The role of MMP under Senate Bill 420 is to implement the State Medical Marijuana ID Card Program in all California counties. CDPH does not oversee the amounts that a patient may possess or grow. When asked what a patient can possess, patients are referred to www.courtinfo.ca.gov, case S164830 which is the Kelly case, changing the amounts a patient can possess from 8 oz, 6 mature plants or 12 immature plants to 'the amount needed for a patient's personal use.' MMP can only cite what the law says."

According to a Jan. 21, 2010 article titled "California Supreme Court Further Clarifies Medical Marijuana Laws," by Aaron Smith, California Policy Director at the Marijuana Policy Project, the impact of the ruling is that people growing more than 6 mature or 12 immature plants are still subject to arrest and prosecution, but they will be allowed to use a medical

Sacramento, CA 95899-7377
Phone: 916-552-8600
Fax: 916-440-5591

mmpinfo@cdph.ca.gov

Website:
CA Medical Marijuana Program

Guidelines for the Security and Non-diversion of Marijuana Grown for Medical Use (55 KB)

Information provided by the state on sources for medical marijuana:
"The MMP is not authorized to provide information on acquiring marijuana or other related products." "Medical Marijuana Program Frequently Asked Questions," cdph.ca.gov(accessed Apr. 24, 2014)

"The California Department of Public Health administers the Medical Marijuana Identification Card (MMIC) program only and does not have any information regarding dispensaries, growing collectives, etc…" "Dispensaries, Cooperatives and Collectives," cdph.ca.gov(accessed Apr. 24, 2014)

Patient Registry Fee:
$66 non Medi-Cal / $33 Medi-Cal, plus additional county fees (varies by location)

Accepts other states' registry ID cards?
No

Registration:
Voluntary

necessity defense in court.]

Attorney General's Guidelines:
On Aug. 25, 2008, California Attorney General Jerry Brown issued guidelines for law enforcement and medical marijuana patients to clarify the state's laws. Read more about the guidelines here.

4. Colorado

Ballot Amendment 20 -- Approved Nov. 7, 2000 by 54% of voters
Effective: June 1, 2001

Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess written documentation from their physician affirming that he or she suffers from a debilitating condition and advising that they "might benefit from the medical use of marijuana." (Patients must possess this documentation prior to an arrest.)

Approved Conditions: Cancer, glaucoma, HIV/AIDS positive, cachexia; severe pain; severe nausea; seizures, including those that are characteristic of epilepsy; or persistent muscle spasms, including those that are characteristic of multiple sclerosis. Other conditions are subject to approval by the Colorado Board of Health.

Possession/Cultivation: A patient or a primary caregiver who has been issued a Medical Marijuana Registry identification card may possess no more than two ounces of a usable form of marijuana and not more than six marijuana plants, with three or fewer being mature, flowering plants that are producing a usable form of marijuana.

Patients who do not join the registry or possess greater amounts of marijuana than allowed by law may argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges.

Amended: House Bill 1284 (236 KB) and Senate Bill 109 (50 KB)
Effective: June 7, 2010

Colorado Governor Bill Ritter signed the bills into law and stated the following in a June 7, 2010 press release:

"House Bill 1284 provides a regulatory framework for dispensaries, including giving local communities the ability to ban or place sensible and much-needed controls on the operation, location and ownership of these establishments.

Senate Bill 109 will help prevent fraud and abuse, ensuring that physicians who authorize medical marijuana for their patients actually perform a physical exam, do not have a DEA flag on their medical license and do not have a financial relationship with a dispensary."

Medical Marijuana Registry
Colorado Department of Public Health and Environment
HSV-8608
4300 Cherry Creek Drive South
Denver, CO 80246-1530
Phone: 303-692-2184

medical.marijuana@state.co.us

Website:
CO Medical Marijuana Registry

Information provided by the state on sources for medical marijuana:
The Marijuana Enforcement Division (MED) website provides a list of licensed Medical Marijuana Centers, which are retail operations "from which Medical Marijuana Registry patients purchase Medical Marijuana and Medical Marijuana infused products." MED "is responsible for the regulation of both the Medical and Retail Marijuana industries, each of which have separate and distinct statute and rules under which they operate."
"Medical Marijuana Licensing Information," colorado.gov/revenue/med (accessed Feb. 26, 2014)
"Licensing Information," colorado.gov/revenue/med (accessed Feb. 26, 2014)

Patient Registry Fee:
$15 (effective Feb. 1, 2014)

Accepts other states' registry ID cards?
No

Registration:
Mandatory

5. Connecticut

HB 5389 (310 KB) -- Signed into law by Gov. Dannel P. Malloy (D) on May 31, 2012
Approved: By House 96-51, by Senate 21-13
Effective: Some sections from passage (May 4, 2012), other sections on Oct. 1, 2012

"A qualifying patient shall register with the Department of Consumer Protection... prior to engaging in the palliative use

Medical Marijuana Program
Department of Consumer Protection (DCP)
165 Capitol Avenue, Room 145
Hartford, CT 06106
Phone: 860-713-6006
Toll-Free: 800-842-2649

dcp.mmp@ct.gov

Website:

of marijuana. A qualifying patient who has a valid registration certificate... shall not be subject to arrest or prosecution, penalized in any manner,... or denied any right or privilege."

Patients must be Connecticut residents at least 18 years of age. "Prison inmates, or others under the supervision of the Department of Corrections, would not qualify, regardless of their medical condition."

Approved Conditions: "Cancer, glaucoma, positive status for human immunodeficiency virus or acquired immune deficiency syndrome [HIV/AIDS], Parkinson's disease, multiple sclerosis, damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity, epilepsy, cachexia, wasting syndrome, Crohn's disease, posttraumatic stress disorder, or... any medical condition, medical treatment or disease approved by the Department of Consumer Protection..."

Possession/Cultivation: Qualifying patients may possess "an amount of usable marijuana reasonably necessary to ensure uninterrupted availability for a period of one month, as determined by the Department of Consumer Protection."

Updates: The Connecticut Medical Marijuana Program website posted an update on Sep. 23, 2012 with instructions on how to register for the program starting on Oct. 1, 2012. "Patients who are currently receiving medical treatment for a debilitating medical conditions set out in the law may qualify for a temporary registration certificate beginning October 1, 2012. To qualify, a patient must also be at least 18 years of age and a Connecticut resident."

Draft Regulations on Medical Marijuana (482 KB) were posted on Jan. 16, 2013.

On Apr. 3, 2014, the Connecticut Department of Consumer Protection announced the names and locations (70 KB) of the first six dispensary facilities that will be authorized by the state. The first dispensary opened on Aug. 20, 2014.

CT Medical Marijuana Program

Information provided by the state on sources for medical marijuana:
"Only producers licensed by the Department of Consumer Protection will be authorized to cultivate marijuana. At any one time, the number of licensed producers shall be at least three and not more than 10." "Dispensary Facility and Producer FAQs," ct.gov, Sep. 11, 2013

Patient Registry Fee:
$100

Accepts other states' registry ID cards?
No

Registration:
Mandatory

6. DC (District of Columbia)

Amendment Act B18-622 (80KB) "Legalization of Marijuana for Medical Treatment Amendment Act of 2010" -- Approved 13-0 by the Council of the District of Columbia on May 4, 2010; signed by the Mayor on May 21, 2010|

Effective: July 27, 2010 [After being signed by the Mayor, the law underwent a 30-day Congessional review period. Neither the Senate nor the House acted to stop the law, so it became effective when the review period ended.]

Approved Conditions: HIV, AIDS, cancer, glaucoma, conditions characterized by severe and persistent muscle spasms, such as multiple sclerosis; patients undergoing chemotherapy or radiotherapy, or using azidothymidine or protease inhibitors.

Possession/Cultivation: "Patients are permitted to purchase up to two (2) ounces of dried medical marijuana per month or the equivalent of two ounces of dried medical marijuana when sold in any other form." ("Patient FAQ," doh.dc.gov, May 2013)

Updates: On Apr. 14, 2011, Mayor Vincent C. Gray announced the adoption of an emergency amendment (450 KB) to title 22 of the District of Columbia Municipal Regulations (DCMR), which added a new subtitle C entitled "Medical Marijuana." The emergency amendment "will set forth the

Health Regulation and Licensing Administration
899 N. Capitol Street, NE
2nd Floor
Washington, DC 20002
Phone: 202-442-5955

doh.mmp@dc.gov

Website:
Medical Marijuana Program

Information provided by the state on sources for medical marijuana:
Patients and caregivers "may only obtain medical marijuana from the dispensary designated on your registration identification card and may not: (a)grow or cultivate medical marijuana); b)purchase medical marijuana through street vendors; or (c) obtain medical marijuana from other patients and caregivers." ("Patient FAQ," doh.dc.gov, May 2013)

Patient Registry Fee:
$100 initial or renewal fee /$25 for low income patients

Accepts other states' registry ID cards?
No

process and procedure" for patients, caregivers, physicians, and dispensaries, and "implement the provisions of the Act that must be addressed at the onset to enable the Department to administer the program." The final rulemaking (800 KB) was posted online on Jan. 3, 2012.

On Feb. 14, 2012, the DC Department of Health's Health Regulation and Licensing Administration posted a revised timeline for the dispensary application process (180 KB), which listed June 8, 2012 as the date by which the Department intends to announce dispensary applicants available for registration.

The first dispensary, Capital City Care, was licensed in Apr. 2013.

Registration:
Mandatory

7. Delaware

Senate Bill 17 (100 KB) -- Signed into law by Gov. Jack Markell (D) on May 13, 2011
Approved: By House 27-14, by Senate 17-4
Effective: July 1, 2011

Under this law, a patient is only protected from arrest if his or her physician certifies, in writing, that the patient has a specified debilitating medical condition and that the patient would receive therapeutic benefit from medical marijuana. The patient must send a copy of the written certification to the state Department of Health and Social Services, and the Department will issue an ID card after verifying the information. As long as the patient is in compliance with the law, there will be no arrest.

The law does not allow patients or caregivers to grow marijuana at home, but it does allow for the state-regulated, non-profit distribution of medical marijuana by compassion centers.

Approved Conditions:
Approved for treatment of debilitating medical conditions, defined as cancer, HIV/AIDS, decompensated cirrhosis (Hepatitis C), ALS, Alzheimer's disease. Also approved for "a chronic or debilitating disease or medical condition or its treatment that produces 1 or more of the following: cachexia or wasting syndrome; severe, debilitating pain that has not responded to previously prescribed medication or surgical measures for more than 3 months or for which other treatment options produced serious side effects; intractable nausea; seizures; or severe and persistent muscle spasms, including but not limited to those characteristic of multiple sclerosis."

"Post-traumatic stress disorder (PTSD) can qualify as a debilitating medical condition when it manifests itself in severe physical suffering, such as severe or chronic pain or severe nausea and vomiting, or otherwise severely impairs the patient's physical ability to carry on the activities of daily living."
("Medical Marijuana Questions & Answers," dhss.delaware.gov (accessed Apr. 21, 2014))

Possession/Cultivation: Patients 18 and older with certain debilitating conditions may possess up to six ounces of marijuana with a doctor's written recommendation. A registered compassion center may not dispense more than 3 ounces of marijuana to a registered qualifying patient in any fourteen-day period, and a patient may register with only one compassion center. Home cultivation is not allowed. Senate Bill 17 contains a provision that allows for an affirmative

Delaware Department of Health and Social Services
Division of Public Health
Phone: 302-744-4749
Fax: 302-739-3071

MedicalMarijuanaDPH@state.de.us

Website:
DE Medical Marijuana Program

Information provided by the state on sources for medical marijuana:
"The Department will issue a permit to the compassion center to begin growing medical marijuana on July 1, 2014. The policy change will allow medical marijuana patients in Delaware to buy the drug in a state-regulated center... The center will only be allowed to cultivate up to 150 marijuana plants, and keep inventory of no more than 1,500 ounces of the drug." ("Medical Marijuana Questions & Answers," dhss.delaware.gov (accessed Apr. 21, 2014))

Patient Registry Fee:
$125 (a sliding scale fee is available based on income)

Accepts other states' registry ID cards?
No

Registration:
Mandatory

defense for individuals "in possession of no more than six ounces of usable marijuana."

Updates: On Feb. 12, 2012, Gov. Markell released the following statement (presented in its entirety), available on delaware.gov, in response to a letter from US District Attorney Charles Oberly (2 MB):

"I am very disappointed by the change in policy at the federal department of justice, as it requires us to stop implementation of the compassion centers. To do otherwise would put our state employees in legal jeopardy and I will not do that. Unfortunately, this shift in the federal position will stand in the way of people in pain receiving help. Our law sought to provide that in a manner that was both highly regulated and safe."

On Aug. 15, 2013, Gov. Markell announced in a letter to Delaware lawmakers (175 KB) his intention to relaunch the state's medical marijuana program, despite his previous decision to stop implementation. Markell wrote that the Department of Health and Social Services "will proceed to issue a request for proposal for a pilot compassion center to open in Delaware next year."

On June 23, 2015, Gov. Markell signed Rylie's Law, SB 90 (100 KB), which allows the use of non-smoked cannabis oil that is no more than 7% THC for minors with intractable epilepsy or dystonia.

On June 26, 2015, the state's first medical marijuana dispensary opened near Wilmington, Delaware.

8. Hawaii

Senate Bill 862 (40 KB) -- Signed into law by Gov. Ben Cayetano on June 14, 2000
Approved: By House 32-18, by Senate 13-12
Effective: Dec. 28, 2000

Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess a signed statement from their physician affirming that he or she suffers from a debilitating condition and that the "potential benefits of medical use of marijuana would likely outweigh the health risks." The law establishes a mandatory, confidential state-run patient registry that issues identification cards to qualifying patients.

Approved conditions: Cancer, glaucoma, positive status for HIV/AIDS; A chronic or debilitating disease or medical condition or its treatment that produces cachexia or wasting syndrome, severe pain, severe nausea, seizures, including those characteristic of epilepsy, or severe and persistent muscle spasms, including those characteristic of multiple sclerosis or Crohn's disease. Other conditions are subject to approval by the Hawaii Department of Health.

Possession/Cultivation: The amount of marijuana that may be possessed jointly between the qualifying patient and the primary caregiver is an "adequate supply," which shall not exceed three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant.

Amended:HB 668 (240 KB)
Effective: June 25, 2013

Establishes a medical marijuana registry special fund to pay

Department of Public Safety
Narcotics Enforcement Division
3375 Koapaka Street, Suite D-100
Honolulu, HI 96819
Phone: 808-837-8470
Fax: 808-837-8474

hawaiicsreg@ned.hawaii.gov

Website:
HI Medical Marijuana Application info

Information provided by the state on sources for medical marijuana:
"Hawaii law does not authorize any person or entity to sell or dispense marijuana... Hawaii law authorizes the medical use of marijuana, it does not authorize the distribution of marijuana (Dispensaries) other than the transfer from a qualifying patient's primary caregiver to the qualifying patient." ("Hawaii Medical Use of Marijuana Physician and Patient Information," dps.hawaii.gov, Sep. 2011)

Patient Registry Fee:
$25

Accepts other states' registry ID cards?
No

Registration:
Mandatory

for the program and transfers the medical marijuana program from the Department of Public Safety to the Department of Public Health by no later than Jan. 1, 2015.

Amended:SB 642 (95 KB)
Effective: Jan. 2, 2015

Redefines "adequate supply" as seven marijuana plants, whether immature or mature, and four ounces of usable marijuana at any given time; stipulates that physician recommendations will have to be made by the qualifying patient's primary care physician.

9. Illinois

House Bill 1 (385 KB)
Approved: Apr. 17, 2013 by House, 61-57 and May 17, 2013 by Senate, 35-21
Signed into law by Gov. Pat Quinn on Aug. 1, 2013
Effective: Jan. 1, 2014

The Compassionate Use of Medical Cannabis Pilot Program Act establishes a patient registry program, protects registered qualifying patients and registered designated caregivers from "arrest, prosecution, or denial of any right or privilege," and allows for the registration of cultivation centers and dispensing organizations. Once the act goes into effect, "a tax is imposed upon the privilege of cultivating medical cannabis at a rate of 7% of the sales price per ounce."

Approved Conditions: "Debilitating medical conditions include 40 chronic diseases and conditions: cancer, glaucoma, positive status for human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, agitation of Alzheimer's disease, cachexia/wasting syndrome, muscular dystrophy, severe fibromyalgia, spinal cord disease (including but not limited to arachnoiditis), Tarlov cysts, hydromyelia syringomyelia, Rheumatoid arthritis, fibrous dysplasia, spinal cord injury, traumatic brain injury and post concussion syndrome, Multiple Sclerosis, Arnold-Chiari malformation and Syringomelia, Spinocerebellar Ataxia (SCA), Parkinson's Disease, Tourette Syndrome, Myoclonus, Dystonia, Reflex Sympathetic Dystrophy, RSD (Complex Regional Pain Syndromes Type I), Causalgia, CRPS (Complex Regional Pain Syndrome Type II), Neurofibromatosis, Chronic inflammatory Demyelinating Polyneuropathy, Chronic Inflammatory Demyelinating Polyneuropathy, Sjogren's Syndrome, Lupus, Interstitial Cystitis, Myasthenia Gravis, Hydrocephalus, nail-patella syndrome or residual limb pain; or the treatment of these conditions."
"Frequently Asked Questions," idph.state.il.us (accessed Apr. 23, 2014)

On July 20, 2014, Gov. Quinn signed Senate Bill 2636 (40 KB), which amended the Compassionate Use of Medical Cannabis Act to allow children under 18 to be treated with non-smokable forms of medical marijuana for the same conditions orginially approved for adults. An underage patient's parent or guardian must serve as caregiver, and signatures from two doctors are required. The bill, which becomes effective Jan. 1, 2015, also added seizures, including those related to epilepsy, to the list of approved conditions.

Possession/Cultivation: "Adequate supply" is defined as "2.5 ounces of usable cannabis during a period of 14 days and that is derived solely from an intrastate source." The law does not allow patients or caregivers to cultivate cannabis.

Illinois Department of Public Health
Division of Medical Cannabis
Illinois Department of Public Health
535 W. Jefferson Street
Springfield, IL 62761-0001
Attn: Rulemaking

DPH.MedicalCannabis@illinois.gov

Website:
Medical Cannabis Program

Information provided by the state on sources for medical marijuana:
Cultivation centers and dispensing organizations will be registered by the Department of Agriculture and Department of Financial and
Professional Regulation, respectively.

Patient Registry Fee:
To be determined during the rulemaking process ($100 proposed)

Accepts other states' registry ID cards?
No

Registration:
Mandatory

Updates: Governor Pat Quinn's Aug. 1, 2013 signing statement (25 KB) explains key points of the law and notes that it is a four-year pilot program.

On Jan. 21, 2014, the Department of Public Health released a draft of the proposed rules (415 KB) for public comments. The proposal included a fingerprint-based criminal history background check and an annual $150 application fee for qualifying patients. The rules also state that qualifying patients and caregivers "are not eligible for a Firearm Owners Identification Card or a Firearm Concealed Carry License."

On Apr. 18, 2014, the Department of Health released revised preliminary rules (240 KB) that removed from the previous versions the restrictions on gun owners applying for medical marijuana cards. The application fees were dropped to $100 ($50 for veterans and eligible patients on Social Security Insurance and Social Security Disability Insurance, and $25 for caregivers).

10. Maine

Ballot Question 2 -- Approved Nov. 2, 1999 by 61% of voters
Effective: Dec. 22, 1999

Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess an oral or written "professional opinion" from their physician that he or she "might benefit from the medical use of marijuana." The law does not establish a state-run patient registry.

Approved diagnosis: epilepsy and other disorders characterized by seizures; glaucoma; multiple sclerosis and other disorders characterized by muscle spasticity; and nausea or vomiting as a result of AIDS or cancer chemotherapy.

Possession/Cultivation: Patients (or their primary caregivers) may legally possess no more than one and one-quarter (1.25) ounces of usable marijuana, and may cultivate no more than six marijuana plants, of which no more than three may be mature. Those patients who possess greater amounts of marijuana than allowed by law are afforded a "simple defense" to a charge of marijuana possession.

Amended: Senate Bill 611
Effective: Signed into law on Apr. 2, 2002

Increases the amount of useable marijuana a person may possess from one and one-quarter (1.25) ounces to two and one-half (2.5) ounces.

Amended: Question 5 (135 KB) -- Approved Nov. 3, 2009 by 59% of voters

List of approved conditions changed to include cancer, glaucoma, HIV, acquired immune deficiency syndrome, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, Alzheimer's, nail-patella syndrome, chronic intractable pain, cachexia or wasting syndrome, severe nausea, seizures (epilepsy), severe and persistent muscle spasms, and multiple sclerosis.

Instructs the Department of Health and Human Services (DHHS) to establish a registry identification program for patients and caregivers. Stipulates provisions for the operation of nonprofit dispensaries.

Maine Medical Use of Marijuana Program (MMMP)
Division of Licensing and Regulatory Services
Department of Health and Human Services
11 State House Station
Augusta, ME 04333
Phone: 207-287-4325

medmarijuana. dhhs@maine.gov

Website:
Maine Medical Marijuana Program

Information provided by the state on sources for medical marijuana:
A list of dispensaries is available on the MMMP website. "The patient may either cultivate or designate a caregiver or dispensary to cultivate marijuana." ("Program Bulletin," Maine.gov, Sep. 28, 2011)

Patient Registry Fee:
$0
Caregivers pay $300/patient(limit of 5 patients; if not growing marijuana, there is no fee)

Accepts other states' registry ID cards?
Yes
"Law enforcement will accept appropriate authorization from a participating state, but that patient cannot purchase marijuana in Maine without registering here. That requires a Maine physician and a Maine driver license or other picture ID issued by the state of Maine. The letter from a physician in another state is only good for 30 days." (Aug. 19, 2010 email from Maine's Division of Licensing and Regulatory Services)

Registration:
Voluntary

"In addition to either a registry ID card or a physician certification form, all patients, including both non-registered and voluntarily registered patients, must also present their Maine driver license or other Maine-issued photo identification card to law enforcement, upon request." ("Program Bulletin," Maine.gov, Sep. 28, 2011)

[**Editor's Note:** An Aug. 19, 2010 email to ProCon.org from Catherine M. Cobb, Director of Maine's Division of Licensing and Regulatory Services, stated:

"We have just set up our interface to do background checks on caregivers and those who are associated with dispensaries. They may not have a disqualifying drug offense."]

Amended: LD 1062 (25 KB)
Effective: Enacted without the governor's signature on June 26, 2013

Adds post-traumatic stress disorder (PTSD) to the list of approved conditions for medical marijuana use.

11. Maryland

House Bill 881 (375 KB)
Approved: Apr. 8, 2014 by House, 125-11 and by Senate, 44-2
Signed by Gov. Martin O'Malley on Apr. 14, 2014
Effective: June 1, 2014

The Natalie M. LaPrade Medical Marijuana Commission and the Maryland Department of Health and Mental Hygiene are tasked with developing regulations for patient registry and identification cards, dispensary licensing, setting fees and possession limits, and more. The Commission will issue yearly request for applications from academic medical centers to operate medical marijuana compassionate use programs.

Approved diagnosis: cachexia, anorexia, or wasting syndrome, severe or chronic pain, severe nausea, seizures, severe or persistent muscle spasms, or other conditions approved by the Commission.

Possession/Cultivation: Patients are allowed to possess a 30-day supply (amount to be determined by the Commission). "Beginning June 1, 2016, the Commission may issue the number of [dispensary] licenses necessary to meet the demand for medical marijuana by qualifying patients and caregivers issued identification cards."

Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201
Phone: 410-767-6500

Website:
Natalie M. LaPrade Medical Marijuana Commission

Information provided by the state on sources for medical marijuana:
"A qualifying patient or caregiver may obtain medical marijuana from a grower's facility or from a satellite facility of the grower."

Patient Registry Fee:
To be determined by the Commission during the rulemaking process

Accepts other states' registry ID cards?
No

Registration:
Mandatory

12. Massachusetts

Ballot Question 3 -- Approved Nov. 6, 2012 by 63% of voters
Effective: Jan. 1, 2013

"The citizens of Massachusetts intend that there should be no punishment under state law for qualifying patients, physicians and health care professionals, personal caregivers for patients, or medical marijuana treatment center agents for the medical use of marijuana...

In the first year after the effective date, the Department shall issue registrations for up to thirty-five non-profit medical marijuana treatment centers, provided that at least one treatment center shall be located in each county, and not more than five shall be located in any one county."

Approved diagnosis: "Cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, multiple sclerosis and other conditions as determined in writing by a qualifying patient's physician."

Department of Public Health of the Commonwealth of Massachusetts
One Ashburton Place
11th Floor
Boston, MA 02108
Phone: 617-624-5062

medicalmarijuana@state.ma.us

Website:
www.mass.gov/medicalmarijuana

Information provided by the state on sources for medical marijuana:
The state will issue registrations for up to 35 nonprofit medical marijuana treatment centers

Patient Registry Fee:
$50

Accepts other states' registry ID cards?
Unknown

Registration:
Mandatory

Possession/Cultivation: Patients may possess "no more marijuana than is necessary for the patient's personal, medical use, not exceeding the amount necessary for a sixty-day supply...

Within 120 days of the effective date of this law, the department shall issue regulations defining the quantity of marijuana that could reasonably be presumed to be a sixty-day supply for qualifying patients, based on the best available evidence."

"The Department shall issue a cultivation registration to a qualifying patient whose access to a medical treatment center is limited by verified financial hardship, a physical incapacity to access reasonable transportation, or the lack of a treatment center within a reasonable distance of the patient's residence. The Department may deny a registration based on the provision of false information by the applicant. Such registration shall allow the patient or the patient's personal caregiver to cultivate a limited number of plants, sufficient to maintain a 60-day supply of marijuana, and shall require cultivation and storage only in an enclosed, locked facility.

The department shall issue regulations consistent with this section within 120 days of the effective date of this law. Until the department issues such final regulations, the written recommendation of a qualifying patient's physician shall constitute a limited cultivation registration."

Updates: The DPH website wrote on Oct. 8, 2014 that "the Medical Use of Marijuana Online System (MMJ Online System) is now available for qualifying patients to register to possess marijuana for medical purposes. You will need to register with the MMJ Online System by January 1, 2015 in order to possess marijuana for medical purposes, even if you already have a paper written certification from your physician. Paper written certifications will no longer be valid as of February 1st, 2015."

The law stated that "Until the approval of final regulations, written certification by a physician shall constitute a registration card for a qualifying patient."

13. Michigan

Proposal 1 (60 KB) "Michigan Medical Marihuana Act" -- Approved by 63% of voters on Nov. 4, 2008
Approved: Nov. 4, 2008
Effective: Dec. 4, 2008

Approved Conditions: Approved for treatment of debilitating medical conditions, defined as cancer, glaucoma, HIV, AIDS, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, agitation of Alzheimer's disease, nail patella, cachexia or wasting syndrome, severe and chronic pain, severe nausea, seizures, epilepsy, muscle spasms, multiple sclerosis, and PTSD.

Possession/Cultivation: Patients may possess up to two and one-half (2.5) ounces of usable marijuana and twelve marijuana plants kept in an enclosed, locked facility. The twelve plants may be kept by the patient only if he or she has not specified a primary caregiver to cultivate the marijuana for him or her.

Amended: HB 4856 (40 KB)
Effective: Dec. 31, 2012

Makes it illegal to "transport or possess" usable marijuana by car unless the marijuana is "enclosed in a case that is carried in the trunk of the vehicle." Violation of the law is a misdemeanor "punishable by imprisonment for not more than 93 days or a fine of not more than $500.00, or both."

Michigan Medical Marihuana Program
Bureau of Health Professions, Department of Licensing and Regulatory Affairs
P.O. Box 30083
Lansing, MI 48909
Phone: 517-373-0395

BHP-MMMPINFO@michigan.gov

Website:
MI Medical Marihuana Program

Information provided by the state on sources for medical marijuana:
"This is not addressed in the MMMA, therefore; the MMP is not authorized to provide information regarding this issue... The MMMA provides for a system of designated caregivers... The MMP is not authorized to associate patients and caregivers nor release the names of registered caregivers."
"Frequently Asked Questions," Michigan.gov (accessed Apr. 24, 2014)

Patient Registry Fee:
$60 new or renewal application

Accepts other states' registry ID cards?
Yes

The Office of Communications in the Department of Licensing and Regulatory Affairs told ProCon.org in an Oct.30, 2014

Amended: HB 4834 (40 KB) **Effective:** Apr. 1, 2013 Requires proof of Michigan residency when applying for a registry ID card (driver license, official state ID, or valid voter registration) and makes cards valid for two years instead of one. **Amended:** HB 4851 (40 KB) **Effective:** Apr. 1, 2013 Requires a "bona fide physician-patient relationship," defined in part as one in which the physician "has created and maintained records of the patient's condition in accord with medically accepted standards" and "will provide follow-up care;" protects patient from arrest only with registry identification card and valid photo ID. **Amended:** State of Michigan vs. McQueen (90 KB) **Decided:** Feb. 8, 2013 The Michigan Supreme Court ruled 4-1 that dispensaries are illegal. As a result, medical marijuana patients in Michigan will have to grow their own marijuana or get it from a designated caregiver who is limited to five patients.	email: "The law says that cards from other states are recognized. However, the Michigan Medical Marihuana Program does not have any control over enforcement of that section of the statute." **Registration:** Mandatory
14. **Minnesota** **SF 2470** (200 KB) -- Signed into law by Gov. Mark Dayton on May 29, 2014 **Approved:** By Senate 46-16, by House 89-40 **Effective:** May 30, 2014 **Approved Conditions:** cancer (if the underlying condition or treatment produces severe or chronic pain, nausea or severe vomiting, or cachexia or severe wasting), glaucoma, HIV/AIDS, Tourette's syndorme, ALS, seizures/epilepsy, severe and persistent muscle spasms/MS, Crohn's disease, terminal illness with a life expectancy of under one year. The commissioner will consider adding intractable pain and other conditions, and must report findings no later than July 1, 2016. **Possession/Cultivation:** The Commissioner of Health will register two in-state manufacturers for the production of all medical cannabis within the state. Manufacturers are required to ensure that the medical cannabis distributed contains a maximum of a 30-day supply of the dosage determined for that patient. "Medical cannabis" is defined as any species of the genus cannabis plant delivered in the form of (1) liquid, including, but not limited to, oil; (2) pill; (3) vaporized delivery method that does not require the use of dried leaves or plant form. **Smoking is not a method approved by the bill.**	**Minnesota Department of Health** **Website:** Medical Cannabis Program **Information provided by the state on sources for medical marijuana:** Manufacturers shall operate four distribution facilities in the state and must agree to begin supplying medical cannabis to patients by July 1, 2015 from at least one facility. **Patient Registry Fee:** $200 / $50 for patients on Social Security disability, Supplemental Security Insurance, or enrolled in MinnesotaCare **Accepts other states' registry ID cards?** No **Registration:** Mandatory
15. **Montana** **Initiative 148** (76 KB) -- Approved by 62% of voters on Nov. 2, 2004 **Effective:** Nov. 2, 2004 **Approved Conditions:** Cancer, glaucoma, or positive status for HIV/AIDS, or the treatment of these conditions; a chronic or debilitating disease or medical condition or its treatment that produces cachexia or wasting syndrome, severe or	**Medical Marijuana Program** Montana Department of Health and Human Services Licensure Bureau 2401 Colonial Drive, 2nd Floor P.O. Box 202953 Helena, MT 59620-2953 Phone: 406-444-0596 jbuska@mt.gov

chronic pain, severe nausea, seizures, including seizures caused by epilepsy, or severe or persistent muscle spasms, including spasms caused by multiple sclerosis or Crohn's disease; or any other medical condition or treatment for a medical condition adopted by the department by rule.

Possession/Cultivation: A qualifying patient and a qualifying patient's caregiver may each possess six marijuana plants and one ounce of usable marijuana. "Usable marijuana" means the dried leaves and flowers of marijuana and any mixture or preparation of marijuana.

Amended: SB 423 (100 KB) -- Passed on Apr. 28, 2011 and transmitted to the Governor on May 3, 2011
Effective: July 1, 2011

SB 423 changes the application process to require a Montana driver's license or state issued ID card. A second physician is required to confirm a chronic pain diagnosis.

"A provider or marijuana-infused products provider may assist a maximum of three registered cardholders..." and "may not accept anything of value, including monetary remuneration, for any services or products provided to a registered cardholder."

Approved Conditions: Cancer, glaucoma, or positive status for HIV/AIDS when the condition or disease results in symptoms that seriously and adversely affect the patient's health status; Cachexia or wasting syndrome; Severe, chronic pain that is persistent pain of severe intensity that significantly interferes with daily activities as documented by the patient's treating physician; Intractable nausea or vomiting; Epilepsy or intractable seizure disorder; Multiple sclerosis; Chron's Disease; Painful peripheral neuropathy; A central nervous system disorder resulting in chronic, painful spasticity or muscle spasms; Admittance into hospice care.

Possession/Cultivation: Amended to 12 seedlings (less than 12"), four mature flowering plants, and one ounce of usable marijuana.

On Nov. 6, 2012, Montana voters approved initiative referendum No. 124 by a vote of 56.5% to 43.5%, upholding SB 423.

Website:
MT Medical Marijuana Program

Medical Marijuana Program FAQs (35 KB)

Information provided by the state on sources for medical marijuana:
"The department does not have information about growing marijuana, but recommends using the internet, family and friends as resources to find information." "Frequently Asked Questions," dphhs.mt.gov, Nov. 29, 2011

Patient Registry Fee:
$75 new application/$75 renewal

Accepts other states' registry ID cards?
No (reciprocity ended when SB 423 took effect)

Registration:
Mandatory

16. Nevada

Ballot Question 9 -- Approved Nov. 7, 2000 by 65% of voters
Effective: Oct. 1, 2001

Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who have "written documentation" from their physician that marijuana may alleviate his or her condition.

Approved Conditions: AIDS; cancer; glaucoma; and any medical condition or treatment to a medical condition that produces cachexia, persistent muscle spasms or seizures, severe nausea or pain, and PTSD. Other conditions are subject to approval by the health division of the state Department of Human Resources.

Possession/Cultivation: Patients (or their primary caregivers) may legally possess no more than one ounce of usable marijuana, three mature plants, and four immature plants.

Registry: The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients.

Nevada State Health Division
4150 Technology Way, Suite 104
Carson City, NV, 89706
Phone: 775-687-7594
Fax: 775-684-4156

medicalmarijuana@health.nv.gov

Website:
NV Medical Marijuana Program

Information provided by the state on sources for medical marijuana:
"The NMMP is not a resource for the growing process and does not have information to give to patients." "Medical Marijuana Frequently Asked Questions," health.nv.gov, Mar. 20, 2014

Patient Registry Fee:
$25 application fee, plus $75 for the card
Accepts other states' registry ID cards?
Yes, starting Apr. 1, 2014 with an affidavit

Patients who do not join the registry or possess greater amounts of marijuana than allowed by law may argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges. Legislators added a preamble to the legislation stating, "[T]he state of Nevada as a sovereign state has the duty to carry out the will of the people of this state and regulate the health, medical practices and well-being of those people in a manner that respects their personal decisions concerning the relief of suffering through the medical use of marijuana." A separate provision requires the Nevada School of Medicine to "aggressively" seek federal permission to establish a state-run medical marijuana distribution program.

Amended: Assembly Bill 453 (25 KB)
Effective: Oct. 1, 2001

Created a state registry for patients whose physicians recommend medical marijuana and tasked the Department of Motor Vehicles with issuing identification cards. No state money will be used for the program, which will be funded entirely by donations.

Amended: Senate Bill 374 (280 KB)
Signed into law by Gov. Brian Sandoval on June 12, 2013

"Provides for the registration of medical marijuana establishments authorized to cultivate or dispense marijuana or manufacture edible marijuana products or marijuana-infused products for sale to persons authorized to engage in the medical use of marijuana...

From April 1, 2014, through March 31, 2016, a nonresident purchaser must sign an affidavit attesting to the fact that he or she is entitled to engage in the medical use of marijuana in his or her state or jurisdiction of residency. On and after April 1, 2016, the requirement for such an affidavit is replaced by computer cross-checking between the State of Nevada and other jurisdictions." Patients who were growing before July 1, 2013 are allowed to continue home cultivation until March 31, 2016.

Updates: The Department of Health and Human Services adopted regulations (340 KB) based on the previous amendment on April 1, 2014.

Registration:
Mandatory

17. New Hampshire

House Bill 573 (215 KB)
Approved: May 23, 2013 by Senate, 18-6 and June 26, 2013 by House, 284-66
Signed into law by Gov. Maggie Hassan on July 23, 2013
Effective: Upon passage

The bill authorizes the use of therapeutic cannabis in New Hampshire, establishes a registry identification card system, allows for the registration of up to four non-profit alternative treatment centers in the state, and establishes an affirmative defense for qualified patients and designated caregivers with valid registry ID cards.

HB 573 also calls for the creation of a Therapeutic Use of Cannabis Advisory Council, which in five years will be required to "issue a formal opinion on whether the program should be continued or repealed."

A valid ID card from another medical marijuana state will be recognized as allowing the visiting patient to possess cannabis for therapeutic purposes, but the "visiting qualifying patient shall not cultivate or purchase cannabis in New

New Hampshire Department of Health and Human Services
Phone: 603-271-9234

Website:
Therapeutic Use of Cannabis Program

Information provided by the state on sources for medical marijuana:
HB 537 requires DHHS to register two nonprofit alternative treatment centers within 18 months of the bill's effective date, provided that at least two applicants are qualified. There can be no more than four alternative treatment centers at one time.

Patient Registry Fee:
To be determined during the rulemaking process

Accepts other states' registry ID cards?
Yes

Registration:
Mandatory

Hampshire or obtain cannabis from alternative treatment centers..."

Approved Conditions: Cancer, glaucoma, positive status for HIV, AIDS, hepatitis C, ALS, muscular dystrophy, Crohn's disease, agitation of Alzheimer's disease, multiple sclerosis, chronic pancreatitis, spinal cord injury or disease, traumatic brain injury, or "one or more injuries that significantly interferes with daily activities as documented by the patient's provider; and a severely debilitating or terminal medical condition or its treatment that has produced at least one of the following: elevated intraocular pressure, cachexia, chemotherapy induced anorexia, wasting syndrome, severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects, constant or severe nausea, moderate to severe vomiting, seizures, or severe, persistent muscle spasms."

Possession/Cultivation: "A qualifying patient shall not obtain more than 2 ounces of usable cannabis directly or through the qualifying patient's designated caregiver during a 10-day period." A patient may possess two ounces of usable cannabis and any amount of unusable cannabis.

Updates: On Apr. 3, 2014, the Department of Health and Human Services (DHHS) posted proposed Therapeutic Cannabis Program Registry Rules (130 KB) and began the formal rulemaking process.

As of Apr. 23, 2014, the DHHS website stated that it was not currently accepting applications for patient registry identification cards or for alternative treatment center registration certificates.

18. New Jersey

Senate Bill 119 (175 KB)
Approved: Jan. 11, 2010 by House, 48-14; by Senate, 25-13
Signed into law by Gov. Jon Corzine on Jan. 18, 2010
Effective: Six months from enactment

Protects "patients who use marijuana to alleviate suffering from debilitating medical conditions, as well as their physicians, primary caregivers, and those who are authorized to produce marijuana for medical purposes" from "arrest, prosecution, property forfeiture, and criminal and other penalties."

Also provides for the creation of alternative treatment centers, "at least two each in the northern, central, and southern regions of the state. The first two centers issued a permit in each region shall be nonprofit entities, and centers subsequently issued permits may be nonprofit or for-profit entities."

Approved Conditions: Seizure disorder, including epilepsy, intractable skeletal muscular spasticity, glaucoma; severe or chronic pain, severe nausea or vomiting, cachexia, or wasting syndrome resulting from HIV/AIDS or cancer; amyotrophic lateral sclerosis (Lou Gehrig's Disease), multiple sclerosis, terminal cancer, muscular dystrophy, or inflammatory bowel disease, including Crohn's disease; terminal illness, if the physician has determined a prognosis of less than 12 months of life or any other medical condition or its treatment that is approved by the Department of Health and Senior Services.

Possession/Cultivation: Physicians determine how much marijuana a patient needs and give written instructions to be

Department of Health (DOH)
P. O. Box 360
Trenton, NJ 08625-0360
Phone: 609-292-0424

Contact form

Website:
Medicinal Marijuana Program

Information provided by the state on sources for medical marijuana:
Patients are not allowed to grow their own marijuana. On Mar. 21, 2011, the New Jersey DOH announced the locations of six nonprofit alternative treatment centers (ATCs) (100 KB) from which medical marijuana may be obtained.

Medical marijuana is not covered by Medicaid.

Patient Registry Fee:
$200 (valid for two years). Reduced fee of $20 for patients qualifying for state or federal assistance programs

Accepts other states' registry ID cards?
No

Registration:
Mandatory

presented to an alternative treatment center. The maximum amount for a 30-day period is two ounces.

Amended: SB 2842 (40 KB)
Signed into law by Gov. Chris Christie on Sep. 10, 2013 following legislative adoption of his conditional veto (10 KB)

Allows edible forms of marijuana only for qualifying minors, who must receive approval from a pediatrician and a psychiatrist.

Updates:
S119 was supposed to become effective six months after it was enacted on Jan. 18, 2010, but the legislature, DHHS, and New Jersey Governor Chris Christie had difficulty coming to agreement on the details of how the program would be run.

The New Jersey Department of Health and Senior Services released draft rules (385 KB) outlining the registration and application process on Oct. 6, 2010. A public hearing to discuss the proposed rules was held on Dec. 6, 2010 at the New Jersey Department of Health and Senior Services, according to the *New Jersey Register*.

On Dec. 20, 2011, Senator Nicholas Scutari (D), lead sponsor of the medical marijuana bill, submitted Senate Concurrent Resolution (SCR) 140 (25 KB) declaring that the "Board of Medical Examiners proposed medicinal marijuana program rules are inconsistent with legislative intent." The New Jersey Senate Health, Human Services and Senior Citizens committee held a public hearing to discuss SCR 140 and a similar bill, SCR 130, on Jan. 20, 2010.

On Feb. 3, 2011, the Department of Health proposed new rules (200 KB) that streamlined the permit process for cultivating and dispensing, prohibited home delivery by alternative treatment centers, and required that "conditions originally named in the Act be resistant to conventional medical therapy in order to qualify as debilitating medical conditions."

On Aug. 9, 2012, the New Jersey Medical Marijuana Program opened the patient registration system on its website. Patients must have a physician's recommendation, a government-issued ID, and proof of New Jersey residency to register. The first dispensary is expected to be licensed to open in September.

On Oct. 16, 2012, the Department of Health issued the first dispensary permit (24 KB) to Greenleaf Compassion Center, allowing it to operate as an Alternative Treatment Center and dispense marijuana. The center opened on Dec. 6, 2012, becoming New Jersey's first dispensary.

As of Apr. 23, 2014, there were Alternative Treatment Centers with permits to operate in all three regions of the state as designated by the medical marijuana program: north, central, and south.

19. New Mexico

Senate Bill 523 (71 KB) "The Lynn and Erin Compassionate Use Act"
Approved: Mar. 13, 2007 by House, 36-31; by Senate, 32-3
Effective: July 1, 2007

Removes state-level criminal penalties on the use and possession of marijuana by patients "in a regulated system for alleviating symptoms caused by debilitating medical

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conditions and their medical treatments." The New Mexico Department of Health designated to administer the program and register patients, caregivers, and providers. **Approved Conditions:** As of Apr. 23, 2014, the 19 current qualifying conditions for medical cannabis were: severe chronic pain, painful peripheral neuropathy, intractable nausea/vomiting, severe anorexia/cachexia, hepatitis C infection, Crohn's disease, Post-Traumatic Stress Disorder, ALS (Lou Gehrig's disease), cancer, glaucoma, multiple sclerosis, damage to the nervous tissue of the spinal cord with intractable spasticity, epilepsy, HIV/AIDS, hospice patients, cervical dystonia, Inflammaory Autoimmune-mediated Arthritis, Parkinson's disease, and Huntington's disease **Possession/Cultivation:** Patients have the right to possess up to six ounces of usable cannabis, four mature plants and 12 seedlings. Usable cannabis is defined as dried leaves and flowers; it does not include seeds, stalks or roots. A primary caregiver may provide services to a maximum of four qualified patients under the Medical Cannabis Program.	**Information provided by the state on sources for medical marijuana:** "The production and distribution of medical cannabis is provided by Licensed Non-Profit Producers (LNPP) throughout the state. A Qualified Patient may also obtain a Personal Production License (PPL) to grow medical cannabis for personal use." "General Information," Medical Cannabis Program website (accessed Apr. 23, 2014) **Patient Registry Fee:** No fee **Accepts other states' registry ID cards?** No **Registration:** Mandatory
20. **New York** **Assembly Bill 6357** (85 KB) **Approved:** June 19, 2014 by Assembly, 117-13; June 20, 2014 by Senate, 49-10 Signed into law by Governor Andrew Cuomo on July 5, 2014 **Effective:** Upon Governor's signature The Department of Health has 18 months to establish regulations and register dispensing organizations. Marijuana will be taxed at 7%, to be paid by the dispensary. The law automatically expires after seven years. **Approved Conditions:** Cancer, HIV/AIDS, ALS (Lou Gehrig's disease), Parkinson's disease, multiple sclerosis, spinal cord damage causing spasticity, epilepsy, inflammatory bowel disease, neuropathies, or Huntington's disease. The Department of Health commissioner has the discretion to add or delete conditions and must decide whether to add Alzheimer's, muscular dystrophy, dystonia, PTSD, and rheumatoid arthritis within 18 months of the law becoming effective. **Possession/Cultivation:** 30-day supply to be determined by the health commissioner during the rule making process or by the physician. **Smoking is not a method approved by the bill.**	**New York Department of Health** **Website:** New York State Medical Marijuana Program **Information provided by the state on sources for medical marijuana:** The health commissioner will register up to five organizations to manufacture medical marijuana, each of which may own and operate no more than four dispensing sites. **Patient Registry Fee:** $50 **Accepts other states' registry ID cards?** No **Registration:** Mandatory
21. **Oregon** **Ballot Measure 67** (75 KB) -- Approved by 55% of voters on Nov. 3, 1998 **Effective:** Dec. 3, 1998 Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess a signed recommendation from their physician stating that marijuana "may mitigate" his or her debilitating symptoms. **Approved Conditions:** Cancer, glaucoma, positive status for HIV/AIDS, or treatment for these conditions; A medical condition or treatment for a medical condition that produces cachexia, severe pain, severe nausea, seizures, including	**Oregon Department of Human Services** Medical Marijuana Program PO Box 14116 Portland, OR 97293 Phone: 855-244-9580 (toll-free) medmj.dispensaries@state.or.us **Website:** Oregon Medical Marijuana Program (OMMP) **Information provided by the state on sources for medical marijuana:** The Oregon Medical Marijuana Dispensary Program publishes a directory of approved dispensaries n its website.

seizures caused by epilepsy, or persistent muscle spasms, including spasms caused by multiple sclerosis. Other conditions are subject to approval by the Health Division of the Oregon Department of Human Resources.

Possession/Cultivation: A registry identification cardholder or the designated primary caregiver of the cardholder may possess up to six mature marijuana plants and 24 ounces of usable marijuana. A registry identification cardholder and the designated primary caregiver of the cardholder may possess a combined total of up to 18 marijuana seedlings. (per Oregon Revised Statutes ORS 475.300 -- ORS 475.346) (52 KB)

Amended: Senate Bill 1085 (52 KB)
Effective: Jan. 1, 2006

State-qualified patients who possess cannabis in amounts exceeding the new state guidelines will no longer retain the ability to argue an "affirmative defense" of medical necessity at trial. Patients who fail to register with the state, but who possess medical cannabis in amounts compliant with state law, still retain the ability to raise an "affirmative defense" at trial.

The law also redefines "mature plants" to include only those cannabis plants that are more than 12 inches in height and diameter, and establish a state-registry for those authorized to produce medical cannabis to qualified patients.

Amended: House Bill 3052
Effective: July 21, 1999

Mandates that patients (or their caregivers) may only cultivate marijuana in one location, and requires that patients must be diagnosed by their physicians at least 12 months prior to an arrest in order to present an "affirmative defense." This bill also states that law enforcement officials who seize marijuana from a patient pending trial do not have to keep those plants alive. Last year the Oregon Board of Health approved agitation due to Alzheimer's disease to the list of debilitating conditions qualifying for legal protection.

In August 2001, program administrators filed established temporary procedures further defining the relationship between physicians and patients. The new rule defines attending physician as "a physician who has established a physician/patient relationship with the patient;... is primarily responsible for the care and treatment of the patients... has reviewed a patient's medical records at the patient's request, has conducted a thorough physical examination of the patient, has provided a treatment plan and/or follow-up care, and has documented these activities in a patient file."

Amended: SB 281 (25 KB)
Signed by Gov. John Kitzhaber on June 6, 2013

Adds post-traumatic stress disorder (PTSD) to the list of approved conditions for medical marijuana use.

Amended: HB 3460 (50 KB)
Signed by Gov. John Kitzhaber on Aug. 14, 2013

Creates a dispensary program by allowing the state licensing and regulation of medical marijuana facilities to transfer marijuana to registry identification cardholders or their designated primary caregivers.

Updates: On March 3, 2014, the program began accepting applications from people seeking a license to operate a medical marijuana dispensary.

Patient Registry Fee:
$200 for new applications and renewals; $100 for application and annual renewal fee for persons receiving SNAP (food stamp) and for Oregon Health Plan cardholders; $20 for persons receiving SSI benefits

An additional $50 grow site registration fee is charged if the patient is not his or her own grower.

Accepts other states' registry ID cards?
No

Registration:
Mandatory

On March 19, 2014, Senate Bill 1531 (30 KB) was signed into law. The bill allows local governments to restrict the operation of medical marijuana dispensaries, including the moratoriums up through May 1, 2015.

On April 18, 2014, the Medical Marijuana Dispensary Program approved 15 dispensary applications, bringing the total number of approved applications to 58.

22. Rhode Island

Senate Bill 0710 -- Approved by state House and Senate, vetoed by the Governor. Veto was over-ridden by House and Senate.

Timeline:

1. June 24, 2005: passed the House 52 to 10
2. June 28, 2005: passed the State Senate 33 to 1
3. June 29, 2005: Gov. Carcieri vetoed the bill
4. June 30, 2005: Senate overrode the veto 28-6
5. Jan. 3, 2006: House overrode the veto 59-13 to pass the Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act (48 KB) (Public Laws 05-442 and 05-443)
6. June 21, 2007: Amended by Senate Bill 791 (30 KB) **Effective:** Jan. 3, 2006

Approved Conditions: Cancer, glaucoma, positive status for HIV/AIDS, Hepatitis C, or the treatment of these conditions; A chronic or debilitating disease or medical condition or its treatment that produces cachexia or wasting syndrome; severe, debilitating, chronic pain; severe nausea; seizures, including but not limited to, those characteristic of epilepsy; or severe and persistent muscle spasms, including but not limited to, those characteristic of multiple sclerosis or Crohn's disease; or agitation of Alzheimer's Disease; or any other medical condition or its treatment approved by the state Department of Health.

If you have a medical marijuana registry identification card from any other state, U.S. territory, or the District of Columbia you may use it in Rhode Island. It has the same force and effect as a card issued by the Rhode Island Department of Health.

Possession/Cultivation: Limits the amount of marijuana that can be possessed and grown to up to 12 marijuana plants or 2.5 ounces of cultivated marijuana. Primary caregivers may not possess an amount of marijuana in excess of 24 marijuana plants and five ounces of usable marijuana for qualifying patients to whom he or she is connected through the Department's registration process.

Amended: H5359 (70 KB) - The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act (substituted for the original bill)

Timeline:

1. **May 20, 2009:** passed the House 63-5
2. **June 6, 2009:** passed the State Senate 31-2
3. **June 12, 2009:** Gov. Carcieri vetoed the bill (60 KB)
4. **June 16, 2009:** Senate overrode the veto 35-3
5. **June 16, 2009:** House overrode the veto 67-0

Effective June 16, 2009: Allows the creation of compassion centers, which may acquire, possess, cultivate, manufacture, deliver, transfer, transport,

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Office of Health Professions Regulation, Room 104
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Providence, RI 02908-5097
Phone: 401-222-2828

mmp@health.ri.gov

Website:
RI Medical Marijuana Program (MMP)

Information provided by the state on sources for medical marijuana:
The Department of Health had approved three compassion centers to be licensed. but only two were operational as of Apr. 24, 2014.

Patient Registry Fee:
$75/$10 for applicants on Medicaid or Supplemental Security Income (SSI)

Accepts other states' registry ID cards?
Yes, but only for the conditions approved in Rhode Island

Registration:
Mandatory

supply, or dispense marijuana, or related supplies and educational materials, to registered qualifying patients and their registered primary caregivers. Rules & Regulations (60 KB) last updated Dec. 2012. The first dispensary, the Thomas C. Slater Compassion Center, opened on Apr. 19, 2013. Compassion centers must be operated on a not-for-profit basis.	
23. Vermont **Senate Bill 76** (45 KB) -- Approved 22-7; House Bill 645 (41 KB) -- Approved 82-59 **"Act Relating to Marijuana Use by Persons with Severe Illness"** (Sec. 1. 18 V.S.A. chapter 86 (41 KB) passed by the General Assembly) *Gov. James Douglas (R), allowed the act to pass into law unsigned on May 26, 2004* **Effective:** July 1, 2004 **Amended:** Senate Bill 00007 (65 KB) **Effective:** May 30, 2007 **Approved Conditions:** Cancer, AIDS, positive status for HIV, multiple sclerosis, or the treatment of these conditions if the disease or the treatment results in severe, persistent, and intractable symptoms; or a disease, medical condition, or its treatment that is chronic, debilitating and produces severe, persistent, and one or more of the following intractable symptoms: cachexia or wasting syndrome, severe pain or nausea or seizures. **Possession/Cultivation:** No more than two mature marijuana plants, seven immature plants, and two ounces of usable marijuana may be collectively possessed between the registered patient and the patient's registered caregiver. A marijuana plant shall be considered mature when male or female flower buds are readily observed on the plant by unaided visual examination. Until this sexual differentiation has taken place, a marijuana plant will be considered immature. **Amended:** Senate Bill 17 (100 KB) "An Act Relating To Registering Four Nonprofit Organizations To Dispense Marijuana For Symptom Relief" Signed by Gov. Peter Shumlin on June 2, 2011 The bill "establishes a framework for registering up to four nonprofit marijuana dispensaries in the state... A dispensary will be permitted to cultivate and possess at any one time up to 28 mature marijuana plants, 98 immature marijuana plants, and 28 ounces of usable marijuana." On Sep. 12, 2012, the State of Vermont Department of Public Safety announced conditional approval (65 KB) of two medical marijuana dispensaries. In June 2013, two dispensaries opened in Vermont.	**Marijuana Registry** Department of Public Safety 103 South Main Street Waterbury, Vermont 05671 Phone: 802-241-5115 DPS.VTMR@state.vt.us **Website:** VT Marijuana Registry Program **Information provided by the state on sources for medical marijuana:** "The Marijuana Registry is neither a source for marijuana nor can the Registry provide information to patients on how to obtain marijuana." (accessed Apr. 24, 2014) **Patient Registry Fee:** $50 **Accepts other states' registry ID cards?** No **Registration:** Mandatory
24. Washington **Chapter 69.51A RCW** (4KB) **Ballot Initiative I-692** -- Approved by 59% of voters on Nov. 3, 1998 **Effective:** Nov. 3, 1998 Removed state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess "valid documentation" from their physician affirming that he or she suffers from a debilitating condition and that the	**Department of Health** PO Box 47866 Olympia, WA 98504-7866 Phone: 360-236-4700 Fax: 360-236-4768 MedicalMarijuana@doh.wa.gov **Website:** Medical Marijuana (Cannabis)

"potential benefits of the medical use of marijuana would likely outweigh the health risks."

Approved Conditions: cachexia; cancer; HIV or AIDS; epilepsy; glaucoma; intractable pain (defined as pain unrelieved by standard treatment or medications); and multiple sclerosis. Other conditions are subject to approval by the Washington Board of Health. **Additional conditions as of Nov. 2, 2008:** Crohn's disease, Hepatitis C with debilitating nausea or intractable pain, diseases, including anorexia, which result in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms, or spasticity, when those conditions are unrelieved by standard treatments or medications. **Added as of Aug. 31, 2010:** chronic renal failure

Amended: **Senate Bill 6032** (29 KB)
Effective: 2007 (rules being defined by Legislature with a July 1, 2008 due date)

Amended: Final Rule (123 KB) based on Significant Analysis (370 KB)
Effective: Nov. 2, 2008

Possession/Cultivation: A qualifying patient and designated provider may possess a total of no more than twenty-four ounces of usable marijuana, and no more than fifteen plants. This quantity became the state's official "60-day supply" on Nov. 2, 2008.

Amended: SB 5073 (375 KB)
Effective: July 22, 2011
Gov. Christine Gregoire signed sections of the bill and partially vetoed others, as explained in the Apr. 29, 2011 veto notice. (50 KB) Gov. Gregoire struck down sections related to creating state-licensed medical marijuana dispensaries and a voluntary patient registry.

Updates: On Jan. 21, 2010, the Supreme Court of the State of Washington ruled that Ballot Initiative "I-692 did not legalize marijuana, but rather provided an authorized user with an affirmative defense if the user shows compliance with the requirements for medical marijuana possession." *State v. Fry* (125 KB)

ProCon.org contacted the Washington Department of Health to ask whether it had received any instructions in light of this ruling. Kristi Weeks, Director of Policy and Legislation, stated the following in a Jan. 25, 2010 email response to ProCon.org:

> "The Department of Health has a limited role related to medical marijuana in the state of Washington. Specifically, we were directed by the Legislature to determine the amount of a 60 day supply and conduct a study of issues related to access to medical marijuana. Both of these tasks have been completed. We have maintained the medical marijuana webpage for the convenience of the public.
>
> The department has not received 'any instructions' in light of State v. Fry. That case does not change the law or affect the 60 day supply. Chapter 69.51A RCW, as confirmed in Fry, provides an affirmative defense to prosecution for possession of marijuana for qualifying patients and caregivers."

Information provided by the state on sources for medical marijuana:
"The law allows a qualifying patient or designated provider to grow medical marijuana. It is not legal to buy or sell it... The law does not allow dispensaries." "General Frequently Asked Questions," doh.wa.gov (accessed Apr. 24, 2014)

Note: Washington now allows state-licensed retail stores to sell marijuana. The state website says that qualified patients "can still grow their own marijuana or participate in a collective garden if they don't want to buy from a state-licensed retail store."

Patient Registry Fee:
No state registration program has been established

Accepts other states' registry ID cards?
No

Registration:
None

On Nov. 6, 2012, Washington voters passed Initiative 502, which allows the state to "license and regulate marijuana production, distribution, and possession for persons over 21 and tax marijuana sales." The website for Washington's medical marijuana program states that the initiative "does not amend or repeal the medical marijuana laws (chapter 69.51A RCW) in any way. The laws relating to authorization of medical marijuana by healthcare providers are still valid and enforceable." SB 5052 (840 KB) passed the House by a vote of 60-36 on Apr. 10, 2015 and the Senate by a vote of 41-8 on Apr. 14, 2015. Gov. Jay Inslee signed the bill into law with partial vetoes on Apr. 24, 2015. The law creates a voluntary registry and allows registered patients to possess three times as much marijuana as allowed by the recreational marijuana law. Patients will be allowed to purchase medical-grade products at some stores that sell legal recreational marijuana.	

For a detailed list of sources used to compile this information, please see our sources page.

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Summaries by State from Various Organizations

A summary listing of states with medical marijuana laws from the Marijuana Policy Project.

A summary listing of states with medical marijuana laws from the Marijuana Policy Project (MPP), updated September 2015.

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"We change laws."

Key Aspects of State and D.C. Medical Marijuana Laws

State	Year Initially Enacted	Home Cultivation	Caregivers	Possession Limits	Dispensaries	Qualifying Conditions	ID Cards?	Recognizes Out-of-State ID Cards?
Alaska	1998, initiative, revised later by the legislature.	Allowed.	Yes. Caregivers can assist only one patient, unless the caregiver is a relative of more than one patient.	One ounce of marijuana, six plants.	Not allowed, but voters legalized marijuana for adults' use in 2012. Beginning in 2016, it will be possible for patients (and everyone else) over 21 to purchase from recreational marijuana stores.	Cancer, HIV/AIDS, glaucoma, cachexia, severe pain, severe nausea, seizures, and persistent muscle spasms.* The health department can approve additional conditions.	Yes, through the Department of Health and Social Services.	No.
Ariz.	2010, initiative.	Allowed in enclosed, locked facility if the patient does not live within 25 miles of a dispensary.	Yes. Caregivers can assist up to five patients. Caregivers cannot be paid for their services, but they may be reimbursed for actual expenses.	Two and one-half ounces of marijuana, 12 plants for those allowed to cultivate.	Yes. As of July 2015, 91 Department of Health Services-regulated non-profit dispensaries have been approved to operate with seven more being processed. Sales are subject to a 6.6% sales tax.	Cancer, HIV/AIDS, Hepatitis C, ALS, Crohn's disease, glaucoma, Alzheimer's, severe and chronic pain, cachexia, severe nausea, seizures, PTSD, or persistent muscle spasms. The Department of Heath Services can approve additional conditions.	Yes, through the Department of Health Services.	Yes, for patients with conditions that qualify under Arizona law. Does not allow out-of-state patients to obtain marijuana from dispensaries.

Last updated: September 9, 2015

Disclaimer: This grid is not intended for or offered for legal advice. It is for informational and educational purposes only. It also does not capture nuances of the laws, many of which are a dozen or more pages. Please consult with an attorney licensed to practice in the state in question for legal advice.

State	Year Initially Enacted	Home Cultivation	Caregivers	Possession Limits	Dispensaries	Qualifying Conditions	ID Cards?	Recognizes Out-of-State ID Cards?
Calif.	1996, initiative, added to later by the legislature.	Allowed.	Yes. Caregivers must have "consistently assumed responsibility for the housing, health, or safety of [the] patient."	No more than eight ounces and six mature plants, or 12 immature plants. Counties can allow more and a defense can be raised for more.	Collectives and cooperatives are allowed. There is no state licensing, but some localities issue licenses and regulations. They pay the state sales tax and some cities have specific taxes.	"Cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief."	Yes, optional. Issued by the Department of Public Health.	No.
Colo.	2000, amendment to state constitution approved by voters, legislation enacted later.	Allowed.	Yes. A caregiver must have "significant responsibility for managing the well-being of the patient." Generally, a caregiver cannot assist more than five patients.	Two ounces of marijuana, six plants.	Yes. 505 licensed medical marijuana centers, 748 growers, and 163 infused product makers are regulated by the department of revenue and local governments as of July 2015. Medical marijuana is subject to sales tax, with an exemption for indigent patients.	Cancer, HIV/AIDS, glaucoma, severe pain, cachexia, severe nausea, seizures, and persistent muscle spasms. The health department can approve additional conditions.	Yes. Issued by the Department of Public Health and Environment.	No.
Conn.	2012, legislation.	Not allowed.	Yes, a caregiver can serve one patient (or more for close family). The need for a caregiver must be evaluated by the physician and be included in a written certification.	A one-month supply, to be determined by the Department of Consumer Protection.	Yes. The Department of Consumer Protection has approved six dispensary facilities and four growers. Medical marijuana is subject to state sales tax.	Cancer, glaucoma, HIV/AIDS, Parkinson's disease, multiple sclerosis, spinal cord damage causing intractable spasticity, epilepsy, cachexia, wasting syndrome, Crohn's disease, or PTSD. The department can add conditions.	Yes. Issued by the Department of Consumer Protection. Temporary registrations are currently available.	No.

State	Year Initially Enacted	Home Cultivation	Caregivers	Possession Limits	Dispensaries	Qualifying Conditions	ID Cards?	Recognizes Out-of-State ID Cards?
Del.	2011, legislation.	Not allowed.	Yes. Caregivers can assist up to five patients.	Up to six ounces at one time.	Yes. A single compassion center opened in 2015. Only revenues above $1.2 million per year are subject to gross receipts taxes.	Cancer, HIV/AIDS, ALS, decompensated cirrhosis, Alzheimer's, PTSD, debilitating pain that has not responded to other treatments or if they produced serious side effects, intractable nausea, seizures, and persistent muscle spasms. The health department can add conditions.	Yes. Issued by the Department of Health and Social Services.	Yes, for patients with conditions that qualify under Delaware law. Dispensaries can only provide marijuana to patients with a Delaware ID card.
D.C.	1998, initiative, later revised by D.C. Council. Because of intervention by Congress, the law did not go into effect until July 2010.	All adults 21 and older may cultivate up to six plants. Medical patients under 21 may not cultivate their own medicine.	Yes. Caregivers can assist only one patient.	Up to two ounces in a 30-day period, obtained from a registered dispensary. The mayor can increase this to four ounces.	Yes, as of August 2015, there are five operational dispensaries and seven operational cultivation centers. Dispensaries must have a sliding scale of prices for low-income patients. Six percent sales tax.	"Any condition for which treatment with medical marijuana would be beneficial, as determined by the patient's physician."	Yes. Issued by the Department of Health.	No.

State	Year Initially Enacted	Home Cultivation	Caregivers	Possession Limits	Dispensaries	Qualifying Conditions	ID Cards?	Recognizes Out-of-State ID Cards?
Hawaii	2000, legislation.	Allowed.	Yes. Caregivers can assist only one patient.	A patient and caregiver can collectively possess four ounces of usable marijuana and seven marijuana plants.	Pursuant to a law enacted in 2015, the department of health will issue eight licenses, with two production centers and two retail dispensaries allowed for each license.	Severe pain, cachexia, severe nausea, seizures, or severe and persistent muscle spasms. The health department can approve additional conditions.	Yes, through the Department of Public Health.	No.
Ill.	2013, legislation.	Not allowed.	Yes. Caregivers can assist only one patient.	2.5 ounces of marijuana, unless a waiver is granted for more.	Yes. There will be 60 dispensaries and 22 cultivation facilities. Licenses were issued in February 2015. Facilities are yet not open as of July 2015. There will be a 7% excise tax at the wholesale level and a 1% sales tax.	One of 33 specific medical conditions, including HIV/AIDS, cancer, spinal cord injury or disease, MS, and residual limb pain. The health department can add conditions.	Yes, through the Department of Public Health.	No.
Maine	1999, initiative, revised later by initiative and the legislature.	Allowed in enclosed, locked location.	Yes. Caregivers can assist up to five patients at a time.	2.5 ounces. The patient, caregiver, or dispensary can grow up to six mature plants for a patient and may have plants at other states of harvesting.	Yes. Health department regulated non-profit dispensaries are allowed. So far, eight have been registered. They are subject to the state sales tax.	Cancer, HIV/AIDS, ALS, Hepatitis C, Crohn's, nail patella, glaucoma, Alzheimer's, intractable pain, cachexia, severe nausea, seizures, persistent muscle spasms, and PTSD. The health department can add conditions.	Yes, optional for patients and some caregivers. Issued by the Department of Health and Human Services.	Yes.

State	Year Initially Enacted	Home Cultivation	Caregivers	Possession Limits	Dispensaries	Qualifying Conditions	ID Cards?	Recognizes Out-of-State ID Cards?
Mass.	2012, initiative.	In some cases, such as financial hardship or if a dispensary is far away. Must grow in enclosed, locked location.	Yes. Unless an exception applies — such as for immediate family and medical professionals — caregivers may assist one patient.	A 60-day supply. The health department set a 10-ounce presumptive amount, but physicians may specify a patient needs a greater amount. No set number of plants is included.	Yes. The health department provisionally approved 15 non-profit dispensaries in 2014. The first one opened in June 2015. More can be approved later. As a medicine, marijuana will not be subject to sales tax.	Cancer, glaucoma, HIV/AIDS, Hepatitis C, ALS, Crohn's disease, Parkinson's, multiple sclerosis, or another debilitating condition approved of by a patient's physician. Debilitating is defined as causing symptoms such as weakness or intractable pain "to such an extent that one or more of a patient's major life activities is substantially limited."	Yes, through the Department of Public Health.	No.
Md.	2014, legislation; prior, incomplete laws in 2013, 2011, and 2003.	No.	Yes. Caregivers can assist up to five patients at a time. For minor patients, parents and legal guardians are automatically considered caregivers.	A 30-day supply, which — unless a physician determines it inadequate — is defined as 120 grams of usable cannabis or 36 grams of THC via an infused product.	Yes. The Medical Marijuana Commission may issue up to two dispensary licenses in each of the 47 state Senate districts. It may also license up to 15 cultivators initially, with the possibility of increasing that number in 2018, each of which may also hold a dispensary license that will not be counted against the limit of two per Senate district.	Any medical condition or treatment that causes cachexia, anorexia, wasting, severe or chronic pain, severe nausea, seizures, or severe or persistent muscle spasms. Also, other severe conditions "for which other medical treatments have been ineffective … if the symptoms reasonably can be expected to be relieved by the medical use of marijuana."	Yes, issued by the Medical Marijuana Commission.	No.
Mich.	2008, initiative, some legislative changes in 2012.	Allowed in enclosed, locked location.	Yes. Caregivers can assist up to five patients at a time.	2.5 ounces. The patient or caregiver can grow up to 12 plants for a patient.	Not provided for in the state law, though some cities have local ordinances.	Cancer, HIV/AIDS, Hepatitis C, ALS, Crohn's disease, nail patella, glaucoma, Alzheimer's, PTSD, severe and chronic pain, cachexia, severe nausea, seizures, or severe and persistent muscle spasms. The department can add conditions.	Yes, through the Department of Licensing and Regulatory Affairs.	Yes.

State	Year Initially Enacted	Home Cultivation	Caregivers	Possession Limits	Dispensaries	Qualifying Conditions	ID Cards?	Recognizes Out-of-State ID Cards?
Minn.	2014, legislation.	Not allowed.	Yes. Caregivers may assist a single patient, unless two patients reside at the same location, in which case they may assist two.	A 30-day supply, as determined by the pharmacist dispensing the cannabis.	Yes, two manufacturers will be approved by December 2014 or May 2015 and each will have at least four distribution points by July 2016. The first two dispensaries opened in July 2015.	Cancer, HIV/AIDS, Tourette's, ALS, seizures, severe spasms, Crohn's, and terminal illnesses. The department may add conditions, provided the legislature does not object. It may add other conditions, starting with intractable pain.	Yes, through the Department of Health.	No.
Mont.	2011, legislation replaced 2004 voter initiative. Parts of the new law have been blocked in court.	Allowed.	Yes. Under the revised law, caregivers can assist only three and cannot be compensated; however, this limitation has been blocked by injunction.	Four mature plants, 12 seedlings, and one ounce.	Not explicitly allowed, but caregivers could assist an unlimited number of patients until mid-2011, resulting in storefront operations. However, the three patient cap part of the new law is currently enjoined.	Cancer, HIV/AIDS, glaucoma, cachexia, intractable nausea or vomiting, seizure disorder, multiple sclerosis, Crohn's, painful peripheral neuropathy, admittance to hospice care, or in some cases, severe pain or spasms.	Yes, through the Department of Health and Human Services.	No. The state had reciprocity prior to the 2011 law.
Nev.	1998 and 2000, amendment to state constitution approved by voters, legislation followed in 2001 and 2013.	Allowed.	Yes. Caregivers must have significant responsibility for managing a patient's well-being. Marijuana cannot be delivered for compensation.	2.5 ounces every 14 days, 12 plants (for those allowed to grow), and an amount of marijuana-infused products to be set by the Health Division.	Yes, a 2013 law allows up to 66 dispensaries regulated by the Health Division, along with growers, infused product makers, and labs. In February 2015, 55 dispensaries were given provisional licenses. The first opened in July 2015. Sales taxes and 2% excise taxes apply.	Cancer, HIV/AIDS, glaucoma, PTSD, severe pain, cachexia, severe nausea, seizures, or persistent muscle spasms. The health department can approve additional conditions.	Yes, through the Department of Health and Human Services.	Yes, since April 2014. The law requires patients to have an ID card and to sign an affidavit created by the Health Division. The division is instead requiring paperwork filed with dispensaries. In April 2016, the process will change.

State	Year Initially Enacted	Home Cultivation	Caregivers	Possession Limits	Dispensaries	Qualifying Conditions	ID Cards?	Recognizes Out-of-State ID Cards?
N.H.	2013, legislation.	Not allowed.	Yes. Caregivers can generally help no more than five patients.	Two ounces of marijuana.	Yes. There will be four non-profit alternative treatment centers. The first centers are expected to open around March 2016.	The patient must have a qualifying symptom and: cancer, glaucoma, HIV/AIDS, Hepatitis C, ALS, muscular dystrophy, Crohn's, Alzheimer's, multiple sclerosis, chronic pancreatitis, spinal cord injury or disease, traumatic brain injury, or injuries that significantly interfere with daily activities. The department may grant waivers for patients with other conditions.	Yes, through the Department of Health and Human Services.	Yes, for patients with conditions qualifying in New Hampshire. They must bring their own marijuana.
N.J.	2010, legislation.	Not allowed.	Yes. Caregivers can assist only one patient.	No more than two ounces can be dispensed to a patient in 30 days.	Yes. In March 2011, six state-regulated "alternative treatment centers" were registered. As of July 2015, five are operational, with three actively dispensing and two more cultivating.	ALS, multiple sclerosis, muscular dystrophy, inflammatory bowel disease, cancer, HIV/AIDS, terminal illness, seizure disorders, intractable skeletal muscular spasticity, and glaucoma.* The health department may add conditions.	Yes, through the Department of Health and Senior Services.	No.

State	Year Initially Enacted	Home Cultivation	Caregivers	Possession Limits	Dispensaries	Qualifying Conditions	ID Cards?	Recognizes Out-of-State ID Cards?
N.M.	2007, legislation.	Allowed with special permit and possible inspection.	Yes. Caregivers can assist up to four patients at a time.	Six ounces. Patients with cultivation licenses are also allowed to cultivate four mature plants and 12 seedlings. Caregivers may assist patients who produce cannabis, but may not do so independently.	Yes. As of September 2015, there are 23 "licensed producers" that can grow no more than 450 plants. The state health department regulates the licensed producers and is reviewing applications for more licensees. Medical marijuana sales are subject to gross receipts tax.	Severe chronic pain, cachexia, epilepsy, neuropathy, ALS, cancer, intractable nausea/vomiting, Hepatitis C, Crohn's, PTSD, glaucoma, MS, spinal cord damage with spasticity, ulcerative colitis, certain types of arthritis, cervical dystonia, inclusion body myositis, Parkinson's, HIV/ AIDS, Huntington's, and hospice patients. The health department may add conditions.	Yes, through the Department of Health.	No.
N.Y.	2014, legislation.	Not allowed.	Yes. Caregivers may assist no more than five patients.	Patients may possess a 30-day supply, an amount that will be determined either by the health commissioner or by the patient's physician.	Yes. In July 2015, the health department gave preliminary approval to five manufacturers (the maximum number), which may have no more than four dispensing locations each. A 7% excise tax will be applied to marijuana sales.	Cancer, HIV/AIDS, Parkinson's, MS, spinal cord damage causing spasticity, epilepsy, inflammatory bowel disease, ALS, neuropathies, or Huntington's disease. The health commissioner may add or delete conditions.	Yes, through the Department of Health.	No.

State	Year Initially Enacted	Home Cultivation	Caregivers	Possession Limits	Dispensaries	Qualifying Conditions	ID Cards?	Recognizes Out-of-State ID Cards?
Ore.	1998, initiative, revised later by legislature.	Allowed at registered grow sites. No one can produce marijuana for more than four people at a time.	Yes. A caregiver must have "significant responsibility for managing the well-being" of the patient.	24 ounces of marijuana, six mature plants, and 18 immature plants.	Yes. State-registered and state-regulated medical marijuana facilities may receive marijuana from patients, caregivers, and persons responsible for grow sites. As of July 2015, 310 dispensaries have been approved.	Cancer, HIV/AIDS, glaucoma, Alzheimer's, cachexia, severe pain, severe nausea, seizures, PTSD, and persistent muscle spasms. The health department can add medical conditions.	Yes, through the Department of Human Services.	No.
R.I.	2006, legislation, revised later by legislature.	Allowed in enclosed, locked facility.	Yes. Patients are allowed up to two caregivers (dispensaries are considered caregivers). Caregivers can assist up to five patients.	2.5 ounces, 12 plants, and 12 seedlings. Caregivers can possess that much per patient, with a total cap of 24 plants and five ounces.	Yes. As of July 2015, two compassion centers are open and a third has been approved but is not yet open. Sales tax applies, along with a 4% surcharge.	Cancer, HIV/AIDS, Hepatitis C, glaucoma, severe nausea, Alzheimer's, debilitating pain, cachexia, seizures, and persistent muscle spasms. The health department can add conditions.	Yes, through the state Department of Health.	Yes.
Vt.	2004, legislation, revised later by legislature.	Allowed in enclosed, locked facility.	Yes. Caregivers can assist only one patient.	Two ounces of marijuana, two mature plants, and seven immature plants.	Yes. Four non-profit dispensaries are open.	Cancer, multiple sclerosis, HIV/AIDS, severe pain, cachexia, severe nausea, or seizures.*	Yes, through the Department of Public Safety.	No.
Wash.	1998, initiative, revised later by legislature.	Allowed.	Yes. Caregivers can only assist one patient at a time.	24 ounces of marijuana and 15 plants, with a defense for more. Patients can collectively grow, with no more than 10 patients, 72 ounces, and 45 plants.	In 2012, voters approved allowing stores to sell adults 21 and older marijuana. The first stores opened in July 2014. As of July 2015, 156 stores are open.	Cancer, HIV/AIDS, multiple sclerosis, seizures, spasm disorders, Crohn's, intractable pain, glaucoma, Hepatitis C, PTSD, Traumatic Brain Injury, nausea, vomiting, and appetite loss.	No. This law only has an affirmative defense that prevents conviction. However, under Washington law, all adults 21 and older can possess up to one ounce of marijuana.	No.

* = Some or all of this state's listed illnesses must be resistant to other treatments.

Summaries by State from Various Organizations

A detailed listing of states with medical marijuana laws from the Marijuana Policy Project.

A detailed listing of states with medical marijuana laws from the Marijuana Policy Project (MPP), updated September 2015.

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"We change laws."

The Twenty-Three States and One Federal District With Effective Medical Marijuana Laws

Twenty-three U.S. states and the District of Columbia have enacted laws that remove criminal sanctions for the medical use of marijuana, define eligibility for such use, and allow some means of access — either through dispensaries, home cultivation, or both. In addition, several states have laws that recognize the medical benefits of medical marijuana — or at least certain strains — but that do not actually provide access to medical marijuana due to federal law or policies.[1]

In each of the states, a doctor's recommendation or certification is required for a patient to qualify. In all of those laws, except California, Massachusetts, and Maryland's, a physician must certify that the patient has a specific serious medical condition or symptom that is listed in the law. The laws generally include cancer, AIDS, multiple sclerosis, severe or debilitating pain, and severe nausea. The laws also protect physicians who make the recommendations and include designated caregivers who may assist one or more patients, such as by picking up their medicine for them from a dispensary. In all of the jurisdictions except Washington state, a patient can obtain a state or county-issued ID card after a state agency receives the patient's application, a fee, and the physician's certification. The cards typically have to be renewed each year, though some states allow them to be renewed every two years.

Most of the laws specify that they do not allow marijuana to be smoked in public or possessed in correctional facilities. The laws generally specify that employers do not have to allow on-site marijuana use or employees working while impaired, and several specify that they do not protect conduct that would be considered negligent. Most specify that insurance is not required to cover the costs of medical marijuana.

Fifteen of the laws allow at least some patients to cultivate a modest amount of marijuana at their homes. In one of those states, Arizona, patient cultivation is only allowed if the patient lives at least 25 miles away from a dispensary. Nevada's law only allows certain patients to cultivate, including those living 25 miles or more from a dispensary. In Massachusetts, patient cultivation is allowed only under certain circumstances, such as due to financial hardship. The states that allow home cultivation also allow patients to designate a caregiver to cultivate for them.

Seventeen states' and D.C.'s laws allow for state-regulated dispensing, though some of the laws are so new their dispensaries are not yet up and running. The states with state-registered dispensary laws are Arizona, Colorado, Connecticut, Delaware, Illinois, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, and Vermont. In addition, California has hundreds of dispensaries, many of which are regulated at the local level, but there is no statewide licensing or regulation of them.

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[1] In addition to those 23 states, several states have laws that recognize marijuana's medical value but these laws are ineffective because they rely on federal cooperation. In 2014, Alabama, Florida, Iowa, Kentucky, Mississippi, Missouri, North Carolina, South Carolina, Tennessee, Utah, and Wisconsin enacted bills intended to allow at least some patients to use CBD (a component of marijuana) or high-CBD marijuana. Unfortunately, with the exception of Missouri and possibly Florida, they fail to include reasonable means for accessing marijuana.

Last updated: July 25, 2014

Finally, Washington state's law does not provide for regulated dispensaries, but it does allow marijuana stores for adults.

This paper provides an overview of key provisions of each of the 24 effective medical marijuana laws.

Alaska — Measure 8, a ballot initiative, passed with 58% of the vote in 1998, and was modified by S.B. 94 in 1999. The law's citation is **Alaska Stat. § 17.37.010** et seq.

Qualifying for the Program: To qualify for an ID card, a patient must have a qualifying condition and a statement from an Alaska-licensed physician who has personally examined the patient stating that "the physician has considered other approved … treatments that might provide relief … and that the physician has concluded that the patient might benefit from the medical use of marijuana." A minor patient only qualifies with the consent of his or her parent or guardian and if the adult controls the dosage, acquisition, and frequency of use of the marijuana. The qualifying conditions in Alaska are cancer, HIV/AIDS, glaucoma, and conditions causing one or more of the following: cachexia, severe pain, severe nausea, seizures, or persistent muscle spasms, including those that are characteristic of multiple sclerosis. The health department can approve additional medical conditions.

Protections, Access, and Possession Limits: Alaska's law allows a patient with a registry identification card to possess one ounce of processed marijuana and cultivate six plants, only three of which can be mature plants. It only provides an affirmative defense, not protection from arrest. Each patient may have one primary caregiver and one alternate caregiver. Caregivers must be 21 years of age or older and can only serve one patient, unless the caregiver is a relative of more than one patient. They cannot be on parole or probation and cannot have certain drug felonies. Alaska's law does not include any protections for unregistered patients.

Arizona — Proposition 203, a ballot initiative, passed with 50.1% of the vote on November 2, 2010. It went into effect when the election results were certified on December 14, 2010. The law is codified at **Ariz. Rev. Stat. Chapter 36-28.1**. The Department of Health Services issued **rules** on March 28, 2011. In 2011, the legislature passed two laws to undermine Prop. 203 — H.B. 2585, which adds the medical marijuana registry to the prescription drug monitoring registry, and H.B. 2541, which relates to employment law. In 2012, the legislature passed another law to undermine Prop. 203 — HB 2349 — which prohibited medical marijuana on college campuses. The next year, in 2013, the legislature passed SB 1443 to clarify that federally approved medical marijuana research could still be conducted at universities.

Qualifying for the Program: To qualify for an ID card, a patient must have a qualifying condition, must be "likely to receive therapeutic or palliative benefit" from the medical use of marijuana, and must obtain a statement from a physician with whom the patient has a bona fide relationship. A minor patient only qualifies with two physician certifications and the consent of his or her parent or guardian. Moreover, the adult must control the dosage, acquisition, and frequency of use of the marijuana. The qualifying conditions in Arizona are cancer, HIV/AIDS, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, glaucoma, agitation related to Alzheimer's disease, PTSD, and conditions causing one or more of the following: severe and chronic pain, cachexia or wasting, severe nausea, seizures, or persistent muscle spasms. The Department of Health Services (DHS) can approve additional medical conditions — PTSD was added by DHS in 2014. The DHS also administers the ID card program.

Patient Protections: Arizona's law allows a patient with a registry identification card to possess 2.5 ounces of processed marijuana. Registered caregivers may possess up to 2.5 ounces for each patient they assist. The law provides that registered patients and caregivers abiding by the act are "not subject to arrest, prosecution or penalty in any manner, or denial of any right or

privilege, including any civil penalty or disciplinary action …" for doing so. It also prevents landlords, employers, and schools from discriminating based on a person's status as a caregiver or patient, unless they would otherwise lose a federal monetary or licensing benefit. In 2012, Gov. Brewer signed HB 2349, which banned medical marijuana on all schools, including college campuses and vocational schools.

Employers generally cannot penalize staff for testing positive for marijuana unless they ingest marijuana at work or are impaired at work. In 2011, the legislature passed and Gov. Brewer signed a bill that undermines employment protections, allowing employers to depend on reports of impairment by a colleague who is "believed to be reliable" and seeming to allow termination based on a positive drug test. Prop. 203 also provides some protection for child custody and visitation rights and some protections for residents of nursing homes and other assisted living facilities.

Arizona honors visiting patients' out-of-state registry identification cards for up to 30 days, but they are not valid for obtaining marijuana. The law has an affirmative defense for unregistered patients with doctors' recommendations and their caregivers, but it sunset once the Department of Health Services began issuing ID cards.

Possession Limits and Access: If a patient lives more than 25 miles away from a dispensary, the patient can cultivate up to 12 plants in an enclosed, locked location, or he or she can designate a caregiver to do so. Patients can have a single caregiver and a caregiver can assist no more than five patients. Caregivers can receive reimbursement for their actual expenses, but cannot receive any compensation for their services.

Arizona's law provides for state-regulated nonprofit dispensaries. The department may charge up to $5,000 for each dispensary application and up to $1,000 for each renewal. Each dispensary employee must register with the department. The department developed rules for dispensaries' oversight, record keeping, and security. In addition, the initiative included several regulations. Dispensaries must be at least 500 feet from schools. Dispensaries may cultivate their own marijuana, either at the retail site or a second enclosed, locked cultivation location that must be registered with the department. They may also sell usable marijuana to one another, but dispensaries cannot purchase marijuana from anyone other than another dispensary. Patients and caregivers may donate marijuana to one another and to dispensaries. Dispensaries can dispense no more than 2.5 ounces of marijuana to a patient every 14 days. The total number of dispensaries cannot exceed one for every 10 pharmacies, which would total about 125 dispensaries.

The Department of Health Services issued certificates to more than 90 dispensaries in August 2012, and 71 were operational by the end of 2013.

California — Proposition 215, a ballot initiative, passed with 56% of the vote in 1996, and the legislature added protections by passing SB 420 in 2003. Some relatively minor changes have been made since then, such as a 2010 measure to add a buffer zone between dispensaries and schools. In California, the legislature cannot amend a voter-initiative, so SB 420 and other statutes enacted by the legislature are only supplementary. The laws are codified at Cal. Health and Safety Code §**11362.5** and **11362.7 et seq**.

Qualifying for the Program: California's law is the only one to allow doctors to recommend medical marijuana for any condition. Medical marijuana can be recommended for "cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief." Patients may get a registry identification card from their county health departments, but cards are not mandatory and the vast majority of patients rely on a written recommendation from a physician.

Patient Protections: A patient is protected from "criminal prosecution or sanction" if he or she has a physician's recommendation for medical marijuana. To qualify as a primary caregiver in California, one must be designated by a patient and must have "consistently assumed responsibility for the housing, health, or safety of [the] patient." The law allows primary caregivers to cultivate marijuana for any number of patients. The California Supreme Court ruled in *Ross v. Ragingwire* that the law does not provide protection from being fired for testing positive for marijuana metabolites, even if the patient is never is impaired at work.

Possession Limits and Access: California's law allows a patient with a physician's recommendation to possess at least eight ounces of processed marijuana and cultivate six mature plants or 12 immature plants, or greater amounts if the county allows a greater amount. Patients may also assert a defense in court for larger amounts that are for "personal medical purposes."

SB 420 provides that patients and caregivers "who associate within the State of California in order collectively or cooperatively to cultivate marijuana for medical purposes, shall not solely on the basis of that fact be subject to state criminal sanctions ... ." It also specifies that it does not "authorize any individual or group to cultivate or distribute marijuana for profit." Based on this collective language, dispensaries are operating in many parts of California. While then-Attorney General Jerry Brown issued guidelines on medical marijuana, state law provides no regulation or registration of collectives and cooperatives. Instead, many localities have moved to regulate them, while others have enacted bans. In early 2012, the California Supreme Court ruled that localities may ban dispensaries.

Colorado — Amendment 20, a constitutional amendment ballot initiative, passed with 54% of the vote in 2000. In 2010, two bills were enacted to amend the medical marijuana law, H.B. 1284 and S.B. 109. More minor revisions have been subsequently approved by the legislature. The citations of the statutes are Colo. Rev. Stat. § **12-43.3-101**, **18-18-406.3**, and **25-1.5-106** et seq. The constitutional amendment is **Article XVIII, Section 14**. Department of Health Rules on medical marijuana are available at **5 CCR 1006-2**. The Medical Marijuana Enforcement Group rules are **available online**. The rule on residency is available at **1 CCR 212-1**.

Qualifying for the Program: To qualify for an ID card, a patient must reside in Colorado and submit a fee and written documentation from a physician in good standing in Colorado certifying that the patient "might benefit from the medical use of marijuana" in connection with a specified qualifying medical condition. The physician must have a treatment or consulting relationship with the patient and must have done a physical exam and be available for follow-up care. The qualifying conditions in Colorado are cancer, HIV/AIDS, glaucoma, and conditions causing one or more of the following: severe pain, cachexia, severe nausea, seizures, or persistent muscle spasms. The health department administers the ID card program and can approve additional qualifying conditions. A minor patient only qualifies with two physicians' authorizations, parental consent, and if the adult controls the dosage, frequency of use, and if they acquire the medical marijuana.

Patient Protections: Colorado's law created an exception from the state's criminal laws for any patient or caregiver in possession of an ID card and a permissible amount of marijuana. The department is required to issue an ID card to a qualified applicant within 35 days of receiving an application. However, if the department fails to do so, 35 days after the submission of the application the patient's applications materials and proof of mailing will serve as an ID card. A patient and his or her caregiver may raise an affirmative defense for more than the specified amount only if the patient's physician specified that that patient needs a specific greater amount. It seems the defense can also be raised whether or not a patient has a registry ID card. The law also says that "the use of medical marijuana is allowed under state law" to the extent it

is carried out in accordance with the state constitution, statutes, and regulations.

Possession Limits and Access: Each patient can possess up to two ounces of marijuana and can cultivate up to six plants, three of which may be mature. Patients can designate a single caregiver or a medical marijuana center to cultivate for them. A caregiver can assist no more than five patients, unless the department of health determines exceptional circumstances exist. A caregiver must have "significant responsibility for managing the well-being of a patient."

Under a law that passed in 2010, medical marijuana centers (dispensaries) and entities that make marijuana-infused products are explicitly allowed and must be licensed by their locality and a state licensing authority under the Department of Revenue. Labs may also be licensed to test marijuana. There are several regulations spelled out in the law including for medical marijuana centers' security, proximity to schools, and hours of operation. On-site marijuana use is forbidden. Specific labels and packaging are required for marijuana sold in food products. Caregivers must have a waiver from the department to be allowed to pick up marijuana for homebound patients. In addition, the licensing authority — the Medical Marijuana Enforcement Division, which is part of the Department of Revenue — set fees and developed additional regulations. The Medical Marijuana Enforcement Division has the authority to impose penalties, including suspending and revoking licenses.

The state's medical marijuana center fees range from $7,500 to $18,000. The infused products and cultivation fees are each $1,200. With the exception of new medical marijuana centers and those granted a waiver due to a catastrophic event related to inventory, medical marijuana centers must cultivate at least 70% of the marijuana they dispense, and the rest can only be purchased from other medical marijuana centers. Although there is an exception, a center generally can possess no more than six plants and two ounces per patient who designates it.

Medical marijuana is subject to sales tax, except for individual patients who the department finds are indigent. Up to $2 million per year in tax revenue is appropriated to services related to substance abuse. The medical marijuana center licensing provisions sunset on July 1, 2015. In June 2014, the Medical Marijuana Enforcement Division reported there were 493 approved medical marijuana centers, 727 medical marijuana cultivation businesses, and 144 medical marijuana infused products manufacturers .

In addition to Colorado's medical marijuana law, voters approved Amendment 64 in November 2012, which allows any adult, 21 and older, to possess up to an ounce of marijuana and up to six plants. It also allows sales of marijuana for adults' use.

Other: The state licensing authority is directed to petition the federal DEA to reschedule marijuana.

Connecticut — The Connecticut Legislature passed and Gov. Dannel Malloy signed HB 5389 in 2012. The law is available at **Conn. Gen. Stat. § 21a-408 to 21a-408o**. The effective date for part of the law — including for patients' temporary registry ID cards — was October 1, 2012. The Department of Consumer Protection regulations are available at Sec. 21a-408-1 to 21a-408-70 of the Regulations of Connecticut State Agencies.

Qualifying for the Program: To qualify for an ID card, a patient is required to have a qualifying condition and a physician's written certification stating that the potential benefits of the palliative use of marijuana would likely outweigh the health risks. Patients must be 18 or older and must be Connecticut residents. The law does not protect patients with out-of-state ID cards.

The qualifying conditions in Connecticut are: cancer, glaucoma, HIV/AIDS, Parkinson's

disease, multiple sclerosis, spinal cord damage causing intractable spasticity, epilepsy, cachexia, wasting syndrome, Crohn's disease, PTSD, and any condition that is added by the Department of Consumer Protection.

Patient Protections: Connecticut's law provides that registered patients, registered caregivers, dispensaries and their employees, producers and their employees, and physicians may not be "subject to arrest or prosecution, penalized in any manner, including, but not limited to, being subject to any civil penalty, or denied any right or privilege, including, but not limited to, being subject to any disciplinary action" by a professional licensing board for acting in accordance with the law.

The law also includes protections from discrimination by landlords, employers, and schools, with an exception for if discrimination is required to obtain federal funding or to comply with federal law. These civil protections are all based on one's status as a patient or caregiver.

Patients cannot ingest marijuana anywhere in public, in a workplace, in any moving vehicle, in the line of sight of a person under 18, or on any school or university grounds, including in dorm rooms.

Possession Limits and Access: Connecticut's law does not provide for home cultivation. It provides for dispensaries, which will be licensed by the Department of Consumer Protection. Only pharmacists were allowed to file applications for dispensaries. The rules required the department to allow at least one dispensary facility and allow it to authorize more if "additional dispensary facilities are desirable to assure access to marijuana for qualifying patients." It has approved six dispensaries, none of which have opened yet, as of July 2014.

Dispensaries are only allowed to obtain marijuana from licensed producers. The Department of Consumer Protection was granted the power to decide how many producers to license, but the number had to be no less than three and no more than 10. The department approved four growers. Producers are charged a non-refundable application fee of $25,000 and a $75,000 annual fee. Dispensary facility application fees are $1,000, and their annual fees are $5,000.

The Department of Consumer Protection decided patients may possess no more than 2.5 ounces of cannabis per month, unless a patient's physician allows a greater amount. An eight member board of physicians was charged with reviewing and recommending protocols to decide the amount that would be reasonably necessary for a one-month supply, including for topical treatment. The board will also make recommendations on whether to add qualifying conditions.

Primary caregivers can serve a single patient, unless they are close relatives or guardians to each patient, and each patient can have only one caregiver. Caregivers cannot have convictions for selling or manufacturing drugs. The need for a caregiver must be evaluated by the physician and be included in a written certification.

Other: Connecticut's law directs the Commissioner of Consumer Protection to submit regulations to reclassify marijuana as a Schedule II substance under state law.

Delaware — Gov. Jack Markell signed SB 17 on May 13, 2011. The bill is codified at **Title 16, Chapter 49A of the Delaware Code**. Following a February 2012 letter from the U.S. attorney for Delaware, Gov. Markell placed the dispensary portion of the bill on hold. Gov. Markell announced on August 15, 2013 that he would restart the program, but he did so in a much more restrictive manner than provided for in the law. The state will allow a single pilot dispensary, which could possess only up to 150 plants and have up to 1,500 ounces of marijuana.

Qualifying for the Program: To qualify for an ID card, a patient must have a qualifying

condition and a physician's statement that the patient is "likely to receive therapeutic or palliative benefit" from the medical use of marijuana. The physician must be the patient's primary care physician or physician responsible for treating the patient's qualifying condition. Patients must be 18 or older. The qualifying conditions in Delaware are cancer, HIV/AIDS, decompensated cirrhosis, amyotrophic lateral sclerosis, agitation related to Alzheimer's disease, post-traumatic stress disorder, and conditions causing one or more of the following: severe debilitating pain that has not responded to other treatments for more than three months or for which other treatments produced serious side effects, intractable nausea, seizures, or severe and persistent muscle spasms. The Department of Health and Social Services can approve additional medical conditions. The department will also administer the ID card program.

Patient Protections: The law provides that registered patients and caregivers abiding by the act are "not subject to arrest, prosecution, or denial of any right or privilege, including but not limited to civil penalty or disciplinary action …" for doing so. It also prevents landlords, employers, and schools from discriminating based on a person's status as a caregiver or patient, unless they would otherwise lose a federal monetary or licensing benefit. Employers generally cannot penalize staff for testing positive for marijuana unless they used, possessed, or were impaired by marijuana at work or during work hours. It provides some protection for child custody and visitation rights and receiving organ donations.

Delaware honors visiting patients' out-of-state registry identification cards for up to 30 days if they have conditions that qualify in Delaware. However, patients must obtain a Delaware registry card to obtain marijuana from a Delaware compassion center. The law has an affirmative defense for unregistered patients with doctors' recommendations, but it only applies until the department begins issuing cards and between when a patient submits a valid application and when the patient receives his or her ID card.

Possession Limits and Access: Delaware's law allows a patient with a registry identification card to possess six ounces at once and to obtain up to three ounces of processed marijuana every 14 days. When patients or caregivers are out of their residences, marijuana must be stored in an approved, sealed container obtained from a compassion center, unless the marijuana is being administered or prepared for administration. Registered caregivers may possess up to six ounces for each patient they assist.

Home cultivation is not allowed in Delaware. Patients are allowed to obtain marijuana from state-registered non-profit compassion centers. The first pilot compassion center is expected to be registered in 2014. Patients can have a single caregiver, and a caregiver can assist no more than five patients. The law directed the health department to develop rules for compassion centers' oversight, record keeping, and security, and to set application and registration fees, which (along with donations) must cover the costs of administering the program.

The department was also charged with selecting compassion centers, based on a scored, competitive application process. Dispensaries must be at least 500 feet from schools. They must cultivate their own marijuana, either at the retail site or at additional enclosed, locked cultivation locations that must be registered with the department. Dispensaries can dispense no more than three ounces of marijuana to a patient every 14 days. The department was supposed to register three compassion centers by January 1, 2013 and three more by January 1, 2014. Additional ones could also be approved if they are needed. However, as was mentioned, that part of the law was put on hold. Now, a single center will be approved in 2014.

Hawaii — S.B. 862 was passed by the Hawaii Legislature in 2000. It was the first medical marijuana bill to be passed legislatively. Its citation is **Haw. Rev. Stat. § 329-121** et seq. The rules are at **HAR Chapter 23-202**.

Qualifying for the Program: To qualify for an ID card, a patient must have a qualifying condition and a statement from a Hawaii physician that the "potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient." Although most states house their medical marijuana programs in their health departments, Hawaii's is administered by the state Department of Public Safety. The qualifying conditions in Hawaii are cancer, HIV/AIDS, glaucoma, and conditions causing one or more of the following: severe pain, cachexia or wasting, severe nausea, seizures, or severe and persistent muscle spasms. The health department can approve additional conditions. A minor patient only qualifies with parental consent and if the adult controls the dosage, frequency of use, and acquisition of marijuana.

Protections, Access, and Possession Limits: Hawaii's law allows a patient with a registry identification card and his or her caregiver to collectively possess three ounces of processed marijuana and cultivate three mature plants and four immature plants. Hawaii's law does not provide for dispensaries and a primary caregiver can only assist one patient at a time. There is also a "choice of evils" defense patients can raise.

Illinois: Gov. Patrick Quinn signed **HB 1** into law on August 1, 2013, after it was approved by the General Assembly. The new law went into effect on January 1, 2014. In 2014, the law was expanded by SB 2636 to include seizure conditions and to allow minors to qualify. Medical cannabis rules were approved in July 2014.

Qualifying for the Program: To qualify for an ID card, a patient must have a qualifying medical condition and a statement from an Illinois-licensed MD or DO who is caring for the patient's condition. The physician must certify that the patient "is likely to receive therapeutic or palliative benefit" from medical marijuana.

Restrictions on Who May Be a Patient: Patients also cannot not be active police officers, firefighters, correctional officers, probation officers, or bus drivers. They cannot have a commercial driver's license or a felony drug conviction. Until July 2014, patients under the age of 18 could not qualify. A new law allows minors to qualify if they suffer from seizures, and it allows the Department of Public Health to adopt rules allowing for minors with other conditions to qualify.

Qualifying Medical Conditions: The qualifying conditions in Illinois are HIV/AIDS; hepatitis C; amyotrophic lateral sclerosis (ALS); Crohn's disease; agitation of Alzheimer's disease; cachexia/wasting syndrome; muscular dystrophy; severe fibromyalgia; spinal cord disease; Tarlov cysts; hydromyelia; syringomyelia; spinal cord injury; traumatic brain injury and post-concussion syndrome; multiple sclerosis; rheumatoid arthritis; Arnold Chiari malformation; Spinocerebellar Ataxia (SCA); Parkinson's disease; Tourette's syndrome; Myoclonus; Dystonia; Reflex Sympathetic Dystrophy (RSD); Causalgia; CRPS; Neurofibromatosis; Chronic Inflammatory Demyelinating Polyneuropathy; Sjogren's syndrome; Lupus; Interstitial Cystitis; Myasthenia Gravis; Hydrocephalus; nail patella syndrome; residual limb pain; seizures; or the treatment of these conditions. The public health department may approve additional conditions.

Caregivers: Patients may have a single caregiver who may pick up medical marijuana for them. Caregivers must be 21 or older and cannot have a disqualifying drug conviction. They may only assist a single patient.

Patient Protections: Registered patients may not be arrested or prosecuted or face criminal or other penalties, including property forfeiture for engaging in the medical use of marijuana in compliance with the law. There are also protections against patients being discriminated against

in medical care — such as organ transplants — and in reference to child custody. In addition, landlords may not refuse to rent to a person solely due to his or her status as a registered patient or caregiver unless doing so violates federal law on the part of the landlord. Landlords may prohibit smoking medical marijuana on their premises. Similarly, schools and employers are prohibited from discriminating based on patient status unless they face restrictions under federal law. However, employers may continue to enforce drug-free workplace policies, and they do not have to allow employees to possess marijuana at work or work while they are impaired.

Possession Limits and Access: Illinois' law allows a patient or caregiver with a registry ID card to possess 2.5 ounces of processed marijuana. Patients and caregivers may not grow marijuana. Instead, they will be allowed to obtain medical marijuana from one of up to 60 state-regulated medical marijuana dispensaries, which may be for-profit. Dispensaries will be subject to rules created by the Department of Financial and Professional Regulation. They will obtain medical marijuana from one of up to 22 cultivation centers. Prospective cultivation centers will have to submit detailed plans to the Department of Agriculture. All cultivation centers will have 24-hour surveillance that law enforcement can access. They will also be required to have cannabis-tracking systems and perform weekly inventories. Grow centers will be required to abide by department rules, including for labeling, safety, security, and record keeping. Centers will also have to comply with local zoning laws and must be located at least 2,500 feet from daycare centers, schools, and areas zoned for residential use.

Fees for both dispensaries and cultivation centers were determined by the regulatory departments. The cultivation fees are the highest in the nation: Applicants will have to pay a non-refundable application fee of $25,000 and a first-year registration fee of $200,000.

Other: The law was created with a “sunset” provision, meaning that if the legislature does not renew the program or create a new law, the program will cease to operate on January 1, 2018. Medical marijuana will be subject to a 7% privilege tax and a 1% sales tax.

Maine — Question 2, a ballot initiative, passed with 61% of the vote in 1999. It was modified in 2002 by S.B. 611 and in 2009 by Question 5, an initiative that passed with 59% of the vote. Several modifications have been made since then. The law’s citation is **Me. Rev. Stat. Ann. tit 22 § 2421** et seq. Rules are available at **10-144 C.M.R, Chapter 122**.

Qualifying for the Program: Registry identification cards are voluntary for patients and for caregivers who are members of their patients’ families or households. They are mandatory for other caregivers. To qualify for protection from arrest, a patient must have a qualifying condition and a statement from a physician with which the patient has a bona fide relationship. The statement must be on tamper-resistant paper, is valid for no more than a year, and must state that the patient is "likely to receive therapeutic or palliative benefit" from the medical use of marijuana. A minor patient only qualifies with the consent of his or her parent or guardian, and the adult must control the dosage, acquisition, and frequency of use of the marijuana.

The qualifying conditions in Maine are cancer, HIV/AIDS, hepatitis C, amyotrophic lateral sclerosis, nail patella, glaucoma, agitation related to Alzheimer’s disease, post-traumatic stress disorder (PTSD), inflammatory bowel disease, dyskinetic and spastic movement, and conditions causing one or more of the following: intractable pain, cachexia or wasting, severe nausea, seizures, or severe and persistent muscle spasms. A health department-created advisory panel can approve additional medical conditions and make recommendations about what an adequate supply of marijuana would be. The department of health also administers the ID card program.

Caregivers must be 21 or older and cannot have a disqualifying drug conviction. They can also

be hospice providers or nursing facilities, but those entities cannot grow for patients. They may have a single employee.

Patient Protections: Maine's law provides that those abiding by the act may not "be denied any right or privilege or be subjected to arrest, prosecution, penalty or disciplinary action" for those medical marijuana-related actions. It also generally prevents landlords and schools from discriminating based on a person's status as a caregiver or patient, though it allows landlords to prevent cultivation and landlords and businesses to prevent smoking in their properties. It also provides some protection for child custody and visitation rights. Maine protects patients from states that allow medical marijuana if they have a written certification, the required identification, and if Maine's health department adds the other state's law to a list.

Possession Limits and Access: Maine's law allows a patient or caregiver with the required documentation or registry ID card to possess 2.5 ounces of processed marijuana per patient. A total of six mature plants may be cultivated for each patient in an enclosed, locked location. The patient can choose to cultivate and/or can designate either a caregiver or a dispensary to cultivate for the patient, as long as the total amount of plants per patient does not exceed six mature plants. Plants in other stages of harvest may also be cultivated. The law has an affirmative defense for patients needing additional amounts of marijuana. Adult patients can have a single caregiver, and a caregiver can assist no more than five patients. Caregivers can receive reasonable monetary compensation. Collective cultivation by caregivers is expressly forbidden, except that two patients or two caregivers may share an enclosed, locked facility if they live together. Caregivers may donate excess marijuana to patients, other caregivers, or to dispensaries. They may also sell up to two pounds of marijuana to dispensaries each year.

Maine's law also provides for state-regulated not-for-profit dispensaries, of which there can be no more than eight in the first year. As of July 2014, eight non-profit dispensaries have been registered. The department charged $15,000 for each registration. In addition, each dispensary employee must register with the department. The state health department developed rules for dispensaries' oversight, record keeping, and security, in addition to several specific requirements from the law. Dispensaries must be at least 500 feet from schools, they must have on-site parking, sufficient lighting, and electronic monitoring. Dispensaries must cultivate their own marijuana, either at the retail site or a second enclosed, locked cultivation location that must be registered with the department. Dispensaries can dispense no more than 2.5 ounces of marijuana to a patient every 15 days. The department may determine the number and location of dispensaries.

Maryland — Twin bills HB 881 and SB 923 were passed by the General Assembly and signed by Gov. Martin O'Malley in April 2014. The law is codified in the Annotated Code of Maryland at Section 13-3301 et seq. The 2014 law expands and renders effective a medical marijuana program first established in 2013, which relied upon academic medical centers to implement the law and distribute the medical marijuana.

Qualifying for the Program: In Maryland, physicians must apply to the Natalie M. LaPrade Medical Marijuana Commission before certifying patients. A doctor's application must include the qualifying conditions for which he or she will recommend marijuana, along with exclusion criteria (what types of patients would not qualify), and the physician's plans for screening for dependence and follow-up treatment. Then, the physician must send in a written certification for individual patients. Upon approval of the application and receipt of the written certifications, the commission will issue the appropriate identification cards. Patients less than 18 years old must have a caregiver.

Qualifying Medical Conditions: The commission is encouraged to approve applications for medical conditions — or medical treatments — that cause: cachexia, anorexia, or wasting

syndrome; severe or chronic pain; severe nausea; seizures; or severe or persistent muscle spasms. In addition, the commission may approve applications that include "any other condition that is severe and for which other medical treatments have been ineffective if the symptoms reasonably can be expected to be relieved by the medical use of marijuana."

Caregivers: For patients under the age of 18, any parent or legal guardian may qualify as a caregiver. For everyone else, a caregiver is simply "a person who has agreed to assist with a qualifying patient's medical use of marijuana."

Patient Protections and Possession Limits: Patients and their caregivers may not be subject to arrest, prosecution, or "any civil or administrative penalty" for the possession of a 30-day supply of marijuana, which has yet to be determined by the commission. There is also an affirmative defense of "medical necessity" that patients and caregivers can raise for possession of up to an ounce of marijuana.

Access: The commission may license up to 15 cultivators to grow medical marijuana and an undetermined number of dispensaries to distribute it. Cultivators may sell their product either through dispensaries, a satellite location, or directly to patients and caregivers. The commission will determine the number of dispensaries that will be allowed.

Massachusetts — Question 3, a ballot initiative, passed with 63% of the vote in 2012. The citation for the law is **Mass. Gen. Laws ch. 94C § 1-2 to 1-17**. Rules are available at 105 CMR 725.000.

Qualifying for the Program: To qualify for protection from arrest, a patient generally must have a registry identification card issued by the health department. To obtain a card, a patient must have a qualifying condition and a statement from a physician with whom the patient has a bona fide relationship. The qualifying conditions in Massachusetts are cancer, glaucoma, HIV/AIDS, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, Parkinson's disease, multiple sclerosis, and other debilitating conditions as determined in writing by a qualifying patient's physician. Until the department has fully implemented the law, a patient's written certification will serve as his or her ID card.

Personal caregivers must be 21 or older and must also generally be registered with the health department.

Patient Protections: Massachusetts' law provides that "Any person meeting the requirements under this law shall not be penalized under Massachusetts law in any manner, or denied any right or privilege, for such actions." Patients, caregivers, and dispensary agents who present their ID cards to law enforcement and possess a permissible amount of marijuana may not be subject to arrest, prosecution, or civil penalty.

Massachusetts' law does not provide recognition for out-of-state ID cards.

Possession Limits and Access: Massachusetts' law allows a patient or caregiver to possess a 60-day supply of marijuana. The rules define a presumptive 60-day supply as 10 ounces, but physicians can certify that a greater amount is needed if they document the rationale.

A patient with limited access to dispensaries may cultivate if he or she receives a hardship registration allowing the patient or his or her caregiver to cultivate a 60-day supply of medical marijuana. The department will issue cultivation registrations to patients whose access to dispensaries is limited by financial hardship, the physical incapacity to access reasonable transportation, or the lack of dispensaries reasonably close to — or that will deliver to — the patient.

Patients may also obtain marijuana from state-regulated nonprofit dispensaries. Question 3 requires the department to issue registration certificates to qualified applicants wishing to operate medical marijuana treatment centers within 90 days of receiving their applications. In June 2014, the department approved 11 dispensary applicants, which now advance to the inspection phase of the process. Additional dispensaries may be approved next year.

Michigan — Proposition 1, a ballot initiative, passed with 63% of the vote in 2008. In late 2012, the Michigan Legislature made some additions and modifications to the act. Michigan's medical marijuana act is codified at **MCL § 333.26421** et seq. Rules are at **Rule 333.101** et seq.

Qualifying for the Program: To qualify for an ID card, a patient must have a qualifying condition and a statement from a physician that the patient has a bona fide relationship with that physician and that the patient is "likely to receive therapeutic or palliative benefit" from the medical use of marijuana. The qualifying conditions in Michigan are cancer, HIV/AIDS, hepatitis C, amyotrophic lateral sclerosis, Crohn's diseases, nail patella, glaucoma, agitation related to Alzheimer's disease, PTSD, and conditions causing one or more of the following: severe and chronic pain, cachexia or wasting, severe nausea, seizures, or severe and persistent muscle spasms. The health department processes ID card applications and can approve additional medical conditions. PTSD was the first condition added by the department. A minor patient only qualifies with two physician recommendations, parental consent, and if the adult controls the dosage, frequency of use, and acquisition of marijuana.

Patient Protections: Michigan's law allows a patient or caregiver with a registry identification card to possess 2.5 ounces of processed marijuana. It provides that those abiding by the act cannot be subject to "arrest, prosecution, or penalty in any manner, or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a business or occupational or professional licensing board or bureau" for actions allowed by the law. Michigan honors visiting patients' out-of-state registry identification cards. If a patient applies for an ID card but has not received a response within 20 days, their doctor's certification and application materials function as an ID card. The law has an affirmative defense available to patients and their caregivers whose physicians believe the patients are "likely to receive therapeutic or palliative benefit" from medical marijuana if they possess "a quantity of marihuana that was not more than was reasonably necessary to ensure the uninterrupted availability" of medical marijuana.

Possession Limits and Access: A patient can choose to cultivate up to 12 plants in an enclosed, locked area, or can designate a caregiver to do so for the patient. Patients can have a single caregiver and caregivers can assist no more than five patients. Caregivers can receive reasonable compensation. While Michigan law does not provide for dispensaries, several cities have enacted ordinances recognizing, licensing, and regulating them.

Other: The legislature added a requirement that marijuana must be in a case in a trunk while it is transported, or — if the vehicle has no trunk — it must be in a case that isn't readily accessible from inside the vehicle.

Minnesota — Gov. Mark Dayton signed SF 2470 on May 29, 2014. The bill is codified at **Chapter 152, Section 152.22 to 152.37** of the Minnesota Statutes.

Qualifying for the Program: To enroll in the program, a patient must have a qualifying condition and submit a certification to the health department from their treating practitioner. The practitioner — who may be a physician, a nurse practitioner, or a physician's assistant — must agree to enroll in the program as well and will be required to submit data on the patient's health records. Qualifying conditions are: cancer (if the patient has severe pain, nausea, or

wasting), HIV/AIDS, Tourette's, ALS, seizures, severe and persistent spasms, Crohn's disease, and terminal illnesses (if the patient has severe pain, nausea, or wasting). The health commissioner may add additional conditions but only after giving the legislature an opportunity to overturn the commissioner's recommendation. Only Minnesota residents may enroll, and patients must renew their enrollment annually.

Caregivers: Patients may have a single caregiver who may pick up and administer medical marijuana for/to them only if a health care practitioner has determined that the patient is unable to administer or acquire their medicine due to a developmental or physical disability. Caregivers must be 21 or older and cannot have a disqualifying drug conviction.

Patient Protections: Registered patients are protected from criminal and civil penalties for possessing and using liquids, oils or pills made out of marijuana in compliance with the medical marijuana law. Patients may not use marijuana in any other form — including its natural state — unless the health commissioner approves the form. While vaporization of extracts is allowed, smoking is forbidden. The law also provides for protections from discrimination in employment, housing, child custody disputes, organ transplants, and other medical care.

Possession Limits and Access: The law allows the state to register two medical marijuana manufacturers by December 1, 2014 or July 1, 2015. Each of the manufacturers must establish a total of four distribution points each by July 1, 2016. The law requires that only pharmacists working with the manufacturers may distribute marijuana products to qualified patients. They may only dispense up to a 30-day supply as determined by the on-site pharmacist after consulting with the individual patient.

Montana — I-148, a ballot initiative, passed with 62% of the vote in 2004. It was amended by SB 325 in 2009, and it was replaced with a much more restrictive law, SB 423, in 2011. Some of SB 423 went into effect on July 1, 2011 and some was enjoined in court. As of July 25, 2014, litigation is still ongoing. The law is codified at **MCA § 50-46-301 et seq**. The original law was codified at **MCA § 50-46-101** et seq.

Qualifying for the Program: To qualify for an ID card under the revised law, a patient must submit an extensive written certification form, completed by the patient's physician that, among other things, states that the patient has a qualifying condition. The qualifying conditions are now: cachexia or wasting syndrome, intractable nausea or vomiting, epilepsy or intractable seizure disorder, multiple sclerosis, Crohn's disease, painful peripheral neuropathy, admittance to hospice, a nervous system disease causing painful spasticity or spasms, conditions whose symptoms severely adversely affect the patient's health, cancer, glaucoma, HIV/AIDS, and severe pain that significantly interferes with daily activities and for which there is objective proof and is verified by an independent second physician. Patients must be Montana residents. Patient ID cards under the original law are valid until they expire.

Under SB 423, physicians must describe all other attempts at treatment and that the treatments have been unsuccessful. Physicians also have to state that they have a "reasonable degree of certainty" that each patient would benefit from medical marijuana. A provision that is currently enjoined provides that physicians will be investigated at their own expense by the medical board if they make 25 or more recommendations in a 12-month period.

A minor patient only qualifies with parental consent and if the adult controls the dosage, frequency of use, and acquisition of marijuana. They must also have two physicians' recommendations. The health department is responsible for issuing ID cards and may approve additional medical conditions.

Protections or Lack Thereof: Montana's law provides that those abiding by the act "may not

be arrested, prosecuted, or penalized in any manner or be denied any right or privilege, including but not limited to civil penalty or disciplinary action by a professional licensing board or the department of labor and industry" for the medical use of marijuana in accordance with the act.

SB 423 lets landlords ban tenants who are patients from using medical marijuana and requires a landlord's written permission for cultivation. A provision that has been enjoined allows state and local law enforcement to make unannounced inspections of caregivers registered premises during business hours. SB 423 bans advertising of marijuana or related products, including on the internet, but that part of the law is currently enjoined.

Previously, Montana honored visiting patients' out-of-state registry identification cards and included an affirmative defense for unregistered patients or those needing larger amounts of marijuana. SB 423 eliminated both of those protections.

Possession Limits and Access: Montana's revised law allows a registered patient or his or her registered provider to possess four mature plants, 12 seedlings, and one ounce of usable marijuana per patient. If a patient cultivates, his or her provider may not. Although the initial law did not mention dispensaries, it also did not limit the number of patients a caregiver could serve. Under I-148, caregivers could receive reasonable compensation, and some cities and counties enacted regulations on dispensaries. However, under parts of SB 423 that were enjoined, providers could only assist up to three patients and could not receive any compensation.

Nevada — Question 9, a constitutional amendment ballot initiative, passed first in 1998 and then with 65% of the vote in 2000. It was implemented by AB 453 in 2001, which was revised by AB 130 in 2003, AB 519 in 2005, and AB 538 in 2009. In 2013, the legislature enacted S.B. 374, which added a dispensary program. Question 9 is codified at **Article 4, section 38** of the Nevada Constitution. The statutory provisions are codified at **Nev. Rev. Stat. 453A**. Rules are at **NAC 453A**.

Qualifying for the Program: To qualify for an ID card in Nevada, a patient must have a qualifying condition and a statement from a Nevada physician who has responsibility for caring for or treating the patient that marijuana "may mitigate the symptoms or effects" of their condition. A minor patient only qualifies with parental consent and if the adult controls the dosage, frequency of use, and acquisition of marijuana. The qualifying conditions in Nevada are cancer, HIV/AIDS, glaucoma, PTSD, and conditions causing one or more of the following: severe pain, cachexia, severe nausea, seizures, or persistent muscle spasms. The department can approve additional conditions, and it added PTSD. Nevada's revised law contains reciprocity provisions, which recognize patients from other medical marijuana states as long as the other state programs are substantially similar to the requirements of Nevada law.

Nevada's registered patients may have a single caregiver. Caregivers must have significant responsibility for managing a qualifying patient's wellbeing and may serve only one patient.

Patient Protections: Registered patients are exempt from prosecution for the acts allowed under Nevada law. Patients may also not be disciplined by a professional licensing board and employers must "attempt to make reasonable accommodations for the medical needs" of employees who are registered patients.

Patients with qualifying conditions may also assert an affirmative defense if they have been advised by a physician that marijuana may mitigate their condition, even if they do not have an ID card. This defense may also be raised by people assisting patients and for greater amounts of

marijuana if the amounts are “medically necessary as determined by the person's attending physician."

Possession Limits: Patients and their caregivers may collectively possess two and a half ounces of marijuana. They can obtain that amount each 14-day period. Those patients or caregivers who are allowed to grow may cultivate up to 12 plants.

Access: The voter-enacted constitutional amendment directed lawmakers to enact a medical marijuana law, including “authorization of appropriate methods for supply of the plant to patients authorized to use it.” However, Nevada's law initially did not allow anyone to deliver marijuana for compensation, including to qualified patients. It allowed patients and their caregivers to cultivate, but did not allow dispensaries. In 2013, the legislature and governor modified the law to allow dispensaries. The revised law also limits which patients can cultivate marijuana. Under the revised law, patients who were already cultivating can continue to cultivate until March 31, 2016. In addition, all patients may cultivate if they do not live near a dispensary, if they cannot travel to one, or if the dispensaries near them do not have an adequate supply of marijuana or of the strain that works for the patient.

There will be a total of up to 66 licensed and regulated dispensaries in the state. Clark County may have up to 40 dispensaries. Washoe County may have 10. Carson City can have two, and each of the other 14 counties can have one. In addition to dispensaries, the Health Division will regulate cultivators, infused product manufacturers, and laboratories. All of the establishments may be for-profit. Dispensaries must have a single, secure entrance for patrons. All cultivation by cultivation centers must occur in an enclosed, locked facilitation that is registered with the department. Marijuana must be tested and labeled, including with the concentration of THC and weight. Medical marijuana businesses may not allow on-site marijuana consumption. Medical marijuana businesses must also have inventory control systems, their staff must register with the state, and they must enter information on patrons into an electronic verification system. Businesses will also have to comply with local rules and those crafted by the Health Division.

Other: Medical marijuana sales will be subject to a 2% excise tax at the wholesale level, along with a 2% excise tax at the retail level. Standard sales taxes also apply. Seventy-five percent of the tax revenue will go to education and 25% to regulatory oversight.

New Hampshire: Gov. Maggie Hassan signed HB 573 into law on July 23, 2013, after it was approved by the legislature. The new law went into effect immediately, but the health department was given a year to craft rules for the patient registry and 18 months for alternative treatment center rules.

Qualifying for the Program: To qualify for an ID card, a patient must obtain a written certification from a physician or an advanced practice registered nurse and send it in to the Department of Health and Human Services (DHHS). The provider must be primarily responsible for treating the patient’s qualifying condition. Minors with qualifying serious medical conditions may register if the parent or guardian responsible for their health care decisions submits written certifications from two providers, one of which must be a pediatrician. The parent must also serve as the patient’s caregiver and control the frequency of the patient’s marijuana use. Out-of-state patients with a valid medical marijuana card from another state will be allowed to bring their cannabis into New Hampshire and use it in the state. They must also have documentation from their physicians that they have a condition that qualifies under New Hampshire law.

Despite the law’s requirement that DHHS develop the form and content of patient applications within a year, DHHS is refusing to issue ID cards until alternative treatment centers are open, pursuant to an opinion from the attorney general, who opposed the program. This leaves

patients with no legal protections while they wait for implementation.

Qualifying Medical Conditions: The law allows patients to qualify if they have one of the listed medical conditions and one of the listed qualifying symptoms. In addition, on a case-by-case basis, the department may allow patients to register who do not have a listed medical condition if their providers certify that they have a debilitating medical condition. The qualifying conditions are cancer, glaucoma, HIV/AIDS, hepatitis C, ALS, muscular dystrophy, Crohn's disease, Alzheimer's, multiple sclerosis, chronic pancreatitis, spinal cord injury or disease, traumatic brain injury, and injuries that significantly interfere with daily activities. The qualifying symptoms are severely debilitating or terminal medical conditions or their treatments that have produced elevated intraocular pressure, cachexia, chemotherapy-induced anorexia, wasting syndrome, severe pain if it has not responded to other treatments or if treatments produced serious side effects, severe nausea, vomiting, seizures, or severe, persistent muscle spasms.

Caregivers: Patients may have a single caregiver who may pick up medical marijuana for them. Caregivers must be 21 or older and cannot have a felony conviction. Caregivers typically may assist no more than five patients.

Patient Protections: Registered patients may not be arrested or prosecuted or face criminal or other penalties for engaging in the medical use of marijuana in compliance with the law. The law also offers protections against discrimination in child custody cases and in medical care — such as organ transplants.

Possession Limits and Access: New Hampshire's law allows a patient with a registry ID card to obtain up to two ounces of processed marijuana every 10 days. Caregivers may possess that amount for each patient they assist. Patients and caregivers may not grow marijuana. Instead, they will be allowed to obtain medical marijuana from one of up to four state-regulated alternative treatment centers (ATCs).

ATCs will be non-profit and may not be located within 1,000 feet of the property of a drug-free zone or school. They must provide patients with educational information on strains and dosage and must collect information patients voluntarily provide on strains' effectiveness and side effects. Staff must be at least 21, wear ATC-issued badges, and cannot have any felony convictions. The law includes numerous additional requirements, including for periodic inventories, staff training, reporting incidents, prohibiting non-organic pesticides, and requiring recordkeeping. ATCs cannot possess more than either 80 mature plants and 80 ounces total, or three mature plants and six ounces per patient. The health department — with input from an advisory council — will set additional rules, including for electrical safety, security, sanitary requirements, advertising, hours of operations, personnel, liability insurance, and labeling. Rules on security must include standards for lighting, physical security, video security, alarms, measures to prevent loitering, and on-site parking

Other: Marijuana cannot be *used* on someone else's property without the written permission of the property owner or, in the case of leased property, without the permission of the tenant. Marijuana cannot be *smoked* on leased premises if doing so would violate rental policies. Marijuana cannot be *smoked or vaporized* in a public place, including a public bus, any other public vehicle, a public park, a public beach, or a public field.

New Jersey — Gov. Jon Corzine signed S.B. 119 into law in early 2010. Its effective date was delayed by S. 2105, which was also enacted in 2010. The law is codified at N.J. Stat. Ann. **C.24:6I** et seq. Regulations are available at N.J.A.C 8:64.

Qualifying for the Program: To qualify for an ID card, a patient will be required to have a

qualifying condition and a physician's certification authorizing the patient to apply to use medical marijuana. The physician must be licensed in New Jersey and must be the patient's primary care or hospice physician, or the physician responsible for treatment for the patient's debilitating medical condition. The qualifying conditions in New Jersey are: amyotrophic lateral sclerosis, multiple sclerosis, muscular dystrophy, inflammatory bowel disease, terminal illness, conditions resistant to conventional treatments, seizure disorders, intractable skeletal muscular spasticity, glaucoma, HIV/AIDS, cancer, or, conditions accompanied by severe pain, severe nausea, vomiting, or cachexia. The department of health and senior services administers the ID card program and can approve additional qualifying conditions. A minor patient only qualifies with parental consent and if the adult controls the dosage, frequency of use, and acquisition of marijuana.

Patient Protections: New Jersey's law provides that patients, caregivers, and others acting in accordance with the law "shall not be subject to any civil or administrative penalty, or denied any right or privilege, including, but not limited to, civil penalty or disciplinary action by a professional licensing board, related to the medical use of marijuana." It also provides that the medical marijuana authorization is an "exemption from criminal liability" and that it shall also be an affirmative defense.

Possession Limits and Access: New Jersey's law does not allow for home cultivation but it does provide for "alternative treatment centers" that are registered with the state to produce and dispense medical marijuana to qualified patients and their caregivers. The department of health and senior services decides how many centers to authorize. It registered the minimum number, six, in March 2011. The first alternative treatment center opened in December 2012; two additional centers opened in 2013.

At least six of the dispensaries will have to be nonprofit. The department set the fee for applications and has drafted regulations to monitor and oversee the dispensaries and to ensure security and adequate record keeping for dispensing. Every two years, the department is directed to evaluate whether there are enough dispensaries in the state and whether the amount of marijuana allowed is sufficient.

No more than two ounces can be dispensed to a patient in 30 days. Physicians must provide written instructions, which can be for up to a 90-day supply, each time marijuana is dispensed. The dispensing must happen within a month of the written instruction. Physicians also are required to furnish information to the division of consumer affairs about their written instructions.

Primary caregivers can serve a single patient. Caregivers and dispensary employees cannot have a drug conviction unless they demonstrate rehabilitation as is provided for in the act or if the conviction is a federal conviction for medical marijuana.

New Mexico — S.B. 523 was passed by the New Mexico legislature in 2007. Its citation is **N.M. Stat. Ann. § 26-2B-1** et seq. Rules are available at **7.34.2-7.34.4 NMAC**.

Qualifying for the Program: To qualify for an ID card, a patient must have a qualifying condition and a statement from a person licensed to prescribe drugs in New Mexico that "the practitioner believes that the potential health benefits of the medical use of cannabis would likely outweigh the health risks for the patient." The qualifying conditions in New Mexico are severe chronic pain, painful peripheral neuropathy, inflammatory autoimmune-mediated arthritis, intractable nausea/vomiting, severe anorexia/cachexia, hepatitis C receiving antiviral treatment, Crohn’s disease, amyotrophic lateral sclerosis, post-traumatic stress disorder, amyotrophic lateral sclerosis, cancer, glaucoma, multiple sclerosis, spinal cord damage with intractable spasticity, epilepsy, HIV/AIDS, Huntington’s disease, and Parkinson’s disease.

Hospice patients also qualify. "Severe chronic pain" only qualifies if the person's primary care physician and a specialist certify all standard treatments have been tried and failed to provide adequate relief.

The health department administers the ID card program and it approved adding several of the qualifying conditions. A minor patient only qualifies with parental consent and if the adult controls the dosage, frequency of use, and acquisition of marijuana. The law required the health department set up an advisory board with medical practitioners to make recommendations on whether to add qualifying conditions and to recommend how much marijuana should be allowed so that patients can possess an adequate supply.

Patient Protections: New Mexico's law provides that qualified patients "shall not be subject to arrest, prosecution, or penalty in any manner for the possession of or the medical use of cannabis if the quantity of cannabis does not exceed an adequate supply."

Possession Limits and Access: Patients may possess up to six ounces of marijuana, and caregivers can possess this amount for each patient who has designated the caregiver. Patients may also request permission to possess a larger supply. Though the law itself was silent on home cultivation, by rule, the state health department has allowed patients to apply for a separate personal cultivation license. If granted, they can cultivate up to four mature plants and 12 seedlings.

The law granted the health department broad discretion to develop rules to regulate licensed nonprofit producers of medical marijuana. The health department developed rules and, as of July 2014, 23 producers are licensed. It determines the number of producers based on factors that include supply of marijuana to patients statewide and the safety of the public. The department conducts an on-site visit. They also consider the applicants' plans for purity and consistency of dose as well as testing, their skills and knowledge, and the board members' experience.

To be producers, applicants must submit a great deal of information, including a $1,000 fee, security plans, the names of persons with authority over the facility's policies, and a description of packaging that will be used. Each producer’s board members must include at least one physician and at least three registered patients. Producers may produce 150 total plants and seedlings and supply marijuana to their patients. Producers cannot be located within 300 feet of schools, churches, or daycare centers. Once a patient registers, the health department provides patients with information on how to contact licensed producers. Annual registration fees range from $5,000 to $30,000 for producers and vary based on how long the producers have been operational.

New York — Gov. Andrew Cuomo signed twin bills A.6357-E and S.7923, known as the Compassionate Care Act, into law on July 5, 2014. This law is codified at N.Y. Public Health Law Art. 33, Title 5-A.

Qualifying for the Program: To qualify, a patient must have a written certification from his or her physician. Physicians must first register with the health department and take a two-to-four hour course. A certification must specify that the patient is in the physician’s continuing care for the condition, that the patient is likely to receive therapeutic or palliative benefits from marijuana, and that he or she has a qualifying condition. The qualifying conditions are cancer, HIV/AIDS, ALS, Parkinson's disease, multiple sclerosis, spinal cord damage causing spasticity, epilepsy, inflammatory bowel disease, neuropathies, or Huntington’s disease. The health commissioner may also add or delete conditions and must decide whether to add Alzheimer’s, muscular dystrophy, dystonia, PTSD, and rheumatoid arthritis within 18 months of the law’s effective date.

Caregivers: Patients may designate up to two caregivers, who may pick up their medical marijuana for them. Caregivers generally must be at least 21, and they may not serve more than five patients. A minor's caregiver must be his or her parent, guardian, or — if neither is available — other appropriate person who is approved by the department.

Patient Protections: Patients will have no legal protection until they have an ID card. They will not be permitted to smoke, and all forms of marijuana must be approved by the health commissioner. The health department will issue registry identification cards to patients and caregivers who submit valid applications, written certifications, and fees of up to $50. Registry identification cards will generally expire after a year, unless the patient has a terminal illness or the physician specified an earlier date. An appropriate person who is 21 or older must fill out an application for a minor patient. A minor's caregiver must be his or her parent, guardian, or — if neither is available — other appropriate person who is approved by the department.

Patients, caregivers, physicians, and staffers of state-legal medical marijuana organizations will not be subject to arrest or prosecution, or subject to any civil penalty, for the actions allowed under the act. In addition, being a medical marijuana patient would be considered a disability for purposes of the state's anti-discrimination laws. The law also includes language to protect patients from discrimination in family law or domestic relations cases.

Possession Limits: Patients may possess a 30-day supply of medical marijuana, an amount that will be determined either by the health commissioner during rulemaking or by the physician. They may refill their 30-day supply seven days before it runs out.

Access: The health department will select no more than five registered organizations to manufacture medical marijuana. They may be for-profit or non-profit and may have no more than four dispensing locations each. The health department will consider factors including whether applicants are of good moral character and if they can prevent diversion and maintain security. Each registered organization must be unionized, and staff are not permitted to strike.

Registered organizations need to consult the prescription monitoring program database to ensure they are not dispensing more than a 30-day supply to a patient. They would also be required to provide a safety insert, which would include information on potential dangers, with marijuana. Registered organizations could submit marijuana to labs for testing and would have to provide information about the products' potency and safety. Marijuana would have to be grown in secure, enclosed, indoor facilities. In most cases, registered organizations' staff members may not have had felony drug convictions within the past 10 years. The department will issue additional regulations, including those related to advertising, security, tracking, and surveillance. A registration may be suspended or terminated for violations of the law. The health commissioner would determine the price of marijuana.

Other: Registry identification cards or registered organizations' registrations will only become effective on the latter of: a) 18 months after enactment; and b) when the superintendent of state police certifies the title can be implemented in accordance with public health and safety interests. In addition, the governor may immediately terminate all registered organizations' licenses based on a recommendation from the head of the state police that there is a risk to public health or safety.

Oregon — Measure 67, a ballot initiative, passed with 55% of the vote in 1998, and was modified throughout the years. Most notably, in 2013, the state legislature approved and Gov. John Kitzhaber signed HB 3640, which allows regulated dispensaries. The law is codified at **Or. Rev. Stat. § 475.300**. Temporary rules for the dispensary program are available at OAR 333-008-1000 et seq.

Qualifying for the Program: To qualify for an ID card, a patient must have a qualifying condition and a statement from a physician who has primary responsibility for treating the patient that marijuana may mitigate their symptoms. A minor patient only qualifies with the consent of his or her parent or guardian and if the adult controls the dosage, acquisition, and frequency of use of the marijuana. The qualifying conditions in Oregon are cancer, HIV/AIDS, glaucoma, agitation related to Alzheimer's disease, and conditions causing one or more of the following: cachexia, severe pain, severe nausea, seizures, or persistent muscle spasms, including those that are characteristic of multiple sclerosis. The health department can approve additional medical conditions.

Patient Protections: Registered patients and caregivers are exempted from the state's criminal laws for acting in accordance with the medical marijuana law. Patients may also assert an affirmative defense if they have a qualifying condition and a physician has recommended medical marijuana even with if they do not have a registry identification card. In April 2010, the Oregon Supreme Court ruled in *Emerald Steel v. BOLI* that patients are not protected from being penalized by their employers.

Possession Limits and Access: Patients can have one designated caregiver, who must have "significant responsibility for managing the well-being" of the patient. Patients can reimburse caregivers for the actual cost of supplies and utilities, but not for their labor. Oregon's law allows a patient with a registry identification card or a primary caregiver to possess 24 ounces of processed marijuana and cultivate six mature plants and 18 immature plants for each patient the caregiver cultivates for. Each grow site must be registered with the health department. The law includes an advisory committee made of patients and advocates to advise the department.

In August 2013, Gov. Kitzhaber signed a bill into law that allows medical marijuana facilities to sell usable marijuana and immature marijuana plants to patients and their designated primary caregivers. The facilities may not grow marijuana; they obtain it from patients, caregivers, or people responsible for grow sites. As of late June 2014, 138 dispensaries were licensed.

Medical marijuana facilities cannot be located within 1,000 feet of elementary or secondary schools and cannot be located within 1,000 feet of another facility. The Oregon Health Authority adopted temporary rules related to testing and security, including requiring a security system, video surveillance, an alarm system, and a safe.

Rhode Island — S. 710 was passed by the Rhode Island legislature in 2006 and amended several times, including by S. 791 in 2007, H. 5359 in 2009, S 2834 in 2010, and H 7888 in 2012. The law is codified at R.I. Gen. Laws **Chapter 21-28.6**. Regulations are at **R21-28.6-MMP(5923)**.

Qualifying for the Program: To qualify for an ID card, a patient must have a qualifying condition and a statement from a prescriber who is licensed in Rhode Island or a physician licensed in Massachusetts or Connecticut that the patient has a bona fide relationship with that physician and that the "potential benefits of the medical use of marijuana would likely outweigh the health risks" for the patient. A minor patient only qualifies with parental consent and if the adult controls the dosage, frequency of use, and acquisition of marijuana. The qualifying conditions in Rhode Island are cancer, HIV/AIDS, hepatitis C, glaucoma, agitation related to Alzheimer's disease, and conditions causing one or more of the following: severe, debilitating pain, cachexia or wasting syndrome, severe nausea, seizures, or persistent muscle spasms. The health department administers the ID card program and may approve additional qualifying conditions.

Patient Protections: Rhode Island's law provides that cardholders abiding by the act "shall not be subject to arrest, prosecution, or penalty in any manner, or denied any right or privilege,

including but not limited to civil penalty or disciplinary action by a business or occupational or professional licensing board or bureau, for the medical use of marijuana." It also explicitly prevents landlords, employers, and schools from discriminating based on a person's status as a caregiver or patient. The law also provides that medical marijuana shall be considered a treatment, not an illicit substance, for the purposes of medical care, such as qualification for an organ transplant. Rhode Island honors visiting patients' out-of-state registry identification cards. The law has an affirmative defense for patients with doctors' recommendations and permissible amounts of marijuana.

Possession Limits and Access: Each patient can possess up to 2.5 ounces of marijuana and can cultivate up to 12 plants and 12 seedlings in an enclosed, locked area. Patients can also designate up to two caregivers or compassion centers to cultivate for them. A caregiver can assist no more than five patients. Caregivers can possess 2.5 ounces per patient they assist and 12 plants per patient, but their total cap is 24 plants and 5 ounces. Caregivers can receive reimbursement for their costs associated with assisting a patient.

Cardholders who collectively cultivate may only do so at a single location. A residential collective grow is limited to 10 ounces of usable marijuana, 24 mature marijuana plants, and 12 seedlings. Non-residential collective grows are limited to 10 ounces of usable marijuana, 48 mature marijuana plants, and 24 seedlings. Collective grows must be inspected for compliance with zoning.

Rhode Island's law provides for up to three state-regulated not-for-profit compassion centers, and the state approved three centers in March 2011 based on a competitive application scoring process. After delays and modifications due to interference from the U.S. attorney in Rhode Island, the first two compassion centers opened in Spring 2013. The modified law limited the number of plants a center could grow and allowed compassion centers to purchase overages from caregivers and patients. In 2014, in light of a 2013 memo from the U.S. Department of Justice, a budget bill removed the cap on the number of plants compassion centers could cultivate.

The state health department charges $5,000 annually for each compassion center registration and $250 for applications. Each compassion center employee must register with the health department. In 2010, the department developed rules for compassion centers' oversight, record keeping, and security. Compassion centers may cultivate either at the retail site or a second cultivation location that must be registered with the department. Dispensaries can dispense no more than 2.5 ounces of marijuana to a patient every 15 days.

Vermont — S. 76 was passed by the Vermont legislature in 2004. The law was expanded by S. 7 in 2007, S. 17 in 2011, and S. 247 in 2014. The law's citation is **Vt. Stat. Ann. tit. 18 § 4472** et seq.

Qualifying for the Program: Vermont is one of two states where the department issuing ID cards is the department of public safety. (The other state, Hawaii, will move its program to the health department by 2015.) To qualify for an ID card, a patient must have a statement from a Vermont, Massachusetts, New York, or New Hampshire-licensed physician, naturopath, advance practice nurse, or physician's assistant who has treated the patient for at least six months that the patient has had a qualifying medical condition. The qualifying conditions are cancer, multiple sclerosis, or HIV/AIDS if the disease results in severe and intractable symptoms, or a chronic, debilitating condition causing one or more of the following, which can not have responded to reasonable medical efforts over a reasonable period of time: severe pain, cachexia, severe nausea, or seizures. Patients must also be Vermont residents. A minor patient only qualifies if his or her parent or guardian also signs the application.

Protections, Access, and Possession Limits: Vermont's law allows a patient to choose to cultivate up to two mature and seven immature plants or to designate either a caregiver or a dispensary to cultivate for the patient. A patient with a registry identification card and his or her caregiver may collectively possess two ounces of processed marijuana. Cultivation must occur in a locked, indoor location. Caregivers must be 21 and have no drug-related convictions. They can only assist one patient.

Pursuant to a law enacted on June 2, 2011, the department of public safety was directed to approve four nonprofit dispensaries. In the first round of applications, only two applicants met the standards, and they both opened in late Spring 2013. Two additional dispensaries were subsequently approved and opened in 2014. Under the law, dispensaries are chosen based on a competitive process, including factors like convenience to patients, the applicants' experience, and their ability to provide for patients. Each dispensary employee must register with the state, and they generally cannot have drug convictions or convictions for violent felonies. Dispensaries must be at least 1,000 feet from schools. Municipalities can regulate their locations and operations and may also ban them within the locality. The state's department of public safety developed rules for dispensaries' oversight, record keeping, and security. Fees will include a $2,500 application fee, a $20,000 registry fee for the first year, and a $30,000 annual fee in subsequent years.

A patient must designate the dispensary he or she wishes to utilize, though the patient can change the designation. Dispensaries may only dispense by appointment, but they may deliver. Dispensaries must cultivate their own marijuana, either at the retail site or a second enclosed, locked cultivation location that must be registered with the department. Dispensaries can dispense no more than two ounces of marijuana every 30 days to a given patient. The law also included a survey of patients and an oversight committee that will assess the effectiveness of the compassion centers and security measures.

Vermont's law does not include any protections for unregistered patients or out-of-state patients.

Washington — Measure 692, a ballot initiative, passed with 59% of the vote in 1998. It was modified by SB 6032 in 2007, SB 5798 in 2010, and SB 5073 in 2011. It is codified at **Wash. Rev. Code § 69.51A.010** et seq. An administrative rule is available at **WAC 246-75-010**.

Qualifying under the Law: Washington is the only medical marijuana state without a registry identification card program. In 2011, Gov. Christine Gregoire vetoed the sections of a bill, SB 5073, which included a patient and caregiver registry and dispensary regulation and licensing. To qualify for protection under Washington's law, a patient must have a signed statement on tamper-resistant paper from a Washington-licensed physician, physician assistant, naturopath, or advanced registered nurse practitioner who advised the patient of marijuana's risks and benefits and advised the patient that he or she "may benefit from the medical use of marijuana." Qualifying conditions include cancer, HIV, multiple sclerosis, epilepsy, seizure and spasm disorders, intractable pain, glaucoma, Crohn's disease, hepatitis C, and diseases causing nausea, vomiting, or appetite loss. Some of those conditions only qualify if they have been unrelieved by standard medical treatments. The health department's Medical Quality Assurance Commission may also add additional conditions and has done so. In Washington, the possession, acquisition, and cultivation of marijuana by a minor patient is the parent or legal guardian's responsibility.

Patient Protections: Washington's medical marijuana law does not provide protection from arrest. Instead, it provides an affirmative defense that patients and caregivers may raise in court.

In June 2011, the state Supreme Court ruled against a person who was fired for being a medical

marijuana patient in *Roe v. Teletech Customer Care Management*. The law that passed in 2011, SB 5073, provides that an employer does not have to accommodate medical marijuana if it establishes a drug-free workplace and that it also does not require employers to allow the on-site medical use of marijuana. Medical marijuana cannot be the "sole disqualifying factor" for an organ transplant unless it could cause rejection or organ failure. Washington's law also restricts when parental rights and residential time can be limited due to the medical use of marijuana.

Access, and Possession Limits: Washington's law allows a patient with valid documentation and his or her designated provider to collectively possess 24 ounces of processed marijuana and 15 plants. A patient also has the ability to argue in court that more marijuana is needed. Up to 10 patients may form a collective garden, which may contain no more than 72 ounces and 45 plants. A person may only serve as a designated provider to one patient at a time and must wait 15 days between serving two different patients. Providers must be 18 or older and must be designated by a patient in writing.

SB 5073 provides that localities may regulate dispensaries, but due to the sectional veto by Gov. Gregoire, Washington law fails to provide any clear legal protections for them. However, in November 2012, voters approved I-502, allowing the regulated sales of marijuana to all adults 21 and older — including for recreational use. Under the initiative, all adults 21 and older may possess up to an ounce of marijuana.

Washington, District of Columbia — On November 3, 1998, 69% of D.C. voters approved Initiative 59. Congress blocked the implementation of the law until December 2009. The D.C. Council then put the law on hold temporarily and enacted amendments to it, B18-622. The revised law went into effect in late July 2010, and regulations were issued on April 15, 2011. A few modifications were made in 2011. In 2014, the council approved temporary and emergency legislation (which does not require Congressional review) to expand the law. The law is codified at District of Columbia Official Code **§ 7-1671.13** et seq.

Qualifying for the Program: To qualify for an ID card, a patient must have a qualifying condition and physician's recommendation that medical marijuana is necessary for the patient's treatment. The physician must be licensed in D.C., have a bona fide relationship with the patient, and have responsibility for ongoing treatment of the patient. The physician must review other approved treatments before making the recommendations. The board of medicine may audit physician recommendations and must audit recommendations for any physician who provides more than 250 recommendations in a 12-month period. A minor patient only qualifies with parental consent and if the adult controls the dosage, frequency of use, and acquisition of marijuana.

The qualifying conditions in D.C. are cancer, HIV/AIDS, glaucoma, severe and persistent muscle spasms, ALS, decompensated cirrhosis, wasting (for adults), Alzheimer's, seizure disorders, and conditions treated with chemotherapy, AZT, protease inhibitors, or radiotherapy. Terminally ill hospice patients also qualify. The health department administers the ID card program and can approve additional qualifying conditions, which it has done. A minor patient only qualifies with parental consent and if the adult controls the dosage, frequency of use, and acquisition of marijuana.

Patient Protections: Registered qualifying patients may possess and administer medical marijuana, and caregivers can do so for the purpose of assisting a patient. The marijuana and paraphernalia must be obtained from a registered dispensary. Medical marijuana can only be administered in a patient's residence or a medical facility that permits its administration. Marijuana cannot be used where its exposure would negatively affect a minor. Marijuana can only be transported in a container or sealed package that has a label received from a dispensary.

The ordinance also provides an affirmative defense for an adult who assists a patient in administering medical marijuana in their home or a permitted medical facility where the caregiver was not reasonably available to assist.

Possession Limits and Access: A patient or caregiver can possess no more than two ounces in a 30-day period, which must be obtained from a dispensary. However, the mayor may increase the amount to up to four ounces. The law provides for regulated cultivation facilities and dispensaries. The facilities and their staff are required to register with the mayor. Cultivation facilities will be allowed to produce up to 95 marijuana plants and to sell them to dispensaries. The ordinance allows for between five and eight dispensaries. The mayor set the number of dispensaries at five and cultivation centers at 10.

On March 30, 2012, the District granted preliminary licenses to six cultivation centers, after having developed standards for deciding who would be licensed. When selecting centers, it was required to consider the security plan, staffing plan, product safety and labeling plan, the suitability of the proposed facility, and input from neighborhood commissions. On April 12 2012, the District announced that four dispensaries had met minimum requirements to move forward to the next stage. The first dispensary began serving patients in July 2013.

No employee with access to marijuana at a cultivation facility or dispensary can have a misdemeanor for a drug-related offense or any felony conviction. Dispensaries and cultivation centers cannot locate in residential districts or within 300 feet of schools or recreation centers. The ordinance requires records to be kept on each transaction, the quantity of medical marijuana stored, and how marijuana is disposed of. Police must be notified immediately of loss, theft, or destruction. Dispensaries may not operate between 9:00 p.m. and 7:00 a.m. Rules also include requirements for signage, labeling, and security — which includes security cameras. Rules include provisions to revoke or suspend a license if the law is violated and for inspections. The dispensary selection criteria include the location’s convenience, the suitability of the building, the staffing plan and knowledge, the security plan, the product safety and labeling plan.

D.C.’s law also establishes an advisory committee to monitor other states' best practices, scientific research, and the effectiveness of D.C.'s medical marijuana program. It also provides for the committee to make recommendations to the council, including whether home cultivation should be allowed and, if so, how to implement it.

Other: The D.C. rules specify that the department will make an educational program on medical marijuana and side effects for physicians and medical institutions. They also provide to allow people or entities to apply to be a “medical marijuana certification provider,” which would conduct education and training, including on medical marijuana’s effects, procedures for handling and dispensing, the medical marijuana law, advertising, and security.

Fees by State

The following presents a summary of applicable fees in those states and the District of Columbia with approved medical marijuana provisions, last updated February 9, 2015.

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"We change laws."

Medical Marijuana Dispensary Laws: Fees and Taxes

Many patients believe medical marijuana should not be subject to sales tax because paying taxes on medicine can pose a hardship. The financial burden is compounded by the fact that medical marijuana is not covered by insurance. While sales taxes generally do not apply to prescription medications, most states' sales taxes apply to marijuana because it cannot be prescribed due to federal law. Instead, it is recommended or patients receive "certifications."

In addition to sales tax revenue, in most or all states with regulated dispensaries, the application and registration fees levied on medical marijuana businesses cover or exceed the costs of regulation. Nonrefundable fees for dispensary applications generally range from $1,000 to $5,000, with registration or annual fees typically between $5,000 and $20,000. While medical marijuana dispensary fees should not be so low that they encourage frivolous applications, it is important that they are not prohibitively high. Costs may be passed on to patients, and medical marijuana businesses are generally unable to get bank loans due to concerns about federal law.

State	Application and/or Registration Fee	Taxes
Arizona	$5,000 application fee, $1,000 for renewal	5.6% sales tax, plus local taxes
California	Varies, all licensing is local	7.5% state sales tax, also local taxes
Colorado	Applications: $7,000 to $15,000 for medical marijuana centers, $1,000 for infused product manufacturers Registrations: $5,200 to $13,200 for centers, $2,200 for infused product manufacturers Renewals: $5,800 to $13,800 for centers, $2,500 for infused product manufacturers	2.9% state sales tax, also local taxes
Connecticut	Applications: $1,000 for dispensaries; $25,000 for producers Permit and annual renewal fees: $5,000 for dispensaries; $75,000 for producers	6.35% state sales tax applies
Delaware	$5,000 compassion center application fee; $40,000 compassion center certification and biennial renewal fee	Gross receipts tax if above $1.2 million in revenue
Illinois	Applications: $5,000 for dispensary centers; $25,000 for cultivation centers License fees: $30,000 per dispensary; $200,000 per cultivation center Annual renewal fees: $25,000 per dispensary; $100,000 per cultivation center	7% excise tax at wholesale level and 1% sales tax
Maine	$15,000 application fee, $14,000 refunded to applicants that aren't chosen; $15,000 renewal fee	5% sales tax and 7% meals and rooms tax on edible products

Last updated: February 9, 2015

State	Application and/or Registration Fee	Taxes
Maryland	Fees in proposed rules: Application fees (in two stages): for growers $6,000; for growers/dispensaries: $11,000; for dispensaries only: $5,000 Biennial licensing fees (payable in annual installments): for growers: $250,000; for dispensaries/growers: $330,000; for dispensaries: $80,000	Likely not taxed; Maryland 6% sales tax does not apply to the sale of medicine
Massachusetts	$1,500 stage 1 application fee; $30,000 stage 2 application fee; $50,000/year license registration fee	Likely not taxed
Minnesota	$20,000 manufacturer application fee; the annual fee is not yet set, but is expected to be between $75,000 and $100,000	Likely not taxed
Nevada	$5,000 medical marijuana establishment application fee; $3,000 cultivation facility certification fee; $3,000 edible marijuana products or marijuana-infused product establishment certification fee; $5,000 independent testing laboratory certification fee; $30,000 medical marijuana dispensary certification fee	6.85% to 8.1% state and local sales tax likely applies, in addition to a 2% excise tax for wholesale sales and 2% excise tax for retail sales
New Hampshire	$3,000 request for application fee; annual registration: $80,000 or $40,000 (payable in stages), depending on the geographic area where the center is located	New Hampshire does not have a sales tax
New Jersey	$20,000 dispensary fee each year, $2,000 for unsuccessful applicants	7% sales tax
New Mexico	$1,000 application fee for producers, annual producer fee from $5,000- $30,000	Gross receipts tax (5.125% to 8.8675% depending on location in state)
New York	Fees proposed in draft rules: $10,000 registered organization application fee; $200,000 registered organization fee (refundable if not selected)	7% excise tax, anticipated percentage of 7% sales tax
Oregon	$250 application fee; $1,000/year license fee	Oregon does not have a sales tax
Rhode Island	$250 application fee, $5,000 biennial registration fee	Compassion center surcharge of 4%; 7% state sales tax
Vermont	$2,500 application fee, $20,000 or $30,000 annual fee	Likely not taxed
Washington, D.C.	$5,000 application fee for dispensaries and cultivators, $3,000/year renewal fee; $10,000/year fee for dispensaries; $5,000/year fee for cultivators	6% sales tax, revenue unknown

Financial Information by State

A Table of Financial Information by State

A short summary of medical marijuana program finances for selected states, prepared by the Marijuana Policy Project.

Medical Marijuana Program Financial Information by State
Revenues from Registries and Licenses and Program Expenses (State-Level)

State	Population[1]	Program			Per 1,000 Population			Year
		Revenues[2]	Expenses	Net	Revenues	Expenses	Net	
Alaska	737,259	$ 20,633	$ 22,277	$ -1,645	$ 28	$ 30	$ -2	FY 2012
Arizona	6,634,997	7,945,277	2,380,459	5,564,818	1,197	359	839	FY 2012
California	38,431,393	45,700	276,000	-230,300	1	7	-6	FY 2011-12
Colorado	5,272,086	6,500,000	5,900,000	600,000	1,233	1,119	114	see below
Dept. of Health[3]		3,800,000	3,800,000	0				FY 2012-13
Dept. of Revenue		2,700,000	2,100,000	600,000				FY 2011-12
DC	649,111	60,000	N/A	N/A	92	N/A	N/A	FY 2012-13
Hawaii	1,408,987	409,325	N/A	N/A	291	N/A	N/A	2013
Maine	1,328,702	612,370	466,028	146,342	461	351	110	2012
Michigan	9,898,193	9,900,000	3,600,000	6,300,000	1,000	364	636	FY 2012
Montana	1,014,864	550,900	N/A	N/A	543	N/A	N/A	2012
Nevada	2,791,494	713,000	N/A	N/A	255	N/A	N/A	2013
New Jersey	8,911,502	300,000	784,000	-484,000	34	88	-54	2013
New Mexico	2,086,895	598,000	598,000	0	287	287	0	FY 2013
Oregon	3,928,068	6,000,000	2,650,000	3,350,000	1,527	675	853	2010
Rhode Island	1,053,354	566,655	589,086	-22,431	538	559	-21	FY 2011 & 2012
Vermont	626,855	140,800	138,500	2,300	225	221	4	FY 2013

[1] U.S. Census Bureau, Population Division, Annual Estimates of the Population for the United States, Regions, and States: July 1, 2013, released December 2014.

[2] In some cases revenues might have been estimated based on patient counts and user fees rather than obtained from the respective departments. Therefore, revenues may be overestimated due to discounts for indigent or Medicaid patients whose counts are not known.

[3] This is an estimate calculated from user fees and patients, based on the self-funding provision of the program. No general funds appropriated.

Financial Information by State

The following presents a summary of program financial information in those states and the District of Columbia with approved medical marijuana provisions.

State Medical Marijuana Programs
Financial Information

State medical marijuana programs have generally had no trouble covering their expenses and have even generated substantial surpluses. Most states require the departments that administer their medical marijuana programs to set the fees high enough to cover all costs of administering the programs. Medical marijuana dispensaries typically have to pay an annual fee of between $5,000 and $30,000, while patients typically pay between $25 and $100 for registry identification cards that they renew once every year or two. In Michigan, Oregon, and Arizona, patient registry programs, dispensary regulation programs, or both, have brought in millions of dollars in surpluses. Other states, such as New Mexico and Maine, have been able to run comprehensive medical marijuana programs for under $700,000, including dispensary regulation, while covering the program costs through fees. In addition to fee-related revenue, most of the states that allow dispensaries impose their generally applicable sales tax on medical marijuana. In Colorado alone, the annual state and local tax revenue from medical marijuana businesses exceeds $11 million. In California, the state sales tax revenue from dispensaries is estimated at up to $105 million per year.

In **New Mexico**, which was the first state to license entities to produce and provide medical marijuana, the entire program will cost $598,000 in FY 2013.[1] The program initially charged minimal fees and was an unfunded mandate. Now, however, it is self-sustaining and covers all of its expenses, despite the fact that the only patients who are charged a fee are those who both cultivate marijuana for themselves and whose income is more than 200% above the federal poverty line.

The total FY 2013 staff costs for the state's program (salary and benefits) are $453,200. The program has seven full-time staff members. Its non-personnel expenses total $134,800 for the fiscal year. Those expenses include office supplies, telephone, mileage, lab testing, attorney fees, mail costs, and other office expenses. The program uses a combination of Microsoft Excel and Access and did not require development of any new software. When the program was new, it purchased a machine to make holographic cards, which cost about $6,000-$8,000.

As of August 30, 2013, 9,760 patients and 23 non-profit producers were licensed in New Mexico. There is a non-refundable $1,000 fee for licensed producer applications. Producers' annual renewal fees depend on how long the non-profit producer has operated. The fee is $5,000 for those who have been licensed less than a year. The fee is $10,000 for those licensed for more than one year, $20,000 for more than two years, and $30,000 for more than three years. 3,119 patients have personal cultivation licenses. Of the revenue in FY 2013, $508,000 comes from licensed producer fees, while $90,000 is generated from patients' personal production license fees.

In New Mexico, medical marijuana sales are subject to a gross receipts tax of 5.125% to 8.8675%, depending on the locality. According to the state Department of Health, in FY 2012, the state collected approximately $650,402 in gross receipts taxes from dispensaries.[2] This is in addition to annual revenue collected from fees, which will equal the regulatory costs of the medical marijuana program.

Colorado has the largest state-regulated dispensary program in the nation. As of FY 2012, more than 1,700 medical marijuana businesses were operating in the state — 532 medical marijuana

[1] The source of the FY 2013 financial information is a March 5, 2013 email from Andrea Sundberg of the New Mexico Department of Health. The information from prior years was obtained via phone calls and emails in 2010 and 2011 to Dominick Zurlo of the New Mexico Department of Health.

[2] Email communications with Andrea Sundberg, June 13, 2013. Ms. Sundberg noted, "This is an approximation as we obtained this information from our Producers and there were some reports that were not submitted."

centers (dispensaries) and 1,459 cultivation facilities and infused products manufacturers.[3] Although there have been a few bumps in the regulatory road after the state regulatory department overestimated revenue and made some questionable large expenditures while not focusing on the more essential aspects of regulation,[4] the program is still fairly new, and it is the most ambitious medical marijuana regulatory program in the nation. Medical marijuana taxes and fees have been quite lucrative, both at the city and state levels. State and city tax, registry, and licensing medical marijuana revenues exceeded $20 million in FY 2012. On November 6, 2012, Colorado voters approved allowing all adults 21 and older to use, grow, and purchase marijuana, but adult retail marijuana sales will not begin until around December 30, 2013, so all of these figures are limited to medical marijuana.

The Department of Public Health and Environment runs the state's patient and caregiver registry, and both the Department of Revenue's Medical Marijuana Enforcement Division (MMED) and individual cities license dispensaries. The state's patient and caregiver registry collects a $35 fee from each patient to cover its costs. No general funds have been appropriated to the program. The department re-evaluates the fee each year, and the fee was reduced from $110 to $90 on June 1, 2007.[5] It was reduced again on January 1, 2012, after the $90 fee generated a substantial surplus.[6] The department has issued about 109,622 current registrations,[7] meaning it generated at least $3.8 million in the past year. The surpluses from patient registrations have been so great in past years that they have been redirected to other purposes. In 2010, the legislature shifted a $3 million surplus from the patient ID program, and then-Governor Bill Ritter discussed using $9 million more from the medical marijuana registry program to help reduce the state's $60 million budget shortfall.[8]

In addition to the patient registry program revenue, the MMED collected $3.779 million in fees in FY 2011-2012. The total MMED expenses for the year were $5.262 million.[9] Although the program was in the red for the year, it started the year with a balance of more than $3.8 million, so it actually ended the fiscal year with a balance of $2.37 million. The decline in revenue was due to the fact that new applications were not accepted for additional medical marijuana businesses, and — as is the case with all businesses — some businesses that had been approved the prior year failed. Another factor was that annual medical marijuana business fees are relatively modest in the state and, in the case of medical marijuana centers, are lower than application fees.

The state application fees for medical marijuana centers are $7,500 for 300 or fewer patients, $12,500 for 301 to 500 patients, and $18,000 for those serving 501 or more patients. A cultivation application is $1,250, as is an infused products manufacturer application.[10] Annual renewal fees are lower, with centers' fees ranging from $3,750 to $14,000, depending on the center's size. Cultivation and infused products manufacturers' annual fees are $2,750.

In addition to medical marijuana patient and business fees, medical marijuana in Colorado generates substantial tax revenue. Unless a patient who has been certified by the state as indigent purchases it, medical marijuana is subject to state and city sales taxes in Colorado. In the 2012 fiscal

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[3] Colorado Department of Revenue, 2012 Annual Report. See p. 38, M-1 and M-2.
[4] http://www.denverpost.com/ci_22872574/colorado-audit-adequate-medical-marijuana-oversight-doesnt-exist
[5] http://www.cdphe.state.co.us/hs/medicalmarijuana/statistics.html. Viewed March 2, 2011.
[6] http://www.cdphe.state.co.us/hs/medicalmarijuana/index.html. Visited September 28, 2011.
[7] http://www.colorado.gov/cs/Satellite/CDPHE-CHEIS/CBON/1251593017044. Accessed on October 18, 2013.
[8] "Governor Ritter wants to use fees from medical marijuana to close budget gap," NBC11news.com, August 27, 2010. "Medical marijuana: Does using $9 million in fees for budget shortfall screw MMJ patients?," *Westword*, August 25, 2010. http://blogs.westword.com/latestword/2010/08/medical_marijuana_does_using_9_million_in_fees_for_budget_shortfall_screw_mmj_patients.php
[9] Colorado Department of Revenue, 2012 Annual Report. See p. 38, M-1 and M-2.
[10] http://www.colorado.gov/cs/Satellite?c=Page&childpagename=Rev-MMJ%2FCBONLayout&cid=1251643932266&pagename=CBONWrapper

year, medical marijuana sales taxes brought in more than $5.4 million to state coffers.[11] In Denver alone, the city collected $2.4 million in sales tax for FY 2012,[12] with a rate of 2.9%. Statewide, it appears that at least $6.3 million was collected in county and local sales taxes on medical marijuana in FY 2012.[13]

Cities have also collected substantial revenue from business licensing. For example, Denver charges $2,000 for a dispensary application fee and $3,000 for an annual or renewal license fee.[14] As of October 2012, there were 266 licensed dispensaries with 272 applications pending,[15] generating $1.35 million in application and licensing fees. Denver reports there were no start-up costs involved when it began licensing dispensaries, and any costs incurred are part of the department's regular operating budget. Medical marijuana is but one of the 91 types of licenses the Community Planning and Development Department provides, and the medical marijuana business licenses do not have a separate dedicated staff.[16]

In **Arizona**, the state's medical marijuana program generated $5.5 million more than it spent from mid-2011 through mid-2012. That was before any sales taxes were collected, since dispensaries did not begin to open until late 2012. The program is generating so much revenue that it has been able to make several substantial non-essential expenditures.

Arizona's medical marijuana fees totaled more than $7.9 million from April 14, 2011 through June 30, 2012.[17] About $2.4 million of the revenue was from dispensary fees and about $5.5 million was from patient ID card fees. Meanwhile, the program — including both patient ID cards and dispensaries — cost under $600,000 in salaries and wages to run. (This does not include litigation, such as Arizona's unsuccessful lawsuit questioning whether federal law preempted the law.) It incurred an additional $1.5 million in operating expenditures and $300,000 on capital equipment.

Arizona's medical marijuana program had approved 98 dispensaries and 28,977 patient applications as of the time the annual report was published. Other than salaries and wages, the expenditures were generally not ones that are essential to a medical marijuana program. For example, the expenses include $284,325 to improve physicians' ability to check the prescription drug monitoring database and $200,000 to the University of Arizona to review the evidence and make recommendations on adding debilitating conditions.

In addition to the $5.5 million surplus generated by Arizona's medical marijuana program last year, marijuana is subject a 6.6% sales tax. It is unknown what the total sales tax revenue will be. The first dispensary opened in late 2012 and about 70 are operational as of October 2013.

In **California**, dispensaries have operated for more than a decade, but no state agency is charged with regulating them. Instead, several cities and counties have set up regulations and collect licensing fees. San Francisco, for example, charges a non-refundable permit application fee of

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[11] "Colorado Medical Marijuana Dispensary Retail Sales and State Sales Tax by County FY2012," Colorado Department of Revenue.

[12] http://blogs.westword.com/latestword/2012/10/medical_marijuana_dispensaries_266_licensed_colorado.php?page=2

[13] This estimate is based on applying local or county sales tax rates to the revenue listed by city in the Colorado Department of Revenue's "Colorado Medical Marijuana Dispensary Retail Sales and State Sales Tax by County FY2012."

[14] http://www.denvergov.org/businesslicensing/DenverBusinessLicensingCenter/BusinessLicenses/MedicalMarijuanaCenters/tabid/441765/Default.aspx. Viewed October 18, 2013.

[15] http://blogs.westword.com/latestword/2012/10/medical_marijuana_dispensaries_266_licensed_colorado.php?page=2

[16] Email communication with Sue Cobb, Communications Director, Denver Community Planning & Development. August 27, 2010.

[17] Arizona Medical Marijuana Program Annual Report – 2012 http://www.azdhs.gov/medicalmarijuana/documents/reports/az-medical-marijuana-program-annual-report-2012.pdf

$8,459.[18] While the state does not regulate medical marijuana sales, it does tax them. The state Board of Equalization collects sales taxes from dispensaries and estimates that they generate $58-$105 million in annual sales tax revenue.[19] In addition to the statewide sales tax of 7.5%, cities levy up to 1.5% more in local sales taxes. In 2012, Los Angeles collected $2.5 million on a 0.6% gross receipts tax on medical marijuana, which was in addition to state and local sales taxes on medical marijuana.[20]

The California Department of Public Health also runs a voluntary registry program for patients, which fewer than 2% of patients utilize. Although there are estimated to be well over 500,000 patients in California, only 5,798 patients obtained registry cards in FY 2012/2013 because the cards are optional.[21] California's registry program is the most complex because each of 58 counties had to implement it. The program funds itself with registry fees, but borrowed $1.5 million in FY 2004/2005 for start-up costs, which were incurred expecting a much higher rate of participation. In FY 2011/2012, the program generated $457,000, and its expenses totaled $276,000.[22] The program has two full-time analysts and one supervisor.

Maine's original medical marijuana law passed in 1999 and voters added dispensaries and a registry system in November 2009. The Department of Human Services' Licensing and Regulatory Services approved eight dispensaries by August 2010, and as is the case with most other states, Maine's program has easily covered its expenses. In 2012, the medical marijuana program generated $10,261 in medical marijuana license application fees and $602,109 in registration fees. It spent $466,028.45 that year.[23] When one adds in sales tax revenue — which totaled $265,655 in 2012[24] — the 2012 surplus was more than $400,000.

The Department of Human Services' Licensing and Regulatory Services requires all dispensary applicants to pay a $15,000 fee, $14,000 of which is refunded if they are not awarded a registration.[25] The annual renewal fee is also $15,000, and a $5,000 fee is charged to change locations. Meanwhile, each employee ID card costs $56 per year, which includes $31 for a background check. Ninety-five dispensary employees were licensed in 2012.

In 2010, the department issued a total of eight non-profit dispensary registrations, which brought in a total of $120,000 in revenue. Thirty-one unsuccessful applications brought in an additional $31,000. The eight dispensaries continue to be registered.

In Maine, patient ID cards are free and voluntary. In 2012, the state issued 1,455 patients identification cards. Meanwhile, the state issued 1,311 cards to 575 caregivers at a cost of $331 each for those who cultivate marijuana (a $300 cultivation fee, plus a $31 background check fee) and $31 for a background check for those that do not cultivate.

As of 2011, the program planned to have two staff run the program — a program specialist and an administrative support person. The department did not provide updated staffing numbers in its 2012 annual report, but it did include the total cost of personnel: $119,460.65. The non-personnel

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[18] San Francisco Health Code, Article 33, Sec. 3304.
[19] "Berkeley cannabis collectives slapped with huge tax bills," *Berkeleyside*, February 3, 2011. http://www.berkeleyside.com/2011/02/03/berkeley-cannabis-collectives-slapped-with-huge-tax-bills
[20] See: http://www.smartvoter.org/2013/05/21/ca/la/meas/D/
[21] http://www.cdph.ca.gov/programs/MMP/Pages/MMPCardDATA.aspx. Viewed October 18, 2013.
[22] The California Budget Act 2012, HHS, Department of Public Health, pages 48-49. http://www.ebudget.ca.gov
[23] "Maine Medical Use of Marijuana Program: January 1, 2012 - December 31, 2012. Annual Report to the Maine State Legislature."
[24] Douglas Rooks, "Tipping point on legal marijuana," *Seacoast Online*. April 14, 2013. http://www.seacoastonline.com/articles/20130414-OPINION-304140317

[25] http://www.maine.gov/dhhs/dlrs/rulemaking/adopted.shtml

expenses in 2012 totaled $346,567.80. The state did not provide an itemization of those expenses in 2012, either. The previous year, it provided more detailed numbers. That year, the department spent $125,000 in IT expenses, which included both monthly expenses and start-up costs for a data management system. There was also a one-time $47,000 expense for law enforcement to confirm the validity of cards roadside.

Rhode Island's medical marijuana registry program opened in 2006, and compassion centers (dispensaries) were added to the law in June 2009. The department finalized rules in March 2010 and registered three compassion centers on March 15, 2011. Because of mixed signals from the federal government and other delays, however, compassion centers did not begin operating until 2013. There are now two operational compassion centers.

In 2011-2012, inclusive, the state's program took in $566,655 in fees, and it spent slightly more — $589,086.16 in personnel and equipment costs.[26] The medical marijuana program shared 2.1 full-time staff (FTE) with other programs, and added 1.25 FTE in 2012, though they were also assigned to other programs. The delays in implementing the compassion center program likely reduced revenue, since there was no need to renew compassion center registrations or register compassion center staff during that time. Another factor in Rhode Island's modest shortfall is that the compassion center fees are lower than in most states.

There were two rounds of compassion center applications, in which first 15, then 18, applicants paid a very modest, non-refundable $250 fee. Each compassion center that was registered paid a $5,000 fee, which will be charged annually. In addition, compassion center agents pay $100 and caregivers are charged $200 in annual fees for registry identification cards. Patients' cards cost $100, unless they receive benefits from Medicaid, SSI, or SSDI, in which case their fee is $25. All of the registry identification card fees were increased in 2012 to ensure adequate funding. As of September 9, 2013, there were 5,941 registered patients and 3,458 registered caregivers in Rhode Island.[27]

Michigan voters approved that state's medical marijuana law in November 2008. The state issues patient and caregiver registry cards, but there are no state-registered dispensaries. The Michigan Department of Licensing and Regulatory Affairs (LARA) is responsible for processing applications and setting fees that are sufficient to cover all program costs.

As of May 31, 2013, LARA has issued 128,441 current patient ID cards.[28] The last time the program responded to the inquiry, it reported that about 60% of applicants are charged $100, and 40%, who demonstrate low-income, are charged $25.[29] Caregivers are also required to pay an application fee of $100 per patient (with a maximum of five). As of May 31, 2013, 26,875 caregiver registrations had been issued, with a "large backlog" awaiting processing.[30] In mid-2012, the program had one manager, 16 full-time staff, seven temporary staff, and one student. During fiscal year 2012, the program generated $9.9 million in revenue, with just $3.6 million in expenditures, leaving a $6.3 million surplus for the year.[31]

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[26] Rhode Island Department of Health, "Rhode Island Medical Marijuana Program Report,", January 1, 2013.
[27] September 9, 2013 telephone communication with Mike Simoli, Acting Health Program Administrator, Licensing Team/Prescription Monitoring Program, Office of Health Professionals Regulation, Rhode Island Department of Health.
[28] http://www.michigan.gov/lara/0,4601,7-154-35299_63294_63303_51869_60731---,00.html. Viewed October 18, 2013.
[29] Email communication with program administrator Rae Ramsdell, June 8, 2009.
[30] Michigan Medical Marihuana Program Data: http://www.michigan.gov/lara/0,4601,7-154-35299_63294_63303_51869_60731---,00.html.
[31] Melissa Anders, "Michigan rakes in $9.9 million in medical marijuana card fees; see patient/caregiver numbers by county," February 7, 2013. (http://www.mlive.com/news/index.ssf/2013/02/michigan_medical_marijuana_1.html)

The **Oregon** Medical Marijuana Program (OMMP) began in 1998 and is run entirely on registry fees. It operates a registry for patients, caregivers, and grow sites. Beginning in 2014, the state will also license dispensaries in Oregon. The OMMP has been in the black every biennium except the first one (ending in 1999), when it was in the red by $14,000. The OMMP surplus was so substantial in 2005 that the Oregon Legislature siphoned off $902,000 to pay for other non-medical-marijuana-related budget needs for the Oregon Department of Human Services.[32] The legislature siphoned off an additional $168,286 to the general fund during the July 2007 to June 2009 fiscal period.[33] At the end of the fiscal period ending in May 2010, the program had a $269,354 balance. Since 2011, the program has not been responsive to MPP's inquires about financial information.

Despite the fact that the program was already generating a surplus, in late 2011, the state doubled the standard patient registry fees to $200, with a discount of $100 for food stamp recipients, or $20 for those patients who receive SSI benefits. On October 1, 2013, it revised the fees to charge $60 to patients receiving food stamps and $50 for patients enrolled in the Oregon Health Plan. It maintained the $20 fee for patients who receive SSI benefits. As of October 1, 2013, there are 58,484 registered patients and 29,323 caregivers.[34] The OMMP website does not provide a breakdown for how many patients pay the discounted rates. The program started out with only one manager and one employee, computers, and basic software. It has slowly grown and, as of early 2011, had 24 full time employees (FTE), including temporary workers. The OMMP initially used Microsoft Access, but the program became more complex after a 2007 law passed, so it developed a custom database. The program also pays expenses for travel and related expenses for a medical marijuana advisory committee.

Although we have not received recent expense data from **Montana**'s medical marijuana program, in the past, the program generated a surplus even with much lower patient fees. The state does not have state registration or regulations for dispensaries. Patients' registry fee was initially set at $200, but that was steadily reduced since such a large fee was not needed to cover costs. The fee had been reduced to $25 for new patient applications and $10 for renewals as of September 2011, but the legislature increased the fees in 2011. The annual registration fee for patients is now $75, and providers are charged $50. As of September 2013, there were 7,150 registered patients.[35] The program, which is housed in the Department of Public Health & Human Services, generated a minimum of $550,900 during the past year. As of mid-2011, when it had far more patients enrolled, the program involved a portion of two supervisors' time and the equivalent of eight full-time employees.

Vermont has operated a patient and caregiver medical marijuana registry since 2004. In 2011, the legislature approved the licensing of four non-profit dispensaries, two of which opened in 2013. The Department of Public Safety, which operates the medical marijuana program, produced a report on actual and projected revenues for the program on January 9, 2012.[36] The report shows that the program expected to operate on a very modest budget of about $140,000, and that it expected to have fee revenue cover all of its costs.

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[32] "Oregon Lawmakers Discover Unexpected Revenue from Medical Marijuana," *Associated Press*, June 1, 2005, *available at* http://www.firstcoastnews.com/news/strange/news-article.aspx?storyid=38168. See also Oregon Medical Marijuana Program Advisory Committee on Medical Marijuana minutes, December 14, 2005, *available at* http://mercycenters.org/ommp/libry/wrkgrp_minutes_121405.doc.

[33] "Oregon Medical Marijuana Program Financial Statement," June 1, 2010.

[34] http://public.health.oregon.gov/diseasesconditions/chronicdisease/medicalmarijuanaprogram/pages/data.aspx. Accessed October 17, 2013.

[35] http://www.dphhs.mt.gov/marijuanaprogram/. Viewed October 18, 2013.

[36] "Report from the Department of Public Safety: In compliance with S.17 of the 2011 Vermont General Assembly, Section 2a and Section 3 of the Act for the Marijuana for Medical Symptom Use by Persons with Severe Illness," Vermont Department of Public Safety, January 9, 2012.

In March 2011, the program reported an estimated annual revenue of $22,000 and an annual cost of $8,000, including $3,700 in staff time (about 16 hours per month) for the year.[37] In its early 2012 report, the department found that the actual revenue in FY 2011 was slightly higher than was projected — $22,750. That figure did not include a final tally for expenses for the year.

For FY 2013, the department estimated annual revenue of $140,800 and estimated the program's cost at $138,500, including $90,000 for a full-time administrator and $30,000 for a half-time data entry staffer. The remaining expenses were for software and office supplies.

Each applicant for a dispensary registration must pay a $2,500 application fee, and those granted registration must pay an annual registration fee of $20,000 their first year and $30,000 in subsequent years. The department also charges patients, caregivers, and dispensary personnel each $50 for registry identification cards. As of September 9, 2013 the program had 846 patients,[38] making it one of the smallest programs in the nation. Those numbers have significantly increased, however, over the years and especially since medical marijuana access improved with the opening of dispensaries.

In **New Jersey**, the state has been very slow to implement its medical marijuana program, which was approved by the legislature and then-Governor Jon Corzine in early 2010. Despite the law providing for six alternative treatment centers (ATCs) initially, only one has opened as of October 2013, with a second expected to open soon. The sole ATC has been unable to meet patient demand,[39] which likely reduces the number of patients registering. The slow implementation has likely reduced both patient registry revenue and revenue from ATCs.

New Jersey Department of Health and Senior Services charges ATC applicants a $20,000 annual fee, $2,000 of which is non-refundable. Every two years, patients must apply for an ID card, which costs $200, unless the patient receives certain benefits, in which case it costs $20. As of September 9, 2013, there were 1,200 patients and 114 caregivers active in New Jersey.[40]

As of March 2013, the program had an annual budget of $784,000. At the time, the program had 12 full-time employees and one part-time employee. It also has assistance from several sister agencies that provide services within their areas of expertise, such as investigations, testing, and legal issues.[41] Gov. Chris Christie requested $1.6 million for the program in FY 2014, and the medical marijuana program requested authorization during FY 2014 to expand its FTEs to a total of 18. Medical marijuana sales are subject to a 7% sales tax.

Alaska has one of the smallest medical marijuana programs in the country. In FY 2012, there were 917 patients and caregivers in the program, which does not allow dispensaries. The state charges a very low fee — $25 for initial applications and $20 for renewals — so it does not cover its modest costs. The state reported the program generated an estimated $20,632.50 in FY 2012. As of

[37] Email communication with Sheri Englert, March 2, 2011.
[38] September 9, 2013 telephone communication with Jeffrey Wallin, Director, Vermont Criminal Information Center.

[39] Jan Hefler, "NJ Marijuana Patients Now At 1000 But Most Just Wait," June 26, 2013 http://www.philly.com/philly/blogs/burlington/NJ-Marijuana-Patients-Now-At-1000-But-Most-Just-Wait.html#wMH280orSBtWcJ5W.99

[40] September 9, 2013 telephone communication with New Jersey Department of Health Medicinal Marijuana Program staffer.

[41] Email from program director John O'Brien, March 19, 2013.

FY 2012, the program took a portion of one staffer's time, totaling $13,410 in personnel costs. The program was also spending $5,272.75 to send out cards and incurring $3,594.64 printing ID cards.[42]

Hawaii officials did not respond to requests for information. The state has a registry program for patients and caregivers, but it does not have a dispensary program. The Hawaii program is run by the state Department of Public Safety's Narcotics Division, but is moving to the health department pursuant to a law passed in 2013. Patients' annual fee is $35.

Nevada's program currently only includes a patient and caregiver registry, but in 2014, it will expand to include a regulated medical marijuana industry. The program is run by the state Health Division, which charges patients $50 for an application and $150 to process the application each year. In addition, patients must pay $11-$22 to the DMV for the ID card and $4-$20 for fingerprinting. Nevada's program has generated such a substantial surplus that one state legislator proposed transferring $700,000 from the fund to substance abuse education each year for the next two years.[43]

Nevada's dispensary law will reduce the maximum patient fee to $100.[44] It sets a schedule of fees for medical marijuana dispensaries (of which there may be up to 66), medical marijuana cultivation facilities, infused product manufacturers, testing laboratories, and staff. The initial fees range from $3,000 for a cultivator to $30,000 for a dispensary. Renewal fees range from $1,000 to $5,000. Annual staff ID cards will be $75. Finally, in addition to standard sales taxes, there is also a 2% excise tax at the wholesale level and a 2% excise tax at the retail level.

Delaware, **Massachusetts**, **Washington D.C.**, **New Hampshire**, and **Illinois**' laws were all enacted recently, between 2011 and 2013. All five jurisdictions are in the process of implementing their programs, so it is too soon to determine their total costs or revenue. They will all regulate dispensaries and issue patients and caregivers ID cards.

In **D.C.**, the District began licensing patients, cultivation locations, and dispensaries in 2012-2013, though the law passed in 2011. The health department is charging $100 per year for patient and caregiver ID cards, but low-income patients and caregivers instead pay $25 per year. Dispensaries are charged $10,000 annually for a registration, and cultivation centers are charged $5,000 annually.[45] In addition, both dispensary and cultivation center applications are $5,000, $2,500 of which is non-refundable. Dispensary and cultivation center directors, officers, members, agents, and incorporators' fees are $200, while managers' are $150, and employees' are $75.[46]

There are currently three medical marijuana dispensaries and three cultivation facilities operating within the city limits. There is a 6% tax on the gross receipts for medical marijuana sales. The health department has not responded to requests for a breakdown of total revenue and expenses, nor did it provide a number of identification card holders.

The **Delaware** Medical Marijuana Act took effect on July 1, 2011. The law calls for three dispensaries ("compassion centers") to be open statewide. However, due to concerns from Gov. Jack Markell, the Delaware Department of Health and Social Services delayed implementation of compassion center rules, and then — in draft rules released on October 1, 2013 — reduced the number of compassion centers to only one. Those concerns were based on mixed signals from the U.S. Department of Justice, which has clarified its position since Gov. Markell announced the requested changes to the program.

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[42] Email communication with Andrew Jessen, March 18, 2013.
[43] "Bill: Divert Nevada medical marijuana money for treatment," *Reno Gazette-Journal*, May 1, 2011.
[44] SB 374 (http://www.leg.state.nv.us/Session/77th2013/Bills/SB/SB374_R3.pdf)
[45] http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Rulemaking_for_MMP_2013.pdf
[46] http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/1210MMPDirector_etalFinal.pdf

As a result of the lack of access to medical marijuana, very few patients have registered, resulting in very limited revenue. Delaware's proposed rules would charge a non-refundable $5,000 application fee to compassion centers. Any compassion centers that are approved would pay a $40,000 annual fee. Patients and caregivers are charged $125 annually for medical marijuana identification cards.

On June 1 2012, **Connecticut** Gov. Dannel Malloy signed a bill to legalize medical marijuana for severely ill patients. Under the state's law, patients may not grow their own medical marijuana. Instead, patients will obtain marijuana from a registered dispensing facility, which in turn will obtain marijuana from a licensed producer. The Department of Consumer Protection proposed draft rules in 2013, which were approved and are now final. The state charges producers far more than other states do for application fees, which may reduce access significantly.

The department requires a non-refundable $25,000 application fee from producers, plus an additional $75,000 annual fee if they are accepted.[47] For dispensaries, the department requires an initial non-refundable application fee of $1,000. If accepted, there is a $5,000 fee for registration and a yearly renewal fee of $5,000.[48]

As of October 15, 2013 1,115 patients have been registered into Connecticut's medical marijuana program.[49] They are charged $100 each for the registration. Caregivers are charged $25. The state has not responded to requests for any additional information on expenses and revenue for the new program. As of October 17, 2013, the state has issued a request for producer applications, but it has not yet licensed producers and dispensary facilities.

On November 6, 2012, **Massachusetts** voters approved Question 3 with 63% voting in favor of establishing a medical marijuana program. Once the law is fully implemented, there should be up to 35 non-profit dispensaries statewide.

Prospective medical marijuana dispensaries are now applying through a two-phase application process. Applicants were required to pay a $1,500 fee for submission and consideration of the Phase 1 application. The Department of Public Health reported receiving 181 dispensary applications by its August 22, 2013 deadline.[50] That generated $271,500 in application fees. Of those applicants, 158 were approved to submit a Phase 2 application. Those that qualify for a Phase 2 application must pay $30,000 to be considered. All of the fees are non-refundable. Dispensaries that are selected will be required to pay a $50,000 annual fee for a certificate of registration. There will also be a $500 annual registration fee for each dispensary agent.[51]

Patients are charged $50 per year for applications. Patients who demonstrate a hardship, including a financial hardship, may be eligible to cultivate a modest supply of their own marijuana. An application for a hardship cultivation license is $100.

On July 23, 2013, Gov. Maggie Hassan signed a bill to allow seriously ill **New Hampshire** residents access to medical marijuana. Currently, New Hampshire is in the process of rulemaking and implementation. Under this law, the state is expected to allow four non-profit alternative treatment centers (dispensaries). ATCs are unlikely to open before late 2014, and the patient registry will

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[47] http://www.ct.gov/dcp/cwp/view.asp?a=4287&q=527988
[48] http://www.ct.gov/dcp/cwp/view.asp?a=4287&q=527978
[49] http://www.ct.gov/dcp/cwp/view.asp?a=4287&q=533228&dcpNav=|&dcpNav_GID=2109

[50] Dan Ring, "Massachusetts releases list of 181 applications for medical marijuana stores," *Mass Live*, August 23, 2013.

[51] http://www.mass.gov/eohhs/gov/newsroom/press-releases/dph/applications-for-registered-marijuana-dispensaries-.html

probably not be available before 2014. The law did not specify the fee structure for ATCs or patient and caregiver applications.

On August 1, 2013, **Illinois** became the most recent state to authorize a medical marijuana program, when Gov. Pat Quinn signed HB 1. Illinois' medical marijuana law will become effective on January 1, 2014. At that point, three state departments will have four months to implement rules, including setting a fee structure for patients, dispensaries, and cultivation centers. The state plans on having 60 dispensaries around the state, with 22 cultivation centers statewide. Illinois also plans on a 7% excise tax and a 1% sales tax for medical marijuana.[52]

Finally, **Washington**'s law is the only one of the 21 that does not provide for a registry card, and there are also no state-regulated dispensaries. Voters, however, approved regulating and taxing marijuana for sales to all adults. Any adult 21 or older will be able to buy marijuana beginning in mid-2014.[53]

[52] http://www.ilga.gov/legislation/98/HB/PDF/09800HB0001lv.pdf
[53] The fiscal analysis for I-502 is available at http://vote.wa.gov/guides/2012/I-502-Fiscal-Impact.html

State	Registered Patients	State Regulated Dispensaries	Breakdown of Expenses	Fees	Total Annual Revenues	Total Annual Expenses
Alaska (population 731,449)	917 patients and caregivers (2012)	No.	Personnel: $13,410 Printing cards: $3,594.64 Mail: $5,272.75	$25 per patient or caregiver; $20 for renewal	Estimated $20,632.50 (FY 2012)	$22,277.39 (FY 2012)
Arizona (population 6.55 million)	40,328 (as of 10/02/13)	98 have been approved, 70 are open as of October 2013.	Salaries, wages and benefits: $570,972 Operating expenses: $1,505,023 Capital equipment**:** $304,464	$5,000 dispensary application fee, $1,000 renewal; $150 per patient, $75 reduced fee for low-income applicants; $200/patient for caregivers; $500 for dispensary agents; 6.6% sales tax	$7,945,277 (FY 2012) plus tax revenue	$2,380,459 (FY 2012) At least some of the surplus is used for interagency expenses, including a lawsuit where Arizona sought unsuccessfully to overturn the law.
California (population 38.04 million)	5,798 patients and 396 caregivers in FY 2012/2013	No, all dispensary regulation is local. (Under state law, they are called collectives and cooperatives.)	Registry program: two full-time, one supervisor; operating expenses and equipment; and indirect costs.	$66 per card to the state, $33 reduced fee for Medi-Cal patients; dispensary fees vary by locality; 7.5% sales tax; local taxes varies	$457,000 to the state registry program (FY 2011-2012); state sales tax: est. up to $100 million	$276,000 for state registry (FY 2011-2012)
Colorado (population 5.19 million)	109,622 (as of 08/31/13)	Yes, in 2012, there were 532 medical marijuana centers (dispensaries) as well as 1,459 infused products manufacturers and cultivation facilities.	The health department (patient registry) did not respond; the Medical Marijuana Enforcement Division (MMED) has 15 staff	$35 patient fee; Annual state dispensary fee: $3,750-$14,000; Annual infused products maker or cultivation fee: $2,750 (applications are more); 2.9% state sales tax; local sales tax varies	MMED revenue: $2.7 million ($3.8 million the prior year); Registry: $3.8 million; State sales taxes: $5.4 million; Local sales taxes: >$6 million	MMED: $2.1 million ($5.2 million the previous year) Health department (patient registry) did not respond, but the fees are set to cover costs, so it was no more than $3.8 million.

State	Registered Patients	State Regulated Dispensaries	Breakdown of Expenses	Fees	Total Annual Revenues	Total Annual Expenses
Connecticut (population 3.59 million)	1,115 (as of 10/15/13)	Yes, there will be a number of dispensaries that is TBD and three to 10 growers.	N/A — The law passed in 2012 and has not been fully implemented yet.	Producers: non-refundable $25,000 application fee and $75,000/year; Dispensaries: non-refundable application fee of $1,000 and $5,000/year; Patients: $100; Caregivers: $25	N/A	N/A
Delaware (population 917, 092)	21	On hold, there would have been three initially, now only one.	Not available	Patient fee: $125; Compassion center rules have not been promulgated yet	Not available, and program is mostly stalled	Not available, and program is mostly stalled
D.C. (population 617,996)	Not available	Six cultivation centers and four dispensaries have been approved. Three dispensaries and three cultivation facilities are open as of October 2013.	Did not respond to inquiry	$5,000 dispensary and grower applications; $5,000 annual fee for cultivators; $10,000 annual fee for dispensaries; $75-200 per staffer; patient and caregivers: $25 or $100; 6% sales tax	Unknown, $60,000 just from the existing cultivator and dispensary annual fees, plus ID cards	Unknown, did not respond to inquiry
Hawaii (population 1.39 million)	11,695	No	Did not respond to inquiry	$35 annual patient fee	At least $409,325	Did not respond to inquiry
Illinois (population 12.88 million)	N/A — program is not yet operational	Yes, the state plans to allow 60 dispensaries statewide and 22 growers.	N/A — program is not yet operational	N/A — program is not yet operational	N/A — program is not yet operational	N/A — program is not yet operational

State	Registered Patients	State Regulated Dispensaries	Breakdown of Expenses	Fees	Total Annual Revenues	Total Annual Expenses
Maine (population 1.33 million)	Registry is voluntary to patients, 1,455 are registered	Yes, eight nonprofit dispensaries.	Staff: $119,460.65 Other: $346,567.80.	$15,000/year per dispensary; staff IDs: $25; no patient fee; $300/patient for most caregivers; 5% sales, plus 7% meals/rooms taxes for edibles	$612,370 in fees in 2012, plus $265,655 in sales tax	$466,028.45 was expended through December 31, 2012
Massachu-setts (population 6.45 million)	N/A — program is not yet operational	Yes, 35 should open in 2014.	N/A — program is not yet operational	Dispensary non-refundable application fees: $1,500 (Phase 1), $30,000 (Phase 2); Annual fee: $50,000; Patients: $50/year, $100 for hardship cultivation certificates	Not yet available, dispensary application process is not done	N/A — program is too new
Michigan (population 9.89 million)	128,441 (as of 05/31/13)	No.	One manager, 16 full-time, 7 temp staff, one student	$100 per patient; reduced fee $25; $100/patient for caregivers	$9.9 million (FY 2012)	$3.6 million (FY 2012)
Montana (population 1.01 million)	7,150 (as of 10/01/13)	No.	Has not provided updated information yet	$75 per year per patient application; $50 per provider per year	At least $550,900 in the past year	Unknown, but significantly less than the revenue
New Hampshire (1.32 million)	N/A — program is not yet operational	Yes, but officials have until January 2015 to establish rules for dispensaries.	N/A — program is not yet operational	N/A — program is not yet operational	N/A — program is not yet operational	N/A — program is not yet operational
New Jersey (population 8.87 million)	1,200 (as of 09/09/13)	One opened in 2012, five more were approved but are not yet open.	12 full-time (FTE), one part-time; MOA with other agencies for various services	$20,000 dispensary fee each year; $2,000 for unsuccessful applicants; $200 or $20 patient ID card fee; 7% sales tax	Should exceed $300,000, not counting sales tax	Current budget: $784,000; Total expected budget for FY 2014: $1.4 million

State	Registered Patients	State Regulated Dispensaries	Breakdown of Expenses	Fees	Total Annual Revenues	Total Annual Expenses
New Mexico (population 2.09 million)	9,760, 3,119 of which have received licenses for personal cultivation (as of 08/30/13)	Yes, 23 "licensed producers."	Seven full time staff; office supplies, telephone, mileage, lab testing, attorney fees, mail costs, office expenses	$30 cultivation license for some patients; $1,000 producer application; annual producer fee: $5,000-$30,000; gross receipts tax of 5.125% to 8.8675%	$598,000 in program fees (FY 2013), $650,402 in gross receipts tax (2012 estimate)	$598,000 (FY 2013)
Nevada (population 2.76 million)	4,322 (as of 09/04/13)	Not yet; there will be up to 60 dispensaries, plus infused products makers, growers, and labs.	Unknown, did not respond to inquiries	Annual patient fees total at least $165-$192; will be reduced to $100 Initial fees range from $3,000 for a cultivator to $30,000 for a dispensary. Renewal fees range from $1,000 to $5,000. Staff IDs: $75 2% excise tax at wholesale and retail level	Exceeds $713,000 in the past year	Did not respond to inquiry, but generated enough of a surplus that a legislator proposed siphoning off $700,000/year
Oregon (population 3.9 million)	55,937 (as of 07/01/13)	Not yet; dispensary law passed in 2013 and they will be registered in 2014.	As of 2011, 24 full-time staff; travel for advisory committee meetings; IT support, including database; office expenses	$200 per patient; reduced fees of $60 (food stamps), $50 (state health program), and $20 (SSI benefits); $50 grow site fee for applications in which patient is not cultivator	Est. at $6 million (Est. $12 million for the 2011-13 biennium)	Est. at $2.65 million (Est. $5.3 million for the 2011-13 biennium; expenses in the biennium: $29,478)

State	Registered Patients	State Regulated Dispensaries	Breakdown of Expenses	Fees	Total Annual Revenues	Total Annual Expenses
Rhode Island (population 1.05 million)	5,941 (as of 09/09/13)	Yes, three "compassion centers" were approved. Two centers are open; it is unclear when the third will open.	Staff: the equivalent of 3.35 full-time as of Jan. 2013; shared card machine with other licensing program	Compassion centers: $250 application fee; $5,000 registration fee; $100 staff fee; $20 or $100 patient fee; $200 caregiver fee	$566,655 2011-2012 combined, without taxes (Note: ID card fees all increased at the end of 2012)	$589,086.16 for 2011-2012, combined
Vermont (population 626,011)	846 (as of 09/09/13)	Two dispensaries are open as of June 2013. Two more dispensaries are set to open in the near future.	One full time staffer, one part-time staffer, software, office supplies	$50 annual fee for patients and caregivers; $2,500 application fee for dispensaries; annual registration fee of $30,000 ($20,000 in first year) for dispensaries	Estimated $140,800 for FY 2013. Revenue expected to increase with more dispensaries and fees.	Estimated $138,500 for FY 2013
Washington (population 6.9 million)	N/A – no registry	No, but the state will allow regulated, taxed sales of marijuana to all adults 21 and older in late 2013.	N/A	N/A	N/A	N/A

Financial Information by State

A Review of Program Finances by State

A review of medical marijuana program finances for selected states, prepared by the Marijuana Policy Project (MPP). The full report that was issued in 2011 is available at: http://www.mpp.org/assets/pdfs/library/State-by-State-Laws-Report-2011.pdf.

Appendix U: State Medical Marijuana Program Finances

With many states around the country facing serious budget shortfalls, one concern frequently raised when debating the need for medical marijuana laws is the cost to state governments of implementing and administering such laws. However, data collected from states with functioning medical marijuana programs show that such concerns are unfounded. Most states require the administering agency to set fees for registry ID cards and dispensary registrations high enough to offset administration costs, and in states where patients can obtain marijuana from dispensaries, transactions are often subject to sales or excise taxes. Consequently, no state medical marijuana program is currently facing significant budget deficits. In fact, most are operating at a surplus, with some generating millions in badly needed revenue.

As of late 2011, eight states – Arizona, Colorado, Delaware, Maine, New Jersey, New Mexico, Rhode Island, and Vermont – and the District of Columbia have laws that recognize dispensaries or other entities where patients can purchase medical marijuana. Of these, only Colorado, Maine, and New Mexico have fully-implemented systems with open dispensaries. A fourth state, California, does not have a statewide regulatory structure but does have several dispensaries licensed at the local level.

Of these, only California, Colorado, and New Mexico have readily available information on revenue generated through taxes. In California, the non-partisan state Board of Equalization estimates that dispensaries generate $58-$105 million in annual sales tax revenue.[1] In Colorado, for the fiscal year ending in June 2010, medical marijuana sales taxes brought in $2.2 million to state coffers,[2] and between Boulder, Colorado Springs, Denver, and Fort Collins, an estimated $3.84 million in local sales taxes has already been collected in 2011.[3] In New Mexico, sales by non-profit producers in the second quarter of 2011 (April – June) totaled $744,079, generating $55,938 in gross receipts tax revenue for state and local governments.[4] This projects to over $223,000 per year in gross receipts tax revenue.

These states also bring in added revenue by assessing dispensaries application and registration fees. Dispensaries are licensed at the local level in both Colorado and California. In California, Oakland, which has licensed four medical marijuana dispensaries, provides a typical example. The fee structure is graduating depending on how many patients the dispensaries serve and ranges from $5,000 (for under 500 patients) to $20,000 (for over 1,500 patients).[5] In Colorado, the Department of Revenue collected at least $8.9 million in fees from July 2010 through March 2011 from medical cannabis businesses.[6] The state application fees for medical marijuana centers are $7,500 for 300 or fewer patients, $12,500 for 301

[1] "Berkeley cannabis collectives slapped with huge tax bills," *Berkeleyside*, February 3, 2011. <http://www.berkeleyside.com/2011/02/03/berkeley-cannabis-collectives-slapped-with-huge-tax-bills>

[2] "City reaps $209k in medical marijuana tax," Coloradan.com, Nov. 6, 2010. <http://www.coloradoan.com/article/20101106/NEWS01/11060341/1002/CUSTOMERSERVICE02>

[3] "State Medical Marijuana Programs' Financial Information, Marijuana Policy Project, available at http://www.mpp.org/issues/medical-marijuana/.

[4] Email communications with Dominick Zurlo, September 28, 2011.

[5] "Oakland approves plan to license medical marijuana farms," *Oakland Tribune*, July 21, 2010. <http://www.mercurynews.com/alameda-county/ci_15566683?nclick_check=1>

[6] "Oversight Office for Medical Pot is Well Off," *Denver Post*, March 18, 2011. < http://www.denverpost.com/news/marijuana/ci_17640484>

to 500 patients, and $18,000 for those serving 501 or more patients. A cultivation license is $1,250, and an infused products manufacturer license is $1,250.[7] New Mexico has a similar graduated fee schedule, though the variance is based on how long the non-profit producer has operated. The fee is $5,000 for those who have been licensed less than a year, $10,000 for those licensed for more than one year, $20,000 for more than two years, and $30,000 for more than three years. In Maine, the Department of Human Services' Licensing and Regulatory Services requires all dispensary applicants to pay a $15,000 application fee, $14,000 of which is refunded if they are not awarded a registration,[8] and the annual renewal fee is $15,000.

Other states that are in the process of implementing dispensary systems will also charge registration fees to dispensaries and similar entities. Application fees range from $20,000 in New Jersey ($2,000 of which is non-refundable) to a $2,500 non-refundable fee in Vermont. Registrations are similar to those in Colorado and New Mexico. For example, the District of Columbia will charge dispensaries $10,000 annually for a registration, and cultivation centers would pay $5,000 annually, while Vermont will charge $20,000 for the first year and $30,000 for subsequent years.

These states also collect revenue through fees for registry ID cards for patients, caregivers, and dispensary employees. Fees are generally around $100 for cards, with some states – including Michigan, Oregon, Maine, and the District of Columbia – reducing the fee for low-income patients. Through the first half of fiscal year 2011 (October-March 2011), these fees have already generated $4,860,783 in revenue in Michigan, while the program required only $687,634 to operate during the same time frame.[9]

Expenses are generally minimal. Programs have reported expenses for database-related software, for machines to make registry cards, and for staffing. Some programs — especially ones with a few thousand patients or fewer — have been able to use software included with Microsoft Office for their databases, and at least one program shares the card-making machines with other health department programs. New Mexico's program purchased a machine to make holographic cards, which cost about $6,000-$8,000.

Most states employ only a handful of staffers. For example, New Mexico has two full-time employees and one manager who also oversees three other programs, while Alaska and Vermont's programs each require less than one full-time employee's time. Oregon and Michigan's programs, which are each operating in the black, employ 25 employees each. Some programs do not even need dedicated staffers. In Rhode Island, for example, staffers are not designated for the medical marijuana program, and instead work on all 35 licensure programs the health department oversees.

For more information on state medical marijuana programs' financial impact, download our full report at **http://www.mpp.org/reports/state-medical-marijuana.html**.

7 <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251643794376&ssbinary=true>

8 <http://www.maine.gov/dhhs/dlrs/rulemaking/adopted.shtml>

9 Report on the Amount Collected and Cost of Administering the Medical Marihuana Program, April 1, 2011. Submitted by Michigan Department of Community Health to Michigan House and Senate Appropriations Committees.

Florida Estimates

Based on the Constitutional Amendment on the 2014 Ballot

Florida Patient Estimates

The following presents a variety of analysis methodologies to determine a range of estimates of possible Florida medical marijuana registrants.

Estimates of Medical Marijuana Users in Florida

A. Summary of estimates of medical marijuana users in Florida in 2015 by various estimation approaches

Note
The update is based on the 2014 ballot petition language, not the proposed 2016 ballot petition language.
Cells in gray have been updated and/or added since the 2013 FIEC.

The Florida Legislature's 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, 2015. Approach I draws on the experience of other states. Approaches II – V attempt to capture eligible users with the specified medical conditions in the proposed ballot initiative, except "other conditions." It is not possible to precisely estimate the number of users that would qualify under "other conditions" as these conditions are currently unknown and 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

		UPDATED
Estimation Approach	**April 1, 2015**	**April 1, 2015**
I. States with medical marijuana laws	452 to 417,252	1,539 to 427,247
II. Disease prevalence	1,295,922	1,330,135
III. Disease incidence	116,456	117,017
IV. Use by cancer patients	173,671	190,239
V. Deaths	46,903	46,829
VI. Self-reported marijuana use	1,052,692 to 1,619,217	1,125,588 to 1,708,814
Range	**452 to 1,619,217**	**1,539 to 1,708,814**

B. Description of estimation approaches

I. Medical marijuana registrants in states that have legalized medical use of marijuana

Approach I applies rates of medical marijuana use from other states to Florida's 2015 projected population. Using the current experience of 16 other states, there may be an estimated 1,539 to 427,247 Floridians using medical marijuana in 2015. 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.

Estimated Marijuana Users for Certain Medical Conditions in Florida
Based on Registered Users in States with Legalized Marijuana for Medical Conditions
Ranked by Estimated Florida Users in 2015

A	B	C	D	E	F	G	H	I	J	K
							UPDATED	UPDATED	ADDED	UPDATED
State	Year Passed[1]	Report Date	Patient Registry	Marijuana Users[2]	Percent of Population (2012)	Florida Estimates (2012)	Population[3] (2014)	Percent of Population (2014)[4]	Users per 1,000 Population (2014)	Florida Estimates (2015)[5]
Colorado	2000	2014	Mandatory	115,467	2.11%	411,225	5,355,866	2.16%	22	427,247
Michigan	2008	2015	Mandatory	175,434	1.30%	337,674	9,909,877	1.77%	18	350,830
Oregon	1998	2014	Mandatory	70,139	1.50%	336,973	3,970,239	1.77%	18	350,101
California	1996	2014	Voluntary	572,762	1.46%	281,557	38,802,500	1.48%	15	292,527
Washington	1998	2014	Voluntary	103,444	1.45%	279,420	7,061,530	1.46%	15	290,307
Montana	2004	2014	Mandatory	10,268	0.71%	191,345	1,023,579	1.00%	10	198,800
Hawaii	2000	2012	Mandatory	13,833	0.80%	185,872	1,419,561	0.97%	10	193,114
Arizona	2010	2014	Mandatory	61,272	0.59%	173,621	6,731,484	0.91%	9	180,386
New Mexico	2007	2014	Mandatory	12,647	0.46%	115,668	2,085,572	0.61%	6	120,175
Rhode Island	2006	2014	Mandatory	6,213	0.46%	112,313	1,055,173	0.59%	6	116,689
District of Columbia	2010	2014	Mandatory	2,140	N/A	61,951	658,893	0.32%	3	64,365
Nevada	2000	2014	Mandatory	8,055	0.16%	54,117	2,839,099	0.28%	3	56,226
Vermont	2004	2014	Mandatory	1,583	0.09%	48,191	626,562	0.25%	3	50,069
Alaska	1998	2015	Mandatory	1,418	0.17%	36,713	736,732	0.19%	2	38,143
Massachusetts	2012	2015	Mandatory	12,396	N/A	35,053	6,745,408	0.18%	2	36,419
Maine	1999	2014	Voluntary	1,723	0.11%	24,709	1,330,089	0.13%	1	25,672
Connecticut	2012	2014	Mandatory	2,326	N/A	12,336	3,596,677	0.06%	1	12,816
New Jersey	2010	2013	Mandatory	1,585	0.00%	3,382	8,938,175	0.02%	0	3,514
Delaware	2011	2014	Mandatory	133	0.00%	2,711	935,614	0.01%	0	2,817
Illinois	2013	2014	Mandatory	1,000	0.00%	1,481	12,880,580	0.01%	0	1,539

Note:
Florida 2015 estimates were developed by applying the 2014 use rates to Florida's April 1, 2015 population. The rates are not age-adjusted. The estimation assumes usage rates will remain the same. These states may not be representative of Florida or the nation, so caution should be used when generalizing their usage rates to Florida.

Sources:
[1] ProCon.org, http://medicalmarijuana.procon.org/view.answers.php?questionID=001199, Last updated 7/1/2015, accessed 9/9/2015.
[2] The data sources for each state are as follows:

Alaska: Count of active cardholders. Data as of September 2015, Alaska Division of Public Health, Bureau of Vital Statistics, e-mail dated 9/16/2015.

Arizona: Count of active cardholders. Arizona Medical Marijuana Act End of Year Report 2014, http://azdhs.gov/documents/licensing/medical-marijuana/reports/2014/arizona-medical-marijuana-end-of-year-report-2014.pdf, accessed on 9/17/2015.

California: No mandatory patient registry, it is estimated that only a small fraction of patients register on the voluntary registry. ProCon.org, estimates as of 10/27/2014 using Marijuana Policy Project estimates based on the ratio of patients to population in Oregon. http://medicalmarijuana.procon.org/view.resource.php?resourceID=005889, accessed on 9/17/2015.

Colorado: Colorado Department of Public Health and Environment, 2014 (December) current patients with valid ID cards, https://www.colorado.gov/pacific/sites/default/files/CHED_MMJ_12_2014_MMR_Report.pdf, accessed on 9/17/2015.

Connecticut: ProCon.org, ProCon.org access to the Connecticut Medical Marijuana Statistics, ct.gov, 9/9/2014 Medical Marijuana Program, October 1, 2014, http://medicalmarijuana.procon.org/view.resource.php?resourceID=005889, accessed on 9/17/2015.

Delaware: ProCon.org, ProCon.org phone call with the Delaware Medical Marijuana Program, October 1, 2014, http://medicalmarijuana.procon.org/view.resource.php?resourceID=005889, accessed on 9/17/2015.

DC: Count of registered patients. Government of the District of Columbia, Department of Health, Medical Marijuana Program Update, http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/MMPProgramUpdateMemo150105docx.pdf, accessed 9/17/2015.

Hawaii: Marijuana Policy Project, Medical Marijuana Patient Numbers, estimates through 3/1/2014, https://www.mpp.org/issues/medical-marijuana/state-by-state-medical-marijuana-laws/medical-marijuana-patient-numbers/, accessed 9/24/2015.

Illinois: Approximate count of approval letters for patient registration. The program started accepting applications on 9/2/2014, Patient numbers as of 2/4/2015, Illinois Department of Public Health, Illinois Medical Cannabis Pilot Program, http://www2.illinois.gov/gov/mcpp/Pages/Updates.aspx, accessed on 9/24/2015.

Maine: Number of patients who voluntarily decided to register during calendar year 2014. Maine Department of Health and Human Services, Medical Use of Marijuana Report, 2014, http://www.maine.gov/dhhs/dlrs/mmm/documents/2014-MMMP-Annual-Report.pdf, accessed 9/24/2015.

Massachusetts: Count of registered and active patients. Massachusetts Department of Health and Human Services, Medical Use of Marijuana Program, http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/medical-marijuana/ , accessed on 9/18/2015.

Michigan: Count of registered and active patients. Department of Licensing and Regulatory Affairs, Medicinal Marijuana Program, phone call 9/9/2015.

Montana: Patients with current enrollment as of December 2014, http://dphhs.mt.gov/Portals/85/qad/documents/LicensureBureau/MarijuanaProgram/MMP%20Registry%20Info%202015.pdf, accessed on 9/17/2015.

Nevada: Count of patients with active registration cards. Nevada Department of Health and Human Services, Division of Public and Behavioral Health, Medical Marijuana Program, monthly reports, December 2014, http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Reg/MM-Patient-Cardholder-Registry/Docs/MMP_December_2014.pdf, accessed on 9/17/2015.

New Jersey: Count of registered and active patients. New Jersey Department of Health, 2013 Annual Report, Medicinal Marijuana Program, http://www.state.nj.us/health/medicalmarijuana/documents/annual_report.pdf, accessed on 9/17/2015 .

New Mexico: Count of registered active patients. New Mexico Department of Health, Medical Cannabis Program Statistics as of 1/2/2015, e-mail dated September 16, 2015.

Oregon: 2015 (January) current patients with valid ID cards, Oregon Health Authority, Medical marijuana Program Statistic Snapshot, https://public.health.oregon.gov/DiseasesConditions/ChronicDisease/MedicalMarijuanaProgram/Documents/ed-materials/OMMP%20Statistic%20Snapshot%20-%2001-2015%20Final_3.pdf, accessed on 9/17/2015.

Rhode Island: Count of approved qualifying patients. Biannual Medical Marijuana Report to General Assembly, December 1, 2014, http://www.health.ri.gov/publications/programreports/2015MedicalMarijuana.pdf, accessed on 9/17/2015.

Vermont: Count of registered patients. Department of Public Safety, Medical Marijuana Program, email dated 9/19/2015.

Washington: No mandatory patient registry. On 4/24/2015 a new law created a voluntary patient registry. 2014 estimates using Marijuana Policy Project estimates based on the ratio of patients to population in Oregon. http://medicalmarijuana.procon.org/view.resource.php?resourceID=005889, accessed on 9/17/2015.

[3] U.S. Census Bureau, Population Division, Annual Estimates of the Population for the United States, Regions, and States: July 1, 2014, released December 2014.

[4] Florida's official April 1, 2014 population estimate was used to generate these estimates.

[5] Florida Demographic Estimating Conference, July 2015, population projection for April 1, 2015 was used to generate these estimates.

II. Disease prevalence[a] (people alive with the disease)

Approach II uses disease prevalence rates (proportion of people alive diagnosed with a certain disease) for cancer, hepatitis C, and HIV to determine the number of eligible patients with the conditions specified in the proposed ballot initiative. There will be an estimated 1,330,135 patients alive in 2015 that have been diagnosed with cancer, hepatitis C, or HIV during their lifetime. These patients represent the pool of eligible patients for medical use of marijuana. Prevalence data for the remaining conditions specified in the proposed ballot initiative were not available. In addition, there are unspecified "other conditions" in the proposed ballot initiative which cannot be estimated under this approach.

Florida Prevalence of Selected Diseases

			UPDATED	UPDATED
Medical Condition	**2002-2012**	**2015**	**2002-2013**	**2015**
Cancer[1]	795,135	835,060	840,263	873,001
Hepatitis C (2002-2006)	300,000	326,289	318,261	327,483
HIV	130,000	134,573	126,000	129,651
Total cancer, hepatitis C, and HIV	**1,225,135**	**1,295,922**	**1,284,524**	**1,330,135**

Notes:
Estimates include cancer, hepatitis C, and HIV prevalence rates. Prevalence rates for the remaining specified conditions in the petition initiative were not identified but they are expected to be relatively low.
[1] Estimates for cancer were developed by applying a national cancer prevalence rate to the Florida's April 1, 2012 population. Florida 2015 estimates were developed by applying the 2002- 2013 prevalence rates to Florida's April 1, 2015 population. The rates are not age-adjusted. The estimation assumes prevalence rates will remain the same.

Sources:
Cancer complete prevalence 2012 data, Surveillance, Epidemiology, and End Results (SEER) Program (www.seer.cancer.gov). Prevalence database: "US Estimated Complete Prevalence Counts on 1/1/2012". National Cancer Institute, DCCPS, Surveillance Research Program, Data Modeling Branch, released April 2015, based on the November 2014 SEER data submission.
Hepatitis C complete prevalence 2002-2006 data, Florida Department of Health, Hepatitis C surveillance report 2002-2006, published 2009, http://www.doh.state.fl.us/disease_ctrl/aids/hep/5_Year_Report_Jan2_09_FINAL.pdf
HIV prevalence as of the end of 2013, Florida Department of Health, Florida 2013 HIV/AIDS Annual report, http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/epi-profiles/HIVAIDS-annual-morbidity-2013.pdf
Florida Demographic Estimating Conference, July 2015, population projection for April 1, 2015.

[a] Prevalence represents the proportion of people alive on a certain day who were diagnosed with the disease, regardless of how long ago the diagnosis was made; National Cancer Institute definitions; complete prevalence: http://surveillance.cancer.gov/prevalence/complete.html; limited prevalence: http://surveillance.cancer.gov/prevalence/limited.html

III. Disease incidence[b] (newly diagnosed with the disease)

Approach III uses disease incidence rates (proportion of people newly diagnosed with a certain disease) for cancer, hepatitis C, HIV, and amyotrophic lateral sclerosis (ALS) 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 117,017 patients newly diagnosed with cancer, hepatitis C, HIV, or ALS in 2015 in Florida. These patients represent the pool of eligible patients for medical use of marijuana. Incidence data for the remaining conditions specified in the proposed ballot initiative were not available. In addition, there are unspecified "other conditions" in the proposed ballot initiative which cannot be estimated under this approach.

Florida New Cases with Selected Diseases (Incidence)

			UPDATED	UPDATED
Medical Condition	**2011**	**2015**	**2013**	**2015**
Cancer	103,783	109,658	107,196	110,302
Hepatitis C	100	104	220	226
HIV	6,046	6,315	5,938	6,110
ALS (Lou Gehrig's disease)	362	378	369	379
Total cancer, hepatitis C, HIV, & ALS	**110,291**	**116,456**	**113,723**	**117,017**

Notes: Estimates include cancer, hepatitis C, HIV, and ALS incidence rates. Incidence rates for the remaining specified conditions in the petition initiative are not available.
Florida 2015 estimates were developed by applying the 2013 incidence rates to Florida's April 1, 2015 population. The rates are not age-adjusted. The estimation assumes incidence rates will remain the same.

Sources:
Florida Cancer Data System, 2012 Annual Report,
http://fcds.med.miami.edu/downloads/FloridaAnnualCancerReport/2012/Table_No_T1_(2012).pdf,
http://fcds.med.miami.edu/downloads/FloridaAnnualCancerReport/2012/Table_No_T4_1_(2012).pdf.
Florida Department of Health, 2013 Annual Morbidity Report, http://www.floridahealth.gov/diseases-and-conditions/disease-reporting-and-management/disease-reporting-and-surveillance/data-and-publications/_documents/2013-fl-msr.pdf.
Florida Department of Health, Florida ALS Surveillance Project.
Florida Demographic Estimating Conference, July 2015, population projection for April 1, 2015.

[b] Incidence: number of new cases during a given time period; National Institute of Health definition: http://painconsortium.nih.gov/symptomresearch/chapter_19/sec4/cihs4pg1.htm

IV. Use rates by cancer patients

Approach IV uses medical marijuana penetration rates by disease, specifically cancer, to estimate medical marijuana users in Florida. The number of Florida cancer patients that are likely to use medical marijuana in 2012 is calculated by applying the average penetration rate among cancer patients from ten other states to the Florida number of cancer patients. 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 in Florida in 2012. The latter is then adjusted to produce 190,239 medical marijuana users with all conditions in 2015.

Florida Medical Marijuana User Estimates
Based on Average Medical Marijuana Usage Rates among Cancer Patients across Ten States

			UPDATED	UPDATED
Population Categories	**2011**	**2015**	**2012**	**2015**
Population with cancer	795,135	835,060	840,263	873,001
Medical marijuana users	5,622	5,905	6,226	6,468
Total medical marijuana users	**165,368**	**173,671**	**183,105**	**190,239**

Note:
Using counts for medical marijuana use by cancer patients and complete cancer prevalence data across the ten states in the table below, an average share of marijuana users among cancer patients was calculated. The share was applied to the Florida cancer prevalence population to estimate potential Florida marijuana users with cancer. The average share that cancer patients represent among all marijuana users from the table below was applied to the estimate of Florida marijuana users with cancer to estimate the total Florida population that may use medical marijuana. The estimation assumes usage rates and cancer prevalence rates will remain the same.

Sources:
100,000 Reasons: Medical Marijuana In The Big Apple, Appendix: Methodology, New York City Comptroller John C. Liu, August 2013.
Cancer complete prevalence 2012 data, Surveillance, Epidemiology, and End Results (SEER) Program (www.seer.cancer.gov). Surveillance, Epidemiology, and End Results (SEER) Program (www.seer.cancer.gov). Prevalence database: "US Estimated Complete Prevalence Counts on 1/1/2012". National Cancer Institute, DCCPS, Surveillance Research Program, Data Modeling Branch, released April 2015, based on the November 2014 SEER data submission.
Florida Demographic Estimating Conference, July 2015, population projection for April 1, 2015.

Cancer Patients Using Medical Marijuana for Selected States
2014

			UPDATED			
A	B	C	D	E	F	G
					Cancer Patients Using Marijuana	
State	**Population**	**Total Users of Medical Marijuana**	**Users of Medical Marijuana with Cancer**	**Cancer patients**	**% of All Cancer Patients**	**% of Total Users of Medical Marijuana**
Arizona	6,731,484	61,272	1,666	296,534	0.56%	2.72%
Colorado	5,355,866	115,467	3,870	235,936	1.64%	3.35%
Hawaii	1,419,561	11,164	152	62,534	0.24%	1.36%
Michigan	9,909,877	103,444	2,526	436,548	0.58%	2.44%
Nevada	2,839,099	8,055	485	125,067	0.39%	6.02%
Oregon	3,970,239	175,434	3,666	174,896	2.10%	2.09%
Rhode Island	1,055,173	6,213	288	46,482	0.62%	4.63%
Montana	1,023,579	10,268	674	45,090	1.49%	6.56%
New Jersey	8,938,175	12,396	172	393,743	0.04%	1.39%
Vermont	626,562	1,723	167	27,601	0.61%	9.69%
Total/ Average	**41,869,615**	**505,436**	**13,666**	**1,844,432**	**0.74%**	**2.70%**

Sources:
Arizona: unique conditions count, indicated cancer as the only debilitating medical condition. Arizona Medical Marijuana Act End of Year Report 2014, http://azdhs.gov/documents/licensing/medical-marijuana/reports/2014/arizona-medical-marijuana-end-of-year-report-2014.pdf, accessed on 9/17/2015.
Colorado: Medical conditions counts are not exclusive, some patients report using medical marijuana for more than one debilitating medical condition. 2014 (December) current patients with valid ID cards,
https://www.colorado.gov/pacific/sites/default/files/CHED_MMJ_12_2014_MMR_Report.pdf, accessed on 9/17/2015."
Hawaii: The Office of Economic and Demographic Research was not able to obtain updated data for Hawaii. Data are for 2012 from the report "100,000 Reasons: Medical Marijuana In The Big Apple", Appendix: Methodology, New York City Comptroller John C. Liu, August 2013.
Michigan: The number of patients is as of September 2015 but the Office of Economic and Demographic Research was not able to obtain an updated breakdown by condition as of 9/25/2015, so the number of cancer patients is for FY 2012.

Montana: Medical conditions are not exclusive, a patient may have more than one condition. Patients with current enrollment as of December 2014 and patients by condition as of July 2015, http://dphhs.mt.gov/marijuana/MMPPriorRegistryInformation, accessed on 9/17/2015.
Nevada: Medical conditions are not exclusive, a patient may have more than one condition. Nevada Department of Health and Human Services, Division of Public and Behavioral Health, Medical Marijuana Program, monthly reports, August 2015, http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Reg/MM-Patient-Cardholder-Registry/dta/Monthly_Reports/MMPAugust2015.pdf, accessed on 9/17/2015."
New Jersey: Medical conditions are not exclusive. Only terminal cancer qualifies as a condition. 2013 data. New Jersey Department of Health, 2013 Annual Report, Medicinal Marijuana Program, http://www.state.nj.us/health/medicalmarijuana/documents/annual_report.pdf, accessed on 9/17/2015.
Oregon: Conditions are not mutually exclusive; one patient may report one or more conditions. 2015 (January) current patients with valid ID cards, Oregon Health Authority, Medical marijuana Program Statistic Snapshot, https://public.health.oregon.gov/DiseasesConditions/ChronicDisease/MedicalMarijuanaProgram/Documents/ed-materials/OMMP%20Statistic%20Snapshot%20-%2001-2015%20Final_3.pdf, accessed on 9/17/2015.
Rhode Island: Medical conditions are not exclusive, a patient may have more than one condition. The total number of users is updated as of December 2014, the percentage of cancer patients is as of August 2015, Rhode Island Department of Health, e-mail dated 9/25/2015.
Vermont: Count of registered patients. Department of Public Safety, Medical Marijuana Program, email dated 9/19/2015.

V. Deaths from specified diseases (as primary cause of death)

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 glaucoma and ALS for which no data were available, in the proposed ballot initiative to estimate the number of users. Adjusting these rates to 2015 population projections produces 46,829 potential medical marijuana patients with the specified conditions. In addition, there are unspecified “other conditions” in the proposed ballot initiative which cannot be estimated under this approach.

Florida Deaths by Selected Causes

			UPDATED	UPDATED
Primary Cause of Death	**2012**	**2015**	**2014**	**2015**
Cancer	41,696	43,235	42,330	43,003
Glaucoma	N/A	N/A	N/A	N/A
HIV	923	957	878	892
AIDS	N/A	N/A	N/A	N/A
Viral Hepatitis	523	542	603	613
Amyotrophic lateral sclerosis (ALS)	N/A	N/A	N/A	N/A
Crohn's disease	89	92	59	60
Parkinson's disease	1,824	1,891	2,031	2,063
Multiple sclerosis	178	185	195	198
Total	**45,233**	**46,903**	**46,096**	**46,829**

N/A – not available
Note: Data for hepatitis C only were not available; data for viral hepatitis were used instead.
Florida 2015 estimates were developed by applying the 2014 cause of death rates to Florida’s April 1, 2015 population. The rates are not age-adjusted. The estimation assumes death rates will remain the same.

Sources:
Florida Department of Health, Florida Vital Statistics Annual Report 2014.
Florida Demographic Estimating Conference, July 2015, population projection for April 1, 2015.

VI. Self-identified marijuana users from the National Health and Drug Use Survey

(This approach was used to estimate the potential number of recreational marijuana users in the fiscal impact statement for the Washington State initiative to legalize recreational marijuana)

Approach VI presents self-reported illicit marijuana use from the 2013 National Survey on Drug Use and Health. Adjusting 2013 survey results to the 2015 Florida population projections shows that there may be an estimated 1,708,714 self-reported recreational users of marijuana 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 1,125,588 self-reported recreational users of marijuana in Florida. However, this may not be a reasonable assumption since some data by age group from other states shows that the younger age groups use more medical marijuana than the older age groups.

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.

Florida Self-Reported Illicit Marijuana Use[1]

				UPDATED	UPDATED	UPDATED
Age Group	**Marijuana Users (% of Age Group)**	**2011**	**2015**	**Marijuana Users (% of Age Group in 2013)**	**2013**	**2015**
Population 12-17	*13.80%*	*192,120*	*191,618*	*13.64%*	*191,678*	*192,032*
Population 18-24	31.19%	544,678	566,525	32.06%	568,965	583,126
Population 25+	7.61%	1,001,331	1,052,692	8.10%	1,089,100	1,125,588
Total population 18+		**1,546,009**	**1,619,217**		**1,658,065**	**1,708,714**

[1] Has used marijuana once or more times during the past year.

Note:
Marijuana use rates for 18-25 and 26+ groups for Florida for 2013 were applied to Florida's April 1, 2013 and 2015 population estimate/projection for ages 18-24 and 25+ groups, respectively. The estimation assumes usage rates will remain the same.

Sources:
Substance Abuse & Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2012 and 2013, Table 2 http://www.samhsa.gov/data/sites/default/files/NSDUHsaeTotals2013/NSDUHsaeTotalsCSVs2013.zip . Florida Demographic Database, August 2015 based on results from the Florida Demographic Estimating Conference, July 2015 and the Florida Demographic Estimating Conference, July 2015.

Florida Estimates

Based on the Constitutional Amendment on the 2014 Ballot

Florida Non-Medical Use of Prescription Drugs

The following presents survey data about nonprescription use of pain relievers in Florida.

Estimates of Nonmedical Users of Pain Relievers in Florida

Self-identified nonmedical pain reliever users

Florida Nonmedical Use of Pain Relievers [1]

Age Group	Percent of Users in Age Group	2011	2015	UPDATED Percent of Users in Age Group in 2013	UPDATED 2013	UPDATED 2015
Population 12-17	5.50%	76,588	76,388	4.44%	62,394	62,509
Population 18-24	8.59%	149,927	155,948	7.83%	138,958	142,417
Population 25+	3.21%	421,925	443,764	2.88%	387,236	400,209
Total		**648,440**	**676,099**		**588,587**	**605,134**

[1] Has used pain relievers for nonmedical reasons once or more times during the past year.

Note:
Nonmedical use of pain relievers rates for the 12-17 age group for Florida for 2013 were applied to Florida's April 1, 2013 and 2015 population estimate/projection for ages 12-17. Single ages 10 and 11 were excluded from the standard 10-17 age group by using shares from the U.S. Census Bureau's single age population estimates from the U.S. Census Bureau's Population Estimates by Age for 2013 and 2014. Nonmedical use of pain relievers rates for 18-25 and 26+ groups for Florida for 2013 were applied to Florida's April 1, 2013 and 2015 population estimate/projection for ages 18-24 and 25+ groups, respectively. The estimation assumes usage rates will remain the same.

Sources:
Substance Abuse & Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2012 and 2013, Table 8 http://www.samhsa.gov/data/sites/default/files/NSDUHsaeTotals2013/NSDUHsaeTotalsCSVs2013.zip.
Florida Demographic Database, August 2015 based on results from the Florida Demographic Estimating Conference, July 2015 and the Florida Demographic Estimating Conference, July 2015.

Reference Table: Self-Identified Illicit Marijuana Users

Florida Self-Reported Illicit Marijuana Use [1]

Age Group	Marijuana Users (% of Age Group)	2011	2015	UPDATED Marijuana Users (% of Age Group in 2013)	UPDATED 2013	UPDATED 2015
Population 12-17	*13.80%*	*192,120*	*191,618*	*13.64%*	*191,678*	*192,032*
Population 18-24	31.19%	544,678	566,525	32.06%	568,965	583,126
Population 25+	7.61%	1,001,331	1,052,692	8.10%	1,089,100	1,125,588
Total population 18+		**1,546,009**	**1,619,217**		**1,658,065**	**1,708,714**

[1] Has used marijuana once or more times during the past year.

Sources:
Substance Abuse & Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2012 and 2013, Table 2 http://www.samhsa.gov/data/sites/default/files/NSDUHsaeTotals2013/NSDUHsaeTotalsCSVs2013.zip.
Florida Demographic Database, August 2015 based on results from the Florida Demographic Estimating Conference, July 2015 and the Florida Demographic Estimating Conference, July 2015.

Florida Estimates

Based on the Constitutional Amendment on the 2014 Ballot

Florida Snowbirds

The following presents data about potential use of marijuana by snowbirds in Florida.

Estimates of Snowbird Users of Medical Marijuana in Florida

Snowbirds (extended stay temporary visitors) represent approximately 6% of Florida's resident population[a].

This analysis assumes there are no residency requirements for access to medical use of marijuana in Florida and tourists will have equal access. This analysis also assumes that in order to register, acquire, and use medical marijuana, a tourist would need to be in Florida for an extended stay (more than one month). Thus, the analysis excludes short-term visitors to Florida (less than 1 month). Snowbird population was used as a proxy for the extended stay visitor, since snowbirds are defined as visitors with a stay of a minimum of one month.

Snowbird Use of Medical Marijuana
2015

			UDATED	UDATED
	Based on State Medical Marijuana Registrants (Approach I)	**Based on Use Rates by Cancer Patients (Approach IV)**	**Based on State Medical Marijuana Registrants (Approach I)**	**Based on Use Rates by Cancer Patients (Approach IV)**
Florida resident population	19,745,376	19,745,376	19,817,596	19,817,596
Snowbirds (all ages)[1]	1,368,245	1,368,245	1,373,250	1,373,250
Self-reported snowbird marijuana users[2]	104,123	104,123	111,233	111,233
Snowbird Users of Medical Marijuana[3]	**41,271**	**17,178**	**42,221**	**18,800**

[1] Snowbird population was calculated by using an estimate of snowbirds 55 and older in 2005 from a study done by the University of Florida's Bureau of Economic and Business Research (BEBR) and expanding the estimate to include population of all ages from demographic characteristics of snowbirds (BEBR 1997 study, see sources below for more information).

[2] The estimate of self-reported snowbirds marijuana users was calculated by applying the Florida percentage of self-reported users for the population 25 and over (8.1%) from Approach VI to the estimate of snowbirds.

[3] EDR assumes medical marijuana users are a subgroup of self-reported marijuana users. The analysis that is based on Approach I applies the share of medical marijuana users in illicit marijuana users (37.96%) to the estimate of self-reported snowbird marijuana users. This ratio was calculated from an estimate of Florida medical marijuana users (427,247) based on Colorado's usage rates divided by an estimate of Florida self-reported marijuana users (1,125,588) for those aged 25 and over. The analysis that is based on Approach IV applies the share of medical marijuana users in illicit marijuana users (16.9%) to the estimate of self-reported snowbird marijuana users. The ratio was calculated by dividing 190,239 by 1,125,588.

Sources:
Smith, Stanley K.; House, Mark, Snowbirds, Sunbirds, and Stayers: Seasonal migration of elderly adults in Florida, Journal of Gerontology:
Social Sciences, v. 61B, No 5, S232-S239, 2006, e-mail correspondence from BEBR dated 10/23/2013, http://www.bebr.ufl.edu/content/snowbirds

[a] Galvez, Janet, *The Florida Elusive Snowbird*, Bureau of Economic and Business Research, University of Florida, 1997, http://www.bebr.ufl.edu/files/snowbirds_0.pdf, accessed October 25, 2013.
Florida Demographic Estimating Conference, July 2015, population projection for April 1, 2015.

Florida Estimates

Based on the Constitutional Amendment on the 2014 Ballot

Florida Sales Tax Estimates

The Following presents examples to demonstrate a range of potential sales tax revenues that is generated by varying assumptions.

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, 2015 Users	Sales ($)		State Sales Tax Revenues ($)	
		$225/ oz	$450/ oz	$225/ oz	$450/ oz
Annual use of 3.53 oz (100 g)[1]					
I. States with medical marijuana laws	427,247	339,340,930	678,681,860	20,360,456	40,720,912
IV. Use by cancer patients	190,239	151,097,326	302,194,652	9,065,840	18,131,679
Annual use of 30 oz (850 g)[2]					
I. States with medical marijuana laws	427,247	2,883,917,250	5,767,834,500	173,035,035	346,070,070
IV. Use by cancer patients	190,239	1,284,113,250	2,568,226,500	77,046,795	154,093,590

Sales and tax revenue estimates do not take into account price and non-price effects on consumption.
Estimates are subject to significant uncertainty regarding how legalization will affect production cost, price, and tax evasion.
The varying potencies of marijuana and quantity discounts are not taken into account.

Price data are from Vermont, June 2013, http://www.wcax.com/story/22679258/vermonts-first-medical-marijuana-dispensaries-open

[1] This estimate of quantity consumed is for illegal use of marijuana for recreational purposes and not specifically for medical use. An annual amount consumed is calculated as the product of the average number of days of use and the average quantity consumed per day. Estimates of the average amount of marijuana consumed are very hard to obtain. Research estimates of global marijuana use per person vary between 94 to 116 grams per year. Bouchard, M. ("Towards a Realistic Method to Estimate the Cannabis Production in Industrialized Countries." Contemporary Drug Problems. Vol. 35., July 1, pp. 291-300) estimates Quebec used on average 94 grams in 2003. He suggests a "100-gram-per-user benchmark." Kilmer and Pacula ("Estimating the Size of the Global Drug Market: A Demand-Side Approach—Report 2", Santa Monica, Calif.: RAND Corporation, TR-711-EC, 2009. As of June 28, 2010: http://www.rand.org/pubs/technical_reports/TR711/) estimate the U.S. average around 93 grams. United Nations Office on Drugs and Crime (2006) uses a weighted average of casual, regular, daily and chronic users to estimate 116 grams per year.
Kilmer et al ("Altered State? Assessing How Marijuana Legalization in California Could Influence Marijuana Consumption and Public Budgets", RAND Corporation, 2010, http://www.rand.org/content/dam/rand/pubs/technical_reports/2009/RAND_TR711.pdf) adopts 100g as average annual amount used for California.

[2] Connecticut's Department of Consumer Protection possession rule specifies that the maximum allowed monthly amount of medical marijuana is 2.5 oz. This estimate assumes a patient uses the maximum allowed amount every month of the year. http://www.ct.gov/dcp/cwp/view.asp?a=4287&q=509630

Prepared by the Florida Legislature's Office of Economic and Demographic Research, September 28, 2015.

Based on the proposed Constitutional Amendment for the 2016 Ballot

Florida Patient Estimates

The following presents a variety of analysis methodologies to determine a range of estimates of possible Florida medical marijuana registrants.

To Be Added at a Later Date

Florida Sales Tax Estimates

To Be Added at a Later Date

Analysis by the Florida Department of Health

Analysis for the 2014 Ballot

The Florida Department of Health's preliminary analysis of the petition initiative language was prepared by the department at the request of the Legislature's Office of Economic and Demographic Research.

Florida Department of Health
"Use of Marijuana for Certain Medical Conditions"
Constitutional Amendment Analysis

I. PLANNING ASSUMPTIONS

This analysis 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 1, 2015. These planning assumptions are based on the best information available as of October 11, 2013 and may be amended as additional information becomes available. These assumptions are not a statement of position of the department.

1.0 General Planning Assumptions

1.1. The Constitutional Amendment will appear on the ballot in November 2014.
1.2. The Constitutional Amendment will be approved by voters and be effective January 1, 2015.
1.3. The Florida Legislature will pass laws necessary to support this Constitutional Amendment and the Governor will enact these laws.
1.4. The program will be supported by fee revenue beginning October 1, 2015 and beyond.
1.5. Definitions included in the Constitutional Amendment will not be altered, but may be clarified in Florida Statute and/or Florida Administrative Code.
1.6. Applicable definitions not included in the Constitutional Amendment will be identified in Florida Statute and/or Florida Administrative Code.
1.7. The Florida Medical Marijuana Program has four components: (1) Physician issuance of certification, (2) Patient and caregiver identification cards, (3) Medical Marijuana Treatment Center registration and regulation and (4) regulation of the adequate supply of marijuana for a qualifying patient's medical use.
1.8. The Florida Medical Marijuana Program will not provide the following:

- Physician referral list. The program will not serve as a referral source. However, any medical doctor (MD), doctor of osteopathy (DO), dentist, or podiatric physician licensed in Florida can certify a patient for the program.
- Caregiver referral. The program will not serve as a referral source for patients who are seeking caregivers.
- Medical research. The program will not provide information or address the health effects of using medical marijuana.
- Legal advice. If there are any questions concerning how to comply with the program requirements, it will be recommended that a person consult a private attorney.
- Growing process resources. The program will not provide resources for the growing process and will not have information about where to get the seeds or plants to start growing medical marijuana.

2.0 Marijuana

2.1. Marijuana (referred to as Marihuana) is a Schedule 1 Controlled Substance under the Federal Controlled Substances Act, 21CFR1308.11.
2.2. Cannabis is a Schedule 1 Controlled Substance in section 893.03(1)(c)7, Florida Statutes, meaning the drug has no current acceptable medical use in treatment in Florida.

2.3. Dronabinol is approved by the Federal Drug Administration and listed as a Schedule III Controlled Substance in section 893.03(3)(f), Florida Statutes.
2.4. The Department of Health does not have the resources or knowledge base to provide information on cultivation or transportation and would need to look to Department of Agriculture and Consumer Services for assistance in these areas.

3.0 Physicians

3.1. Florida licensed physicians authorized to provide certification of a qualified patient include medical doctors, doctor of osteopathy, dentists, and podiatric physicians. These physicians are currently authorized to prescribe controlled substances in schedules II through V as defined in Chapter 893, Florida Statutes. Currently, optometrists may diagnose glaucoma; however, no optometrists may prescribe any oral ocular pharmaceutical agent unless the drug is specifically listed in statute.
3.2. Licensed physicians in Florida cannot prescribe marijuana under Florida law, see section 893.03(1), Florida Statutes.
3.3. Licensed physicians will not be required to offer patients a certification for use of medical marijuana.
3.4. Pharmacies and dispensing physicians are not authorized to dispense Schedule 1 Controlled Substances.
3.5. Physician certification and other documentation that links the patient to their medical condition are protected health information and exempt from public records release.
3.6. Physical exam and full assessment of patient's medical history will be required prior to issuing a physician certification.
3.7. Existing physician disciplinary laws and rules are sufficient for this program.

4.0 Qualifying Patients & Personal Caregivers

4.1. Qualifying patient and personal caregiver identification cards will authorize the holder to acquire and possess medical marijuana.
4.2. All records of the qualifying patients will be exempt from public records release.
4.3. Qualifying patient and personal caregiver request for an identification card will be conducted via web-based and mail-in processes.
4.4. Qualifying patients under the age of eighteen will have custodial parent or legal guardian permission to obtain an identification card.
4.5. Personal caregivers will be at least twenty-one (21) years old and have agreed to assist a qualifying patient.

5.0 Medical Marijuana Treatment Centers

5.1. Medical Marijuana Treatment Centers will register with the Florida Department of Health (DOH) using a web-based system.
5.2. Medical Marijuana Treatment Centers will have to comply with any federal registration requirement prior to applying for registration in Florida.
5.3. Medical Marijuana Treatment Centers will be inspected quarterly by the DOH.

6.0 Department of Health

6.1. The DOH will promulgate rules by June 30, 2015 to implement the program regulation outlined in the Constitutional Amendment.

6.2. Education materials or required trainings for caregivers, patients, physicians, treatment centers and DOH staff will be available prior to the issuance of identification cards and registrations.
6.3. The DOH will begin issuance of patient and caregiver identification cards prior to October 1, 2015.
6.4. The DOH will begin registering Medical Marijuana Treatment Centers prior to October 1, 2015.

II. PROGRAM DESCRIPTION

If the proposed Constitutional Amendment is enacted, the Florida Department of Health will establish a Florida Medical Marijuana Program. The Program will have four components: (1) Physician issuance of certification, (2) Patient and caregiver identification cards, (3) Medical Marijuana Treatment Center licensure and regulation and (4) regulation of the adequate supply of marijuana for a qualifying patient's medical use. The key responsibilities for each of the Program components are outlined below.

1. Physician Certification Issuance

Definitions from Proposed Constitutional Amendment

- Debilitating Medical Condition means cancer, glaucoma, positive status for human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, multiple sclerosis or other conditions for which a physician believes that the benefits of the medical use of marijuana would likely outweigh the potential health risks for a patient.
- Marijuana has the meaning given cannabis in Section 893.02(3), Florida Statutes (2013).
- Medical Use: means the acquisition, possession, use, delivery, transfer, or administration of marijuana or related supplies by a qualifying patient or personal caregiver for use by a qualifying patient for the treatment of a debilitating medical condition.
- Physician: A physician who is licensed in Florida
- Physician Certification: A written document signed by a physician, stating that in the physician's professional opinion, the patient suffers a debilitating medical condition, that the potential benefits of the medical use of marijuana would likely outweigh the health risks for the patient, and for how long the physician recommends the medical use of marijuana for the patient.

FDOH Responsibilities

1. Establish standards for the certification issued by physicians
2. Educate physicians on the requirements to issue certifications based on current Florida Statutes

2. Patient and Caregiver Identification Cards

Definitions from Constitutional Amendment

- Identification Card means a document issued by the Department that identifies a person who has a physician certification or a personal caregiver who is at least twenty-one (21) years old and has agreed to assist with a qualifying patient's medical use of marijuana.

- Personal 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 a caregiver identification card issued by the Department. A personal caregiver may assist no more than five (5) qualifying patients at one time. An employee of a hospice provider, nursing, or medical facility may serve as a personal caregiver to more than five (5) qualifying patients as permitted by the Department. Personal caregivers are prohibited from consuming marijuana obtained for the personal, medical use by the qualifying patient.
- 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.

FDOH Responsibilities

1. Develop and maintain administrative rules which define procedures for:
    - Issuance and renewal of qualifying patient identification cards
    - Issuance and renewal of personal caregiver identification cards
2. Develop a registry to maintain qualified patient information and personal caregiver information
3. Educate patients and caregivers on identification card issuance processes
4. Educate law enforcement partners on patient and caregiver identification cards
5. Ensure qualifying patient information is kept confidential.
6. Collect fees for identification cards
7. Issue identification cards
8. Replace lost identification cards, if necessary
9. Renew identification cards

3. Medical Marijuana Treatment Center Licensure and Regulation

Definitions from Constitutional Amendment

- Medical Marijuana Treatment Center: 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 personal caregivers and is registered by the Department.

FDOH Responsibilities

1. Develop and maintain administrative rules which:
    - Define procedures for registration of Medical Marijuana Treatment Centers, including issuance, renewal, suspension and revocation of registration
    - Establish standards to ensure security, record-keeping, testing, labeling, inspection and safety
2. Develop a treatment center registry
3. Collect fees for registered treatment centers
4. Educate treatment center owners on laws, rules and procedures
5. Educate law enforcement partners on treatment centers requirements and authority
6. Issue registrations to treatment centers

7. Inspect treatment centers based on established standards
8. Investigate, suspend and revoke registrations as established procedures
9. Renew treatment center registrations

4. Regulation of the Adequate Supply for Qualifying Patients' Medical Use

Definition from Constitutional Amendment

- 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.

FDOH Responsibilities

1. Develop and maintain administrative rules which:
    - Define adequate supply for qualifying patients
    - Determine the evidence necessary to define an adequate supply.
    - Outline a threshold for a particular patient's appropriate medical use.
2. Educate physicians, caregivers, patients and law enforcement on administrative rules concerning adequate supply of qualifying patients' medical use.

III. COST ANALYSIS

Table 1
Florida Medical Marijuana Program
Qualified Patient, Caregiver & Treatment Facility Estimates

	Number	Methodology
Estimated Number of Qualified Patients	347,700	Estimate assumes mature program - 18 patients per 1,000 population, based on average actual 2012 experience of Colorado and Oregon. Florida 2012 population (19,317,568/1,000 *18), rounded to nearest 100. First year registration estimate assumes 6 per 1,000 population, based on Arizona actual 2011 experience. (19,317,568/1,000 *6, rounded to nearest 100) = 115,900. **Alternate methodology to consider** - proportion of prevalence of named debilitating diseases compared across states.
Estimated Number of Personal Caregivers	208,620	Estimate assumes mature program - 6 caregivers for every 10 patients, based on Colorado actual 2012 experience, rounded. First year registration (115,900/10*6) = 69,540
Estimated Number of Medical Marijuana Treatment Centers to be Registered	809	Estimated number of facilities based on Colorado program. Approximate Number of Facilities: • 629 dispensaries (1 dispensary/30,325 persons) • 60 commercial transporters (transporting from cultivator/processor to dispensary or dispensary to patient) • 60 processors • 60 cultivators (commercial or patient)

Florida Department of Health
"Use of Marijuana for Certain Medical Conditions"
Constitutional Amendment Analysis

Table 2
Florida Medical Marijuana Program
Cost Estimates, 2015 & 2016

Cost of Program Implementation	Year 1 2015	Year 2 2016	Description
Program Staff – State Health Office Year 1 – Program Manager Only Year 2 – Program manager, environmental consultant and senior clerk.	$96,541	$217,121	Year 1 Program Manager, $60,000 salary, fringe (35%) & expense package ($15,541). Expense = $6,211 recurring expense, $3,762 non-recurring, $5,568 limited travel. Recurring FTE. Year 2 additional 2.0 FTEs to manage established program. Environmental Consultant ($82,587) and Senior Clerk ($37,993).
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	$42,120	$21,060	Contracted educator $20.00 hr/1500 hours plus fringe (35%) and contract overhead (4%). One-time contractual. Year 2 includes 750 hours of contracted time to refresh training materials.
Business Analyst for data system	$88,400	$0	$85 per hour for 1040 hours. One-time contractual.
Data system for patient/caregiver registration & medical treatment center management	$150,000	$0	Cost to design, develop, and test data system based on business requirements. One-time contractual 1800 hours at $75.00 per hour and $15,000 for hardware.
Annual data system user support and maintenance	$0	$25,000	Annual cost of help desk and software maintenance 625 hours per year at $40 per hour. Recurring $25,000 after Year 1 implementation.
Treatment facility inspections, reinspections, and complaint investigations Year 1 – 3 months Year 2 – 12 months	$110,394	$444,075	Cost per service determined from biomedical waste program with similar program/inspection components. Cost for services for 12 months - 749 dispensary/ transporter/processor quarterly inspections @ $85 each= $254,660; 25% reinspections rate = $63,665; 20% complaint investigations 150 @ $85 = $12,750; 125 cultivators quarterly inspections @ $170 = $85,000; 25% reinspections rate $21,250; 20% complaint investigations 25 @ $170 = $4,250. Interagency Agreement with DOACS for inspections of cultivators/processors - $2,500 per year beginning year 2.
Regional Inspector Transportation, Computers and Connectivity	$366,440	$0	One-time cost for 10 state vehicles @ $35,000 each and 10 pentablets @ $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 – $1,440. Year 2 costs included in cost per service.
Total Estimated Costs	**$913,301**	**$707,256**	

IV. OPEN DISCUSSION ITEMS

ATTACHMENTS

Florida Department of Health
"Use of Marijuana for Certain Medical Conditions"
Constitutional Amendment Analysis
Cost Analysis, Version 2.1, 11/1/13

Follow-Up Questions Received October 31, 2013:

Question: Based on the assumption that the potential number of qualified patients would be up to 417,252 would you expect a larger impact? Your current analysis only contemplates 347,700. It appears that this would impact the number of personal caregivers and Medical Marijuana Treatment Centers as well.

> The analysis has been amended to reflect the revised number of qualified patients, personal caregivers and Medical Marijuana Treatment Centers. The treatment center number increased due to additional information provided by the Colorado Program. As of 10/11/13, Colorado had 470 licensed Medical Marijuana Centers for 109,622 registered patients. The original estimate used the 174 Colorado centers included on public website as total licensed centers.

Question: You request $42,120 in the first year of implementation to Develop and Disseminate Educational Materials-would this include outreach and education for Physicians through the Board of Medicine? Do you anticipate any changes in Continuing Education requirements for Physicians and would that have any impact on MQA processes and costs?

> This cost was intended to include development the physician education materials. The analysis has been updated to include cost of dissemination to physicians through the Board of Medicine. The department did not contemplate changes in physician continuing education in year one or two of the program. No additional costs are anticipated for the licensing activities at this time.

Question: Your analysis requests a total of 3 FTE for "program staff" over the two year period. Is this impacted by an increase in the number of patients as discussed above?

> The analysis has been amended to increase the number of State Office FTEs for year one due to increased number of expected qualified patients, personal caregivers and Medical Marijuana Treatment Centers. The cost for help desk support to 800 hours or $7,000 to support the increased expected patients and caregivers.

Question: In the section titled "Regional Inspector Transportation, Computers, and Connectivity" you request 10 state vehicles and 10 pen tablets as well as some other IT costs. Why does this not include a request for additional staff? Who will drive the vehicles and use the pen tablets? If you anticipate using existing staff shouldn't your analysis contemplate charging whatever time devoted to this measure to this regulatory program?

> The Department assumes the complaint investigation component of the Medical Marijuana Program statewide will require 13.25 new FTEs. The amended cost per service analysis includes a total of 9,303 services at $85.00 per service for a total cost of $790,755. This cost supports the staff used to deliver the services. The analysis has been amended to reflect the FTEs necessary to deliver the services.
>
> For planning purposes the department has assumed 10 regional areas for coordination of the inspection and investigation services. The department is requesting one vehicle and one pentablet per region.

III. COST ANALYSIS

The department's preliminary cost analysis has been amended to:

- Increase expected number of qualified patients and personal caregivers based on Colorado experience.
- Increase expected number of Medical Marijuana Treatment Centers based on Colorado experience.
- Increase the number of FTEs for Year 1 due to increased number of patients, caregivers and treatment centers.
- Increase cost for dissemination of physician educational materials.
- Increase the number of hours of contracted help desk support to increased expected qualified patients and personal caregivers.
- Reflect the number of FTEs necessary to provide inspection & investigation services.
- Standardize Medical Marijuana Treatment Center inspection cost of service regardless of which services may be provided by an individual center (i.e. transport, cultivation, dispensary).

Table 1
Florida Medical Marijuana Program
Qualified Patient, Caregiver & Treatment Facility Estimates

	Number	Methodology
Estimated Number of Qualified Patients	417,252	Estimated based on Colorado August 2013 percent of registrants per population, (109,622 registrants per 5,187,582 population=2.1%) applied to Florida 2015 population.
Estimated Number of Personal Caregivers	250,351	Estimate assumes mature program - 6 caregivers for every 10 patients, based on Colorado actual 2012 experience, rounded.
Estimated Number of Medical Marijuana Treatment Centers to be Registered	1,789	Estimated number of facilities based on Colorado program. As of 10/11/13, 470 licensed centers for 109,622 registered patients. Florida estimate (470/109,622*417,252=1,789)

Florida Department of Health
"Use of Marijuana for Certain Medical Conditions"
Constitutional Amendment Analysis
Cost Analysis, Version 2.1, 11/1/13

Table 2
Florida Medical Marijuana Program
Cost Estimates, 2015 & 2016

Cost of Program Implementation	Year 1 2015	Year 2 2016	Description
Program Staff – State Health Office Year 1 – Program Manager & Environmental Consultant Year 2 – Program manager, Environmental Consultant and Senior Clerk.	$179,128	$217,121	Year 1 Program Manager, $60,000 salary, fringe (35%) & expense package ($15,541). Expense = $6,211 recurring expense, $3,762 non-recurring, $5,568 limited travel. Environmental Consultant ($82,587) Recurring FTEs. Year 2 additional 1.0 FTEs to manage established program. and Senior Clerk ($37,993).
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	$150,000	$0	Cost to design, develop, test and data system based on business requirements. One-time contractual 1800 hours at $75.00 per hour and $15,000 for hardware.
Annual data system user support and maintenance	$0	$32,000	Annual cost of help desk and software maintenance 800 hours per year at $40 per hour. Recurring $32,000 after Year 1 implementation.
Field Staff (13.25 FTEs)– Treatment facility inspections, reinspections, and complaint investigations Year 1 – 3 months Year 2 – 12 months	$197,689	$790,755	Cost for services for 12 months – 9,303 services @ $85.00 per service = $790,755. 1,789 treatment centers – 7.156 quarterly inspections, 1,789 reinspections (25% rate) and 358 complaint investigation (20% of centers). Funds 13.25 Environmental Specialist II's to conduct inspections & investigations. (Salary $37,357, Fringe $12,451 and Travel $9,606) for a total of $787,236. Interagency Agreement with Department of Agriculture & Consumer Services= $2,500. Miscellaneous cost of services=$1,019.
Regional Inspector Transportation, Computers and Connectivity	$366,440	$0	One-time cost for 10 state vehicles @ $35,000 each and 10 pentablets @ $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 – $1,440. Year 2 costs included in cost per service.
Total Estimated Costs	**$1,090,183**	**$1,060,936**	

Analysis for the 2016 Ballot

To Be Added at a Later Date

Responses from State and Local Agencies

Based on the Constitutional Amendment on the 2014 Ballot

STATE OF FLORIDA

PAM BONDI
ATTORNEY GENERAL

October 24, 2013

The Honorable Ricky Polston
Chief Justice, and Justices of
The Supreme Court of Florida
The Supreme Court Building
Tallahassee, Florida 32399-1925

Dear Chief Justice Polston and Justices:

A political committee called People United for Medical Marijuana (the "Sponsor") has sponsored an initiative petition to amend the Florida Constitution. On September 26, 2013, this office received the initiative petition from the Secretary of State, along with a certification that the Sponsor obtained sufficient signatures to initiate this Court's review. *See* Fla. Const. art. IV, § 10; § 16.061, Fla. Stat. Accordingly, I now petition this Honorable Court for an opinion regarding the initiative petition's validity.

Introduction

When asked to amend our Constitution, Florida voters deserve full disclosure. They deserve proposals presented accurately and fairly—proposals that allow "an intelligent and informed vote." *Advisory Opinion to Atty. Gen. re Ltd. Casinos*, 644 So. 2d 71, 74 (Fla. 1994). Some proposals, though, use "wording techniques in an attempt to persuade voters." *Fla. Dep't of State v. Slough*, 992 So. 2d 142, 149 (Fla. 2008). These techniques can hide an amendment's true meaning, and when they "render a ballot title and summary deceptive or misleading to voters, the law requires that such proposal be removed from the ballot—regardless of the substantive merit of the proposed changes " *Id.*

In this case, the Sponsor has presented its proposal in a way that does not convey its "true meaning and ramifications." *Advisory Opinion to the Attorney Gen. re Tax Limitation*, 644 So. 2d 486, 495 (Fla. 1994). Indeed, the Sponsor has obscured the most fundamental issue underlying its proposal: the nature and scope of marijuana use the amendment would allow. The ballot title and summary suggest that the amendment would allow medical marijuana in narrow, defined circumstances, and only for patients with "debilitating diseases." But if the amendment passed, Florida law would allow marijuana in limitless situations. Any physician could approve marijuana for seemingly

any reason to seemingly any person (of any age)—including those without any "debilitating disease." So long as a physician held the opinion that the drug use "would likely outweigh" the risks, Florida would be powerless to stop it

In addition, rather than informing voters that federal criminal law restricts medical marijuana, the ballot summary misleadingly suggests the opposite. The summary says the amendment "[a]llows the medical use of marijuana," even though federal law prohibits it. And by saying that the amendment "[d]oes not authorize violations of federal law," the summary implies that the amendment squares with existing federal law, rather than flatly contradicting it.

Because of how the amendment is presented, its true scope and effect remain hidden And because Florida voters deserve the truth, this Court has long rejected proposals that "'hide the ball' as to the amendment's true effect." *Armstrong v. Harris*, 773 So. 2d 7, 16 (Fla 2000).

The Amendment's Text, Ballot Title, and Ballot Summary

The full text of the proposed amendment, which would add a new section 29 to Article X of the Florida Constitution, is:

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

(a) PUBLIC POLICY.

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

(2) A physician licensed in Florida shall not be subject to criminal or civil liability or sanctions under Florida law for issuing a physician certification to a person diagnosed with a debilitating medical condition in a manner consistent with this section

(3) Actions and conduct by a medical marijuana treatment center registered with the Department, or its employees, as permitted by this section and in compliance with Department regulations, shall not be subject to criminal or civil liability or sanctions under Florida law except as provided in this section.

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

(1) "Debilitating Medical Condition" means cancer, glaucoma, positive status for human immunodeficiency virus (HIV), acquired immune

deficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, multiple sclerosis or other conditions 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 person who has a physician certification or a personal caregiver who is at least twenty-one (21) years old and has agreed to assist with a qualifying patient's medical use of marijuana.

(4) "Marijuana" has the meaning given cannabis in Section 893.02(3), Florida Statutes (2013)

(5) "Medical Marijuana Treatment Center" 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 personal caregivers and is registered by the Department

(6) "Medical use" means the acquisition, possession, use, delivery, transfer, or administration of marijuana or related supplies by a qualifying patient or personal caregiver for use by a qualifying patient for the treatment of a debilitating medical condition.

(7) "Personal 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 a caregiver identification card issued by the Department. A personal caregiver may assist no more than five (5) qualifying patients at one time. An employee of a hospice provider, nursing, or medical facility may serve as a personal caregiver to more than five (5) qualifying patients as permitted by the Department. Personal caregivers are prohibited from consuming marijuana obtained for the personal, medical use by the qualifying patient.

(8) "Physician" means a physician who is licensed 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 potential benefits of the medical use of marijuana would likely outweigh the 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 of the patient and a full assessment of the patient's medical history.

(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 shall affect laws relating to non-medical use, possession, production or sale of marijuana.

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

(3) Nothing in this section allows the operation of a motor vehicle, boat, or aircraft while under the influence of marijuana.

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

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

(6) 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.

(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 of qualifying patient identification cards to people with physician certifications, and standards for the renewal of such identification cards

b. Procedures for the issuance of personal caregiver identification cards to persons qualified to assist with a qualifying patient's medical use of marijuana, and standards for the renewal of such identification cards.

c Procedures for the registration of Medical Marijuana Treatment Centers that include procedures for the issuance, renewal, suspension, and revocation of registration, and standards to ensure 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) Issuance of identification cards and registrations The Department shall begin issuing qualifying patient and personal caregiver identification cards, as well as begin registering Medical Marijuana Treatment Centers no later than nine months (9) 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 Medical Marijuana Treatment Centers 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 provision

(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 any court of competent jurisdiction other provisions shall continue to be in effect to the fullest extent possible.

The proposed amendment's ballot title is "Use of Marijuana for Certain Medical Conditions," and the proposed amendment's ballot summary is.

Allows the medical use of marijuana for individuals with debilitating diseases 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 authorize violations of federal law or any non-medical use, possession or production of marijuana.

Pursuant to Rule 9 510(b), Florida Rules of Appellate Procedure, I also provide the following information:

1. The name of the sponsor and address: The sponsor of the initiative is People United for Medical Marijuana, 20 North Orange Avenue, Suite 1600, Orlando, Florida 32801.

2. The name and address of the sponsor's attorney, if the sponsor is represented: Mr. Jon L. Mills, Boies, Schiller & Flexner, LLP, 100 Southeast 2nd Street, Suite 2800, Miami, Florida 33131.

3. A statement as to whether the sponsor has obtained the requisite number of signatures to have the initiative placed on the ballot: As of September 26, 2013, the sponsor had not obtained the necessary number of signatures to place the initiative on the ballot.

4. The current status of the signature collection process: The Secretary of State's September 26, 2013, letter states that the Supervisors of Elections have certified to the Division of Elections a total of 94,541 valid petition signatures. This number represents more than 10% of the total number of valid signatures needed from electors statewide and in a least one-fourth of the congressional districts in order to place the initiative on the general election ballot

5. The date of the election during which the sponsor is planning to submit the proposed amendment: The initiative itself does not specify the date of the election The Department of State advises that the earliest date that this proposed amendment could be placed on the ballot is November 4, 2014, provided the sponsor successfully obtains the requisite number of valid signatures by February 1, 2014.

6. The last possible date that the ballot for the target election can be printed in order to be ready for the election: The Department of State advises that this date is September 4, 2014, if the amendment is to be placed on the November 2014 ballot.

7. A statement identifying the date by which the Financial Impact Statement will be filed, if the Financial Impact Statement is not filed concurrently with the

request. This office has been advised that the Financial Impact Estimating Conference intends to file the financial impact statement no later than November 8, 2013.

8. The names and complete mailing addresses of all of the parties who are to be served:

Mr. John Morgan, Chairperson
People United for Medical Marijuana
Post Office Box 560296
Orlando, Florida 32856

Mr. Jon L. Mills
Boies, Schiller & Flexner, LLP
100 SE 2nd Street, Suite 2800
Miami, Florida 33131

The Honorable Rick Scott
Governor, State of Florida
The Capitol
400 South Monroe Street
Tallahassee, Florida 32399-0001

Mr. Ken Detzner, Secretary
Florida Department of State
R A. Gray Building, Room 316
500 South Bronough Street
Tallahassee, Florida 32399-0250

The Honorable Don Gaetz
President, Florida Senate
Senate Office Building, Room 212
420 The Capitol
404 South Monroe Street
Tallahassee, Florida 32399-1100

The Honorable Will Weatherford
Speaker, Florida House of
Representatives
402 South Monroe Street
Tallahassee, Florida 32399-1300

Financial Impact Estimating
Conference Director's Office
Attention: Amy Baker, Coordinator
Office of Economic and
Demographic Research
111 West Madison Street, Suite 574
Tallahassee, Florida 32399-6588

Department of State
Division of Elections
Room 316, R. A. Gray Building
500 South Bronough Street
Tallahassee, Florida 32399-0250

Mr. Allen Winsor
Solicitor General
The Capitol PL-01
Tallahassee, Florida 32399-1050

The Ballot Title and Summary Do Not Convey the Amendment's True Meaning

As this Court has explained, "[t]he citizen initiative constitutional amendment process relies on an accurate, objective ballot summary for its legitimacy." *In re Advisory Opinion to the Atty Gen. re Additional Homestead Tax Exemption*, 880 So. 2d 646, 653 (Fla. 2004). Indeed, because the actual text of a proposed amendment does not appear on the ballot, "an accurate, objective, and neutral summary of the proposed amendment is the *sine qua non* of the citizen-driven process of amending our constitution." *Id.* at 653-54. The proposal at issue falls short because it misleads regarding both the amendment's scope and its conflict with existing federal law.

This Petition identifies these two prominent defects, which I respectfully suggest require this Court's attention. *See* § 16.061(1), Fla. Stat. (petition may identify issues for resolution) Within the Court's deadline for doing so, this office will also submit a brief with legal argument regarding the proposal's validity, addressing the issues raised here and identifying other, independent defects. *See* Fla. Const. art. IV, § 10 (providing for "interested persons to be heard on the questions presented")

The Ballot Title and Summary Mislead Voters Regarding the Amendment's True Scope.

Among other requirements, a ballot title and summary must "accurately describe the scope of the text of the amendment " *Roberts v. Doyle*, 43 So 3d 654, 659 (Fla. 2010). When the title or summary suggest a more limited scope than the amendment provides, they mislead the public and invalidate the proposal. *See, e.g., Advisory Opinion to the Atty. Gen* , 656 So. 2d 466, 469 (Fla. 1995) Here, the narrow scope presented in the title and summary cannot square with the amendment's true scope, which is anything but narrow.

According to the ballot summary, medical marijuana would be only for those "with debilitating diseases." But the amendment itself does not limit use to individuals with "debilitating diseases," instead allowing marijuana for those with imprecise "other conditions " Nowhere does the amendment even require that the individual's "condition" be a "disease" or "debilitating." Rather, the amendment creates a defined term—"debilitating medical condition"—that includes not only cancer, ALS, HIV, AIDS, and Parkinson's disease, but also "other conditions for which a physician believes that the medical use of marijuana would likely outweigh the potential health risks for a patient." Amendment § 29(b)(1). This open-ended catchall includes no qualification: so long as

a "physician"[1] conducts "a physical examination of the patient and a full assessment of the patient's medical history," that physician may certify "that in the physician's professional opinion," the patient has a "debilitating medical condition." Particularly for a physician who considers marijuana's health risks low, there is no "condition" beyond the amendment's reach. The ballot summary does not convey this breathtaking scope, instead telling voters that marijuana would be limited to "individuals with debilitating diseases."

This Court has invalidated summaries that use narrower terms than the amendment's text. In *Advisory Opinion to the Atty. Gen.*, 656 So. 2d 466, 469 (Fla. 1995), for example, the summary described allowing casinos in "hotels." The amendment itself, though, used the phrase "transient lodging establishments"—not "hotels". As this Court explained, "the public perceives the term 'hotel' to have a much narrower meaning than the term 'transient lodging establishment.'" *Id.* "Thus, while the summary leads the voters to believe that casinos will be operated only in 'hotels,' the proposed amendment actually permits voters to authorize casinos in any number of facilities, including a bed and breakfast inn." *Id.* Similarly, while this summary leads voters to believe that medical marijuana is for "debilitating diseases" only, the proposed amendment actually permits marijuana for any number of conditions, including those that are neither "debilitating" nor "diseases." *Cf. Advisory Opinion to the Attorney General re Amendment to Bar Government from Treating People Differently Based on Race in Public Education*, 778 So 2d 888, 897 (Fla. 2000) (invalidating amendment because summary used "divergent terminology" from amendment's text).

The ballot title is likewise defective because it, too, suggests a more restrictive scope than the amendment delivers. The title—"use of marijuana for certain medical conditions"—wrongly indicates the specific conditions are determined. The term "certain" is understood to mean fixed, definite, or settled. *See, e.g*, Am. Heritage

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[1] The amendment's text defines "physician" only as "a physician who is licensed in Florida," without specifying whether the term is limited to medical doctors or includes chiropractors, podiatrists, and others who are considered "physicians" under some provisions of Florida law. *Compare, e g.*, § 456 056(a), Fla Stat ("'Physician' means a physician licensed under chapter 458, an osteopathic *physician licensed under chapter 459, a chiropractic physician licensed under chapter 460, a podiatric physician licensed under chapter 461, or an optometrist licensed under chapter 463.") with id § 409 9131(2)(e) ("'Physician' means a person licensed to practice medicine under chapter 458 or a person licensed to practice* osteopathic medicine under chapter 459 ")

Dictionary, 254 (2d ed 1990) ("definite" or "fixed"); Merriam-Webster Dictionary ("fixed" or "settled") (available at www m-w.com).[2] For example, the ballot title "limited political terms in certain elected offices," used the term "certain" to refer to a fixed and settled set of offices—not an open-ended group to be determined later *See Advisory Opinion to Attorney Gen.—Ltd. Political Terms in Certain Elective Offices*, 592 So 2d 225, 228 (Fla 1991). Here, by contrast, there is nothing "certain" about the medical conditions to which the amendment would apply.

Next, the proposal is not saved by the summary's suggestion that the amendment allows marijuana only "for individuals with debilitating diseases *as determined by a licensed Florida physician*." (emphasis added). This only adds to the problem by misleadingly signaling that the physician is, in fact, diagnosing the presence of a "debilitating disease." The summary offers no hint that the amendment requires no such finding Indeed, under the amendment, a "debilitating medical condition" means anything a physician wants it to mean.

The limitless definition of "debilitating medical condition" has even greater significance because of another undisclosed feature of the amendment: a physician's certification is effectively unreviewable. Specifically, the amendment provides that "[a] physician licensed in Florida shall not be subject to criminal or civil liability or sanctions under Florida law for issuing a physician certification to a person diagnosed with a debilitating medical condition in a manner consistent with this section." Amendment § 29(a)(2). While existing law allows for discipline when physicians fall short of the appropriate standard of care, *see, e.g* , §§ 458 331(1)(t); 456.50(1)(g), Fla. Stat., the amendment purports to immunize physicians from consequences of negligently authorizing marijuana. Neither the title nor the summary notifies voters that the amendment frees physicians from existing requirements regarding standard of care—or that the current cause of action for medical negligence will be unavailable for the negligent prescription of marijuana.

If Florida voters are asked to approve an amendment to grant physicians unbridled discretion to allow marijuana for limitless "conditions," they should have adequate notice to allow intelligent and informed ballots. *See Advisory Opinion to the Attorney Gen re Tax Limitation*, 644 So. 2d 486, 495 (Fla. 1994) ("[T]he ballot title and summary must advise the electorate of the true meaning and ramifications of the amendment and, in particular, must be accurate and informative."). Here, though, the

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[2] Black's Law Dictionary defines "certain" this way "Ascertained, precise, identified, settled; exact, definitive, clearly known; unambiguous, or, in law, capable of being identified or made known, without liability to mistake or ambiguity, from data already given Free from doubt " *Black's Law Dictionary*, 225 (6th ed 1990)

title and summary hide the amendment's true scope and purpose. *Cf. Doyle*, 43 So. 3d at 659 ("A proposed amendment must be removed from the ballot when the title and summary do not accurately describe the scope of the text of the amendment, because it has failed in its purpose.").

The Ballot Summary Leads Voters To Believe there Is No Conflict With Federal Law.

The summary is defective for an additional, independent, reason. Its first words are. "Allows the medical use of marijuana for individuals with debilitating diseases." But what the ballot summary says the amendment "allows" is forbidden under federal law *See* 21 U.S.C. § 801, *et seq.*; *see also Gonzales v. Raich*, 545 U.S 1, 14 (2005) ("By classifying marijuana as a Schedule I drug, as opposed to listing it on a lesser schedule, the manufacture, distribution, or possession of marijuana became a criminal offense, with the sole exception being use of the drug as part of a Food and Drug Administration preapproved research study."). The amendment's legal effect, then, is not to "allow" marijuana, notwithstanding the summary's suggestion. *See In re Advisory Opinion to the Atty. Gen. re Additional Homestead Tax Exemption*, 880 So. 2d 646, 653 (Fla. 2004) ("This misleading language does not reflect the true legal effect of the proposed amendment.")

Nonetheless, rather than remain silent about federal law, the summary raises the topic by cryptically stating that the amendment "[d]oes not authorize violations of federal law " This tells the voter nothing Certainly, the amendment does not authorize violations of federal law, which no state law could Yet the Sponsor chose this "wording technique" rather than explaining that marijuana use is criminal under federal law. Because voters know that state law cannot authorize violations of federal law—and because voters would find it counterintuitive that Florida law would authorize conduct federal law prohibits—the summary will mislead some voters into believing that federal law already permits medical marijuana (as opposed to recreational marijuana) or that the amendment utilizes some federal-law exception. This, of course, is not correct. Congress has "designate[d] marijuana as contraband for any purpose" and "expressly found that the drug has no acceptable medical uses " *Gonzales*, 545 U S at 27. Voters deserve to know that. As this Court has said, "[t]he voters of Florida deserve nothing less than clarity when faced with the decision of whether to amend our state constitution, for it is the foundational document that embodies the fundamental principles through which organized government functions." *Fla. Dep't of State v. Slough*, 992 So 2d 142, 149 (Fla. 2008).

* * *

Pursuant to Section 16.061, Florida Statutes, I respectfully request this Honorable Court's opinion as to whether the proposed amendment complies with Article XI, section 3, Florida Constitution, and whether the amendment's ballot title and summary comply with section 101.161, Florida Statutes.

Respectfully submitted,

Pamela Jo Bondi

Pamela Jo Bondi
Attorney General

FLORIDA DEPARTMENT *of* STATE

RICK SCOTT
Governor

KEN DETZNER
Secretary of State

September 26, 2013

The Honorable Pam Bondi
Attorney General
Department of Legal Affairs
PL-01 The Capitol
Tallahassee, Florida 32399-1050

Dear General Bondi:

Section 15.21, Florida Statutes, provides that the Secretary of State shall submit an initiative petition to the Attorney General when the sponsoring political committee has obtained ten percent of the signatures in one fourth of the Congressional Districts, as required by section 3, Article XI of the Florida Constitution, and has met registration and submission requirements.

Section 16.061, Florida Statutes, provides that the Attorney General must then petition the Supreme Court for an advisory opinion regarding the compliance of the text of the proposed amendment with the State Constitution, and its ballot title and substance with section 101.161, Florida Statutes.

People United for Medical Marijuana has successfully met the requirements of section 15.21, Florida Statutes, for the initiative petition titled *Use of Marijuana for Certain Medical Conditions*, Serial Number 13-02. Therefore, I am submitting the proposed constitutional amendment, ballot title, and substance of the amendment, along with a status update for the initiative petition, and a current county-by-county signature count.

Sincerely,

Ken Detzner
Secretary of State

KD/am

pc: John Morgan, Chairperson
People United for Medical Marijuana

Enclosures

CONSTITUTIONAL AMENDMENT PETITION FORM

Note
- All information on this form, including your signature, becomes a public record upon receipt by the Supervisor of Elections.
- Under Florida law, it is a first degree misdemeanor, punishable as provided in s 775 082 or s 775 083, Florida Statutes, to knowingly sign more than one petition for a candidate, a minor political party, or an issue [Section 104.185, Florida Statutes]
- If all requested information on this form is not completed, the form will not be valid

Your name_____
Please print name as it appears on your Voter Information Card

Your residential street address_____

City_____Zip_____County_____

Voter Registration Number_____ **OR** Date of Birth_____

I am a registered voter of Florida and hereby petition the Secretary of State to place the following proposed amendment to the Florida Constitution on the ballot in the general election

BALLOT TITLE: Use of Marijuana for Certain Medical Conditions

BALLOT SUMMARY: Allows the medical use of marijuana for individuals with debilitating diseases 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 authorize violations of federal law or any non-medical use, possession or production of marijuana.

ARTICLE AND SECTION BEING AMENDED OR CREATED: Article X, Section 29

Full text of proposed constitutional amendment is as follows:

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

(a) PUBLIC POLICY

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

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

(3) Actions and conduct by a medical marijuana treatment center registered with the Department, or its employees, as permitted by this section and in compliance with Department regulations, shall not be subject to criminal or civil liability or sanctions under Florida law except as provided in this section.

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

(1) "Debilitating Medical Condition" means cancer, glaucoma, positive status for human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, multiple sclerosis or other conditions 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 person who has a physician certification or a personal caregiver who is at least twenty-one (21) years old and has agreed to assist with a qualifying patient's medical use of marijuana.

(4) "Marijuana" has the meaning given cannabis in Section 893.02(3), Florida Statutes (2013).

(5) "Medical Marijuana Treatment Center" 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 personal caregivers and is registered by the Department.

(6) "Medical use" means the acquisition, possession, use, delivery, transfer, or administration of marijuana or related supplies by a qualifying patient or personal caregiver for use by a qualifying patient for the treatment of a debilitating medical condition.

(7) "Personal 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 a caregiver identification card issued by the Department. A personal caregiver may assist no more than five (5) qualifying patients at one time. An employee of a hospice provider, nursing, or medical facility may serve as a personal caregiver to more than five (5) qualifying patients as permitted by the Department. Personal caregivers are prohibited from consuming marijuana obtained for the personal, medical use by the qualifying patient.

(8) "Physician" means a physician who is licensed in Florida.

(Continues on next page)

(Continued from previous page)

(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 potential benefits of the medical use of marijuana would likely outweigh the 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 of the patient and a full assessment of the patient's medical history

(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 shall affect laws relating to non-medical use, possession, production or sale of marijuana

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

(3) Nothing in this section allows the operation of a motor vehicle, boat, or aircraft while under the influence of marijuana

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

(5) Nothing in this section shall require any accommodation of any on-site medical use of marijuana in any place of education or employment, or of smoking medical marijuana in any public place

(6) 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.

(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 of qualifying patient identification cards to people with physician certifications, and standards for the renewal of such identification cards

b. Procedures for the issuance of personal caregiver identification cards to persons qualified to assist with a qualifying patient's medical use of marijuana, and standards for the renewal of such identification cards

c Procedures for the registration of Medical Marijuana Treatment Centers that include procedures for the issuance, renewal, suspension, and revocation of registration, and standards to ensure 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) Issuance of identification cards and registrations The Department shall begin issuing qualifying patient and personal caregiver identification cards, as well as begin registering Medical Marijuana Treatment Centers no later than nine months (9) 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 Medical Marijuana Treatment Centers 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 provision

(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 any court of competent jurisdiction other provisions shall continue to be in effect to the fullest extent possible.

DATE OF SIGNATURE _____

X _____
SIGNATURE OF REGISTERED VOTER

Include below the name and address of paid petition circulator if one was used to obtain signature (Section 106 19(3), F S)

Name of paid circulator (if applicable) _____

Address _____

RETURN TO:

People United for Medical Marijuana
Post Office Box 560296
Orlando, FL 32856

For official use only *Serial number* 13-02
Date approved 7/10/2013

Pd pol. adv. paid for and sponsored by People United for Medical Marijuana, P O Box 560296, Orlando, FL 32856

Attachment for Initiative Petition
Use of Marijuana for Certain Medical Conditions
Serial Number 13-02

1. **Name and address of the sponsor of the initiative petition:** People United for Medical Marijuana, 20 North Orange Avenue, Suite 1600, Orlando, Florida 32801; Chairperson is John Morgan, Esq.

2. **Name and address of the sponsor's attorney, if the sponsor is represented:** Unknown

3. **A statement as to whether the sponsor has obtained the requisite number of signatures on the initiative petition to have the proposed amendment put on the ballot:** As of September 26, 2013, the sponsor has not obtained the requisite number of signatures to have the proposed amendment placed on the ballot. A total of 683,149 valid signatures is required for placement on the 2014 general election ballot.

4. **If the sponsor has not obtained the requisite number of signatures on the initiative petition to have the proposed amendment put on the ballot, the current status of the signature-collection process:** As of September 26, 2013, the Supervisors of Elections have certified a total of 94,541 valid petition signatures to the Division of Elections for this initiative petition. This number represents more than 10% of the total number of valid signatures needed from electors statewide and in at least one-fourth of the congressional districts in order to have the initiative placed on the 2014 general election ballot.

5. **The date of the election during which the sponsor is planning to submit the proposed amendment to the voters:** Unknown. The earliest date of election that this proposed amendment can be placed on the ballot is November 4, 2014, provided the sponsor successfully obtains the requisite number of valid signatures by February 1, 2014.

6. **The last possible date that the ballot for the target election can be printed in order to be ready for the election:** September 4, 2014, if amendment is to be placed on November 2014 Ballot.

7. **A statement identifying the date by which the Financial Impact Statement will be filed, if the Financial Impact Statement is not filed concurrently with the request:** Unknown (The Secretary of State forwarded a letter to the Financial Impact Estimating Conference in the care of the coordinator on September 26, 2013.)

8. **The names and complete mailing addresses of all of the parties who are to be served.** This information is unknown at this time.

FLORIDA DEPARTMENT OF STATE
DIVISION OF ELECTIONS

SUMMARY OF PETITION SIGNATURES

Political Committee **People United for Medical Marijuana**

Amendment Title **Use of Marijuana for Certain Medical Conditions**

Congressional District	Voting Electors in 2012 Presidential Election	For Review 10% of 8% Required By Section 15 21 Florida Statutes	For Ballot 8% Required By Article XI, Section 3 Florida Constitution	Signatures Certified
FIRST	356,435	2,851	28 515	0
SECOND	343,558	2,748	27 485	2,022
THIRD	329,165	2,633	26 333	1,277
FOURTH	351,564	2,813	28 125	3,307
FIFTH	279,598	2,237	22,368	4,986
SIXTH	363,402	2,907	29,072	4,624
SEVENTH	333,990	2,672	26,719	2,912
EIGHTH	365,738	2,926	29,259	2,168
NINTH	277 101	2,217	22,168	1,995
TENTH	329,366	2,635	26,349	1,749
ELEVENTH	359,004	2,872	28,720	1,166
TWELFTH	345,407	2,763	27,633	3,723
THIRTEENTH	344,500	2,756	27,560	4,298
FOURTEENTH	295,917	2,367	23,673	6,340
FIFTEENTH	304,932	2,439	24,395	2,472
SIXTEENTH	360,734	2,886	28,859	2,383
SEVENTEENTH	299,464	2,396	23,957	790
EIGHTEENTH	345,399	2,763	27,632	2,568
NINETEENTH	323,317	2,587	25,865	949
TWENTIETH	264,721	2,118	21,178	8,271
TWENTY-FIRST	326,392	2,611	26,111	2,927
TWENTY-SECOND	329,816	2,639	26,385	5,110
TWENTY-THIRD	290,042	2,320	23,203	5,694
TWENTY-FOURTH	263,367	2,107	21,069	13,000
TWENTY-FIFTH	240,521	1,924	19,242	1,932
TWENTY-SIXTH	268,898	2,151	21,512	4,441
TWENTY-SEVENTH	247,023	1,976	19,762	3,437
TOTAL:	**8,539,371**	**68 314**	**683,149**	**94,541**

Date 9/26/2013 11 18 06 AM

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing has been furnished by U.S. Mail delivery this 24th day of October, 2013, to the following:

Mr John Morgan
Chairperson, People United for Medical Marijuana
P O Box 560296
Orlando, FL 32856

Mr. Jon L Mills
Boies, Schiller & Flexner, LLP
100 SE 2nd Street, Suite 2800
Miami, Florida 33131

Financial Impact Estimating Conference
Attention. Amy Baker, Coordinator
Office of Economic and Demographic
Research
111 West Madison Street, Suite 574
Tallahassee, Florida 32399-6588

I hereby certify that a true and correct copy of the foregoing has been furnished via interoffice mail delivery this 24th day of October, 2013, to the following

Mr. Ken Detzner, Secretary of State
ATTN: General Counsel

The Honorable Rick Scott Governor, State of Florida
ATTN: General Counsel

The Honorable Don Gaetz, President, Florida Senate
ATTN· General Counsel

The Honorable Will Weatherford, Speaker, Florida House of Representatives
ATTN. General Counsel

Director, Division of Elections

Allen Winsor
Solicitor General
Florida Bar Number 016295

Responses from State and Local Agencies

The following presents:

- An email from Amy Mercer, Executive Director, The Florida Police Chiefs Association, to Amy Baker, dated October 25, 2013

Baker, Amy

From: Amy Mercer <amercer@fpca.com>
Sent: Friday, October 25, 2013 12:22 PM
To: Baker, Amy
Subject: FW: Financial Impact Estimating Conference
Attachments: medical marijuana laws.docx; CFC-Amendment-64-Study-final2.pdf

Importance: High

Hello Amy, I pulled together the attached chart on state medical marijuana laws. Most of the info was gathered from the NCSL. If you look under Colorado in the attached chart there is a link to the cost analysis of amendment 64 from an April 2013 report. I have also attached the report for your reference. I hope you find this helpful.

Also, at this time the Florida Police Chiefs Association will not be able to provide accurate information relating to what we anticipate to be a negative fiscal impact to our agencies.

Thank you, Amy

Amy Mercer
Executive Director
The Florida Police Chiefs Association
P.O. Box 14038
Tallahassee, FL 32317
Phone: 850-219-3631
Fax: 850-219-3640
Email: amercer@fpca.com

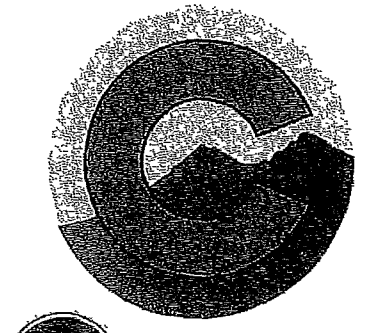
STARS... By providing Selection, Training, Assessment, Recruitment and support, the ***Florida Police Chiefs STARS Program*** *is setting the standard for finding, retaining and supporting the best police chiefs available. To learn more about STARS visit us at:*
http://www.fpca.com/stars-program

State	Statutory Language (year)	Patient Registry	Allow Dispensaries	State Allows for Recreational Use
Alaska	Measure 8 (1998) SB 94 (1999) Statute Title 17, Chapter 37	Yes	No	
Arizona	Proposition 203 (2010)	Yes	Yes	
California	Proposition 215 (1996) SB 420 (2003)	Yes	Yes	
Colorado	Amendment 20 (2000)	Yes	Yes	Amendment 64 (2012) Task Force Implementation Recommendations (2013) Analysis of CO Amendment 64 (2013)
Connecticut	HB 5387 (2012)	Yes	Yes	
Delaware	SB 17 (2011)	Yes	Yes	
District of Columbia	Initiative 59 (1998) LR 720 (2010)	Yes	Yes	
Hawaii	SB 862 (2000)	Yes	No	
Illinois	HB 1 (2013) *Eff. 1/1/2014*	Yes	Yes	
Maine	Question 2 (1999) LD 611 (2002) Question 5 (2009) LD 1811 (2010) LD 1296 (2011)	Yes	Yes	
Maryland* (NOT a fully functioning public program, see	HB 702 (2003) SB 308 (2011) HB 180/SB 580 (2013) HB 1101- Chapter	No	No	

below)	403 (2013)			
Massachusetts	Question 3 (2012) Regulations (2013)	Yes	Yes	
Michigan	Proposal 1 (2008)	Yes	No	
Montana	Initiative 148 (2004) SB 423 (2011)	Yes	No**	
Nevada	Question 9 (2000) NRS 453A NAC 453A	Yes	No	
New Hampshire	HB 573 (2013)	Yes	Yes	
New Jersey	SB 119 (2009)	Yes	Yes	
New Mexico	SB 523 (2007)	Yes	Yes	
Oregon	Oregon Medical Marijuana Act (1998) SB 161 (2007)	Yes	No	
Rhode Island	SB 791 (2007) SB 185 (2009)	Yes	Yes	
Vermont	SB 76 (2004) SB 7 (2007) SB 17 (2011)	Yes	Yes	
Washington	Initiative 692 (1998) SB 5798 (2010) SB 5073 (2011)	No	No	Initiative 502 (2012)

* Maryland's law allows for medical marijuana use as a legal defense in court. Possession of more than one ounce of marijuana and public consumption for medical reasons is still illegal.

** While Montana's revised medical marijuana law limits caregivers to three patients, caregivers may serve an unlimited number of patients due to an injunction issued on January 16, 2013.



Colorado State University

The Fiscal Impact of Amendment 64 on State Revenues

April 24, 2013

Prepared by:

Charles Brown
Director
Colorado Futures Center

Phyllis Resnick
Lead Economist
Colorado Futures Center

www.colostate.edu/coloradofutures

Summary

Colorado voters approved Amendment 64 in November 2012, legalizing the production, sale and use of adult recreational marijuana under Colorado law. Since then, various mechanisms of state government have been looking at how to implement the amendment, including how best to regulate and tax the sale of recreational marijuana. The Colorado General Assembly's Joint Select Committee on the Implementation of Amendment 64 recently handed down legislation that includes the following proposed taxes related to Amendment 64:

- An excise tax levy of 15% of the wholesale value of marijuana;
- A special sales tax of 15% on the retail sale of marijuana; and
- Extension of the state's existing 2.9% general sales tax to sales of marijuana and marijuana products.

The Colorado Futures Center at Colorado State University sought to provide a clear-eyed and unbiased analysis of the fiscal impact of the proposed Amendment 64 tax measures as part of a broader commitment to look holistically at the sustainability of Colorado's state budget. This paper will address the following key findings:

1. ***The adult recreational marijuana market in Colorado will be $605.7 million and taxation of that market will bring an additional $130.1 Million in state tax revenue in fiscal year 2014-15.***[1,2]
2. ***The 15% wholesale excise tax created by the amendment will not reach the goal of $40 Million for school construction as stipulated in the ballot language approved by voters.***
3. ***The high water mark for marijuana tax revenue is likely to be in the first few post-legalization years with revenue flattening or declining thereafter.***
4. ***Marijuana tax revenues may not cover the incremental state expenditures related to legalization.***
5. ***Marijuana tax revenues will not close Colorado's structural budget gap.***

[1] This amount does not include sales tax revenue from the sale of marijuana paraphernalia but does include consumables such as baked goods. It also does not account for the effect of local sales taxes on consumption and the price of marijuana or the offsetting loss in state revenue from declining medical marijuana sales as medical patients transition to the adult recreational marijuana market.

[2] These revenue estimates come from a model CFC built to estimate the revenue potential of marijuana taxation. The model was populated with what we believe are the most likely assumptions concerning cost, consumer behavior and tax rates. However, others may hold different assumptions. To allow for changes to the assumptions, the model is available on our website, www colostate edu/coloradofutures, in an interactive form for users to assess the revenue impact under different assumptions than those used for this study.

Background

Amendment 64, legalizing adult recreational marijuana for Coloradans 21 years and over, was passed by Colorado voters in November 2012. In December 2012, Governor John Hickenlooper created a task force charged with making recommendations concerning the regulatory and taxing environment for this new industry. In February 2013, the task force reported to the governor a series of 58 recommendations, a copy of which is available at www.colorado.gov/cms/forms/dor-tax/A64TaskForceFinalReport.pdf.

The gubernatorial task force recommended two separate and distinct taxes for marijuana, which are now being considered by the General Assembly. The first is a 15% excise tax imposed at the point of transaction between marijuana cultivators and production facilities or retail stores. This tax was proposed in the original language of the amendment, but since the taxing language in Amendment 64 was not TABOR compliant, the excise tax must be resubmitted for approval by the voters. The language of the amendment dedicates the first $40 million of proceeds from the excise tax to the Building Excellent Schools Today (BEST) program for school capital construction.

In addition to the excise tax, the task force recommended that voters be asked to approve a special sales tax of up to 25% imposed at the point of retail for marijuana products and paraphernalia. A select committee of the legislature lowered the special sales tax cap to15% and recommended a mechanism for the proceeds to be shared with localities. Cities or counties that prohibit marijuana licensees would not be eligible for a share of proceeds from the special sales tax.

Finally, under the current tax code, the sale of marijuana products and paraphernalia will be subject to the 2.9% existing state sales tax as well as local sales taxes without a vote of the people. A separate recommendation of the legislative select committee directed that all proceeds from the taxation and fees on marijuana transactions be deposited into a newly formed marijuana cash fund for the purposes of regulating the industry. Currently, the General Assembly is considering the committee recommendations, and assuming the tax recommendations will not be amended, we estimated the revenue potential of the proposed taxes as currently proposed.

Revenue Potential of the Proposed Marijuana Taxes

Estimating the revenue potential of proposed marijuana taxes is a four step process. Building on previously published methodologies[3], the Colorado Futures Center model estimates post-legalization demand for marijuana, the wholesale cost and retail price, the price induced changes in consumption behavior likely to result from a decision to legalize, and ultimately the tax revenue that will result from legalization. Estimations of tax revenue are heavily influenced by assumptions about demand for and the wholesale and retail prices of marijuana. Assumptions used in the Center's model, along with the rationale for each, are detailed in the sections below. However, to allow for changes to the assumptions, the model is available on our website, www.colostate.edu/coloradofutures, in an interactive form for users to assess the revenue impact under other assumptions.

- *STEP ONE: Estimate Demand for Adult Marijuana (not including consumables)*

The demand for adult marijuana is dependent on the number of consumers and the amount consumed per user. Under Colorado law, the purchase of adult recreational marijuana will be legal for anyone 21 years old and over. The current recommendation from the legislature would not limit access to Coloradans, making the purchase of marijuana legal for those 21 and over regardless of their place of residence. This extension to non-Coloradans makes the estimation of demand more complicated. While there are data by state on the rate of marijuana usage, it is difficult to determine the extent of the demand for marijuana that will come from non-Coloradans. In addition, while illegal, it is likely that marijuana will be purchased and transferred to those under the age of 21. Since there is no reliable data on the probable extent of marijuana tourism and illegal transfers to minors, these activities are not accounted for in the Center's model, so our estimates may be understated to some extent.

The most reliable data on marijuana usage comes from the National Survey on Drug Use and Health.[4] The latest survey data from 2010-11 report shares of the population, by age cohort, that have used marijuana in the previous year. For those years, the survey reports the following usage rates for Colorado:

- 41.29% in the age cohort 18 – 25
- 11.54% in the age cohort 26 and above

To establish our estimate for the number of Coloradans using marijuana in 2014, the first year of legalization, we applied the usage rates from the survey to the Colorado State Demography Office's 2014 forecast for population in those age cohorts. To adjust the 18 – 25 cohort to the 21-and-over cohort that is legally able to purchase marijuana, we assumed that the usage was evenly distributed and used a straight line approach. Initially we estimate that 554,710 Coloradans will use marijuana in 2014.

Since this estimate is based on survey data concerning a topic that is both illegal and may carry a social stigma, we assume that usage is underreported in the survey. Studies suggest that the range of underreporting may be anywhere between 0% and 40%. Consistent with the CCLP's analysis, we assume an underreporting rate of 20%. Adjusting our estimate of users for underreporting, we forecast that 665,652 Coloradans will use legal marijuana in 2014. However, as of February 2013, 108,951

[3] See for example the Colorado Center on Law and Policy (CCLP) at http://www.cclponline.org/postfiles/amendment_64_analysis_final.pdf

[4] http://www.samhsa.gov/data/NSDUH/2k11State/NSDUHsaeTOC2011.htm

Coloradans held medical marijuana cards. Again, consistent with the CCLP analysis, we assumed that 79% of those currently purchasing medical marijuana will migrate to the adult recreational marijuana market with the remainder continuing to access marijuana through medical marijuana establishments. Accounting for this adjustment, we estimate that the market for legal marijuana to be 642,772 Coloradans. Finally, we assumed a per person per year usage rate of 3.53 ounces, again consistent with the CCLP analysis. ***This results in a pre-legalization estimate of demand for marijuana of 2,268,985 ounces annually.***

There are threats to this estimate. Two that are mentioned above – marijuana tourism and the purchase of marijuana to be illegally transferred to those under the age of 21 – make our estimate of use somewhat conservative. If either or both of those effects occur, demand will be higher than we estimate. Our estimate of demand also does not account for changes in behavior due to legalization. There are likely to be offsetting effects of those attracted to marijuana or inclined to consume larger quantities because it is now legal and those who lose interest in marijuana now that the "forbidden fruit" aspect of marijuana use is eliminated. We implicitly assume that those effects offset.

- *STEP TWO: Estimate the Post Legalization Wholesale and Retail Prices*

The next component necessary to estimate the size of the legal marijuana market, and thus the tax revenue potential, is the price of marijuana. Because of the differing structure of the proposed excise and special sales taxes, both the wholesale and retail prices of marijuana are relevant.

Since growing marijuana is federally illegal and continues to be illegal in most states, there is scant data on the cost structure of a grow operation. However, in 2010 researchers at the Rand Institute estimated a range on the cost of growing marijuana in California. Their estimates vary widely – from de minimis to a top estimate of $400/lb for a grow operation that uses a 1500 square-foot home as the location of the cultivation.[5] Inflating Rand's high end 2010 estimate of $400/lb with a producer price index forecast for all farm products from Moody's Economy.com, we estimate that marijuana will cost $592/lb to grow in 2014. In our model we used a rounded assumption of $600/lb to grow marijuana.

Building from wholesale cost to retail price requires accounting for excise taxes, distribution costs, and various markups along the supply chain. ***After accounting for all of the additions to wholesale cost, we estimate the post legalization, pre sales tax retail price of marijuana to be $2,509/lb or $157/oz. After applying the recommended sales taxes, we estimate that the retail price for marijuana will be $2,959/lb or $185/oz.*** Again, the retail price calculation is extremely sensitive to the assumptions made for all adjustments along the supply chain as well as to the cultivation (wholesale) cost of marijuana. The table below shows our calculations from cultivation cost to retail price, along with the basis for our assumptions. Users wishing to vary some of these assumptions may do so on our interactive model at www.colostate.edu/coloradofutures.

[5] http://www.rand.org/content/dam/rand/pubs/working_papers/2010/RAND_WR764.pdf and http://www.rand.org/content/dam/rand/pubs/occasional_papers/2010/RAND_OP315.pdf

Table 1. Calculations from Cultivation Cost to Retail Price

Cost Item	Value (all per lb. unless noted)	Basis for Assumption
Wholesale Cost, per lb.	$ 600	Rand Study, adjusted for inflation
Excise Tax at 15%	$ 90	Amendment 64
Producer Markup Rate at 25%	$ 183	CCLP study, based on similar agricultural product markups
Distribution Cost, per lb.	$ 40	CCLP assumption, based on Rand analysis
Retailer Markup Rate at 175%	$1,597	Middle estimate between CCLP analysis and numerous marijuana blogs. Also accounts for overhead costs associated with operating marijuana retail establishments.
Retail Price, per lb/oz. (before sales tax)	$2,509/lb. $157/oz.	
Special Sales Tax at 15%	$ 376	Select Committee recommendation for maximum rate
State Sales tax at 2.9%	$ 73	
Retail Price, per lb. (after sales tax)	$2,959/lb.	
Retail Price, per oz. (after sales tax)	$185/oz.	

- *STEP THREE: Estimate Price Induced Consumption Changes and the Post Legalization Demand for Adult Marijuana*

Assuming high end estimates for the cost of cultivation and retailer markups on marijuana and accounting for the tax burden, we forecast the post legalization price of $185/oz to be lower than current black market prices in Colorado. The best source for prices for black market marijuana in Colorado is the crowdsourcing website The Price of Weed[6] which reported, as of April 10, 2013, that the average price of an ounce of marijuana of all qualities was $206. As with most other goods, a reduction in the price results in an increase in the quantity demanded. We expect the same to be true for marijuana.

The relationship between price and quantity of goods consumed is characterized by the elasticity of demand. Elasticitities measure the percent change in quantity demanded that results from a 1% change in the price of a good. The best estimate for the elasticity of demand for marijuana comes from the researchers at the Rand Institute[7] who estimate that marijuana has a price elasticity of demand of -0.54. The interpretation of this measure is that a 1% decrease in the price of marijuana results in a 0.54% increase in quantity demanded. Applying this measure to our forecast 10% decrease in the price of marijuana after legalization, we expect a 6% increase in quantity demanded, ultimately ***resulting in a post legalization demand for marijuana (not including consumables) of 2,394,428 ounces.***

[6] http://www.priceofweed.com/

[7] Kilmer et al 2010 pg. 23 at http://www.rand.org/content/dam/rand/pubs/occasional_papers/2010/RAND_OP315.pdf

- *STEP FOUR: Calculate Tax Revenue*

Under the proposed tax measures, and assuming approval by the voters, all marijuana and marijuana related purchases will be subject to the excise, special sales and existing state sales tax. While we do not have good data on the sales of marijuana paraphernalia, we can use the model above and other research to estimate the tax revenue potential from all other marijuana purchases, including consumables such as baked goods.

According to the investor relations website for Medical Marijuana Inc.[8], consumable (or edible) marijuana accounts for 38% of the total market for medical marijuana. Assuming that the share will remain the same for recreational marijuana, we can impute the size of the total market for all marijuana, including consumables, by knowing that the non-edible purchases, estimated above, account for 62% of the total market. By that calculation, and assuming the demand and cost structure outlined above, the total dollar value of the retail and wholesale markets for adult marijuana are estimated to be $605.7 Million and $144.8 Million, respectively. Applying the 15% tax at wholesale, the 2.9% state sales tax at retail and the proposed special sales tax at retail of 15% yields the following tax revenue estimates for 2014-15, the first fiscal year of adult marijuana:

- ***A 15% excise tax imposed at the point of cultivation will yield $21.7 Million***
- ***A special sales tax of 15% will yield $90.9 Million***
- ***The existing state sales tax of 2.9% will yield $17.6 Million***

[8] http //www medicalmarijuanainc.com/index.php/press/22-press-releases/2012-press-releases/107-medical-marijuana-inc-portfolio-company-red-dice-holdings-sees-continued-brand-recognition-with-co-based-dixie-elixirs

Concluding Thoughts: What will Marijuana Taxation Mean for the State Budget?

In November 2013, Colorado voters will be asked to approve taxes related to this new industry. Passage of the tax measures would result in approximately $130.1 Million in additional state revenue in FY 2014-15 (including the $17.6 Million estimated to be generated by the existing state sales tax). What will these new revenues mean for the fiscal position of the state?

- *IMPACT: The 15% Excise Tax will not Yield $40 Million for the Building Excellent Schools Today (BEST) Program*

The language of Amendment 64 dedicated the first $40 Million in revenue from the marijuana wholesale excise tax to the BEST program. Although the excise tax rate will need to be submitted to the voters, the 2013 ballot language is likely to comport with the language of Amendment 64 and dedicate the first $40 Million to school construction.

Consistent with Amendment 64, the excise tax likely will be structured as 15% of the wholesale cost of marijuana. In the current vertically integrated system for medical marijuana, with few or no arm's-length transactions between cultivator and seller, it is difficult to ascertain the wholesale cost of marijuana. Our assumption of $600/lb. based on estimates by the Rand Institute and adjusted for inflation results in ***our $21.7 million estimate for the revenue potential from the excise tax, which falls significantly short of the target of $40 Million for school construction.*** In order to generate $40 Million for the BEST program, the cost to grow a pound of marijuana would need to be in the range of $1,100/lb., a level almost two times the Rand estimate adjusted for inflation and one which risks raising the retail price of marijuana to a level that would encourage the continuation of a black market.

- *IMPACT: Revenue Likely to be Highest in Early Years with Revenue Flattening or Declining in Subsequent Years*

While this study did not model beyond the first full year after legalization, our preliminary analysis suggests that the high water mark for marijuana tax revenues will be in the years just following legalization. This will be the result of core and interrelated economic and behavioral phenomena including:

- *Increased competition in the cultivation (wholesale) and retail markets for marijuana which will drive efficiencies and erode margins in the industry.* As competition forces growers and sellers to be more efficient, margins will erode and both wholesale cost and retail prices will forecast to fall. Without offsetting increases in consumption, falling prices result in lower tax revenue.

- *A decline in the rate of growth of consumption as the "wow" factor erodes over time and any marijuana tourism begins to decline, particularly if other states follow Colorado and Washington and legalize marijuana.* One way to stabilize revenue in an environment of falling cost and price is for consumption increases to be sufficient to offset the lower prices. However, our expectation is that after an initial post legalization period of intense interest and curiosity, consumption growth rates will stabilize or even perhaps decline as has been the case with cigarette consumption.

- *IMPACT: Marijuana Related Revenues May Not Cover Incremental State Expenditures Related to Legalization*

While it was outside the scope of our study to estimate the expenditure implications of legalized marijuana, we recognize that the recommended regulatory structure, public health and safety initiatives, human services responsibilities, and potential law enforcement needs will place a demand on the state's budget. The General Assembly's Joint Select Committee also recognized this and made a recommendation that all marijuana related revenues be deposited into a marijuana cash fund dedicated to funding the regulatory function in the Department of Revenue.

In recognition that the cash fund may be insufficient to support the regulatory function, the committee recommended a general fund supplement for marijuana enforcement with an expectation that it will be reimbursed in the future. This structure raises some questions and concerns:

- *Will the revenues from marijuana, either in the early years or as the industry matures, ever be sufficient to fund the regulatory structure and other state expenditure needs?*
- *If not, what will be the longer term mechanism for funding the required regulation, making any necessary reimbursements to the General Fund, and funding the other public health, public safety and human service initiatives recommended by the Amendment 64 Task Force?*

These questions are of even more concern in light of our expectation that the most productive marijuana tax revenue years will be the years just after legalization.

- *IMPACT: Marijuana Tax Revenues will not Close Colorado's Structural Budget Gap*

Colorado's long term general fund structural gap is well documented in previous work done by the staff of the Colorado Futures Center at CSU. One conclusion from our work was that raising sin taxes, particularly those on cigarettes and tobacco, will not close the structural budget gap. We have every reason to believe that the same is true for marijuana. ***After meeting the obligations for BEST and funding the regulatory and other public health and safety budget demands, revenue from marijuana taxes will contribute little or nothing to the state's general fund.*** While taxes from marijuana will contribute to school capital construction needs and may cover the incremental costs associated with legalization, they will not contribute in any significant way to solving the structural gap developing in the state budget.

Responses from State and Local Agencies

The following presents responses from state and local agencies.

- A table detailing Marijuana Use by Substance Abuse Clients from the Florida Department of Children and Families, forwarded via email on October 24, 2013

Marijuana Use by Substance Abuse Clients
Department of Children & Families

		Fiscal Year 2009-2010			Fiscal Year 2010-2011			Fiscal Year 2011-2012			Fiscal Year 2012-2013		
Substance Abuse Program Client	Gender	Total Served	Persons served with marijuana as a substance of choice	Percent of persons served with marijuana as a substance of choice	Total Served	Persons served with marijuana as a substance of choice	Percent of persons served with marijuana as a substance of choice	Total Served	Persons served with marijuana as a substance of choice	Percent of persons served with marijuana as a substance of choice	Total Served	Persons served with marijuana as a substance of choice	Percent of persons served with marijuana as a substance of choice
Adults	Female	40,414	10,541	26.1%	44,113	10,928	24 8%	44,244	10,596	24 0%	43,163	9,809	22 2%
	Male	60,097	19,127	31.8%	60,340	18,800	31 2%	58,483	17,858	29 6%	57,095	16,706	28 6%
Children	Female	13,896	4,898	35 2%	13,668	4,925	36 0%	13,785	4,670	34 2%	12,690	4,263	30 9%
	Male	33,797	15,447	45 7%	30,466	15,741	51 7%	30,139	15,083	49 5%	27,173	13,813	45 8%

Source Attachment to an Email received from Jane Johnson, Chief of Staff, Department of Children & Families, to Amy Baker, Coordinator, Office of Economic and Demographic Research, Thursday, October 24, 2013, 2 58 PM

Responses from State and Local Agencies

The following presents:

- An email from the Florida Association of Counties regarding the impact of the proposed ballot initiative on local governments.

From: Deena Reppen <dreppen@fl-counties com>
Sent. Tuesday, October 29, 2013 12:35 PM
To Schenker, Pamela
Cc Lisa Hurley, Eric Poole
Subject. Re: Financial Impact Estimating Conference

Dear Pam:

The Florida Association of Counties appreciates EDR reaching out to our organization. FAC is unable to make a determination about the financial impact of the proposed amendment on local governments

We respectfully request that you keep FAC apprised of EDR's determinations so that they may be shared with our membership.

Sincerely,
Deena Reppen
Legislative Director
Florida Association of Counties

Sent from my iPad

Responses from State and Local Agencies

The following presents:

- An email from the Florida Agency for HealthCare Administration regarding the impact of the proposed ballot initiative on the agency.

From: Chaney, Chris [mailto:Chris Chaney@ahca.myflorida com]
Sent. Monday, October 28, 2013 8 45 AM
To Williams, Phil
Subject Re. Financial Impact Estmating Conference: Medical Use of Marijuana

The definition of "personal Caregiver" in the medical marijuana petition uses the term "medical facility". "Medical facility" it not defined so it is not clear if it would include all facilities licensed by the Agency As an example, although most licensed facilities are under the statutory heading of "Public Health" (chapter 381-408), Chapter 429 falls under "Social Welfare" and includes assisted living facilities which provide some level of nursing services and may serve hospice residents.

Under LIMITATIONS the language states "(5) Nothing in this section shall require any accommodation of any on-site medical use of marijuana in any place of education or employment, or of smoking medical marijuana in any public place." It is not clear if hospitals or other medical facilities would be required to allow patients to use medical marijuana

We do not expect the amendment to have a significant impact on the Agency for Health Care Administration (Agency). However, potential impacts are listed below·

· AHCA staff would refer information to the Department of Health (DOH) if potential violations are identified during health care facility licensure duties.. For example, an employee of a hospice, nursing home or any facility regulated by AHCA that is assisting more than 5 people, or is not registered with DOH.

· AHCA staff may have to review how marijuana is stored and dispensed at facilities regulated by AHCA, similar to reviews of prescribed controlled substances used by patients in health care facilities.

· There may be some growth in the number of Health Care Clinics licensed by the Agency, but the growth cannot be determined at this time. A health care clinic license is required if a clinic provides health care services and bills a third party for those services There are several exemptions from health care clinic licensure for clinics that are owned by physicians or other health care providers already licensed by the state. The language does not require a health insurance provider or government agency to reimburse for expenses related to the medical use of marijuana, if a clinic does not bill a third party no licensed is required There are currently 1,994 licensed health care clinics in Florida and the Agency has issued 9,317 health care clinic exemption certificates

Please let us know if you would like additional information

"Personal 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 a caregiver identification card issued by the Department A personal caregiver may assist no more than five (5) qualifying patients at one time. An employee of a hospice provider, nursing, or medical facility may serve as a personal caregiver to more than five (5) qualifying patients as permitted by the Department Personal caregivers are prohibited from consuming marijuana obtained for the personal, medical use by the qualifying patient.

Sent from my iPhone

Responses from State and Local Agencies

The following presents:

- An email from the Florida Sheriffs Association regarding the impact of the proposed ballot initiative.

From: Sarrah Carroll <scarroll@flsheriffs.org>
Sent: Sunday, October 27, 2013 9.33 PM
To Baker, Amy
Subject. Fiscal estimating conference

Hello Amy,

We've compiled a bit more information for the meeting tomorrow Please let me know if you have any questions

Thank you,

Sarrah

Law enforcement would certainly face additional costs in many different ways if medical marijuana were to become legal in the state of Florida. According to the Federal Bureau of Investigation's 2012 report on crime in the U.S , marijuana accounted for 48 percent of drug related arrests Whether the medical marijuana industries in these states are highly regulated or not, there is still much confusion over when a person may be breaking the law.

Verifying the medical marijuana licenses for individuals and grow houses will take more time and resources in the course of an investigation. It would be incumbent on law enforcement to prove the grow house was not being maintained for the sale of medicinal marijuana before a search warrant would be issued While law enforcement researched the validity of the status, the grow house could close up shop or claim to be victims of a burglary/theft

In states that have legalized marijuana, crime has increased Dispensaries have been the target of robberies, as well as its customers. Dispensaries primarily take cash only because credit card companies refuse to process any payments made to dispensaries due to the federal laws This makes the dispensaries easy targets for those criminals looking for quick cash

Another concern we have is that dispensaries may become the next generation of "pill mill" storefronts. Many states have seen large number of dispensaries open within their state Cities, like Los Angeles, have created moratorium ordinances in an attempt to prevent more from sprouting up and to close those functioning illegally. It is thought that 850 dispensaries are operating illegally. (http://articles latimes com/2013/oct/12/local/la-me-closing-pot-shops-20131012) Resources such as the PDMP have since been created to assist law enforcement in their eradication

In the state of Washington, the laws were so cumbersome on law enforcement to prove that the marijuana grow operations were for medicinal purposes, the state returned funds back to the federal government because they were unable to comply with the agreement in place to prevent and investigate marijuana cultivation. It is highly probable that the Department of Agriculture and Consumer Services would lose federal revenue for the domestic marijuana eradication program if this ballot initiative were to pass.

Additional costs would be borne be local and state law enforcement to enforce DUI statutes for marijuana use. The ballot is written so permissively that we anticipate many Floridians seeking a doctors certification, increasing the need for education and enforcement of the traffic laws.

Sarrah Carroll
Florida Sheriffs Association
850-284-5993
www flsheriffs org

Based on the proposed Constitutional Amendment for the 2016 Ballot

To Be Added at a Later Date

Draft – Summary of Initiative Financial Information Statement

Use of Marijuana for Certain Medical Conditions
Serial Number 15-01

To Be Added at a Later Date