HB 1040

Department of Legislative Services
Maryland General Assembly
2007 Session

FISCAL AND POLICY NOTE

House Bill 1040 (Delegate Oaks, *et al.*)
Judiciary

Maryland Compassionate Use Act

This bill establishes the Compassionate Use Registry Program within the Department of Health and Mental Hygiene (DHMH) to allow patients suffering from a debilitating medical condition to use marijuana for medical purposes. The bill also repeals provisions that allow a person charged with possession or use of marijuana or related paraphernalia to introduce evidence related to medical necessity and, if the person is convicted and the court finds there was medical necessity, limits the maximum punishment to a fine of $100.

Fiscal Summary

State Effect: Special fund revenue and expenditure increases of $160,900 in FY 2008. Out-year costs reflect annualization and inflation. Reporting requirements could be met with the existing budgeted resources of DHMH. The civil and criminal penalty provisions are not expected to significantly affect State finances or operations.

(in dollars)	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
SF Revenue	$160,900	$176,100	$184,700	$193,800	$203,400
SF Expenditure	160,900	176,100	184,700	193,800	203,400
Net Effect	$0	$0	$0	$0	$0

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: Minimal. Local health agencies may have to assist DHMH with program requirements, including digital photographs for registry identification cards.

Small Business Effect: Minimal.

Analysis

Bill Summary: The bill requires DHMH to issue "registry identification cards" to "qualifying patients" who submit specified documents in order to qualify for use of marijuana for a "debilitating medical condition." A registry identification card may not be issued to a person under 18 years old without the consent by a parent, guardian, or person having legal custody, as specified.

DHMH is required to verify application information and approve or deny an application or renewal within 90 days. If DHMH fails to meet that deadline for an initial issuance or a renewal, the registration must be deemed granted. The bill allows judicial review by a circuit court of a denial of an application or renewal. DHMH must issue a registry identification card to each qualifying patient and primary caregiver within 10 business days of approval.

The bill specifies that a registry identification card is issued for one year and details the information that is required to be contained on the card, including a photograph and a random registry identification number. The bill provides for limited reciprocity with other states.

The bill provides that a qualifying patient or a "primary caregiver," or other specified persons may not be subject to arrest or other penalty or disciplinary action for medical use of marijuana under these provisions. A qualifying patient or primary caregiver may not possess more than 12 marijuana plants plus 2.5 ounces of "usable marijuana." A practitioner may not be subject to arrest or other penalty or disciplinary action for providing certifications of qualifying patients' debilitating medical conditions or other information, as specified. A nurse practitioner or pharmacist may not be subject to arrest or other penalty or disciplinary action solely for discussing the benefits or health risks of medical marijuana or other information, as specified.

The bill provides that an application for or possession of a registry identification card may not be used to support the search of a person or property. A school, employer, or landlord is prohibited from refusing to enroll, employ, or lease to a person solely based on the person's status as a registered qualifying patient or primary caregiver.

A primary caregiver may only assist five qualifying patients with medical use of marijuana in the same time period. A primary caregiver may receive reimbursements for costs associated with assisting a registered qualifying patient's medical use of marijuana. Reimbursement does not constitute the sale of a controlled dangerous substance.

The bill creates a rebuttable presumption that a qualifying patient or primary caregiver is engaged in the medical use of marijuana if either possesses a registry identification card and possesses an amount of marijuana allowed under these provisions.

DHMH is required to adopt regulations, as specified, to implement these provisions within 90 days after October 1, 2007, including the establishment of application and renewal fees to provide for program cost recovery. The bill provides for notifications of changes of address by a patient or caregiver. A failure to provide such a notification subjects the person to a maximum civil penalty of $75. The bill provides for a change of caregiver by a qualifying patient.

Applications and supporting information submitted by qualifying patients are confidential and exempt from the Maryland Public Information Act. DHMH may verify to law enforcement personnel whether a registry identification card is valid by confirming the random registry identification number. A violator of confidentiality provisions is subject to maximum penalties of imprisonment for six months and/or a fine of $1,000. DHMH may notify law enforcement officials about falsified or fraudulent information submitted to the department.

DHMH is required to report to the Governor and the General Assembly, in a specified manner, on the medical use of marijuana by December 31, 2009. The bill specifies the information that must be contained in the report.

The bill allows a person or a person's primary caregiver to assert a medical use defense to a prosecution involving marijuana, as specified. A person may assert the medical purpose in a motion to dismiss charges for possession of marijuana. The bill exempts property used in connection with the medical use of marijuana from forfeiture, as specified.

Current Law: Marijuana has been a Schedule I controlled dangerous substance under both State and federal drug prohibitions since 1970. Generally, Schedule I drugs are considered to have the highest potential for abuse and offenses involving these drugs are generally treated as more serious than those involving substances on the other four schedules. With the exception of marijuana, there is no distinction made in the law between illegal possession of any controlled dangerous substance regardless of which schedule it is on.

Chapter 442 of 2003 allows a person charged with possession or use of marijuana or related paraphernalia to introduce evidence related to medical necessity and, if the person is convicted and the court finds there was medical necessity, limits the maximum punishment to a fine of $100.

However, it is also important to note that federal felony prohibitions against the manufacture, sale, or distribution of a Schedule II narcotic drug (such as cocaine) subject a violator to maximum imprisonment of 20 years, while the same offense if involving marijuana subjects the violator to a maximum five-year term.

An oral form of marijuana's principal active ingredient, delta-9-tetrahydrocannabinol (THC), called dronabinol, is approved as a treatment for nausea and vomiting related to cancer chemotherapy. Dronabinol also is used to stimulate the appetite of AIDS patients.

It is a violation of federal law to medically prescribe marijuana. Federal policy dictates that a physician who prescribes marijuana or other Schedule I drugs to a patient may lose his or her federal license to prescribe drugs and be prosecuted.

An affirmative defense, in pleading, is matter asserted by a defendant that, assuming the complaint to be true, constitutes a defense to it. In criminal cases, affirmative defenses include insanity, intoxication, self-defense, automatism, coercion, alibi, and duress.

Background: In all, 23 states have some current statute relating to the medical use of marijuana. All these laws are now dormant because they conflict with federal law, or are reliant on the federal government to supply the state with marijuana, and federal officials are no longer supplying marijuana to states.

The District of Columbia had a medical marijuana use initiative on the ballot in November 1998. The initiative was approved by 69% of the voters. Virginia, Connecticut, Vermont, and New Hampshire are among the states that have authorized doctors to prescribe marijuana.

The statutes passed in Alaska, Oregon, Nevada, and Washington exempt patients from criminal penalties when they use marijuana under the supervision of a physician. The laws passed in Alaska and Oregon legalize the possession of specified amounts of medical marijuana to patients enrolled in a state identification program. Patients not enrolled in the program, but who possess marijuana under their doctor's supervision, may raise an affirmative defense of medical necessity against state criminal marijuana charges.

Washington state's medical marijuana law allows patients to possess up to a 60-day supply of marijuana if they have authorization from their physician. The medical marijuana law for the District of Columbia is similar to that of Washington State.

The U.S. Drug Enforcement Administration (DEA) continues to oppose state medical marijuana enactments. According to DEA, "marijuana is a highly addictive drug and has no medical value."

State Fiscal Effect: Special fund expenditures could increase by an estimated $160,870 in fiscal 2008, which accounts for the bill's October 1, 2007 effective date. This estimate reflects the cost of hiring a program administrator, an office secretary, and a fiscal clerk to administer and manage the medical marijuana registration program. It includes salaries, fringe benefits, one-time start-up costs (including electronic licensing and database programming as well as equipment and programming to provide photo licensing), and the services of a consultant physician to assist in reviewing applications.

Salaries and Fringe Benefits	$111,410
Photo Licensing and Database Start-up Costs	20,000
Consulting Physician	11,250
Operating Expenses	18,210
Total FY 2008 DHMH Expenditures	**$160,870**

Future year expenditures reflect • full salaries with 4.5% annual increases and 3% employee turnover; • an annualization of physician consulting costs of $15,000; and • 1% annual increases in ongoing operating expenses.

It should be noted that DHMH believes that program costs under this bill would be about $951,400 in fiscal 2008, including one-time database development costs of $500,000. Future year costs are estimated by the agency to be $561,800 in fiscal 2009 and growing to $649,000 by fiscal 2012. Legislative Services advises that these estimates are out of line with prior program estimates. In 2003, the costs for a similar program to be run by the Board of Physicians (but without some of the detail of this bill) was estimated to cost about $28,000 in the first year of operation and require only a part-time clerk and some limited consultant physician services.

While it is difficult to know how many persons with a qualifying debilitating medical condition would seek to treat that condition with marijuana use allowed under the bill, it is assumed that, by regulation, DHMH would set fees in such a manner to fully recover program costs cited above.

Additional Information

Prior Introductions: Similar bills were introduced in 2006. SB 816 and HB 1458 received unfavorable reports from the Senate Judicial Proceedings Committee and the House Judiciary Committee, respectively. SB 502 and HB 702 of 2003, as introduced, would have established a Medical Marijuana Research Program in the Board of Physician Quality Assurance. SB 502, as amended (including the elimination of the program), passed the Senate and had a hearing in Judiciary but no further action taken. HB 702, as amended, was enacted as Chapter 442 (cited above).

Cross File: SB 757 (Senator Gladden) – Judicial Proceedings.

Information Source(s): Department of Health and Mental Hygiene, Department of Public Safety and Correctional Services, Department of Legislative Services

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mll/jr

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