# Department of Legislative Services

Maryland General Assembly
2013 Session

## FISCAL AND POLICY NOTE

House Bill 302 (Delegate Glenn, *et al.*)
Health and Government Operations and Judiciary

**Maryland Medical Marijuana Act**

This bill authorizes the medical use of marijuana under specified conditions; establishes the Medical Marijuana Advisory Board in the Department of Health and Mental Hygiene (DHMH); requires DHMH to establish an Internet-based verification system; and establishes specified requirements, protections, and application processes for compassion centers, compassion center associates, qualifying patients, and designated caregivers. DHMH must annually report specified information to the Governor and the General Assembly on the medical use of marijuana under the bill. In addition, DHMH must adopt regulations to implement the bill by September 1, 2013. Furthermore, the bill establishes a right of action (as well as specifies other consequences) for a failure by the department to adopt regulations as required by the bill.

The bill takes effect June 1, 2013.

## Fiscal Summary

**State Effect:** It is assumed that neither revenues nor expenditures are affected in FY 2013, during which time board members are appointed and DHMH begins developing regulations with existing staff. Despite the bill's requirement for regulations to be adopted by September 1, 2013, the Department of Legislative Services (DLS) advises that, because the bill requires DHMH to take a number of actions before the program can be fully implemented, the earliest registrants could begin participating in the program is FY 2016. Thus, this estimate assumes that no general fund revenues are generated in FY 2014 or 2015, but that general fund revenues increase significantly beginning in FY 2016 due to fees collected from registrants and compassion centers. The exact amount of this increase cannot be reliably determined at this time, but DLS anticipates that DHMH will attempt to set its fees to approximate the costs of

administering the program. In accordance with program growth and corresponding staffing needs (and accounting for significant one-time start-up costs), general fund expenditures increase by $790,900 in FY 2014 and by $3.9 million in FY 2018.

| (in dollars) | FY 2014 | FY 2015 | FY 2016 | FY 2017 | FY 2018 |
|---|---|---|---|---|---|
| GF Revenue | $0 | $0 | - | - | - |
| GF Expenditure | $790,900 | $2,637,600 | $2,224,500 | $2,823,000 | $3,854,400 |
| Net Effect | ($790,900) | ($2,637,600) | ($2,224,500) | ($2,823,000) | ($3,854,400) |

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

**Local Effect:** Any impact on local government finances is likely minimal and may be offset by fewer violations of current law.

**Small Business Effect:** Minimal. Because the bill requires compassion centers to operate on a nonprofit basis, the bill is not anticipated to have a significant impact on small businesses.

## Analysis

**Bill Summary:**

*Medical Marijuana Advisory Board*

The bill establishes a seven-member Medical Marijuana Advisory Board in DHMH, which must provide staff for the board. A member of the board – which must meet at least monthly – may not receive compensation as a member of the board but is entitled to reimbursement for expenses. The board is tasked with establishing a procedure (which must include a public hearing) for designating debilitating medical conditions; making recommendations to DHMH regarding regulations for the issuance of registry identification cards (*i.e.*, DHMH-issued documents that identify an individual as a qualifying patient, designated caregiver, or compassion center associate, and which may include a photograph if required by the department); and determining the circumstances in which it is medically appropriate for a practitioner to prescribe more than certain specified amounts of marijuana to a qualifying patient.

*Compassion Centers and Compassion Center Associates*

The bill establishes requirements for and limitations on the operation of "compassion centers" (*i.e.*, registered entities that acquire, possess, cultivate, manufacture, deliver, transport, supply, or dispense marijuana or related supplies and educational materials to – and only to – qualifying patients and designated caregivers). DHMH must, within 90 days of a compassion center's application, register the center for operation in the State

if (1) the center submits specified application materials, including a fee; (2) neither the center nor an affiliated marijuana cultivation center is located within 500 feet of a preexisting school; (3) issuing the registration would not violate a reasonable limitation on the number of centers that can register in the center's jurisdiction; and (4) none of the center's principal officers or board members (all of whom must be age 21 or older and residents of the State) has either been convicted of a felony or worked for a center that has had its registration revoked. Registration certificates are valid for one year and must be renewed within 10 days of a center's submission of a renewal fee (unless the center's registration has been suspended or revoked).

A compassion center is subject to certain limitations. For example, a center must operate on a nonprofit basis, as specified by the bill, is required to enact specified security measures, and is subject to reasonable inspection by DHMH with at least 24 hours' notice. In addition, the bill authorizes each county and municipality to enact reasonable limits and zoning regulations with regard to the number and location of centers that may operate in the jurisdiction. A center may cultivate marijuana (at the location of the center and in no more than one additional location) only in an enclosed and locked facility that is accessible solely to compassion center associates.

DHMH must issue a registry identification card – valid for up to one year and subject to renewal, suspension, and revocation as specified by the bill – to a "compassion center associate" (*i.e.*, a principal officer, board member, employee, volunteer, or agent of a compassion center) who meets specified requirements. For example, a compassion center associate must be age 21 or older and cannot have been convicted of a felony. (The bill authorizes, but does not require, DHMH to conduct a criminal background check of a compassion center associate.) If DHMH refuses to issue a registration identification card to a compassion center associate, the department must notify the compassion center in writing of the reason for the refusal.

A compassion center must provide DHMH with specified information regarding a compassion center associate both before the associate begins to work at the center and after the associate ceases to be affiliated with the center. An associate who fails to notify DHMH of a name or address change within 10 days of the change is subject to a civil penalty of up to $150.

*Qualifying Patients and Designated Caregivers*

DHMH is required to issue a registry identification card to a "qualifying patient" (*i.e.*, a State resident who has been diagnosed by a physician as having a debilitating medical condition) who submits required information to the department, as specified by the bill. A "debilitating medical condition" is a chronic or debilitating disease or medical condition (or the treatment of such a disease or condition) that produces one or more of

the following: (1) cachexia or wasting syndrome; (2) severe, debilitating, or chronic pain; (3) severe nausea; (4) seizures; (5) severe and persistent muscle spasms; (6) agitation of Alzheimer's disease; (7) anxiety; (8) depression; or (9) any other medical condition (or treatment of such a condition) that is approved by the Medical Marijuana Advisory Board, as specified by the bill. (The bill also identifies a number of specific conditions which fall under the definition of "debilitating medical condition.") A qualifying patient is subject to specified age restrictions and limits on the amount of marijuana that the patient may possess. DHMH is required to notify a qualifying patient, as specified by the bill, of clinical studies of the risk or efficacy of marijuana.

DHMH must issue a registry identification card to a "designated caregiver" (*i.e.*, an individual who has agreed to assist a qualifying patient with the medical use of marijuana) who meets specified requirements, but the department may issue a card to only one caregiver per qualifying patient. If DHMH does not issue a card to a designated caregiver, the department must notify the qualifying patient. A designated caregiver is subject to specified age requirements and limits on the amount of marijuana that the caregiver may possess. In addition, a designated caregiver may not have been convicted of specified crimes. A designated caregiver may receive compensation as specified by the bill. The bill does not establish limits on the number of qualifying patients a designated caregiver may assist.

The department is required to approve or deny the application or renewal of a qualifying patient within 15 days of receipt. In addition, DHMH must issue a registry identification card to a qualifying patient or designated caregiver within five days of approval. Denial of a qualifying patient's application is subject to judicial review in the circuit court.

A qualifying patient or designated caregiver is required to notify DHMH of specified changes within 10 days and is subject to a civil penalty of up to $150 for the failure to give such notice. In circumstances described by the bill, a new or updated registry identification card must be issued within a specified timeframe for a $10 fee.

An out-of-state registry identification card has the same force and effect in the State as a registry identification card issued by DHMH.

*Protections, Penalties, and Other Legal Considerations*

The bill repeals provisions of law allowing the imposition of a fine for the use or possession of marijuana or related paraphernalia for medical purposes. The bill also establishes, for specified persons acting in accordance with the bill, protections from arrest, criminal prosecution, specified penalties, and the denial of specified rights and privileges. In addition, a law enforcement agency is prohibited, in circumstances described by the bill, from providing information from an investigation related to medical

marijuana to a law enforcement agency that does not recognize the protections established by the bill. However, the bill may not be construed to prevent an occupational or professional licensing board from sanctioning a practitioner from violating standards of care.

The bill does not authorize a person to (1) undertake a task while under the influence of marijuana when doing so would constitute negligence or professional malpractice; (2) smoke marijuana on any form of public transportation or in any public place; (3) possess or use marijuana in a school bus, on school grounds, or in a correctional facility; (4) operate, navigate, or be in actual physical control of a motor vehicle, aircraft, or motorboat while under the influence of marijuana; or (5) use marijuana if the person does not have a debilitating medical condition. However, a qualifying patient who is a cardholder may not be considered to be under the influence solely for having marijuana metabolites in the patient's system.

Fraudulent representation to a law enforcement official of any fact or circumstance relating to the medical use of marijuana to avoid arrest or prosecution is punishable by a fine of $500 in addition to any other applicable penalties.

The bill may not be construed to require (1) a government medical assistance program or private insurer to reimburse a person for costs associated with the medical use of marijuana; (2) an employer to accommodate the medical use of marijuana in a workplace; or (3) a person to allow a guest, client, customer, or other visitor to use marijuana on or in property owned by the person.

An application for or possession of a registry identification card may not be used to support the search of a person or property but may not preclude the existence of probable cause on other grounds. In addition, the bill establishes a rebuttable presumption that a qualifying patient or designated caregiver is engaged in the medical use of marijuana if the patient or caregiver is in possession of a registry identification card and an allowable amount of marijuana.

For purposes of medical care, including organ transplants, the medical use of marijuana in accordance with the bill may not constitute the use of an illicit substance.

*Confidentiality and Verification System*

Applications and supporting information submitted under the bill are confidential, with the following exceptions: (1) a DHMH employee may, under specified circumstances, notify law enforcement officials about falsified or fraudulent information submitted to the department; (2) DHMH may, under specified circumstances, notify law enforcement officials about apparent criminal violations of the bill; and (3) a compassion center

associate may notify DHMH of a suspected or attempted violation of either the bill or regulations adopted under the bill. An individual who breaches the bill's confidentiality provisions is guilty of a misdemeanor and on conviction is subject to imprisonment for up to six months and/or a fine of up to $1,000.

Although the bill does not require DHMH to communicate on any specified basis with law enforcement, the department must, by October 1, 2013, establish a secure, password-protected, Internet-based, continuously operational verification system that may be used by law enforcement personnel and compassion center associates to verify registration identification cards. The verification system must allow users to access specified information, including the name and photograph (but not the address) of the cardholder and information regarding the date, time, and amount of marijuana dispensed to a qualifying patient or designated caregiver. The verification system must also include specified security features.

*Fees*

DHMH must adopt regulations that establish reasonable application and renewal fees for registry identification cards and compassion center registration certificates. Fees may not exceed $5,000 for compassion center registration applications or $1,000 for compassion center registration renewals. Application and renewal fees must generate revenues sufficient to offset the expenses of implementing and administering the bill. DHMH may accept donations from private sources in order to reduce fees and may vary fees along a sliding scale that accounts for a qualifying patient's income.

*Sanctions for Failure to Act*

If DHMH does not adopt required regulations by September 1, 2013, an action to compel the department to perform the actions mandated by the bill may be filed in circuit court by a qualifying patient, a prospective board member of a compassion center, or a prospective principal officer of a compassion center. Furthermore, if DHMH does not adopt regulations regarding applications for qualifying patients by September 1, 2013, a qualifying patient's notarized statement containing specified information must be deemed a valid registry identification card.

**Current Law:** In general, a defendant in possession of marijuana is guilty of a misdemeanor and subject to imprisonment for up to one year and/or a fine of up to $1,000. However, pursuant to Chapters 193 and 194 of 2012 (SB 214/HB 350), a person in possession of less than 10 grams of marijuana is subject to a reduced penalty of imprisonment for up to 90 days and/or a maximum fine of $500. The law went into effect on October 1, 2012.

The use or possession of less than 10 grams of marijuana may not be considered a lesser-included crime of any other crime unless specifically charged by the State. If a person is convicted of possessing less than 10 grams of marijuana, the court must stay any imposed sentence that includes an unserved, nonsuspended period of imprisonment without requiring an appeal bond (1) until the time for filing an appeal has expired and (2) during the pendency of a filed appeal of the conviction.

If the court finds that the defendant used or possessed marijuana out of medical necessity, the maximum punishment is a $100 fine. An affirmative defense is available to defendants for use or possession of marijuana or related paraphernalia due to a debilitating medical condition.

Pursuant to Chapters 504 and 505 of 2012 (SB 422/HB 261), as of January 1, 2013, a police officer must issue a citation for possession of marijuana if (1) the officer is satisfied with the defendant's evidence of identity; (2) the officer reasonably believes that the defendant will comply with the citation; (3) the officer reasonably believes that the failure to charge on a statement of charges will not pose a threat to public safety; (4) the defendant is not subject to arrest for another criminal charge arising out of the same incident; and (5) the defendant complies with all lawful orders by the officer. A police officer who has grounds to make a warrantless arrest for an offense that may be charged by citation may (1) issue a citation in lieu of making the arrest or (2) make the arrest and subsequently issue a citation in lieu of continued custody.

**Background:** In 1996, California became the first state to allow the medical use of marijuana. Since then, 17 other states (as well as the District of Columbia) have enacted similar laws. States with medical marijuana laws generally have some form of patient registry and provide protection from arrest for possession of up to a certain amount of marijuana for medical use. Maryland is an exception; although State law allows for medical necessity as an affirmative defense, it does not provide a means for patients to actually obtain marijuana.

*Federal Activity*

Marijuana is classified as a Schedule I controlled substance at the federal level, making distribution a federal offense. In October 2009, the Obama Administration sent a memorandum advising federal prosecutors that it is not an efficient use of resources to prosecute individuals who use marijuana for medical purposes in accordance with state laws. In June 2011, however, the Obama Administration sent another memorandum advising that, while this view of the efficient use of resources had not changed, persons who are in the business of cultivating, selling, or distributing marijuana (and those who knowingly facilitate such activities) are in violation of federal law and are subject to federal enforcement action.

*State Activity*

Chapter 215 of 2011 (SB 308) required the Secretary of Health and Mental Hygiene to convene a workgroup to develop a model program for facilitating patient access to marijuana for medical purposes. The Secretary was required to report, by December 1, 2011, on the workgroup's findings, including draft legislation that would establish a program to provide access to marijuana in the State for medical purposes. Due to a lack of consensus, the workgroup ultimately submitted two separate plans for consideration by the General Assembly: one that was based on an investigational use model and another that more closely resembled the traditional medical marijuana program model that is used in other states. While both plans were considered during the 2012 session, neither bill passed.

**State Fiscal Effect:**

*Assumptions*

Based largely upon information gathered from other states (and in particular, from Colorado, which has a population similar to that of Maryland) and accounting for differences, where they exist, between other states' programs and this legislation, DLS relied upon the following assumptions in preparing this estimate:

- Neither revenues nor expenditures are affected in fiscal 2013, during which time board members are appointed and DHMH begins developing regulations with existing staff.

- The first qualifying patients and designated caregivers will be registered no earlier than fiscal 2016 due to the bill's requirement that DHMH take certain actions associated with program implementation. Specifically, the bill tasks DHMH with establishing the Medical Marijuana Advisory Board, developing regulations, and developing and reviewing applications for participation. In addition, DHMH must have in place, before any marijuana is dispensed, a verification system and an infrastructure for issuing registry identification cards. It is, therefore, assumed that, consistent with the experience of other states (including Colorado), preparation for implementation is likely to take at least two years.

- The adoption by DHMH of regulations by September 1, 2013, is not feasible even on an emergency basis. However, given the timeline specified in the bill, aggressive implementation is assumed. The estimate does not account for any potential legal costs resulting from the bill's establishment of a right of action for DHMH's failure to adopt regulations by the specified date.

- The number of registered qualifying patients and designated caregivers is likely to grow significantly in the early years of implementation before reaching a point of saturation after several years. The number of registrants in Colorado, for example, increased from approximately 500 to approximately 110,000 (where the number of registrants has apparently leveled off) in a span of several years. Accordingly, it is assumed that there will be 5,000 registered patients in the first year of implementation, 15,000 in the second year of implementation, and 30,000 in the third year of implementation. It is further assumed, based on other states' experience, that 20% of qualifying patients will require the registration of a designated caregiver.

- Qualifying patients and designated caregivers are likely to pay a registration fee of $100 (which is similar to the registration fee charged by other states). DLS notes that DHMH may set registration fees on a sliding scale; however, the number of registrants who may pay discounted fees on such a scale cannot reliably be determined. Actual registration fees may vary in accordance with registrants' income levels.

- The amount of fees likely to be collected from compassion centers cannot be reliably estimated at this time. The bill limits fees to $5,000 for initial applications and $1,000 for renewals. However, DLS notes that the bill's requirement for compassion centers to operate on a nonprofit basis may result in fewer compassion centers than would likely participate otherwise. Thus, DLS advises that the number of centers that will participate cannot be reliably determined at this time. However, DLS further advises that, given program costs (and depending on how many centers actually participate), DHMH may be unable to collect sufficient revenues to offset program costs without exceeding the fee limits set by the bill.

- The bill authorizes DHMH to accept donations from private sources in order to reduce fees. However, DLS does not anticipate significant additional funds from any source. All revenues and expenditures are assumed to be general funds.

- Any additional payments to the Criminal Justice Information System (CJIS) for criminal history records checks are cost-recovery only. CJIS can handle the bill's requirements with existing resources. Revenues and expenditures do not account for any potential violations of the bill.

- Compassion centers are readily able to obtain the necessary seeds to cultivate marijuana and harvest it for purchase by qualifying patients and designated caregivers. Any delay for germination and growth of plants has not been accounted for in the estimate.

Regardless of how many compassion centers eventually participate in the program, DLS notes that fees generated under the bill are unlikely to offset the cost of program administration in the initial years of implementation. This situation is likely unavoidable due to one-time start-up costs, some of which are incurred before any revenues are generated. DLS advises that, in other states with medical marijuana programs, revenues have exceeded administration costs within a few years of program implementation. (For point of reference, program revenues in Colorado currently exceed program expenditures by 16.5%, which is the statutory limit.) However, the bill's requirement for compassion centers to operate on a nonprofit basis is likely to constrain the growth of the program (and, accordingly, reduce potential revenues). DLS advises that the actual rate of program growth and number of registrants and compassion centers could vary significantly from the estimates in this fiscal and policy note; program costs will vary accordingly.

Finally, DLS notes that the estimates discussed below differ from DHMH's estimate, which is based on costs associated with a fully implemented program and does not account for any revenues. The estimates below reflect the phasing in of staff and shifting of staff duties in accordance with a more likely timeline for program development, implementation, and growth. Expenditures reflect staff increases in accordance with the program's growth, annual salary increases, employee turnover, and annual increases in ongoing operating expenses.

*Fiscal 2014 – Establishing the Board and Developing Regulations*

Revenues are not generated in fiscal 2014, during which time DHMH establishes the board and begins to develop regulations to implement the bill.

General fund expenditures increase by $790,870 in fiscal 2014. The estimate includes $100,000 for one-time contractual services for a consultant to assist with the development of regulations related to security. It also includes $690,870 for staffing and operating costs necessary to provide administrative support to the board and assist with the development of regulations. Staff includes one full-time program director, one full-time staff attorney, three full-time program administrators, one full-time agronomist, one full-time pharmacist, and two full-time administrative aides.

*Fiscal 2015 – Reviewing Applications, Installing Verification System, and Preparing for Implementation*

Revenues are not generated in fiscal 2015, during which time DHMH reviews applications, installs a verification system, and establishes an infrastructure for issuing registry identification cards.

General fund expenditures increase by $2.6 million in fiscal 2015. The estimate reflects $500,000 for one-time software and contractual services associated with the development of a verification system; $500,000 for one-time equipment and contractual services associated with developing the infrastructure for issuing registry identification cards; and $1.6 million for ongoing and additional staff, including two full-time systems administrators, two full-time information technology specialists, five full-time inspectors (who can later shift from reviewing applications to conducting inspections), two full-time administrative specialists, and two full-time administrative aides.

DLS advises that costs associated with the issuance of registry identification cards could vary widely depending on how cards are issued in practice. (For example, because the bill specifies that DHMH must issue the identification cards, it is unlikely that an existing system which already has unique identifiers such as soundex numbers could be utilized. It is also unclear whether patients would be registered on a centralized or regional basis.)

*Fiscal 2016 – First Year of Implementation*

General fund revenues increase by at least $600,000 in fiscal 2016, which reflects the registration by DHMH of 5,000 qualifying patients and 1,000 primary caregivers. General fund revenues also increase significantly to reflect fees collected by DHMH from compassion centers; however, the exact amount of this increase cannot be reliably determined at this time, as discussed above.

General fund expenditures increase by $2.2 million in fiscal 2016 for ongoing expenses and to hire additional staff to conduct inspections and register qualifying patients and primary caregivers. The estimate reflects the hiring of two full-time inspectors, four full-time administrative specialists, and two full-time administrative aides.

*Fiscal 2017 – Second Year of Implementation*

General fund revenues increase by at least $1.8 million in fiscal 2017, which reflects the registration by DHMH of 15,000 qualifying patients and 3,000 primary caregivers. General fund revenues also increase significantly to reflect fees collected by DHMH from compassion centers; however, the exact amount of this increase cannot be reliably determined at this time, as discussed above.

General fund expenditures increase by $2.2 million in fiscal 2017 for ongoing expenses and to hire additional staff in accordance with the growth of the program. The estimate reflects the hiring of six full-time administrative specialists and two full-time administrative aides.

*Fiscal 2018 – Third Year of Implementation*

General fund revenues increase by at least $3.6 million in fiscal 2015, which reflects the registration by DHMH of 30,000 qualifying patients and 6,000 primary caregivers. General fund revenues also increase significantly to reflect fees collected by DHMH from compassion centers; however, the exact amount of this increase cannot be reliably determined at this time, as discussed above.

General fund expenditures increase by $3.9 million in fiscal 2018 for ongoing expenses and to hire additional staff in accordance with the growth of the program. The estimate reflects the hiring of 10 full-time administrative specialists and three full-time administrative aides.

## Additional Information

**Prior Introductions:** HB 15 of 2012, a similar bill, as introduced, passed the House with amendments, but no further action was taken. HB 1388 of 2010 was withdrawn without a hearing.

**Cross File:** None.

**Information Source(s):** Caroline, Howard, and Montgomery counties; Baltimore City; Governor's Office of Crime Control and Prevention; Department of Health and Mental Hygiene; Judiciary (Administrative Office of the Courts); Maryland Association of Counties; Maryland Municipal League; Office of the Public Defender; Department of Public Safety and Correctional Services; State's Attorneys' Association; Department of Legislative Services

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