IS THE GRASS ALWAYS GREENER? AN UPDATED LOOK AT OTHER STATE MEDICAL MARIJUANA PROGRAMS

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FOREWORD

During the 2000 Regular Session, the Hawaii Legislature enacted the Medical Use of Marijuana law, codified as Part IX of Chapter 329, Hawaii Revised Statutes. Essentially, the medical use of marijuana by qualifying individuals in Hawaii is permitted under certain conditions. However, the law does not provide these individuals with a legal method of obtaining medical marijuana.

Pursuant to Act 29, First Special Session Laws of Hawaii 2009, the Bureau conducted a study on the policies and procedures of other state medical marijuana programs, with regard to issues of access, distribution, and security. In a report submitted in August 2009, the Bureau found that, of the thirteen states that had established medical marijuana programs, only three states had policies and procedures to address these issues. The Bureau further determined that, even in these three states, the policies and procedures were still in a very early stage of development.

This report was undertaken in response to House Concurrent Resolution No. 48, H.D. 2, S.D. 1 (2014). The Bureau was requested to complete and submit to the Medical Marijuana Dispensary System Task Force "an updated report on the policies and procedures for access, distribution, security, and other relevant issues related to the medical use of cannabis in all states that currently have a medical cannabis program[.]"

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EXECUTIVE SUMMARY

History of Hawaii's Medical Marijuana Program

Hawaii was the first state to establish a medical marijuana program by legislation rather than by ballot initiative. Authorized by Act 228, Session Laws of Hawaii 2000. Hawaii's medical marijuana program became effective on June 14, 2000, and is codified as part IX, chapter 329, Hawaii Revised Statutes (HRS). The Department of Public Safety adopted administrative rules to implement the provisions of Act 228 on December 28, 2000.

Current Operating Structure of the Hawaii Medical Marijuana Program

Currently administered by the Department of Public Safety, the Hawaii medical marijuana program affords certain protections to qualifying patients, primary caregivers, and treating physicians by providing that the medical use of marijuana is an affirmative defense to any prosecution involving marijuana, so long as the qualifying patient or primary caregiver has strictly complied with the requirements of the program. Hawaii law also provides that no physician shall be subject to arrest or prosecution, penalized in any manner, or denied any right or privilege for providing written certification for the medical use of marijuana for a qualifying patient so long as the physician strictly complies with the requirements of the program. The cumulative effect of these protections is the decriminalization of medical use of marijuana by qualifying patients.

Under the Hawaii medical marijuana program, the medical use of marijuana by a qualifying patient is permitted only so long as the amount of marijuana possessed does not exceed "an adequate supply," which Hawaii state law presently defines as not more than three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant, jointly possessed between a qualifying patient and a primary caregiver.

In order to qualify as a patient under the program, a person must have written certification from a physician, affirming that the person has been diagnosed with a debilitating medical condition and that the potential benefits of the medical use of marijuana would likely outweigh the health risks for the particular qualifying patient.

Qualifying patients and their primary caregivers are required to provide registration information for a confidential patient registry administered by the Department of Public Safety in order to participate in the medical marijuana program. Upon verification of registration information, the Department of Public Safety issues registry identification certificates. Failure to obtain a registry identification certificate would disqualify a patient or caregiver from participating in the medical marijuana program and could render the person subject to criminal prosecution.

Issues that Remain Uncertain Under Hawaii's Medical Marijuana Program

Access to Medical Marijuana

Although the Hawaii medical marijuana program permits qualifying patients to use medical marijuana, it does not provide patients with a method of obtaining marijuana other than by allowing the patient or caregiver to grow a limited amount of marijuana. Under federal law, pharmacies are only permitted to dispense medications that have been prescribed. However, since marijuana is classified under federal law as a Schedule I controlled substance, physicians are not allowed to write prescriptions for its use. Under Hawaii law, a physician does not prescribe marijuana for medical purposes, but merely issues a written certification to a qualifying patient. The law is silent regarding how the qualifying patient is to obtain the marijuana.

Furthermore, while the State's medical marijuana program permits a qualifying patient and primary caregiver to grow marijuana plants for the patient's medical use, the program does not supply marijuana seeds or plants, nor provide a source or means of obtaining them. Nor does the program offer guidance on the cultivation of marijuana. Moreover, the sale of marijuana in any amount is strictly prohibited under state law. As a result, there is no place within the State where a person, even a qualifying patient with a valid registry identification certificate, can legally purchase marijuana.

Transportation of Medical Marijuana in Hawaii

Federal law does not allow for the interstate transportation of medical marijuana, or transportation of medical marijuana through federal security checkpoints. However, as an island state, Hawaii must contend with a layer of potential federal intervention that other states may not otherwise have to contend with when implementing an efficient medical marijuana dispensing program. The vast majority of passengers who travel between Hawaii and other states, or from one of Hawaii's islands to another, do so primarily via commercial passenger aircraft and traverse federal Transportation Security Administration checkpoints located in airports operated by the State of Hawaii. Further, federal authorities have long recognized that the channels between the State's major islands are international waters, and thus, travel by air or sea between those islands constitutes interstate travel, even though the destinations are within a single state. The potential for federal prosecution of Hawaii qualified patients traveling interisland who possess medical marijuana underscores the need for any medical marijuana dispensing strategy developed by the state of Hawaii to recognize and address this concern.

Moreover, Hawaii state law remains unsettled concerning the transportation of medical marijuana outside the home, given the inconsistency in Hawaii law between the definition of "medical use" in section 329-121, HRS, which includes the "transportation of marijuana," and the prohibition on the use of medical marijuana in any "place open to the public" under section 329-122(c)(2)(E), HRS. In 2013, the Hawaii Supreme Court overturned a qualifying patient's conviction for promoting a detrimental drug in the third degree, in relation to his possession of medical marijuana in a public place, but emphasized that the decision applied only to the specific facts and circumstances of that case. The court held that there was an "irreconcilable

inconsistency between the authorized transportation of medical marijuana under HRS § 329-121, and the prohibition on transport of medical marijuana through 'any . . . place open to the public' under HRS § 329-122(c)(E)." Thus, under the rule of lenity, the defendant was entitled to an affirmative defense and a judgment of acquittal. The court explicitly did not address whether other circumstances, including other locations or modes of transportation, may similarly trigger the rule of lenity, which strictly construes an ambiguous statute against the government and in favor of the accused. However, the court noted that Hawaii's medical marijuana laws do not explicitly provide for how medical marijuana would initially arrive at the qualifying patient's home, nor provide for its possession outside the home, even though "qualifying patients, like other ordinary people, may be absent from the home" for legitimate purposes.

Thus, at present, it is uncertain whether or to what extent a Hawaii qualifying patient or caregiver may transport medical marijuana anywhere outside the home, even when limited to travel within the same island, without violating state drug enforcement laws. The inconsistency between sections 329-121 and 329-122, HRS, presently presents an impediment to an effective medical marijuana distribution system in Hawaii and would need to be addressed if the State is to implement a distribution system.

Recent Developments in Hawaii's Medical Marijuana Laws

During the Regular Session of 2013, two laws were enacted that will have a significant effect on Hawaii's medical marijuana program commencing in January 2015.

Act 177, Session Laws of Hawaii 2013

Act 177, Session Laws of Hawaii 2013, implements the 2009 Medical Cannabis Working Group's recommendation to transfer the administration of Hawaii's medical marijuana program from the Department of Public Safety to the Department of Health no later than January 1, 2015.

Act 178, Session Laws of Hawaii 2013

Aside from making various technical as well as conforming amendments that address the transfer of administration of the medical marijuana program to the Department of Health in 2015, the most significant amendment to the Hawaii medical marijuana program included in Act 178, Session Laws of Hawaii 2013, is that, beginning January 2, 2015, the definition of "adequate supply" will change from "three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant" to "seven marijuana plants, whether immature or mature, and four ounces of usable marijuana at any given time."

No One "Model" Program

Twenty-three states have medical marijuana programs: Alaska, Arizona, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Vermont, and Washington. As would be expected, there are some issues or program characteristics that all or nearly all of the states with medical marijuana programs have addressed in one fashion or another. Exactly how they have addressed these issues or characteristics likely depends in large part upon a number of factors, which may include the size of their medical marijuana patient population, whether the majority of their population lives in urban or rural areas, whether distance from or access to medical marijuana is an issue, support for such programs within the state's population and among its decision-makers, what is politically feasible at the time the program is established, and other factors that may be peculiar to a particular state.

As a result, there are many similarities, as well as many differences, among the various states' medical marijuana programs. Accordingly, there does not appear to be any one model that can be touted as an exemplary program that all states should follow. Moreover, while many states have established medical marijuana programs, some of these are relatively new, and the programs, or aspects of the program such as the distribution systems, are not yet operational. For example, while eighteen states provide for distribution systems, only eight states (Arizona, California, Colorado, Maine, New Jersey, New Mexico, Rhode Island, and Vermont) have operational distribution systems. Further, it should be noted that many of the earlier states to adopt medical marijuana programs did not provide for distribution systems at that time. Thus only a few states have much of a track record concerning programmatic aspects of a medical marijuana distribution system and such concomitant issues as those relating to cultivation, access, safety, security, etc. That said, some general observations and conclusions about the states' medical marijuana programs may be made.

General Program Characteristics of State Medical Marijuana Programs

All states with medical marijuana programs:

(1) Provide for the removal of state-level criminal penalties for the use of marijuana for medical purposes;

(2) Require that qualifying patients be certified by a physician as having a medical condition that would benefit from the medical use of marijuana; and

(3) Specify the maximum amount of medical marijuana that a qualifying patient and caregiver may possess.

Finally, nearly all of the state programs, with the exception of Washington, have confidential patient registries that are administered by a state agency.

Access to Medical Marijuana

Of the twenty-three states that have medical marijuana programs, fifteen (Alaska, Arizona, California, Colorado, Hawaii, Maine, Massachusetts, Michigan, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont, and Washington) allow qualifying patients to cultivate marijuana, under certain conditions, and eighteen (Arizona, California, Colorado, Connecticut, Delaware, Illinois, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, and Vermont) incorporate some form of distribution system into their programs. Further, ten (Arizona, California, Colorado, Maine, Massachusetts, Nevada, New Mexico, Oregon, Rhode Island, and Vermont) of the twenty-three states appear to both allow patients to cultivate marijuana and provide for medical marijuana dispensaries.

Regulation of Distribution Systems

Of the eighteen states with some form of medical marijuana distribution system, seventeen states (with the exception of California) provide for statewide regulation of the distribution systems. In a majority of these states (Arizona, Delaware, Maine, Massachusetts, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oregon, and Rhode Island), the entity responsible for regulation is the state health agency. In a different mix of a majority of states (Arizona, Delaware, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Hampshire, New York, Oregon, Rhode Island, and Vermont), the regulation takes the form of a registration requirement. In other states, regulation is through a licensure (Colorado, Connecticut, Maryland, and New Mexico) or permit (New Jersey) requirement. In yet a differing majority of these states (Arizona, Colorado, Delaware, Maine, Massachusetts, Minnesota, New Hampshire, New Jersey, New Mexico, New York, Rhode Island, and Vermont), the same regulated third party entity may both cultivate and dispense medical marijuana.

Common Elements of Statewide Distribution Systems

Other issues or program characteristics generally considered by the states with medical marijuana programs that provide for some type of statewide distribution systems, and ways the majority of states have addressed these issues or characteristics, are as follows:

- **Fees and Taxes**

  All seventeen of these states impose one or more operational fees, at widely varying amounts, on medical marijuana cultivation centers and dispensaries, and most (with the exception of Massachusetts, Minnesota, New Hampshire, Oregon, and Vermont) also impose various state or local taxes on the sale of medical marijuana.

- **Training and Educational Requirements**

  The majority of these states (with the exception of Illinois, Maryland, and New York) appear to have incorporated some level of training requirements for medical marijuana dispensary staff, and most (with the exception of Colorado, Maryland, Minnesota, and Oregon) also require that certain educational information be provided to patients.

- **Labeling**

  Most states (with the exception of Maryland) have also adopted some form of labeling requirement for medical marijuana products; however, these requirements differ widely among the states.

- **Quality Control**

  At least eleven of the seventeen states (Colorado, Connecticut, Delaware, Illinois, Maine, Minnesota, Nevada, New Hampshire, New Mexico, New York, and Oregon) have statutory provisions that address quality control to some extent. Of these, nine states (Colorado, Delaware, Illinois, Maine, Minnesota, Nevada, New Mexico, New York, and Oregon) have provisions that involve marijuana testing.

- **Quantity Control**

  The majority of states (with the exception of Colorado, New Mexico, and Oregon) also appear to generally control the supply of medical marijuana by establishing either minimum or maximum limits on the number of cultivation centers or dispensaries that may be operated in the state. Further, nearly half of the states (Colorado, Maine, New Hampshire, New Jersey, New Mexico, Oregon, Rhode Island, and Vermont) provide for a limitation on the inventory of cultivation centers or dispensaries.

  The majority of the seventeen states (with the exception of Maryland and New Mexico) also limit the amounts of medical marijuana that dispensaries may provide to patients, which generally coincide with, or at least prevent exceeding, a patient's legal possession limits. Finally, the statutes in a number of states (Colorado, Delaware, Illinois, Maine, Nevada, New Hampshire, Rhode Island, and Vermont) also provide that a patient may only obtain marijuana from a particular dispensary if that dispensary has been designated by the patient.

- **Limits on Channels of Supply and Distribution**

  The regulatory statutes of all seventeen states establish controls on the channels of supply and distribution of medical marijuana. Generally, these statutes establish a closed circuit in which medical marijuana circulates only among cultivation centers, dispensaries, patients, and their caregivers. To this end, the majority of states

(Arizona, Connecticut, Delaware, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Hampshire, New York, Rhode Island, and Vermont) place restrictions on the cultivation site by specifying that the cultivation center may cultivate marijuana only in an enclosed, locked facility, and nearly half of these states (Arizona, Delaware, Illinois, Maine, Nevada, New Hampshire, and Vermont) also require that access to the facility be restricted.

To maintain this closed circuit, a number of states (Arizona, Connecticut, Delaware, Illinois, Maine, Nevada, New Mexico, Oregon, and Vermont) also limit the external sources from which cultivation centers or dispensaries may obtain medical marijuana that they themselves do not cultivate; these permissible sources include other dispensaries, other cultivation centers, or patients or their caregivers.

The states also limit the entities to whom medical marijuana may be distributed. All seventeen states specify that a dispensary may distribute medical marijuana to two entities -- a patient or the patient's caregiver. Ten of these states (Connecticut, Illinois, Maine, Maryland, Massachusetts, Minnesota, New Jersey, Oregon, Rhode Island, and Vermont) limit distribution to only those two entities. Another six states (Arizona, Colorado, Nevada, New Hampshire, New Mexico, and New York) also permit a dispensary to distribute medical marijuana to another dispensary.

- **Security Requirements**

  Finally, all seventeen states require their cultivation centers and dispensaries to comply with various security requirements. These requirements range from as simple as installing a functional security alarm, to requiring facilities to meet certain design specifications. The majority of states (with the exception of Maryland, Minnesota, New Mexico, New York, and Rhode Island) require, at minimum, installation of an alarm system and video surveillance of the premises, and most states (with the exception of Maryland, New Mexico, and New York) impose various additional security requirements.

Medical Marijuana Programs Resist Simple Categorization

There may be a tendency to want to categorize medical marijuana programs along artificial lines (such as restrictive or nonrestrictive programs) in order to better grasp the similarities and differences of programs established by other states. The reader is cautioned against such an attempted approach, however, given the wide variation in how states have addressed the issues and program characteristics in establishing their medical marijuana programs. Such an approach would seem too simplistic and would ignore significant nuances of each state's program.

Limited Access Marijuana Product Laws

In addition to the twenty-three states with medical marijuana programs, eleven other states have enacted limited access marijuana product laws over the past year that make provision for the use of certain strains of marijuana for limited medical or research purposes. While not as comprehensive as more traditional medical marijuana programs, these limited access laws have the attraction of focusing on strains of marijuana that have little or no psychoactive effects. As a result, an increasing number of states have shown interest in pursuing similar laws.

Federal Position on the Medical Use of Marijuana

Controlled Substances Act

The Controlled Substances Act, enacted by the United States Congress in 1970, is the basis for federal drug policy under which the manufacture, use, possession, and distribution of certain substances is regulated. The Controlled Substances Act classifies marijuana as a Schedule I substance, which means that the federal government considers marijuana to have a high potential for abuse and no currently accepted medical use in treatment in the United States.

United States Department of Justice Guidelines

On October 19, 2009, the United States Department of Justice issued a memorandum that advised federal prosecutors in states with medical marijuana programs to refrain from pursuing cases against individuals for marijuana offenses that did not violate state medical marijuana laws.

In a subsequent memorandum issued on August 29, 2013, the Department of Justice clarified its position on marijuana by enumerating specific nationwide enforcement priorities and noted that it 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 and that it has generally left enforcement to state and local authorities unless the marijuana-related activities run afoul of the enumerated enforcement priorities.

The Department of Justice indicated that it is inclined to defer to state and local enforcement in states that authorize the production, distribution, and possession of medical marijuana, provided the affected states 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. However, the 2013 memorandum also warned that states that enact marijuana legalization schemes but fail to implement them effectively could be subject to federal intervention.

United States Department of the Treasury Guidelines

Marijuana-related businesses have complained that federal marijuana prohibitions, combined with federal requirements regarding financial institutions, block their access to banking and credit card services and limit them to cash transactions that raise security concerns. Banks have also raised concerns that providing services to marijuana-related businesses could subject them to federal penalties. These combined concerns resulted in medical marijuana-related businesses being unable to deposit revenues from their businesses into financial institutions.

Given these concerns, the United States Department of the Treasury issued a memorandum on February 14, 2014, to clarify Bank Secrecy Act expectations for financial institutions, such as banks, that seek to provide services to medical marijuana-related businesses.

The Treasury memorandum establishes guidelines to clarify and streamline federally-required reporting requirements for financial institutions seeking to provide financial services to medical marijuana-related businesses. The Treasury memorandum provides guidance on how to indicate whether or not the marijuana-related business raises suspicion of any illegal activity, other than a violation of the federal prohibitions against marijuana, or any activity that implicates any of the Department of Justice's enforcement priorities regarding marijuana.

Recent Federal Developments

Pending Legislation

There do not appear to be any strong indications that the United States Congress will approve the legalization of marijuana for medical purposes in the near future. However, it is possible that Congress will prohibit certain federal spending on enforcement that interferes with state implementation of laws authorizing the use of medical marijuana, which could effectively curtail federal enforcement.

The United States House of Representatives has approved an amendment to an appropriations bill that would, if approved by the Senate and the President, prohibit the United States Department of Justice from spending federal funds in federal fiscal year 2015 to prevent states from implementing state laws that authorize the use, distribution, possession, or cultivation of marijuana for medical purposes. It should be noted that, as currently drafted, the measure would not explicitly preclude federal enforcement of prohibitions against marijuana despite state legalization schemes and could therefore be subject to interpretation. Also, the measure would not affect federal spending for such purposes in subsequent years.

Proposed Legislation

In addition to the pending legislation discussed above, other bills or amendments to existing bills have recently been proposed. For example, on July 24, 2014, an amendment was proposed to a bill being heard by the United States Senate that would recognize the right of states to enact laws that authorize the use, distribution, possession, or cultivation of marijuana for medical use.

On July 28, 2014, a bill was introduced to the United States House of Representatives that would remove therapeutic hemp and cannabidiol from the definition of marijuana in the Controlled Substances Act. If enacted, most strains of marijuana would still be prohibited under federal law. However, strains of marijuana with extremely low THC concentrations and cannabidiol oil would effectively become legal on a national basis.

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Chapter 1

INTRODUCTION

State Medical Marijuana Programs

House Concurrent Resolution No. 48, H.D. 2, S.D. 1 (2014) (hereinafter "Resolution") -- the measure to which this report responds -- is attached as Appendix A. Specifically, the Resolution directs the Bureau to "report on the policies and procedures for access, distribution, security, and other relevant issues related to the medical use of cannabis in all states that currently have a medical cannabis program[.]"

Scope of the Study

Colorado and Washington have enacted laws that effectively legalize the possession and use of marijuana by people within those states who are twenty-one years of age or older. However, since the Resolution directs the Bureau to report on *medical marijuana* programs, other programs, such as *"recreational marijuana"* or *"retail marijuana"* programs, are not addressed by this study.

Organization of the Study

Chapter 2 reviews the policies and procedures of the Hawaii medical marijuana program. Chapter 3 provides a general overview of the medical marijuana programs of other states. Chapter 4 examines the policies and procedures of states that currently have or are developing systems for distribution of medical marijuana. Chapter 5 discusses the federal government's position regarding state medical marijuana programs. Chapter 6 presents a brief summary.

Chapter 2

HAWAII MEDICAL MARIJUANA PROGRAM

Establishment of the Hawaii Medical Marijuana Program

Hawaii was the first state to establish a medical marijuana program by legislation rather than by ballot initiative.[1] Hawaii's medical marijuana program was authorized by Act 228, Session Laws of Hawaii 2000. Act 228 became effective on June 14, 2000, and is codified as part IX, chapter 329, Hawaii Revised Statutes (HRS) (entitled "Medical Use of Marijuana"). The Department of Public Safety adopted administrative rules to implement the provisions of Act 228 on December 28, 2000.[2]

Current Operating Structure of the Hawaii Medical Marijuana Program

Currently administered by the Department of Public Safety, the Hawaii medical marijuana program affords certain protections to qualifying patients, primary caregivers, and treating physicians. Specifically, section 329-125, HRS, provides that a qualifying patient or the primary caregiver of a qualifying patient may assert the medical use of marijuana as an affirmative defense to any prosecution involving marijuana, so long as the qualifying patient or primary caregiver has strictly complied with the requirements of the program. Similarly, section 329-126, HRS, provides that "[n]o physician shall be subject to arrest or prosecution, penalized in any manner, or denied any right or privilege for providing written certification for the medical use of marijuana for a qualifying patient[,]" so long as the physician strictly complies with the requirements of the program. The cumulative effect of these protections is the removal of state-level criminal penalties for the medical use of marijuana by qualifying patients.

Section 329-121, HRS, defines "medical use" as "the acquisition, possession, cultivation, use, distribution, or transportation of marijuana or paraphernalia relating to the administration of marijuana to alleviate the symptoms or effects of a qualifying patient's debilitating medical condition." A qualifying patient is generally allowed to select a primary caregiver, a person of at least eighteen years of age who agrees to undertake the responsibility for managing the well-being of the qualifying patient with respect to the medical use of marijuana.[3] Section 329-121, HRS, also states that "[f]or the purposes of 'medical use', the term distribution is limited to the transfer of marijuana and paraphernalia from the primary caregiver to the qualifying patient."

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[1] Alaska, California, Maine, Oregon, and Washington established medical marijuana programs by ballot initiative prior to the enactment of Hawaii's Act 228.

[2] Although the Hawaii medical marijuana program is currently administered by the Department of Public Safety, the program will be transferred to the Department of Health, beginning January 1, 2015. *See* discussion of Recent Developments, *infra*.

[3] In the case of a minor or an adult lacking legal capacity, the primary caregiver shall be a parent, guardian, or person having legal custody. Section 329-121, Hawaii Revised Statutes (HRS).

Under section 329-122, HRS, the medical use of marijuana by a qualifying patient is permitted only so long as the amount of marijuana does not exceed an "adequate supply," which restricts the amount of marijuana jointly possessed between a qualifying patient and a primary caregiver to "not more than is reasonably necessary to assure the uninterrupted availability of marijuana for the purpose of alleviating the symptoms or effects of a qualifying patient's debilitating medical condition[.]"[4] Specifically, this amount must not exceed "three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant."[5]

In order to qualify as a patient under the program, a person must have written certification from a physician, affirming that the person has been diagnosed with a debilitating medical condition and that "the potential benefits of the medical use of marijuana would likely outweigh the health risks for the particular qualifying patient[.]"[6] Section 329-126, HRS, requires a certifying physician to:

(1) Diagnose the patient as having a debilitating medical condition;

(2) Explain the potential risks and benefits of the medical use of marijuana;

(3) Complete a full assessment of the patient's medical history and current medical condition, in the course of a bona fide physician-patient relationship; and

(4) Register information regarding patients who have been issued written certifications with the Department of Public Safety.

Section 329-121, HRS, defines the term "debilitating medical condition" as:

(1) Cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, or the treatment of these conditions;

(2) A chronic or debilitating disease or medical condition or its treatment that produces one or more of the following:

(A) Cachexia or wasting syndrome;

(B) Severe pain;

(C) Severe nausea;

(D) Seizures, including those characteristic of epilepsy; or

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[4] *Id.*
[5] *Id. See also* discussion of Act 178, Session Laws of Hawaii 2013, *infra*.
[6] Section 329-122, HRS.

(E) Severe and persistent muscle spasms, including those characteristic of multiple sclerosis or Crohn's disease; or

(3) Any other medical condition approved by the Department of Health pursuant to administrative rules in response to a request from a physician or potentially qualifying patient.

Qualifying patients and their primary caregivers are required to provide registration information for a confidential patient registry administered by the Department of Public Safety in order to participate in the medical marijuana program.[7] Upon verification of registration information, the Department of Public Safety issues registry identification certificates. Failure to obtain a registry identification certificate would disqualify a patient or caregiver from participating in the medical marijuana program and could render the person subject to criminal prosecution.

Issues that Remain Uncertain Under Current State Law

Distribution of Medical Marijuana

Although the Hawaii medical marijuana program permits qualifying patients to use medical marijuana, it does not provide patients with a method of obtaining marijuana other than by allowing the patient or caregiver to grow the marijuana. Qualifying patients cannot simply have a prescription for medical marijuana filled at a pharmacy. Under federal law, pharmacies are only permitted to dispense medications that have been prescribed. However, since marijuana is classified under federal law as a Schedule I controlled substance, physicians are not allowed to write prescriptions for its use. Under Hawaii law, a physician does not prescribe marijuana for medical purposes, but merely issues a written certification to a qualifying patient. The law is silent regarding how the qualifying patient is to obtain the marijuana.

Furthermore, while the State's medical marijuana program permits a qualifying patient and primary caregiver to grow marijuana plants for the patient's medical use, the program does not supply marijuana seeds or plants, nor provide a source or means of obtaining them. Nor does the program offer guidance on the cultivation of marijuana. Moreover, the sale of marijuana in any amount is strictly prohibited under state law.[8] As a result, there is no place within the State where a person, even a qualifying patient with a valid registry identification certificate, can legally purchase marijuana.

After careful review of Hawaii's medical marijuana program, as codified under part IX of chapter 329, HRS (the Uniform Controlled Substances Act), and administered under chapter 23-202, Hawaii Administrative Rules, it appears that current state law is essentially silent with regard to issues of access, distribution, and security related to the medical use of marijuana.

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[7] Section 23-202-10, Hawaii Administrative Rules (HAR).
[8] Section 712-1247, HRS.

Transportation of Medical Marijuana

Hawaii law is unsettled with regard to the circumstances in which a qualifying patient or primary caregiver may legally possess or transport medical marijuana outside the home.

In 2013, the Hawaii Supreme Court overturned a qualifying patient's conviction for promoting a detrimental drug in the third degree, in relation to his possession of medical marijuana in a public place, but emphasized that the decision applied only to the specific facts and circumstances of that case.[9]

The case centered on the defendant's possession of marijuana in the Kona International Airport.[10] The parties stipulated that the marijuana was medical marijuana and that the defendant possessed a valid medical marijuana certificate. However, the State argued that the statutory prohibition on medical use of marijuana in public places, found in section 329-122(c)(2)(E), HRS, should be strictly construed to include strict prohibition on the transportation of medical marijuana, since "medical use" is defined in section 329-121, HRS, to include transportation of marijuana. The court held that "there is an irreconcilable inconsistency between the authorized transportation of medical marijuana under HRS § 329-121, and the prohibition on transport of medical marijuana through 'any . . . place open to the public' under HRS § 329-122(c)(E)" and that, under the rule of lenity, the defendant was entitled to an affirmative defense and a judgment of acquittal.[11]

The court explicitly did not address whether other circumstances, including other locations or modes of transportation, may similarly trigger the rule of lenity, which strictly construes an ambiguous statute against the government and in favor of the accused. However, the court noted that Hawaii law "makes no provision for how medical marijuana would even arrive at the qualifying patient's home,"[12] and "makes no provision for its possession outside the home, even though qualifying patients, like other ordinary people, may be absent from the home for many hours at a time; travel for extended periods of time; move residences; reside in more than one residence; evacuate their homes during emergencies like tsunami warnings, floods, and fires; and become homeless."[13] The court observed that "the lack of clarity in the statute is apparent" when considering what type of transport of marijuana would be legally permissible if transport cannot occur in a public place. Because such statutory construction would produce an "absurd result," the court concluded that "[t]his reading of HRS § 329-125's strict compliance *results in an impracticality the legislature could not have intended.*"[14]

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[9] *See State v. Woodhall*, 129 Hawaii 397, 301 P.3d 607 (2013).
[10] The marijuana was discovered at a Transportation Security Administration checkpoint, but there was no federal prosecution.
[11] *Woodhall*, 129 Hawaii at 410, 301 P.3d at 620.
[12] *Woodhall*, 129 Hawaii at 407, 301 P.3d at 617.
[13] *Id.*
[14] *Id.* at 409, 301 P.3d at 619 (emphasis added). The court's review of the legislative history surrounding Act 228, Session Laws of Hawaii 2000, establishing Hawaii's medical marijuana program, reveals that this issue was discussed at length, but not resolved. ("This legislative history reveals that even as Act 228 became law, many of the details were left to future legislative action but remain unclear over a decade later.") *Id.*

In a concurring and dissenting opinion, Chief Justice Mark E. Recktenwald agreed that it would be "absurd" to construe the statute to prohibit *all* transportation of medical marijuana in public places, as it would provide no mechanism for a patient to *initially* obtain or transport it, but he argued that there was no indication that the legislature intended to allow a patient to transport medical marijuana outside the home *after* obtaining an initial supply.[15]

The effective implementation of a medical marijuana distribution system in Hawaii will require resolution of this issue.

Recent Developments

During the Regular Session of 2013, two laws were enacted that will have a significant effect on Hawaii's medical marijuana program.

Act 177, Session Laws of Hawaii 2013

In October 2009, the Medical Cannabis Working Group (Working Group) was convened to examine Hawaii's medical marijuana program. In a report submitted to the Legislature in February 2010, the Working Group made several recommendations to improve the program -- four of which were designated as being of the highest priority. One of the recommendations that the Working Group considered to be of the highest priority was that oversight of Hawaii's medical marijuana program should be transferred from the Department of Public Safety to the Department of Health.[16] The Working Group believed that medical marijuana should be treated primarily as an issue of public health and expressed the view that law enforcement agencies, such as the Department of Public Safety, tend to have "little or no expertise in horticultural, health and medical affairs."[17] As a result, the Working Group concluded that the Department of Health was the agency best suited to administer Hawaii's medical marijuana program.

Act 177, Session Laws of Hawaii 2013, implements the Working Group's recommendation by, among other things, requiring that administration of Hawaii's medical marijuana program be transferred from the Department of Public Safety to the Department of Health and establishing a time frame for the transfer. Pursuant to Act 177, "[n]o later than January 1, 2015, all rights, powers, functions, and duties of the department of public safety relating to the medical use of marijuana under part IX of chapter 329, Hawaii Revised Statutes, shall be transferred to the department of health."[18]

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[15] *See Woodhall*, 129 Hawaii at 411-13, 301 P.3d at 621-23 (Recktenwald, C. J., concurring and dissenting).
[16] The Medical Cannabis Working Group also included the following in its list of recommendations that it considered to be of the highest priority: (1) creating a distribution system for medical marijuana; (2) increasing the allowable number of plants and usable marijuana per qualifying patient; and (3) allowing caregivers to care for at least five qualifying patients.
[17] Medical Cannabis Working Group, *Report to the Hawaii State Legislature*, 19 (February 2010).
[18] Section 4(a) of Act 177, Session Laws of Hawaii 2013.

Act 178, Session Laws of Hawaii 2013

Act 178, Session Laws of Hawaii 2013, makes various amendments to Hawaii's medical marijuana law, as codified in part IX, chapter 329, HRS. These include several technical amendments, as well as conforming amendments that address the transfer of administration of the medical marijuana program to the Department of Health. Beyond these amendments, the change that will have the most significant impact on the medical marijuana program is that, beginning January 2, 2015, the definition of "adequate supply" will change from "three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant" to "seven marijuana plants, whether immature or mature, and four ounces of usable marijuana at any given time."[19]

It should be noted that neither Act 177 nor Act 178 addresses the underlying inconsistency in Hawaii law with respect to the transportation of medical marijuana in public places.[20]

[19] Section 2 of Act 178, Session Laws of Hawaii 2013, and section 329-121, HRS.
[20] *See* notes 9-15, *supra*, and accompanying text.

Chapter 3

MEDICAL MARIJUANA USE IN OTHER STATES

Medical Marijuana Programs

Twenty-three states and the District of Columbia have established programs to legalize the use of marijuana for medical purposes. In addition to Hawaii, the twenty-two other states with medical marijuana programs are Alaska, Arizona, California, Colorado, Connecticut, Delaware, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Vermont, and Washington.

The medical marijuana programs of the other states generally approach the issue in a manner similar to the Hawaii medical marijuana program. Like the Hawaii program, the programs of the other states remove state-level criminal penalties for the use of marijuana for medical purposes. All the state programs require that qualifying patients be certified by a physician as having a medical condition that would benefit from the medical use of marijuana. While the lists of actual qualifying medical conditions vary from state to state, each state program specifies the conditions that qualify for legal protection.[1] Each state program also specifies the maximum amount of medical marijuana a qualifying patient and caregiver may possess. Finally, nearly all of the state programs establish, either by statute or administrative rule, confidential patient registries that are administered by a state agency -- often that state's agency responsible for health.[2] These agencies usually issue identification cards to qualifying patients and caregivers who have registered with their state's medical marijuana program.

The following table summarizes major policy components of the medical marijuana programs in the twenty-three states.[3] As the table below indicates, out of the twenty-three states with medical marijuana programs, only five states (Alaska, Hawaii, Michigan, Montana, and Washington) do not provide qualifying patients with a method of obtaining medical marijuana. This demonstrates a marked increase in medical marijuana programs that incorporate some form of distribution system.[4] In 2009, of the thirteen states that had medical marijuana programs, only

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[1] Each state has its own list of medical conditions that qualify for legal protection under its respective medical marijuana program. Generally, qualifying medical conditions tend to include chronic or debilitating diseases as well as conditions that involve seizures, muscle spasticity, chronic pain, or severe nausea. Many states also provide that medical conditions not specifically included in their programs' list of qualifying medical conditions may still qualify for legal protection if approved by the appropriate state agency.

[2] Washington appears to be the only state that has not provided for some type of patient registry, although the registries in six states (Illinois, Maryland, Massachusetts, Minnesota, New Hampshire, and New York) are not yet operational. *See* note 10, *infra*.

[3] Although the District of Columbia has established a medical marijuana program, it is not included on this table because the focus is on state medical marijuana programs.

[4] It should be noted that many of these states have established their medical marijuana programs recently and thus have not had sufficient time to implement their distribution systems. As a result, only eight states (Arizona, California, Colorado, Maine, New Jersey, New Mexico, Rhode Island, and Vermont) currently have operational distribution systems. *See* note 8, *infra*.

three states (California, New Mexico, and Rhode Island) made provisions for a system of distribution to allow qualifying patients to obtain medical marijuana safely and legally.

Table 3-1

MEDICAL MARIJUANA PROGRAMS:
MAJOR POLICY COMPONENTS

State and Year Established	Removes State-Level Criminal Penalties?	Establishes Patient Registry and Issues ID Cards?	Accepts Other States' Registry ID Cards?	Maximum Marijuana Amount Allowed	Allows Qualifying Patients to Cultivate Marijuana?	Allows Dispensaries?
Alaska (1998)	Yes	Yes	No	1 ounce, 6 plants (up to 3 mature plants)	Yes	No
Arizona (2010)	Yes	Yes	Yes[5]	2.5 ounces, 12 plants	Yes[6]	Yes
California (1996)	Yes	Yes	No	8 ounces, 6 mature plants (or 12 immature plants)	Yes	Yes
Colorado (2000)	Yes	Yes	No	2 ounces, 6 plants (up to 3 mature plants)	Yes	Yes
Connecticut (2012)	Yes	Yes	No	One-month supply[7]	No	Yes[8]
Delaware (2011)	Yes	Yes	No	6 ounces	No	Yes[8]
Hawaii (2000)	Yes	Yes	No	3 ounces, 7 plants (3 mature, 4 immature)[9]	Yes	No
Illinois (2013)	Yes	Yes[10]	No	2.5 ounces per 14-day period	No	Yes[8]

[5] Accepts out-of-state registry identification cards, but does not allow out-of-state patients to obtain marijuana from in-state dispensaries. *See* discussion of Reciprocity, *infra*.
[6] Home cultivation is allowed if residence is further than twenty-five miles from a state-licensed dispensary.
[7] Amount determined by the state Department of Consumer Protection.
[8] Although state law provides for a dispensary system, the dispensaries are not yet operational.
[9] Effective January 2, 2015, the definition of "adequate supply" will change to four ounces and seven plants (regardless of whether the plants are mature or immature). *See* section 329-121, Hawaii Revised Statutes.
[10] Although state law calls for the establishment of a patient registry and the issuance of identification cards, this system is not yet operational.

State and Year Established	Removes State-Level Criminal Penalties?	Establishes Patient Registry and Issues ID Cards?	Accepts Other States' Registry ID Cards?	Maximum Marijuana Amount Allowed	Allows Qualifying Patients to Cultivate Marijuana?	Allows Dispensaries?
Maine (1999)	Yes	Yes	Yes[5]	2.5 ounces, 6 mature plants	Yes	Yes
Maryland (2014)	Yes	Yes[10]	No	30-day supply[11]	No	Yes[8]
Massachusetts (2012)	Yes	Yes[10]	Unknown	60-day supply (10 ounces)	Yes[12]	Yes[8]
Michigan (2008)	Yes	Yes	Yes	2.5 ounces, 12 plants	Yes	No
Minnesota (2014)	Yes	Yes[10]	No	30-day supply of non-smokable marijuana	No	Yes[8]
Montana (2004)	Yes	Yes	No	1 ounce, 4 mature plants, 12 seedlings	Yes	No
Nevada (2000)	Yes	Yes	No	2.5 ounces per 14-day period, 12 plants	Yes[13]	Yes[8]
New Hampshire (2013)	Yes	Yes[10]	Yes[14]	2 ounces	No	Yes[8]

[11] Amount to be determined by the Natalie M. LaPrade Medical Marijuana Commission.

[12] During the period that the Massachusetts Department of Public Health implements its medical marijuana program, qualifying patients are permitted to cultivate a limited supply of marijuana sufficient to maintain a sixty-day supply. State law also authorizes the Department of Public Health to issue "hardship cultivation registrations" to qualifying patients who have limited access to a medical marijuana treatment center.

[13] Home cultivation is prohibited if a medical marijuana dispensary opens in the county where a qualifying patient or primary caregiver resides. However, this prohibition does not apply if:

(1) The dispensary is unable to produce the strain of marijuana necessary to treat the qualifying patient's specific medical condition;
(2) The qualifying patient or primary caregiver is unable to reasonably travel to a dispensary; or
(3) No dispensary was operating with twenty-five miles of the qualifying patient at the time the qualifying patient first applied for a registry identification card.

Also, qualifying patients or primary caregivers who were cultivating medical marijuana, in compliance with state law, prior to July 1, 2013, may continue to do so until March 31, 2016. *See* Section 453A.200, Nevada Revised Statutes.

[14] New Hampshire recognizes registry identification cards from out-of-state qualifying patients, provided that the qualifying patient has written certification of a qualifying medical condition recognized under New Hampshire law. Even so, out-of-state qualifying patients are not allowed to purchase or grow marijuana in New Hampshire. *See* discussion of Reciprocity, *infra.*

State and Year Established	Removes State-Level Criminal Penalties?	Establishes Patient Registry and Issues ID Cards?	Accepts Other States' Registry ID Cards?	Maximum Marijuana Amount Allowed	Allows Qualifying Patients to Cultivate Marijuana?	Allows Dispensaries?
New Jersey (2010)	Yes	Yes	No	2 ounces	No	Yes
New Mexico (2007)	Yes	Yes	No	6 ounces, 4 mature plants, 12 seedlings	Yes	Yes
New York (2014)	Yes	Yes[10]	No	30-day supply of non-smokable marijuana	No	Yes[8]
Oregon (1998)	Yes	Yes	No	24 ounces, 6 mature plants, 18 seedlings	Yes	Yes
Rhode Island (2006)	Yes	Yes	Yes	2.5 ounces, 12 mature plants, 12 seedlings	Yes	Yes
Vermont (2004)	Yes	Yes	No	2 ounces, 2 mature plants, 7 immature plants	Yes	Yes
Washington (1998)	Yes	No	No	24 ounces, 15 plants	Yes	No

Reciprocity

As the table above indicates, most states do not accept the registry identification cards of other states. Of the twenty-three states with medical marijuana programs, only five states (Arizona, Maine, Michigan, New Hampshire, and Rhode Island) accept the registry identification cards of other states. While this means that visiting patients with valid out-of-state registry identification cards would be entitled to protection under the laws of these five states, it should be noted that three of these states (Arizona, Maine, and New Hampshire) explicitly prohibit visiting patients from obtaining medical marijuana from in-state dispensaries. Although Rhode Island law has no such prohibition, it does define the term "qualifying patient" as a resident of the state. Therefore, as a practical matter, it does not appear that dispensaries in Rhode Island would be permitted to dispense medical marijuana to visiting patients. Since Michigan has no distribution system, it appears that none of the five states that accept out-of-state registry identification cards provide a method for visiting patients to obtain medical marijuana.

Limited Access Marijuana Product Laws

In addition to the twenty-three states that have enacted medical marijuana programs, eleven states (Alabama,[15] Florida,[16] Iowa,[17] Kentucky,[18] Mississippi,[19] Missouri,[20] North Carolina,[21] South Carolina,[22] Tennessee,[23] Utah,[24] and Wisconsin[25]) have recently enacted statutes that, while not as comprehensive, provide for very limited access to marijuana for medical use. Unlike comprehensive medical marijuana programs, which generally provide for the use of a variety of marijuana strains, the statutes of these eleven states make provisions only for certain strains of marijuana and for limited medical or research purposes.

These statutes, often referred to as "limited access marijuana product laws," generally make provisions only for marijuana or marijuana-derived products that have low concentrations of tetrahydrocannabinol (THC), the main psychoactive constituent in marijuana. Some states additionally require that marijuana products have high concentrations of cannabidiol, a chemical compound of marijuana that is believed to be effective in the treatment of seizures and may counteract the psychoactive effects of THC. Most limited access states also specify that these types of marijuana products may only be used for treatment or research of specific health disorders, such as epileptic conditions or seizures.

Distribution models within these limited access states vary widely. Five states (Alabama,[26] Kentucky,[27] Mississippi,[28] Tennessee,[29] and Utah[30]) limit distribution of medical marijuana products to educational institutions. Florida limits distribution to five dispensing organizations, each located in a different state region.[31] Missouri authorizes the establishment of two cultivation and production facilities in the state, which will dispense products at cannabidiol oil care centers.[32] North Carolina does not specify a distribution model, other than to require that marijuana products be acquired from another jurisdiction.[33] South Carolina's law is silent regarding the manufacture and distribution of marijuana products, but does stipulate that clinical trials and products to be dispensed as part of any clinical trials are subject to approval by the United States Food and Drug Administration.[34] Iowa does not define the distribution method

[15] Act 2014-277, Acts of Alabama.
[16] Chapter 2014-157, Laws of Florida.
[17] Senate File 2360, Iowa Acts 2014.
[18] 2014 Kentucky Acts Chapter 112.
[19] Chapter 501, General Laws of Mississippi of 2014.
[20] House Bill 2238, Laws of Missouri, 2014.
[21] Session Law 2014-53, Session Laws of North Carolina.
[22] Act 221, Acts and Joint Resolutions of South Carolina, 2014.
[23] Chapter 936, Public Acts of Tennessee 2014.
[24] Chapter 25, Laws of Utah 2014.
[25] Act 267, 2014 Wisconsin Session Laws.
[26] Section 2 of Act 2014-277, Acts of Alabama.
[27] Section 1 of 2014 Kentucky Acts Chapter 112.
[28] Section 3 of Chapter 501, General Laws of Mississippi of 2014.
[29] Section 1 of Chapter 936, Public Acts of Tennessee 2014.
[30] Sections 2 and 3 of Chapter 25, Laws of Utah 2014.
[31] Section 2 of Chapter 2014-157, Laws of Florida.
[32] Section A of House Bill 2238, Laws of Missouri, 2014.
[33] Section 2 of Session Law 2014-53, Session Laws of North Carolina.
[34] Section 1 of Act 221, Acts and Joint Resolutions of South Carolina, 2014.

and Wisconsin provides no mechanism for production or manufacture of marijuana products. None of the limited access states recognize patients who are registered with other limited access states.

Chapter 4

DISTRIBUTION SYSTEMS

Eighteen states currently have medical marijuana programs that provide for the establishment of distribution systems. Most of these states require that distribution be regulated primarily at the state level. However, Colorado gives independent, dual jurisdiction to both the state and its counties. California is the only state where distribution of medical marijuana is regulated exclusively at the county and city level.

State Regulation of Distribution

Regulatory Structure

The distribution systems generally entail statewide regulation through registration, licensure, or permitting of third party entities to distribute medical marijuana.[1] In the seventeen states that have statewide regulation, twelve states (Arizona, Delaware, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Hampshire, New York, Oregon, Rhode Island, and Vermont) have regulatory statutes that are registration statutes. Among the remaining five states, the regulatory statutes are licensing statutes (Colorado, Connecticut, Maryland, and New Mexico) or a permitting statute (New Jersey). These regulatory statutes were enacted as permanent laws in all but two of the states.[2]

With respect to these regulated third party entities, many states differentiate between "cultivation centers" and "dispensaries." Generally, cultivation centers grow medical marijuana, while dispensaries dispense medical marijuana to qualifying patients or their caregivers. However, the majority of the states (Arizona, Colorado, Delaware, Maine, Maryland,[3] Massachusetts, Minnesota, New Hampshire, New Jersey, New Mexico, New York, Rhode Island, and Vermont) allow the same entity to conduct both cultivation and dispensing operations. It should be noted that, even if an entity is allowed to dispense medical marijuana to a qualifying patient, states specifically do not permit the consumption of marijuana on the premises of such an entity.

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[1] Licensure and permitting statutes are generally considered to provide a more extensive level of oversight than a registration statute. For example, an application for registration may require basic information about a proposed business (e.g., name of the parties, address of the business, description of the business, etc.) in order for the state to determine whether its registration requirements have been met. On the other hand, an application for licensure may require more extensive information (e.g., detailed business plan, audited financial statements, tax records, background checks of the parties, etc.) in order to determine whether the parties involved have the financial resources and technical ability to operate the proposed business. However, this is merely a generalization and results may vary depending on the requirements of a particular state.

[2] Illinois enacted its regulatory statutes as a pilot program with a four-year sunset date, while New York enacted its statutes with a seven-year sunset date.

[3] *See* note 16, *infra*.

As indicated in table 4-1 below, the statutory terms used by states to refer to a third party that *cultivates* medical marijuana include "producer" (Connecticut), "cultivation center" (Illinois), and "cultivation facility" (Nevada). Likewise, the statutory terms used by states to refer to a third party that *dispenses* medical marijuana to a patient include "dispensary" (Connecticut), "dispensing organization" (Illinois), and "medical marijuana dispensary" (Nevada). In states where the third party entity engages in both cultivation and dispensing, and is regulated as an entity that engages in both types of activities, the statutory terms used to describe the third party entity include "compassion center" (Delaware, Rhode Island), "medical marijuana treatment center" (Massachusetts), "alternative treatment center" (New Hampshire), as well as "dispensary" (Arizona, Maine, and Vermont). For the purposes of general discussion, this report will use the terms "cultivation centers" and "dispensaries" to refer to third party entities that cultivate or dispense medical marijuana, respectively.

In eleven of the seventeen states (Arizona, Delaware, Maine, Massachusetts, Minnesota, New Hampshire, New Jersey, New Mexico, New York, Rhode Island, and Vermont), both the cultivation of medical marijuana and the dispensing of it to patients are covered under a single license, registration, or permit. Among the remaining states, the cultivation of medical marijuana and the dispensing of it to patients are covered under separate licenses (Colorado, Connecticut, and Maryland) or separate registrations (Illinois, Nevada, and Oregon). Colorado is somewhat unique in that a single entity generally holds the two separate licenses -- an "optional premises cultivation operation" license for cultivation and a "medical marijuana center" license for dispensing.

State regulation is generally placed under the jurisdiction of the state's health agency, although other alternatives include the state revenue agency (Colorado), the state consumer protection agency (Connecticut), and the state public safety agency (Vermont). Where separate state licenses are required for cultivation and for dispensing, regulation of both activities tends to be placed under the jurisdiction of the same state agency (Colorado, Connecticut, Maryland, Nevada, and Oregon), although one state, Illinois, divides state level jurisdiction between two different state agencies, specifically, its agriculture agency and its financial and professional regulation agency.

The table below lists the seventeen states and outlines their basic regulatory structure. Specifically, it indicates: whether the regulation of cultivation centers and dispensaries is handled jointly or separately; whether the level of regulation is licensure, registration, or permit; and the designation of the regulating authority.

Table 4-1. Regulatory Structure

State	Regulation	Cultivation Centers	Dispensaries
Arizona	Registration by the Department of Health Services	Nonprofit Medical Marijuana Dispensaries[4]	
Colorado[5]	State Licensure by the Executive Director of the Department of Revenue	Optional Premises Cultivation Operations[6]	Medical Marijuana Centers[7]
	County Licensure by the local licensing authority[8]	Optional Premises Cultivation Operations	Medical Marijuana Centers
Connecticut	Licensure by the Commissioner of Consumer Protection	Producers[9]	Dispensaries[10]

[4] Section 36-2801(11), Arizona Revised Statutes, defines "nonprofit medical marijuana dispensary" as "a not-for-profit entity that acquires, possesses, cultivates, manufactures, delivers, transfers, transports, supplies, sells or dispenses marijuana or related supplies and educational materials to cardholders."

[5] The state and county agencies do not issue joint licenses. They issue licenses independently of each other. Pursuant to Colorado Revised Statutes section 12-43.3-310(2), an applicant for a license "may not operate until it has been licensed by the local licensing authority and the state licensing authority pursuant to this article. If the state licensing authority issues the applicant a state license and the local licensing authority subsequently denies the applicant a license, the state licensing authority shall consider the local licensing authority denial as a basis for the revocation of the state-issued license."

[6] Colorado Revised Statutes section 12-43.3-403(1) specifies that an "optional premises cultivation license may be issued only to a person licensed pursuant to section 12-43.3-402(1) . . . who grows and cultivates medical marijuana at an additional Colorado licensed premises contiguous or not contiguous with the licensed premises of the person's medical marijuana center license[.]"

[7] Colorado Revised Statutes section 12-43.3-402(1), which specifies that a "medical marijuana center license shall be issued only to a person selling medical marijuana pursuant to the terms and conditions of this article." Section 12-43.3-402(3) also specifies that "[e]very person selling medical marijuana as provided for in this article shall sell only medical marijuana grown in its medical marijuana optional premises licensed pursuant to this article."

[8] Colorado Revised Statutes section 12-43.3-104(5) defines "local licensing authority" as "an authority designated by municipal or county charter, ordinance, or resolution, or the governing body of a municipality, city and county, or the board of county commissioners of a county if no such authority is designated."

[9] Pursuant to sections 21a-408(4) and 21a-408i, Connecticut General Statutes, a "producer" is licensed by the Commissioner of Consumer Protection, "organized for the purpose of cultivating marijuana for palliative use in [Connecticut,]" and is "qualified to cultivate marijuana and sell, deliver, transport or distribute marijuana solely within [Connecticut.]"

[10] Pursuant to sections 21a-408(3) and 21a-408h, Connecticut General Statutes, a "dispensary" is a pharmacist licensed by the Commissioner of Consumer Protection to "acquire, possess, distribute and dispense marijuana[.]"

State	Regulation	Cultivation Centers	Dispensaries
Delaware	Registration by the Department of Health and Social Services	Registered Compassion Centers[11]	
Illinois[12]	Registration by the Department of Agriculture	Cultivation Centers[13]	
	Registration by the Department of Financial and Professional Regulation		Dispensing Organizations[14]

[11] Delaware Code, title 16, section 4902A(12) defines "registered compassion center" as " a not-for-profit entity registered pursuant to § 4914A of this title that acquires, possesses, cultivates, manufactures, delivers, transfers, transports, sells, supplies, or dispenses marijuana, paraphernalia, or related supplies and educational materials to registered qualifying patients who have designated the dispenser to cultivate marijuana for their medical use and the registered designated caregivers of these patients."

[12] The Illinois statutes took effect on January 1, 2014, and are scheduled for repeal on January 1, 2018, pursuant to 410 Illinois Compiled Statutes 130/220 and 999 (2013).

[13] 410 Illinois Compiled Statutes 130/10(e) (2013) defines "cultivation center" as "a facility operated by an organization or business that is registered by the Department of Agriculture to perform necessary activities to provide only registered medical cannabis dispensing organizations with usable medical cannabis."

[14] 410 Illinois Compiled Statutes 130/10(o) (2013) defines "dispensing organization" as "a facility operated by an organization or business that is registered by the Department of Financial and Professional Regulation to acquire medical cannabis from a registered cultivation center for the purpose of dispensing cannabis, paraphernalia, or related supplies and educational materials to registered qualifying patients."

State	Regulation	Cultivation Centers	Dispensaries
Maine	Registration by the Department of Health and Human Services	Dispensaries[15]	
Maryland	Licensure by the Natalie M. LaPrade Medical Marijuana Commission	Medical Marijuana Growers[16]	Dispensaries[17]
Massachusetts	Registration by the Department of Public Health	Medical Marijuana Treatment Centers[18]	
Minnesota	Registration by the Commissioner of Health	Medical Cannabis Manufacturers[19]	

[15] Maine Revised Statutes, title 22, section 2422(6), defines "dispensary" as "a not-for-profit entity registered under section 2428 that acquires, possesses, cultivates, manufactures, delivers, transfers, transports, sells, supplies or dispenses marijuana or related supplies and educational materials to qualifying patients and the primary caregivers of those patients."

[16] Although their primary purpose is to cultivate medical marijuana, section 13-3309 of the Health-General Article, Code of Maryland (as amended by chapters 240 and 256, 2014 Laws of Maryland), authorizes medical marijuana growers to provide medical marijuana directly to qualifying patients and caregivers, as well.

[17] Section 13-3301 of the Health-General Article, Code of Maryland (as amended by chapters 240 and 256, 2014 Laws of Maryland), defines "dispensary" as "an entity licensed under this subtitle that acquires, possesses, processes, transfers, transports, sells, distributes, dispenses, or administers marijuana, products containing marijuana, related supplies, related products including food, tinctures, aerosols, oils, or ointments, or educational materials for use by a qualifying patient or caregiver."

[18] Chapter 369, section 2(H), Massachusetts Acts 2012, defines "medical marijuana treatment center" as "a not-for-profit entity, as defined by Massachusetts law only, registered under this law, 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."

[19] Chapter 311, section 2, Laws of Minnesota 2014, defines "medical cannabis manufacturer" as "an entity registered by the commissioner to cultivate, acquire, manufacture, possess, prepare, transfer, transport, supply, or dispense medical cannabis, delivery devices, or related supplies and educational materials." *But see* note 54, *infra*, and accompanying text.

State	Regulation	Cultivation Centers	Dispensaries
Nevada	Registration by the Division of Public and Behavioral Health of the Department of Health and Human Services	Cultivation Facilities[20]	Medical Marijuana Dispensaries[21]
New Hampshire	Registration by the Department of Health and Human Services	Alternative Treatment Centers[22]	
New Jersey	Permit from the Department of Health	Alternative Treatment Centers[23]	
New Mexico	Licensure by the Department of Health	Licensed Producers[24]	

[20] Section 453A.056, Nevada Revised Statutes, defines "cultivation facility" as a business registered with the Department of Health and Human Services that "[a]cquires, possesses, cultivates, delivers, transfers, transports, supplies or sells marijuana and related supplies to:

(a) Medical marijuana dispensaries;
(b) Facilities for the production of edible marijuana products or marijuana-infused products; or
(c) Other cultivation facilities."

[21] Section 453A.115, Nevada Revised Statutes, defines "medical marijuana dispensary" as a business registered with the Department of Health and Human Services that "[a]cquires, possesses, delivers, transfers, transports, supplies, sells or dispenses marijuana or related supplies and educational materials to the holder of a valid registry identification card."

[22] Section 126-X:1(I), New Hampshire Revised Statutes, defines "alternative treatment center" as a not-for-profit entity registered with the Department of Health and Human Services that "acquires, possesses, cultivates, manufactures, delivers, transfers, transports, sells, supplies, and dispenses cannabis, and related supplies and educational materials, to qualifying patients and alternative treatment centers."

[23] Section 24:6I-3, New Jersey Revised Statutes, defines "alternative treatment center" as "an organization approved by the department to perform activities necessary to provide registered qualifying patients with usable marijuana and related paraphernalia[.]" Section 24:6I-7, New Jersey Revised Statutes, authorizes alternative treatment centers to "acquire a reasonable initial and ongoing inventory, as determined by the department, of marijuana seeds or seedlings and paraphernalia, possess, cultivate, plant, grow, harvest, process, display, manufacture, deliver, transfer, transport, distribute, supply, sell, or dispense marijuana, or related supplies to qualifying patients or their primary caregivers who are registered with the department[.]"

[24] Section 26-2B-3, New Mexico Statutes Annotated, defines "licensed producer" as "any person or association of persons within New Mexico that the [Department of Health] determines to be qualified to produce, possess, distribute and dispense cannabis pursuant to the Lynn and Erin Compassionate Use Act and that is licensed by the department[.]"

State	Regulation	Cultivation Centers	Dispensaries
New York	Registration by the Commissioner of Health	Registered Organizations[25]	
Oregon	Registration by the Oregon Health Authority	Marijuana Grow Sites[26]	Medical Marijuana Facilities[27]
Rhode Island	Registration by the Department of Health	Compassion Centers[28]	
Vermont	Registration by the Department of Public Safety	Dispensaries[29]	

Operational Requirements

The seventeen states impose a variety of operational requirements on cultivation centers and dispensaries. Simply doing business as a cultivation center or dispensary will subject an entity to various application and renewal fees, and sales of medical marijuana will likely be subject to various state and local taxes. The following table outlines the taxes and fees that apply to cultivation centers and dispensaries.

[25] New York Public Health Law, section 3364(1), defines "registered organization" as "a for-profit business entity or not-for-profit corporation organized for the purpose of acquiring, possessing, manufacturing, selling, delivering, transporting, distributing or dispensing marihuana for certified medical use."

[26] Section 475.302(7), Oregon Revised Statutes, defines "marijuana grow site" as a location registered with the Oregon Health Authority "where marijuana is produced for use by a registry identification cardholder."

[27] Pursuant to section 475.314(1), Oregon Revised Statutes, a medical marijuana facility is authorized to transfer "usable marijuana and immature marijuana plants from:

(a) A registry identification cardholder, the designated primary caregiver of a registry identification cardholder, or a person responsible for a marijuana grow site to the medical marijuana facility; or

(b) A medical marijuana facility to a registry identification cardholder or the designated primary caregiver of a registry identification cardholder."

[28] Section 21-28.6-3(2), Rhode Island General Laws, defines "compassion center" as "a not-for-profit corporation . . . that acquires, possesses, cultivates, manufactures, delivers, transfers, transports, supplies or dispenses marijuana, and/or related supplies and educational materials, to registered qualifying patients and/or their registered primary caregivers who have designated [the compassion center] as one of their primary caregivers."

[29] Vermont Statutes, title 18, section 4472(5), defines "dispensary" as "a nonprofit entity . . . which acquires, possesses, cultivates, manufactures, transfers, transports, supplies, sells, or dispenses marijuana, marijuana-infused products, and marijuana-related supplies and educational materials for or to a registered patient who has designated it as his or her center and to his or her registered caregiver for the registered patient's use for symptom relief."

Table 4-2. Fees and Taxes Applicable to Cultivation Centers and Dispensaries

State	Fees	Taxes
Arizona[30]	$5,000 application fee, $1,000 renewal fee	5.6% state sales tax, Variable local taxes
Colorado[31]	Medical Marijuana Centers: $6,000 to $14,000 application fee $3,000 to $11,000 license fee $3,300 to $11,300 renewal fee Optional Premises Cultivation Operations: $1,000 application fee $2,200 license fee $2,500 renewal fee	2.9% state sales tax, Variable local taxes
Connecticut[32]	Dispensaries: $1,000 application fee, $1,000 per year license and renewal fees Producers: $25,000 application fee, $75,000 annual license and renewal fee	6.35% state sales tax
Delaware[33]	$5,000 application fee, $40,000 annual certification and renewal fees	Gross receipts tax on revenue in excess of $1.2 million
Illinois[34]	Fees will be determined by administrative rule	7% excise tax, 1% state sales tax
Maine[35]	$15,000 application fee, $15,000 renewal fee	5.5% state sales tax, or 8% tax on edible products
Maryland[36]	Fees to be determined by administrative rule	6% state sales tax
Massachusetts[37]	$31,500 in fees for a 2-step application process, $50,000 annual registration fee	Likely not subject to state sales tax
Minnesota[38]	$20,000 application fee, Annual fee to be established by Commissioner of Health	Sale of medical cannabis is not taxed

[30] *See* section R9-17-102, Arizona Administrative Code.
[31] *See* sections M 206, 207, and 208 of 1 Colorado Code of Regulations 212-1.
[32] *See* section 21a-408-28, Regulations of Connecticut State Agencies.
[33] *See* sections 7.6.1, 7.9.1, and 7.10.2.1 of 16 Delaware Administrative Code 4470.
[34] *See* 410 Illinois Compiled Statutes 130, sections 115, 125, 200, and 915, Laws of Illinois 2013.
[35] *See* sections 7.4.1, and 7.4.2 of 10-144 Code of Maine Rules chapter 122.
[36] *See* section 13-3304(c) of the Health-General Article, Code of Maryland (as amended by chapters 240 and 256, 2014 Laws of Maryland).
[37] *See* 801 Code of Massachusetts Regulations 4.02(105).
[38] *See* chapter 311, section 15, Laws of Minnesota 2014.

State	Fees	Taxes
Nevada[39]	Medical Marijuana Dispensaries: $5,000 application fee $30,000 registration fee $5,000 renewal fee Cultivation Facilities: $5,000 application fee $3,000 registration fee $1,000 renewal fee	2% excise tax on wholesale sales, 2% excise tax on retail sales, 6.85% state sales tax, Variable local taxes
New Hampshire[40]	Fees will be established by Department of Health and Human Services	No sales tax
New Jersey[41]	$20,000 application fee ($18,000 refunded to unsuccessful applicants), $20,000 renewal fee	7% state sales tax
New Mexico[42]	$1,000 application fee, $5,000 to $30,000 renewal fee	5.125 state gross receipts tax, Variable local taxes
New York[43]	Fees to be determined by the Commissioner of Health	7% excise tax
Oregon[44]	$4,000 application fee, $4,000 renewal fee	No sales tax
Rhode Island[45]	$250 application fee, $5,000 registration fee, $5,000 renewal fee	4% compassion center surcharge, 7% state sales tax
Vermont[46]	$2,500 application fee, $20,000 registration fee, $30,000 renewal fee	Likely not subject to state sales tax

Further, the majority of the seventeen states also require dispensaries to comply with various requirements pertaining to the training of employees who dispense medical marijuana to qualifying patients, as well as to provision of educational materials to qualifying patients. The following table summarizes these requirements.

[39] *See* sections 453A.344 and 372A.075, Nevada Revised Statutes.
[40] *See* section 126-X:7, New Hampshire Revised Statutes.
[41] *See* sections 8:64-6.5 and 8:64-7.10, New Jersey Administrative Code.
[42] *See* section 7.34.4.8(Q), New Mexico Administrative Code.
[43] *See* New York State Public Health Law, section 3364(3)-(5), and New York State Tax Law, section 490(2).
[44] *See* section 333-008-1030, Oregon Administrative Rules.
[45] *See* sections 21-28.6-12(c) and (d) and 44-67-3, Rhode Island General Laws.
[46] *See* 28-000-003 Code of Vermont Rules section 7.4 and 7.5.

Table 4-3. Staff Training and Patient Education Requirements

State	Staff Training	Patient Education
Arizona[47]	• Guidelines for providing information to qualifying patients related to risks, benefits, and side effects associated with marijuana; • Guidelines for providing support to qualifying patients related to the patient's self-assessment of the patient's symptoms; • Recognizing signs and symptoms of substance abuse; and • Guidelines for refusing to provide medical marijuana to an individual who appears to be impaired or abusing medical marijuana.	Patient education and support, including: • Availability of different strains of marijuana and the purported effects of each strain; • Information about the purported effectiveness of various methods, forms, and routes for medical marijuana administration; • Methods of tracking the effects of different strains and forms of marijuana; and • Prohibition on the smoking of marijuana in public places.
Colorado[48]	Occupational licenses required	--
Connecticut[49]	• On-the-job and other related education; • Professional conduct, ethics, and state and federal statutes and regulations regarding patient confidentiality; and • Developments in the field of the medical use of marijuana.	Informational material related to: • Limitations on the right to possess and use marijuana; • Safe techniques for proper use of marijuana and paraphernalia; • Alternative methods and forms of consumption or inhalation; • Signs and symptoms of substance abuse; and • Opportunities to participate in substance abuse programs.
Delaware[50]	• Professional conduct, ethics, and state and federal laws regarding patient confidentiality; • Informational developments in the field of medical use of marijuana; • The proper use of security measures and controls that have been adopted; and • Specific procedural instructions for responding to an emergency, including robbery or violent accident.	Explanation of: • Limitations on the right to use medical marijuana under state law; • Ingestion options of usable marijuana; • Safe smoking techniques; and • Potential side effects.

[47] *See* sections R9-17-310(A)(2)(e) and R9-17-313(C), Arizona Administrative Code.
[48] *See* section M 233 of 1 Colorado Code of Regulations 212-1.
[49] *See* sections 21a-408-34(o) and 21a-408-44(a), Regulations of Connecticut State Agencies.
[50] *See* sections 7.3.9 and 7.4 of 16 Delaware Administrative Code 4470.

State	Staff Training	Patient Education
Illinois[51]	--	Department of Public Health must develop and distribute educational information on health risks of abuse of cannabis and prescription drugs.
Maine[52]	Dispensaries must have written policies regarding job description and employment contracts, including training.	Educational materials regarding: • Strains of marijuana and different effects; • Proper dosage for different modes of administration; • Tolerance, dependence, and withdrawal; • Substance abuse signs and symptoms; and • Whether the dispensary's marijuana and associated products meet organic certification standards.
Maryland	--	--
Massachusetts[53]	8 hours of ongoing annual training on topics specified by the Department of Public Health, including confidentiality.	Educational materials, including: • Health and safety warnings; • Information to assist in the selection of marijuana; • Materials to enable patients to track the strains used and their associated effects; • Information describing proper dosage and titration for different routes of administration; • A discussion of tolerance, dependence, and withdrawal; • Substance abuse signs and symptoms; • Referral information for substance abuse treatment programs; • A statement that qualifying patients may not distribute marijuana to any other individual, and that they must return unused, excess, or contaminated product to the dispensary for disposal; and • Any other information required by the Department of Public Health.

[51] *See* 410 Illinois Compiled Statutes 130, section 15(a)(2), Laws of Illinois 2013.
[52] *See* sections 6.9.3 and 6.9.5 of 10-144 Code of Maine Rules chapter 122.
[53] *See* 105 Code of Massachusetts Regulations 725.105(H) and (K).

State	Staff Training	Patient Education
Minnesota[54]	Only licensed pharmacists may dispense medical marijuana to patients.	--
Nevada[55]	• Security measures and controls that have been adopted by the dispensary; • Procedures and instructions for responding to an emergency; • State and federal statutes and regulations regarding confidentiality; • Instruction on different strains of cannabis and different methods of using cannabis and cannabis products; and • Learning to recognize signs of medicine abuse or instability in patient use of medical marijuana.	Patient education and support, including: • Availability of different strains of marijuana and the purported effects of the different strains; • Information about the purported effectiveness of various methods, forms and routes of medical marijuana administration; and • Prohibition on the smoking of medical marijuana in public places, places open to the public, and places exposed to public view.
New Hampshire[56]	Alternative treatment centers must develop, implement, and maintain policies on employee training, including instruction on confidentiality laws and security measures and controls adopted by the center.	Educational materials including information on: • Strains of cannabis, routes of administration, and their different effects; • Proper dosage for different modes of administration; • Tolerance, dependence, and withdrawal; • Substance abuse signs and symptoms; • Whether the alternative treatment center's cannabis and associated products meet organic certification standards; and • Possible side effects from the use of cannabis for therapeutic purposes.

[54] *See* chapter 311, section 9(3), Laws of Minnesota 2014.
[55] *See* sections 41(d)(3) and 54(e) of Adopted Regulation of the Division of Public and Behavioral Health of the Nevada Department of Health and Human Services No. R004-14.
[56] *See* section 126-X:8(XVI)(c) and (XVII)(a), New Hampshire Revised Statutes.

State	Staff Training	Patient Education
New Jersey[57]	• Professional conduct, ethics and state and federal laws regarding patient confidentiality; • Informational developments in the field of medical use of marijuana; • Proper use of security measures and controls that have been adopted by the alternative treatment center; and • Specific procedural instructions for responding to an emergency, including a robbery or workplace violence.	Provision of information on: • Limitations of the right to possess and use marijuana under state law; • Potential side effects of marijuana use; • Differing strengths of products dispensed; • Safe techniques for use of medical marijuana and paraphernalia; • Alternative methods and forms of consumption or inhalation; • Signs and symptoms of substance abuse; • Opportunities to participate in substance abuse programs; and • Tolerance, dependence, and withdrawal.
New Mexico[58]	• State and federal confidentiality laws; • Professional conduct and ethics; • Informational developments in the field of medical use of cannabis; and • Employee safety and security training.	Educational materials on: • The limitation of the right to possess and use cannabis; • The quality of the product; • Ingestion options of usable marijuana; • Safe smoking techniques; and • Potential side effects.
New York[59]	--	Provision of a safety insert with information on: • Methods for administering medical marijuana in individual doses; • Any potential dangers stemming from the use of medical marijuana; • How to recognize what may be problematic usage of medical marijuana and obtain appropriate services or treatment for problematic usage; and • Other information, as determined by the Commissioner of Health.

[57] *See* sections 8:64-9.5(b) and 8:64-11.1, New Jersey Administrative Code.
[58] *See* sections 7.34.4.8(I) and 7.34.4.10(D), New Mexico Administrative Code.
[59] *See* New York State Public Health Law, section 3364(6).

State	Staff Training	Patient Education
Oregon[60]	Employees must be trained in the registered facility's policies and procedures regarding: • Security; • Testing; • Transfers of usable marijuana and plants to and from the facility; • Operation of a registered facility; • Required record keeping; • Labeling; and • Violations and enforcement.	--
Rhode Island[61]	• Professional conduct, ethics, and patient confidentiality; • Informational developments in the field of medical use of marijuana; • Proper use of security measures and controls that have been adopted; and • Specific procedural instructions on how to respond to an emergency, including robbery or violent accident.	Provision of information on: • The limitations on the right to use medical marijuana under state law; • Ingestion options of useable marijuana; • Safe smoking techniques; and • Potential side effects.
Vermont[62]	• Confidentiality laws; • Proper use of security measures and controls that have been adopted; and • Specific procedural instructions on how to respond to an emergency, including robbery or violent incident.	Educational materials regarding: • Strains of marijuana and different effects; • Proper dosage for different modes of administration; • Tolerance, dependence, and withdrawal; and • Substance abuse signs and symptoms.

The majority of the seventeen states also require dispensaries to affix labels to the products they dispense. These labels are intended to convey important information about the products to the qualifying patients. The following table summarizes the labeling requirements of the seventeen states.

[60] *See* section 333-008-1200(4), Oregon Administrative Rules.
[61] *See* sections 5.1.8(i) and 5.1.9 of the Rules and Regulations Related to the Medical Marijuana Program [R21-28.6-MMP], Rhode Island Department of Health.
[62] *See* Vermont Statutes, title 18, section 4474e(j) and 28-000-003 Code of Vermont Rules section 6.25.4.

Table 4-4. Labeling Requirements

State	Labeling Requirements
Arizona[63]	• Dispensary's registration identification number; • Amount, strain, and batch number of marijuana; • Safety and health warnings; • Source of marijuana; • Date of harvest or sale; • List of all chemical additives, including nonorganic pesticides, herbicides, and fertilizer; and • Registry identification number of the qualifying patient. In addition, edible products must also indicate the total weight of the product.
Colorado[64]	• List of all ingredients; • List of all chemical additives, including nonorganic pesticides, herbicides, and fertilizer; • Batch number of the marijuana; • List of solvents and chemicals used in the creation of any medical marijuana concentrate; • License number of the optional premises cultivation facility; • License number of the medical marijuana center; • Date of sale; and • Registry identification number of the qualifying patient. In addition, edible products must also indicate product identity and net weight.
Connecticut[65]	• Serial number, as assigned by the dispensary facility; • Date of dispensing the marijuana; • Quantity of marijuana dispensed; • Name and registration certificate number of the qualifying patient; • Name of the certifying physician; • Directions for use; • Name of the dispensary; • Name and address of the dispensary facility; • Any required cautionary statements; and • Expiration date.
Delaware[66]	• The name of the strain, batch, and quantity of marijuana; • A statement that the product is for medical use only, and not for resale; and • Details indicating (1) the medical marijuana is free of contaminants and (2) the levels of active ingredients in the product.

[63] *See* section R9-17-317, Arizona Administrative Code.
[64] *See* section M 1003 of 1 Colorado Code of Regulations 212-1.
[65] *See* section 21a-408-40(b), Regulations of Connecticut State Agencies.
[66] *See* section 7.3.10 of 16 Delaware Administrative Code 4470.

State	Labeling Requirements
Illinois[67]	The following information must be on labels of medical cannabis infused products: • Name and address of the cultivation center where the item was manufactured; • Common or usual name of the item; • All ingredients; • Allergen labeling; • Pre-mixed total weight of usable cannabis in the package; • A warning that the item is a medical cannabis infused product and not a food; • A warning that the product contains medical cannabis and is intended for consumption by qualifying patients only; and • Date of manufacture and "use by date."
Maine[68]	Must comply with applicable state labeling law.
Maryland	--
Massachusetts[69]	• Qualifying patient's name; • Name, registration number, and contact information of the dispensary; • Quantity of usable marijuana; • Date of packaging; • Batch number, serial number, and bar code of the marijuana; • Cannabinoid profile of the marijuana, including THC level; • Statement that the product is free of contaminants, and date of testing; and • Health and safety warning.
Minnesota[70]	• Patient's name and date of birth; • Name and date of birth of the patient's registered designated caregiver; • Patient's registry identification number; • Chemical composition of the medical cannabis; and • Dosage.
Nevada[71]	• Name and the registration number of the cultivation facility that produced, processed, and sold the usable marijuana; • Lot number of the marijuana; • Quantity of marijuana and date dispensed; • Name and registry identification card number of the qualified patient, and the name of the designated caregiver, if any; • Name and address of the medical marijuana dispensary; • Cannabinoid profile and potency levels and terpinoid profile, as determined by the independent testing laboratory; • A warnings that the product has intoxicating effects and may be habit forming; • A statement that the product may be unlawful outside of Nevada; and • Date of harvest. In addition, edible products must also indicate batch number, net weight, expiration date, and list all ingredients and allergens.

[67] *See* 410 Illinois Compiled Statutes 130, section 80(a)(3), Laws of Illinois 2013.
[68] *See* section 6.14 of 10-144 Code of Maine Rules chapter 122.
[69] *See* 105 Code of Massachusetts Regulations 725.105(E)(2).
[70] *See* chapter 311, section 9(3)(c)(5), Laws of Minnesota 2014.
[71] *See* sections 77-79 of Adopted Regulation of the Division of Public and Behavioral Health of the Nevada Department of Health and Human Services No. R004-14.

State	Labeling Requirements
New Hampshire[72]	• Name of the alternative treatment center; • Patient's registry number; • Amount and form of marijuana; • Time and date of origin; and • Destination of the product.
New Jersey[73]	• Name and address of the alternative treatment center; • Quantity of marijuana; • Date of packaging; • Serial number, lot number and bar code of the marijuana; • Cannabinoid profile of the medicinal marijuana, including THC level; • Whether the marijuana is of a low, medium, or high strength strain; • A statement that the product is for medical use by a qualifying patient and not for resale; • A list of any other ingredients besides marijuana contained within the package; • Date of dispensing; and • Qualifying patient's name and registry identification card number.
New Mexico[74]	• Name of the strain, batch, and quantity of marijuana; and • A statement that the product is for medical use and not for resale.
New York[75]	• The name, address, and registry identification number of the registered organization; • The name and registry identification number of the qualifying patient; • The date of sale; • Recommended form of medical marijuana and dosage for the certified patient; • The form and quantity of medical marijuana sold; • The packaging date; • Use by date; • Health warnings; • Number of individual doses contained in the package; and • A warning that the medical marijuana must be kept in the original container in which it was dispensed.
Oregon[76]	• The amount of THC and cannabidiol in the usable marijuana; • If pre-packaged, the weight or volume of the packaged usable marijuana; • The amount of usable marijuana in a finished product; • Potency information; and • Who performed the testing.
Rhode Island[77]	• Name of the strain, batch, and quantity of marijuana; and • A statement that the product is for medical use and not for resale.

[72] *See* section 126-X:8(XIV)(b), New Hampshire Revised Statutes.
[73] *See* sections 8:64-10.6(c), New Jersey Administrative Code.
[74] *See* section 7.34.4.10(B)(4), New Mexico Administrative Code.
[75] *See* New York State Public Health Law, section 3364(12).
[76] *See* section 333-008-1220, Oregon Administrative Rules.
[77] *See* section 5.1.8(j) of the Rules and Regulations Related to the Medical Marijuana Program [R21-28.6-MMP], Rhode Island Department of Health.

State	Labeling Requirements
Vermont[78]	• The strain of marijuana; and • A statement that Vermont does not attest to the medicinal value of cannabis.

Quality Control

With regard to the regulation of cultivation centers and dispensaries, it appears that at least eleven of the seventeen states (Colorado, Connecticut, Delaware, Illinois, Maine, Minnesota, Nevada, New Hampshire, New Mexico, New York, and Oregon) have statutory provisions that address quality control to some extent. Of these, nine states (Colorado, Delaware, Illinois, Maine, Minnesota, Nevada, New Mexico, New York, and Oregon) have provisions that involve marijuana testing.

With regard to the states that have provisions that involve marijuana testing, Colorado allows a medical marijuana center to provide a sample of its products to a licensed laboratory for testing and research purposes. This testing serves to ensure that products are safe for patient consumption and free of contaminants. The Colorado Department of Revenue has adopted rules relating to acceptable testing and research practices, including testing, standards, quality control analysis, equipment certification and calibration, and chemical identification and other substances used in bona fide research methods.[79]

Delaware requires safety compliance facilities to register with the Delaware Department of Health and Social Services in order to obtain authority to test medical marijuana produced for medical use for potency and contaminants.[80]

Under current law, cultivation centers in Illinois are required to comply with state and federal rules and regulations relating to the use of pesticides.[81] Further, pursuant to requirements under state law, the Illinois Department of Agriculture is currently drafting administrative rules, applicable to cultivation centers, relating to standards for the testing, quality, and cultivation of medical cannabis.[82]

The Maine Department of Health and Human Services is authorized to perform laboratory testing on marijuana obtained from patients, caregivers, and dispensaries, in order to ensure compliance with the state medical marijuana law.[83] Such testing is used to detect pests, mildew, heavy metals, and pesticides.[84]

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[78] *See* 28-000-003 Code of Vermont Rules section 6.31.
[79] *See* Section 12-43.3-402(6), Colorado Revised Statutes, and 1 Colorado Code of Regulations 212-1.
[80] Delaware Code, title 16, sections 4902A(13) and 4915A(a).
[81] 410 Illinois Compiled Statutes 130, section 105(k), Laws of Illinois 2013.
[82] 410 Illinois Compiled Statutes 130, section 165(c)(7), Laws of Illinois 2013.
[83] Maine Revised Statutes, title 22, section 2430-A.
[84] *See* Section 6.7.3 of 10-144 Code of Maine Rules 122.

Minnesota requires medical marijuana manufacturers to contract with a laboratory approved by the Minnesota Commissioner of Health for the purposes of testing medical marijuana as to content, contamination, and consistency.[85]

Nevada requires the Division of Public and Behavioral Health of the Department of Health and Human Services to certify laboratories to test marijuana and other marijuana products that are sold in the state.[86] The purpose of the testing is to accurately determine the concentration of THC and cannabidiol in the marijuana, whether the tested material is organic or non-organic, the presence and identification of molds and fungus, and the presence and concentration of fertilizers and other nutrients.[87] Furthermore, the statutes evidently encourage medical marijuana dispensaries and similar entities to sell edible marijuana products and marijuana-infused products on the basis of the concentration of THC in the products, rather than by the weight of the products.[88]

New Mexico requires licensed producers to submit marijuana samples for testing to the New Mexico Department of Health upon request.[89] The department may make such a request upon receiving a complaint regarding the presence of mold, bacteria, or another contaminant in the marijuana produced by the licensed producer, or if the department has reason to believe that the presence of mold, bacteria, or another contaminant may jeopardize the health of a patient.[90] Costs of testing required by the department are borne by the licensed producer.[91]

New York requires registered organizations to contract with an independent laboratory approved by the New York Commissioner of Health to test the medical marijuana produced by the registered organization.[92] The commissioner is authorized to "issue regulation requiring the laboratory to perform certain tests and services."[93] However, as of this writing, the commissioner has not yet adopted rules to clarify the requirements of such testing.

Oregon requires medical marijuana facilities to comply with rules adopted by the Oregon Health Authority regarding the testing of usable marijuana and immature plants received by the facility for the presence of pesticides, mold, and mildew.[94] Such testing is necessary before usable marijuana or immature plants may be transferred to a qualifying patient or caregiver.[95]

In addition to these nine states, New Hampshire has provisions regarding the use of organic pesticides on marijuana, while Connecticut has provisions regarding the ability of cultivation centers to cultivate pharmaceutical grade marijuana. New Hampshire requires

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[85] Chapter 311, sections 5 and 9, Laws of Minnesota 2014.
[86] Section 453A.368(1), Nevada Revised Statutes.
[87] Section 453A.368(2), Nevada Revised Statutes.
[88] Section 453A.360, Nevada Revised Statutes.
[89] Section 7.34.4.8(R), New Mexico Administrative Code.
[90] *See id.*
[91] *See id.*
[92] New York State Public Health Law, section 3364(3).
[93] *Id.*
[94] Section 475.314(3)(e)(B), Oregon Revised Statutes.
[95] *See* Section 333-008-1190, Oregon Administrative Rules.

alternative treatment centers to use only organic pesticides in cannabis.[96] Alternative treatment centers are also required to collect data on marijuana strains used and methods of delivery for qualifying conditions and symptoms, any side effects experienced, and therapeutic effectiveness for each patient who is willing to provide the information.[97] Connecticut requires producers to demonstrate their ability to cultivate pharmaceutical grade marijuana for palliative use in a secure indoor facility.[98] State law also provides that only a licensed pharmacist may apply for and receive a dispensary license.[99]

Quantity Control vs. Quality Control

It should be noted that, with regard to the regulation of cultivation centers and dispensaries, the seventeen states appear to place a greater emphasis on *quantity* control (i.e., controlling the supply of medical marijuana), as opposed to *quality* control.

Number of Cultivation Centers and Dispensaries

In particular, states generally control the supply of medical marijuana by establishing either minimum or maximum limits on the number of cultivation centers or dispensaries that may be operated in the state. Notable exceptions are Colorado, New Mexico, and Oregon, which do not specify a numerical limit on the cultivation centers or dispensaries that may operate within the state. Ten of the seventeen states (Arizona, Connecticut, Illinois, Maryland, Massachusetts, Nevada, New Hampshire, New York, Rhode Island, and Vermont) set maximum limits, while the remaining four states (Connecticut, Delaware, Maine, and New Jersey) set minimum limits. The limits are specified as a total number of cultivation centers and dispensaries or, alternatively, as a proportionate number of cultivation centers or dispensaries in relation to either a county or a specified number of pharmacies.

The table below outlines the statutory limits on the number of cultivation centers or dispensaries among the seventeen states:

[96] Section 126-X:8(X), New Hampshire Revised Statutes.
[97] Section 126-X:8(XVI)(b), New Hampshire Revised Statutes.
[98] Section 21a-408-20(c)(5), Regulations of Connecticut State Agencies.
[99] Section 21a-408h(b)(B), Connecticut General Statutes. *See also* definition of "dispensary" at note 10, *supra*.

Table 4-5. Limits on the Number of Cultivation Centers or Dispensaries

State	Limits on the Number of Establishments:	
	Cultivation Centers	**Dispensaries**
Arizona	Not more than 1 dispensary for every 10 pharmacies[100]	
Colorado	--	
Connecticut	Not less than 3 nor more than 10 producers in the state[101]	Maximum number of dispensaries in the state to be administratively determined[102]
Delaware	1 compassion center per county by 1/1/2013; at least 3 more overall by 1/1/2014[103]	
Illinois	Up to 22 cultivation centers[104]	Up to 60 dispensing organizations[105]
Maine	Not less than 8 dispensaries[106]	
Maryland	Currently, up to 15 growers.[107] Beginning 6/1/2016, the Commission may issue the number of licenses necessary to meet demand.[108]	--
Massachusetts	Up to 35 medical marijuana treatment centers; with at least 1, but not more than 5, in each county[109]	
Minnesota	Two medical cannabis manufacturers, each of which shall operate four distribution facilities[110]	

[100] Arizona Revised Statutes section 36-2804(C).
[101] Connecticut General Statutes section 21a-408i(b)(A).
[102] Connecticut General Statutes section 21a-408h(b)(A).
[103] Delaware Code title 16, section 4914A(d).
[104] 410 Illinois Compiled Statutes 130/85(a) (2013).
[105] 410 Illinois Compiled Statutes 130/115(a) (2013).
[106] Maine Revised Statutes title 22, section 2428(11).
[107] Section 13-3309(a)(2)(I) of the Health-General Article, Code of Maryland (as amended by chapters 240 and 256, 2014 Laws of Maryland).
[108] Section 13-3309(a)(2)(II) of the Health-General Article, Code of Maryland (as amended by chapters 240 and 256, 2014 Laws of Maryland).
[109] Chapter 369, section 9(C), Massachusetts Acts 2012.
[110] Chapter 311, sections 5(1) and 9(1), Laws of Minnesota 2014.

State	Limits on the Number of Establishments:	
	Cultivation Centers	**Dispensaries**
Nevada	Appropriate number of cultivation facilities, administratively determined, necessary to serve and supply the dispensaries[111]	Not more than 1 dispensary for every 10 pharmacies in a county; provided there is at least 1 dispensary per county[112]
New Hampshire	No more than 4 alternative treatment centers at one time[113]	
New Jersey	At least 2 alternative treatment centers each in the northern, central, and southern regions of the state[114]	
New Mexico	--	
New York	No more than 5 registered organizations, each of which may operate no more than 4 dispensing facilities[115]	
Oregon	--	
Rhode Island	No more than 3 compassion centers at one time[116]	
Vermont	No more than 4 dispensaries at one time[117]	

Inventory Limits

Eight of the seventeen states (Colorado, Maine, New Hampshire, New Jersey, New Mexico, Oregon, Rhode Island, and Vermont) have statutes that also control quantity by limiting, or authorizing the limitation of, a cultivation center's or dispensary's inventory. These statutes generally place per-patient limits on the number of plants, usable marijuana, or other form of marijuana that the cultivation center or dispensary may possess. For example, Colorado and Maine impose limits of six plants per patient, while Colorado and Vermont impose limits of two ounces of marijuana per patient. The statutes in the remaining nine states are silent on the matter of inventory limits.

The table below outlines the statutory inventory limits for cultivation centers and dispensaries among the seventeen states:

[111] Chapter 547, section 11(3), Statutes of Nevada 2013.
[112] Chapter 547, section 11(2), Statutes of Nevada 2013.
[113] New Hampshire Revised Statutes section 126-X:7(III).
[114] New Jersey Revised Statutes section 24:6I-7(a).
[115] New York State Public Health Law, section 3365(9).
[116] Rhode Island General Laws section 21-28.6-12(b)((8).
[117] Vermont Statutes title 18, section 4474f(b).

Table 4-6. Limits on the Inventory of a Cultivation Center or Dispensary

State	Limits
Arizona	--
Colorado	Not more than 6 medical marijuana plants and 2 ounces of medical marijuana per patient[118]
Connecticut	--
Delaware	--
Illinois	--
Maine	Not more than 6 mature marijuana plants per patient[119]
Maryland	--
Massachusetts	--
Minnesota	--
Nevada	--
New Hampshire	Not more than 80 cannabis plants, 160 seedlings, and 80 ounces of usable cannabis (or 6 ounces of usable cannabis per patient); and Not more than 3 mature cannabis plants, 12 seedlings, and 6 ounces of usable cannabis per patient[120]
New Jersey	A reasonable inventory of marijuana seeds or seedlings to be determined administratively[121]
New Mexico	Not more than a total of 150 mature plants and seedlings, and an inventory of usable marijuana and seeds that reflects current patient needs[122]
New York	--
Oregon	Marijuana grow sites may possess no more than a total of 24 ounces of usable marijuana, 6 mature plants, and 18 seedlings per patient. Grow sites may produce marijuana for no more than 4 patients concurrently.[123]
Rhode Island	Not more than 150 marijuana plants, of which not more than 99 are mature, and 1,500 ounces of usable marijuana[124]

[118] Colorado Revised Statutes section 12-43.3-901(4)(e).
[119] Maine Revised Statutes title 22, section 2428(1-A)(B) and (9)(A).
[120] New Hampshire Revised Statutes section 126-X:8(XV)(a).
[121] New Jersey Revised Statutes section 24:6I-7(a).
[122] Section 7.34.4.8(A)(2), New Mexico Administrative Code.
[123] Section 333-008-0080(3) and (4), Oregon Administrative Rules.
[124] Rhode Island General Laws section 21-28.6-12(i)(1).

State	Limits
Vermont	Not more 28 mature plants, 98 immature plants, and 28 ounces of usable marijuana. In the alternative, for a dispensary with more than 14 patients, not more than 2 mature plants, 7 immature plants, and 2 ounces of usable marijuana per patient[125]

Dispensing Limits

The statutes in the majority of the seventeen states also set quantity controls by limiting the amounts of medical marijuana that dispensaries may dispense to patients.[126] These statutes generally prohibit a dispensary from dispensing marijuana to a patient at a rate that exceeds a specified dispensing rate. The maximum dispensing rate per patient tends to range from two to five ounces of marijuana within a ten- to thirty-day period. The statutory limits are generally made applicable to the dispensaries, with the exception of Arizona, which applies the limit to the patient. The dispensing rates are also evidently established to be consistent with the patient possession limits, which are constitutionally or statutorily established. In other words, the dispensing rates are set to prevent exceeding a patient's possession limits.

The statutes in a number of states (Colorado,[127] Delaware,[128] Illinois,[129] Maine,[130] Nevada,[131] New Hampshire,[132] Rhode Island,[133] and Vermont[134]) also provide that a patient may

[125] Vermont Statutes title 18, section 4474e(a)(3).
[126] The exceptions are Connecticut, Maryland, Massachusetts, New Mexico, New Jersey, and Oregon, in which the statutes relating to dispensaries appear to be silent on the matter.
[127] Section 25-1.5-106(8)(f), Colorado Revised Statutes, specifies that "[i]f the patient elects to use a licensed medical marijuana center, the patient shall register the primary center he or she intends to use."
[128] Delaware Code title 16, section 4919A(h) specifies that "[b]efore marijuana may be dispensed to a … registered qualifying patient, a compassion center agent must determine that … the registered compassion center is the designated compassion center for the registered qualifying patient who is obtaining the marijuana[.]"
[129] 410 Illinois Compiled Statutes 130/130(i)(3) (2013) specifies that before medical cannabis may be dispensed to a registered qualifying patient, the dispensing organization agent must determine whether the dispensing organization is the designated dispensing organization for the registered qualifying patient who is obtaining the cannabis.
[130] Maine Revised Statutes title 22, section 2423-A(1)(F), specifies that a qualifying patient may "[d]esignate one . . . registered dispensary to cultivate marijuana for the medical use of the patient[.]"
[131] Section 453A.366, Nevada Revised Statutes, specifies that a "patient who holds a valid registry identification card . . . may select one medical marijuana dispensary to serve as his or her designated medical marijuana dispensary at any one time."
[132] Section 126-X:8(XV)(b), New Hampshire Revised Statutes, specifies that an "alternative treatment center . . . shall not dispense, deliver, or otherwise transfer cannabis to any person or entity other than . . . [a] qualifying patient who has designated the relevant alternative treatment center[.]"
[133] Section 21-28.6-12(i)(2), Rhode Island General Laws, specifies that a "compassion center may not dispense, deliver, or otherwise transfer marijuana to a person other than a qualifying patient who has designated the compassion center as a primary caregiver or to such patient's other primary caregiver."
[134] Vermont Statutes title 18, section 4474e(a)(1), specifies that a "dispensary … may … dispense marijuana … for or to a registered patient who has designated it as his or her dispensary …" while section 4474h(a) specifies that "[a] registered patient may obtain marijuana only from the patient's designated dispensary and may designate only one dispensary."

only obtain marijuana from a particular dispensary if that dispensary has been designated by the patient.

The table below outlines the statutorily-established medical marijuana dispensing rates among the seventeen states, in comparison with the state's patient possession limits. States listed in bold print have statutes that limit a qualifying patient to obtaining medical marijuana only from a dispensary that has been designated by the patient:

Table 4-7. Patient Dispensing Limits

State	Dispensing Rate per Patient	Patient Possession Limits
Arizona	Not more than 2.5 ounces of marijuana in any 14-day period[135]	Not more than 2.5 ounces of usable marijuana, and not more than 12 plants[136]
Colorado	Not more than 2 ounces of usable marijuana[137]	Not more than 2 ounces of usable marijuana and 6 marijuana plants (of which, not more than 3 may be mature plants) [138]
Connecticut	Not more than a one-month supply during a one-month period[139]	Not more than a one-month supply, amount to be determined administratively[140]
Delaware	Not more than 3 ounces of marijuana in any 14-day period[141]	Not more than 6 ounces of usable marijuana[142]
Illinois	Not more than 2.5 ounces of cannabis in any 14-day period[143]	Not more than 2.5 ounces of usable cannabis during a 14-day period[144]
Maine	Not more than 2.5 ounces of prepared marijuana during a 15-day period[145]	Not more than 2.5 ounces of usable marijuana, and not more than 6 mature plants[146]
Maryland	--	30-day supply, to be administratively defined[147]
Massachusetts	Not more than 10 ounces in a 60-day period[148]	60-day supply (10 ounces)[149]

[135] Arizona Revised Statutes section 36-2816(A).
[136] Arizona Revised Statutes section 36-2801(1)(a).
[137] Colorado Revised Statutes section 12-43.3-402(3).
[138] Colorado Constitution Art. XVIII, Section 14(4)(a).
[139] Section 21a-408-38(e), Regulations of Connecticut State Agencies.
[140] Connecticut General Statutes section 21a-408a(a)(2).
[141] Delaware Code title 16, section 4919A(i).
[142] Delaware Code title 16, section 4903A(a).
[143] 410 Illinois Compiled Statutes 130/130(h) (2013).
[144] 410 Illinois Compiled Statutes 130/10(a)(1) and 25(a) (2013).
[145] Maine Revised Statutes title 22, section 2428(7).
[146] Maine Revised Statutes title 22, section 2423-A(1).
[147] Section 13-3313(a)(1) of the Health-General Article, Code of Maryland (as amended by chapters 240 and 256, 2014 Laws of Maryland).

State	Dispensing Rate per Patient	Patient Possession Limits
Minnesota	Not more than a 30-day supply of non-smokable marijuana[150]	30-day supply of non-smokable marijuana[151]
Nevada	Not more than 2.5 ounces of usable marijuana, 12 marijuana plants, and a maximum allowable quantity of edible marijuana products and marijuana-infused products, as established administratively, in any 14-day period[152]	Not more than 2.5 ounces of usable marijuana in a 14-day period, 12 marijuana plants, and a maximum allowable quantity of edible marijuana products and marijuana-infused products, as administratively established[153]
New Hampshire	Not more than 2 ounces of usable cannabis during a 10-day period[154]	Not more than 2 ounces of usable cannabis[155] and any amount of unusable cannabis[156]
New Jersey	Not more than 2 ounces in a 30-day period[157]	Not more than 2 ounces in a 30-day period[158]
New Mexico	--	Not more than 6 ounces of usable marijuana, 4 mature plants, and 12 seedlings[159]
New York	Not more than a 30-day supply of non-smokable marijuana[160]	30-day supply of non-smokable marijuana[161]
Oregon	Not more than patient is permitted to possess[162]	Not more than 24 ounces of usable marijuana, 6 mature plants, and 18 seedlings[163]
Rhode Island	Not more than 2.5 ounces of usable marijuana during a 15-day period[164]	Not more than 2.5 ounces of usable marijuana, 12 mature plants, and 12 seedlings[165]
Vermont	Not more than 2 ounces of usable marijuana during a 30-day period[166]	Not more than 2 ounces of usable marijuana, 2 mature plants, and 7 immature plants[167]

[148] 105 Code of Massachusetts Regulations 725.105(F)(2).
[149] 105 Code of Massachusetts Regulations 725.004.
[150] Chapter 311, section 9(3)(c)(6), Laws of Minnesota 2014.
[151] *Id*.
[152] Chapter 547, section 19.3(2), Statutes of Nevada 2013; Nevada Revised Statutes section 453A.200.
[153] Nevada Revised Statutes section 453A.200(3)(b).
[154] New Hampshire Revised Statutes section 126-X:8(XIII)(a) and (b).
[155] New Hampshire Revised Statutes section 126-X:2(I).
[156] Section 126-X:1(XIV), New Hampshire Revised Statutes, defines "unusable cannabis" as "any cannabis, other than usable cannabis, including the seeds, stalks, and roots of the plant."
[157] New Jersey Revised Statutes sections 24:6I-10(a).
[158] *Id*.
[159] Section 7.34.4.7(D), New Mexico Administrative Code.
[160] New York State Public Health Law, section 3364(5)(B).
[161] New York State Public Health Law, section 3362(1)(A).
[162] Section 333-008-1240(3), Oregon Administrative Rules.
[163] Section 475.320, Oregon Revised Statutes.
[164] Rhode Island General Laws section 21-28.6-12(g)(1).
[165] Rhode Island General Laws section 21-28.6-4(a).

Controls on the Channels of Supply and Distribution/Security Requirements

The regulatory statutes of the seventeen states also establish controls on the channels of supply and distribution of medical marijuana. Generally, these statutes establish a closed circuit in which medical marijuana circulates only among cultivation centers, dispensaries, patients, and their caregivers. A simplified outline of the channels of supply and distribution established by these statutes may be described as follows:

- A cultivation center or dispensary cultivates marijuana in an enclosed, locked facility with restricted access.
- A cultivation center or dispensary may also obtain marijuana from the following sources:
  - Another cultivation center or dispensary;
  - A patient;
  - The patient's caregiver.
- A dispensary may distribute medical marijuana to the following entities:
  - Another dispensary;
  - A patient;
  - The patient's caregiver.

Most of the seventeen states have statutes that place restrictions on the cultivation site. Twelve states (Arizona,[168] Connecticut,[169] Delaware,[170] Illinois,[171] Maine,[172] Massachusetts,[173] Minnesota,[174] Nevada,[175] New Hampshire,[176] New York,[177] Rhode Island,[178] and Vermont[179]) specify that the cultivation center may cultivate marijuana only in an enclosed, locked facility, with seven of these states also requiring that access to the facility be restricted. Connecticut,

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[166] Vermont Statutes title 18, section 4474e(k)(1)(C).
[167] Vermont Statutes title 18, sections 4472(10) and 4474b(a).
[168] Section 36-2806(E), Arizona Revised Statutes.
[169] Section 21a-408i(b)(H), Connecticut General Statutes.
[170] Delaware Code, title 16, section 4919A(f).
[171] 410 Illinois Compiled Statutes 130/105(d) (2013).
[172] Maine Revised Statutes, title 22, section 2428(6)(I).
[173] Chapter 369, section 9(B)(1)(c), Massachusetts Acts 2012.
[174] Chapter 311, section 9(2)(b), Laws of Minnesota 2014.
[175] Section 453A.352(4), Nevada Revised Statutes.
[176] Section 126-X:8(XV)(c), New Hampshire Revised Statutes.
[177] New York State Public Health Law, section 3364(8).
[178] Section 21-28.6-12(c)(1)(iv), Rhode Island General Laws.
[179] Vermont Statutes, title 18, section 4474e(d)(1).

Massachusetts, Minnesota, New York, and Rhode Island are silent on the matter of restricted access. Connecticut also has statutes that prohibit out-of-state locations for cultivation.[180]

A number of states also limit the external sources from which cultivation centers or dispensaries may obtain medical marijuana that they themselves do not cultivate. For example, among the states in which dispensaries are not regulated separately from cultivation centers, the statutes of several states limit the dispensary's external sources to other dispensaries (Arizona,[181] Delaware,[182] and New Mexico[183]), patients or their caregivers (Arizona,[184] Maine[185]), or the dispensary's principal officers, board members, or employees (Vermont[186]).

Likewise, among the states in which dispensaries are regulated separately from cultivation centers, the statutes in a few of the states limit a dispensary's external sources to a cultivation center (Connecticut,[187] Illinois,[188] Nevada,[189] and Oregon[190]). The statutes in two of these states also permit a dispensary to obtain marijuana from patients or their caregivers (Nevada[191] and Oregon[192]). Finally, two of these states also prohibit dispensaries from obtaining marijuana from outside the state (Illinois[193]), or prohibit cultivation centers and dispensaries from obtaining marijuana from outside the state (Connecticut[194]), in violation of state or federal law.

The states also limit the entities to whom medical marijuana may be distributed. All seventeen states specify that a dispensary may distribute medical marijuana to two entities -- a patient or the patient's caregiver. Ten of the seventeen states (Connecticut,[195] Illinois,[196] Maine,[197] Maryland,[198] Massachusetts,[199] Minnesota,[200] New Jersey,[201] Oregon,[202] Rhode Island,[203] and Vermont[204]) limit distribution to only those two entities. Six of the seventeen

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[180] Section 21a-408i(b)(F), Connecticut General Statutes.
[181] Section 36-2816(C), Arizona Revised Statutes.
[182] Delaware Code, title 16, section 4919A(g).
[183] Section 7.34.4.8(A)(2), New Mexico Administrative Code.
[184] Section 36-2816(C), Arizona Revised Statutes.
[185] Maine Revised Statutes, title 22, sections 2423-A(2)(H) and 2428(9)(E).
[186] Vermont Statutes, title 18, section 4474e(k)(1)(B).
[187] Sections 21a-408j(a)(1) and 21a-408k(a)(1), Connecticut General Statutes.
[188] 410 Illinois Compiled Statutes 130/130(e) (2013).
[189] Sections 453A.056 and 453A.340(2), Nevada Revised Statutes.
[190] Section 475.314(1), Oregon Revised Statutes.
[191] Section 453A.352(5), Nevada Revised Statutes.
[192] Section 475.314(1), Oregon Revised Statutes.
[193] 410 Illinois Compiled Statutes 130/130(e) (2013), for dispensing organizations.
[194] Connecticut General Statutes section 21a-408k(a)(2), for producers; and sections 21a-408h(b)(C) and 21a-408j(a)(3), for dispensaries.
[195] Section 21a-408j(a)(2), Connecticut General Statutes.
[196] 410 Illinois Compiled Statutes 130/25(i) and 130(f) (2013).
[197] Maine Revised Statutes, title 22, 2428(9)(B).
[198] Section 13-3310 of the Health-General Article, Code of Maryland (as amended by chapters 240 and 256, 2014 Laws of Maryland).
[199] Chapter 369, section 9(D), Massachusetts Acts 2012.
[200] Chapter 311, section 9(3)(c), Laws of Minnesota 2014.
[201] Section 24:6I-7(a), New Jersey Revised Statutes.
[202] Section 475.314(1), Oregon Revised Statutes.
[203] Section 21-28.6-12(i)(2), Rhode Island General Laws.

states (Arizona,[205] Colorado,[206] Nevada,[207] New Hampshire,[208] New Mexico,[209] and New York[210]) also permit a dispensary to distribute medical marijuana to another dispensary, while Delaware permits a dispensary to transfer medical marijuana to and from a safety compliance facility for analytical testing.[211] Two of the states (Connecticut[212] and New Mexico[213]) explicitly prohibit a cultivation center or dispensary from transporting marijuana outside the state, in violation of state or federal law. However, in contrast, Delaware permits a dispensary to distribute marijuana *seeds* to entities that are licensed or registered in another jurisdiction to dispense marijuana for medical purposes.[214]

As mentioned above, these regulatory statutes are intended to establish channels of supply and distribution that resemble a closed circuit. In order to prevent medical marijuana from being diverted from this closed circuit, all seventeen states require their cultivation centers and dispensaries to comply with various security requirements. Some requirements are as simple as installing a functional security alarm, while others require facilities to meet certain design specifications. At a minimum, most states require installation of an alarm and video surveillance of the premises.

The table below outlines the various security requirements imposed on cultivation centers and dispensaries among the seventeen states:

Table 4-8. Security Requirements for Cultivation Centers and Dispensaries

State	Security Requirements
Arizona[215]	Alarm, video surveillance, exterior lighting, single entrance
Colorado[216]	Lighting, physical security, video, alarm, internal control procedures
Connecticut[217]	Alarm, video surveillance, storage vaults, backup power, failure notification system
Delaware[218]	Alarm, exterior lighting, video surveillance, inventory controls

[204] Vermont Statutes, title 18, section 4474e(k)(1)(E).
[205] Section 36-2816(B), Arizona Revised Statutes.
[206] Section 12-43.3-402(3), Colorado Revised Statutes.
[207] Section 453A.340(1), Nevada Revised Statutes.
[208] Section 126-X:8(XV)(b), New Hampshire Revised Statutes.
[209] Section 7.34.4.8(A)(2), New Mexico Administrative Code.
[210] New York State Tax Law, section 490(8).
[211] Delaware Code, title 16, section 4903A(i)(3).
[212] Connecticut General Statutes sections 21a-408i(b)(B) and 21a-408k(a)(2), for producers; and sections 21a-408h(b)(C) and 21a-408j(a)(3), for dispensaries.
[213] Section 7.34.4.14(D), New Mexico Administrative Code.
[214] Delaware Code, title 16, section 4903A(i)(2).
[215] *See* section R9-17-318, Arizona Administrative Code.
[216] *See* section M 305 and 306 of 1 Colorado Code of Regulations 212-1.
[217] *See* section 21a-408-62, Regulations of Connecticut State Agencies.
[218] *See* section 7.2 of 16 Delaware Administrative Code 4470.

State	Security Requirements
Illinois[219]	Alarm, security plan reviewed by state police including but not limited to: facility access controls, perimeter intrusion detection systems, personnel identification systems, 24-hour interior and exterior surveillance
Maine[220]	Fence, exterior lighting, intrusion detection, video surveillance
Maryland[221]	--
Massachusetts[222]	Alarm, storage vaults, exterior lighting, video surveillance, backup systems, failure notification system
Minnesota[223]	Alarm, facility access controls, perimeter intrusion detection systems, personnel identification system
Nevada[224]	Alarm, single entrance, intrusion detection, exterior lighting, video surveillance, battery backup, failure notification system
New Hampshire[225]	Lighting, physical security, video security, alarm requirements, measures to prevent loitering, on-site parking
New Jersey[226]	Alarm, exterior lighting, video surveillance, power backup, automatic notification system
New Mexico[227]	Alarm system
New York[228]	Surveillance system
Oregon[229]	Alarm, video surveillance, safe
Rhode Island[230]	Alarm, emergency notification system, exterior lighting
Vermont[231]	Alarm, exterior lighting, intrusion detection, video surveillance

[219] *See* 410 Illinois Compiled Statutes 130/105(b) and 165(c)(3) and (d)(4) (2013).
[220] *See* sections 2.7.1.1 and 6.8 of 10-144 Code of Maine Rules chapter 122.
[221] Administrative rules are currently being drafted.
[222] *See* 105 Code of Massachusetts Regulations 725.110(D).
[223] *See* chapter 311, section 9(1)(d), Laws of Minnesota 2014.
[224] *See* section 60 of Adopted Regulation of the Division of Public and Behavioral Health of the Nevada Department of Health and Human Services No. R004-14.
[225] *See* section 126-X:6(III), New Hampshire Revised Statutes.
[226] *See* sections 8:64-9.7, New Jersey Administrative Code.
[227] *See* section 7.34.4.11, New Mexico Administrative Code.
[228] *See* New York State Public Health Law, section 3366(2).
[229] *See* Section 475.314(3)(e)(A), Oregon Revised Statutes.
[230] *See* sections 2.13 and 5.1.7 of the Rules and Regulations Related to the Medical Marijuana Program [R21-28.6-MMP], Rhode Island Department of Health.
[231] *See* 28-000-003 Code of Vermont Rules section 6.24.

Local Regulation of Distribution in California

As noted previously, California is the only state where distribution of medical marijuana is regulated exclusively at the city and county level.

History of the California Medical Marijuana Program

On November 5, 1996, voters in California approved Proposition 215, the Medical Use of Marijuana Initiative Statute, which led to the enactment of the Compassionate Use Act of 1996 in that state. The following summary of Proposition 215 was prepared by California's Attorney General:[232]

- Exempts patients and defined caregivers who possess or cultivate marijuana for medical treatment recommended by a physician from criminal laws which otherwise prohibit possession or cultivation of marijuana.
- Provides physicians who recommend use of marijuana for medical treatment shall not be punished or denied any right or privilege.
- Declares that measure not be construed to supersede prohibitions of conduct endangering others or to condone diversion of marijuana for non-medical purposes.
- Contains severability clause.

The Compassionate Use Act was later amended by Senate Bill No. 420, also known as the Medical Marijuana Program Act, which was enacted in October 2003 and took effect on January 1, 2004. As stated in section 1(b), the legislative intent of the Medical Marijuana Program Act was to:

(1) Clarify the scope of the application of the act and facilitate the prompt identification of qualified patients and their designated primary caregivers in order to avoid unnecessary arrest and prosecution of these individuals and provide needed guidance to law enforcement officers.

(2) Promote uniform and consistent application of the act among the counties within the state.

(3) Enhance the access of patients and caregivers to medical marijuana through collective, cooperative cultivation projects.

The provisions of the Compassionate Use Act and the Medical Marijuana Program Act are codified in sections 11362.5 - 11362.83 of the California Health and Safety Code. Like Hawaii, California's state law is essentially silent regarding qualifying patients' access to medical marijuana. Since marijuana is classified under federal law as a Schedule I controlled substance, patients in California are unable to obtain a prescription for marijuana. Also, like Hawaii, California does not provide qualifying patients with marijuana, seeds, or advice on how to obtain marijuana. Further, California's state law does not explicitly call upon any state agency or other

[232] California, Attorney General. Summary of Medical Use of Marijuana Initiative Statute. *Available at* http://vote96.sos.ca.gov/Vote96/html/BP/215.htm.

entity to establish a distribution system for medical marijuana. However, certain provisions of the Medical Marijuana Program Act have led to the development of a system of cooperatives and collectives formed by patients and caregivers for the purpose of cultivating medical marijuana.

Cooperatives and Collectives

Although California state law prohibits the cultivation or distribution of medical marijuana for profit, section 11362.765 of the California Health and Safety Code allows a primary caregiver to receive reasonable compensation for services provided to a qualifying patient that enables that patient to use medical marijuana. Section 11362.765 further states that reasonable compensation is permitted to "[a]ny individual who provides assistance to a qualified patient or a person with an identification card, or his or her designated primary caregiver, in administering medical marijuana to the qualified patient or person or acquiring the skills necessary to cultivate or administer marijuana for medical purposes to the qualified patient or person."

In order to "[e]nhance the access of patients and caregivers to medical marijuana[,]" section 11362.775 of the California Health and Safety Code provides that "[q]ualified patients, persons with valid identification cards, and the designated primary caregivers of qualified patients and persons with identification cards, 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 . . . ." (emphasis added)

Based on the foregoing language, hundreds of cooperatives and collectives have been established throughout California.[233] In August, 2008, the Attorney General of California issued its "Guidelines for the Security and Non-Diversion of Marijuana Grown for Medical Use" ("Guidelines").[234] While not having the force and effect of law, the Guidelines provide guidance as to how the Attorney General might choose to proceed with regard to state enforcement. In the Guidelines, the Attorney General differentiates between the terms "cooperatives" and "collectives" as follows:

> 1. **Statutory Cooperatives:** A cooperative must file articles of incorporation with the state and conduct its business for the mutual benefit of its members. No business may call itself a “cooperative” (or “coop”) unless it is properly organized and registered as such a corporation under the Corporations or Food and Agricultural Code. Cooperative corporations are “democratically controlled and are not organized to make a profit for themselves, as such, or for their members, as such, but primarily for their members as patrons.” The earnings and savings of the business must be used for the general welfare of its members or equitably distributed to members in the form of cash,

[233] Since Senate Bill No. 420 -- The Medical Marijuana Program Act -- was enacted in 2003, the number of medical marijuana cooperatives and collectives has grown at a rapid pace, making it difficult to determine the actual number of cooperatives and collectives that currently exist in California. Making estimates even more difficult is the fact that hundreds of storefront dispensaries are operating across the state, and it is unclear how many are being operated as part of a cooperative or collective.

[234] California, Attorney General. Guidelines for the Security and Non-Diversion of Marijuana Grown for Medical Use. *Available at* http://ag.ca.gov/cms_attachments/press/pdfs/n1601_medicalmarijuanaguidelines.pdf.

> property, credits, or services. Cooperatives must follow strict rules on organization, articles, elections, and distribution of earnings, and must report individual transactions from individual members each year. Agricultural cooperatives are likewise nonprofit corporate entities "since they are not organized to make profit for themselves, as such, or for their members, as such, but only for their members as producers." Agricultural cooperatives share many characteristics with consumer cooperatives. Cooperatives should not purchase marijuana from, or sell to, non-members; instead, they should only provide a means for facilitating or coordinating transactions between members.
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> 2. **Collectives:** California law does not define collectives, but the dictionary defines them as "a business, farm, etc., jointly owned and operated by the members of a group." Applying this definition, a collective should be an organization that merely facilitates the collaborative efforts of patient and caregiver members – including the allocation of costs and revenues. As such, a collective is not a statutory entity, but as a practical matter it might have to organize as some form of business to carry out its activities. The collective should not purchase marijuana from, or sell to, non-members; instead, it should only provide a means for facilitating or coordinating transactions between members.[235]

While the Attorney General differentiates between cooperatives and collectives, they are essentially treated equally, so long as they are organized with sufficient structure to ensure security, non-diversion of marijuana to illicit markets, and compliance with all state and local laws.[236] To ensure this, the Attorney General makes the following suggestions regarding the operation of a cooperative or collective:[237]

> 1. **Non-Profit Operation**: Nothing in Proposition 215 or the [Medical Marijuana Program Act (MMP)] authorizes collectives, cooperatives, or individuals to profit from the sale or distribution of marijuana . . . .
>
> 2. **Business Licenses, Sales Tax, and Seller's Permits**: The State Board of Equalization has determined that medical marijuana transactions are subject to sales tax, regardless of whether the individual or group makes a profit, and those engaging in transactions involving medical marijuana must obtain a Seller's Permit. Some cities and counties also require dispensing collectives and cooperatives to obtain business licenses.
>
> 3. **Membership Application and Verification**: When a patient or primary caregiver wishes to join a collective or cooperative, the group can help prevent the diversion of marijuana for non-medical use by having potential members complete a written membership application. The following application guidelines should be followed to help ensure that marijuana grown for medical use is not diverted to illicit markets:
>
> a) Verify the individual's status as a qualified patient or primary caregiver. Unless he or she has a valid state medical marijuana identification card, this should involve personal contact with the recommending physician (or his or her agent), verification of the physician's identity, as well as his or her state licensing status.

[235] *Id.* (Citations omitted.)
[236] *See id.*
[237] *See id.*

Verification of primary caregiver status should include contact with the qualified patient, as well as validation of the patient's recommendation. Copies should be made of the physician's recommendation or identification card, if any;

b) Have the individual agree not to distribute marijuana to non-members;

c) Have the individual agree not to use the marijuana for other than medical purposes;

d) Maintain membership records on-site or have them reasonably available;

e) Track when members' medical marijuana recommendation and/or identification cards expire; and

f) Enforce conditions of membership by excluding members whose identification card or physician recommendation are [sic] invalid or have [sic] expired, or who are caught diverting marijuana for non-medical use.

4. **Collectives Should Acquire, Possess, and Distribute Only Lawfully Cultivated Marijuana**: Collectives and cooperatives should acquire marijuana only from their constituent members, because only marijuana grown by a qualified patient or his or her primary caregiver may lawfully be transported by, or distributed to, other members of a collective or cooperative. (§§ 11362.765, 11362.775.) The collective or cooperative may then allocate it to other members of the group. Nothing allows marijuana to be purchased from outside the collective or cooperative for distribution to its members. Instead, the cycle should be a closed circuit of marijuana cultivation and consumption with no purchases or sales to or from non-members. To help prevent diversion of medical marijuana to nonmedical markets, collectives and cooperatives should document each member's contribution of labor, resources, or money to the enterprise. They also should track and record the source of their marijuana.

5. **Distribution and Sales to Non-Members are Prohibited**: State law allows primary caregivers to be reimbursed for certain services (including marijuana cultivation), but nothing allows individuals or groups to sell or distribute marijuana to non-members. Accordingly, a collective or cooperative may not distribute medical marijuana to any person who is not a member in good standing of the organization. A dispensing collective or cooperative may credit its members for marijuana they provide to the collective, which it may then allocate to other members. (§ 11362.765(c).) Members also may reimburse the collective or cooperative for marijuana that has been allocated to them. Any monetary reimbursement that members provide to the collective or cooperative should only be an amount necessary to cover overhead costs and operating expenses.

6. **Permissible Reimbursements and Allocations**: Marijuana grown at a collective or cooperative for medical purposes may be:

a) Provided free to qualified patients and primary caregivers who are members of the collective or cooperative;

b) Provided in exchange for services rendered to the entity;

c) Allocated based on fees that are reasonably calculated to cover overhead costs and operating expenses; or

d) Any combination of the above.

7. **Possession and Cultivation Guidelines**: If a person is acting as primary caregiver to more than one patient under section 11362.7(d)(2), he or she may aggregate the possession and cultivation limits for each patient. For example, applying the MMP's basic possession guidelines, if a caregiver is responsible for three patients, he or she may possess up to 24 oz. of marijuana (8 oz. per patient) and may grow 18 mature or 36 immature plants. Similarly, collectives and cooperatives may cultivate and transport marijuana in aggregate amounts tied to its membership numbers. Any patient or primary caregiver exceeding individual possession guidelines should have supporting records readily available when:

a) Operating a location for cultivation;

b) Transporting the group's medical marijuana; and

c) Operating a location for distribution to members of the collective or cooperative.

8. **Security**: Collectives and cooperatives should provide adequate security to ensure that patients are safe and that the surrounding homes or businesses are not negatively impacted by nuisance activity such as loitering or crime. Further, to maintain security, prevent fraud, and deter robberies, collectives and cooperatives should keep accurate records and follow accepted cash handling practices, including regular bank runs and cash drops, and maintain a general ledger of cash transactions.

Decentralized Regulation

As noted above, there is no statewide regulation of cooperatives and collectives. Rather, many cities and counties have issued ordinances to regulate the operation of medical marijuana dispensaries run by cooperatives and collectives within their respective jurisdictions. As a result, a patchwork system of regulation has emerged across the state, with regulatory requirements varying greatly between the various cities and counties.[238] In other words, one county might have extensive zoning, operational, and security regulations in place regarding dispensaries, while the neighboring county may ban the operation of dispensaries altogether.

Recent Developments in California

In recent years, the United States Department of Justice has indicated an inclination to defer to state and local enforcement in states that authorize the production, distribution, and

[238] As of this writing, Americans for Safe Access lists 44 cities and 10 counties in California that have issued ordinances to regulate medical marijuana dispensaries, and 193 cities and 20 counties that have banned medical marijuana dispensaries. *Available at* http://www.safeaccessnow.org/california_local_regulations.

possession of medical marijuana, provided that those states establish sufficiently robust and effective regulatory and enforcement systems.[239] However, as noted above, California has no statewide regulation of medical marijuana collectives, cooperatives, and dispensaries. As a result, on October 7, 2011, the four California-based United States Attorneys announced the commencement of coordinated enforcement actions to target illegal operations of the state's commercial marijuana industry.[240] Arguing that large commercial marijuana operations use dispensaries to disguise their illegal activities, federal authorities began a widespread enforcement campaign that included the targeting of medical marijuana dispensaries.[241] Since then, hundreds of medical marijuana dispensaries in California have been shut down by federal authorities.[242]

In addition, two recent California court cases have increased the degree of inconsistency that exists between jurisdictions within the state. In 2013, the California Supreme Court held that neither the Compassionate Use Act nor the Medical Marijuana Program Act preempt the right of a county to ban cooperatives, collectives, or dispensaries within its jurisdiction.[243] Similarly, the Court of Appeals of the Third District of California held that the Compassionate Use Act and the Medical Marijuana Program Act do not preempt a city's police power to prohibit all marijuana cultivation within its jurisdiction.[244] As a result, an increasing number of cities and counties have begun adopting ordinances to ban the operation of dispensaries and the cultivation of marijuana, including cultivation by medical marijuana patients and their caregivers.

In an attempt to establish a statewide system of regulation for medical marijuana, Assembly Bill No. 1894 (AB 1894) was introduced in the California Legislature on February 19, 2014. Had it been enacted, AB 1894 would have, among other things:

(1) Placed regulatory oversight of commercial medical marijuana activities under the state Alcoholic Beverages Commission;

(2) Imposed extensive regulatory requirements on California's medical marijuana industry; and

(3) Authorized the board of supervisors of a county, subject to voter approval, "to impose, by ordinance, a tax on the privilege of cultivating, dispensing, producing, processing, preparing, storing, providing, donating, selling, or distributing cannabis or cannabis products, including a transactions and use tax at any rate specified by the board."

However, on May 29, 2014, the California Assembly voted against passage of AB 1894.

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[239] *See* discussion of United States Department of Justice Guidelines in Chapter 5, *infra*.
[240] *See* News Release, United States Department of Justice, California's Top Federal Law Enforcement Officials Announce Enforcement Actions Against State's Widespread and Illegal Marijuana Industry (Oct. 7, 2011). *Available at* http://www.justice.gov/dea/pubs/pressrel/pr100711.html.
[241] *See id.*
[242] *See* Joe Mozingo, Ari Bloomekatz, and David G. Savage, *U.S. Won't Interfere with States on Marijuana Sales*, Los Angeles Times, Aug. 29, 2013, http://www.latimes.com/local/lanow/la-me-ln-us-wont-interfere-with-states-on-marijuana-sales-20130829-story.html.
[243] *See City of Riverside v. Inland Empire Patients Health and Wellness Center, Inc.*, 56 Cal.4th 729, 753-63, 300 P.3d 494, 506-13 (2013).
[244] *See Maral v. City of Live Oak*, 221 Cal.App.4th 975, 983-85, 164 Cal.Rptr.3d 804, 810-11 (2013).

A similar bill, Senate Bill No. 1262 (SB 1262), was introduced in the California Legislature on February 21, 2014. Had it been enacted, SB 1262 would have established a new regulatory body, the Bureau of Medical Marijuana Regulation, within the state Department of Consumer Affairs. The Bureau would have been required to consult with the California Marijuana Research Program at the University of California regarding the administration and use of medical marijuana. The Bureau would also have been required to set standards for commercial medical marijuana activity, as well as standards for laboratories that test medical marijuana. It should be noted that this bill was considered controversial by some medical marijuana advocates. Among the concerns raised was the fact that the bill appeared to preserve a county's right to ban the operation of dispensaries and cultivation of marijuana within its jurisdiction. It is therefore unclear whether SB 1262, if enacted, would have been effective in reducing the level of inconsistency that exists between the jurisdictions of the state. The California Assembly Appropriations Committee declined to vote on SB 1262, effectively bringing an end to the possibility of the measure's enactment.

Medical Marijuana Programs Resist Simple Categorization

There may be a tendency to want to categorize medical marijuana programs along artificial lines (such as restrictive or nonrestrictive programs) in order to better grasp the similarities and differences of programs established by other states. The reader is cautioned against such an attempted approach, however, given the wide variation in how states have addressed the issues and program characteristics in establishing their medical marijuana programs. Such an approach would seem too simplistic and would ignore significant nuances of each state's program. The following examples may illustrate the point.

Patient dispensing limits and possession limits vary considerably between the states. New Jersey and Vermont both impose dispensing limits of no more than two ounces of usable marijuana in a thirty-day period. On the other hand, New Hampshire's dispensing limit is two ounces per ten-day period -- effectively three times that of New Jersey and Vermont. Also, Colorado and Oregon do not base their dispensing limits on a set period of time. Therefore, it appears that dispensaries in Colorado and Oregon could continue to dispense medical marijuana to a qualifying patient, so long as the patient did not exceed possession limits for that particular point in time. In this sense, it might be interpreted that the New Jersey and Vermont systems are more restrictive, while the Colorado, New Hampshire, and Oregon systems are less restrictive.

Alternatively, one might attempt to look at the annual fees imposed by the states to determine which systems are more or less restrictive. For example, Delaware imposes a $40,000 annual fee and Massachusetts imposes a $50,000 annual fee. Conversely, Arizona imposes a $1,000 annual fee. Connecticut is unusual in this regard since it imposes a $1,000 annual fee for dispensaries, but a $75,000 annual fee for cultivation centers. Therefore, if one were to use annual fees as a benchmark, the Delaware and Massachusetts systems might be considered more restrictive, the Arizona system less restrictive, with Connecticut being somewhere in between.

Similarly, tax treatment of medical marijuana sales might also be used to compare the various state distribution systems. Illinois, Nevada, New York, and Rhode Island have all established a tax or surcharge that applies specifically to the sale of medical marijuana. Arizona, Colorado, Connecticut, Delaware, Maine, Maryland, New Jersey, and New Mexico apply the state sales or gross receipts tax to the sale of medical marijuana. On the other hand, Massachusetts, Minnesota, New Hampshire, Oregon, and Vermont either have no sales tax, or the tax does not apply to the sale of medical marijuana. In this sense, the Illinois, Nevada, New York, and Rhode Island systems might be considered more restrictive, while the Massachusetts, Minnesota, New Hampshire, Oregon, and Vermont systems might be considered less restrictive, with the remaining states somewhere in the middle.

Chapter 5

FEDERAL POSITION ON THE MEDICAL USE OF MARIJUANA

Controlled Substances Act

The Controlled Substances Act, which was enacted by the United States Congress in 1970, is the basis for federal drug policy under which the manufacture, use, possession, and distribution of certain substances is regulated. The Controlled Substances Act establishes five categories, or "schedules," into which controlled substances are placed. Marijuana is classified as a Schedule I substance.[1] This means that the federal government considers marijuana to have a high potential for abuse and no currently accepted medical use in treatment in the United States.[2] The federal position is that marijuana has not met the rigorous safety and efficacy standards of the United States Food and Drug Administration's approval process and that smoking marijuana is a particularly unsafe delivery system that produces harmful effects.[3]

Under the Controlled Substances Act, possession of any amount of marijuana is punishable as follows:

(1) For a first offense:

(A) A term of imprisonment of not more than one year;

(B) A minimum fine of $1,000; or

(C) Both;

(2) For a second offense:

(A) A term of imprisonment of not less than fifteen days, but not more than two years; and

(B) A minimum fine of $2,500; and

(3) For all subsequent offenses:

(A) A term of imprisonment of not less than ninety days, but not more than three years; and

(B) A minimum fine of $5,000.[4]

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[1] 21 U.S.C. § 812(c).
[2] 21 U.S.C. § 812(b).
[3] *See* OFFICE OF NATIONAL DRUG CONTROL POLICY, ANSWERS TO FREQUENTLY ASKED QUESTIONS ABOUT MARIJUANA, *available at* http://www.whitehouse.gov/ondcp/frequently-asked-questions-and-facts-about-marijuana.
[4] 21 U.S.C. § 844.

Further, distributing marijuana or possessing marijuana with the intent to distribute carries penalties ranging from up to five years of imprisonment and a $250,000 fine (in cases involving less than fifty kilograms of marijuana) to life imprisonment and a $10,000,000 fine (in cases involving 1,000 kilograms or more of marijuana).[5] Penalties may be doubled, or tripled for repeat offenders, in cases involving distribution of marijuana to a person under twenty-one years of age or cases where distribution of marijuana or possession of marijuana with intent to distribute occurs within one thousand feet of a school, college, university, or public housing facility or within one hundred feet of a youth center, public swimming pool, or video arcade.[6, 7]

United States Department of Justice Guidelines

On October 19, 2009, the United States Department of Justice issued a memorandum (hereafter 2009 memorandum) to federal prosecutors in the fourteen states that, at that time, had enacted state laws to address the medical use of marijuana.[8] In the 2009 memorandum, the Department of Justice reiterated its commitment to enforcing the Controlled Substances Act in all states, but advised prosecutors to abstain from pursuing cases against individuals for marijuana offenses that did not violate state medical marijuana laws.

The 2009 memorandum stated, in pertinent part:

> The 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 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. For example, prosecution of individuals with cancer or other serious illnesses who use marijuana as part of a recommended treatment regimen consistent with applicable state law, or those caregivers in clear and unambiguous compliance with existing state law who provide individuals with marijuana, is unlikely to be an efficient use of limited federal resources. On the other hand, prosecution of commercial enterprises that unlawfully market and sell marijuana for profit continues to be an enforcement priority of the Department. To be sure, claims of compliance with state or local law may mask operations inconsistent with the terms, conditions, or purposes of those laws, and federal law enforcement should not be deterred by such assertions when otherwise pursuing the Department's core enforcement priorities.[9]

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[5] *See* 21 U.S.C. § 841.
[6] *See* 21 U.S.C. §§ 859 and 860.
[7] This overview is representative but not exhaustive. The Controlled Substances Act prohibits and provides additional penalties for related acts, such as cultivating marijuana, selling or transporting paraphernalia, operating a continuing criminal enterprise, investing illicit drug profits, and maintaining drug-involved premises.
[8] *See* Memorandum from Deputy Attorney General David W. Ogden to selected United States Attorneys (Oct. 19, 2009). *Available at* http://www.justice.gov/opa/documents/medical-marijuana.pdf.
[9] *Id.* at 1-2.

The 2009 memorandum emphasized that:

(1) No state can authorize violations of federal law;

(2) Issuance of the memorandum did not alter in any way the Department of Justice's authority to enforce federal law, including prohibitions related to marijuana on federal property; and

(3) The memorandum did not in any way "legalize" marijuana or provide a legal defense to the violation of federal law.[10]

In a subsequent memorandum issued on August 29, 2013 (hereafter 2013 memorandum), the Department of Justice enumerated the following specific nationwide enforcement priorities regarding marijuana:

- 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.[11]

The 2013 memorandum noted that 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[,]" but has generally left enforcement to state and local authorities unless the marijuana-related activities implicated the priorities enumerated above.[12]

The Department of Justice indicated that it is inclined to defer to state and local enforcement in states that authorize the production, distribution, and possession of medical marijuana only if the affected states "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."[13]

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[10] *See id.* at 2.
[11] Memorandum from Deputy Attorney General James M. Cole to all United States Attorneys (Aug. 29, 2013). *Available at* http://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf.
[12] *Id.* at 2.
[13] *Id.*

The 2013 memorandum emphasized the need for effective implementation of state regulatory schemes: "Jurisdictions that have implemented systems that provide for regulation of marijuana activity 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."[14] The 2013 memorandum warned that states that enact marijuana legalization schemes but fail to implement them effectively could be subject to federal intervention: "If state enforcement efforts are not sufficiently robust to protect against [the harms that are the bases of the enforcement priorities enumerated 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."[15]

The 2013 memorandum also explicitly stated that it is intended "solely as a guide to the exercise of investigative and prosecutorial discretion[,]" but "does not alter in any way the Department's authority to enforce federal law, including federal laws relating to marijuana, regardless of state law."[16] The 2013 memorandum further cautioned that "[n]either 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 [Controlled Substances Act,]" and that investigation and prosecution that serve an important federal interest may continue regardless of a state's strong and effective regulatory system for marijuana.

It should be noted that the federal government has taken enforcement action in Hawaii and other states, despite these states' adoption of laws authorizing the use of marijuana for medical purposes. For example, a resident of Hawaii County who promoted the use of medical marijuana as part of his ministry was sentenced on April 28, 2014, to sixty months in federal prison after pleading guilty to one count of conspiring to manufacture, distribute, and possess with intent to distribute one hundred or more marijuana plants.[17] It should also be noted, however, that the amount of marijuana at issue in this case far exceeded the amount authorized by state law for personal medical use,[18] and the prosecution centered on sales and distribution rather than personal medical use.[19]

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[14] *Id.* at 2-3.
[15] *Id.* at 3.
[16] *Id.* at 4.
[17] *See* Press Release, United States Department of Justice, Roger and Sherryanne Christie Sentenced to Prison (Apr. 28, 2014). *Available at* http://www.justice.gov/usao/hi/news/1404christie.html.
[18] Current state law limits a qualifying patient's possession of medical marijuana to no more than three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant. Section 329-121, HRS.
[19] *See U.S. v. Christie*, No. 1:10-cr-00384-LEK (D. Hawaii 2014).

United States Department of the Treasury Guidelines

Marijuana-related businesses have complained that federal marijuana prohibitions, combined with federal requirements regarding financial institutions, block their access to banking and credit card services and limit them to cash transactions that raise security concerns.[20] This blocking of access to banking services includes the inability of state-authorized marijuana businesses to deposit money received in connection with marijuana-related transactions into financial institutions. Banks have also raised concerns that providing services to marijuana-related businesses could subject them to federal penalties.[21] Given the recent state initiatives to legalize certain marijuana-related activity and the Department of Justice enforcement priorities relating to marijuana, the United States Department of the Treasury issued a memorandum[22] (hereafter Treasury memorandum) on February 14, 2014, to clarify Bank Secrecy Act[23] expectations for financial institutions, such as banks, that seek to provide services to marijuana-related businesses.

Bank Secrecy Act

To detect and deter money laundering and other financial transactions constituting or related to criminal activity, the Bank Secrecy Act requires United States financial institutions to maintain specific records and submit various reports to the federal government, including Suspicious Activity Reports regarding any transaction relevant to a possible violation of a law or regulation.[24] In summary, the Treasury memorandum advises financial institutions to report business dealings with marijuana-related businesses to the Financial Crimes Enforcement Network, an agency of the Department of the Treasury, and to indicate whether or not there is suspicion of any illegal activity, other than a violation of the federal prohibitions against marijuana, or any activity that implicates any of the Department of Justice's enforcement priorities regarding marijuana.

Treasury Memorandum Guidelines

The guidance provided by the Treasury memorandum is intended to "enhance the availability of financial services for, and the financial transparency of, marijuana-related businesses" by clarifying how financial institutions can provide services to such businesses consistent with their obligations to comply with the Bank Secrecy Act.[25] In deciding whether to provide services to a marijuana-related business, the Treasury memorandum recommends that

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[20] *See* Serge F. Kovaleski, *U.S. Issues Marijuana Guidelines for Banks*, New York Times, Feb. 14, 2014, http://www.nytimes.com/2014/02/15/us/us-issues-marijuana-guidelines-for-banks.html.
[21] *See id.*
[22] Memorandum FIN-2014-G001 from the Department of the Treasury, Financial Crimes Enforcement Network, *BSA Expectations Regarding Marijuana-Related Businesses* (Feb. 14, 2014), *available at* http://www.fincen.gov/statutes_regs/guidance/pdf/FIN-2014-G001.pdf. (Hereafter Treasury memorandum.)
[23] 31 U.S.C. § 5311 et seq. Also referred to as the Financial Recordkeeping and Reporting of Currency and Foreign Transactions Act of 1970.
[24] *Id*.
[25] *See* Treasury memorandum, *supra* note 22, at 1.

financial institutions assess the risk of providing services and conduct customer due diligence.[26] The Treasury memorandum clarifies that because "financial transactions involving a marijuana-related business would generally involve funds derived from illegal activity[,]" and because "the obligation to file a [Suspicious Activity Report] is unaffected by any state law that legalizes marijuana-related activity[,]" financial institutions providing financial services to a marijuana-related business are thus required to file suspicious activity reports. [27]

The Treasury memorandum specifies that a financial institution should file a "Marijuana Limited" Suspicious Activity Report if the institution reasonably believes, based on its customer due diligence, that the marijuana-related business it provides service to *does not* implicate any of the priorities enumerated in the Department of Justice's 2013 memorandum[28] or violate state law. The Treasury memorandum advises that a Marijuana Limited report should be limited to identifying the subject and related parties, addresses of the subject and related parties, the fact that the filing institution is filing the report *solely* because the subject is engaged in a marijuana-related business, and the fact that *no additional suspicious activity* has been identified.[29]

Conversely, the Treasury memorandum advises that a financial institution that reasonably believes a marijuana-related business implicates any of the Justice Department's enumerated enforcement priorities or violates state law should file a "Marijuana Priority" Suspicious Activity Report that includes comprehensive details about the enforcement priorities the financial institution believes have been implicated and all pertinent information regarding the financial transactions involved in the suspicious activity.[30] The Treasury memorandum also provides examples of possible signs that a marijuana-related business is involved in money laundering or other criminal activity, such as receiving substantially more revenue than may reasonably be expected given relevant regulations, competition, and population demographics.[31]

Recent Federal Developments

Pending Legislation

There do not appear to be any strong indications that the United States Congress will approve the legalization of marijuana for medical purposes in the near future. However, it is

[26] The Treasury memorandum recommends that due diligence include "(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 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." *Id.* at 2-3.
[27] *Id.* at 3.
[28] *Supra* note 11.
[29] *Supra* note 22, at 3-4.
[30] *Id.* at 4.
[31] *Id.* at 5-6.

possible that Congress will prohibit certain federal spending on enforcement that interferes with state implementation of laws authorizing the use of medical marijuana, which could effectively curtail federal enforcement.

The United States House of Representatives has approved an amendment to an appropriations bill that would, if approved by the Senate and the President, prohibit the United States Department of Justice from spending federal funds in federal fiscal year 2015 to prevent states from implementing state laws that authorize the use, distribution, possession, or cultivation of marijuana for medical purposes.[32]

The measure, House Amendment 748, would amend the Commerce, Justice, and Science, and Related Agencies Appropriations Act of 2015 (H.R. 4660), and states in pertinent part:

> None of the funds made available in this Act to the Department of Justice may be used, with respect to the States of Alabama, Alaska, Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Illinois, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Washington, and Wisconsin, to prevent such States from implementing their own State laws that authorize the use, distribution, possession, or cultivation of medical marijuana.[33]

It should be noted that, as currently drafted, the measure would not explicitly preclude federal enforcement of prohibitions against marijuana despite state legalization schemes -- it merely states that the funds provided by the measure are not to be used to prevent states with medical marijuana programs from implementing medical marijuana-related laws -- and could therefore be subject to interpretation. Also, the measure would not affect federal spending for such purposes in subsequent years.

Proposed Legislation

In addition to the pending legislation discussed above, other bills or amendments to existing bills have recently been proposed. For example, on July 24, 2014, an amendment was proposed to a bill being heard by the United States Senate that would recognize the right of states to enact laws that authorize "the use, distribution, possession, or cultivation of marijuana for medical use."[34] The amendment also states that "No prosecution may be commenced or maintained against any physician or patient for a violation of any Federal law (including regulations) that prohibits [the use, distribution, possession, or cultivation of marijuana for medical use] if the State in which the violation occurred has in effect a law [authorizing the use,

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[32] *See* H. Amdt. 748 to H.R. 4660, 113th Cong. (approved by a vote of 219 to 189 on May 30, 2014). *Available at* http://beta.congress.gov/amendment/113th-congress/house-amendment/748.
[33] *Id*.
[34] S.Amdt.3630 to S.2569, 113th Cong. (submitted on July 24, 2014). *Available at* https://beta.congress.gov/amendment/113th-congress/senate-amendment/3630.

distribution, possession, or cultivation of marijuana for medical use] before, on, or after the date on which the violation occurred[.]"[35]

On July 28, 2014, a bill was introduced to the United States House of Representatives that would remove therapeutic hemp[36] and cannabidiol from the definition of marijuana in the Controlled Substances Act.[37] If this bill were enacted, most strains of marijuana would still be prohibited under federal law. However, strains of marijuana with extremely low THC concentrations and cannabidiol oil would effectively become legal on a national basis.

As of this writing, it is unclear whether either of these measures will be voted upon.

Issues Regarding Transportation of Medical Marijuana in Hawaii

Federal law does not allow for the interstate transportation of medical marijuana, or transportation of medical marijuana through federal security checkpoints. Given federal prohibitions, Hawaii's unique geography as a state comprising eight major islands that are separated by ocean raises additional issues regarding the transportation of medical marijuana. The vast majority of passengers who travel between Hawaii and other states, or from one of Hawaii's islands to another, do so primarily via commercial passenger aircraft and traverse federal Transportation Security Administration checkpoints located in airports operated by the State of Hawaii. Also, courts have held that the state's territory is divided by international waters between the state's major islands, and that travel between those islands therefore constitutes interstate travel even though the destinations are within the same state.[38] Federal district and appellate court decisions found that "the State of Hawaii, both in coming into union with and in its annexation to the United States, had not considered or insisted that the *channels* between the various islands of Hawaii were 'historic waters' acquired by Hawaii by prescription."[39] The courts concluded that the airspace above the international waters between Hawaii's islands is likewise a place outside the state's territory and thus transportation through that air space constitutes interstate commerce.[40] In addition, federal law expressly defines interstate air transportation, in pertinent part, as transportation of passengers or property by aircraft as a common carrier for compensation "between a place in . . . Hawaii and another place in Hawaii through the airspace over a place outside Hawaii."[41]

As discussed in Chapter 2, Hawaii law is unsettled with regard to the circumstances in which a qualifying patient or primary caregiver may legally possess or transport medical marijuana outside the home.[42] It should be noted that, in the *Woodhall* case discussed in Chapter

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[35] *Id.*
[36] For the purposes of this bill, "therapeutic hemp" refers to marijuana that has a THC concentration of not more than 0.3 percent.
[37] *See* H.R.5226, 113th Cong. (introduced on July 28, 2014). *Available at* https://beta.congress.gov/bill/113th-congress/house-bill/5226.
[38] *See, e.g., Island Airlines, Inc. v. Civil Aeronautics Board*, 352 F.2d 735 (9th Cir., 1965).
[39] *Id.*, at 742.
[40] *Id.*
[41] 49 U.S.C.A. § 40102(a)(25)(A)(ii).
[42] *See* discussion of Transportation of Medical Marijuana in chapter 2, *supra*.

2, the defendant was a qualifying medical marijuana patient who was arrested in the Kona International Airport for possession of marijuana.[43] Although the Hawaii Supreme Court overturned the patient's conviction based on the specific facts of that case, the court explicitly did *not* decide whether other circumstances, locations, or modes of transportation would allow for the legal transportation of medical marijuana outside the home in Hawaii, much less between islands.[44]

Thus, at present, it does not appear that a qualifying patient or caregiver may transport medical marijuana from one island to another within the State of Hawaii without violating federal and, possibly, state drug enforcement laws.

[43] *See State v. Woodhall*, 129 Hawaii 397, 301 P.3d 607 (2013).
[44] *See id.*, 129 Hawaii at 409-10, 301 P.3d at 619-20.

Chapter 6

SUMMARY

State Medical Marijuana Programs

In 2009, the Bureau conducted a study on the policies and procedures of other state medical marijuana programs with regard to issues of access, distribution, and security. At the time, the Bureau found that, of the thirteen states that had established medical marijuana programs, only three states -- California, New Mexico, and Rhode Island -- had policies and procedures to address these issues. In the five years since that study was completed, the regulatory landscape has changed dramatically. Today, there are twenty-three states that have enacted medical marijuana programs.[1] Eighteen of these have incorporated some form of distribution system,[2] and seventeen of these are regulated at the state level.[3]

As would be expected, there are some issues or program characteristics that all or nearly all of the states with medical marijuana programs have addressed in one fashion or another. For example, universal to all medical marijuana programs are:

- Decriminalization of medical marijuana use;
- Certification by a physician that qualifying patients have a medical condition that would benefit from the medical use of marijuana; and
- Maximum limits on the amount of medical marijuana possessed by a qualifying patient and caregiver.

Nevertheless, how a state addresses other issues or program characteristics likely depends in large part upon a number of factors -- some of which may be unique to that state. As a result, while there are some general similarities, there are many differences as well among the various states' medical marijuana programs. Accordingly, there does not appear to be any one model that can be touted as an exemplary program that all states should follow. Further, only a few states have much of a track record concerning programmatic aspects of a medical marijuana distribution system and such concomitant issues as those relating to cultivation, access, safety, and security. Many of the first states to adopt medical marijuana programs did not originally provide for distribution systems, and the distribution systems are not yet operational in many of the states that only recently established medical marijuana programs.

That said, the seventeen states that provide for some type of statewide regulation of distribution systems have generally addressed, again in varying fashion, the following issues or program characteristics:

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[1] *See* discussion of Medical Marijuana Programs in chapter 3, *supra*.
[2] *See id*.
[3] *See* discussion of State Regulation of Distribution in chapter 4, *supra*.

- Means of regulation of the distribution system;
- Operational requirements, including imposition of fees and taxes, dispensary staff training, patient education information, product labeling;
- Quality and quantity control, including dispensing limits; controls on channels of supply and distribution of medical marijuana; and
- Security requirements for cultivation centers and dispensaries.

Nearly all state medical marijuana programs also have confidential patient registries that are administered by a state agency.

Medical Marijuana Programs Resist Simple Categorization

There may be a tendency to want to categorize medical marijuana programs along artificial lines (such as restrictive or nonrestrictive programs) in order to better grasp the similarities and differences of programs established by other states. The reader is cautioned against such an attempted approach, however, given the wide variation in how states have addressed the issues and program characteristics in establishing their medical marijuana programs. Such an approach would seem too simplistic and would ignore significant nuances of each state's program.

Limited Access Marijuana Product Laws

It should also be noted that a new trend in state legislation appears to be developing. In addition to the twenty-three states with medical marijuana programs, eleven other states have enacted limited access marijuana product laws over the past year that make provision for the use of certain strains of marijuana for limited medical or research purposes.[4] While not as comprehensive as more traditional medical marijuana programs, these limited access laws have the attraction of focusing on strains of marijuana that have little or no psychoactive effects. As a result, an increasing number of states have shown interest in pursuing similar laws.

Recent Federal Action

Despite the growing number of states that have enacted some form of medical marijuana legislation, the federal prohibition on marijuana remains in effect. However, during the past five years, the United States Department of Justice has indicated that it is inclined to defer to state and local enforcement in states that have medical marijuana programs, provided that those states also establish sufficiently robust and effective regulatory and enforcement systems.[5] And in response to concerns that federal prohibition blocks marijuana-related businesses from accessing banking and credit card services, the United States Department of the Treasury has issued

[4] *See* chapter 3, notes 15-34, and accompanying text, *supra*.
[5] *See* chapter 5, notes 13-15, and accompanying text, *supra*.

guidelines to clarify and streamline the federal reporting requirements of financial institutions that serve those businesses.[6]

These developments underscore the fact that, while an efficient distribution system can contribute significantly to the success of any medical marijuana program, ensuring that such a distribution system can be effectively regulated is also of vital importance to stave off increased federal drug enforcement activities that may thwart the operation of a state's medical marijuana program.

Transportation of Medical Marijuana in Hawaii

Nevertheless, these changes in federal drug enforcement policy regarding state medical marijuana programs do not specifically address Hawaii's unique geographic problems. As an island state, Hawaii must contend with a layer of potential federal intervention that other states may not otherwise have to contend with when implementing an efficient medical marijuana dispensing program. Hawaii's medical marijuana patients who travel interisland and to points outside the State must do so almost exclusively through commercial air carriers, placing them within federal law enforcement jurisdiction.[7] The potential for federal prosecution of qualifying patients traveling interisland who possess medical marijuana underscores the need for any medical marijuana dispensing strategy developed by the State of Hawaii to recognize and address this concern.

Moreover, Hawaii state law remains unsettled concerning the transportation of medical marijuana outside the home given, the inconsistency in Hawaii law between the definition of "medical use" in section 329-121, HRS, which includes the "transportation of marijuana," and the prohibition on the use of medical marijuana in any "place open to the public" under section 329-122(c)(2)(E), HRS. The Hawaii Supreme Court's holding in the *Woodhall* case, overturning the patient's conviction, was based on the specific facts of that case, and the court explicitly did *not* decide whether other circumstances, locations, or modes of transportation would allow for the legal transportation of medical marijuana outside the home in Hawaii, much less between islands.[8]

Thus, at present, it does not appear that a qualifying patient or caregiver may transport medical marijuana from one island to another within the State of Hawaii without violating federal drug enforcement laws. However, even if this were not the case, it remains unclear whether a qualifying patient or caregiver may transport medical marijuana from one island to another within the State, or even outside the home *within the same island*, without violating state drug enforcement laws.

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[6] *See* chapter 5, notes 20-31, and accompanying text, *supra*.
[7] *See* chapter 5, notes 38-41, and accompanying text, *supra*.
[8] *See State v. Woodhall*, 129 Hawaii at 409-10, 301 P.3d at 619-20.

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HOUSE OF REPRESENTATIVES
TWENTY-SEVENTH LEGISLATURE, 2014
STATE OF HAWAII

H.C.R. NO. 48 H.D. 2 S.D. 1

HOUSE CONCURRENT RESOLUTION

REQUESTING THE CONVENING OF A TASK FORCE TO DEVELOP RECOMMENDATIONS FOR THE ESTABLISHMENT OF A REGULATED STATEWIDE DISPENSARY SYSTEM FOR MEDICAL MARIJUANA.

WHEREAS, Hawaii's Medical Use of Marijuana Law was enacted on June 14, 2000, as Act 228, Session Laws of Hawaii 2000, to provide medical relief for seriously ill individuals in the State; and

WHEREAS, implementation of Act 228, Session Laws of Hawaii 2000, recognizes the beneficial use of marijuana in treating or alleviating pain or other symptoms associated with certain debilitating illnesses, and recognizes the medical benefits of marijuana; and

WHEREAS, Hawaii's Medical Use of Marijuana Law is silent on how patients can obtain medical marijuana if they or their caregivers are unable to grow their own supplies of medical marijuana; and

WHEREAS, many of the State's almost 13,000 qualifying patients lack the ability to grow their own supply of medical marijuana due to a number of factors, including disability, limited space to grow medical marijuana, and an inadequate supply of medical marijuana to take care of their medical needs; and

WHEREAS, a regulated statewide dispensary system for medical marijuana is urgently needed by qualifying patients in the State; and

WHEREAS, 20 states and Washington, D.C., have medical marijuana laws, and 13 of these 20 jurisdictions have an active regulated system of dispensaries; and

WHEREAS, several other states are in the process of implementing laws relating to the establishment of dispensaries for medical marijuana; and

WHEREAS, a regulated statewide dispensary system for medical marijuana will enable qualifying patients to obtain an inspected, safe supply of medical cannabis that is labeled as to the composition, strain, and strength of the cannabis to be most helpful to each patient's condition; and

WHEREAS, in response to Act 29, First Special Session Laws of Hawaii 2009, the Legislative Reference Bureau published a report entitled, "Access, Distribution, and Security Components of State Medical Marijuana Programs," which discussed the policies and procedures for access, distribution, security, and other relevant issues related to the medical use of marijuana in all states that had a medical marijuana program; and

WHEREAS, establishment of a tightly regulated statewide dispensary system was the number one recommendation of the 2010 Medical Marijuana Working Group; and

WHEREAS, the transfer of Hawaii's Medical Marijuana Program from the Department of Public Safety to the Department of Health in 2015 is an acknowledgement by the Legislature that the program is a public health program; and

WHEREAS, a tightly regulated dispensary system for medical marijuana will comport with the spirit and intent of the Medical Use of Marijuana Law: compassion for Hawaii's suffering patients and the provision of safe, legal, and reliable access for qualifying patients; and

WHEREAS, there are many models of medical marijuana dispensary systems available in other state jurisdictions, including models that were enacted after the passage of Hawaii's Medical Use of Marijuana Law; and

WHEREAS, to provide equitable access to medical marijuana, the unique geography of the State with its four counties on different islands must be considered in the design and implementation of a regulated statewide dispensary system for medical marijuana; now, therefore,

BE IT RESOLVED by the House of Representatives of the Twenty-seventh Legislature of the State of Hawaii, Regular Session of 2014, the Senate concurring, that the Public Policy Center in the College of Social Sciences at the University of Hawaii at Manoa (Public Policy Center) is requested to convene a Medical Marijuana Dispensary System Task Force (Task Force) to develop recommendations for the establishment of a regulated statewide dispensary system for medical marijuana to provide safe and legal access to medical marijuana for qualified patients; and

BE IT FURTHER RESOLVED that the Task Force be assigned to the Public Policy Center for administrative purposes and is requested to make recommendations and propose legislation on the design and structure of a regulated statewide dispensary system for medical marijuana; and

BE IT FURTHER RESOLVED that the Task Force shall be comprised of:

(1) The Attorney General, or the Attorney General's designee;

(2) The Director of Health, or the Director's designee;

(3) The Director of Public Safety, or the Director's designee;

(4) The Director of Taxation, or the Director's designee;

(5) The Director of Commerce and Consumer Affairs, or the Director's designee;

(6) The Director of the Public Policy Center, or the Director's designee;

(7) The Prosecuting Attorney of the City and County of Honolulu, or the Prosecuting Attorney's designee;

(8) A police chief chosen by the Law Enforcement Coalition, or the police chief's designee;

(9) The Chairperson of the Senate Committee on Health;

(10) The Chairperson of the House Committee on Health;

(11) A state senator who is selected by the Senate President to serve on the Task Force;

(12) A state representative who is selected by the Speaker of the House of Representatives to serve on the Task Force;

(13) A representative from the University of Hawaii College of Tropical Agriculture and Human Resources;

(14) A representative of the Drug Policy Forum of Hawaii;

(15) A physician participating in Hawaii's Medical Marijuana Program;

(16) Two participants in Hawaii's Medical Marijuana Program, one of whom is a patient who is over the age of 18, and one of whom is a parent or guardian of a patient who is under the age of ten;

(17) A caregiver participating in Hawaii's Medical Marijuana Program;

(18) A representative from the American Civil Liberties Union of Hawaii;

(19) A representative from the Hawaii Medical Association; and

(20) A representative from the Coalition for a Drug-Free Hawaii; and

BE IT FURTHER RESOLVED that the issues to be addressed by the Task Force include the appropriate number and location of dispensaries statewide; the design of a tax structure (state and county); location and restriction issues; methodology for ensuring safety of supply; a framework for cultivating and manufacturing medical marijuana products; regulations to ensure security and public safety; restrictions on advertising; issues raised and compliance with any guidelines and/or directives issued by federal agencies with respect to medical marijuana; and

BE IT FURTHER RESOLVED that no later than September 1, 2014, the Legislative Reference Bureau is requested to complete and submit to the Task Force an updated report on the policies and procedures for access, distribution, security, and other relevant issues related to the medical use of cannabis in all states that currently have a medical cannabis program; and

BE IT RESOLVED that, as part of its report, the Legislative Reference Bureau is requested to examine and include information concerning the policies and procedures adopted by other states relating to the growth and cultivation of medical marijuana and the regulation of medical marijuana dispensaries; and

BE IT FURTHER RESOLVED that the Task Force is requested to hold at least one public hearing to receive public input on the updated report received from the Legislative Reference Bureau containing the policies and procedures for access, distribution, security, and other relevant issues related to the medical use of cannabis in all states that currently have a medical cannabis program; and

BE IT FURTHER RESOLVED that the Task Force is requested to submit a report of its findings and recommendations, including any proposed legislation, to the Legislature no later than 20 days prior to the convening of the Regular Session of 2015; and

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the Governor, President of the Senate, Speaker of the House of Representatives, Attorney General, Director of Health, Director of Public Safety, Director of Taxation, Director of Commerce and Consumer Affairs, Director of the Public Policy Center in the College of Social Sciences at the University of Hawaii at Manoa, Prosecuting Attorney of the City and County of Honolulu, Executive Director of the American Civil Liberties Union of Hawaii, Executive Director of the Drug Policy Forum of Hawaii, Dean of the University of Hawaii College of Tropical Agriculture and Human Resources, Executive Director of the Hawaii Medical Association, Law Enforcement Coalition, Executive Director of the Coalition for a Drug-Free Hawaii, and Acting Director of the Legislative Reference Bureau.