SENATE BILL REPORT
SB 5887

As of February 18, 2014

Title: An act relating to the medical use of cannabis.

Brief Description: Concerning the medical use of cannabis.

Sponsors: Senators Rivers, Tom and Litzow.

Brief History:
Committee Activity: Ways & Means: 4/16/13, 1/16/14 [w/oRec-HLTH]; 2/19/14.
Health Care: 1/21/14, 1/23/14 [DPS-CL, w/oRec].
Commerce & Labor: 2/05/14, 2/07/14 [DP2S-WM, DNP].

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That it be referred without recommendation and be referred to Committee on Health Care.

Signed by Senators Hill, Chair; Honeyford, Capital Budget Chair; Keiser, Assistant Ranking Member on the Capital Budget; Bailey, Becker, Billig, Braun, Dammeier, Fraser, Frockt, Hasegawa, Hatfield, Hewitt, Kohl-Welles, Padden, Parlette, Rivers and Tom.

Staff: Dean Carlson (786-7305)

SENATE COMMITTEE ON HEALTH CARE

Majority Report: That Substitute Senate Bill No. 5887 be substituted therefor, and the substitute bill do pass and be referred to Committee on Commerce & Labor.

Signed by Senators Becker, Chair; Dammeier, Vice Chair; Pedersen, Ranking Member; Angel, Bailey, Cleveland and Keiser.

Minority Report: That it be referred without recommendation.

Signed by Senator Parlette.

Staff: Kathleen Buchli (786-7488)

SENATE COMMITTEE ON COMMERCE & LABOR

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Majority Report: That Second Substitute Senate Bill No. 5887 be substituted therefor, and the second substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Braun, Vice Chair; Conway, Ranking Member; Hasegawa, Hewitt, King and Kohl-Welles.

Minority Report: Do not pass.

Signed by Senator Holmquist Newbry, Chair.

Staff: Edith Rice (786-7444)

Background: Medical Use of Marijuana. In 1998 voters approved Initiative 692 which permitted the use of marijuana for medical purposes by qualifying patients. The Legislature subsequently amended the chapter on medical use of marijuana in 2007, 2010, and 2011. In order to qualify for the use of medical marijuana, patients must have a terminal or debilitating medical condition such as cancer, the human immunodeficiency virus, multiple sclerosis, intractable pain, glaucoma, Crohn's disease, hepatitis C, nausea or seizure diseases, or a disease approved by the Medical Quality Assurance Commission, and the diagnosis of this condition must be made by a health care professional. The health care professional who determines that a person would benefit from the medical use of marijuana must provide that patient with valid documentation written on tamper-resistant paper.

Qualifying patients who hold valid documentation may assert an affirmative defense at trial that they are authorized medical cannabis patients. These patients are not currently provided arrest protection.

Patients may grow medical marijuana for themselves or designate a provider to grow on their behalf. Designated providers may only provide for one patient at a time, must be 18 years of age, and must be designated in writing by the qualifying patient to serve in this capacity. There is no age limit for patients. Qualified patients and their designated providers may possess no more than 15 marijuana plants and 24 ounces of useable marijuana product. Up to ten qualified patients may pool resources and grow marijuana for their personal medical use by creating and participating in collective gardens.

No state agency is provided with regulatory oversight of medical marijuana. The Department of Health (DOH) does provide guidance to its licensees who recommend the medical use of marijuana, and is the disciplinary authority for its providers who authorize the medical use of marijuana in violation of the statutory requirements. DOH does not perform investigations until a complaint is made that someone is unlawfully authorizing the medical use of marijuana. There are no statutory licensing or production standards for medical marijuana and there are no provisions for taxation of medical marijuana sales.

Recreational Use of Marijuana. In 2012 voters approved Initiative 502 which established a regulatory system for the production, processing, and distribution of limited amounts of marijuana for non-medical purposes. Under this system, the Liquor Control Board (LCB) issues licenses to marijuana producers, processors, and retailers and adopts standards for the regulation of these operations. Persons over 21 years of age may purchase up to one ounce of useable marijuana, 16 ounces of solid marijuana-infused product, and 72 ounces of liquid marijuana-infused product at a licensed retailer.

The operating budget passed in the 2013 legislative session contains a proviso that requires LCB to work with DOH and the Department of Revenue (DOR) to address medical use of cannabis in light of legalization of the recreational use of cannabis and develop recommendations for the Legislature regarding the interaction of medical marijuana regulations and the provisions of Initiative 502. As requested, recommendations on age limits, collective gardens, taxation issues, oversight of health care professionals, and possession amounts were developed. In general the recommendations integrated the medical and recreational systems into one licensing system. LCB must retain authority over licensees and develop a medical marijuana endorsement for those licensees who choose to provide medical products to qualifying patients. DOH must retain authority over the health care professionals and will develop a registry to verify qualifying patients and designated providers. Patients and providers must be entered into the registry by their authorizing health care professional, but the recommendations suggest that they be provided with additional benefits not available to those people in the recreational market. These include the ability to possess up to three ounces of useable marijuana, to be able to grow up to six plants in their own homes, and the ability to purchase marijuana without paying sale and use taxes.

Other recommendations of the workgroup include allowing 18 to 20 year olds to have access to medical marijuana; allowing access to medical marijuana for children under 18 years old with parent or guardian consent; allowing access to the registry for law enforcement, DOR, and health professions disciplining authorities; requiring DOH to define debilitating and intractable pain; and eliminating collective gardens.

Federal Response to State Marijuana Regulations. Washington is one of 20 states that have passed legislation allowing the use of marijuana for medicinal purposes, and one of two states that allow its recreational use. These activities, however, remain illegal under federal law. Absent congressional action, state laws permitting the use of marijuana will not protect a person from legal action by the federal government. In recent years, the United States Department of Justice (DOJ) has issued several policy statements regarding state regulation of marijuana. The latest of these was issued in August 2013. In this memorandum, federal prosecutors were instructed to focus investigative and prosecutorial resources related to marijuana on specific enforcement priorities to prevent the distribution of marijuana to minors; marijuana sales revenue from being directed to criminal enterprises; marijuana from being diverted from states where it is legal to states in which it is illegal; state-authorized marijuana activity from being used as a cover for trafficking other illegal drugs or other illegal activity; violence and the use of firearms in the production and distribution of marijuana; drugged driving and other marijuana-related public health consequences; the growth of marijuana on public lands; and marijuana possession or use on federal property.

The memorandum maintains that DOJ has not historically prosecuted individuals in cases that pertain to the possession of small amounts of marijuana for personal use on private property. With respect to state laws that authorize marijuana production, distribution, and possession, the memorandum asserts that when these activities are conducted in compliance with strong and effective regulatory and enforcement systems, there is a reduced threat to federal priorities. In those instances, the memorandum provides that state and local law enforcement should be the primary means of regulation. The memorandum, however,

continues to affirm its authority to challenge the regulatory system and to bring individual enforcement actions in cases in which state enforcement efforts are inadequate.

Summary of Bill: The bill as referred to committee not considered.

Summary of Bill (Recommended Second Substitute): DOH must develop a Medical Marijuana Registry (Registry) and issue authorization cards to qualifying patients and their designated providers. The Registry must allow health care professionals to enter qualifying patients or designated providers; law enforcement officers and marijuana retailers to confirm the validity of authorization cards; LCB and DOR to verify tax-exempt purchases; and DOH to monitor entries and ensure health care professional compliance. After a health care professional enters a qualifying patient or designated provider into the Registry, DOH must issue an authorization card to that person. Authorization cards are valid for one year and when they expire, the patient or provider must seek reauthorization and reentry into the Registry. Authorization cards must include the patient or provider's name, the name of the patient the provider is assisting, the effective and expiration dates of the verification card, and the name of the health care professional who entered the patient in the Registry, and the amount of useable marijuana and plants for which the patient is authorized. The Registry must ensure patient and provider privacy, and ensure that patient information is not subject to the Public Disclosure Act.

A qualifying patient or designated provider who holds an authorization card is provided with arrest protection; may possess up to eight ounces of useable marijuana, 48 ounces of marijuana-infused product in solid form, and 216 ounces of marijuana-infused product in liquid form; and may grow up to 15 marijuana plants for the personal medical use of the qualifying patient. Marijuana retailers who hold an endorsement and sell to patients are exempt from the 25 percent excise tax collected at the point of sale, and patients and providers with valid authorization cards are provided a sales and use tax exemption. A sales tax exemption is provided to current sales of medical marijuana.

Collective gardens are eliminated as of July 30, 2016.

LCB must develop a medical marijuana endorsement to retail licenses. A licensed marijuana retailer who holds a marijuana endorsement may sell to qualifying patients 18 years of age and older and designated providers 21 years of age or older; and sell up to eight ounces of useable marijuana, 48 ounces of marijuana-infused product in solid form, and 216 ounces of marijuana-infused product in liquid form. The retailer must also carry useable marijuana and marijuana-infused products with a cannabidol level identified by LCB as appropriate for medical use. Marijuana retailers who hold a medical marijuana endorsement may indicate on their retail sign that they hold an endorsement by adding a green cross to the sign.

In issuing retail licenses, LCB must consider the number of marijuana retail stores holding medical endorsements necessary to meet the medical needs of qualifying patients and allowing for a number of such stores to be solely medical. In determining how licenses will be allocated to applicants, LCB must include a preferences for those stores that are applying for a medical marijuana endorsement and that intend to be solely medical. Marijuana retailers who apply for a medical marijuana endorsement must indicate in their application whether they intend to sell recreational and medical, or solely medical.

Thirty percent of the excise tax collected from marijuana retailers at the point of sale must be distributed to counties and towns for the purposes of law enforcement and public safety activities. Revenue from marijuana excise taxes that had been directed to the Basic Health Plan are redirected to fund low-income health care and mental health services.

Health care professionals may authorize the medical use of marijuana to persons under the age of 18 if the minor's parent or guardian participates in the minor's treatment and agrees to the medical use by the minor, and the parent or guardian has sole control over the minor's medical marijuana. However, the minor may possess up to the amount of that minor's next dose. Minors may not grow plants nor may they purchase from a marijuana retailer. Health care professionals who authorize the medical use of marijuana for a minor must consult with other health care providers involved in the child's treatment as medically indicated and reexamine the child at least once per year or more frequently as medically indicated.

DOH must convene a workgroup including the Medical Quality Assurance Commission, the Board of Osteopathic Medicine and Surgery, the Nursing Care Quality Assurance Committee, and the Board of Naturopathy. The workgroup must develop practice guidelines for health care professionals to consider when authorizing the medical use of marijuana. DOH must make these practice guidelines broadly available to health care professionals.

It is a class C felony to produce any record purporting to be valid documentation or backdate valid documentation; produce a verification card or tamper with a verification card; or sell, donate, or otherwise provide marijuana obtained for a qualifying patient to another person.

EFFECT OF CHANGES MADE BY COMMERCE & LABOR COMMITTEE (Proposed First Substitute):

- Changes the name of the Liquor Control Board to the Liquor and Cannabis Board.
- Rather than mandating that the Liquor and Cannabis Board give a preference to marijuana retailers who indicate they intend to be solely medical, the Liquor and Cannabis Board may give such a preference in licensing if it determines that the needs of qualifying patients are not being met by currently licensed marijuana retailers.
- Corrects the dates in which the sales and use tax exemptions take effect or expire. Qualifying patients are provided a sales tax exemption beginning July 1, 2015, to coincide with the beginning of the medical marijuana endorsement system, including the patient registry. Sales at collective gardens are provided a sales tax exemption through July 30, 2016, to coincide with the repeal of that statute.
- Permits health care professionals to remove patients from the registry if the patient no longer qualifies for the medical use of marijuana.
- Provides effective and expiration dates. The medical marijuana registry and the medical marijuana endorsements take effect July 1, 2015. Collective gardens expire July 30, 2016.

EFFECT OF CHANGES MADE BY HEALTH CARE COMMITTEE (Recommended Substitute): Qualifying patients who are below the age of 18 may enter retail stores that have medical marijuana endorsements if those stores are solely medical. Minors must have a

parent or guardian with them in the store. Persons age 18–21 who are qualifying patients may enter retail stores with medical marijuana endorsements that sell to both the recreational and medical market. Current sales of medical marijuana are exempt from sales tax. The amount of useable marijuana a patient may possess and the number of plants a patient may grow is modified: unless a health care professional recommends otherwise, a patient may purchase three ounces of useable marijuana and may grow six plants. The patient my also possess as much marijuana as can be made from three plants, or a health care professional may recommend up to eight ounces and 15 plants if the professional determines that the patient requires the additional amounts. Additional amounts authorized must be included in the registry, and the amount the patient is authorized for must be included on their authorization card. In developing practice guidelines, DOH must consult with medical marijuana stakeholders who are appointed by the Governor. The guidelines must also consider the conditions that may benefit from the medical use of marijuana. The repeal of local government zoning authority over medical marijuana is delayed in order to coincide with the repeal of the collective gardens.

Revenue directed under I-502 to the Basic Health Plan is directed to low-income health care and mental health care rather than funding research and the Medical Marijuana Registry.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on January 19, 2014.
[OFM requested ten-year cost projection pursuant to I-960.]

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on Original Bill (Ways & Means): None.

Persons Testifying (Ways & Means): No one.

Staff Summary of Public Testimony on Proposed Substitute as Heard in Committee (Health Care): PRO: This bill is not an attack on medical marijuana. This bill will allow me to grow enough to treat my son. Many people will not be able to afford marijuana from a dispensary and are also concerned that they will not be able to find the products they need in an I-502 store. The alignment of the recreational and the medical systems that include mechanisms for patient access is supported. The approaches that share revenue with local governments is also good; it is imperative that local governments be provided resources to help implement these systems. The federal government will be watching closely, so the state and the local governments will need to develop a partnership to ensure regulation of these markets is successful. The Legislature must get this right this year and there is no more time for delay. The I-502 system is not ready to incorporate the medical system. We need a transition period for collective gardens. We support appropriated regulation that provides a practical approach and appropriate methodology in regulating the medical system. I-502 stores will underserve the recreational users and we are concerned about levels of care for the medical patients. The 1000-foot buffer rule needs to be amended to be similar to the approach provided for in SB 6178. The bill does not provide standards for medical

standards. Standards have been put together for the state to ensure safety of the products used by medical patients. There is concern about the lack of regulation relating to patient safety and addressing quality control; we would like a voluntary board to set out real standards for patient protection. Regulation is necessary. Both bills adopt many of LCB's final recommendations. This bill provides better clarity and a balanced approach to the divergent needs of patients, providers, and law enforcement and addresses the enforcement priorities of the DOJ memorandum.

CON: The federal reasons for these bills do not add up; the federal government does not make a distinction between medical and recreational marijuana. I-502 was not written to work. These bills keep the shortcomings in I-502 in place. The tax structure should be modified to allow for profitability. Physicians are punished by these proposals. Decisions must be based on public process and stakeholder involvement which has not happened here. These bills are products of a secret workgroup and this is not what the public voted for in passing I-502. These bills will cost jobs and create a minor economic disaster in those cities with dispensaries that will be eliminated. It is appropriate to wait until next session and move forward with input from stakeholders. The Pharmacy Board says that marijuana is an herbal medicine and we already have an exemption for medical cannabis determined by the Board. If you want to get rid of recommendation mills, you can do it with two sentences. You do not need to interfere with relationships between patients and doctors. People will die if they cannot get their medicine. The bills do not address the issues of patients who need more medicine from plants and who do not have the funds to spend on medicine. These bills are taking patients' vested constitutional and civil rights. These bills are not patient friendly and go against the intent of I-692 and I-502. There is no need for a registry when possession of small amounts of marijuana is permitted. LCB is not equipped to address medical marijuana.

OTHER: We want to make sure that patients have safe, reliable, and affordable access to products that will actually help them. The recreational system is being created and the medical system is being squeezed into the recreational system without considering the needs of medical patients. We are concerned that the medical interests of patients will be overrun. We believe that a deregulated medical system will not be able to stand side by side with a recreational system and we want to provide assistance in developing this legislation. My doctor should be the one to decide how much cannabis I need to use. I need to keep my home grow because I will not be able to purchase it in the store.

Persons Testifying (Health Care): PRO: Senator Rivers, prime sponsor; Ryan Day, Brian Enslow, WA State Assn. of Counties; Candice Bock, Assn. of WA Cities; Philip Dawdy, WA Cannabis Assn.; Alex Cooley, Solstice, Coalition for Cannabis Standards and Ethics; Dawn Darington, Tammy Ramsay, Mark Hubbard, Volunteer Cannabis Standards & Quality Board; Kristi Weeks, DOH.

CON: John Worthington, American Alliance for Medical Cannabis, Cannabis Action Coalition; Steve Sarich, Arthur West, Cannabis Action Coalition; Adam Assenberg, Adam 4 Sheriff; Jerry Dierker; Kirk Ludden, citizens.

OTHER: Craig Engelking, Kari Boiter, Health Before Happy Hour; Nightmare Alabama, Kief Radio.

Staff Summary of Public Testimony on Recommended First Substitute (Commerce & Labor): PRO: We need communal gardens. Current law is very generous for medical marijuana patients. Cancer patients need this badly. We need a separate system for medical. Desire for pleasure should not be over that of our health. We question if there will be enough stores. We should not roll these products together. We support a dual system. Cannabidol (CBD) saves people's lives. Medical strains are hard to find. We support the mandatory registry which will allow for accurate data collection. We should have non-disclosure of produce and processer sites. There needs to be better education on CBD and THC.

CON: Wait until we see how 502 is implemented. Patients expose themselves to federal prosecution by signing a registry. Do as little harm to patients as possible. Allow home grows. I-502 was not meant to treat medical patients. I have concerns about the tax issues. This interferes with the physician-patient relationship. Please do not threaten access for patients. Cannabis can cure leukemia. I need cannabis regulated. Health professionals do not know about cannabis and its benefits. Do not discriminate against patients with these bills.

OTHER: Available to answer questions.

Persons Testifying (Commerce & Labor): PRO: Doug Levy, cities of Everett, Kent, Renton, Redmond, Puyallup, Issaquah, Fife, Lake Stevens; Jacob Lamont, Philip Dawdy, WA Cannabis Assn.; Kristi Weeks, DOH; Candice Bock, Assn. of WA Cities; Brian Enslow, WA State Assn of Counties; Jeff Gilmore, Ryan Day, Joanna McKee, citizens.

CON: John Worthington, Cannabis Action Coalition, American Alliance for Medical Cannabis; Steve Sarich, Cannabis Action Coalition, CANNACARE; Poppi Sidhu; Arthur West, Cannabis Action Coalition; John Novak, Brian Stone, Jerry Derker, 420LEAKS.COM; Jerry Dierker, 420 Panel; Ramona Leber, WA Assn. for Substance Abuse and Violence Prevention; Evelyn Lentz, Grammas for Ganja.

OTHER: Tawnee Cowan, Jeremy Kaufman, Coalition for Cannabis Standards and Ethics; Doreen Bomar, Spotted Owl Organics; Shawn DeNae, WA Bud Company; Dawn Darington, Debbie Hansen, Tammy Ramsay; S Rowan Wilson, MBA; Mike Cencim, WA Fish and Wildlife Police.