SENATE BILL REPORT
SB 6178

As of January 21, 2014

Title: An act relating to aligning the medical marijuana system with the recreational marijuana system.

Brief Description: Aligning the medical marijuana system with the recreational marijuana system.

Sponsors: Senators Kohl-Welles, Litzow, Keiser, Pedersen, Cleveland and Kline.

Brief History:
Committee Activity: Health Care: 1/21/14.

SENATE COMMITTEE ON HEALTH CARE

Staff: Kathleen Buchli (786-7488)

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

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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.

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: DOH must develop a Medical Marijuana Verification Program (Program) and issue verification cards to qualifying patients and their designated providers. The Program must allow health care professionals to enter qualifying patients or designated providers; law enforcement officers and marijuana retailers to confirm the validity of verification cards; 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 Program, DOH must issue an verification card to that person. Verification cards are valid for one year and when they expire, the patient or provider must seek reauthorization and reentry into the Program. Verification 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 Program. Health care professionals may be charged a fee by DOH for entering qualifying patients and designated providers into the Program, but this fee must not exceed the costs of administering the Program. The Program 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 a verification 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 ten 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.

Collective gardens are eliminated as of July 1, 2015. However, up to five qualifying patients and designated providers may grow marijuana together if: all members have verification cards and the grow location is entered in the Program; only members entered in the Program may receive marijuana grown at the location; and all members provide labor and not money

in order to participate. If a member stops growing with the group, the member must contract the Program and have that member's name removed from association with the location. New participants may not grow with the group at the location until 90 days have passed since the last patient or provider left the group.

A qualifying patient holding a verification card may apply to DOH for a waiver from the possession limits for patients if that patient's health care professional believes the amount for the medical needs of the qualifying patient exceed the amounts provided in statute. DOH must adopt rules on the terminal or debilitating medical conditions and treatment plans that would require a greater amount of marijuana than what is provided in law.

Qualifying patients who are provided with valid documentation by their health care professional that those patients would benefit from the medical use of marijuana, but who do not sign up in the Program, may not possess greater amounts of marijuana than is allowed recreationally or grow for their medical use. However, valid documentation does allow a person to assert an affirmative defense to charges of violating the laws on medical marijuana by demonstrating that the person is a qualifying patient. An affirmative defense may also be asserted by qualifying patients or designated providers who exceed the statutory possession amounts if they are able to demonstrate that this greater amount is necessary for the patient's medical care.

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 three ounces of useable marijuana, 48 ounces of marijuana-infused product in solid form, and 216 ounces of marijuana-infused product in liquid form. In order to receive a medical marijuana endorsement, the retailer must ensure that there is one employee or volunteer on the premises of the retail store who is able to provide assistance to qualifying patients in the medical use of marijuana. The retailer must also carry useable marijuana and marijuana-infused products with a cannabidol level identified by LCB as appropriate for medical use.

Marijuana excise taxes that had been directed to the Basic Health Plan are redirected as follows: 8 percent to the University of Washington and 8 percent to Washington State University to fund research; 12 percent to counties and 12 percent to cities to assist in law enforcement and public safety activities and distributed to those local governments based on how many licensees are in their locations; 5 percent to DOH to fund the Program; and 5 percent to the Department of Social and Health Services to provide grants to regional support networks.

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, and reexamine the child at least once per year or more frequently as medically indicated.

DOH must convene a workgroup to include the University of Washington, Washington State University, the Medical Quality Assurance Commission, the Board of Osteopathic Medicine and Surgery, the Nursing Care Quality Assurance Committee, the Board of Naturopathy, and persons able to demonstrate through experience and education expertise in the medical use of marijuana. The workgroup must develop evidence-based practice guidelines for health care professionals to consider when authorizing the medical use of marijuana. DOH must create a training program that incorporates these guidelines, and health care professionals may not enter patients or providers into the Program until they successfully complete the training program.

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.

The Washington State Institute for Public Policy must study access issues for qualifying patients and consult with other states to learn of their experiences relating to allowing patients and providers to grow in their homes. The study is due July 1, 2016. LCB, in conjunction with DOH, must report on the number of medical marijuana endorsements issued by LCB; the number of purchases made by qualifying patients or designated providers at marijuana retailers holding medical marijuana endorsements; the location of retail stores holding endorsements in relation to other non-endorsed stores; the need for medical-only stores; the experience of patients and providers in purchasing marijuana for their medical needs at retail stores; and recommendations to improve patient access. The LCB report is due January 1, 2016.

Appropriation: None.

Fiscal Note: Requested on January 16, 2014.
[OFM requested ten-year cost projection pursuant to I-960.]

Committee/Commission/Task Force Created: No.

Effective Date: The bill contains several effective dates. Please refer to the bill.