

Policy Subcommittee Report to HCR 48 Medical Marijuana

Dispensaries Task Force

November 3, 2014

EXECUTIVE SUMMARY

These are recommendations of the Policy Subcommittee of the HCR 48 Task Force. As set forth in more detail herein, we recommend the following.

1. Number and location of dispensaries. The Subcommittee recommends that:

- The Legislature require the Department of Health to offer a minimum of 15-30 dispensary licenses, representing a ratio of approximately 500 to 1,000 patients per dispensary;
- The Department of Health issue dispensary licenses by county in proportion to patient density within each county (based on county of residency, rather than county of certification).

2. Design of a tax structure. The Subcommittee recommends that:

- The Legislature adhere to the existing GET for purchases of medical marijuana at dispensaries;
- The Legislature allow dispensary owners to deduct business expenses from income for purposes of state income taxation;
- The Legislature require dispensaries to be incorporated as non-profit corporations pursuant to Hawai'i Revised Statutes chapter 414D.

3. Location and restriction issues. The Subcommittee recommends that:

- The Legislature remain silent as to buffer zones around dispensaries. The Subcommittee is not aware of any evidence to suggest that buffer zones yield any benefit to public safety, or that buffer zones are effective at limiting non-patients' access to medical marijuana. Nevertheless, if the Legislature believes that a buffer zone is a political necessity to ensure passage of a dispensary bill, then the

Subcommittee suggests a buffer zone between dispensaries and schools, narrowly defined, of not more than 500 feet, set by statute;

- The counties maintain their traditional authority over zoning matters, but that the Legislature should explicitly state that counties may not enact zoning ordinances that apply only to (or have as their principal targets) medical marijuana dispensaries;
- The Department of Health be required to enact administrative rules that allow traveling dispensers to service smaller, less-populous islands.

4. Methodology for ensuring safety of supply. The Subcommittee recommends that:

- The Legislature require the Department of Health to promulgate rules to provide for screening of medical marijuana for content, contamination, and consistency;
- The Department of Health employ a medical marijuana health educator, funded by licensing fees paid by dispensaries and growers;
- The Department of Health establish a training or certification program for dispensary employees.

5. A framework for cultivating and manufacturing medical marijuana. The

Subcommittee recommends that:

- Any proposed dispensary statute remain silent with respect to a statutory limit on the number of plants allowed per grower, with a clear understanding that the grower takes on all risk of federal prosecution in producing medical marijuana;
- The Legislature explicitly provide that qualifying patients possess the right to continue to cultivate their own medical marijuana if they wish to do so;

- The Legislature allow dispensaries to grow medical marijuana on the premises and/or at a second secured and registered location, or to contract out the growing and production to one or more other entities which shall also be licensed by the Department of Health;
- The Legislature require growers to obtain a license from the Department of Health and pay a licensing fee (which will be lower than the licensing fee for a dispensary).

6. Regulations to ensure security and public safety. The Subcommittee recommends that:

- The Legislature require the Department of Health to promulgate regulations mandating the following security measures to ensure that marijuana is provided only to patients and is not diverted to non-medical use:
 - i. For dispensaries:
 1. Video surveillance
 2. Inventory tracking software (“seed to sale”)
 3. Alarm system
 4. Exterior lighting
 - ii. For grow sites:
 1. Video surveillance
 2. Inventory tracking software (“seed to sale”)
 3. Black-out fencing

7. Restrictions on advertising. The Subcommittee recommends that:

- The Legislature allow the Department of Health to promulgate rules limiting the size and format of any sign(s) outside the dispensary itself;
- The Legislature require the Department of Health to promulgate rules prohibiting dispensaries and producers from using cartoon characters or other designs intended to appeal to children;
- No additional advertising restrictions are necessary, insofar as dispensaries will have no financial incentive to advertise to non-patients. Nevertheless, the Subcommittee recommends that, if the Legislature believes additional restrictions are necessary, the Legislature could allow the Department of Health to promulgate rules prohibiting dispensaries and producers from advertising in a way that primarily targets individuals who are not medical marijuana patients.

8. Preventing federal interference. The Subcommittee recommends that:

- The Legislature eliminate the statutory inconsistencies in HRS §§ 329-121 and 329-122 to clarify allowable transport of medical marijuana by qualifying patients, caregivers, dispensary operators, and manufacturers; and
- The Legislature explicitly provide that growing medical marijuana on public lands is prohibited.
- By enacting the above-referenced recommendations, the Subcommittee believes that the Legislature will have fully addressed the Department of Justice's stated priorities in enforcing federal marijuana laws.

These recommendations, along with viable alternatives that the Subcommittee identified, are discussed in greater detail in the rest of this report.

I. INTRODUCTION: CREATION OF TASK FORCE AND SUBCOMMITTEE

The Policy Subcommittee of the House Concurrent Resolution (“HCR”) 48 Medical Marijuana Dispensaries Task Force presents this report summarizing our work and resulting recommendations to the Task Force, as we look to create a functional and safe medical marijuana dispensary system in Hawai‘i. We believe that the avenues set out herein represent the best direction for our dispensary system: a patient-focused network of dispensaries, manufacturers, and producers specifically tailored to Hawai‘i.

a. Establishment of the Task Force

House Concurrent Resolution 48, passed by the Hawai‘i State Legislature during the 2014 legislative session (“the Resolution”), established a task force (“the Task Force”) to “develop recommendations for the establishment of a regulated statewide dispensary system for medical marijuana.”¹ This occurs as the Hawai‘i Medical Marijuana Program is transitioning from the Department of Public Safety to the Department of Health.²

The Resolution received broad support in the Legislature. In fact, only one lawmaker voted against adoption of the resolution in its final form.³ Several pieces of testimony submitted in support of the Resolution called into question the legitimacy of legalizing possession of a substance for medical purposes without providing a legal way to obtain it.⁴ This is the essence of the Task Force’s mission at present: to provide a safe, legal method whereby certified patients can obtain medicinal marijuana.

¹ HCR 48 is reproduced in full as Appendix 1.

² The transition will be complete January 1, 2015.

³ See

http://www.capitol.Hawaii.gov/measure_indiv.aspx?billtype=HCR&billnumber=48&year=2014.

⁴ See www.capitol.Hawaii.gov/Session2014/Testimony/HCR48_HD1_TESTIMONY_JUD_03-28-14_PDF.

b. Duties of the Task Force

The Legislature requested that the Task Force develop recommendations for the following eight sub-topics:

- (1) Appropriate number and location of dispensaries statewide;
- (2) Design of a tax structure;
- (3) Location and restriction issues;
- (4) Methodology for ensuring safety of supply;
- (5) A framework for cultivating and manufacturing medical marijuana products;
- (6) Regulations to ensure security and public safety;
- (7) Restrictions on advertising; and
- (8) Potential federal interference.

c. Membership of the Task Force

As set forth in the Resolution, the Task Force is 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 Hawai'i College of Tropical Agriculture and Human Resources;
- (14) A representative of the Drug Policy Forum of Hawai'i;
- (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 Hawai'i;
- (19) A representative from the Hawai'i Medical Association; and
- (20) A representative from the Coalition for a Drug-Free Hawai'i.

d. Establishment of the Subcommittee

At the first meeting of the full Task Force, several members expressed interest in forming a subcommittee that would study policy options and alternatives for Hawaii's program. This group was intended to function as a supplement to the full Task Force by meeting approximately

every two weeks to discuss the eight sub-topics set forth by the Legislature and provide information and policy options to the Task Force. The subcommittee meetings were organized such that members discussed one to three of the topics set forth by the Legislature in HCR 48 at each meeting.

e. Purpose of the Subcommittee

The Policy Subcommittee endeavored to develop a loose set of potential recommendations for the Task Force to consider, while also exploring alternative policies that may (or may not) function as well as the recommended route. While the Subcommittee was open to every member of the Task Force, the Subcommittee was smaller than the full Task Force and provided an open space for discussion of the more technical aspects of a prospective dispensary system. The Subcommittee was also open to any member of the general public, thus allowing anyone – not just individuals appointed to the Task Force itself – to participate in the Subcommittee’s policy discussions.

f. Membership and Meetings of the Subcommittee

Prior to the first meeting of the Policy Subcommittee, all Task Force members received an invitation via e-mail to participate in the Subcommittee’s initial conference call. The Policy Subcommittee was open to any Task Force member or member of the public who wished to participate.

The first meeting was held entirely by phone; each subsequent meeting was held at the Hawai‘i State Capitol, but there was always an option for anyone wishing to participate by telephone to do so. Membership and attendance at meetings fluctuated as the research progressed.

Nearly half the members of the Task Force attended at least one meeting of the Policy Subcommittee, including the following:

- (1) Dana Ciccone, caregiver in the Medical Marijuana Program;
- (2) Dr. Chris Flanders, CEO of the Hawai'i Medical Association;
- (3) Daniel Gluck, Senior Staff Attorney at the ACLU of Hawai'i;
- (4) Rafael Kennedy, representative from the Drug Policy Forum of Hawai'i
- (5) Karl Malivuk, patient in the Medical Marijuana Program;
- (6) Dr. Clif Otto, prescribing physician in the Medical Marijuana Program;
- (7) Jari Sugano, parent of a patient in the Medical Marijuana Program under the age of 10;
- (8) Representative Gregg Takayama, appointed to the Task Force by the Speaker of the House;
- (9) Lee Ann Teshima, representative from the Department of Commerce and Consumer Affairs,
- (10) Jonathan White, representative from the Department of Tax; and
- (11) Peter Whiticar, representative from the Department of Health.

The Subcommittee met a total of seven times between July and October, 2014. Rough minutes of the Subcommittee's meetings are attached hereto as Appendix 2. The Subcommittee provided the full Task Force with four written updates, attached hereto as Appendix 3.

II. HISTORY OF THE MEDICAL MARIJUANA PROGRAM IN HAWAI‘I

During the 2000 legislative session, with the passage of Senate Bill 862, Hawai‘i became the first state to pass a medical marijuana initiative through its Legislature (rather than via a ballot initiative or court decision). While the bill passed in a close vote,⁵ proponents expressed support for the idea that patients with legitimate medical need for marijuana ought to be able to use it without fear of penalty. Since then, the percentage of the population supporting legal medical use of marijuana has continued to grow, both in Hawai‘i and around the country.

There are approximately 13,000 patients currently registered with the Hawai‘i Medical Marijuana Program. As set forth in HRS §329-121, qualifying conditions include:

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
 - 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.

⁵ See http://www.capitol.Hawai‘i.gov/session2000/status/SB862_his_.htm.

In 2000, the Legislature gave jurisdiction over the Medical Marijuana Program to the Department of Public Safety. However, perhaps because medical marijuana had never before passed through a legislative process (and, as such, there was no model to follow) the Legislature chose not to integrate a dispensary system into the statute that eventually allowed patients to cultivate and possess medical marijuana without penalty. Fifteen states and the District of Columbia currently have a system of medical marijuana dispensaries. All of these states, with the exception of Vermont, place the medical marijuana program under the jurisdiction of their respective departments of health.

Under Hawaii's Medical Marijuana Program, patients have two options for obtaining medication. The patient herself may cultivate up to seven plants for her own personal use. Alternatively, the patient may designate one caregiver to cultivate up to seven plants on her behalf. No caregiver may cultivate for more than one patient, and no patient may have more than one caregiver. Patients or designated caregivers may possess up to three ounces of dried marijuana plant at one time; the possession limit will increase to four ounces on January 1, 2015.

The current Medical Marijuana Program does not work as well as it could for the majority of patients. Qualifying conditions include several debilitating diseases, and the notion that patients afflicted with such conditions are able to cultivate their own medical marijuana or find someone willing to cultivate it for them is unrealistic. Even many patients that are physically capable of growing their own medicine simply lack the horticultural knowledge and skill to produce usable marijuana on a consistent basis. Furthermore, a disproportionate percentage of Hawaii's population lives in rented accommodations. These patients find it difficult or impossible to grow their own medicine either because it is forbidden or for want of space. In this way some lower-income patients are excluded from the current program.

In addition to these concerns, there is no legal way for patients or their caregivers to obtain medical marijuana seeds or clones to begin cultivating (even the transfer of seeds without exchanging money is unlawful). Thus, not only are many patients constrained by lack of space, physical fitness, and time required to obtain medication, but all patients are initially forced to break the law or find a caregiver willing to break the law for them.

In addition, patients with ailments that respond best to medical marijuana concentrates or oils have no way to obtain those products legally or safely. Many patients resort to purchasing these through online retailers, and have no real recourse if they find that the products are impure, ineffective, or even harmful.

The current Medical Marijuana Program in Hawai‘i also sets forth contradictory requirements for transporting medical marijuana throughout the state. There is a notable discrepancy in the allowable behaviors related to transporting medical marijuana set out in HRS chapter 329. On the one hand, HRS § 329-121 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. For 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.

At the same time, HRS § 329-122(c)(E) states: “The authorization for the medical use of marijuana in this section shall not apply to the medical use of marijuana at any . . . place open to the public.” Taken together, these sections seem to say that a qualifying patient may transport marijuana for medical use, but may not transport it in any place open to the public (*e.g.*, sidewalks, roads, or airports). This creates uncertainty for the patient and, as we consider

establishing a dispensary system, it is important to note that the existing statute will also create uncertainty for the dispenser who will need to transport medical marijuana if it is produced at a location other than the physical location of the retail establishment itself.

Ultimately, Hawaii's Medical Marijuana Program is flawed. It requires that patients who are acting in good faith become criminals – exactly what the Legislature attempted to curtail by instituting the Medical Marijuana Program in the first place. Recognizing this, the Hawai'i Legislature has asked the Task Force to study these issues and recommend a functional, sensible, and safe way for patients to obtain their medication. Fifteen other states have shown that this can be done. At this juncture, the HCR 48 Task Force is attempting to fill a void in the Medical Marijuana Program, and the Policy Subcommittee hopes that this report will be helpful to the Task Force as it crafts its recommendations to the Legislature.

a. Questions addressed by this Subcommittee Report

This Subcommittee Report reflects the Subcommittee's recommendations and the reasoning behind those recommendations. As noted previously, the Subcommittee was organized such that the members discussed several of the topics set forth by the Legislature in HCR 48 at each meeting. In total, the subcommittee met seven times and discussed all eight topics set contained in HCR 48. This report is divided into sections that mirror the eight topics. We hope that this Subcommittee Report can function as a guide to the policy options available (and the discussions of Task Force Members about those options) as we craft a dispensary system, while also providing what we believe to be the most suitable recommendation in each sub-topic. Subcommittee recommendations are bolded in this report.

b. What is a dispensary?

For the purposes of the subcommittee, “dispensary” means the storefront housing a retail operation that dispenses medical marijuana to qualifying patients. However, we recognize that there are many factors involved in a dispensary program that do not directly pertain to the dispensary. For example, the grow site for medical marijuana to be sold at a dispensary is an integral part of the medical marijuana program. Because it is the purview of the task force to develop a working system of dispensaries, we cannot ignore interrelated elements of the entire process of medical marijuana production and distribution. Therefore, where applicable, we have attempted to provide policy guidance, not only as it relates to the dispensary, but also as it relates to the underlying factors that impact dispensary operations (such as growth and manufacture of medical marijuana products).

III. DISPENSARIES IN OTHER STATES

Thirty-two states and Washington, D.C. have passed laws that recognize medical uses for marijuana (including authorizations for medical marijuana research). Of those thirty-two, twenty-one jurisdictions currently allow access to and use of marijuana for patients with a physician’s certification. Twelve of these were enacted through a ballot initiative and nine through state legislative processes.⁶

Fifteen states with effective medical marijuana laws have operational dispensary systems. As part of HCR 48, the Legislature also commissioned the Legislative Reference Bureau to produce a report chronicling the ways in which other states have organized their dispensary

⁶ See <http://www.mpp.org/assets/pdfs/library/State-by-State-Laws-Report-2013.pdf> at 1.

networks and implemented those networks through legislation and departmental regulations. This thorough, well-researched report includes the following information:

- A summary of the Hawai‘i Medical Marijuana Program;
- Medical marijuana use in other states;
- State regulation of distribution, including regulatory structure, operational requirements, quality control, quantity control, number of dispensaries, dispensing limits, and controls on the channels of supply;
- Local regulation of distribution in California; and
- Federal position on the medical use of marijuana.

The Legislative Reference Bureau report did not make recommendations as to which model was best; rather, the report described each state’s system.

IV. CONCERNS FROM PATIENTS

The Task Force held two public forums at which members of the public could speak to the Task Force about their concerns regarding Hawaii’s medical marijuana program and what they would like to see in a dispensary system. The first, held September 10, was in Hilo. The second was in Honolulu on September 24.

Patient concerns varied. One of the primary issues raised was the need for a reassurance that patients who wished to continue cultivating their own medication, even after the establishment of a dispensary system, would be allowed to do so. This was an especially prevalent attitude in Hilo – as discussed earlier, patients on Hawai‘i Island, with more space to grow marijuana than many prospective patients on O‘ahu -- have taken more readily to individual cultivation.

Second, patients were concerned about the price of medical marijuana and wanted assurance that the existence of dispensaries would not raise the price. This is a reasonable concern given that, to many medical marijuana patients, access to medication is crucial for basic daily functioning. Many are older persons on a fixed income; these patients would not be able to afford their medication at a higher price point. This is a valid concern; Connecticut, for example, began with legal medical marijuana prices significantly higher than those found in the underground market.⁷ However, officials in Connecticut were hopeful that the price would drop as more patients began using dispensaries. By contrast, in Colorado, the price of medical marijuana at a dispensary was far lower than the price of marijuana in stores open for adult recreational use.⁸ Concerns over price also bring up questions about a taxation system for medical marijuana, which will be discussed in further detail in the next section. For now, the patient concern about price of medication is an argument for the idea that medical marijuana should *not* be subject to an additional “sin tax” – this has the potential to make marijuana sold in a dispensary more expensive than marijuana from the underground market – insofar as marijuana is being consumed for medical, rather than recreational, use.

Lastly, a common patient concern focused on restrictions on traveling with medical marijuana, both inter-island and on public streets and roads in Hawai‘i. Inter-island travel via air is a fact of life for Hawai‘i residents, especially those living on islands other than O‘ahu. It is worth noting that many patients with debilitating conditions must travel to O‘ahu for some types of medical treatments. Patients expressed frustration at the lack of clarity surrounding travel with

⁷ See <http://www.ctpost.com/local/article/Legal-marijuana-comes-at-high-cost-5776099.php>.

⁸ See <http://fivethirtyeight.com/features/medical-marijuana-is-still-the-best-deal-in-colorado/>

their medication and the very real possibility of (and, for many patients, actual experience with) arrest and prosecution for transporting their medicine.

V. POLICY RECOMMENDATIONS

a. Broad Policy Considerations

For the last decade, medical marijuana patients have faced constant uncertainty as to whether they will be able to continue to find their medication. It is not feasible to expect a patient either to cultivate his or her own medication (especially when the patient suffers from a debilitating condition) or find a caregiver who is willing to spend an extraordinary amount of time and effort, as well as assume the inherent risk of federal prosecution, to cultivate on behalf of the patient. Many patients, unable to take advantage of either of these options, must resort to the underground market to obtain essential medication. This means that the patient has very little information about the medication s/he purchases and, again, has no recourse if the medication is flawed or contaminated in any way. Anecdotal reports suggest that many more eligible patients simply do not register with the Medical Marijuana Program at all, despite having a qualifying condition, because there is no legal way to obtain the medication; indeed, New Mexico saw a 25% increase each year in the number of registered patients once those patients had a legal way to obtain their medicine.⁹ In other words, creating a dispensary program will bring patients out of the shadows and into the above-ground market, allowing them to obtain licenses and comply with state law. In addition, even when the patient is able to cultivate the medication (or find a willing designated caregiver), it remains unlawful to buy or exchange seeds or plants, even between

⁹ Conversation with Ken Groggle, New Mexico Department of Health Medical Cannabis Program Manager, September 3, 2014.

qualifying patients. Currently, medical marijuana patients are forced to break the law in order to fulfill their medical needs. The Legislature recognized the hardship patients face, and asked the Task Force to study the issue of medical marijuana dispensaries.

The Legislature has already recognized the Department of Health as the most appropriate department to regulate a dispensary system for medication in transferring oversight of the program from the Department of Public Safety to the Department of Health. Nevertheless, the Subcommittee recognizes that the Department of Health can benefit from other Departments' expertise in certain subject areas, and will likely consult with the Departments of Agriculture, the Attorney General, Public Safety, Taxation, and Transportation in promulgating its regulations. Proper regulation will ensure that patients are getting quality medication and that they have a method of recourse if the medication they obtain is sub-standard.

1. Focus on dispensaries, excluding other models such as patient cooperatives

While the Subcommittee did consider the value of including other models in potential legislation, the Legislature specifically requested that the Task Force examine the feasibility of dispensaries; as such, the Subcommittee focused on this method of delivery of medical marijuana. Even if the Legislature had provided a broader mandate, however, our ultimate recommendation is that dispensaries (*i.e.*, store-fronts that carry a variety of strains of dried marijuana flowers, in addition to concentrates and marijuana-infused products) remain the best way to ensure that the most patients have safe access to medication that is of good quality. While other models, such as patient cooperatives, exist in California (and only California), the dispensary model has proven to provide the best options for patients, in addition to being the simplest to regulate for quality control purposes. A co-op model may not provide sufficient oversight to ensure not only that

patients are getting the strain with the correct amounts of THC (Tetrahydrocannabinol) and CBD (Cannabidiol) to treat their particular condition, but also that patients are getting medication that is free of mold and bacteria.

The Subcommittee stresses, however, our strong recommendation that the Legislature expressly continue to allow patients to grow their own marijuana. Patients at both public hearings indicated to the Task Force that there is substantial interest among patients, particularly in rural areas, to continue to produce their own medication. We recommend adding language specifically to preserve this right, as we believe it is crucial that patients continue to have access to the medication that is most effective and convenient for them: particularly where, as here, patients have been required to invest in knowledge and equipment to produce their own medication for the last fourteen years. Indeed, most other states with dispensary systems also provide the option for patients to continue to cultivate their own medication, sometimes charging a nominal fee (such as \$30) to each patient who wishes to cultivate.¹⁰

It is important to note that the only state with a formal allowance and promulgated guidelines for cooperatives is California, where the medical marijuana industry is regulated at the county level. In California, the Attorney General issued guidelines for establishing patient cooperatives including sections on non-profit operation, business licenses, membership criteria, distribution, permissible reimbursements, possession and cultivation guidelines, and security

¹⁰ This right has occasionally been limited. Arizona, for example, prohibits personal cultivation if a patient lives within twenty-five miles of a registered dispensary. The Subcommittee does not recommend that Hawaii's program follow this model; rather, any patient who wishes to cultivate his or her own medication ought to be allowed to do so.

measures.¹¹ While this model suits some patients in California, and may be something that the Legislature wishes to consider after Hawaii's dispensary system has matured, the Subcommittee believes that a dispensary system is more feasible in the near term. Thus, a model in which patients agree to grow medication in a single location and share costs associated with doing so would not seem to be prohibited under a law creating a regulatory system for dispensaries, but we do not recommend that the Legislature institute special provisions for a patient cooperative system.

2. Statutory provisions and departmental regulation

Throughout the Subcommittee's discussions, members continued to discuss whether certain aspects of a dispensary system ought to be set by statute or by administrative rule. The Subcommittee recognized that the Department of Health has the expertise to address certain issues via regulation, and should be afforded the flexibility to respond to changing conditions through rulemaking.

An example of a policy matter that is best left to departmental regulation is the number of licenses granted in each county. While we can make a guess about where patients will most need dispensaries, the distribution of patients between the different islands is likely to change, as discussed earlier in this report. When such shifts happen, it is crucial that the Department of Health is able to respond and adjust the location of dispensaries as needed.

¹¹ Ching, Lance and Brannon, Johnny, "Is the grass always greener? An updated look at other state medical marijuana programs." Honolulu, HI: Legislative Reference Bureau, August 2014, 46.

b. Specific Policy Recommendations

1. Location and number of dispensaries statewide

- The Subcommittee recommends that the Legislature require the Department of Health to offer a minimum of 15-30 dispensary licenses, representing a ratio of approximately 500 to 1,000 patients per dispensary; and
- The Subcommittee recommends that the Department of Health issue dispensary licenses by county in proportion to patient density within each county (based on county of residency, rather than county of certification).

Based on the current numbers of registered patients (roughly 13,000 state-wide), the subcommittee recommends that Hawai‘i maintain a floor of 15-30 dispensaries. Depending on the method of calculation, across the country, the average dispensary has between 500 and 1000 patients.¹² This ratio generally is not enshrined in other states’ statutes, but rather is a ratio that appears to be natural given the limitations on the volume of medication that each dispensary can conceivably handle. If we look at how this ratio might play out in Hawai‘i, one dispensary for

¹² In calculating this range, one Subcommittee member looked at the 15 working dispensary systems nationwide: Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Maine, Michigan, Montana, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, and Washington, D.C. He totaled up the number of medical marijuana patients in these states and divided that by the total number of dispensaries across the nation. Using this method, he found the ratio of patients to dispensary to be 463:1.

Using a second method of calculating the average number of patients per dispensary, the same Subcommittee member attempted to preserve each state’s unique chosen ratio of patients to dispensary, arguing that this method could potentially better reflect the average. Grouping all the states together would not reflect these unique ratios, as in the first method. He averaged each state separately and then averaged those figures across all 15 states, which came out to 976 patients per dispensary.

every 500-1000 registered patients would come out to between 15 and 30 dispensaries state-wide. That said, the Subcommittee does not recommend that there be a cap on the overall number of dispensaries. If the Legislature prefers to begin with a small program with the intent to expand the number of dispensaries as the number of patients increases, 15 to 30 would be an appropriate floor for the Legislature to set.

We expect that the number of registered patients will increase substantially after dispensaries are established, for several reasons. First, other states that have implemented a dispensary system have seen this trend. New Mexico's patient population increased from 9,000 to 13,000 patients since the state began its dispensaries program in 2007. Second, because the only way to obtain medication currently is to cultivate it, patients with limited space or limited physical abilities are well aware that, even if they had a medical marijuana card, they would have no reasonable way to access it. As a result, these patients are much less likely to register with the program in the first place.¹³ Once medical marijuana is accessible even to those in urban areas, it is very likely that the number of registrants will increase and patient density will become more proportional to population density.

In order to accommodate this expected increase in registered patients, the Legislature should require the Department of Health to issue enough licenses to dispensary operators to reach a ratio of approximately 500 patients per dispensary. This policy – allowing the number of licenses to fluctuate based on actual patient need, rather than setting a fixed number of dispensaries by statute – provides the Department of Health with adequate legislative parameters

¹³ By contrast, patients who are able to grow for themselves are more likely to register for the program, and the disproportionate number of patients registered on Hawai'i Island is likely evident of this: patients there are more likely to live in rural areas, giving them the space to cultivate, whereas patients with qualifying conditions who live on O'ahu do not register for a medical marijuana card because they have no way to cultivate the medication.

and flexibility to achieve the Legislature's goals. Legislation could preclude any private cause of action for deviating from the 500:1 ratio unless the ratio reached a critical point (*e.g.*, if the Department of Health failed to issue dispensary licenses in a timely manner and the ratio of patients to dispensaries reached 1,500:1).

Further, the Legislature should set a minimum number of dispensaries in each County (allocated by registered patient population), distributed according to the county where the patient resides, rather than the county where the patient was certified).¹⁴

2. Design of a tax structure/corporate structure issues

- The Subcommittee recommends that the Legislature require dispensaries to be incorporated as non-profit corporations pursuant to Hawai'i Revised Statutes chapter 414D;
- The Subcommittee recommends that the Legislature adhere to the existing GET for purchases of medical marijuana at dispensaries; and
- The Subcommittee recommends that the Legislature allow dispensary owners to deduct business expenses from income for purposes of state income taxation.

The Subcommittee began with four options for structuring dispensaries:

- (1) government-run;
- (2) for-profit-only;
- (3) non-profit-only; or

¹⁴ The Task Force need not determine specific geographic areas for each dispensary beyond recommending allocation by patient density in each County (to be determined by the Department of Health). Alternatively, the Legislature itself may specify certain geographic locations, in the event that legislative representatives feel strongly about having, or not having, a dispensary in their individual districts.

(4) not specified by statute (meaning that dispensaries could be incorporated as non-profits or for-profits).

While the Policy Subcommittee was somewhat inclined to remain silent on the issue, there is a benefit to having a unified system whereby the Department of Health (the entity regulating dispensaries) only has to supervise one kind of corporate structure, rather than having to supervise multiple kinds of corporate structures (partnerships, for-profit corporations, and non-profit corporations). If the Department of Health has to regulate only one kind of entity, this should make administration of the program a bit easier for the Department.

The Subcommittee analyzed each of the possible corporate structures. Each is addressed in turn.

(1) Government-run

Because the industry will be heavily regulated by the State, there may be some efficiency in having the Department of Health operate the dispensaries themselves. However, no other state currently runs its dispensary system this way, and the subcommittee has concerns about trying a model that has not been tested in another jurisdiction before.

(2) For-profit vs. non-profit

The Subcommittee considered the implications of restricting dispensaries to non-profit structure, and initially determined that this is unnecessary, except for potential political considerations. The only significant difference between hypothetical non-profit and for-profit dispensaries is that non-profits are not allowed to distribute profits to shareholders. All organizations, for-profit or non-profit, should have revenues every year (otherwise they are unable to continue to operate). While some people may have the idea that non-profit status will act as a

proxy for local or community-based participants (compared to a for-profit corporation), nothing in HRS Chapter 414D limits non-profits to local ownership or local board-members.

Thus, the title of “non-profit” is something of a misnomer, and only has meaning where organizations are registered as 501(c)(3) entities and receive tax benefits as a result. Because Hawaii’s tax code conforms to the federal tax code, and dispensaries, as entities that conduct federally illegal activities, would not be able to register as 501(c)(3) organizations with the Internal Revenue Service, the categorization as “non-profit” is not particularly important except for political reasons (*i.e.*, there may be a perception that a non-profit entity is more benign than a for-profit entity).

Insofar as dispensaries will be taxed in the same way, regardless of whether they are categorized as “non-profit” or “for-profit,” the only real difference between the two structures rests in the ability of for-profit corporations to distribute profits to shareholders. Nevertheless, given the desire for uniformity across dispensaries, the Subcommittee recommends that the Task Force pick one structure. Insofar as there does not appear to be a benefit to having the dispensaries designated as for-profit corporations, and there is at least a possible perceived benefit in having the dispensaries designated as non-profit corporations, the latter is recommended.

The simplest tax structure (and, therefore, the easiest to implement) is applying the existing General Excise Tax and income tax structure to medical marijuana. This means that retail purchases by customers at a dispensary would be subject to either a 4.0% or a 4.5% (on Oahu) tax. Wholesale transactions (any transaction *before* the retail purchase) would be subject to a 0.5% tax. The Subcommittee discussed applying an additional tax to marijuana purchases that would then be appropriated to drug treatment programs. However, the Members concluded that this type of additional tax is not appropriate for purchases that are medical in nature. The

Department of Tax generally prefers that new programs be taxed at the same rate as all other existing programs, rather than creating a new tax structure that would be more difficult to administer. Thus, the Subcommittee recommends applying only the existing wholesale and retail GET to medical marijuana that is manufactured for distribution to dispensaries and then purchased at a dispensary.

Using the existing GET/income tax structure means that the revenue would go into the General Fund, which is the main source of revenue for the State. The Legislature appropriates funds for the state budget from the General Fund. This will likely mean that any funds to administer the medical marijuana program will have to come from licensing fees, rather than from the general fund, insofar as it may be difficult to earmark general fund revenue for specific programs.

Most states charge an application fee to anyone who wants to open a dispensary, regardless of whether their application to open a dispensary is eventually accepted, in addition to a yearly registration fee, which is generally much higher than the application fee. This yearly registration fee will ideally cover all costs of administering the medical marijuana program. Subcommittee members were generally *not* opposed to the idea of high licensing fees. While the Subcommittee did not reach a consensus on a dollar figure for the application and registration fees, several options, each with advantages and disadvantages, were proposed:

- 1) Lower application/licensing fees (e.g., \$250 application fee and \$5,000 yearly registration fee if the application is accepted). This structure is the same as Rhode Island's. The advantage of instituting a relatively low-cost fee system, such as this one, is that it lowers the barriers to entry. This encourages smaller, community-based dispensaries that may be more attentive to the needs of patients.

- 2) Higher application/licensing fees (*e.g.*, \$15,000 application fee, \$14,000 of which gets refunded if an application is not accepted (emulating Maine's fee structure); yearly licensing fee of \$15,000 or more). If the application is accepted, the \$15,000 fee goes toward the yearly registration costs. With a high barrier to entry, applicants will be more likely to be able to afford the other start-up costs of running a dispensary, which can be almost \$250,000. A high initial fee also helps ensure that applicants are serious about providing medication to Hawai'i medical marijuana patients before the DOH expends valuable resources evaluating the application. However, higher licensing fees may also raise the price of the medical marijuana sold at the dispensary, and we are aware that this would hinder the program and patients who participate in it.

The Subcommittee also discussed revenue that might be gained from the income tax paid by dispensary operators. Because the Hawai'i income tax code conforms to the federal income tax code, dispensary owners would only be able to deduct about half of their business expenses when filing their income tax returns. This means that dispensary owners would be required to pay taxes on a higher portion of their income than owners of other businesses (essentially paying income tax on gross income, rather than net income). However, the Legislature can, and often does, create exemptions to conformity with the federal tax code. The Subcommittee recommends that the Legislature create such an exemption to conformity, so that dispensary owners can take advantage of the same tax benefits as owners of other businesses in Hawai'i.

3. Location and restriction issues

- The Subcommittee recommends that the Legislature remain silent as to buffer zones around dispensaries. The Subcommittee is not aware of any evidence to suggest that buffer zones yield any benefit to public safety, or that buffer zones are effective at limiting non-patients' access to medical marijuana. Nevertheless, if the Legislature believes that a buffer zone is a political necessity to ensure passage of a dispensary bill, then the Subcommittee suggests a buffer zone between dispensaries and schools, narrowly defined, of not more than 500 feet, set by statute;
- The Subcommittee recommends that the counties maintain their traditional authority over zoning matters, but that the Legislature should explicitly state that counties may not enact zoning ordinances that apply only to (or have as their principal targets) medical marijuana dispensaries;
- The Subcommittee recommends that the Department of Health be required to enact administrative rules that allow traveling dispensers to service smaller, less-populous islands.

The Subcommittee considered several issues relating to location and restriction issues. Most importantly, the Subcommittee discussed the distribution of dispensaries throughout Hawaii, and how we might be able to ensure that dispensaries *can* exist in such a way as to reach all patients on all islands.

Number of dispensaries per island

The Subcommittee recommends that the Department of Health distribute the total number of licenses to each county based on patient density. This shall be subject to change based on demand. The Department of Health must award at least the population-distributed number of

licenses in each county to applicants who suitably fulfill departmental requirements for dispensaries (such as security requirements, tax clearances, or other requirements set forth by the department).

The Subcommittee recommends a provision in the statute establishing dispensaries that would allow registered dispensary employees to carry medical marijuana to other islands in the same county. These traveling dispensers would be required to keep all medical marijuana on their person at all times, and, as such, would not be subject to the departmental security requirements for dispensaries, as there would be no physical facility on smaller islands. With this provision, we could ensure that patients on Moloka‘i, Lana‘i, and Ni‘ihau (if such patients wish to utilize the dispensary system) would have a way to plausibly obtain their medication. A provision such as this one would shift risk from the patient to the dispenser – the dispenser would conceivably be willing to take on this risk in exchange for the financial reward of gaining additional customers. The Subcommittee cannot predict whether dispensary owners would use such a provision, but the Subcommittee believes that the Legislature ought to provide an option for patients in isolated areas who do not wish to cultivate their own medication, other than having them risk federal prosecution as they attempt to carry medication home from a dispensary on a different island.

Zoning and buffer zones

The Subcommittee recommends allowing each county to continue to regulate zoning (as they currently do) and may pass zoning ordinances that affect medical marijuana dispensaries, but prohibiting counties from implementing zoning ordinances that pertain *only* to medical marijuana dispensaries. This allows the counties to maintain their traditional power over zoning rules, while ensuring that county governments cannot undermine the program or zone dispensaries out of existence altogether.

The Subcommittee discussed location restrictions on dispensaries that create a buffer zone between dispensaries and schools, daycares, or other youth centers. Members agree that there is no evidence that adding additional criminal penalties to drug possession or sale near a school decreases the likelihood that children will use drugs, and that such policies have been shown to be vectors of racial bias in drug policy.¹⁵ A significant body of research shows that, in states that have removed criminal penalties from medical marijuana, teen use of marijuana has decreased in a majority of states where sufficient data is available.¹⁶ In addition, the density of schools and other similar facilities in urban areas, such as downtown Honolulu, means that dispensaries would be barred from those areas altogether, leaving patients who live there without a dispensary nearby.

A second part of this discussion is the federal Drug-Free School Zone law (21 U.S.C. § 860), a supplement to the Controlled Substances Act, which adds additional criminal penalties for drug violations committed within 1,000 feet real property comprising “public or private elementary, vocational, or secondary school or a public or private college, junior college, or university, or a playground, or housing facility owned by a public housing authority, or within 100 feet of a public or private youth center, public swimming pool, or video arcade facility.”¹⁷ There is an argument that conforming to federal Drug-Free School Zone regulations in crafting zoning regulations for dispensaries would be beneficial in that it would avoid inviting federal prosecution of dispensaries that are within 1,000 feet of a school (or other location that is included in the Drug-Free School Zone law).

The Legislature may wish to create a buffer zone around schools to further demonstrate compliance with the Drug-Free School Zone law, notwithstanding the lack of any evidence to

¹⁵ See <http://www.drugpolicy.org/docUploads/SchoolZonesReport06.pdf>.

¹⁶ See www.mpp.org/assets/pdfs/library/TeenUseMMJShortHandout.pdf.

¹⁷ See <http://www.deadiversion.usdoj.gov/21cfr/21usc/860.htm>.

suggest a public benefit from such a restriction. Colorado, for example, has a state-law requirement that prohibits medical marijuana dispensaries from operating within 1,000 feet of schools (though municipalities may raise or lower the footage requirements); in 2012, the federal government contacted medical marijuana dispensaries in Colorado within 1,000 feet of schools – that is, those dispensaries that were violating both state and federal law – and threatened them with prosecution under the Drug Free School Zones Act if they did not relocate.¹⁸ To the Subcommittee’s knowledge, this type of action by the federal government has not occurred against dispensary owners in any other state, many of which do allow dispensaries within 1,000 feet of schools, as set forth below:

At least 300 feet from schools	Washington, D.C.
At least 500 feet from schools	Arizona, Maine, Delaware
At least 1,000 feet from schools	Vermont, Colorado
At least 1,000 feet from any other dispensary and from schools	Oregon
At least 2,500 feet from schools	Illinois
At least 1,000 feet from property used for school purposes by any publicly funded primary school and within or immediately adjacent to school buses	New Hampshire

Table 1: Buffer zones between dispensaries and schools¹⁹

¹⁸ See http://www.denverpost.com/ci_19729288.

¹⁹ See www.mpp.org/assets/pdfs/library/MMJLawsSummary.pdf. California is not included in this table because dispensaries are regulated on the county/municipality level and, as such, buffer zone laws vary widely.

The federal government's action towards Colorado dispensaries may therefore have more to do with dispensaries' compliance with *state* law than with *federal* law – particularly where other states require a buffer zone that is less than the 1,000 feet required by federal law.

The Subcommittee recognizes that dispensary owners are capable of evaluating risk involved in selecting a specific location for a storefront, and conformity would eliminate the possibility of setting up a storefront in urban areas like Honolulu for prospective dispensary owners – areas where patient demand would likely be particularly high. At the same time, the Subcommittee also recognizes that there may be political capital to be gained by prohibiting dispensaries and growing operations within a certain distance from schools. This may also reduce the risk of federal prosecution.

Despite a lack of evidence that buffer zones actually improve public safety, the Subcommittee generally is not opposed to instituting a reasonable (300-500 foot) buffer zone around schools. Because the existing state law relating to drug free school zones set out in HRS § 712-1250 includes many secondary locations such as parks, roads and school buses (which, if used in the context of dispensaries, would likely mean that a dispensary could not operate anywhere in the urban Honolulu area), the Subcommittee recommends a stand-alone, narrow definition of “school” for such a buffer zone.

4. Methodology for ensuring safety of supply

- The Subcommittee recommends that the Legislature require the Department of Health to promulgate rules to provide for screening of medical marijuana for content, contamination, and consistency;
- The Subcommittee recommends that the Department of Health employ a medical marijuana health educator, funded by licensing fees paid by dispensaries and growers; and
- The Subcommittee recommends that the Department of Health establish a training or certification program for dispensary employees.

There are two parts of the safety and security component that the subcommittee identified: quality control of the medication itself (addressed below) and security to protect against diversion of medical marijuana to non-patients (addressed in section 6).

To ensure that the patient is getting the most effective medication and that the medication is free of contaminants such as pesticides or mold, the Subcommittee recommends making laboratory screening available at the request of the patient or the dispensary and required on a regular basis. The Department of Health continues to research the best system for spot-checking dried flowers, edibles, and concentrates that would be sold at dispensaries. On a basic level, screening requires a laboratory. There are currently four state-affiliated laboratories in Hawai'i: State Laboratory (O'ahu), Hawai'i District Health Lab, Kauai District Health Lab, and Maui District Health Lab. The capabilities of each of these laboratories vary; several generally only perform urinalyses. However, based on a presentation from Dr. Mark Hagadone, a physical chemist with Technical Experts, Inc., the Subcommittee believes that a reasonably well-equipped laboratory could prepare to do basic screening on samples of medical marijuana within a

relatively short time-frame. In addition to the existing state laboratories, there are several commercial labs in Hawai‘i. However, their capacity to become accredited to screen medical marijuana is unknown.

In order to properly screen medical marijuana, laboratories should be accredited by an internationally recognized body, such as the International Laboratory Accreditation Cooperation (ILAC). Accrediting bodies like ILAC set standards for screening for accredited laboratories, providing a clear framework and procedure for screening (though these standards have not yet been developed for medical marijuana).

The Subcommittee developed a list of crucial questions for ensuring quality control, and recommends that the Department of Health create regulations that answer these questions:

1) Who does the screening?

The Subcommittee recommends that the Department require screening to be done in laboratories accredited by ILAC or a similarly-respected accrediting body (whether these are State/District labs or commercial labs). In addition, it would be helpful – but not necessary – for the laboratory to possess a Schedule 1 license (which would give it the ability to possess and test Federal Schedule 1 substances without fear of criminal penalties). However, such licenses are extremely difficult to obtain, so a Schedule 1 license should not be a Departmental requirement for laboratories to test medical marijuana.

2) How is the sample transported, how much is screened, and how often is it screened?

The Subcommittee recommends screening *de minimis* samples (*i.e.*, samples that have no potential for abuse and therefore are legal to possess and test) with clear written guidelines for methods of transportation.

3) What is the sample screened for?

The Subcommittee recommends screening for pesticides, mold/bacteria, and filth. However, the Subcommittee members recommends that the Legislature not include specific screening requirements in the statute itself, but rather allow the Department of Health to do so (drawing upon its own expertise, and in consultation with the Department of Agriculture and the Department of Public Safety as necessary). The Subcommittee recommends emulating Minnesota's statutory screening language, which refers to screening of medical marijuana products for "content, contamination, and consistency." The Minnesota statute places the burden for obtaining screening services on dispensary owners. The Subcommittee recommends this language, insofar as it provides sufficient guidance to the Department of Health while allowing the Department the flexibility to amend screening practices as the dispensary framework matures.

In addition, the Subcommittee recommends allowing patients to bring their own medical marijuana (whether it was cultivated by the patient or obtained from a dispensary) for the same screening laboratories will perform on products for dispensaries. This is important to patients whose conditions respond best to medical marijuana with a particular potency, and to all patients who wish to ensure that the product they consume is free of contaminants such as mold and bacteria (as these contaminants can also affect plants that the patient cultivates individually).

5. **Framework for cultivating and manufacturing**

- The Subcommittee recommends that the Legislature remain silent with respect to a statutory limit on the number of plants allowed per grower, with a clear understanding that the grower takes on all risk of federal prosecution in producing medical marijuana;
- The Subcommittee recommends that the Legislature explicitly state that qualifying patients possess the right to continue to cultivate their own medical marijuana if they wish to do so;
- The Subcommittee recommends that the Legislature allow dispensaries to grow medical marijuana on the premises and/or at a second secured and registered location, or to contract out the growing and production to one or more other entities which shall also be licensed by the Department of Health; and
- The Subcommittee recommends that the Legislature require growers to obtain a license from the Department of Health and pay a licensing fee (which will be lower than the licensing fee for a dispensary).

Dispensaries will require suppliers. As of January 2015, patients are allowed to possess up to 4 ounces of medical marijuana. Approximately 39,000 plants are required to supply 13,000 patients with four ounces of medication per month, assuming that one plant can produce four ounces of dried material each month. This is an optimistic estimate; one plant can produce four ounces of usable marijuana only under optimal conditions and with reasonable luck. Each plant needs approximately three square feet of growing space if grown horizontally. Some patients will likely continue to grow their own marijuana, but, based on evidence from New Mexico, where

90% of patients use a dispensary at least once a month,²⁰ we anticipate the vast majority of patients will rely on the dispensary system.

It is important to note that the lower the number of dispensaries, the higher the number of plants and growers per dispensary necessary. In other words, if the Legislature allows only 15 dispensaries, then each dispensary will need to grow (or contract with outside growers to produce) more marijuana than if the Legislature allows for 30 or more dispensaries. As the ratio of patients to dispensary rises, the production capacity of each dispensary must also rise.

Some states place limits on the numbers of plants any one grower may cultivate. California, for example, limits all growers to 99 plants or less, because possession of more than 99 plants would place growers in a higher tier of punishment by the federal government. Some jurisdictions, such as Washington, D.C. allow up to 500 plants per grower.²¹ Again, the lower the number of plants allowed per grower, the higher the overall number of growers necessary. Generally, Subcommittee members recommend that the Hawai'i statute ought to remain silent on the issue of number of plants allowed per grower, but that the application to be a dispenser or the registration form to become a grower should explicitly say (as in other states) that the individual assumes all risks associated with producing and selling marijuana.

When Colorado's medical marijuana program began, the program required that dispensaries be vertically integrated – that is, 70% of the product sold in the dispensary must be grown by the retailer. However, many criticized this stipulation for stifling the market and forcing

²⁰ Conversation with Ken Groggle, New Mexico Medical Cannabis Program Manager, September 3, 2014.

²¹ See <http://www.mpp.org/states/district-of-columbia/>.

dispensary owners to balance time and resources to run a growing operation in addition to their storefront, and Colorado recently eliminated the requirement.²²

The general consensus among Subcommittee members is that, for Hawai‘i, a mix of vertical integration and diversification is ideal, and that Hawai‘i can achieve this mix by letting market forces determine whether dispensaries will be vertically integrated. This will allow dispensaries to carry a larger variety of strains (insofar as patients and caregivers want a variety of options, because different strains are better suited to treating different conditions and individuals), while also having the opportunity to integrate a growing operation into the dispensary for increased ease of access. An integrated growing operation would also provide the dispensary with additional oversight in and knowledge of the medicine it sells; this would conceivably enhance the ability of the dispensary to recommend particular products based on the specific needs of the patient. To that end, the optimal legislation would, again, remain silent on the issue of vertical integration, except to specify that the dispensary may grow on the premises, at a second secured location, or may contract out the growing and production to a second entity that shall also register with the Department of Health. Requiring contracted growers to register with the Department will protect the growers from prosecution under state law, and will ensure that growers will be subject to regulation by the state.

²² See <http://mmjbusinessdaily.com/colorado-welcomes-new-rec-entrepreneurs-abandons-vertical-integration/>.

6. Regulations to ensure public safety and security of supply

- The Subcommittee recommends that the Legislature require the Department of Health to promulgate regulations mandating the following security measures to ensure that marijuana is provided only to patients and is not diverted to non-medical use:
 - For dispensaries:
 - Video surveillance
 - Inventory tracking software (“seed to sale”)
 - Alarm system
 - Exterior lighting
 - For grow sites:
 - Video surveillance
 - Inventory tracking software (“seed to sale”)
 - Black-out fencing

The second part of “safety and security” is physical security for the dispensary and grow site. Most states require dispensaries to take specific security precautions. States are generally similar to each other in this area: most require alarms, video surveillance, and exterior lighting at a basic level, with some states requiring additional security measures. The table below shows these precautions by state. It is important to note that dispensers and manufacturers will likely take security very seriously, regardless of how stringent security regulations are, simply to protect their financial interests (like any other business owner would). With the exception of Minnesota, Illinois, Oregon, and New Hampshire, these regulations are set by departmental rule, rather than by statute. The Subcommittee recommends that Hawai‘i follow suit and task the Department of Health with developing departmental rules for security requirements. Based on Table 2, the

Subcommittee recommends that the Department of Health require an alarm system, video surveillance, and exterior lighting as those seem to be the most common security measures. The Subcommittee also recommends that the Department of Health require a blacked-out fence around medical marijuana grow sites.

Security Requirement	States
Alarm	Arizona, Colorado, Connecticut, Delaware, Illinois, Massachusetts, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Rhode Island, Vermont
Video surveillance	Arizona, Colorado, Connecticut, Delaware, Illinois, Massachusetts, Nevada, New Hampshire, New Jersey, New York, Oregon, Vermont
Lighting	Arizona, Colorado, Delaware, Maine, Massachusetts, Nevada, New Hampshire, New Jersey, Rhode Island, Vermont
Intrusion Detection	Illinois, Maine, Minnesota, Nevada, Vermont
Failure notification	Connecticut, Massachusetts, Nevada
Single Entrance	Arizona, Nevada
Security guard	Colorado, New Hampshire
Storage vaults	Connecticut, Massachusetts
Facility access controls	Illinois, Minnesota
Personnel ID systems	Illinois, Minnesota
Backup power	Connecticut
Inventory controls	Delaware
Safe	Oregon
Measures to prevent loitering	New Hampshire
Fence	Maine

Table 2: Security regulations for dispensaries (store-fronts) and the states that require them.²³

In addition to quality control and physical security measures, the Subcommittee recommends a criminal background check for dispensary owners and employees. The Subcommittee was not opposed to the suggestion that a drug-related felony would disqualify a

²³ Ching, Lance and Brannon, Johnny, “Is the grass always greener? An updated look at other state medical marijuana programs.” Honolulu, HI: Legislative Reference Bureau, August 2014.

person from owning or working at a dispensary, unless that conviction was for medical marijuana. Lastly, the subcommittee recommends that inventory tracking software (seed-to-sale) be required of all dispensaries and grow sites to decrease the risk of internal diversion of product.

Related to physical safety and quality control, the subcommittee also discussed education and training for dispensary staff and patients (with guest presentation from Dr. Mark Tomita, Hawai'i Pacific University). The Subcommittee recognizes a real need for education as a tool for workforce development, improving patient health, and expanding public knowledge of marijuana as a medication. The subcommittee generally agrees that the Department of Health should have a health educator on staff, similar to New Mexico's medical marijuana program.

In addition, members are generally supportive of the establishment of a training or certification program for dispensary employees and any members of the public who might be interested. Dr. Tomita is in the process of establishing a medical cannabis program at Hawai'i Pacific University College of Nursing and Health Sciences; while this would be very helpful, an 8- or 16-hour course open to dispensary employees and the general public is a small first step that we might be able to take sooner.

7. Restrictions on advertising

- The Subcommittee recommends that the Legislature allow the Department of Health to promulgate rules limiting the size and format of any sign(s) outside the dispensary itself;
- The Subcommittee recommends that the Legislature require the Department of Health to promulgate rules prohibiting dispensaries and producers from using cartoon characters or other designs intended to appeal to children;
- The Subcommittee does not believe that additional advertising restrictions are necessary, insofar as dispensaries will have no financial incentive to advertise to non-patients.

Nevertheless, the Subcommittee recommends that, if the Legislature believes additional restrictions are necessary, the Legislature could allow the Department of Health to promulgate rules prohibiting dispensaries and producers from advertising in a way that primarily targets individuals who are not medical marijuana patients.

The Subcommittee weighed concerns about advertising to the general public against patients' needs for information about medical marijuana dispensaries. Patients who are new to medical marijuana will have a critical need for information: where they can get their medication, the best way to administer it, the strain that might be most helpful for their particular condition, and so on. Thus, information of this nature should be encouraged, while keeping in mind that dispensaries should not be targeting non-patients with advertisements. Thus, the Subcommittee recommends that dispensaries should be allowed to have a sign outside the storefront, though the Department of Health may regulate specific aspects of that sign including size or imagery as it sees fit. While it would be detrimental to limit information to patients, the Subcommittee agrees that the Legislature or the Department of Health may place restrictions on where that information

may be distributed. Because dispensaries will not, and should not, be attempting to attract children as customers, the Subcommittee also recommends prohibiting imagery that is directed at children, such as cartoon characters. In general, while the Subcommittee believes that dispensary owners will have no financial incentive to advertise to non-patients, the Subcommittee nevertheless recommends that the Legislature require the Department of Health to promulgate regulations that prohibit dispensaries from advertising in a way that primarily targets non-patients.

8. Preventing federal interference

- The Subcommittee recommends that the Legislature eliminate the statutory inconsistencies in HRS §§ 329-121 and -122 to clarify allowable transport of medical marijuana by qualifying patients, caregivers, dispensary operators, and manufacturers; and
- The Subcommittee recommends that the Legislature explicitly provide that growing medical marijuana on public lands is prohibited.
- The Subcommittee believes that, by enacting the above-referenced recommendations, the Legislature will have fully addressed the Department of Justice's stated priorities in enforcing federal marijuana laws.

Because inter-island transportation entails crossing international waters, carrying medical marijuana between islands is treated as "inter-state" for the purposes of federal law and therefore poses an issue for medical marijuana patients who live on smaller, less-populous islands that may not be able to support a dispensary.

In addition, as stated earlier, Hawai'i law is unsettled as it relates to transportation of medical marijuana. In *State v. Woodhall*, the Hawai'i Supreme Court ruled 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).”²⁴ In order to eliminate this discrepancy, the Subcommittee recommends that the Legislature amend HRS § 329-122(c)(E) to apply only to the *use* (*i.e.*, ingestion) of medical marijuana (rather than the mere *transportation* of medical marijuana) in any place open to the public. This will accomplish the ostensible goal of the Legislature in including this provision in the legislation that allowed medical use of marijuana (preventing rampant public use of federally prohibited substances) while easing some fears of patients who need to travel to obtain medical marijuana.

These recommendations will work together with the Subcommittee’s recommendation that the Legislature create provisions for traveling dispensers to smaller islands, where the patient population may not be large enough to sustain a permanent dispensary.

A recurring theme in Subcommittee and Task Force meetings was concern regarding federal oversight and potential criminal penalties under federal law. Generally, the federal government appears to have allowed dispensaries to operate in other states, with some exceptions. A 2009 memorandum from the United States Department of Justice encouraged prosecutors not to pursue federal prosecution for marijuana offenses that did not violate the individual state’s medical marijuana laws,²⁵ and a 2013 follow-up memo listed the Department of Justice’s enforcement priorities related to medical marijuana.²⁶ These seem to indicate that dispensary owners are generally safe from federal prosecution, assuming they do not fall into one of the DOJ’s enforcement priorities:

²⁴ See *State v. Woodhall*, 129 Hawai’i 397, 301 P.3d 607 (2013).

²⁵ Ching, Lance and Brannon, Johnny, “Is the grass always greener? An updated look at other state medical marijuana programs.” Honolulu, HI: Legislative Reference Bureau, August 2014, 53.

²⁶ See www.mpp.org/assets/pdfs/library/DOJmemoAugust2013.pdf.

- 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.

The Subcommittee believes that the recommendations above address factors 1 through 5. As for factor 6, drugged driving is already a crime in Hawai‘i; the Legislature may want to re-emphasize this fact in any proposed legislation. As for factors 7 and 8, the subcommittee recommends that the Legislature ought to make clear (if it is not already clear) that growing marijuana on public lands is illegal (factor 7), and that nothing in any state law should suggest that growing or consuming marijuana on federal property is made legal by the passage of state legislation.

The Subcommittee has attempted to balance the interests of dispensary owners, who will likely prefer to be in populated areas, with the interests of the state in avoiding federal interference with the program by recommending specific security requirements and raising the possibility of a buffer zone between dispensaries and schools. It is worth mentioning, however, that dispensary owners also have a clear interest in preventing federal interference; to that end, the Department of Health may wish to issue a set of guidelines for prospective dispensary owners, outlining the possible risks of establishing a dispensary or a grow site in particular locations.

VI. CONCLUSION

The creation of a functional dispensary system in Hawai‘i is long overdue. As the first state to allow medical use of marijuana through the legislative process, we have lagged behind other states in providing a way for patients to obtain medication in a legal and practical way, sometimes forcing patients with a legitimate medical need for marijuana to resort to the underground market, unnecessarily criminalizing them. Through this report, the Policy Subcommittee has provided a set of concrete and achievable recommendations that we believe will lead to a successful dispensary system if implemented.

Dispensaries are operating well in other states, and Hawaii has the benefit of learning from many other states’ experiences. We have the opportunity to build Hawaii’s program using the best elements of those programs that already exist. The Subcommittee believes that we are well-positioned to take advantage of the tools and information available to create a patient-focused network of dispensaries in Hawai‘i.

Appendix 1 to Policy Subcommittee Report to HCR 48

Medical Marijuana Dispensaries Task Force

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.

Appendix 2 to Policy Subcommittee Report to HCR 48

Medical Marijuana Dispensaries Task Force

Date: Wednesday, July 2, 2014

Meeting #1 (Conference Call)

Attendees: Dana Ciccone, Lee Ann Teshima, Karl Malivuk, Representative Takayama, Jonathan White, Dr. Chris Flanders, Dr. Clif Otto, Daniel Gluck, Holly Berlin

- 1) Scope and purpose of the subcommittee
 - a. Seven topics set forth by the Legislature
 - b. Agreed to discuss one to three topics each meeting
 - c. Members specifically concerned with geographic location of dispensaries given Hawai'i's composition
- 2) Statute v. Regulation
 - a. What needs to be in the statute?
 - b. Example of New Mexico: broad statute, specific regulations to implement the program
 - c. If the program is defined too narrowly in the statute, we could be unnecessarily constraining ourselves
 - d. The number and location of dispensaries as well as safety regulations might be best suited to regulations from the Department of Health
- 3) Assignments and next meeting(s)
 - a. Face-to-face meetings generally preferable to conference calls
 - b. We will connect with contacts in other states' medical marijuana programs (specifically New Mexico and Colorado)
 - c. We should all discuss all of the topics, rather than dividing up into smaller groups to research topics of particular interest

d. Some members would like to focus on cannabis education

Date: Wednesday, July 16, 2014

Meeting #2 (Hawaii State Capitol Room 325)

Attendees: Lee Ann Teshima, Representative Takayama, Karl Malivuk, Dana Ciccone, Dr. Chris Flanders, Dr. Clif Otto, Jari Sugano, Kit Grant, Holly Berlin. Daniel Gluck joining by phone.

- 1) Outline discussion: goal is to bring recommendations back to full task force
- 2) Structure (state-run, non-profit, statute silent)
 - a. Delaware, Maine, Massachusetts, New Hampshire, and New Mexico limit dispensaries to non-profit structure
 - b. No state requires that dispensaries be government-run
 - i. May be good arguments for government-run (there are already so many restrictions placed on dispensaries)
 - ii. However, the majority of the group disfavors this structure (it's untested)
- 3) Location and number
 - a. Dr. Otto gives a short presentation on the process of cultivating medical marijuana
 - b. Karl Malivuk presents calculations of the average number of patients per dispensary nationwide – based on these, approximately 15-30 would be an appropriate starting point for Hawai'i's 13,000 patients
 - c. Several ideas posed re: location
 - i. Distributing by city council district
 - ii. Letting demand determine location (and number)
 - iii. Distributing by patient or population density

- iv. Distributing by county (setting a minimum and/or maximum number of licenses that must be offered to dispensaries in each county)

Date: July 30, 2014

Meeting #3 (Hawaii State Capitol Room 325)

Attendees: Representative Takayama, Jonathan White, Mike Attocknie, Daniel Gluck, Dana Ciccone, Karen Kawamoto, Dr. Chris Flanders, Karl Malivuk. Jari Sugano, Dr. Clif Otto, and Lee Ann Teshima joining by phone.

1) Continued discussion about location of dispensaries

a. We would like to know how many patients would use dispensaries if they were available

b. Consensus that by county based on patient density is best and most feasible

i. This would mean 5 on Oahu, 5 on Hawaii Island, 3 on Maui, and 2 on Kauai (if we settled on a minimum of 15 statewide

ii. Should patients have to choose only one dispensary?

1. Should allow patients to subscribe to more than one OR allow dispensaries to trade product among themselves to ensure that patients get the necessary strain

c. Important to note that start-up costs will be higher if there are fewer dispensaries/manufacturers, because each will have to produce more. Consensus that we can start with 15-30 with the understanding that we want to expand the program as patient numbers grow

2) A framework for cultivating and manufacturing

a. Vertical integration: good or bad?

i. A mix is probably best – don't mandate either way

- ii. Karl Malivuk adds that in his experience in New Mexico, it is less desirable for a storefront to grow its own product on the premises (less variety)
 - b. Should we impose a 99-plant limit for growers given federal penalties for possessing more than 99 plants?
 - i. No, growers understand the risk they take by having more than 99 plants, and no states impose this limit (though several place some limits on the number that are higher than 99)
 - ii. In addition, given our patient numbers, this limit would mean that we would need 150 different growers, and that is just not possible
 - iii. A larger number of growers also means that quality control operations will be more difficult
- 3) Discussed presentation of progress to full task force: agreed that Daniel Gluck will make this presentation

Date: Wednesday, August 27, 2014

Meeting #4 (Hawaii State Capitol Room 325)

Attendees: James Anthony, Mayor Robert Jacob, Dana Ciccone, Jonathan White, Kat Brady, Rafael Kennedy, Dr. Chris Flanders, Pam Lichty, Karen Kawamoto, Lee Ann Teshima, Henry Curtis, Daniel Gluck, Kit Grant, Holly Berlin. Dr. Clif Otto and Representative Della Belatti joining by phone.

- 1) Finishing manufacturing discussion: what do we want in the statute?
 - a. We can leave the statute silent on many of these issues – silence means flexibility
- 2) Taxation
 - a. Option to keep the GET as it applies to all other goods
 - i. 0.5% wholesale and 4.0/4.5% retail
 - ii. Makes it difficult to appropriate for some specific purpose
 - iii. Sin tax unnecessary for medication
 - iv. Jonathan White provided an extremely helpful series of calculations of potential income from GET on medical marijuana
 - v. The simplest path is the best: sticking with GET. Easiest for Department of Tax
 - b. Income tax
 - i. Hawaii conforms to Federal Income Tax Code so dispensers wouldn't be able to deduct business expenses for federally illegal activities
 - ii. Dispensers would end up being able to deduct approximately half of their business expenses (cost of goods sold)
 - iii. Legislature can create an exception to conformity for dispensers

c. Registration fees

i. Lower (like Rhode Island): \$250 application fee, \$5,000 yearly licensing fee

1. Encourages small producers

2. Lower barrier to entry

ii. Higher (like Maine): \$15,000 to apply, \$14,000 refunded if application is not accepted

1. Higher barrier to entry ensures that accepted applicants have the resources to operate the dispensary

2. Encourages only serious candidates to apply

3. Raises significant revenue needed to pay for administration of the program (since there will be no additional tax on the product)

iii. How to award licenses?

1. Lottery

a. Less subject to personal biases of selecting staff

b. Might not result in the very best applications being selected

2. Scoring system based on suitability

a. Generally more favored among members: allows staff to critically evaluate plans for security, acquiring product, etc.

d. Q and A with Mayor Robert Jacob (of Sebastopol, CA) and James Anthony, land use attorney

i. Vertical integration (disfavored)

- ii. Ceiling on number of plants? (None in CA – if there is a surplus, the market adjusts)
- iii. Is there diversion? (Inventory tracking part of every state system)
- iv. Underage access? (100% passage rate for dispensaries in CO when sting operation conducted)
- v. Number of retailers should be specified but number of growers should not be, because that is more directly dependent on the number of patients, which will likely change rapidly

Date: Wednesday, September 3, 2014

Meeting #5 (Hawaii State Capitol Room 325)

1) Location and restriction issues

- a. Because counties already control zoning laws, they should be allowed to continue to make zoning regulations that could affect dispensaries (such as zoning areas for commercial vs. residential use). However, counties should not be allowed to pass zoning ordinances that *only* affect dispensaries. This will allow counties some control over the location of storefronts and grow sites, but will prevent them from zoning these out of existence entirely.
- b. Discussed compliance with federal Drug Free School Zone laws that add extra penalties to drug violations if they occur within 1000 feet of a variety of institutions (including schools, daycares, arcades, parks, public housing complexes, etc.)
 - i. No evidence that DFSZ laws actually do anything to prevent kids from getting drugs or make kids safer in any way
 - ii. However, may be some political capital in including some provision that prohibits dispensaries and grow sites within a certain range of schools
 - iii. Subcommittee is not necessarily opposed to a buffer zone around schools (except where that would mean that there could be no dispensaries anywhere – such as downtown Honolulu), but stresses that there is no evidence-based reason to do this.

2) Quality assurance

- a. Patients want the option to get their medication tested (whether they grow it themselves or obtain it from a dispensary)
 - b. There is a push to test for pesticides, mold, other contaminants, and potency
 - c. The Department of Health is looking in to the best way to ensure quality: contracting with commercial labs, using state labs, UH Department of Tropical Agriculture labs (which has the equipment and skills to do testing)
 - d. All-in-all, agree that more research is necessary
- 3) Discussion about limiting dispensary licenses to those who have been in Hawaii for a certain number of years
- a. May not be constitutional
 - b. Lee Ann Teshima suggests requiring a tax clearance from dispensary owners, which would require owners to have paid taxes in Hawaii previously. This would ensure that the applicant has ties to Hawaii without being overly restrictive.

Date: October 1, 2014

Meeting #6 (Hawaii State Capitol Room 325)

Attendees: Dr. Chris Flanders, Karl Malivuk, Dana Ciccone, Lee Ann Teshima, Karen Kawamoto, Kat Brady, Henry Curtis, Pam Lichty, Rafael Kennedy, Daniel Gluck, Mark Hagadone, Dr. Mark Tomita, Jonathan White, Holly Berlin. Peter Whiticar and Dr. Clif Otto joining by phone.

- 1) Continued discussing location and restriction issues – an audience member expressed that dispensaries should not be allowed near schools.
 - a. Quick research during the meeting yielded the following:
 - i. In Arizona, Maine, and Delaware, dispensaries must be at least 500 feet from schools
 - ii. In Illinois, dispensaries must be at least 2,500 feet from schools, daycare centers, and areas zoned for residential use
 - iii. In New Hampshire, dispensaries conform to federal DFSZ laws
 - iv. In Washington, D.C., dispensaries must be at least 300 feet from schools, churches, or daycare centers
 - v. In Oregon, dispensaries may not be located within 1,000 feet of another facility (worth noting that Oregon dispensaries are allowed to sell immature marijuana plants)
 - vi. In Vermont, dispensaries must be at least 1,000 feet from schools
 - vii. While there may be other regulations on proximity to schools, these seem to indicate that most states do not conform to federal DFSZ.

- b. Thus, the consensus is still that counties can regulate dispensaries as they regulate other businesses, but cannot pass zoning rules specifically targeting dispensaries.
- 2) Quality control
- a. Complicated topic and requires special knowledge
 - b. Mark Hagadone, physical chemist with experience with cannabinoids attended the meeting and shared his expertise
 - i. Chemical and microbiological contaminants are a major concern
 - ii. Don't make the testing process too complex at the beginning
 - iii. There are currently no labs in Hawaii accredited to do marijuana screening
 - iv. Labs should conform to internationally accepted standards: ILAC
 - v. Two main issues are safety and contamination and potency
 - vi. Colorado has a good model for lab screening
 - c. The Department of Health should create guidelines for the following:
 - i. Who does the screening?
 - 1. Is the lab accredited and by whom?
 - ii. How is the screening done?
 - 1. How is the sample transported?
 - 2. How much is screened?
 - 3. How often?
 - iii. What is the sample screened for?
 - 1. Pesticides
 - 2. Bacteria/mold
 - 3. THC

- d. Good language in Nevada statute: Department of Health can screen for content, contamination, and consistency
 - e. These regulations will take a substantial amount of time and will come from the Department of Health, the Department of Agriculture, or both
- 3) Physical security of dispensary and grow site
- a. Consensus among current programs about equipment needed (alarm, lights, cameras) and dispensers and growers will do these anyway for their own safety
 - b. Seed-to-sale tracking to prevent diversion
 - c. Some type of criminal background check on dispensary employees
- 4) Education component (for patients and employees)
- a. Dr. Mark Tomita spoke briefly about his efforts to establish a cannabis certification program at HPU's School of Nursing and Health Sciences
 - b. There is a need for education among patients about which types of marijuana will be best for their particular condition – this requires training for dispensary employees
 - i. The training could be an 8 or 16 hour course open to anyone who wants to learn about cannabis
 - c. In addition, the Department of Health should have a health educator on staff (similar to New Mexico) – assuming that fits into the budget and can be paid for through application and licensing fees

Date: October 8, 2014

Meeting #7 (Hawaii State Capitol Room 325)

Attendees: Ren MacDonald (Office of Rep. Gregg Takayama), Rafael Kennedy, Jonathan White, Daniel Gluck, Lee Ann Teshima. By phone: Peter Whitaker, Clif Otto. Members of the public: Terri Heede, Kat Brady, Henry Curtis, John Reese.

1) Adoption of agenda

Add to agenda, if time – tax forecasts, setting price of medical marijuana, flexibility to Dept. of Health

2) Reporting to full Task Force

- a. Subcommittee recommends that Jonathan White, from DOT, take the lead on reporting subcommittee's recommendations to full Task Force.
- b. Daniel Gluck and Holly Berlin will continue to prepare draft report for subcommittee's review.

3) Topics for discussion

Restrictions on Advertising:

- a. Encompassing all areas of advertising, including but not limited to print, radio, TV, and Internet. Most states have restrictions, like no ads on TV, outdoor placement restrictions. To whom are you advertising? Patients will already know where to go to get their medicine, they don't need it. And we're not trying to advertise to kids.
- b. Our need for advertising is different from states like WA and CO because we don't have marijuana on recreational level. Strictly medicinal, no advertising may

be needed. Advertising could be used to differentiate dispensaries to show what they offer.

- c. Karl received list of dispensaries in mailed out packet when he got his medical marijuana card. This could be an option.
- d. Need websites to show what they offer so patients can see which dispensaries offer which strain, etc. “menu” with information. Should be limited or no advertising to non-patients.
- e. The difference between advertising and information.
- f. Password protected websites from dispensaries to patients.
- g. However, even if you restrict advertising you can’t restrict information from leaking.
- h. Weedmaps; put in your zip code, list of dispensaries, list of links to their websites.
- i. Doctors cannot refer patients to dispensaries under case law but DOH can.
- j. To make barriers higher for non-patients: 1) limit visual advertisements 2) cannot limit Internet. Allow for distribution of written materials at dispensary itself.
- k. Also show intent of dispensary on their website.
- l. OK to give patients information. OK to restrict advertising to non-patients, specifically children. May be away to target intention to patients only.
- m. Federal Alcohol Administration (FAA) regulates advertising for alcohol.
- n. Ultimately: Web based information is OK, signage/ advertising on road NOT OK.

Signs:

- a. Establishment can have a sign. Perhaps restrict actual leaf emblem. Maybe a green cross, or herbal.
- b. In New Mexico signs are small glass, 2-inch tall lettering, often depicting a green cross or the words "Compassionate Patient Care".
- c. There should be no cartoon characters, toys, or anything on the sign to lure children.
- d. Is there a meaningful distinction between advertising and information? Probably not.

However, you can restrict information, pamphlets can be distributed at dispensaries once patient is registered, there can be web-based info, or dispensaries can give all information to DOH to distribute to patients.

Conclusions:

- a. no need for restrictions on internet advertising. Look at intent of advertisement, whether it's clearly targeting non-patients. Allow DOH flexibility to review advertisements.
- b. Allow restrictions on storefront signs
- c. Allow for distribution of written materials at dispensary itself.

Federal Interference:

- a. Federal government will refrain from prosecuting those that are not violating state law.

Civil Asset Forfeiture, how do we prevent fed. gov't from taking everything from a patient?

8 DOJ Priorities:

- (1) Preventing the distribution of marijuana to minors;

- (2) Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs, and cartels;
- (3) Preventing the diversion of marijuana from states where it is legal under state law in some form to other states;
- (4) Preventing state-authorized marijuana activity from being used as a cover or pretext for the trafficking of other illegal drugs or other illegal activity;
- (5) Preventing violence and the use of firearms in the cultivation and distribution of marijuana;
- (6) Preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use;
- (7) Preventing the growing of marijuana on public lands and the attendant public safety and environmental dangers posed by marijuana production on public lands; and
- (8) Preventing marijuana possession or use on federal property.

Certain steps can still be taken to protect dispensaries, perhaps a defense fund, rescheduling under state law to stop fed. interference with state dispensary program. Look at the 8 policies DOJ has laid out. Specifically prohibit growing on public lands. Hawaii law already prohibits drugged driving – more education work needed.

Conclusions:

- a. Encourage DOH to continue education work
- b. Explicitly prohibit growing marijuana on public land.

Remaining Questions.

- Providing for travelling dispensaries for Lana'i, Moloka'i, and Ni'ihau—unique situation in the nation.
- How do we conform to a state and federal level? Do we transport the patient?
- Need to implement protocol for how to handle this in airport.
- In Oakland if you have medical card, TSA looks the other way. You can possess up to 7 lbs. They don't care if you are departing, the issue will be on your arrival and that is the patient's responsibility.
- Issue with screening: fed. employees doing screening will refer to police, we can do something about what police do in response but we can't impact how TSA reacts initially.
- Some states do training of police similar to that of Syringe Exchange Program.
- Regardless of if you're taking a plane or a boat, after 3 miles it is international waters, so either way you are subject to fed. law, it is not intra-state travel.
- Could suggest a delivery system for these travelling patients/or patient has to travel.
- Moloka'i may be big enough to set up its own dispensary.
- Perhaps have an outreach worker visit the islands, or small dispensaries on these other islands.
- Would need a different fee structure and security measures for smaller islands.
- Maui dispensary could transport product to other islands.
- Molokai is an agricultural community that would probably want its own dispensary.
- Tiered fee structure to account for smaller islands.

- Defer to DOH suggesting that we recognize the special needs of those on Moloka‘i, Lana‘i, and Ni‘ihau to access medicine. Encourage DOH to take steps to allow for access for those patients either by allowing dispensary owners from major islands to travel to these islands or a lower licensing fee to operate a dispensary.
- DOH in consultation with other departments of state and county as necessary (specifically dept. of transportation, police dept.).
- Medical use transportation issues, legislature should also consider clarifying the language to address statutory ambiguities by the Supreme Court.
- Introducing legislation to fix that ambiguity, separate transportation issue. Relates to vendors, dispensaries, and their patients. A request to the legislature that it may clear anyone who is procuring medicine at a dispensary and transporting it, so they are not violating state laws.
- Licensed cultivator, vendors. Need vendor licenses.
- Ask DOH in consultation with other state and county agencies to provide for transport of medical marijuana and products between islands from vendors to dispensaries, from dispensaries to patients.
- Remain silent on the issue of vertical integration.
- Number of vendors/producers, should be limited. We have limit on amount of product. If there is no limit everyone will try to produce.
- Vendors should be equal to number of dispensary or double.
- Patients can produce for their own use, can't sell to dispensary unless you have it tested first by lab.
- Leave it to market; it will determine how much need for dispensaries, vendors, etc.

- Risk of federal prosecution increases when number of plants increases.
- Conclusions:
 - Allow for traveling dispensaries; DOH shall create rules in consultation with federal/state/county agencies.
 - Alternatively, DOH could allow for smaller dispensaries with lower licensing fees.
 - Fix HRS § 329-121 and -122 to allow for transportation by patients and dispensaries
 - Better education for law enforcement officials on how Hawaii's medical marijuana program operates.
 - Allow price to be determined by market

Appendix 3 to Policy Subcommittee Report to HCR 48

Medical Marijuana Dispensaries Task Force

First Update to HCR48 Task Force from Policy Subcommittee
August 12, 2014

1) Appropriate number of dispensaries statewide

- a. Based on the current numbers of registered patients (roughly 13,000 state-wide), the subcommittee recommends a minimum of 15-30 dispensaries.
 - i. Most mainland states allow for one dispensary for every 500-1000 registered patients; with approximately 13,000 patients statewide, a range of 15-30 would allow for roughly 500-1000 patients per dispensary.
 - ii. The subcommittee does not necessarily recommend that there be a cap on the overall number of dispensaries, but assuming the Legislature wants to start the program with a relatively small number of dispensaries, this would be an appropriate range.
- b. Alternatives:
 - i. Rather than having the Legislature set a fixed number, the Legislature could adopt a policy that allows numbers to fluctuate, based on a ratio of patients to dispensary (*e.g.*, 500 patients per dispensary). This would ensure that supply can meet demand, with the expectation that patient registrations will increase when we have a dispensary system
 - ii. Similarly, the Legislature could set a minimum number of dispensaries by statute, but refrain from putting a cap on the number so as to make room for expanded patient demand. One way to accomplish this would be to allow the Dept. of Health to decide by administrative rule or otherwise.

2) Appropriate location of dispensaries

- a. Propose having the Legislature set a minimum number of dispensaries in each County (allocated by registered patient population).
- b. The subcommittee does not believe that the Task Force needs to determine specific geographic areas for each dispensary; this can be left to the Dept. of Health (or to the Legislature itself, in the event that legislative representatives feel strongly about having a dispensary in their individual districts).

3) Structure of dispensaries (non-profit, for-profit, government-run)

- a. Government-run (disfavored):
 - i. Because the industry will be heavily regulated by the State, there may be some efficiency in having the Dept. of Health operate the dispensaries themselves. However, no other state currently runs its dispensary system this way, and the subcommittee has concerns about trying a model that has not been tested in another jurisdiction before.
- b. Non-profit vs. for-profit:

- i. Of the 15 currently functioning dispensary systems, four limit dispensaries to non-profit structure.
- ii. The other 11 are silent on the issue, which effectively means that dispensaries are allowed to be either for-profit or non-profit
 1. Important note: although “non-profit” may sound more benign, the only significant difference between hypothetical non-profit and for-profit dispensaries is that non-profits are not allowed to have shareholders. We are assuming that dispensaries will be taxed, regardless of whether they are categorized as “non-profit” or “for-profit,” so the categorization is not particularly important.
 2. The general consensus of most of the subcommittee members is that there are no particularly strong policy arguments either for or against specifically limiting dispensaries to non-profit structure; however, the Legislature may believe that, politically, non-profit dispensaries would have a better chance of passage.

4) Framework for manufacturing

- a. The subcommittee is still discussing the logistics of manufacture, including whether to allow each dispensary to grow on the premises; to allow dispensaries to grow off-site; or to allow dispensaries to purchase from third-party growers.
- b. Approximately 39,000 plants are required to supply 13,000 patients with four ounces of medication per month assuming that one plant can produce four ounces of dried material each month. (Patient possession increases to four ounces as of Jan-2015.) Each plant needs approximately three square feet of growing space if grown horizontally. Some patients will likely continue to grow their own marijuana, but we anticipate the vast majority will rely on the dispensary system.
- c. Important note: the lower the number of dispensaries, the higher the number of plants/growers per dispensary. In other words, if the Legislature allows only 15 dispensaries, then each dispensary will need to grow (or contract with outside growers to produce) 2,600 plants per month.
- d. Some states place limits on the numbers of plants any one grower may cultivate. California, for example, limits all growers to 99 plants or less, because possession of more than 99 plants would place growers in a higher tier of punishment by the federal government; some states allow up to 150 plants. Again, the lower the number of plants allowed per grower, the higher the overall number of growers necessary.

Second Update to HCR48 Task Force from Policy Subcommittee
September 9, 2014

1) Appropriate number of dispensaries statewide

- a. Based on the current numbers of registered patients (roughly 13,000 state-wide), the subcommittee recommends a minimum of 15-30 dispensaries.
 - i. Most mainland states allow for one dispensary for every 500-1000 registered patients; with approximately 13,000 patients statewide, a range of 15-30 would allow for roughly 500-1000 patients per dispensary.
 - ii. The subcommittee does not necessarily recommend that there be a cap on the overall number of dispensaries, but assuming the Legislature wants to start the program with a relatively small number of dispensaries, this would be an appropriate range.
- b. Alternatives:
 - i. Rather than having the Legislature set a fixed number, the Legislature could adopt a policy that allows numbers to fluctuate, based on a ratio of patients to dispensary (*e.g.*, 500 patients per dispensary). This would ensure that supply can meet demand, with the expectation that patient registrations will increase when we have a dispensary system.
 - ii. Similarly, the Legislature could set a minimum number of dispensaries by statute, but refrain from putting a cap on the number so as to make room for expanded patient demand. One way to accomplish this would be to allow the Dept. of Health to decide by administrative rule or otherwise.

2) Appropriate location of dispensaries

- a. Propose having the Legislature set a minimum number of dispensaries in each County (allocated by registered patient population).
- b. The subcommittee does not believe that the Task Force needs to determine specific geographic areas for each dispensary; this can be left to the Dept. of Health, the Legislature itself (in the event that legislative representatives feel strongly about having a dispensary in their individual districts), or market forces to determine ideal locations.

3) Structure of dispensaries (non-profit, for-profit, government-run)

- a. Government-run (disfavored):
 - i. Because the industry will be heavily regulated by the State, there may be some efficiency in having the Dept. of Health operate the dispensaries themselves. However, no other state currently runs its dispensary system this way, and the subcommittee has concerns about trying a model that has not been tested in another jurisdiction before.
- b. Non-profit vs. for-profit:
 - i. Of the 15 currently functioning dispensary systems, four limit dispensaries to non-profit structure.
 - ii. The other 11 are silent on the issue, which effectively means that dispensaries are allowed to be either for-profit or non-profit
 - 1. Important note: although “non-profit” may sound more benign, the only significant difference between hypothetical non-profit and for-profit dispensaries is that non-profits are not allowed to have shareholders. We are assuming that dispensaries will be taxed, regardless of whether they are categorized as “non-profit” or “for-profit,” so the categorization is not particularly important.
 - 2. The general consensus of most of the subcommittee members is that there are no particularly strong policy arguments either for or against specifically limiting dispensaries to non-profit structure; however, the Legislature may believe that, politically, non-profit dispensaries would have a better chance of passage.

4) Framework for manufacturing

- a. Approximately 39,000 plants are required to supply 13,000 patients with four ounces of medication per month assuming that one plant can produce four ounces of dried material each month. (Patient possession increases to four ounces as of Jan-2015.) Each plant needs approximately three square feet of growing space if grown horizontally. Some patients will likely continue to grow their own

marijuana, but we anticipate that, as in New Mexico, the vast majority will rely on the dispensary system.

- b. Important note: the lower the number of dispensaries, the higher the number of plants/growers per dispensary. In other words, if the Legislature allows only 15 dispensaries, then each dispensary will need to grow (or contract with outside growers to produce) 2,600 plants per month.
- c. Some states place limits on the numbers of plants any one grower may cultivate. California, for example, limits all growers to 99 plants or less, because possession of more than 99 plants would place growers in a higher tier of punishment by the federal government; some states allow up to 150 plants, and one (Washington, D.C.) allows up to 500, though this provision will expire on October 27 if the City Council passes legislation extending it. Again, the lower the number of plants allowed per grower, the higher the overall number of growers necessary. Generally, subcommittee members felt that the Hawai'i statute ought to remain silent on this issue, but that the application to be a dispenser or grower should explicitly say (as in other states) that the individual assumes all risks associated with producing and selling marijuana.
- d. Some states, such as Colorado, require vertical integration: the dispensary itself must grow at least 75% of the medication it dispenses. However, the general consensus among subcommittee members is that a mix of vertical integration and diversification is ideal. This will allow dispensaries to carry a larger variety of strains (insofar as patients and caregivers want a variety of options, because different strains are better suited to treating different conditions/individuals), while also having the option to integrate a growing operation into the dispensary for increased ease of access. To that end, the optimal legislation would, again, remain silent on the issue of vertical integration, except to specify that the dispensary may grow on the premises, at a second secured location, or may contract out the growing and production to a second (DOH-licensed) entity.

5) Taxes and Fee Structure

- a. GET
 - i. The simplest GET tax structure (and, therefore, the easiest to implement) is applying the existing General Excise Tax and income tax structure to medical marijuana. This means that retail purchases by customers at a dispensary would be subject to either a 4.0% or a 4.5% (on Oahu) tax.

Wholesale transactions (any transaction *before* the retail purchase) would be subject to a 0.5% tax.

- ii. The Department of Tax generally prefers that new programs be taxed at the same rate as all other existing programs, rather than creating a new tax structure that would be more difficult to administer.
- iii. Using the existing GET/income tax structure means that the revenue would go into the General Fund, which is the main source of revenue for the State. The Legislature appropriates funds for the state budget from the General Fund. This will likely mean that any funds to administer the medical marijuana program will have to come from licensing fees, rather than from the general fund, insofar as it may be difficult to earmark general fund revenue for specific programs.

The Department of Tax provided a very helpful series of calculations of the amount of GET revenue we might expect from sales of medical marijuana. Depending on four variables (number of patients, average monthly use, average cost per ounce, and price markup percentage), the state can expect to see between \$393,190.43 and \$6,622,102.68 in additional yearly revenue. Because New Mexico's medical marijuana program has about the same number of qualifying patients as Hawai'i and a similar tax structure, information from New Mexico provides a good starting point to determine about the revenue we might expect here. With 90% of patients in New Mexico using dispensaries to obtain medication, New Mexico brings in approximately \$1 million in tax revenue from the sales of medical marijuana. Based on the GET calculations from the Hawai'i Department of Tax, this might indicate that patients in New Mexico are using an average of 0.25 – 0.5 ounces per month. If Hawai'i's patients used a similar average amount per month, we could also expect to see GET revenue of approximately \$1 million. (This figure is likely to rise as the number of patients tends to increase once dispensaries are accessible.) While these calculations are rough and the subcommittee continues to research this issue, the above numbers show a reasonable estimate.

b. Licensing Fees

- i. As explained above, any funds to administer the medical marijuana program will have to come from licensing fees, rather than from the

general fund, insofar as it may be difficult to earmark general fund revenue for specific programs.

- ii. Most states charge an application fee to anyone who wants to open a dispensary, in addition to a yearly registration fee (which is generally much higher than the application fee). This yearly registration fee will ideally cover all costs of administering the medical marijuana program. Subcommittee members were generally *not* opposed to the idea of substantial licensing fees. While the subcommittee did not reach a consensus on a dollar figure for the application and registration fees, several options, each with advantages and disadvantages, were proposed:
 1. Lower application/licensing fees (*e.g.*, \$250 application fee and \$5,000 yearly registration fee if the application is accepted). This structure is the same as Rhode Island's. The advantage of instituting a relatively low-cost fee system, such as this one, is that it lowers the barriers to entry. This encourages smaller, community-based dispensaries that may be more attentive to the needs of patients. It also encourages local people, who may not have the same cash resources as mainland-based companies that already own dispensaries in other states, to get involved.
 2. Larger application/licensing fees (*e.g.*, \$15,000 application fee, \$14,000 of which gets refunded if an application is not accepted (emulating Maine's fee structure); yearly licensing fee of \$15,000 or more). If the application is accepted, the \$15,000 fee goes toward the yearly registration costs. With a high barrier to entry, applicants will be more likely to be able to afford the other start-up costs of running a dispensary, which can be almost \$250,000. A high initial fee also helps ensure that applicants are serious about providing medication to Hawai'i medical marijuana patients before the DOH expends valuable resources evaluating the application.
- iii. Yearly registration fee
 1. Members of the subcommittee do not object to establishing high yearly registration fees, a policy that has been successful in other states. A substantial yearly registration fee (such as \$30,000), that would go to the Department of Health to cover the costs of the

medical marijuana program, would help ensure that the program is administered effectively.

c. Income Tax

- i. The Hawai'i income tax code generally conforms to the federal income tax code, though the Legislature can (and does) create exceptions. According to the federal tax code, dispensary owners can only deduct about half of their business expenses when filing their income tax returns; this means that dispensary owners will pay taxes on a higher portion of their income than owners of other businesses, essentially paying income tax on gross income, rather than net income).
- ii. While the Legislature cannot change the federal income tax for Hawaii dispensary operators, the Legislature could easily change the state income tax for Hawaii dispensary operators by creating a deviation from the federal tax code. The subcommittee recommends that the Legislature do so, though only after the dispensary system is operational. This is because only then will the necessary structure and language of the deviation be apparent. Also, before dispensaries are in place and operational, only illegitimate businesses would be able to take advantage of such a deviation.

6) Location and Restriction Issues

- a. The subcommittee began discussing zoning issues, but has not yet concluded the discussion. The general consensus thus far is that the Department of Health should set a number of licenses that will be offered in each county. The counties will be allowed to make zoning laws that could apply to medical marijuana dispensaries, but they should not be allowed to pass zoning ordinances that pertain *only* to medical marijuana dispensaries. This allows the counties to maintain their traditional power over zoning rules, while ensuring that county government cannot undermine the program under the guise of zoning rules.
- b. Conforming to Drug-Free School Zone Laws
 - i. The subcommittee began, but has not concluded, its discussion on this topic. Subcommittee members agree that there is no evidence that adding

additional criminal penalties to drug possession or sale near a school decreases the likelihood that children will use drugs. In addition, the density of schools and other similar facilities affected by Drug-Free School Zone laws (parks, public housing complexes, public swimming pools, arcades) means that in urban areas (especially Honolulu), it would be virtually impossible to open a dispensary.

- ii. However, there is an argument that conforming to federal Drug-Free School Zone regulations in crafting zoning regulations for dispensaries would be beneficial, in that it would avoid inviting federal prosecution of dispensaries that are within 1,000 feet of a school (or other location that is included in the Drug-Free School Zone law).
- iii. The subcommittee also recognizes that there may be political capital to be gained by conforming to these federal regulations as we attempt to pass a dispensaries bill through the Legislature.

7) Methods for ensuring public safety and security of supply

- a. The subcommittee also began questions related to safety and security, but did not conclude the discussion. There are two parts of this that the subcommittee identified:
 - i. Quality control
 - 1. In order to ensure that the patient is getting the most effective medication and that the medication is free of contaminants such as pesticides or mold, it would be ideal to have some type of laboratory testing available and required on a regular basis. The Department of Health is currently researching the best system for spot-checking dried flowers, edibles, and concentrates that would be sold at dispensaries.
 - ii. Physical security of supply
 - 1. Most states require specific security precautions, such as lighting, cameras, and/or fences. The LRB report details this information. The subcommittee is still reviewing the report, and we plan to continue this discussion at our next meeting.

Third Update to HCR48 Task Force from Policy Subcommittee

October 14, 2014

1) Appropriate number of dispensaries statewide

- a. Based on the current numbers of registered patients (roughly 13,000 state-wide), the subcommittee recommends a minimum of 15-30 dispensaries.
 - i. Most mainland states allow for one dispensary for every 500-1000 registered patients; with approximately 13,000 patients statewide, a range of 15-30 would allow for roughly 500-1000 patients per dispensary.
 - ii. The subcommittee does not necessarily recommend that there be a cap on the overall number of dispensaries, but assuming the Legislature wants to start the program with a relatively small number of dispensaries, this would be an appropriate range.
- b. Alternatives:
 - i. Rather than having the Legislature set a fixed number, the Legislature could adopt a policy that allows numbers to fluctuate, based on a ratio of patients to dispensary (*e.g.*, 500 patients per dispensary). This would ensure that supply can meet demand, with the expectation that patient registrations will increase when we have a dispensary system.
 - ii. Similarly, the Legislature could set a minimum number of dispensaries by statute, but refrain from putting a cap on the number so as to make room for expanded patient demand. One way to accomplish this would be to allow the Dept. of Health to decide by administrative rule or otherwise.

2) Appropriate location of dispensaries

- a. Propose having the Legislature set a minimum number of dispensaries in each County (allocated by registered patient population).
- b. The subcommittee does not believe that the Task Force needs to determine specific geographic areas for each dispensary; this can be left to the Dept. of Health, the Legislature itself (in the event that legislative representatives feel strongly about having a dispensary in their individual districts), or market forces to determine ideal locations.

3) Structure of dispensaries (non-profit, for-profit, government-run)

- a. Government-run (disfavored):
 - i. Because the industry will be heavily regulated by the State, there may be some efficiency in having the Dept. of Health operate the dispensaries themselves. However, no other state currently runs its dispensary system this way, and the subcommittee has concerns about trying a model that has not been tested in another jurisdiction before.
- b. Non-profit vs. for-profit:
 - i. Of the 15 currently functioning dispensary systems, four limit dispensaries to non-profit structure.
 - ii. The other 11 are silent on the issue, which effectively means that dispensaries are allowed to be either for-profit or non-profit
 - 1. Important note: although “non-profit” may sound more benign, the only significant difference between hypothetical non-profit and for-profit dispensaries is that non-profits are not allowed to have shareholders. We are assuming that dispensaries will be taxed, regardless of whether they are categorized as “non-profit” or “for-profit,” so the categorization is not particularly important.
 - 2. The general consensus of most of the subcommittee members is that there are no particularly strong policy arguments either for or against specifically limiting dispensaries to non-profit structure; however, the Legislature may believe that, politically, non-profit dispensaries would have a better chance of passage.

4) Framework for manufacturing

- a. Approximately 39,000 plants are required to supply 13,000 patients with four ounces of medication per month assuming that one plant can produce four ounces of dried material each month. (Patient possession increases to four ounces as of Jan-2015.) Each plant needs approximately three square feet of growing space if grown horizontally. Some patients will likely continue to grow their own

marijuana, but we anticipate that, as in New Mexico, the vast majority will rely on the dispensary system.

- b. Important note: the lower the number of dispensaries, the higher the number of plants/growers per dispensary. In other words, if the Legislature allows only 15 dispensaries, then each dispensary will need to grow (or contract with outside growers to produce) 2,600 plants per month.
- c. Some states place limits on the numbers of plants any one grower may cultivate. California, for example, limits all growers to 99 plants or less, because possession of more than 99 plants would place growers in a higher tier of punishment by the federal government; some states allow up to 150 plants, and one (Washington, D.C.) allows up to 500, though this provision will expire on October 27 if the City Council passes legislation extending it. Again, the lower the number of plants allowed per grower, the higher the overall number of growers necessary. Generally, subcommittee members felt that the Hawai‘i statute ought to remain silent on this issue, but that the application to be a dispenser or grower should explicitly say (as in other states) that the individual assumes all risks associated with producing and selling marijuana.
- d. Some states, such as Colorado, require vertical integration: the dispensary itself must grow at least 75% of the medication it dispenses. However, the general consensus among subcommittee members is that a mix of vertical integration and diversification is ideal. This will allow dispensaries to carry a larger variety of strains (insofar as patients and caregivers want a variety of options, because different strains are better suited to treating different conditions/individuals), while also having the option to integrate a growing operation into the dispensary for increased ease of access. To that end, the optimal legislation would, again, remain silent on the issue of vertical integration, except to specify that the dispensary may grow on the premises, at a second secured location, or may contract out the growing and production to a second (DOH-licensed) entity.

5) Taxes and Fee Structure

- a. GET
 - i. The simplest GET tax structure (and, therefore, the easiest to implement) is applying the existing General Excise Tax and income tax structure to medical marijuana. This means that retail purchases by customers at a dispensary would be subject to either a 4.0% or a 4.5% (on Oahu) tax.

Wholesale transactions (any transaction *before* the retail purchase) would be subject to a 0.5% tax.

- ii. The Department of Tax generally prefers that new programs be taxed at the same rate as all other existing programs, rather than creating a new tax structure that would be more difficult to administer.
- iii. Using the existing GET/income tax structure means that the revenue would go into the General Fund, which is the main source of revenue for the State. The Legislature appropriates funds for the state budget from the General Fund. This will likely mean that any funds to administer the medical marijuana program will have to come from licensing fees, rather than from the general fund, insofar as it may be difficult to earmark general fund revenue for specific programs.

The Department of Tax provided a very helpful series of calculations of the amount of GET revenue we might expect from sales of medical marijuana. Depending on four variables (number of patients, average monthly use, average cost per ounce, and price markup percentage), the state can expect to see between \$393,190.43 and \$6,622,102.68 in additional yearly revenue. Because New Mexico's medical marijuana program has about the same number of qualifying patients as Hawai'i and a similar tax structure, information from New Mexico provides a good starting point to determine about the revenue we might expect here. With 90% of patients in New Mexico using dispensaries to obtain medication, New Mexico brings in approximately \$1 million in tax revenue from the sales of medical marijuana. Based on the GET calculations from the Hawai'i Department of Tax, this might indicate that patients in New Mexico are using an average of 0.25 – 0.5 ounces per month. If Hawai'i's patients used a similar average amount per month, we could also expect to see GET revenue of approximately \$1 million. (This figure is likely to rise as the number of patients tends to increase once dispensaries are accessible.) While these calculations are rough and the subcommittee continues to research this issue, the above numbers show a reasonable estimate.

- b. Licensing Fees (with general input from Mayor Robert Jacob of Sebastopol, CA and James Anthony, land use attorney)

- i. As explained above, any funds to administer the medical marijuana program will have to come from licensing fees, rather than from the general fund, insofar as it may be difficult to earmark general fund revenue for specific programs.
- ii. Most states charge an application fee to anyone who wants to open a dispensary, in addition to a yearly registration fee (which is generally much higher than the application fee). This yearly registration fee will ideally cover all costs of administering the medical marijuana program. Subcommittee members were generally *not* opposed to the idea of substantial licensing fees. While the subcommittee did not reach a consensus on a dollar figure for the application and registration fees, several options, each with advantages and disadvantages, were proposed:
 1. Lower application/licensing fees (e.g., \$250 application fee and \$5,000 yearly registration fee if the application is accepted). This structure is the same as Rhode Island's. The advantage of instituting a relatively low-cost fee system, such as this one, is that it lowers the barriers to entry. This encourages smaller, community-based dispensaries that may be more attentive to the needs of patients. It also encourages local people, who may not have the same cash resources as mainland-based companies that already own dispensaries in other states, to get involved.
 2. Larger application/licensing fees (e.g., \$15,000 application fee, \$14,000 of which gets refunded if an application is not accepted (emulating Maine's fee structure); yearly licensing fee of \$15,000 or more). If the application is accepted, the \$15,000 fee goes toward the yearly registration costs. With a high barrier to entry, applicants will be more likely to be able to afford the other start-up costs of running a dispensary, which can be almost \$250,000. A high initial fee also helps ensure that applicants are serious about providing medication to Hawai'i medical marijuana patients before the DOH expends valuable resources evaluating the application.
- iii. Yearly registration fee
 1. Members of the subcommittee do not object to establishing high yearly registration fees, a policy that has been successful in other states. A substantial yearly registration fee (such as \$30,000), that

would go to the Department of Health to cover the costs of the medical marijuana program, would help ensure that the program is administered effectively.

c. Income Tax

- i. The Hawai'i income tax code generally conforms to the federal income tax code, though the Legislature can (and does) create exceptions. According to the federal tax code, dispensary owners can only deduct about half of their business expenses when filing their income tax returns; this means that dispensary owners will pay taxes on a higher portion of their income than owners of other businesses, essentially paying income tax on gross income, rather than net income).
- ii. While the Legislature cannot change the federal income tax for Hawaii dispensary operators, the Legislature could easily change the state income tax for Hawaii dispensary operators by creating a deviation from the federal tax code. The subcommittee recommends that the Legislature do so, though only after the dispensary system is operational. This is because only then will the necessary structure and language of the deviation be apparent. Also, before dispensaries are in place and operational, only illegitimate businesses would be able to take advantage of such a deviation.

6) Location and Restriction Issues

- a. The general consensus thus far is that the Department of Health should set a number of licenses that will be offered in each county. The counties will be allowed to make zoning laws that could apply to medical marijuana dispensaries, but they should not be allowed to pass zoning ordinances that pertain *only* to medical marijuana dispensaries. This allows the counties to maintain their traditional power over zoning rules, while ensuring that county government cannot undermine the program under the guise of zoning rules.
- b. Conforming to Drug-Free School Zone Laws
 - i. Subcommittee members agree that there is no evidence that adding additional criminal penalties to drug possession or sale near a school

decreases the likelihood that children will use drugs. In addition, the density of schools and other similar facilities affected by Drug-Free School Zone laws (parks, public housing complexes, public swimming pools, arcades) means that in urban areas (especially Honolulu), it would be virtually impossible to open a dispensary.

- ii. However, there is an argument that conforming to federal Drug-Free School Zone regulations in crafting zoning regulations for dispensaries would be beneficial, in that it would avoid inviting federal prosecution of dispensaries that are within 1,000 feet of a school (or other location that is included in the Drug-Free School Zone law).
- iii. The subcommittee also recognizes that there may be political capital to be gained by conforming to these federal regulations as we attempt to pass a dispensaries bill through the Legislature.

7) Methods for ensuring public safety and security of supply

a. There are two parts of the safety and security component that the subcommittee identified:

i. Quality control (guest presentation from Dr. Mark Hagadone, Technical Experts, Inc.)

1. In order to ensure that the patient is getting the most effective medication and that the medication is free of contaminants such as pesticides or mold, it would be ideal to have some type of laboratory testing available and required on a regular basis. The Department of Health is currently researching the best system for spot-checking dried flowers, edibles, and concentrates that would be sold at dispensaries.

2. Main questions, which the DOH should create guidelines to answer:

a. Who does the screening?

i. Is the lab accredited and by whom?

b. How is the screening done?

i. How is the sample transported?

ii. How much is screened?

iii. How often?

- c. What is the sample screened for?
 - i. Pesticides
 - ii. Bacteria/mold
 - iii. Potency
 3. The Department of Health expressed that Nevada’s statute could provide a good model for Hawaii (with the appropriate amount of direction for the Department) – the Department of Health may screen for “content, contamination, and consistency.”
 4. The subcommittee agrees that beginning with this type of broad language will allow us the flexibility to create an adequate screening system.
- ii. Physical security of supply
 1. Most states require dispensaries to take specific security precautions. The LRB report details this information. States are generally similar to each other in this area: most require alarms and cameras at a basic level, with some states requiring additional security measures.
 2. These requirements are almost always (with the exception of three states) determined by departmental regulation.
 3. The subcommittee recommends that the Department of Health develop these recommendations for Hawaii’s program.
 4. In addition, the subcommittee recommends some type of criminal background check for employees of dispensaries, though we have not determined what background check results would disqualify a person from working at a dispensary.
 5. Lastly, the subcommittee recommends that inventory tracking software (seed-to-sale) be required of all dispensaries to decrease the risk of internal diversion of product.
- b. Related to physical safety and quality control, the subcommittee also discussed education and training for dispensary staff and patients (with guest presentation from Dr. Mark Tomita, Hawaii Pacific University)
 - i. The subcommittee recognizes a real need for education (both as workforce development and for patient health).

- ii. The subcommittee generally agrees that the Department of Health should have a health educator on staff, similar to New Mexico's medical marijuana program.
- iii. In addition, members were generally supportive of the establishment of a training or certification program for dispensary employees and any members of the public who might be interested.

Fourth and Final Update to HCR48 Task Force from Policy Subcommittee

5) Appropriate number of dispensaries statewide

- a. Based on the current numbers of registered patients (roughly 13,000 state-wide), the subcommittee recommends a minimum of 15-30 dispensaries.
 - i. Most mainland states allow for one dispensary for every 500-1000 registered patients; with approximately 13,000 patients statewide, a range of 15-30 would allow for roughly 500-1000 patients per dispensary.
 - ii. The subcommittee does not necessarily recommend that there be a cap on the overall number of dispensaries, but assuming the Legislature wants to start the program with a relatively small number of dispensaries, this would be an appropriate range.
- b. Alternatives:
 - i. Rather than having the Legislature set a fixed number, the Legislature could adopt a policy that allows numbers to fluctuate, based on a ratio of patients to dispensary (*e.g.*, 500 patients per dispensary). This would ensure that supply can meet demand, with the expectation that patient registrations will increase when we have a dispensary system.
 - ii. Similarly, the Legislature could set a minimum number of dispensaries by statute, but refrain from putting a cap on the number so as to make room for expanded patient demand. One way to accomplish this would be to allow the Dept. of Health to decide by administrative rule or otherwise.

6) Appropriate location of dispensaries

- a. Propose having the Legislature set a minimum number of dispensaries in each County (allocated by registered patient population).
- b. The subcommittee does not believe that the Task Force needs to determine specific geographic areas for each dispensary; this can be left to the Dept. of Health, the Legislature itself (in the event that legislative representatives feel strongly about having a dispensary in their individual districts), or market forces to determine ideal locations.
- c. Special issues relating to Molokai, Lanai, and Niihau
 - i. The subcommittee does not believe that the market of patients on Molokai, Lanai, or Niihau is large enough to sustain its own dispensary.
 - ii. As such, the subcommittee recommends that the Dept. of Health create administrative rules (in consultation with federal, State, and/or County agencies as appropriate) to allow dispensary operators on Oahu, Hawaii, Maui, and/or Kauai the ability to travel to Molokai, Lanai, and/or Niihau to serve patients living on those islands, or create a special class of dispensary (with much lower licensing fees) for those islands.
 - iii. To do so, the Legislature ought to clarify the language contained within HRS §§ 329-121 and 329-122 regarding the transportation of medical marijuana. *See State v. Woodhall*, 129 Hawai'i 397, 301 P.3d 607 (2013).

7) Structure of dispensaries (non-profit, for-profit, government-run)

a. Government-run (disfavored):

- i. Because the industry will be heavily regulated by the State, there may be some efficiency in having the Dept. of Health operate the dispensaries themselves. However, no other state currently runs its dispensary system this way, and the subcommittee has concerns about trying a model that has not been tested in another jurisdiction before.

b. Non-profit vs. for-profit:

- i. Of the 15 currently functioning dispensary systems, four limit dispensaries to non-profit structure.
- ii. The other 11 are silent on the issue, which effectively means that dispensaries are allowed to be either for-profit or non-profit
 1. Important note: although “non-profit” may sound more benign, the only significant difference between hypothetical non-profit and for-profit dispensaries is that non-profits are not allowed to have shareholders. We are assuming that dispensaries will be taxed, regardless of whether they are categorized as “non-profit” or “for-profit,” so the categorization is not particularly important.
 2. The general consensus of most of the subcommittee members is that there are no particularly strong policy arguments either for or against specifically limiting dispensaries to non-profit structure; however, the Legislature may believe that, politically, non-profit dispensaries would have a better chance of passage.

8) Framework for manufacturing

- a. Approximately 39,000 plants are required to supply 13,000 patients with four ounces of medication per month assuming that one plant can produce four ounces of dried material each month. (Patient possession increases to four ounces as of Jan-2015.) Each plant needs approximately three square feet of growing space if grown horizontally. Some patients will likely continue to grow their own marijuana, but we anticipate that, as in New Mexico, the vast majority will rely on the dispensary system.
- b. Important note: the lower the number of dispensaries, the higher the number of plants/growers per dispensary. In other words, if the Legislature allows only 15 dispensaries, then each dispensary will need to grow (or contract with outside growers to produce) 2,600 plants per month.
- c. Some states place limits on the numbers of plants any one grower may cultivate. California, for example, limits all growers to 99 plants or less, because possession of more than 99 plants would place growers in a higher tier of punishment by the federal government; some states allow up to 150 plants, and one (Washington, D.C.) allows up to 500, though this provision will expire on October 27 if the City Council passes legislation extending it. Again, the lower the number of plants allowed per grower, the higher the overall number of growers necessary. Generally, subcommittee members felt that the Hawai'i statute ought to remain silent on this issue, but that the application to be a dispenser or grower should explicitly say (as in other states) that the individual assumes all risks associated with producing and selling marijuana.
- d. Some states, such as Colorado, require vertical integration: the dispensary itself must grow at least 75% of the medication it dispenses. However, the general consensus among subcommittee members is that a mix of vertical integration and diversification is ideal. This will allow dispensaries to carry a larger variety of strains (insofar as patients and caregivers want a variety of options, because different strains are better suited to treating different conditions/individuals), while also having the option to integrate a growing operation into the dispensary for increased ease of access. To that end, the optimal legislation would, again, remain silent on the issue of vertical integration, except to specify that the dispensary may grow on the premises, at a second secured location, or may contract out the growing and production to a second (DOH-licensed) entity.

- i. To be clear, our recommendation is that growers would need to obtain a license to produce marijuana, even if the growers are not dispensing the marijuana directly to patients, so that everyone involved in producing, distributing, and consuming medical marijuana would be licensed by the State.
- ii. Our assumption is that growers would also pay a licensing fee, but that the fee to produce would be substantially less than the fee to dispense. This would allow for small, local farms to produce different varieties of products for patients' needs.
- iii. Anyone growing marijuana for use in a dispensary would have to use the seed-to-sale software (and other security measures) used by vertically integrated dispensaries.

9) Taxes and Fee Structure

a. GET

- i. The simplest GET tax structure (and, therefore, the easiest to implement) is applying the existing General Excise Tax and income tax structure to medical marijuana. This means that retail purchases by customers at a dispensary would be subject to either a 4.0% or a 4.5% (on Oahu) tax. Wholesale transactions (any transaction *before* the retail purchase) would be subject to a 0.5% tax.
- ii. The Department of Tax generally prefers that new programs be taxed at the same rate as all other existing programs, rather than creating a new tax structure that would be more difficult to administer.
- iii. Using the existing GET/income tax structure means that the revenue would go into the General Fund, which is the main source of revenue for the State. The Legislature appropriates funds for the state budget from the General Fund. This will likely mean that any funds to administer the medical marijuana program will have to come from licensing fees, rather than from the general fund, insofar as it may be difficult to earmark general fund revenue for specific programs.

The Department of Tax provided a very helpful series of calculations of the amount of GET revenue we might expect from sales of medical marijuana. Depending on four variables (number of patients, average monthly use, average cost per ounce, and price markup percentage), the state can expect to see between \$393,190.43 and \$6,622,102.68 in additional yearly revenue. Because New Mexico's medical marijuana program has about the same number of qualifying patients as Hawai'i and a similar tax structure, information from New Mexico provides a good starting point to determine about the revenue we might expect here. With 90% of patients in New Mexico using dispensaries to obtain medication, New Mexico brings in approximately \$1 million in tax revenue from the sales of medical marijuana. Based on the GET calculations from the Hawai'i Department of Tax, this might indicate that patients in New Mexico are using an average of 0.25 – 0.5 ounces per month. If Hawai'i's patients used a similar average amount per month, we could also expect to see GET revenue of approximately \$1 million. (This figure is likely to rise as the number of patients tends to increase once dispensaries are

accessible.) While these calculations are rough and the subcommittee continues to research this issue, the above numbers show a reasonable estimate.

- b. Licensing Fees (with general input from Mayor Robert Jacob of Sebastopol, CA and James Anthony, land use attorney)
 - i. As explained above, any funds to administer the medical marijuana program will have to come from licensing fees, rather than from the general fund, insofar as it may be difficult to earmark general fund revenue for specific programs.
 - ii. Most states charge an application fee to anyone who wants to open a dispensary, in addition to a yearly registration fee (which is generally much higher than the application fee). This yearly registration fee will ideally cover all costs of administering the medical marijuana program. Subcommittee members were generally *not* opposed to the idea of substantial licensing fees. While the subcommittee did not reach a consensus on a dollar figure for the application and registration fees, several options, each with advantages and disadvantages, were proposed:
 1. Lower application/licensing fees (e.g., \$250 application fee and \$5,000 yearly registration fee if the application is accepted). This structure is the same as Rhode Island's. The advantage of instituting a relatively low-cost fee system, such as this one, is that it lowers the barriers to entry. This encourages smaller, community-based dispensaries that may be more attentive to the needs of patients. It also encourages local people, who may not have the same cash resources as mainland-based companies that already own dispensaries in other states, to get involved.
 2. Larger application/licensing fees (e.g., \$15,000 application fee, \$14,000 of which gets refunded if an application is not accepted (emulating Maine's fee structure); yearly licensing fee of \$15,000 or more). If the application is accepted, the \$15,000 fee goes toward the yearly registration costs. With a high barrier to entry, applicants will be more likely to be able to afford the other start-up costs of running a dispensary, which can be almost \$250,000. A high initial fee also helps ensure that applicants are serious about

providing medication to Hawai‘i medical marijuana patients before the DOH expends valuable resources evaluating the application.

iii. Yearly registration fee

1. Members of the subcommittee do not object to establishing high yearly registration fees, a policy that has been successful in other states. A substantial yearly registration fee (such as \$30,000), that would go to the Department of Health to cover the costs of the medical marijuana program, would help ensure that the program is administered effectively.
2. We assume that non-dispensing producers would also pay a licensing fee, but one that is substantially smaller than what is paid by the dispensary itself.

c. Income Tax

- i. The Hawai‘i income tax code generally conforms to the federal income tax code, though the Legislature can (and does) create exceptions. According to the federal tax code, dispensary owners can only deduct about half of their business expenses when filing their income tax returns; this means that dispensary owners will pay taxes on a higher portion of their income than owners of other businesses, essentially paying income tax on gross income, rather than net income).
- ii. While the Legislature cannot change the federal income tax for Hawaii dispensary operators, the Legislature could easily change the state income tax for Hawaii dispensary operators by creating a deviation from the federal tax code. The subcommittee recommends that the Legislature do so, though only after the dispensary system is operational. This is because only then will the necessary structure and language of the deviation be apparent. Also, before dispensaries are in place and operational, only illegitimate businesses would be able to take advantage of such a deviation.

d. Price

- i. The subcommittee believes that market forces ought to determine the price of medical marijuana. A shortage of medical marijuana will encourage production; a glut in supply will lead to a decrease in production.

10) Location and Restriction Issues

- a. The general consensus thus far is that the Department of Health should set a number of licenses that will be offered in each county. The counties will be allowed to make zoning laws that could apply to medical marijuana dispensaries, but they should not be allowed to pass zoning ordinances that pertain *only* to medical marijuana dispensaries or producers. This allows the counties to maintain their traditional power over zoning rules, while ensuring that county government cannot undermine the program under the guise of zoning rules.
- b. Conforming to Drug-Free School Zone Laws
 - i. Subcommittee members agree that there is no evidence that adding additional criminal penalties to drug possession or sale near a school decreases the likelihood that children will use drugs. In addition, the density of schools and other similar facilities affected by Drug-Free School Zone laws (parks, public housing complexes, public swimming pools, arcades) means that in urban areas (especially Honolulu), it would be virtually impossible to open a dispensary.
 - ii. However, there is an argument that conforming to federal Drug-Free School Zone regulations in crafting zoning regulations for dispensaries would be beneficial, in that it would avoid inviting federal prosecution of dispensaries that are within 1,000 feet of a school (or other location that is included in the Drug-Free School Zone law).
 - iii. The subcommittee also recognizes that there may be political capital to be gained by conforming to these federal regulations as we attempt to pass a dispensaries bill through the Legislature.

11) Methods for ensuring public safety and security of supply

a. There are two parts of the safety and security component that the subcommittee identified:

i. Quality control (guest presentation from Dr. Mark Hagadone, Technical Experts, Inc.)

1. In order to ensure that the patient is getting the most effective medication and that the medication is free of contaminants such as pesticides or mold, it would be ideal to have some type of laboratory testing available and required on a regular basis. The Department of Health is currently researching the best system for spot-checking dried flowers, edibles, and concentrates that would be sold at dispensaries.

2. The Dept. of Health should adopt administrative rules as follows:

a. Who does the screening?

i. Is the lab accredited and by whom?

b. How is the screening done?

i. How is the sample transported?

ii. How much is screened?

iii. How often?

c. What is the sample screened for?

i. Pesticides

ii. Bacteria/mold

iii. Potency

3. The Dept. of Health expressed that Nevada's statute could provide a good model for Hawaii (with the appropriate amount of direction for the Department) – the Department of Health may screen for “content, contamination, and consistency.”

4. The subcommittee agrees that beginning with this type of broad language will allow us the flexibility to create an adequate screening system.

ii. Physical security of supply

1. Most states require dispensaries to take specific security precautions. The LRB report details this information. States are generally similar to each other in this area: most require alarms and

cameras at a basic level, with some states requiring additional security measures.

2. These requirements are almost always (with the exception of three states) determined by departmental regulation.
 3. The subcommittee recommends that the Department of Health develop these recommendations for Hawaii's program.
 4. In addition, the subcommittee recommends some type of criminal background check for employees of dispensaries, though we have not determined what background check results would disqualify a person from working at a dispensary.
 5. Lastly, the subcommittee recommends that inventory tracking software (seed-to-sale) be required of all dispensaries to decrease the risk of internal diversion of product.
- b. Related to physical safety and quality control, the subcommittee also discussed education and training for dispensary staff and patients (with guest presentation from Dr. Mark Tomita, Hawaii Pacific University)
- i. The subcommittee recognizes a real need for education (both as workforce development and for patient health).
 - ii. The subcommittee also recognizes the need for education of police officers, TSA employees, and other public safety officials, and recommends that the Dept. of Health take affirmative steps to educate law enforcement officials about Hawaii's medical marijuana program.
 - iii. The subcommittee agrees that the Dept. of Health should have a health educator on staff, similar to New Mexico's medical marijuana program.
 - iv. In addition, members were generally supportive of the establishment of a training or certification program for dispensary employees and any members of the public who might be interested.
 - v. Furthermore, the subcommittee supports the Dept. of Health's continued work on education and prevention efforts relating to the misuse and abuse of alcohol, tobacco, marijuana, and other drugs.

12) Advertising Restrictions

- a. The subcommittee wishes to strike a balance between patients' desire for accurate information on dispensaries' services and the desire to prevent wide-scale advertising on television and radio (though recognizing that wide-scale advertising seems unlikely, given the lack of financial incentives for dispensaries in Hawaii – which will only be able to sell to Hawaii's 13,000 patients – to spend the money on wider-scale advertising). Insofar as Hawaii's dispensaries will sell only to patients, and not to the general public, the restrictions seen in Colorado and Washington seem unnecessary.
- b. As such, the subcommittee recommends the following:
 - i. The Department of Health should adopt administrative rules limiting the size and format of the sign outside the dispensary itself. (For example, some other states prohibit the use of pictures or depictions of marijuana leaves on dispensaries' signs; instead, many dispensaries use a green cross as a symbol of medical marijuana.)
 - ii. Similarly, the Department of Health should adopt rules prohibiting dispensaries and producers from using cartoon characters or other designs targeting children.
 - iii. Although the subcommittee discussed several options regarding internet advertising, including the possibility of password-protected sites, these restrictions seem ineffective because anyone with the password for a site could simply copy the content of the page onto his/her Facebook page or other internet site, thus making the content available for anyone to see. Instead, we recommend that the Department of Health adopt administrative rules that prohibit dispensaries or producers from advertising in a way that demonstrates an intent to solicit purchases from individuals who are not certified medical marijuana patients.

13) Federal Interference

- a. The Department of Justice lists eight factors it considers in considering enforcement of federal marijuana laws where state law allows marijuana consumption. *See* James M. Cole, Deputy Attorney General, Memorandum for all United States Attorneys: Guidance Regarding Marijuana Enforcement, Aug. 29, 2013, available at <http://www.mpp.org/assets/pdfs/library/DOJmemoAugust2013.pdf>. They are:
 - 1) Preventing the distribution of marijuana to minors;
 - 2) Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs, and cartels;
 - 3) Preventing the diversion of marijuana from states where it is legal under state law in some form to other states;
 - 4) Preventing state-authorized marijuana activity from being used as a cover or pretext for the trafficking of other illegal drugs or other illegal activity;
 - 5) Preventing violence and the use of firearms in the cultivation and distribution of marijuana;
 - 6) Preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use;
 - 7) Preventing the growing of marijuana on public lands and the attendant public safety and environmental dangers posed by marijuana production on public lands; and
 - 8) Preventing marijuana possession or use on federal property.

- b. The subcommittee believes that the recommendations adopted above address factors 1 through 5. As for factor 6, drugged driving is already a crime in Hawaii; the Legislature may want to re-emphasize this fact in any proposed legislation. As for factors 7 and 8, the subcommittee recommends that the Legislature ought to make clear (if it is not already clear) that growing marijuana on public lands is illegal (factor 7), and that nothing in any state law should suggest that growing or consuming marijuana on federal property is made legal by the passage of state legislation.