

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.