F I S C A L I M P A C T R E P O R T

SPONSOR McSorley **ORIGINAL DATE / LAST UPDATED** 1/25/17 **HB**

SHORT TITLE Medical Marijuana Changes **SB** 8

ANALYST Chenier

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY17	FY18	FY19		
		$2,248.6	Recurring	General Fund

(Parenthesis ( ) Indicate Revenue Decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY16	FY17	FY18	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total			$511.4	$511.4	Recurring	Medical Cannabis

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION

LFC Files

Responses Received From
Department of Health (DOH)
Administrative Office of the Courts (AOC)
Attorney General's Office (AGO)
Medical Board

SUMMARY

Synopsis of Original Bill

Senate Bill 8 would remove DOH's authority to determine by rule "adequate supply" of medical cannabis and would set patient possession limits at 5 ounces of cannabis during any thirty-day period, set licensed producer possession limits to no more than 1,000 cannabis plants during a three month period, and remove tetrahydrocannabinol (THC) limits on cannabis-derived products. The bill also defines registry identification (ID) card, requires presumptive eligibility

when issuing ID cards, removes the five day deadline for issuance after the department determines eligibility, and removes the one year expiration after issuance. Also, if a patient's debilitating condition is considered chronic, then reapplication would be required no sooner than three years from the date of issuance. However, if the condition is not chronic reapplication would be no sooner than one year.

FISCAL IMPLICATIONS

Currently, Section 26-2B-1 NMSA 1978 provides the Department of Health with administrative flexibility to limit the number of licensed nonprofit producers (currently set at 35) and limit the number of cannabis plants a producer is allowed to possess (currently set at 450). Licensed producers are charged a fee of $200 per plant and at any given time as many as 15,750 plants are legally allowed to be in production. In FY18 licensed producers are expected to pay fees on about 13,800 plants amounting to $2.76 million. The sole source of revenue for the Medical Cannabis Program is licensing and fees. Expenditures are expected to match revenues.

It is presumed that if per plant licensing fees were maintained at the current rate but plant limits were increased, production would likely increase. For example, if the current 13,800 plant count was doubled to 27,600 by the end of FY19 and current license fee rates were maintained, approximately $2.76 million in additional fee revenue would be generated.

Unexpended revenue to the program reverts to the general fund. If plant counts were doubled, new revenue less new costs would revert to the general fund.

DOH stated that the Medical Cannabis Program would need to hire new staff in the licensing and compliance division and new staff for the patient services division. Projected annual costs include: inspectors plus benefits (4 FTE costing $272 thousand); information and records clerks (3 FTE costing $127.4 thousand); additional office space costing $60 thousand; and two vehicles costing $52 thousand for a total annual cost of $511.4 thousand.

SIGNIFICANT ISSUES

Some states have restrictions on the number of plants producers are allowed to have and other states such as Nevada and Arizona have none. California and Washington limit the square footage of plant production facilities and other states such as Delaware, Maine, and New Hampshire limit plant counts based on patient need.

During the first quarter of 2016, the most recent period for which data are available, producers averaged 286 plants in production. The number of plants ranged from 0 to 450, the maximum allowed under current state regulations. The number of plants harvested by licensed nonprofit producer in the same period ranged from 0 to 310, yielding total production of 1.3 million grams.

The Medical Cannabis Program licenses two classes of producers. The first class of producers are Personal Production License (PPL) holders. The second class of producers are licensed nonprofit producers (LNPPs).

DOH provided the following:

> It is unclear what effect presumptive eligibility would have on NMDOH's processing of applications. However, it can be anticipated that NMDOH could be required to issue an enrollment card, even though it was awaiting further information from a certifying practitioner for verification purposes. If NMDOH later discovered that it needed to rescind the issuance of an enrollment card due to the information provided being false, it would need to provide the opportunity for an evidentiary hearing to the affected applicant.
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> The bill does not define the word "chronic" and does not propose to define what conditions would be classified as "chronic." NMDOH would be required to determine which qualifying conditions are "chronic" via rulemaking, and SB8 is unclear how such a determination would be made. For example, some persons might argue that PTSD is a chronic condition, although the DSM-V diagnostic manual identifies PTSD diagnosis as being dependent upon active symptoms. Likewise, it can be argued that cancer is chronic, although cancer can be in remission for decades.
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> The supply limit proposed by the bill does not distinguish between dried usable cannabis material and cannabis-derived products. Cannabis derived products (CDPs) include concentrates, edible products, salves, etc. As noted, 7.34.3.9 NMAC utilizes a "unit" based system, in which one gram of dried usable cannabis or 200 milligrams of THC in a cannabis derived product, constitute a unit. THC is the primary psychoactive ingredient in cannabis. The THC-based equivalency was adopted to avoid creating an arbitrary possession limit for CDPs. As SB8 is written, the possession limit would be based solely on weight, and as such, there would be no distinction made between dried material containing 18percent THC and a concentrate containing 70 percent THC.

AOC stated that Section 26-2B-4(A) and (B) NMSA 1978 provide exemption from criminal and civil penalties for medical use and possession of cannabis by a qualified patient and a qualified patient's primary caregiver, "…if the quantity of cannabis does not exceed an adequate supply." The bill amends the definition of "adequate supply" to mean an amount in accordance with Section 5, rather than "…by rule of the department to be no more than reasonably necessary to ensure the uninterrupted availability of cannabis for a period of 3 months." Section 26-2B-4(D) provides that a qualified patient or primary caregiver shall be granted the full legal protections provided if the patient or caregiver is in possession of a registry ID card. In requiring that an ID card be issued within 30 days of receipt of an application, SB 8 provides legal protections immediately rather than five days subsequent to approval. This change could lead to fewer arrests, criminal charges and court appearances and proceedings.

AGO stated that by providing a statutory presumption to an applicant's eligibility for a registry identification card in accordance with the Act, it could limit the Department from denying the application on other grounds, such as the Department's own analysis as to whether or not a physician's written certification of a patient's diagnosis of having a debilitating medical condition and the physician's opinion of the potential health benefits of medical cannabis satisfies the Department's own review. However, the language of SB8 still provides that the application must be completed in accordance with "department rules."

The Medical Board suggested that following the same reasoning that led the Medical Board to include, in its Rule 16.10.14, Management of Pain and other Conditions with Controlled Substances, a requirement for continuing medical education, CME, (16.10.14.11), it would be appropriate to add a requirement for five hours of specific CME relating to the pharmacology of cannabinoids, their risk of abuse, addiction, and diversion, and appropriate management by the caregiver of acute and chronic treatment with those substances, specifically for those providers that incorporate marijuana into their practice and that authorize Medical Cannabis Cards.

TECHNICAL ISSUES

AGO provided the following:

> The changes in SB8 that increase the amount of a patient or caregiver's "adequate supply" and the number of plants a producer may possess are described only as maximums. There is no provision that definitely indicates a patient, caregiver, or producer is entitled to possess these maximum amounts set by SB8. If the intent of the legislature is to guarantee that any licensed patient or caregiver is entitled to up to five ounces of cannabis, then the language could be amended from "shall possess no more than" to "may possess up to." Similar changes could be made to the language regarding amounts of plants for producers. Without such clarification, the Department may not have enough clarity as to whether or not it has authority to place different limitations on possession based on other conditions.
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> Placing maximums for a period of time may also cause confusion (30 day maximum of 5 ounces for patients/caregivers; 3 month maximum of 1000 plants for producers). For example, if a producer has 1000 plants on January 1 and sells 800 of them that day, they would not be able to possess a single additional plant until April 1, after 3 months had passed. Similarly, a patient who is dispensed 5 grams of cannabis on day 1 and uses it all in a month would not be able to obtain another 5 grams on day 31. Instead, they would only be able to obtain the amount they used on the first day of the prior 30 day period. This is similar to supply issues under the Department's current rules, which limit amounts over a period of time versus setting limits on how much can be prescribed for a future period of time or, alternatively, placing a limit on how much can be possessed at any given time. It could be helpful to clarify this.
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> SB8, Page 2 Lines 8-9, refers to "Section 5 of this 2017 act", and appears to be an incorrect citation. The language of this clause removes responsibility from the Department of defining "adequate supply", and replaces it with a reference to Section 5, which exists in SB8 and describes "adequate supply." However, if passed as legislation, Section 5 of SB8 will likely not be Section 5 of the Act because Section 26-2B-5 already exists in statute and Section 5 of SB8 is identified as a new section of the Act. Page 2 Lines 8-9 of SB8 could be amended to read "in accordance with this act" or amend Section 5 of SB8 to be new language under Section 5 of the current statute.
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> The definition of "Written Certification" in Section 2 of the Bill (Page 4, Lines 8-15) does not reference whether the debilitating medical condition should be indicated as "chronic" or "not chronic", which would be necessary to be considered for a longer renewal period as contemplated in Section 4 of the Bill.

EC/al/jle