FINANCIAL IMPACT ESTIMATING CONFERENCE

COMPLETE INITIATIVE FINANCIAL INFORMATION STATEMENT: USE OF MARIJUANA FOR DEBILITATING MEDICAL CONDITIONS (15-01)

SUMMARY OF INITIATIVE FINANCIAL INFORMATION STATEMENT

The amendment allows the use of medical marijuana for certain specified debilitating medical conditions, and other debilitating medical conditions of the same kind or class as or comparable to the specified conditions, for which a physician believes that the medical use of marijuana would likely outweigh the potential health risks for the patient. The amendment also establishes a process for the sale of medical marijuana to qualifying patients and designated caregivers. Based on information provided through public workshops and staff research, the Financial Impact Estimating Conference expects the amendment to have the following financial effects:

- Based on Colorado's experience, the Department of Health estimates that it will incur $2.7 million in annual costs for its regulatory responsibilities, upon full implementation. These costs may be offset by fees charged to the medical marijuana industry and users. However, the imposition of fees may require further action by the Legislature.
- The Department of Business and Professional Regulation, the Agency for Health Care Administration, the Department of Children and Families and the Department of Agriculture and Consumer Services do not expect the amendment to significantly affect their regulatory functions. Any regulatory impacts that occur will likely be offset by fees charged to the affected industries.
- The Department of Highway Safety and Motor Vehicles, the Department of Law Enforcement, the Police Chiefs Association, and the Sheriffs Association expect additional law enforcement costs based on the experience of other states with similar laws. The magnitude of such costs cannot be determined.
- Local governments were unable to quantify the amendment's impact, if any, on the services they provide.
- The Conference determined that medical marijuana is tangible personal property. Therefore, its purchase is subject to sales and use tax, unless a specific exemption exists.
- Based on the testimony from affected state agencies, the Conference determined that medical marijuana is currently not classified and likely will not be classified as a common household remedy entitled to a sales tax exemption.
- Based on information provided by the Department of Revenue and the Department of Agriculture and Consumer Services, the Conference determined that the applicability of agricultural-related exemptions to the sale or production of medical marijuana is uncertain. Should the exemptions apply, the direct sale or dispensation of medical marijuana in its raw form by the grower or cultivator to an end-user or designated caregiver would be exempt. This uncertainty also applies to exemptions for items used in the production of medical marijuana such as power farm equipment, fertilizer and pesticides.
- The increase in sales tax revenues to state and local governments cannot be determined precisely because too many unknowns affect the amount of taxable sales, but the increase will be substantial. For example, assuming Florida's medical marijuana consumption mirrors Colorado's experience, annual state and local government sales tax revenues could increase by an estimated $67 million after taking into account lawful consumption of medical marijuana currently authorized in Florida.
- The impact on property taxes, either positive or negative, cannot be determined.

FINANCIAL IMPACT STATEMENT

Increased costs from this amendment to state and local governments cannot be determined. There will be additional regulatory costs and enforcement activities associated with the production, sale, use and possession of medical marijuana. Fees may offset some of the regulatory costs. Sales tax will likely apply to most purchases, resulting in a substantial increase in state and local government revenues that cannot be determined precisely. The impact on property tax revenues cannot be determined.

SUBSTANTIVE ANALYSIS

A. Proposed Amendment
Ballot Title:

Use of Marijuana for Debilitating Medical Conditions.

Ballot Summary:

Allows medical use of marijuana for individuals with debilitating medical conditions as determined by a licensed Florida physician. Allows caregivers to assist patients' medical use of marijuana. The Department of Health shall register and regulate centers that produce and distribute marijuana for medical purposes and shall issue identification cards to patients and caregivers. Applies only to Florida law. Does not immunize violations of federal law or any non-medical use, possession or production of marijuana.

Proposed Amendment to the Florida Constitution:

ARTICLE X, SECTION 29. - Medical marijuana production, possession and use.

(a) PUBLIC POLICY.

(1) The medical use of marijuana by a qualifying patient or caregiver in compliance with this section is not subject to criminal or civil liability or sanctions under Florida law.
(2) A physician shall not be subject to criminal or civil liability or sanctions under Florida law solely for issuing a physician certification with reasonable care to a person diagnosed with a debilitating medical condition in compliance with this section.
(3) Actions and conduct by a Medical Marijuana Treatment Center registered with the Department, or its agents or employees, and in compliance with this section and Department regulations, shall not be subject to criminal or civil liability or sanctions under Florida law.

(b) DEFINITIONS. For purposes of this section, the following words and terms shall have the following meanings:

(1) "Debilitating Medical Condition" means cancer, epilepsy, glaucoma, positive status for human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), post-traumatic stress disorder (PTSD), amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, multiple sclerosis, or other debilitating medical conditions of the same kind or class as or comparable to those enumerated, and for which a physician believes that the medical use of marijuana would likely outweigh the potential health risks for a patient.
(2) "Department" means the Department of Health or its successor agency.
(3) "Identification card" means a document issued by the Department that identifies a qualifying patient or a caregiver.

(4) "Marijuana" has the meaning given cannabis in Section 893.02(3), Florida Statutes (2014), and, in addition, "Low-THC cannabis" as defined in Section 381.986(1)(b), Florida Statutes (2014), shall also be included in the meaning of the term "marijuana."
(5) "Medical Marijuana Treatment Center" (MMTC) means an entity that acquires, cultivates, possesses, processes (including development of related products such as food, tinctures, aerosols, oils, or ointments), transfers, transports, sells, distributes, dispenses, or administers marijuana, products containing marijuana, related supplies, or educational materials to qualifying patients or their caregivers and is registered by the Department.
(6) "Medical use" means the acquisition, possession, use, delivery, transfer, or administration of an amount of marijuana not in conflict with Department rules, or of related supplies by a qualifying patient or caregiver for use by the caregiver's designated qualifying patient for the treatment of a debilitating medical condition.
(7) "Caregiver" means a person who is at least twenty-one (21) years old who has agreed to assist with a qualifying patient's medical use of marijuana and has qualified for and obtained a caregiver identification card issued by the Department. The Department may limit the number of qualifying patients a caregiver may assist at one time and the number of caregivers that a qualifying patient may have at one time. Caregivers are prohibited from consuming marijuana obtained for medical use by the qualifying patient.
(8) "Physician" means a person who is licensed to practice medicine in Florida.
(9) "Physician certification" means a written document signed by a physician, stating that in the physician's professional opinion, the patient suffers from a debilitating medical condition, that the medical use of marijuana would likely outweigh the potential health risks for the patient, and for how long the physician recommends the medical use of marijuana for the patient. A physician certification may only be provided after the physician has conducted a physical examination and a full assessment of the medical history of the patient. In order for a physician certification to be issued to a minor, a parent or legal guardian of the minor must consent in writing.
(10) "Qualifying patient" means a person who has been diagnosed to have a debilitating medical condition, who has a physician certification and a valid qualifying patient identification card. If the Department does not begin issuing identification cards within nine (9) months after the effective date of this section, then a valid physician certification will serve as a patient identification card in order to allow a person to become a "qualifying patient" until the Department begins issuing identification cards.

(c) LIMITATIONS.

(1) Nothing in this section allows for a violation of any law other than for conduct in compliance with the provisions of this section.
(2) Nothing in this section shall affect or repeal laws relating to non-medical use, possession, production, or sale of marijuana.
(3) Nothing in this section authorizes the use of medical marijuana by anyone other than a qualifying patient.
(4) Nothing in this section shall permit the operation of any vehicle, aircraft, train or boat while under the influence of marijuana.
(5) Nothing in this section requires the violation of federal law or purports to give immunity under federal law.
(6) Nothing in this section shall require any accommodation of any on-site medical use of marijuana in any correctional institution or detention facility or place of education or employment, or of smoking medical marijuana in any public place.
(7) Nothing in this section shall require any health insurance provider or any government agency or authority to reimburse any person for expenses related to the medical use of marijuana.

(8) Nothing in this section shall affect or repeal laws relating to negligence or professional malpractice on the part of a qualified patient, caregiver, physician, MMTC, or its agents or employees.

(d) DUTIES OF THE DEPARTMENT. The Department shall issue reasonable regulations necessary for the implementation and enforcement of this section. The purpose of the regulations is to ensure the availability and safe use of medical marijuana by qualifying patients. It is the duty of the Department to promulgate regulations in a timely fashion.

(1) Implementing Regulations. In order to allow the Department sufficient time after passage of this section, the following regulations shall be promulgated no later than six (6) months after the effective date of this section:
   a. Procedures for the issuance and annual renewal of qualifying patient identification cards to people with physician certifications and standards for renewal of such identification cards. Before issuing an identification card to a minor, the Department must receive written consent from the minor's parent or legal guardian, in addition to the physician certification.
   b. Procedures establishing qualifications and standards for caregivers, including conducting appropriate background checks, and procedures for the issuance and annual renewal of caregiver identification cards.
   c. Procedures for the registration of MMTCs that include procedures for the issuance, renewal, suspension and revocation of registration, and standards to ensure proper security, record keeping, testing, labeling, inspection, and safety.
   d. A regulation that defines the amount of marijuana that could reasonably be presumed to be an adequate supply for qualifying patients' medical use, based on the best available evidence. This presumption as to quantity may be overcome with evidence of a particular qualifying patient's appropriate medical use.

(2) Identification cards and registrations. The Department shall begin issuing qualifying patient and caregiver identification cards, and registering MMTCs no later than nine (9) months after the effective date of this section.

(3) If the Department does not issue regulations, or if the Department does not begin issuing identification cards and registering MMTCs within the time limits set in this section, any Florida citizen shall have standing to seek judicial relief to compel compliance with the Department's constitutional duties.

(4) The Department shall protect the confidentiality of all qualifying patients. All records containing the identity of qualifying patients shall be confidential and kept from public disclosure other than for valid medical or law enforcement purposes.

(e) LEGISLATION. Nothing in this section shall limit the legislature from enacting laws consistent with this section.

(f) SEVERABILITY. The provisions of this section are severable and if any clause, sentence, paragraph or section of this measure, or an application thereof, is adjudged invalid by a court of competent jurisdiction other provisions shall continue to be in effect to the fullest extent possible.

Effective Date

Article XI, Section 5(e), of the Florida Constitution states that, unless otherwise specified in the Florida Constitution or the proposed constitutional amendment, the proposed amendment will become effective on the first Tuesday after the first Monday in January following the election. Assuming the amendment passes in 2016, the effective date is January 3, 2017. However, the amendment allows the Department of Health six months after the effective date to promulgate regulations and nine months after the effective date to begin registering medical marijuana treatment facilities and begin issuing identification cards.

B. Substantive Effect of Proposed Amendment

Input Received from Proponents and Opponents

The Conference sought input from those groups who were on record as supporting or opposing the petition initiative. The sponsor chose not to provide a response to a request for overall input on the initiative. However, a representative of the Medical Marijuana Business Association of Florida attended the meetings and expressed support for the amendment.

An opponent group, Drug Free America/Save Our Society from Drugs (S.O.S.), a non-profit drug policy organization based in St. Petersburg, submitted written testimony specific to the petition initiative. The testimony focused on the potential costs to the state if the proposed constitutional amendment passes. The testimony noted that administrative costs for licensing and regulating the marijuana industry in Florida would be close to the $9.5 million spent by Colorado in Fiscal Year 2013-14 for 35 full-time positions and other expenses associated with developing regulations, training, websites, materials, and labeling requirements, even though these costs were for medical and recreational marijuana enforcement. The testimony also enumerates costs to other state agencies. The full written testimony can be found on the Office of Economic and Demographic Research's website at: http://edr.state.fl.us/Content/constitutional-amendments/2016Ballot/DrugFreeAmericaMemo_9-30-15.pdf.

Background

Current Legal Status of Marijuana in Florida

Florida law defines cannabis as "all parts of any plant of the genus *Cannabis*, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant or its seeds or resin"[1] and places it, along with other sources of tetrahydrocannabinol (THC), on the list of Schedule I drugs.[2] Schedule I drugs are substances that have a high potential for abuse and no currently accepted medical use in treatment in the United States. As a Schedule I drug, possession and trafficking in cannabis carry criminal penalties that vary from a misdemeanor of the first degree[3] up to a felony of the first degree with a possible minimum sentence of 15 years in prison and a $200,000 fine.[4] Paraphernalia[5] that is sold, manufactured, used, or possessed with the intent to be used to plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, inject, ingest, inhale, or otherwise introduce into the human body a controlled substance is also prohibited and carries criminal penalties ranging from a misdemeanor of the first degree to felony of the third degree.[6]

[1] S. 893.02(c), F.S.
[2] S. 893.03(c)7. and 37., F.S.
[3] For possessing or delivering less than 20 grams. See s. 893.13(3) and (6)(b), F.S.
[4] Trafficking in more than 25 pounds, or 300 plants, of cannabis is a felony of the first degree with a minimum sentence that varies from 3 to 15 years in prison depending on the amount of cannabis. See s. 893.135(1)(a), F.S.
[5] As defined in s. 893.145, F.S.
[6] S. 893.147, F.S.

Notwithstanding the above, the Florida Legislature passed the Compassionate Medical Cannabis Act of 2014[7] (act), which legalized a low tetrahydrocannabinol (THC) and high cannabidiol (CBD) form of cannabis (low-THC cannabis)[8] for the medical use[9] by patients suffering from cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms.

Compassionate Medical Cannabis Act of 2014

Patient Treatment with Low-THC Cannabis

The Compassionate Medical Cannabis Act of 2014 provides that a Florida licensed allopathic or osteopathic physician who has completed the required training[10] and has examined and is treating such a patient may order low-THC cannabis for that patient to treat a disease, disorder, or condition or to alleviate its symptoms, if no other satisfactory alternative treatment options exist for that patient. In order to meet the requirements of the act all of the following conditions must apply:

- The patient is a permanent resident of Florida;
- The physician determines that the risks of ordering low-THC cannabis are reasonable in light of the potential benefit for that patient;[11]
- The physician registers as the orderer of low-THC cannabis for the patient on the compassionate use registry (registry) maintained by the Department of Health (DOH) and updates the registry to reflect the contents of the order;
- The physician maintains a patient treatment plan that includes the dose, route of administration, planned duration, and monitoring of the patient's symptoms and other indicators of tolerance or reaction to the low-THC cannabis;
- The physician submits the patient treatment plan quarterly to the UF College of Pharmacy for research on the safety and efficacy of low-THC cannabis on patients; and
- The physician obtains the voluntary informed consent of the patient or the patient's legal guardian to treatment with low-THC cannabis after sufficiently explaining the current state of knowledge in the medical community of the effectiveness of treatment of the patient's condition with low-THC cannabis, the medically acceptable alternatives, and the potential risks and side effects.

---

[7] *See* ch. 2014-157, L.O.F., and s. 381.986, F.S.

[8] The act defined "low-THC cannabis," as the dried flowers of the plant *Cannabis* which contain 0.8 percent or less of tetrahydrocannabinol and more than 10 percent of cannabidiol weight for weight, or the seeds, resin, or any compound, manufacture, salt, derivative, mixture, or preparation of the plant or its seeds or resin. *See* s. 381.986(1)(b), F.S. Eleven states allow limited access to marijuana products (low-THC and/or high CBD-cannabidiol): Alabama, Florida, Iowa, Kentucky, Mississippi, Missouri, North Carolina, South Carolina, Tennessee, Utah, and Wisconsin. Twenty-three states, the District of Columbia, and Guam have laws that permit the use of marijuana for medicinal purposes. See infra note 28. *See* http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx (Tables 1 and 2), (last visited on Sep. 28, 2015).

[9] Pursuant to s. 381.986(1)(c), F.S., "medical use" means administration of the ordered amount of low-THC cannabis; and the term does not include the possession, use, or administration by smoking, or the transfer of low-THC cannabis to a person other than the qualified patient for whom it was ordered or the qualified patient's legal representative. Section 381.986(1)(e), F.S., defines "smoking" as burning or igniting a substance and inhaling the smoke; smoking does not include the use of a vaporizer.

[10] Section 381.986(4), F.S., requires such physicians to successfully complete an 8-hour course and examination offered by the Florida Medical Association or the Florida Osteopathic Medical Association that encompasses the clinical indications for the appropriate use of low-THC cannabis, appropriate delivery mechanisms, contraindications for such use, and the state and federal laws governing its ordering, dispensing, and processing.

[11] If a patient is younger than 18 years of age, a second physician must concur with this determination, and such determination must be documented in the patient's medical record.

A physician who orders low-THC cannabis for a patient without a reasonable belief that the patient is suffering from a required condition and any person who fraudulently represents that he or she has a required condition to a physician for the purpose of being ordered low-THC cannabis commits a misdemeanor of the first degree. The DOH is required to monitor physician registration and ordering of low-THC cannabis in order to take disciplinary action as needed.

The act creates exceptions to existing law to allow qualified patients[12] and their legal representatives to purchase, acquire, and possess low-THC cannabis (up to the amount ordered) for that patient's medical use, and to allow dispensing organizations (DO), and their owners, managers, and employees, to acquire, possess, cultivate, and dispose of excess product in reasonable quantities to produce low-THC cannabis and to possess, process, and dispense low-THC cannabis. DOs and their owners, managers, and employees are not subject to licensure and regulation under ch. 465, F.S., relating to pharmacies.[13]

Dispensing Organizations

The act requires the DOH to approve five DOs with one in each of the following regions: northwest Florida, northeast Florida, central Florida, southeast Florida and southwest Florida.[14] In order to be approved as a DO, an applicant must possess a certificate of registration issued by the Department of Agriculture and Consumer Services for the cultivation of more than 400,000 plants, be operated by a nurseryman, and have been operating as a registered nursery in this state for at least 30 continuous years. Applicants are also required to demonstrate:

- The technical and technological ability to cultivate and produce low-THC cannabis.
- The ability to secure the premises, resources, and personnel necessary to operate as a DO.
- The ability to maintain accountability of all raw materials, finished products, and any byproducts to prevent diversion or unlawful access to or possession of these substances.
- An infrastructure reasonably located to dispense low-THC cannabis to registered patients statewide or regionally as determined by the department.
- The financial ability to maintain operations for the duration of the 2-year approval cycle, including the provision of certified financials to the department;
- That all owners and managers have been fingerprinted and have successfully passed a level 2 background screening pursuant to s. 435.04, F.S.; and
- The employment of a medical director, who must be a physician and have successfully completed a course and examination that encompasses appropriate safety procedures and knowledge of low-THC cannabis.[15]

Upon approval, a DO must post a $5 million performance bond. The DOH is authorized to charge an initial application few and a licensure renewal fee, but is not authorized to charge an initial licensure fee.[16] An approved DO must also maintain all approval criteria at all times.

Beginning on July 7, 2014, the DOH held several rule workshops intended to write and adopt rules implementing the provisions of s. 381.986, F.S., and the DOH put forward a proposed rule on September 9, 2014. This proposed rule was challenged by multiple organizations involved in the rulemaking workshops and was found to be an invalid exercise of delegated legislative

[12] *See* s. 381.986(1)(d), F.S., which provides that a "qualified patient" is a Florida resident who has been added by a physician licensed under ch. 458, F.S., or ch. 459, F.S., to the compassionate use registry to receive low-THC cannabis from a DO.
[13] *See* s. 381.986(7)(c), F.S.
[14] *See* s. 381.986(5)(b), F.S.
[15] Id.
[16] Id.

authority by the Administrative Law Judge on November 14, 2014.[17] Afterward, the DOH held a negotiated rulemaking workshop in February of 2015, which resulted in a new proposed rule being published on February 6, 2015.[18] The new proposed rule was also challenged on, among other things, the DOH's statement of estimated regulatory costs (SERC) and the DOH's conclusion that the rule will not require legislative ratification. Hearings were held on April 23 and 24, 2015, and a final order was issued on May 27, 2015, which found the rule to be valid.[19] Currently, the rules have taken effect as of June 17, 2015, and the DOH held an application period for DO approval which ended on July 8, 2015. The DOH received 28 applications for DO approval but has not approved any DOs at present.[20]

The Compassionate Use Registry

The act requires the DOH to create a secure, electronic, and online registry for the registration of physicians and patients and for the verification of patient orders by DOs, which is accessible to law enforcement. The registry must allow DOs to record the dispensation of low-THC cannabis, and must prevent an active registration of a patient by multiple physicians. Physicians must register qualified patients with the registry and DOs are required to verify that the patient has an active registration in the registry, that the order presented matches the order contents as recorded in the registry, and that the order has not already been filled before dispensing any low-THC cannabis. DOs are also required to record in the registry the date, time, quantity, and form of low-THC cannabis dispensed. The DOH has indicated that the registry is built and ready to move to the operational phase.[21]

The Office of Compassionate Use and Research on Low-THC Cannabis

The act requires the DOH to establish the Office of Compassionate Use under the direction of the deputy state health officer to administer the act. The Office of Compassionate Use is authorized to enhance access to investigational new drugs for Florida patients through approved clinical treatment plans or studies, by:

- Creating a network of state universities and medical centers recognized for demonstrating excellence in patient-centered coordinated care for persons undergoing cancer treatment and therapy in this state.[22]
- Making any necessary application to the United States Food and Drug Administration or a pharmaceutical manufacturer to facilitate enhanced access to compassionate use for Florida patients; and
- Entering into agreements necessary to facilitate enhanced access to compassionate use for Florida patients.[23]

The act includes several provisions related to research on low-THC cannabis and cannabidiol including:

- Requiring physicians to submit quarterly patient treatment plans to the UFCP for research on the safety and efficacy of low-THC cannabis;

---

[17] *See* https://www.doah.state.fl.us/ROS/2014/14004296.pdf (last accessed March 27, 2015).
[18] The rule is available at http://www.floridahealth.gov/programs-and-services/office-of-compassionate-use/_documents/64-4-rule-text.pdf, (last visited on Sep. 28, 2015).
[19] The final order is available at http://www.floridahealth.gov/programs-and-services/office-of-compassionate-use/_documents/final-order-15-1694rp.pdf (last visited on Sep. 28, 2015).
[20] Phone conversation with Marco Paredes, Legislative Planning Director for the DOH, on Sep. 23, 2015.
[21] Conversation with Jennifer Tschetter, Chief of Staff (DOH) (March 20, 2015).
[22] *See* s. 381.925, F.S.
[23] *See* s. 385.212, F.S.

- Authorizing state universities to perform research on cannabidiol and low-THC cannabis and exempting them from the provisions in ch. 893, F.S., for the purposes of such research; and
- Appropriating $1 million to the James and Esther King Biomedical Research Program for research on cannabidiol and its effects on intractable childhood epilepsy.

The Necessity Defense in Florida

Despite the fact that the use, possession, and sale of marijuana is prohibited by state law, other than what is allowed under the Compassionate Medical Cannabis Act of 2014, Florida courts have found that circumstances can necessitate medical use of marijuana and circumvent the application of any criminal penalties. The necessity defense was successfully applied in a marijuana possession case in Jenks v. State[24] where the First District Court of Appeal found that "section 893.03 does not preclude the defense of medical necessity" for the use of marijuana if the defendant:

- Did not intentionally bring about the circumstance which precipitated the unlawful act;
- Could not accomplish the same objective using a less offensive alternative available; and
- The evil sought to be avoided was more heinous than the unlawful act.

In the cited case the defendants, a married couple, were suffering from uncontrollable nausea due to AIDS treatment and had testimony from their physician that he could find no effective alternative treatment. Under these facts, the First District found that the Jenks met the criteria for the necessity defense and ordered an acquittal of the charges of cultivating cannabis and possession of drug paraphernalia.

Medical Marijuana Laws and Practices in Other States

Currently, 23 states and the District of Columbia[25] have some form of law that permits the use of marijuana for medicinal purposes. Recently approved laws in 15 additional states and Florida allow use of "low THC, high cannabidiol (CBD)" products for medical reasons in limited situations or as a legal defense. These states' laws were not considered in this analysis since the proposed constitutional amendment does not limit the type of marijuana that can be sold.[26]

Medical marijuana laws vary widely in detail but most are similar in that they touch on several recurring themes. Most state laws include the following in some form:

- A list of medical conditions for which a practitioner can recommend the use of medical marijuana to a patient.

[24] 582 So. 2d 676

[25] These states include Alaska, Arizona, California, Colorado, Connecticut, Delaware, Hawaii, Illinois (effective 2014), Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, and Washington. California was the first to establish a medical marijuana program in 1996 and Minnesota and New York were the most recent states to pass medical marijuana legislation in 2014. Source: http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx, accessed 9/8/2015.

26 These states include Alabama, Georgia, Iowa, Kentucky, Louisiana, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming. Source: http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx, accessed 9/8/2015.

    - Nearly every state has a list of medical conditions though the particular conditions vary from state to state. Most states also include a way to expand the list either by allowing a state agency or board to add medical conditions to the list or by including a "catch-all" phrase.[27] Most states require that the patient receive certification from at least one, but sometimes two, physicians designating that they have a qualifying condition before they can be issued an ID card.
- Provisions for the patient to designate one or more caregivers who can possess the medical marijuana and assist the patient in preparing and using the medical marijuana.
    - The number of caregivers allowed and the qualifications to become a caregiver vary from state to state. Most states allow 1 or 2 caregivers and require that they be at least 21 years of age and, typically, cannot be the patient's physician. Caregivers are generally allowed to purchase or grow marijuana for the patient, be in possession of the allowed quantity of marijuana, and aid the patient in using the marijuana, but are prohibited from using the marijuana themselves.
- A required identification card for the patient, caregiver, or both that is typically issued by a state agency.
- A registry of people who have been issued an ID card.
- A method for registered patients and caregivers to obtain medical marijuana.
- General restrictions on where medical marijuana may be used.

Different states have varying provisions on who is allowed to grow medical marijuana: patients, caregivers, cultivation centers, or dispensaries or a combination thereof. Most states that currently have medical marijuana allow dispensaries for the purchase of the product. In addition, caregivers or cultivation centers may be allowed to sell in some states. Caregivers are sometimes not explicitly allowed to sell and in some cases prohibited from receiving compensation. They may only be allowed to recoup costs of materials and supplies but not labor (see table below).

[27] Such as in California's law that includes "any other chronic or persistent medical symptom that either: Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990, or If not alleviated, may cause serious harm to the patient's safety or physical or mental health."

Cultivation and Sales of Medical Marijuana by State

State	Grow Own	Who Can Grow	Purchase	Who Can Sell
Alaska	Yes	Patients, caregivers	No	No one
Arizona	Yes, in some cases	Patients, caregivers, dispensaries	Yes	Dispensaries (dispensaries can acquire product) *Caregivers (reimbursement for expenses but not compensation for services)*
California	Yes	Patients, caregivers, dispensaries	Yes	Dispensaries (collectives & cooperatives), (dispensaries can acquire product) Caregivers (not clear what limitations apply)
Colorado	Yes	Patients, caregivers, dispensaries	Yes	Dispensaries (dispensaries must grow 70% of product sold, can acquire the rest from other dispensaries) Caregivers (not clear what limitations apply)
Connecticut	No	Dispensaries	Yes	Dispensaries
Delaware	No	Dispensaries	Yes	Dispensaries
District of Columbia	Yes	Patients, cultivation centers, dispensaries	Yes	Dispensaries (dispensaries may acquire from cultivation centers)
Hawaii	Yes	Patient, dispensaries	Yes	Dispensaries, caregivers
Illinois	No	Cultivation centers, dispensaries	Yes	Dispensaries
Maine	Yes	Patients, caregivers, dispensaries	Yes	Dispensaries, caregivers
Maryland	No	Cultivation centers, dispensaries	Yes	Cultivation centers, caregivers, dispensaries
Massachusetts	Yes, in some cases	Patients, caregivers, dispensaries	Yes	Dispensaries, caregivers
Michigan	Yes	Patients, caregivers, dispensaries	Yes	Caregivers, dispensaries (dispensaries not in state law but in some local ordinances)
Minnesota	No	Dispensaries	Yes	Dispensaries
Montana	Yes	Patient OR caregiver, but not both	Yes	Caregivers (conflicting laws regarding compensation ofcaregivers or limits on number of patients per caregiver, litigation still ongoing), may be regulated as dispensaries locally
Nevada	Yes, in some cases	Patients, caregivers, dispensaries	Yes	Dispensaries
New Hampshire	No	Dispensaries	Yes	Dispensaries
New Jersey	No	Cultivation centers, dispensaries	Yes	Cultivation centers, dispensaries
New Mexico	Yes, in some cases	Cultivation centers	Yes	Cultivation centers with own dispensing locations
New York	No	Cultivation centers	Yes	Cultivation centers with own dispensing locations
Oregon	Yes, at registered sites	Patients, caregivers	Yes	Dispensaries (dispensaries cannot grow, they must acquire from patients or caregivers) caregivers (reimburse for cost of supplies and utilities but not labor)
Rhode Island	Yes	Patients, caregivers, dispensaries	Yes	Caregivers, dispensaries (dispensaries can grow at cultivation sites or acquire from patients or caregivers)
Vermont	Yes	Patients, caregivers, dispensaries	Yes	Caregivers, dispensaries (dispensaries must grow their own at cultivation sites)
Washington	Yes	Patients, caregivers	No	Collective gardens

NOTE: Additional detail and sources can be found at EDR's website: http://edr.state.fl.us/Content/constitutional-amendments/2016Ballot/MedMSummary_Table_10-21-15.pdf

Medical Marijuana Laws and the Federal Government

Regardless of whether an individual state has allowed the use of marijuana for medicinal purposes, or otherwise, the Federal Controlled Substances Act lists it as a Schedule I drug with no accepted medical uses. Under federal law possession, manufacturing, and distribution of marijuana is a crime.[28] Although state medical marijuana laws protect patients from prosecution for the legitimate use of marijuana under the guidelines established in that state, such laws do not protect individuals from prosecution under federal law should the federal government choose to act on those laws.

In August of 2013, the United States Justice Department issued a publication entitled "Smart on Crime: Reforming the Criminal Justice System for the 21st Century." [29] This document details the federal government's changing stance on low-level drug crimes announcing a "change in Department of Justice charging policies so that certain people who have committed low-level, nonviolent drug offenses, who have no ties to large-scale organizations, gangs, or cartels will no longer be charged with offenses that impose draconian mandatory minimum sentences. Under the revised policy, these people would instead receive sentences better suited to their individual conduct rather than excessive prison terms more appropriate for violent criminals or drug kingpins." This announcement indicates the justice department's relative unwillingness to prosecute low-level drug cases leaving such prosecutions largely up to state authorities.

In February 2014, the U.S. Department of Justice Deputy Attorney General Cole issued a "Memorandum for All United States Attorneys: Guidance Regarding Marijuana Related Financial Crimes."[30] The memorandum's purpose was to clarify Bank Secrecy Act ("BSA") expectations for financial institutions seeking to provide services to marijuana-related businesses. The Cole Memo reiterates Congress's determination that marijuana is a dangerous drug and that the illegal distribution and sale of marijuana is a serious crime that provides a significant source of revenue to large-scale criminal enterprises, gangs, and cartels. A concurrent guidance, issued by The Department of the Treasury Financial Crimes Enforcement Network, clarifies how financial institutions can provide services to marijuana-related businesses consistent with their BSA obligations.[31]

Potential Users of Medical Marijuana

The Office of Economic and Demographic Research (EDR) developed six approaches that estimate the potential number of medical marijuana users in Florida as of April 1, 2017. Approach I draws on the experience of other states. Approaches II – V attempt to estimate the pool of eligible users with the specified medical conditions in the proposed ballot initiative, but not the "other debilitating conditions of the same kind or class as or comparable to those enumerated". It is not possible to precisely estimate the number of users that would qualify

[28] The punishments vary depending on the amount of marijuana and the intent with which the marijuana is possessed. See http://www.fda.gov/regulatoryinformation/legislation/ucm148726.htm#cntlsbd. Last visited Oct. 21, 2015.
[29] See http://www.justice.gov/ag/smart-on-crime.pdf. Last accessed on Oct. 17, 2013.
[30] James M. Cole, Deputy Attorney General, U.S. Department of Justice, Memorandum for All United States Attorneys: Guidance Regarding Marijuana Related Financial Crimes (February 14, 2014), http://www.justice.gov/sites/default/files/usao-wdwa/legacy/2014/02/14/DAG%20Memo%20-%20Guidance%20Regarding%20Marijuana%20Related%20Financial%20Crimes%202%2014%2014%20(2).pdf, accessed 9/29/2015.
[31] The Department of the Treasury Financial Crimes Enforcement Network Guidance, BSA Expectations Regarding Marijuana-Related Businesses, February 14, 2014, http://www.fincen.gov/statutes_regs/guidance/pdf/FIN-2014-G001.pdf, accessed 9/29/2015.

under “other debilitating medical conditions of the same kind or class as or comparable to those enumerated” as these conditions are currently unknown and are to be determined by the physician when he or she believes that the medical use of marijuana would likely outweigh the potential health risks for a patient. Approach VI uses the number of illicit recreational marijuana users as a guide.

Estimates of Potential Florida Medical Marijuana Users

Estimation Approach	April 1, 2017
I. States with medical marijuana laws	1,586 to 440,552
II. Disease prevalence	2,038,131
III. Disease incidence	130,237
IV. Use by cancer patients	247,689
V. Deaths	47,805
VI. Self-reported marijuana use	1,168,775 to 1,752,277
Range	**1,586 to 1,752,277**

The following is a summary of each of these approaches.

Approach I. States with Medical Marijuana Laws

Approach I applies rates of medical marijuana use from other states to Florida’s 2017 projected population. Data from the medical marijuana patient registries for 2014 and in a few cases, 2012, 2013 or 2015 from 19 other states and the District of Columbia were used. Using the current experience of these states and the District of Columbia, there may be an estimated 1,586 to 440,552 Floridians using marijuana for debilitating medical conditions in 2017. The lower range of the estimate is more likely if the medical marijuana program is rolled out slowly, such as in New Jersey, or faces implementation, administrative, and/or legal challenges that will limit the number of registrants in the first year. The higher range of the estimate may be more likely at full implementation of a more mature program, such as in Colorado.

Approach II. Disease Prevalence

Approach II uses disease prevalence rates (proportion of people alive diagnosed with a certain disease) for cancer, epilepsy, HIV, multiple sclerosis, Parkinson’s disease, and Posttraumatic Stress Disorder (single year prevalence) to determine the number of eligible patients with the conditions specified in the proposed ballot initiative. There will be an estimated 2,038,131 patients alive in 2017 that, during their lifetime, have been diagnosed with cancer, epilepsy, HIV, multiple sclerosis, Parkinson’s disease, and Posttraumatic Stress Disorder (single year prevalence). These patients represent the pool of eligible patients for use of marijuana. This approach does not make assumptions about the percentage of eligible patients who will avail themselves of the opportunity to use marijuana. Analysis of data from states that have medical marijuana shows that a relatively small percentage of all patients with a certain disease use marijuana. Prevalence data for the remaining conditions specified in the proposed ballot initiative were not available. In addition, there are unspecified “other debilitating medical conditions of the same kind or class as or comparable to those enumerated” in the proposed ballot initiative which cannot be estimated under this approach.

Approach III. Disease Incidence

Approach III uses disease incidence rates (proportion of people newly diagnosed with a certain disease per year) for amyotrophic lateral sclerosis (ALS), cancer, epilepsy, and HIV to determine the number of eligible patients with the conditions specified in the proposed ballot initiative. Disease incidence cases are a subset of disease prevalence cases, so Approach III has a smaller estimate than Approach II. There will be an estimated 130,237 patients newly diagnosed with ALS, cancer, epilepsy, and HIV in 2017 in Florida. These patients represent the pool of eligible patients for medical use of marijuana. This approach does not make assumptions about the percentage of eligible patients who will avail themselves of the opportunity to use marijuana. Incidence data for the remaining conditions specified in the proposed ballot initiative were not available. In addition, there are unspecified "other debilitating medical conditions of the same kind or class as or comparable to those enumerated" in the proposed ballot initiative which cannot be estimated under this approach.

Approach IV. Use by Cancer Patients

Approach IV uses medical marijuana penetration rates (usage rates) among cancer patients and/or survivors, to estimate (1) medical marijuana users among cancer patients in Florida and (2) total potential marijuana users under the proposed amendment. The number of Florida cancer patients that are likely to use medical marijuana is calculated by applying the average penetration rate (usage rate of medical marijuana) among cancer patients from ten other states to the estimated number of cancer patients in Florida in 2017. Assuming Florida will have the same average proportion of cancer patients in the total medical marijuana users as these ten states, the number of medical marijuana users with cancer is grown to represent total medical marijuana users with all conditions. This approach produces 247,689 medical marijuana users with all conditions in Florida in 2017.

Approach V. Deaths

Approach V assumes that mostly terminally ill patients will use medical marijuana. Thus, it uses 2014 death rates by disease for the specified diseases, excluding ALS, glaucoma, and Posttraumatic Stress Disorder, for which no data were available, in the proposed ballot initiative to estimate the number of users. Assuming Florida will have the same proportion of deaths from these diseases, applying these rates to 2017 population projections produces a pool of 47,805 potential eligible medical marijuana patients with the specified conditions. This approach does not make assumptions about the percentage of eligible patients who will avail themselves of the opportunity to use marijuana. In addition, there are unspecified "other debilitating medical conditions of the same kind or class as or comparable to those enumerated" in the proposed ballot initiative which cannot be estimated under this approach.

Approach VI. Self-Reported Marijuana Use (Illicit Recreational Use)

Approach VI presents self-reported illicit marijuana use from the 2013 National Survey on Drug Use and Health. Assuming that marijuana use rates will remain the same and adjusting 2013 survey results to the 2017 Florida population projections shows that there may be an estimated 1,752,277 self-reported recreational users of marijuana 18 years of age or older in Florida. If we exclude the population 18 to 24 from this estimate since they would not be as likely to suffer from the debilitating conditions envisioned in the ballot initiative as their older counterparts, it is estimated that there may be 1,168,775 self-reported recreational users of marijuana in Florida. Approach VI was

included because some of the current illicit use may be for medical purposes. This estimation approach has been used by other states to estimate recreational marijuana use. Also, this approach was included to give an upper bound to the estimates that captures the intent of "other debilitating medical conditions of the same kind or class as or comparable to those enumerated." Since it is not clear how this language will be implemented, approach VI assumes that all illicit drug users would be able to obtain physician certifications for debilitating medical conditions.

EDR also estimated the extent to which a pill mill scenario and medical marijuana tourism may affect the potential number of users of medical marijuana.

- *Pill Mills:* The potential medical marijuana population was compared to the estimates of the population illicitly using pain relievers for nonmedical reasons to examine whether "pill mills" can develop for medical marijuana. Applying use rates from the 2013 National Survey on Drug Use and Health, it is estimated that there will be 622,398 pain reliever users for nonmedical reasons in 2017, with higher rates among the 12 to 17 and 18 to 24 age groups compared to the 25 and over age group. The multi-step process consisting of (1) an examination and assessment by a physician in order for a patient to receive a physician certification and (2) the application process through the Department of Health for an identification card may dissuade a pill mill scenario. Further, the amendment allows the Department of Health to issue implementing regulations, and allows the Legislature to enact laws consistent with the amendment that may provide additional regulatory protection.
- *Medical Marijuana Tourism:* The multi-step process described above would discourage shorter-duration visitors from participating in Florida's medical marijuana program. Snowbirds (visitors staying one month or longer) were used as a potential universe for medical marijuana tourists. An estimated 24,307 to 43,233 snowbirds may apply for ID cards.

After careful consideration and review of all methods, the Conference estimated that the number of potential users of medical marijuana upon full implementation of the amendment would be approximately 450,000 persons per year.

C. Fiscal Impact of Proposed Amendment

Summary of the Department of Health's Analysis

The Department's Planning Assumptions

The analysis from the Department of Health assumes the proposed Constitutional Amendment entitled "Use of Marijuana for Certain Medical Conditions" will be approved by the Florida voters and will have an effective date of January 3, 2017. The analysis further assumes the Department of Health will: (1) promulgate rules by June 30, 2017, (2) issue qualified patient and caregiver identification cards prior to October 1, 2017, and (3) register Medical Marijuana Treatment Centers prior to October 1, 2017.

The department analysis provides general planning assumptions, as well as a series of assumptions specific to marijuana, physician authority under state and federal law and regulations, qualifying patient and caregiver identification cards, qualifications and standards for caregivers, medical marijuana treatment centers licensure and regulation, and the department's responsibilities.

The department estimates the following numbers of annual program participants: (1) 440,552 qualified patients, (2) 130,844 caregivers and (3) 1,993 registered Medical Marijuana Treatment Centers. These estimates were derived based on experience data for the state of Colorado.

The department states that it may need additional legislative authority to levy fees for the purpose of implementing this constitutional amendment.

Program Components

The Department of Health will establish a Florida Medical Marijuana Program which supports: (1) acceptance of physician certifications, (2) patient and caregiver identification cards, (3) qualifications and standards for caregivers, (4) medical marijuana treatment center registration and regulation, and (5) regulation of the adequate supply of marijuana for a qualifying patient's medical use. For each of these components, the department's analysis cited relevant definitions as provided in the petition initiative language and indicates the department's responsibilities relative to each component.

Program Costs

According to the analysis provided by the Department of Health, the department will incur an estimated $2.9 million in costs in Year 1 (2017) and $2.7 million in costs in Year 2 (2018) to comply with the regulatory responsibilities assigned to it by the constitutional amendment. Details regarding these costs are in the following table.

Cost Analysis, 2017 and 2018

Cost of Program Implementation	Year 1 2017	Year 2 2018	Description
Program Staff – State Health Office Year 1 – Program Administrator, Environmental Consultant, Gov't Operations Consultant II and Senior Clerk Year 2 – Program Administrator, Environmental Consultant, Gov't Operations Consultant II and Senior Clerk	$264,686	$299,950	<u>Year 1 Total Salary, Fringe, Expense & HR</u> 25% Lapse Factor Program Administrator ($78,393) Environmental Consultant ($71,733) Gov't Operations Consultant II ($79,578) Senior Clerk ($34,982) <u>Year 2 Total Salary, Fringe, Expense & HR</u> Program Administrator ($95,322) Environmental Consultant ($85,096) Gov't Operations Consultant II ($79,578) Senior Clerk ($39,954)
Support for rule development	$59,406	$0	Contracted operations management consultant $20 hr. /2080 hours plus fringe (35%) and contract overhead (4%). One-time contractual.
Develop & disseminate educational materials	$49,120	$21,060	Contracted educator $20.00 hr. /1500 hours plus fringe (35%) and contract overhead (4%). One-time contractual. Costs to disseminate materials to physician = $7,000 Year 2 includes 750 hours of contracted time to refresh training materials.
Business Analyst for data system	$88,400	$0	$85 per hours for 1040 hours. One-time contractual.
Data system for patient/caregiver registration & medical treatment center management	$255,000	$0	Cost to design, develop, test and data system based on business requirements. One-time contractual cost based on Five Points purchase order for the implementation of SB 1030.
Annual data system user support and maintenance	$0	$129,600	Annual cost of help desk and software maintenance based on Five Points agreement for the implementation of SB 1030.
Field Staff (30 FTEs)– Treatment facility inspections, reinspections, and complaint investigations Year 1 – 3 months Year 2 – 12 months	$1,121,156	$2,216,804	Funds 30 Environmental Specialist II's to conduct inspections & investigations. Environmental Specialist II ($404,036) + non-recurring standard package ($116,460) + recurring expense package ($184,980) + maximum travel ($405,360) + HR Costs ($10,320) for a total of $1,121,156. (Salary $ Fringe $53,871, Travel $9,606, Expense $6,166 Recurring $3,882 Nonrecurring and HR $344) for a total of $2,216,804.
Regional Inspector Transportation, Computers and Connectivity	$1,099,320	$17,280	One-time cost for 30 state vehicles @ $35,000 each and 30 pen tablets @ $1,500 each for regional inspectors. Routine repair and maintenance in Year 2 included in cost per service. VPN connectivity service $48 per month per inspector for 3 months in year 1 – $4,320. Year 2 costs included in cost per service.
Total Estimated Costs	**$2,937,088**	**$2,684,694**	

NOTE: Based on the limited information regarding how the program would be implemented these cost estimates could change when more information becomes available.

Requested Information from State Agencies

The following table reflects a summary of information received from several agencies that were asked to provide comments to the Conference. Note the information specific to the Department of Revenue is addressed separately under tax discussions that appear subsequently in this document.

State / Local Agency	Date Info Provided	Result
Florida Department of Health	10/16/2015	Written preliminary and final analyses and testimony showing $2.9 million in costs in Year 1 (2017) and $2.7 million in costs in Year 2 (2018), at least a portion of which is likely to be offset by regulatory fees (see preceding section).
Florida Department of Children and Families Substance Abuse and Mental Health Program	10/19/2015	The department's position remains the same as regarding the proposed constitutional amendment 13-02. The department indicated that the budget impact cannot be determined. The budget for these services is set in the General Appropriations Act which is controlled by the Legislature and Governor. These services are not an entitlement.
Florida Agency for Health Care Administration	10/19/2015	Discussed the possible impact regarding "caregivers". The activity would fall into current regulatory oversight and would not significantly change regulatory duties. Health care clinics would only be impacted if the clinics accept 3rd party reimbursement.
Florida Board of Pharmacy	10/19/2015	The Medical Marijuana Treatment Center would be a separate facility or entity and the certificate is not a prescription, so there would be no additional costs.
Florida Department of Business and Professional Regulation (DBPR) Division of Drugs, Devices and Cosmetics	10/18/2015	Whether medical marijuana is a "common household remedy" is currently unknown. "Common household remedy" is not defined in statute and DBPR has no authority to further define the term. Making the determination involves the forming of a technical assistance advisory committee which is outside of DBPR's purview. At this time marijuana is a schedule I controlled substance under both state and federal law, having no currently accepted medical use in treatment in the United States. DBPR has not been petitioned to include medical marijuana on the list of common household remedies. Additionally, no schedule I controlled substance is currently listed as a common household remedy. The form of the substance does not greatly matter, unless it is a food or has been processed. DOH is the agency delegated responsibility with implementing the proposed constitutional amendment. DBPR is not delegated any authority or responsibility regarding the implementation of the proposed constitutional amendment, but would serve as a resource to DOR and DOH as necessary.
Florida Department of Agriculture and Consumer Services	10/16/2015	The department's position remains the same as regarding the proposed constitutional amendment 13-02. Would not result in a significant regulatory impact to the agency: oversight of the plants; nursery stock dealers' license; commercial weights; agricultural inspection stations, etc. Fees would cover any additional costs.

State / Local Agency	Date Info Provided	Result
Florida Department of Law Enforcement	10/19/2015	The Florida Department of Law Enforcement does not anticipate a fiscal impact as long as the criminal justice community does not have an expectation FDLE labs would determine whether cannabis found by officers is medical cannabis < 0.8 % THC and >10% CBD or recreational grade. Currently the laboratories identify the plant and whether THC is present. Current laboratory testing cannot determine the difference between medical grade and recreational cannabis. The implementation of a quantification procedure for THC and CBD based on previous workload for cannabis, could require more than 30 additional FTE chemistry positions statewide and appropriate space to house them. The estimated fiscal impact to fund 30 crime laboratory analyst positions is more than $2.2 million. In addition, the department anticipates the increased availability of cannabis with higher THC concentrations would increase driving under the influence laboratory evidence submissions by law enforcement agencies. This would have a fiscal impact on the toxicology sections of the department's crime laboratories, in terms of additional staffing and instrumentation. However, this impact is undetermined at this time.
Florida Office of the Attorney General	10/19/2015	Referred the Conference to a letter that was submitted to the Chief Justice and Justices of the Florida Supreme Court.
Florida Department of Highway Safety and Motor Vehicles	10/20/2015	The department's position remains the same as regarding the proposed constitutional amendment 13-02. Indicated that there may be some additional costs, but cannot quantify them at this time. The costs may be due to law enforcement training needs and public education and outreach.
Florida Association of Counties	10/15/2015	The association's position remains the same as regarding the proposed constitutional amendment 13-02. The Florida Association of Counties is unable to make a determination about the financial impact of the proposed amendment on local governments as per email.
Florida League of Cities	10/19/2015	Phone conversation indicating that the League of Cities is unable to quantify any potential impact to costs at this time.
Florida Police Chiefs Association	10/20/2015	Email indicating additional enforcement and training costs based on the experience from other states that have similar amendments, but they were unable to quantify these costs at this time.
Florida Sheriffs Association	10/20/2015	The association's position remains the same as regarding the proposed constitutional amendment 13-02. At that time, their presentation and email indicated additional enforcement costs based on the experience from other states that have similar amendments, but they were unable to quantify these costs at this time.

Florida Sales Tax Treatment of Medical Marijuana

Since medical marijuana is tangible personal property for the purposes of Chapter 212, Florida Statutes, its purchase is subject to Florida sales and use tax unless a specific exemption exists. In this regard, there were three possible areas of current law exemptions considered by the Conference: prescription-based exemptions, the common household remedy exemption, and agricultural-related exemptions.

The Conference has determined that the prescription-based exemptions do not apply to medical marijuana purchases due to technical constraints that include the interaction of state and federal law. The Florida Statutes define a prescription as "any order for drugs or medicinal supplies written or transmitted by any means of communication by a duly licensed practitioner authorized by the laws of the state to prescribe such drugs or medicinal supplies and intended to be dispensed by a pharmacist." Current federal law prohibits a physician from writing prescriptions for Schedule I controlled substances, which would include marijuana. In addition, the proposed amendment establishes a certification process that allows the end-user to control both the product type and dosage frequency without the need for an authorizing prescription, making the certification process fundamentally different from the typical prescription purchase. Moreover, the proposed amendment requires medical marijuana to be dispensed by a Medical Marijuana Treatment Center that is not required to be a pharmacy. Similarly, the exemption for medical products requires a prescription and would not be applicable to the sales of supplies related to medical marijuana.

The exemption for common household remedies does not require the presence of a prescription. Pursuant to Florida Statutes, the Department of Business and Professional Regulation (DBPR) must approve a list of these items, and that list is then certified to and adopted by the Department of Revenue through the rule-making process. There is also a process for inclusion of additional items. The existing list contains a mixture of specifically named remedies and broad classes of remedies. Both departments have identified reasons why the exemption may not apply, emphasizing the restrictive nature of the dispensing process. DBPR stated that medical marijuana does not fit under any category on the currently adopted Common Household Remedies list (DR-46NT, R. 07/10), nor does DBPR expect to modify the "Common Household Remedies" listing to add medical marijuana in the foreseeable future. The department cites federal regulations which continue to designate any form of marijuana as a Schedule I drug with no current authorized use and no treatment value.

Based on information provided by the Department of Revenue and the Department of Agriculture and Consumer Services, the Conference determined that the applicability of agricultural-related exemptions to the sale or production of medical marijuana is uncertain because medical marijuana may not be considered an agricultural product. Should the exemptions apply, the direct sale or dispensation of medical marijuana in its raw form by the grower or cultivator to an end-user or designated caregiver would be exempt. Also exempt would be items used in the production of medical marijuana such as power farm equipment, fertilizer and pesticides.

Potential Sales Tax Impact

In an attempt to quantify the potential magnitude of the sales tax impact, the Conference looked to other states to analyze their results. Of the *18 states and the District of Columbia* that have approved the use of medical marijuana *and levy a sales tax*, at least 12 states and the District of Columbia have a sales tax structure that encompasses medical marijuana transactions.[32] In New Jersey and Illinois, legislation explicitly made the sale of medical marijuana subject to tax. In the District of Columbia, marijuana's status as a Schedule I drug appears to disqualify it from an exemption.

The Office of Economic and Demographic Research used the information from other states to analyze the potential range of state sales tax revenues. The number of users, the consumption per user and the cost of the product are all critical assumptions and cause the projections to change dramatically as they are varied. Using price data from Vermont, allowable usage from Connecticut, survey data on the illegal use of marijuana for recreational purposes, and two of the estimates of projected Florida users discussed earlier, the estimated sales tax collections range from a low of $11.8 million to a maximum of $356.8 million.

Potential Range of State Sales Tax Revenues from Medical Marijuana End-Users Assuming No Sales Tax Exemptions Apply

The Following Examples Demonstrate a Range that is Generated by Varying Assumptions

UPDATED					
Quantity Consumed/ Estimation Approach	**April 1, 2017 Users**	**Sales ($)**		**State Sales Tax Revenues ($)**	
		$225/ oz	**$450/ oz**	**$225/ oz**	**$450/ oz**
Annual use of 3.53 oz (100 g)[1] (Illicit Drug Use Pattern, 1.5 gram, 5-6 times/month)					
I. States with medical marijuana laws	440,552	349,908,426	699,816,852	20,994,506	41,989,011
IV. Use by cancer patients	247,689	196,726,988	393,453,977	11,803,619	23,607,239
Annual use of 30 oz (850 g)[2] (1.5 g 1.6 times per day, all year round)					
I. States with medical marijuana laws	440,552	2,973,726,000	5,947,452,000	178,423,560	356,847,120
IV. Use by cancer patients	247,689	1,671,900,750	3,343,801,500	100,314,045	200,628,090

NOTE: Additional detail can be found at EDR's website:
http://edr.state.fl.us/Content/constitutional-amendments/2016Ballot/MedMTab28.pdf

Another approach to estimate potential sales tax revenues uses sales tax collections, number of registrants, and amount of medical marijuana sold in Colorado for 2014. Assuming Florida will have a medical marijuana consumption pattern similar to Colorado, annual sales tax collections are estimated to be close to $84.9 million. After deducting the updated estimated sales tax collections for the low-THC cannabis authorized by CS/CS/SB1030 of $17.6 million, the net sales tax collections under the proposed constitutional amendment are estimated at $67.3 million.

[32] Arizona, California, Colorado, Connecticut, Illinois, Maine, Nevada, New Jersey, New Mexico, New York, Rhode Island, Washington, and the District of Columbia have sales taxes.

Florida 2017 Sales Tax Collection Estimates
Based on Colorado's 2014 Experience

	Colorado	Florida
Patients	115,115	440,552
Amount per patient (oz)	16.14	16.14
Pretax price per oz	199	199
Sales	334,751,145	1,414,675,735
Sales tax collections	**9,997,717**	**84,880,544**
Sales tax collections from updated impact of CS/CS/SB1030		**17,579,912**
NET impact of proposed amendment		**67,300,632**

NOTE: Additional detail can be found at EDR's website:http://edr.state.fl.us/Content/constitutional-amendments/2016Ballot/MedMTab28_update%202.pdf

In conclusion, the increase in sales tax revenues to state and local governments cannot be determined precisely because too many unknowns affect the amount of taxable sales, but the increase will be substantial. As shown above, the estimates vary from a low of $11.8 million to a high of $356.8 million. Assuming Florida's medical marijuana consumption mirrors Colorado's experience, annual state and local government sales tax revenues could increase by an estimated $67 million after taking into account lawful consumption of medical marijuana in Florida.

Florida Property Tax Treatment of Medical Marijuana

It is unclear whether land used for growing medical marijuana will be considered agricultural property for property tax purposes. If the land is considered agricultural property, it will receive a classified use agricultural assessment. Regardless of whether the land is considered agricultural property, taxable value may increase or decrease relative to its current value. Therefore, the impact on property taxes is indeterminate—both in terms of magnitude and direction.