

Testimony
Human Services Committee
Senate Bill 2344
Wednesday, February 8, 2017
North Dakota Department of Health

Good morning, Chairman Lee and members of the Human Services Committee. My name is Arvy Smith, and I am the co-acting director of the North Dakota Department of Health (DoH). I am here to support and provide information on Senate Bill 2344 regarding a medical marijuana program in North Dakota.

On November 8, 2016, the people of North Dakota voted to establish a medical marijuana program in the state. As we have stated, the new law posed some challenges for which we immediately started analyzing and seeking solutions to. SB 2344 provides those solutions. In addition the bill increases safety and efficiency factors, at levels selected by the sponsors of this bill, and addresses priorities identified in U.S. Deputy Attorney General, James M. Cole's August 29, 2013 letter regarding marijuana enforcement by the federal government. In the Cole Memo, the U.S. Department of Justice (DOJ) reiterated that marijuana remains illegal under the federal Controlled Substances Act but the DOJ would focus its efforts on certain enforcement priorities including: preventing the distribution of marijuana to minors, diversion of marijuana from a legal market to an illegal market, and preventing violence and the use of firearms in the cultivation and distribution of marijuana.

The legal marijuana industry is a relatively new industry and states are still learning how best to establish policy and regulate this industry. While we reviewed other states' practices, policies, laws, etc. and a model law developed by the National Conference of State Legislatures (NCSL), it is important to note that the early implementers are continuing to update their laws and regulations to make improvements. We are using this information in developing North Dakota's medical marijuana program.

Clarifications and Technical Changes

With regard to regulation of compassion centers, the North Dakota law was based on Delaware administrative rule and while this provided a good start, changes continue to be made to Delaware laws and rules. Also, administrative rule is essentially how an agency will implement a law passed by the legislature. Rules contain a higher level of detail than what is typically contained in state law. The high degree of technicalities incorporated in the original measure make it less

flexible to adjust as needed for a new industry. In using Delaware rules to develop the language of the measure that passed, the authors failed to change references to “these rules” to “this law” and in a couple of instances specifically referred to Delaware law. In addition to fixing these references, one of our suggested changes includes moving certain aspects of the law to administrative rule to provide the ability to change more rapidly where necessary through rule rather than law.

The medical marijuana system includes several key components including growing and manufacturing facilities, dispensaries, laboratories, designated caregivers, and finally qualifying patients. The term compassion center is used when discussing both the manufacturing facilities and the dispensaries. One improvement to the law we are proposing is to clearly define each of these terms and use them consistently throughout the law.

The measure, as passed, contained fourteen pages of requirements for compassion centers. Language included requirements to operate a compassion center, application requirements to be a compassion center and requirements for things to be included in the operating manual. The language of these requirements was not always consistent, causing confusion as to which requirements to follow. It is critical that the requirements to be consistent with the application requirements so that the department receives quality applications that address the requirements to operate and so that the compassion centers are regulated in accordance with the same rules for operation. If we are abundantly clear as to the requirements up front, we will receive better applications and be able to have operational compassion centers earlier than if we are continually sending their applications back to meet a set of regulations they were unaware of when they applied.

Finally, a critical component we added to the law is the language to decriminalize the growing, manufacturing, dispensing, possession and use of marijuana for medical purposes. The language is necessary to prevent patients, caregivers, and agents of compassion centers, including lab testers and transporters, from arrest or prosecution, under state law, for their actions in compliance with medical marijuana laws. These protections from arrest and prosecution are included in Section 31 of this bill. It is important to note that this language does not change the fact that use of marijuana is still illegal under federal law, and, while the federal government is not currently enforcing this law, there is nothing preventing the federal government from changing that stance. A state agency cannot, and should not, have employees violating federal law in order to accomplish their job duties. Because of this, Risk Management has advised the DoH that we cannot require our employees to handle, be in possession of, or transport marijuana for regulatory

purposes. Consequently, the Department will have to find unique ways to conduct random, controlled lab testing and use law enforcement if we find that marijuana product needs to be confiscated.

Additional clarifications the DoH is supporting are as follows:

- Establish that jurisdiction for judicial review is Burleigh County district court
- Establish all fees in law, not to exceed a certain amount; fees for compassion centers were in the measure but not maximum fees for designated caregivers and qualifying patients
- Remove the petition/public hearing process and use existing ND rules
- Clarify that the continuing appropriation included in the original measure is to the DoH
- Add violations and penalties
- Require conducting of an annual comprehensive inventory rather than biennially
- Clarify registry identification card contents

Safety

With regard to safety and to address priorities of the U.S. Deputy Attorney General, the following changes are included in SB 2344:

- Allows patients to purchase the equivalent of 2.5 oz. per month instead of 3 oz. every fourteen days and limits the amount patients can possess 3 oz. at any given time (Section 2; page 5 line 30). This is to reduce diversion as a result of excessive purchasing and excessive use. Many sources indicated that 3 oz. every fourteen days was excessive.
- Limits forms of use for minors to oils, limits the THC contents for minors at less than 6%, and requires pediatrician sign off for individuals under age 18 (Section 2; page 8 line 21). This doesn't allow smoking of marijuana for any individuals. The original measure allowed all forms of use for all qualifying patients.
- Requires seed to sale bar coding of every plant by manufacturing facilities (Section 25; page 65 line 17).
- Prohibits the sale of usable marijuana in any form other than pill or liquid by a dispensary (Section 2; page 9 line 23). Patients would be able to purchase an oil form which they can use to create an edible form or use in a vaporizing system.
- Prohibits minors from purchasing or being in possession of marijuana.
- Strengthens various security requirements.

Efficiency and Cost Effectiveness

With regard to efficiency and cost effectiveness, the following changes are included in SB 2344:

- Removes the non-profit status requirement; Since federal 501(c)(3) status is not available because marijuana is federally illegal, a clear standard is not available. Discussion with other states indicates that this requirement doesn't seem to add value to the process.
- Allows only 4 manufacturing facilities to grow, manufacture and sell marijuana to dispensaries; allows only 8 dispensaries to sell marijuana to qualifying patients and designated caregivers; the DoH may add dispensaries if product is not readily accessible to ND clients. (Section 12; page 55 line 1). Limitation of growing and dispensing significantly reduces the cost to state and local government and reduces the possibility for diversion.
- Requires fees to cover all DoH implementation costs by the 2019-21 biennium (Section 42; page 81 line 29). This requirement is included in other states and NCSL model law.
- Moves deadlines for processing qualifying patient, designated caregiver and compassion center applications from law to administrative rule. This will allow better managing of staff time and workload and flexibility to adjust deadlines.
- Allows the department to establish rules to add debilitating conditions petitioned by the public (Section 11; page 54 line 1)
- Requires local planning and zoning approval prior to reviewing the application. (Section 14, page 56, lines 23-25) This is consistent with model law and other states' laws to avoid unnecessary costs.
- Requires a bond to ensure adequate clean-up in the event a compassion center goes out of business. (Section 15, page 59, lines 1-3) This improves safety and potential cleanup costs to the DoH.
- Requires compassion centers to ensure access to qualifying patients and include a distribution plan in their application. (Section 26, page 67, lines 27-28)

Fiscal Note

In summary the fiscal note for SB 2344 shows the following:

<u>DoH</u>	<u>2017-19</u>	<u>2019-21</u>
Expenses	2,643,684	3,190,350
Revenue	<u>1,317,500</u>	<u>3,190,350</u>
General Fund App Needed	1,326,184	0

Attorney General

Expenses	162,085	346,516
Revenue	<u>0</u>	<u>0</u>
General Fund App Needed	162,085	346,516

In the 2017-19 biennium, there won't be two years of revenue and there will be some start-up costs so one-time general funding of \$1,317,500 is needed. By the 2019-21 biennium, the revenue must be sufficient to cover all costs so the general fund need is \$0 for the DoH. The cost for the Attorney General is to conduct the criminal background checks. While the designated caregivers and compassion centers or the agents must pay for the background checks, those fees are deposited directly to the general fund, not to the Attorney General's Office.

There are two reasons this fiscal note is significantly lower than the original fiscal note for the measure that passed. First, in looking at other states' programs we learned that we can obtain the management information system at a much lower cost than we first expected.

Second, SB 2344 eliminates the ability of qualifying patients and designated caregivers to grow their own marijuana for medical use. In estimating the number of potential qualifying patients and caregivers, we noted from other states' information that those that did not allow individuals to grow their own marijuana had lower numbers of patients and caregivers. So this fiscal note revises the numbers down to 3,800 qualifying patients and 1,900 designated caregivers each year, reducing the number of criminal background checks that need to be done. This also greatly reduces the amount of regulation by the DoH, the attorney General's Office and local law enforcement. It is important to note that if the ability of caregivers and patients to grow their own is reinstated, costs will increase significantly for all three entities.

The fiscal note also shows that revenue to the general fund and the state aid distribution fund totals \$1,700,000 in the 2017-19 biennium and \$3,400,000 in the 2019-21 biennium (91.3% to the general fund and 8.7% to the state aid distribution fund). The Tax Department is unable to calculate the amount of income tax that will be generated as a result of this legislation.

Neither the DoH nor the Attorney General's appropriation bills contain an appropriation for this at this time. Governor Burgum's budget included \$6,216,884 with \$4,525,508 from fees and \$1,691,376 from the general fund, and 13 FTE for the DoH.

The assumptions used to calculate the fiscal note for each biennium are included in the fiscal note. We were able to use registration amounts less than what is proposed in SB 2344 for qualifying patients, designated caregivers and compassion centers and their agents at this time. However, it is very difficult to estimate the numbers of qualified patients and designated caregivers that will pursue registration so these numbers could change. Looking at other states, some were as low as .6 per 1,000 population and one was as high as 15.7 per 1,000 population. It appeared that those that allowed patients and caregivers to grow their own had higher numbers of registrants. Registrations are lower where the number of conditions covered and the forms of use are significantly restricted. Based on this information, we assumed 5 qualifying patients per 1,000 population, and assumed that half of the qualifying patients would have a designated caregiver resulting in 3,800 qualifying patients and 1,900 designated caregivers each year. The fiscal note assumed a \$200 per year registration fee for qualified patients, designated caregivers and compassion center agents, a \$80,000 per two years registration fee for manufacturing facilities and a \$60,000 per two years registration fee for dispensaries.

Timeline

Finally, while not ideal, we plan to begin developing administrative rules immediately and make adjustments once legislation is finalized so that we can move them through the approval process as soon as possible. Once the rules for compassion centers are finalized, we can begin accepting applications from compassion centers and awarding registrations. We have been told that from the time they are approved to operate it will take two months to set up business and three months until product can be harvested. Based on that, we expect product to be available for purchase approximately one year from now.

This concludes my testimony. I am happy to answer any questions you may have.