December 11, 2018

The Honorable Larry Hogan
Governor
State of Maryland
Annapolis, MD 21401-1991

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
Annapolis, MD 21401-1991

The Honorable Michael E. Busch
Speaker of the House
H-101 State House
Annapolis, MD 21401-1991

RE: Health-General Article, §13-3303.1(f), Natalie M. LaPrade Medical Cannabis Compassionate Use Fund

Dear Governor Hogan, President Miller, and Speaker Busch:

Pursuant to Health-General Article, §13-3303.1(f), Annotated Code of Maryland, the Natalie M. LaPrade Medical Cannabis Commission (the "Commission") respectfully submits this legislative report on the revenue necessary to implement the Natalie M. LaPrade Medical Cannabis Compassionate Use Fund (the "Compassionate Use Fund"). Specifically, the enclosed report evaluates:

1. The revenues the Commission anticipates are necessary to implement the program;
2. The types of funding mechanisms that may be used to implement the program; and
3. Any anticipated savings in prescription drug costs for the Maryland Medical Assistance Program that would result from the provision of medical cannabis under this Subtitle.

The Commission appreciates your commitment to providing a successful yet consumer-friendly medical cannabis industry in the State, and ensuring that patients have affordable and adequate access to medical cannabis. If you have questions about this report, please contact Will Tilburg, JD, MPH, Director, Policy and Government Relations, at (410) 487-8069 or william.tilburg@maryland.gov.

Sincerely,

Joy A. Strand, MHA
Executive Director

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Webster Ye, Deputy Chief of Staff, Maryland Department of Health
William C. Tilburg, Director, Policy and Government Relations, Maryland Medical Cannabis Commission
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Report on the Natalie M. LaPrade Medical Cannabis Compassionate Use Fund

Submitted by the Natalie M. LaPrade Medical Cannabis Commission

December 2018

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I. Introduction

Health-General Article, §13-3303.1, as amended by Chapter 598 of the Acts of 2018 (HB 2), established the Natalie M. LaPrade Medical Cannabis Compassionate Use Fund ("Compassionate Use Fund"). The Compassionate Use Fund is a special, nonlapsing fund administered by the Maryland Department of Health (the "Department") to "provide access to medical cannabis for individuals enrolled in the Maryland Medical Assistance Program or in the Veterans Administration Maryland Health Care System." Md. Code Ann. Health-Gen., §13-3303.1(d).

Health-General Article, §13-3303.1 does not appropriate funds to the Compassionate Use Fund or otherwise provide funding to implement the program. Rather, the statute requires the Commission to submit a report to the General Assembly on the revenues that may be necessary to implement the program. The Department is required to (1) establish the program and (2) set any fees that may be necessary to provide medical cannabis at "no cost or a reduced cost" to eligible Maryland Medical Assistance Program and Veterans Administration Maryland Health Care System enrollees. Md. Code Ann. Health-Gen., §13-3303.1(c). No fees may be assessed on a medical cannabis business until at least two years following the issuance of a Stage One pre-approval of a license. Md. Code Ann. Health-Gen., §13-3303.1(c).

II. Background

Medical cannabis is not covered by any health insurance provider operating in the State. Cannabis remains a Schedule I drug under the federal Controlled Substances Act (CSA), meaning there is "no currently accepted medical use and a high potential for abuse." Since there is no accepted medical use under federal law health insurers do not consider cannabis to be "medical care" eligible for health insurance coverage. Moreover, private health insurance, Medicaid and Medicare are only required to cover drugs approved for use by the U.S. Food and Drug Administration (FDA). The FDA does not approve Schedule I drugs for medical use, and therefore insurance companies are not required to cover it as part of their insurance plans. Health insurance companies may cover Marinol, Syndros, and Epidiolex, which contain cannabinoids, but each drug was re-scheduled upon receiving FDA approval and is no longer considered cannabis under federal law.

In Maryland, the price of medical cannabis is not set by statute or regulation. Prices vary significantly based on content (i.e. THC or CBD concentration) or location, but 1 gram of flower typically ranges between $5-20. A patient is permitted to purchase up to 120 grams of medical cannabis in a rolling 30-day period, which means a patient purchasing the maximum allowable amount of flower product could spend $600-2,400 per 30-day period. The cost of medical cannabis concentrates and medical cannabis-infused products also vary significantly based on content and location, and are generally more expensive than flower products.

HB 2 established the Compassionate Use Fund to fill the void created by the lack of health insurance reimbursement for medical cannabis and reduce the economic burden for medical cannabis patients enrolled in Medicaid or in the Veterans Administration Maryland Health Care System ("VA Health Care System"). In order to determine the amount necessary to fund the Compassionate Use Fund, HB 2 requires the Commission to submit a report the General Assembly on the revenues needed to fund the Compassionate Use Fund, potential funding mechanisms, and any anticipated savings in prescription drug costs for the State's Medicaid program. This report satisfies these requirements.

III. Reduced Cost Programs in other Jurisdictions

As of November 6, 2018, thirty-three states, the District of Columbia, and Puerto Rico have legalized medical cannabis (see Table 1). Medical cannabis dispensaries in these jurisdictions, including Maryland, commonly offer discounts for low-income individuals and veterans; however, only the District of Columbia and Vermont require dispensaries to provide discounted medical cannabis to these populations. Significantly, the D.C. and Vermont programs have fewer than 5,000 registered medical cannabis patients; less than $1/10^{th}$ the number of certified patients (51,304) in the Maryland program.

The City of Berkeley, California goes a step further, requiring dispensaries to provide medical cannabis at no cost to "very low-income City residents." Rather than imposing a flat fee on licensed medical cannabis businesses, each jurisdiction requires dispensaries to allocate a percent of their annual gross revenue to discount the cost of medical cannabis for eligible qualifying patients. Linking the discount to an individual dispensary's gross revenue reduces the economic burden on rural, independent, and/or small businesses that average fewer patients and generate less revenue. A brief summary of each medical cannabis discount program is included below. (See Appendix A for the statute and/or regulations implementing the medical cannabis discount programs).

(a) *Berkeley, California*

In 2014, the Council of the City of Berkeley adopted Ordinance No. 7,359-N.S., which requires a medical cannabis dispensary to provide at least 2% (by weight) of its annual medical cannabis sold at no cost to qualifying patients who are "very low income" The 2% figure is based on the amount dispensed during the previous six months. Very low income is defined as 50% or less of the area median income, or approximately $40,000.

(b) *District of Columbia*

In 2013, the District of Columbia enacted a first-in-the-nation program requiring medical cannabis dispensaries to allow qualifying low-income patients to be able to purchase medical cannabis on a sliding scale. Dispensaries must allocate 2% of their annual gross revenue to qualifying patients with an income at or below 200% of the federal poverty level. Patients must register with the D.C. Department of Health to qualify, and qualifying patients are entitled to a discount of at least 20% of the regular retail price.

(c) *Vermont*

The Vermont Administrative Code requires medical cannabis dispensaries to "implement and operate a sliding-scale fee system that takes into account a patient's ability to pay." However, the law does not establish a minimum amount of product to set aside, or revenue to allocate, for qualifying individuals. Vermont currently has four medical cannabis dispensaries operating in the State, and each provide discounts to low-income individuals and veterans. Patients must provide documentation proving eligibility. While discounts vary by dispensary, the discount range is 10-20%.

Table 1. U.S. jurisdictions with medical cannabis laws and year passed

State	Year Passed	State	Year Passed
1.Alaska	1998	18.Montana	2004
2.Arizona	2010	19.Nevada	2000
3.Arkansas	2016	20.New Hampshire	2013
4.California	1996	21.New Jersey	2010
5.Colorado	2000	22.New Mexico	2007
6.Connecticut	2012	23.New York	2014
7.Delaware	2011	24.North Dakota	2016
8.Florida	2016	25.Ohio	2016
9.Hawaii	2000	26.Oklahoma	2018
10.Illinois	2013	27.Oregon	1998
11.Louisiana	2016	28.Pennsylvania	2016
12.Maine	1999	29.Rhode Island	2006
13.Maryland	2014	30.Utah	2018
14.Massachusetts	2012	31.Vermont	2004
15.Michigan	2008	32.Washington	1998
16.Minnesota	2014	Washington, DC	2010
17.Missouri	2018	33.West Virginia	2017

IV. Current Discounts for Maryland Medical Assistance Program and Veterans Administration Maryland Health Care System Enrollees

Prior to passage of HB 2, Maryland law did not place any pricing or discount requirements on licensed medical cannabis dispensaries. Yet, each of the sixty-nine (69) licensed dispensaries operating in the State offer discounts to qualifying patients. The Maryland Medical Dispensary Association (MDMA), the trade association for medical cannabis dispensaries in the State, reported to the Commission that every dispensary offers a discount to veterans. The amount of the discount ranges from 10 to 22%, with 22% being the most common as a recognition of "the 22 veterans who commit suicide each day." (See Appendix B). In addition, many dispensaries offer a "compassion discount" for patients with terminal diagnoses, low-income patients, minor patients, and others. These discounts typically range from 10 to 25%.

Due to market competition and the deleterious effects of the federal tax code on medical cannabis businesses, discounts of 20 to 25% may result in a dispensary selling a product at or below cost. Under 26 U.S.C. 280E, businesses engaging in the trafficking of Schedule I or II controlled substances, including cannabis, are prohibited from deducting ordinary and necessary businesses expenses. Medical cannabis businesses may deduct the costs of goods sold (COGS), which are costs directly attributable to the production of a good, including the cost of labor and materials. However, the Department of Legislative Services estimates that 30% of a medical cannabis dispensary's expenses may not be deducted due to 280E restrictions, and that these businesses pay significantly higher federal tax bills than similar retail facilities.

V. Eligible Maryland Medical Assistance Program and Veterans Administration Maryland Health Care System Enrollees

Individuals enrolled in Medicaid or the Veterans Administration Maryland Health Care System ("VA Health Care System") make up a significant percent of the State's population. As of September 2018, Maryland has a combined enrollment of 1,299,510 individuals across Medicaid and CHIP. In total, more than 20% of the State's population is enrolled in Medicaid and CHIP. The Maryland Department of Veterans Affairs estimates that 399,036 or 8.87% of the adult population in Maryland are veterans and 152,216 veterans or 3.4% of the adult population in Maryland, are enrolled in the VA Health Care System.

The Maryland medical cannabis program is significantly smaller than either Medicaid or the VA Health Care System. As of November 6, 2018, there were 93,672 individuals who had submitted patient applications to the Commission since the patient registry open in April 2017. The number of individuals who are registered with the Commission and certified by a licensed Maryland provider to purchase, possess, and use medical cannabis ("certified patients") is considerably lower at 51,304. Overall, 1.5% of the total state population has submitted a patient application, and less than .9% of the total state population is a certified medical cannabis patient. In states with more established medical cannabis programs (e.g., 5 years or more post-implementation) the percent of residents who are qualifying patients typically falls between 1 and 3% of the total population.

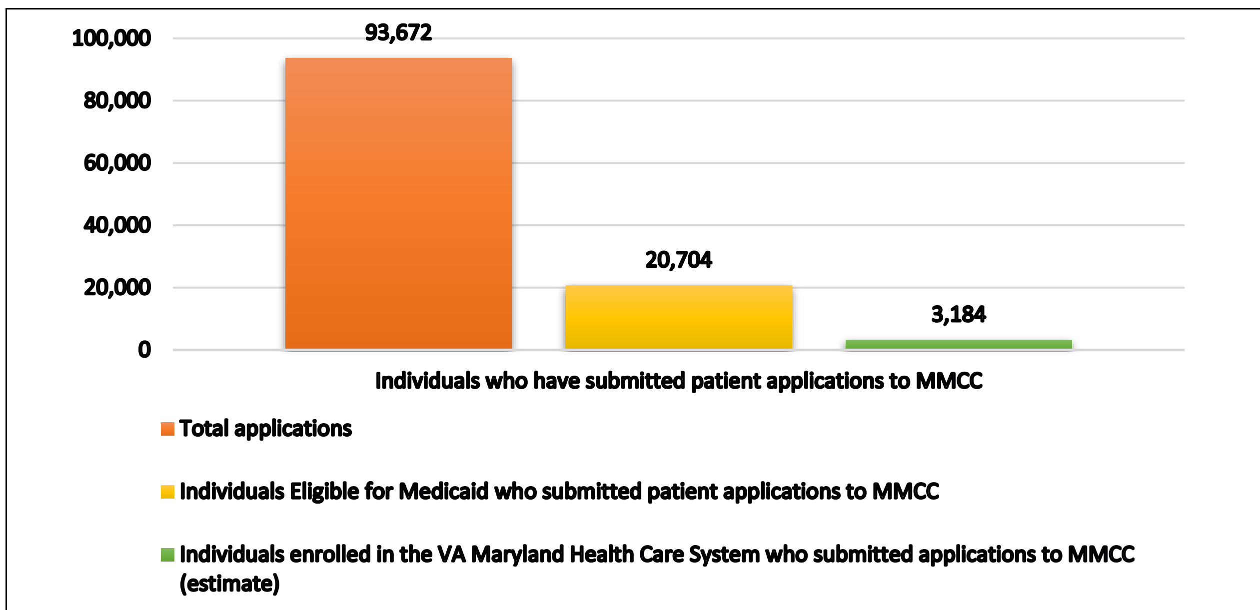
(a) *Medicaid*

At the request of the Department of Health, the Hilltop Institute at the University of Maryland Baltimore County (UMBC) identified Medicaid participants who were eligible to purchase, possess, and use medical cannabis. Applying first and last name, date of birth, and last 4 digits of Social Security Number criteria, the Hilltop Institute determined that 20,704, or 22.1%, of the individuals who submitted a medical cannabis patient application from April 2017 through October 2018 were eligible for Medicaid as of October 2018. Using this data, the Commission estimates that 11,388 certified patients were eligible for Medicaid as of October 2018.

(b) *VA Health Care System*

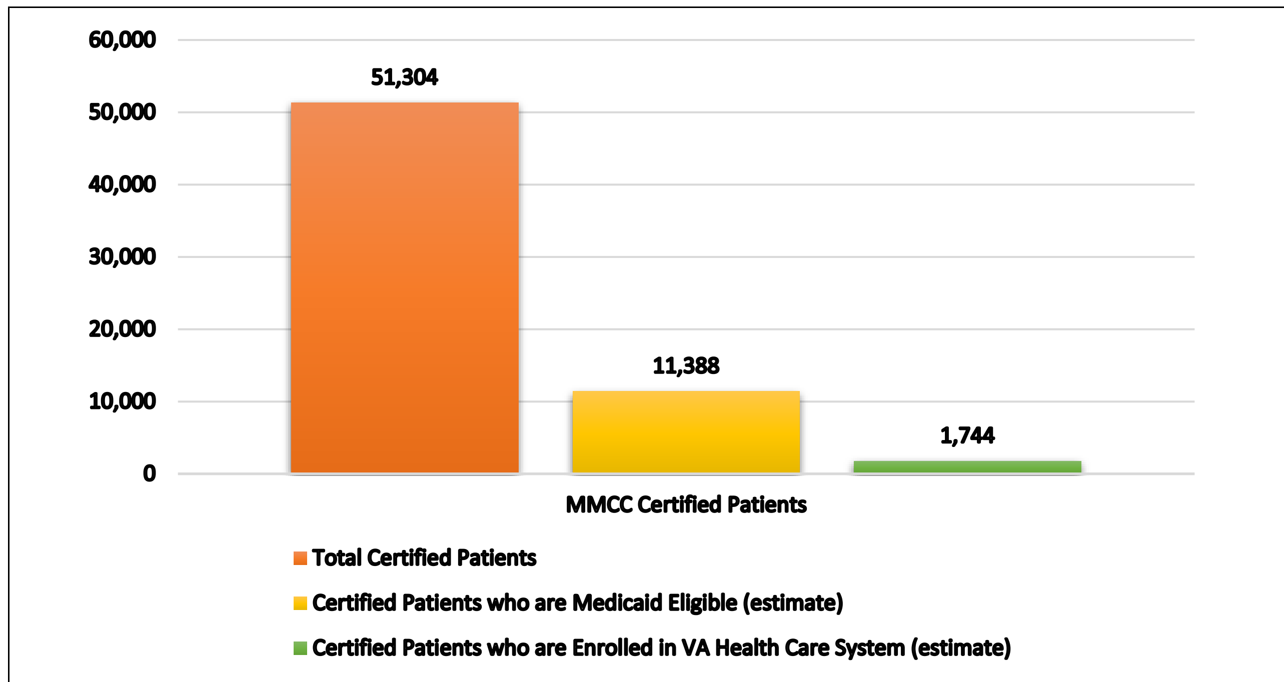
The U.S. Department of Veterans Affairs (VA) is required to follow all federal laws, including the federal Controlled Substances Act (CSA). Since cannabis remains a Schedule I drug under the federal CSA, VA health care providers may not recommend it or assist veterans to obtain it. Subsequently, the Commission was unable to identify the number of veterans currently registered or certified as patients within the State's medical cannabis program. The following analysis estimates that the number of medical cannabis patients who are enrolled in the VA Health Care System reflects the percent of this group as part of the total adult population of the State (3.4%).[1] Accordingly, the Commission estimates that 3,184 of the individuals who submitted a patient application from April 2017 through October 2018 are enrolled in the Veterans Administration Maryland Health Care System. In addition, the Commission estimates that 1,744 of the certified patients in the medical cannabis program are enrolled in the VA Health Care System.

Figure 1. Total number of patient applications submitted to MMCC (through November 6, 2018)



[1] While the medical cannabis program does permit minor patients, individuals under the age of 18 currently represent less than .2% of the total patient population.

Figure 2. Total number of MMCC certified patients (through November 6, 2018)



(c) *Anticipated Program Growth*

The number of patients enrolled in a state medical cannabis program typically ranges from 1 to 3% of the total state population. Through November 6, 2018, 1.5% of the total state population had submitted a patient application to MMCC, and .084% of the population were certified patients. The projections for the revenue necessary to fund the Compassionate Use Fund anticipate that patient registration and certification rates will increase at current rates until achieving 2% of the total state population by FY 2021. Beginning in FY 2022 the patient population is anticipated to increase consistent with the State's population rate of change.

Table 2. Estimated patient applications and certified patients, FY 2020-FY 2022

	FY 2020	FY 2021	FY 2022
Maryland Total Population	6,098,109	6,144,179	6,190,248
Certified Patients	88,744	117,304	123,805
Certified Patients Eligible for Medicaid	19,612	25,924	27,360
Certified Patients Enrolled in VA Health System	3,017	3,988	4,209

VI. Revenues Necessary for Compassionate Use Fund

The anticipated revenues necessary to fund the Compassionate Use Fund are included below. The necessary revenue was calculated using patient estimates included in Table 2 (above) and current average per patient sales figures ($138.38 per month or $1,660.56 per year). Estimates were calculated for a 15% discount, 20% discount, and no cost (i.e. 100% discount) for Medicaid and VA Health Care System enrollees.

Important: The anticipated revenues necessary to fund the Compassionate Use Fund (Table 3) are based on projections that the percent of certified patients who are Medicaid and VA Health Care System enrollees will be constant in FY 2020 through FY 2022 (e.g. 22.1% and 3.4%, respectively). However, the Commission anticipates that providing reduced cost or no cost medical cannabis to Medicaid and VA Health Care System enrollees would significantly increase the number of each group who become certified patients. Since no other jurisdiction in the United States has implemented a medical cannabis discount program of the size and scope of the Compassionate Use Fund, the Commission is unable to determine the impact that providing reduced cost or no cost medical cannabis to Medicaid and VA Health Care System enrollees will have on the total number of each group who become certified medical cannabis patients. Therefore, the figures below should be viewed as low-end cost estimates.

Table 3. Estimated revenue necessary to fund the Compassionate Use Fund, FY 2020-FY 2022

	FY 2020	FY 2021	FY 2022
15% Discount	$5,636,522	$7,450,601	$7,863,333
20% Discount	$7,515,362	$9,934,134	$10,484,444
No Cost	$37,576,812	$49,670,671	$52,422,219

From December 1, 2017 to November 30, 2018, the gross revenue for medical cannabis sales in Maryland was $96,091,758.08. Requiring dispensaries to provide no cost medical cannabis to Medicaid and VA Health Care System enrollees – using current Medicaid and veteran registration figures – would cost $37,576,812 in FY 2020. This low-end estimate represents nearly 40% of the gross revenue for medical cannabis sales during the past 12 months. Establishing a 20% discount would cost $7,515,362 in FY 2020, which represents 7.8% of the gross revenue. A 15% discount would cost $5,636,522 in FY 2020, or 5.8% of the gross revenue. By comparison, the programs in Washington D.C. and Berkeley, California require dispensaries to allocate 2% of the gross revenue to medical cannabis for qualifying low-income patients.

VII. Potential Funding Mechanisms

Pursuant to HB 2, the Commission identified potential funding mechanisms for the Compassionate Use Fund. Each of the proposals below would require regulatory and/or statutory authorization to implement.

(a) *Flat Fees*

The Maryland medical cannabis program has one hundred and two (102) licensed growers, processors, and dispensaries. An additional thirty-six (36) entities have received Stage-One pre-approval for licensing as a medical cannabis grower, processor, or Dispensary. Finally, the Commission has the authority to award up to an additional four (4) medical cannabis grower licenses, and ten (10) medical cannabis processor licenses. Therefore, the maximum total number of licenses currently allowed under law is one-hundred and fifty-two (152).

Table 4. Number of medical cannabis license holders and pre-approvals

License Category	License	Pre-Approval	Total
Grower	15	3	18
Processor	16	2	18
Dispensary	71	31	102

House Bill 2 restricts the Department from assessing fees until at least two years "immediately following the preapproval of the licensee for a license under this subtitle. The Commission issued the initial fifteen (15) grower and fifteen (15) processor pre-approvals in August 2016. The Commission issued one-hundred and two (102) dispensary pre-approvals in December 2016. As of July 1, 2019, a maximum of 132 growers, processors and dispensaries could be assessed fees to fund the Compassionate Use Fund. An additional 6 growers and processors could be assessed fees beginning in June 2020, and the yet-to-be awarded four (4) grower and ten (10) processor licensees could potentially be assessed fees beginning as early as July 2021. Table 5 below shows the fee per license holder to fund the Compassionate Use Fund beginning in FY 2020.

Dispensary revenue for Q1 of FY 2019 ranged from $380,000 to $1.9 million. Assessing a flat fee on all medical cannabis businesses could disproportionately impact Maryland small businesses. In other medical cannabis jurisdictions, fees are assessed based on a licensee's gross revenue. Therefore, the cost is directly linked to a licensee's ability to pay.

Important: The flat fees included in Table 5 are low-end estimates, because the fees are based on the percent of certified patients who are Medicaid or VA Health Care System enrollees remaining constant in FY 2020 through FY 2022 (i.e. 22.1% and 3.4%, respectively). The Commission anticipates that providing reduced cost or no cost medical cannabis to Medicaid and VA Health Care System enrollees will significantly increase the number of each who become certified medical cannabis patients. Since Maryland is the first medical cannabis jurisdiction to require price discounts for Medicaid and VA Health Care System enrollees, the Commission is unable to determine the impact that the discount will have on certified medical cannabis patient figures.

Table 5. Estimated flat fees per license holder.

	FY 2020	FY 2021	FY 2022
15% Discount	$42,701	$49,017	$51,733
20% Discount	$56,935	$65,356	$68,976
No Cost	$284,673	$326,781	$344,883.02

(b) *Percent of Gross Revenue*

The reduced cost programs implemented in Washington D.C. and Berkeley, California require medical cannabis dispensaries to allocate 2% of their annual gross revenue or product sold (by weight) to qualifying low-income patients. Rather than assessing fees or taxes on medical cannabis businesses, dispensaries are required to submit sales data biannually or annually. The gross revenue or product sold reported is used to determine the amount of revenue or product the dispensary must offer to qualifying patients. In addition, the authorizing ordinance establishes a minimum cost discount that each dispensary must provide (i.e. 20%).

The advantage of a "percent of gross revenue" program is that the cost is linked to a businesses' ability to pay. Therefore, small and rural dispensaries would not be subject to the same fees as larger businesses or those operating in more densely populated areas of the State. Dispensary gross revenue for Q1of FY 2019 ranged from $380,000 to $1,900,000. Assessing a flat fee across all licenses would disproportionately impact Maryland small businesses.

(c) *Tax Check-Off*

The Maryland tax return form enables taxpayers to contribute money to protect natural resources, support individuals with developmental disabilities, and support cancer research. Currently, individuals may contribute any amount to the Chesapeake Bay and Endangered Species Fund, Developmental Disabilities Services and Support Fund, Maryland Cancer Fund, and Fair Campaign Financing Fund. The amount contributed will either reduce an individual's state tax refund or increase the amount of additional state tax owed. Each contribution is tax deductible for the year it was made. Any money collected by the Comptroller is distributed to the designated fund, minus any costs associated with administering the tax checkoff program. Each tax checkoff program receives significant contributions each year. For instance, in FY 2016 $251,445 was contributed to the Maryland Cancer Fund.

A tax check off would likely not provide the revenue necessary to fund the Compassionate Use Fund, but would provide another potential funding mechanism. The General Assembly must authorize the Comptroller to include a tax checkoff for the Compassionate Use Fund on the state income tax return form.

(d) *Medical Cannabis Excise Tax*

The sale of medical cannabis in Maryland is not subject to an excise tax. Likewise, under the Tax-General Article, §11-211 the sale of medicine is exempt from the 6% sales and use tax. At least twelve (12) states levy an excise tax on the sale of medical cannabis. In at least four (4) additional states the sale of medical cannabis is subject to the state sales tax (Table 6). The excise tax rate in other medical cannabis states ranges from 1% to 37%. In addition, two states assess a $3.50 per gram tax on medical cannabis sales.

Table 6. State taxation rates on medical cannabis.

State	Medical Cannabis Tax
Arizona	6.6% excise tax
Arkansas	4% excise tax
Colorado	2.9% state sales tax
Connecticut	$3.50 per gram excise tax
Hawaii	4% state sales tax
Illinois	All sales subject to 1% pharmaceutical excise tax (dispensaries); 7% wholesale tax (cultivators)
Michigan	3% excise tax and 6% state sales tax
Minnesota	$3.50 per gram excise tax
Montana	2% excise tax
Nevada	2% excise tax
New Jersey	7% state sales tax
New York	7% excise tax
Ohio	5.75% state sales tax
Pennsylvania	5% wholesale tax
Rhode Island	4% excise tax and 7% state sales tax
Washington	37% excise tax (medical program merged with adult use program and subject to same tax rate)

The mean state medical cannabis excise tax rate is 7.56% and the median state medical excise tax rate is 5%. Table 7 below shows the projected tax revenue based on the medical cannabis gross revenue during the first year of program operation ($96, 091,758.08). An excise tax rate of 7.56% would provide $7,264,537 in revenue, which exceeds the anticipated revenue necessary to fund a 20% discount for Medicaid and VA Health Care System enrollees in FY 2020. An excise tax rate of 2% would provide projected revenue of $1,921,835, and an excise tax rate of 5% would provide projected revenue of $4,804,588. These revenue figures are less than the anticipated revenue necessary to fund the Compassionate Use Fund in FY 2020, but would enable the Department to provide reduced cost medical cannabis to a sizeable population of Medicaid and VA Health Care System enrollees.

Table 7. Excise tax rate revenue projections.

Excise Tax Rate	Projected Tax Revenue Based on Gross Revenue, 12/1/2017-11/30/2018
2%	$1,921,835
5%	$4,804,588
7.56%	$7,264,537

VIII. Anticipated Savings in Prescription Drug Costs

Due to federal restrictions on cannabis research, limited data exist on the impact medical cannabis laws may have on reducing prescription drug costs among Medicaid enrollees. Moreover, no published studies demonstrate that subsidizing medical cannabis costs for low-income patients will further reduce Medicaid prescription drug expenditures. This is likely due in part to no jurisdiction having implemented a reduced cost program of the size and scope of the Compassionate Use Fund. Existing data are summarized below.

- From 2011-2016, state implementation of medical cannabis laws was associated with a 5.88% reduction in opioid prescriptions among Medicaid enrollees. The study compared Medicaid prescription data between states with medical cannabis laws and those without during the relevant period. (H. Wen and J.M. Hockenberry, *Association of Medical and Adult-Use Marijuana Laws With Opioid Prescribing for Medicaid Enrollees*, JAMA Intern Med. 2018;178(5):673-679).
- From 2007-2014, the use of prescription drugs (not exclusive to opioids) in fee-for-service Medicaid was lower in states with medical marijuana laws than in states without such laws in five of the nine broad clinical areas examined. It showed a 17% reduction in drugs used to treat nausea, a 13% reduction in drugs used to treat depression, a 12% reduction for drugs used to treat psychosis and seizure disorders, and an 11% reduction in drugs used to treat pain. There was no association between Medicaid drugs used for anxiety, glaucoma, sleep disorders or spasticity and medical cannabis. See A.C. Bradford and W.D. Bradford, *Medical Marijuana Laws May Be Associated With A Decline In The Number Of Prescriptions For Medicaid Enrollees*, Health Affairs, 2016; 36(5):945-951.

- From 1993-2014, medical cannabis legalization was associated with a 29.6% reduction in the number of Schedule III opioid prescriptions. No association was found between medical cannabis legalization and reduction in Schedule II opioid prescriptions. The authors estimated that if all 50 states had legalized medical cannabis by 2014 annual Medicaid expenditures on prescription opioids would be reduced by $17.8 million per year. (D. Liang et al., *Medical cannabis legalization and opioid prescriptions: evidence on US Medicaid enrollees during 1993–2014*, Addiction, 2018 Nov;113(11):2060-2070).

The 2018 *Addiction* study concluded that if all fifty (50) states had legalized medical cannabis by 2014 annual Medicaid expenditures in the United States would be modestly reduced by $17.8 million, with $7.78 million in savings for state governments. While this study did not contemplate a reduced cost program for Medicaid enrollees, data clearly demonstrate that medical cannabis laws generally do not result in substantial Medicaid prescription drug savings.

IX. Conclusion

Cannabis remains a Schedule I drug under the federal Controlled Substances Act, which means private health insurance, Medicaid, and Medicare do not reimburse patients who use the drug. HB 2 established the Compassionate Use Fund to address this insurance gap and provide reduced cost or no cost medical cannabis to Medicaid and VA Health Care System enrollees. Currently, only the District of Columbia and Vermont require dispensaries to provide reduced cost medical cannabis to low-income patients, and the patient population in each jurisdiction is 1/10th the current Maryland patient registry.

The revenue necessary to provide Medicaid and VA Health Care System enrollees with even modest price reductions is substantial. The Compassionate Use Fund would require at least $5.6 million in FY 2020 to provide a 15% discount, and $7.5 million to provide a 20% discount to Medicaid enrollees and veterans, based on current patient enrollment figures. Wholly subsidizing medical cannabis would require at least $37.5 million in FY 2020. In comparison, the gross revenue for December 1, 2017 to November 30, 2018 was $96,091,758. Due to existing licensing fees ($40,000 per year for dispensaries and processors, and $125,000 for growers) and the heavy federal tax burden carried by medical cannabis business, it may be difficult for license holders to fund the Compassionate Use Fund without significantly increasing retail prices.

The Commission identified four potential funding mechanisms for the Compassionate Use Fund: (1) flat fee, (2) percent of gross revenue, (3) tax checkoff, and (4) cannabis excise tax. Each funding mechanism would require additional legislation or regulations to implement. Other states most commonly levy a cannabis excise tax or require a percent of gross revenue in order to provide reduced cost or no cost medical cannabis, or otherwise fund the medical cannabis program.

Due to federal restrictions on cannabis research and no other state having implemented a program of the size and scope of the Compassionate Use Fund, limited data exist on whether and how prescription drug expenditures may be affected. However, recent studies suggest that expanded access to medical cannabis generally results in only a modest reduction in Medicaid prescription drug expenditures.

Appendix A

Reduced Cost Programs in Other Medical Cannabis Jurisdictions

Berkeley, California

12.27.080 Medical cannabis for low income Members

A. At least 2% (by weight) of the annual amount of Medical Cannabis in dried plant form provided by a Dispensary to all Members, shall be provided at no cost to very low income Members who are Berkeley residents. This amount shall be calculated every six months, based on the amount dispensed during the immediately preceding six months. Medical Cannabis provided under this Section shall be the same quality on average as Medical Cannabis that is dispensed to other members.

B. For purposes of this Section, income shall be verified using federal income tax returns or other reliable method approved by the City Manager.

C. For purposes this Section, "very low income" shall mean the household income established by the most recent annual City Council resolution that establishes the maximum income levels for qualification for exemption from specified local taxes and fees.

District of Columbia

22-C6300 DCMR

6300 SLIDING SCALE PROGRAM

6300.1 A registered dispensary shall devote two percent (2%) of its annual gross revenue to provide medical marijuana on a sliding scale to qualifying patients determined eligible pursuant to § 1300.4 of this subchapter.

6300.2 Not later than February 15th of each calendar year, each registered dispensary in the District of Columbia shall submit to the Director:

(a) A statement of its gross revenues for the previous calendar year;

(b) A statement detailing how the dispensary devoted two percent (2%) of its annual gross revenue to eligible qualifying patients on a sliding scale, which shall include:

(1) The name, patient registration number, and date of dispensing for each patient who received medical marijuana on a sliding scale during the previously calendar year; and

(2) The discounted amount provided to patients under this program; and

(c) An attestation, made under penalty of perjury, of the accuracy and truthfulness of the statements submitted pursuant to this subsection.

6300.3 A qualifying patient who establishes pursuant to § 1300.4 of this subchapter that his or her income is equal to or less than two hundred percent (200%) of the federal poverty level, shall be entitled to purchase medical marijuana directly, or through a caregiver, on a sliding scale from a registered dispensary in the District of Columbia.

6300.4 A registered dispensary shall sell medical marijuana to a qualifying patient, who is registered to purchase medical marijuana on a sliding scale, and possesses a registration card denoting such, at a discount of not less than twenty (20%) of its regular retail price.

6300.5 Not later than April 15th of each calendar year, the Department shall review the sliding scale program. As part of its review, the Department may adjust the percentage required to be devoted by dispensaries and the required discount to qualifying patients.

6300.6 The gross revenue amount to be devoted by each dispensary to the sliding scale program shall be subject to audit by the Department.

6300.7 In addition to any other applicable sanctions, any dispensary that fails to comply with the provisions of this chapter shall be subject to a civil fine under the Civil Infractions Act of two thousand dollars ($2,000.00) per offense, and each day of violation shall constitute a separate offense.

6300.8 Notwithstanding Subsection 6300.7 of this chapter, the Director may revoke the registration of a dispensary that commits egregious or multiple violations of this chapter; that uses fraud to conceal its annual gross revenue; or that submits false or misleading reports to the Director.

Vermont

Vt. Admin. Code 17-2-3:6. Registered Dispensary

6.1.4 Shall implement and operate a sliding-scale fee system that takes into account a registered patient's ability to pay.

Appendix B

Written comment submitted by medical cannabis businesses

(See Next Page)

The Maryland Medical Dispensary Association (MDMDA) was established in May, 2017 in order to promote the common interests and goals of the Medical Cannabis Dispensaries in Maryland. MDMDA advocates for laws, regulations and public policies that foster a health, professional and secure medical cannabis industry in the State. MDMDA works on the State and local level to advance the interest of licensed dispensaries as well as to provide a forum for the exchange of information in the Medical Cannabis Industry.

Since dispensaries are the face of the cannabis industry for patients, we are very aware that there are patients who struggle to purchase medical cannabis needed to treat their particular conditions. Most dispensaries in Maryland already offer a number of ways to assist these patients in receiving medical cannabis.

Discounts are one way that dispensaries currently help patients afford the cost of medicine. Every dispensary already offers different kinds of discounts, but all dispensaries offer veterans discounts. The amount of this discount can vary from 10-22%, and there are many dispensaries that continue to offer 22% to all veterans in recognition of the 22 veterans who commit suicide each day.

Many dispensaries also offer a compassion discount, called different names by different dispensaries. This discount is applied to those with terminal diagnoses, those struggling financially, minor patients, and more. This discount usually ranges between 10-25%. Some dispensaries offer bulk discounts. For example, one dispensary offers cancer patients RSO at $5 above cost if a patient purchases at least 10. However, as the industry has grown and continues to grow, pricing pressure has significantly increased as the number of out of state corporate owners has increased. Discounts of 20-25% results in the dispensary selling at or below cost due to the small margins, effect of 280E and overhead.

While thinking about the best ways to fund the compassion fund required by HB2, it is important to remember that dispensaries have limited control over price. Growers and processors who manufacture the products set prices when a product is sold to a dispensary. The margin necessary to cover costs varies greatly across the state and depends on factors such as dispensary location, salary and amount of staff. That pressure increases even more on the locally owned independent dispensaries as some vertically integrated growers/processors sell directly to consumers at wholesale prices.

Lastly, we also feel this program could inadvertently lead to diversion. Providing medical cannabis to patients at a cost well below the market rates could create an incentive for patients to resell medical and foster the black market which we are attempting to eliminate.

Thank you for keeping these important points in mind as you continue to give thought to the framework of a compassionate care program.

Commissioner Brian Lopez, Chair
Executive Director Joy A. Strain, MHA
Maryland Medical Cannabis Commission
849 International Drive Suite 450,
Linthicum, MD 21090

October 30, 2018

Re: § 13-3303.1. Natalie M. LaPrade Medical Cannabis Compassionate Use Fund

FAVORABLE

Dear Chair Lopez and Executive Director Strain,

This letter is written on behalf of Mary and Main Dispensary located in Prince George's county. Mary and Main is 100% African American, Women, Disabled Veteran owned. Mary & Main's mission is to provide safe and premium quality products with exemplary and compassionate services to all medical patients who are suffering from a number of chronic debilitating illness.

In keeping with its mission, Mary & Main supports the establishment of the Compassionate Use Fund.

Medical Cannabis is not covered by health insurance. Since it is not approved by the U.S. Food and Drug Administration as a medicine, private and federal insurance programs will not cover it. Marijuana also remains classified as a Schedule I drug by the U.S. Drug Enforcement Administration, meaning it has been deemed as having no medical use and a high potential for abuse.

The fact remains that medical cannabis has been documented to improve the quality of life of those suffering with anxiety, post-traumatic stress disorder, chronic pain and other health issues. A glaring issue remains: Those who may benefit the most from Maryland's medical cannabis program may not be able to shoulder the costs. Participation in the program is extremely expensive, especially if you're living on Social Security and disability benefits.

Due to the extremely high cost of medical cannabis, we ask that consideration is given to allow dispensaries to receive financial support or reimbursement under the fund for discounts given to the following:

Veterans 22%. There currently is an initiative in the state to give a 22% discount on the price of medical cannabis to veterans, in an effort to address PTSD. PTSD is a leading cause of suicide among veterans. Due to the steep wholesale costs and 280E restrictions on writing off expenses, participation in the 22% program is very costly to dispensaries. Mary & Main would like to offer the discount but assistance (reimbursement) from the fund is needed.

Pediatrics. Ill Children in the program may be considered the most vulnerable and their parents or care takers should not have to decide between medicine or putting food on the table, due to the high cost of medical cannabis. Cost should not prevent these sick patients from accessing medicine. Dispensaries should be reimbursed under the fund for discounts provided to children in need.

Hospice- Those in hospice care benefit greatly from use of medical cannabis. Terminally ill patients should not let the high cost of medical cannabis prevent them from accessing their medicine. Dispensaries should be reimbursed under the fund for discounts provided to those in hospice care.

Low Income Patients-Since buying medical cannabis is an out of pocket expense, low income patients will benefit greatly from any discounts provided. We suggest low income patients must provide proof of eligibility to determine their economic status by some method of documentation (w2 pay stubs, or other qualifying documentation).

Educational Material and Classes- The key to Maryland's medical Cannabis program's growth lies within education. Dispensaries have the most direct access to patients and potential patients and therefore should be aided in their educational outreach efforts. A grant or other finical support should be provided to dispensaries from the fund to aid in educational outreach efforts.

It is our hope that these written comments will help in the development of the Natalie M. LaPrade Medical Cannabis Compassionate Use Fund. We thank you for the opportunity to submit these comments.

Please feel free to contact me if any questions

Respectfully yours,

Bryan Alston
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