

Medical Marijuana in California: An Analysis of the 2015 Legislation

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ALERT

Local jurisdictions should be aware of a critical deadline included in the medical marijuana legislation described in this Issue Briefing. **The state will exercise exclusive jurisdiction over the licensing of medical marijuana cultivation in those cities and counties that do not regulate or prohibit cultivation by March 1, 2016.**¹

As described in more detail herein, the legislation includes only minimal state standards regarding the location of cultivation, the size of cultivation sites, measures for limiting their impacts on surrounding properties and neighborhoods, among other public health and safety concerns. Local legislation that augments the state's requirements can effectively address these policy topics. Local government action to protect its authority to regulate medical marijuana cultivation is therefore urged by the March 1, 2016 deadline.

I. INTRODUCTION

On October 9, 2015, Governor Brown signed into law Assembly Bill 266,² Assembly Bill 243,³ and Senate Bill 643,⁴ which together establish a framework for regulating medical marijuana.⁵ The Compassionate Use Act of 1996, a voter initiative, decriminalized medical marijuana under state law (although not affecting marijuana's continued illegality under federal law). The state has provided little guidance since its passage regarding marijuana cultivation, availability, product quality, environmental impacts, marketing, and requirements for obtaining medical approval for usage. With the lack of state oversight, a profitable, largely unregulated industry has developed, with cities and counties struggling to enact a patchwork of local policies to address the resulting public health, safety, and environmental problems. This in turn has created confusion for patients, law enforcement, marijuana growers, dispensary operators as well as litigation over the extent of local authority to regulate various cannabis activities.

The new legislation seeks to address this confusion. Although it is directed at medical marijuana, it establishes a framework that includes components that may serve as a foundation for a potential voter initiative to legalize marijuana use generally. The language in the bills is suggestive of this tacit purpose, as they refer to "commercial cannabis activity." This contrasts sharply with the current legal structure, which requires medical marijuana cultivation and distribution to be handled by non-profit organizations.⁶

Although there is some repetition between the three interlocking bills, they fall generally into three distinct regulatory arenas:

- AB 266 establishes a Bureau of Medical Marijuana Regulation to oversee licensing and operating rules for marijuana growers, product producers, and retailers.

- AB 243 authorizes the state to use licensing fees to carry out the framework and a fund for helping local governments address environmental problems associated with cultivation.
- SB 643 addresses medical clinics that specialize in issuing medical marijuana recommendations to patients without valid health needs and creates standards for labeling products.

This report analyzes the implications of these three bills for public health and safety. The Ventura County Behavioral Health Department (VCBH) previously published an issue briefing entitled: *Protecting our Youth: Options for Marijuana Regulation in California*,⁷ which proposes a set of guidelines for reducing public health problems, particularly as they relate to young people. The briefing is based on a comprehensive review of the research literature, including an assessment of experiences in alcohol policy that may be applicable to marijuana regulation. This report uses as a benchmark VCBH’s *Protecting our Youth* issue briefing for its analysis.

The three bills cover a wide range of issues and industry practices. The primary focus here is on those provisions which address industry structure, cultivation, distribution, sales practices and restrictions, taxes, and local control of commercial cannabis operations, topics that the research literature suggests should be of particular concern for public health prevention practitioners.⁸ Provisions related to environmental protection, product testing criteria, and labor relations are not included.

II. SUMMARY OF NEW LEGISLATION

A. INDUSTRY STRUCTURE

1. Creates a Tiered System

The legislation creates a tiered, commercial industry. There are seventeen (17) specific license types, which can be grouped into the following categories⁹:

- Cultivation
- Manufacturer
- Testing
- Dispensary
- Distribution
- Transporter

The process by which commercial medical cannabis will reach a patient is: (1) cultivation;¹⁰ (2) manufacturing (if being turned into another product type);¹¹ (3) transport from a cultivator or manufacturer to a distributor for inspection and testing;¹² (4) transport to a dispensary; and (5) sale to patient (either in the dispensary or through a delivery).¹³ Mobile dispensaries are required to have a business address. This will likely result in current mobile delivery businesses partnering with a dispensary.

2. Restricts Vertical Integration

Small cultivators, manufacturers, and dispensaries with Type 10A licenses are permitted to engage in at least two of the three tiers.¹⁴ A Type 10A dispensary licensee can hold both a manufacturer’s and cultivator’s license if the total canopy size of all its cultivation does not exceed four acres.¹⁵ A distribution licensee must apply for a transporter license; transporter licensees may apply for a distribution license but are not required to do so. Distribution licensees are not permitted to hold any other type of license. Testing licensees are prohibited from holding any other type of license.¹⁶ Operators are limited from holding financial interests in assets used in license categories other than those that they already hold and are prohibited from holding an alcoholic beverage retail license.^{17, 18}

3. Restricts Horizontal Integration and Number of Licenses

Cultivator licenses are divided into four basic types: (1) specialty (5,000 square feet or less total canopy size on one premise or parcel or up to 50 mature plants on noncontiguous plots); (2) small (5,001 – 10,000 square feet); (3) medium (10,001 square feet to one acre for outdoor; 10,001 – 22,000 for indoor); and (4) nurseries (no limits on square footage).¹⁹ Each of the first three categories is further subdivided into outdoor, indoor, and mixed-light. There are two levels of manufacturing licenses differentiated by whether the licensees use volatile solvents. The Department of Public Health is charged with limiting the number of Manufacturer level 2 licenses (those that use volatile solvents), although no specifications are provided.²⁰ There are also two types of dispensary/retail licenses, Type 10 and Type 10A. A Type 10A license permits operation of up to three retail sites.²¹ This limitation does not apply to Type 10 dispensary licenses. However, unlike Type 10A licensees, Type 10 licensees cannot obtain a cultivation or manufacture license (see above). There do not appear to be any limitations on the number of licenses of the same type a single individual or entity can hold.

4. Exempts Personal Use Cultivation and Distribution²²

An individual is exempt “if the area he or she uses to cultivate marijuana does not exceed 100 square feet and he or she cultivates marijuana for his or her personal medical use and does not sell, distribute, donate, or provide marijuana to any other person or entity.”

A primary caregiver²³ is exempt:

“... if the area he or she uses to cultivate marijuana does not exceed 500 square feet and he or she cultivates marijuana exclusively for the personal medical use of no more than five specified qualified patients for whom he or she is the primary caregiver.... and does not receive remuneration for these activities, except for compensation provided in full compliance with subdivision (c) of Section 11362.765.”²⁴

The exemptions described above:

“... shall be measured by the aggregate area of vegetative growth of live marijuana plants on the premises [and do] not limit or prevent a city, county, or city and county from regulating or banning the cultivation, storage, manufacture, transport, provision, or other activity by the exempt person, or impair the enforcement of that regulation or ban.”

These licensing regulations establish a basic structure for the medical cannabis industry. As discussed below, local governments can develop complementary provisions to impose more stringent requirements regarding vertical and horizontal integration and the exemptions for personal use.

B. ROLE OF STATE AND LOCAL GOVERNMENTS

1. State Government

The government will not be directly involved with the production, distribution, or sale of medical cannabis. Instead the government will license operators to engage in these activities. The Bureau of Medical Marijuana Regulation is created within the Department of Consumer Affairs and serves as the primary state regulatory agency.²⁵ The Department of Food and Agriculture, Department of Pesticide Regulation, the Department of Public Health, the Department of Fish and Wildlife, the State Water Resources Control Board, and the Medical Board of California also have regulatory responsibilities. Protection of the public shall be the highest priority for the bureau in exercising its licensing, regulatory and disciplinary functions. Whenever there is a conflict between protecting the public and other interests, protection of the public will be paramount.²⁶ An advisory committee may be convened by the bureau and may include members from industry, the government, and public health, among other interest groups.²⁷

2. Local Governments – No State Preemption

A dual licensing/permitting system is created. An operator must maintain both a state and local license/permit, revocation of one will result in revocation of the other. City and counties may adopt ordinances establishing additional standards, requirements, and regulations that must be at least as strict as those established by state law.²⁸ Local governments may prohibit cultivation.²⁹ If a local government does not enact a licensing/permitting system or “... have land use regulations or ordinances regulating or prohibiting the cultivation of marijuana, either expressly or otherwise under principles of permissive zoning,” then only a state license is required.³⁰

In addition, a local government may forfeit its local authority to regulate medical marijuana cultivation if it does not ban or enact regulations related to cultivation by March 1, 2016. The relevant provision states:

“If a [local jurisdiction] does not have land use regulations or ordinances regulating or prohibiting the cultivation of marijuana, either expressly or otherwise under principles of permissive zoning, or chooses not to administer a CUP program pursuant to this section, then commencing March 1, 2016, the division shall be the sole licensing authority for medical marijuana cultivation applicants in that [local jurisdiction].”³¹

The impact of this provision is uncertain for at least three reasons. First, it gives the state sole licensing authority over cultivation should the local government fail to act, but it is unclear whether the local government forfeits its land use authority. Second, the phrase “either expressly or otherwise under principles of permissive zoning” is not defined and is subject to diverse interpretations. Third, it appears to contradict a complementary provision that apparently grants local governments authority over all aspects of the medical marijuana trade without qualification.³² The prudent course in these circumstances is to assume that local jurisdiction will be substantially restricted unless a local prohibition, regulation or CUP program is enacted prior to the statutory deadline.

Enforcement of local zoning requirements is expressly permitted.³³ Local governments can impose both fees and taxes (see below). The bills are silent as to whether a local government can directly control cultivation, distribution, or retail operation, although the definitions of those that may apply for licenses would appear to include a local governmental agency.³⁴

C. REGULATORY REQUIREMENTS

1. Regulates Marijuana Products

Products include smokable marijuana, edible marijuana and marijuana concentrates.³⁵ “Edible cannabis product” means manufactured cannabis that is intended to be used, in whole or in part, for human consumption, including, but not limited to, chewing gum.³⁶ An edible medical cannabis product is not considered food as defined by Section 109935 of the Health and Safety Code or a drug as defined by Section 109925 of the Health and Safety Code. The Department of Public Health shall develop standards for the production and labelling of edible cannabis products.³⁷ “Cannabis concentrate” means manufactured cannabis that has undergone a process to concentrate the cannabinoid active ingredient, thereby increasing the product’s potency.³⁸ All medical cannabis products shall be tested for quality assurance, concentration and contaminants. Testing shall be done by independent registered laboratories.³⁹ A certificate of analysis shall be issued for each lot of medical cannabis that is tested, and contain certain specific information.⁴⁰

2. Requires Special Labeling on Packages

A. Prior to delivery or sale at a dispensary, medical cannabis products shall be labeled and in a tamper-evident package. Labels and packages of medical cannabis products shall meet the following requirements:

- (1) Medical cannabis packages and labels shall not be made to be attractive to children.

- (2) All medical cannabis product labels shall include the following information, prominently displayed and in a clear and legible font:
- (a) Manufacture date and source.
 - (b) The statement “SCHEDULE I CONTROLLED SUBSTANCE.”
 - (c) The statement “KEEP OUT OF REACH OF CHILDREN AND ANIMALS” in bold print.
 - (d) The statement “FOR MEDICAL USE ONLY.”
 - (e) The statement “THE INTOXICATING EFFECTS OF THIS PRODUCT MAY BE DELAYED BY UP TO TWO HOURS.”
 - (f) The statement “THIS PRODUCT MAY IMPAIR THE ABILITY TO DRIVE OR OPERATE MACHINERY. PLEASE USE EXTREME CAUTION.”
 - (g) For packages containing only dried flower, the net weight of medical cannabis in the package.
 - (h) A warning if nuts or other known allergens are used.
 - (i) List of pharmacologically active ingredients, including, but not limited to, tetrahydrocannabinol (THC), cannabidiol (CBD), and other cannabinoid content, the THC and other cannabinoid amount in milligrams per serving, servings per package, and the THC and other cannabinoid amount in milligrams for the package total.
 - (j) Clear indication, in bold type, that the product contains medical cannabis.
 - (k) Identification of the source and date of cultivation and manufacture.
 - (l) Any other requirement set by the bureau.
 - (m) Information associated with the unique identifier issued by the Department of Food and Agriculture pursuant to Section 11362.777 of the Health and Safety Code.

B. Only generic food names may be used to describe edible medical cannabis products.⁴¹

3. Imposes Certain Requirements on Cultivators and Manufacturers

The Department of Food and Agriculture shall establish procedures for the issuance and revocation of unique identifiers for activities associated with a marijuana cultivation license.⁴² Various restrictions are placed regarding water conservation and pesticide use.⁴³ The Department of Food and Agriculture shall limit the total number of medium cultivation licenses, although limits are not specified.⁴⁴ Cultivation sites shall not be located within 600 feet of any school.⁴⁵ The Department of Public Health shall promulgate regulations governing the licensing of cannabis manufacturers.⁴⁶

4. Imposes Certain Requirements on Dispensaries

Dispensaries cannot be located within 600 feet of any school.⁴⁷ The dispensary definition does not appear to prohibit on-premise consumption, although this may be a matter of statutory interpretation.⁴⁸ Security measures are required to both deter and prevent unauthorized entrance into the dispensary and to prevent theft.⁴⁹

5. Restricts Advertising Practices of Recommending Physicians

Advertising for physician recommendations shall bear a notice regarding the legal requirements for obtaining such a recommendation. Price advertising regarding receiving a physician recommendation shall not be fraudulent, deceitful, or misleading, including statements or advertisements of bait, discounts, premiums, gifts, or statements of a similar nature.⁵⁰

D. TAXES AND FEES

1. Permits Local Taxation

Counties may impose a tax on the privilege of cultivating, dispensing, producing, processing, preparing, storing, providing, donating, selling, and distributing medical cannabis. The tax may be imposed regardless of whether the activity is taken individually, collectively, or cooperatively, and regardless of whether the activity is for compensation or gratuitous. The tax is subject to applicable voter approval.^{51,52}

2. Imposes State Fees and Permits Local Fees

Local governments retain the power to impose taxes and fees on business activities of licensees.⁵³ State agencies shall establish a scale of application, licensing, and renewal fees, based upon the cost of enforcing the new law.⁵⁴ The Medical Marijuana Regulation and Safety Act Fund is established for collecting fees as well as fines and civil penalties. The Director of Finance has the authority to provide a \$10 million operating loan to the fund.⁵⁵ The Fund may also fund a grant program to assist with enforcement of the new law and other relevant state and local laws and to fund local and state agencies and law enforcement to remedy the environmental impacts of cannabis cultivation.⁵⁶

E. IMPLEMENTATION SCHEDULE

Because implementing the licensing program will take time, facilities operating in compliance with local ordinances prior to January 1, 2018 may continue to do so. While the language in the law is unclear, it seems to suggest that this continued operation requires that an application been submitted to the licensing authority. The licensing authority is required to prioritize issuing licenses to those entities that can demonstrate that they were in operation and in good standing with the local jurisdiction by January 1, 2016.⁵⁷

III. ANALYSIS: PUBLIC HEALTH AND SAFETY CONSIDERATIONS

A. OVERVIEW

The new legislation carries three primary themes:

1. It establishes an orderly structure for the commercialization of medical marijuana, with an industry and regulatory structure that can serve as a basis for possible full legalization. Commercial firms are likely to grow and thrive financially in this new system.
2. Public health concerns are largely limited to insuring the safety of the marijuana products. The product safety provisions complement the sections on environmental protection and the integrity of the doctor recommendation process. The most striking aspect of the three bills from a public health perspective is what is lacking – major public health issues are simply ignored or delegated to state agency oversight.
3. The state is largely delegating to local governments the responsibility of addressing public health and safety concerns beyond those related to product quality, illegal production, and product tracking.

Each of these themes is discussed in more detail on the following pages.

B. ESTABLISHING AN ORDERLY COMMERCIAL MEDICAL MARIJUANA STRUCTURE THAT WILL LIKELY RESULT IN A HIGHLY PROFITABLE, CONSOLIDATED INDUSTRY

As described above, the legislation establishes a complex set of licensing provisions that are designed to ensure that a safe product reaches the market through a tiered industry structure. *It does not, however, adequately protect against industry consolidation into large, highly profitable commercial enterprises.* As demonstrated in the experience with the alcohol and tobacco industry, such a commercial system puts public health priorities at risk because of the undue influence these large enterprises can have over the legislative and regulatory process.⁵⁸

Careful examination of the new legislation highlights this problem. Regarding the cultivation/manufacturing tier, the amount of cultivation that is authorized under a single license is limited to some degree (no more than one acre); there do not appear to be any limits on the number of licenses a single individual or entity can hold. If this is the case, cultivation is likely to be controlled in a shrinking number of larger growers over time, holding multiple licenses. There are also no controls over whether acreage held by separate licenses can be contiguous. Thus, it appears that large cultivation sites (consisting of many acres) can be created by obtaining multiple cultivation licenses and locating them next to each other.

On the retail side, limiting Type 10A dispensary licensees to operating only three retail outlets will reduce the development of large retail firms, although this limitation does not apply to Type 10 dispensaries. Large chains of retailers can therefore occur if they hold Type 10 licenses, although such an enterprise would not be permitted to hold cultivation or manufacturing licenses.

The production (cultivators and manufacturers) and retail tiers are not adequately separated. A single entity or individual can hold licenses to both produce and retail (although, as noted above, the retail side of the business would be limited to three retail outlets). This will also encourage consolidation in the industry into a smaller number of large commercial entities over time. The legislation does keep the distribution/transportation tier of the industry separate from the other tiers, which offers at least some protection for domination of the market by a small consortium of large enterprises.

In sum, the legislation establishes an orderly system in which the growing marijuana industry may operate. It appears that larger firms will have a distinct advantage in the system because of the costs associated with complying with the regulations that ensure quality, purity and environmental safety standards. The firms that successfully operate in the new system are likely to expand over time and become highly profitable. This will be dependent to some degree on whether state and local governments have adequate resources and resolve to identify and prosecute illegal growers, distributors, and retailers. Based on the experience with the alcohol and tobacco industries, this burgeoning industry is likely to become a powerful lobby in the state legislature, crafting legislation that protects their interests, expands the market, and enhances profitability over time.⁵⁹ As with alcohol and tobacco products, this may be done with little regard to the public health and safety costs to local communities. It also represents a radical departure from the current system, which requires all participants in the market to operate in a not-for-profit manner.

NOTE REGARDING THE PERSONAL USE EXEMPTION

One caveat to this overall assessment is the fact that cultivation for personal use by individuals and caregivers is so generous. Individual patients can cultivate up to 100 square feet of marijuana; caregivers can grow up to 500 square feet of marijuana for up to five patients. These limits may encourage the cultivation of large volumes of excess marijuana that go far beyond the likely consumption of one to five individuals.⁶⁰ The excess production may encourage a black market that will be difficult to detect since personal and caregiver cultivation is legal and outside the regulatory structure. This may in turn undercut the industry operating within the new regulatory system.

The legislation thus ignores central lessons from alcohol and tobacco policy, which include:

1. Restrict the production and retail tiers in a manner that promotes responsible, small business operations, e.g., by limiting the size and number of companies, prohibiting the accumulation of licenses by single individuals or corporations, and prohibiting license transfers;
2. Establish and strictly enforce a three-tier industry structure, keeping each tier separate from the others, and exercising direct state control over at least the distribution/wholesaling tier; and
3. Limit the retail tier to not-for-profit organizations, as is currently the case with medical marijuana dispensaries.

C. THE NEW LEGISLATION LARGELY IGNORES PUBLIC HEALTH AND SAFETY CONCERNS BEYOND THOSE RELATED TO PRODUCT PURITY AND THE INTEGRITY OF THE MEDICAL RECOMMENDATION PROCESS

Lessons from alcohol policy point to the importance of regulating the four “P’s” of marketing – product, place, price, and promotion – as a means to protect public health and safety, including youth consumption.⁶¹ The legislation is striking in its lack of attention to these variables. There are no statutory limits on the products that may be produced. This contrasts sharply with the legislation’s detailed restrictions related to product purity and environmental protection. Instead, the Department of Public Health is to develop standards through the regulatory process. Labelling requirements are included that address some public health concerns. There are no “place” restrictions other than a 600 foot rule applied to schools, an apparent prohibition of on-premise consumption, and provisions related to security. Retail and cultivation location and density are not restricted except for the distance limit from schools. In addition, the exceptions for personal cultivation by both individuals and caregivers are likely to greatly expand medical marijuana’s availability. No guidance is provided regarding in-store management practices or other proven prevention strategies used in tobacco and alcohol sales.

The legislation does not assert direct state control over either the distribution or retail tiers of the industry, a successful public health strategy in alcohol policy for reducing problems associated with retail availability. It is possible, although not explicitly stated, that local governments might exercise this form of control, through government operation of a distributor or dispensary license. This could be done either by a local agency or by a contractor reporting to a local agency. (However, the fact that marijuana is illegal under federal law is likely to discourage direct government involvement in the marijuana industry.)

Price variables are also largely ignored. State fees are to be set based on the cost of implementing and enforcing the new law. New state taxes that could serve as prevention tools are not included, and there are no restrictions on price promotions. Nor are there any advertising restrictions except a general provision applicable to physicians promoting their ability to provide medical marijuana recommendations. Funding for counter-advertising to offset the likely increase in pro-marijuana messages is also lacking.

The legislation thus ignores significant lessons from alcohol policy designed to reduce public health problems associated with marijuana use, particularly for young people. These include:

1. Establishing and enforcing a strict 21-year marijuana furnishing, use, and possession age limit;
2. Limiting sales of products that are attractive to young people or put them at heightened risk of harm;
3. Restricting marketing and advertising practices that appeal to youth;
4. Keeping marijuana prices artificially high, although not too high to foster underground market and covert cultivation;

5. Strictly limiting the number, type, location, and sales practices of marijuana retail outlets; and
6. Deterring public nuisance activities associated with retail outlets.⁶²

As discussed above, the establishment of a commercial medical marijuana industry that is likely to become highly concentrated, controlled by a relatively small number of large entities will likely undermine public health measures. A strong industry lobby will likely promote expanded marketing practices. Without funding for community action groups (similar to the funding provided to local tobacco advocacy organizations through Proposition 99), public health advocates will face a daunting task in countering these industry political initiatives at both the state agency and state legislative level.

D. STATE RELIANCE ON LOCAL CONTROL TO PROTECT PUBLIC HEALTH AND SAFETY

The new legislation does recognize one critical lesson from alcohol and tobacco policy: the importance of protecting local authority and limiting state preemption.⁶³ It explicitly authorizes local regulations to protect public health and safety.

In general, local authority is likely to be most effective when operating within a comprehensive state statutory structure that provides basic guidelines for addressing marijuana availability (including restrictions on youth availability), marketing, taxation, and product development. This ensures a baseline of public health protections that can be further restricted by local governments, developing new and innovative prevention strategies to complement the state controls.⁶⁴ States can also provide leadership in developing new prevention initiatives, promoting local action, conducting evaluations of the impact of various regulatory measures, and coordinating and funding local enforcement and compliance.

The new legislation's abdication of these functions (except in the area of local law enforcement) will make local governments' role in public health-oriented medical marijuana regulation more difficult. Local leadership in developing practical, effective local ordinances to regulate industry structure, practices and marketing will be critical and should be treated with a sense of urgency in light of the rapidly changing legal environment. Acting with a sense of urgency is particularly important regarding local regulation or bans of medical marijuana cultivation. As discussed above, the state gains exclusive authority to license cultivation in local jurisdictions that do not enact cultivation provisions by March 1, 2016. Collaboration across cities and counties will be essential to promote dissemination of effective strategies, avoid duplication of effort, and discourage reliance on strategies that are shown to be ineffective.

REFERENCES

- ¹ A.B. 243, 2015-2016, Reg. Sess., Health & Safety § 11362.777(c)(4) (Cal. 2015).
- ² Available at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB266.
- ³ Available at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB243.
- ⁴ Available at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB643.
- ⁵ The terms marijuana and cannabis are used interchangeably.
- ⁶ See California Attorney's General "Guidelines for the Security and Non-Diversion of Marijuana Grown for Medical Use" (2008). Available at http://ag.ca.gov/cms_attachments/press/pdfs/n1601_medicalmarijuanaguidelines.pdf. See also California Senate Bill 420 (2003). Available at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=200320040SB420.
- ⁷ Mosher, J. Protecting our Youth: Options for Marijuana Regulation in California. Oxnard, CA: Ventura County Behavioral Health Department, April 2015.
- ⁸ Babor, T., Caetano R., Casswell S., et al. (2010). Alcohol: No ordinary commodity (2nd ed.). New York, NY: Oxford University Press.
- ⁹ A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. § 19300.7 (Cal. 2015). License classifications pursuant to this chapter are as follows:
 - (a) Type 1 = Cultivation; Specialty outdoor; Small.
 - (b) Type 1A = Cultivation; Specialty indoor; Small.
 - (c) Type 1B = Cultivation; Specialty mixed-light; Small.
 - (d) Type 2 = Cultivation; Outdoor; Small.
 - (e) Type 2A = Cultivation; Indoor; Small.
 - (f) Type 2B = Cultivation; Mixed-light; Small.
 - (g) Type 3 = Cultivation; Outdoor; Medium.
 - (h) Type 3A = Cultivation; Indoor; Medium.
 - (i) Type 3B = Cultivation; Mixed-light; Medium.
 - (j) Type 4 = Cultivation; Nursery.
 - (k) Type 6 = Manufacturer 1.
 - (l) Type 7 = Manufacturer 2.
 - (m) Type 8 = Testing.
 - (n) Type 10 = Dispensary; General.
 - (o) Type 10A = Dispensary; No more than three retail sites.
 - (p) Type 11 = Distribution.
 - (q) Type 12 = Transporter.
- ¹⁰ See A.B. 243, 2015-2016, Reg. Sess., Bus. & Prof. § 19300.5 (Cal. 2015) definition for Cultivation.
- ¹¹ See A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. § 19300.5 (Cal. 2015) definition for Manufacturer.
- ¹² See A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. § 19326 (Cal. 2015).
- ¹³ See A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. § 19300.5 (Cal. 2015) definition for Dispensary.
- ¹⁴ See A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. § 19328(a).
- ¹⁵ See A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. § 19328(a)(9).
- ¹⁶ AB 266. Sec. 19328(a).
- ¹⁷ AB 266. Sec. 19328(b).
- ¹⁸ Licensees cannot also be licensed as a retailer of alcoholic beverages. AB 266. Sec. 19329.
- ¹⁹ AB 266 Sec. 19300.7; AB 647 Sec. 19332(g)
- ²⁰ AB 266. Sec. 19341.
- ²¹ AB 266 Sec. 19300.7(o). Note that there are two types of dispensary licenses, Type 10 and Type 10A. The three retail sites limit applies only to Type 10A licenses. No such limit applies to Type 10 licenses. See *supra*, n.
- ²² S.B. 643, 2015-2016, Reg. Sess., Health & Safety § 11362.777(g) (Cal. 2015).
- ²³ Health and Safety Code, Sec. 11362.7(d): "Primary caregiver" means the individual, designated by a qualified patient or by a person with an identification card, who has consistently assumed responsibility for the housing, health, or safety of that patient or person, and may include any of the following:
 - (1) In any case in which a qualified patient or person with an identification card receives medical care or supportive services, or both, from a clinic licensed pursuant to Chapter 1 (commencing with Section 1200) of Division 2, a health care facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, a residential care facility for persons with chronic life-threatening illness licensed pursuant to Chapter 3.01 (commencing with Section 1568.01) of Division 2, a residential care facility for the elderly licensed pursuant to Chapter 3.2 (commencing with Section 1569) of Division 2, a hospice, or a home health agency licensed pursuant to Chapter 8 (commencing with Section 1725) of Division 2, the owner or operator, or no more than three employees who are designated by the owner or operator, of the clinic, facility, hospice, or home health agency, if designated as a primary caregiver by that qualified patient or person with an identification card.
 - (2) An individual who has been designated as a primary caregiver by more than one qualified patient or person with an identification card, if every qualified patient or person with an identification card who has designated that individual as a primary caregiver resides in the same city or county as the primary caregiver.
 - (3) An individual who has been designated as a primary caregiver by a qualified patient or person with an identification card who resides in a city or county other than that of the primary caregiver, if the individual has not been designated as a primary caregiver by any other qualified patient or person with an identification card.

- ²⁴ Health and Safety Code, Sec. 11362.765 (c): A primary caregiver who receives compensation for actual expenses, including reasonable compensation incurred for services provided to an eligible qualified patient or person with an identification card to enable that person to use marijuana under this article, or for payment for out-of-pocket expenses incurred in providing those services, or both, shall not, on the sole basis of that fact, be subject to prosecution or punishment under Section 11359 or 11360.
- ²⁵ A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. §§ 19302, 19303 (Cal. 2015).
- ²⁶ A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. § 19303 (Cal. 2015).
- ²⁷ A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. § 19306 (Cal. 2015).
- ²⁸ A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. § 19316 (Cal. 2015). A.B. 243, 2015-2016, Reg. Sess., Health & Safety § 11362.777(c)(1) (Cal. 2015).
- ²⁹ S.B. 643, 2015-2016, Reg. Sess., Health & Safety § 11362.777(c)(4) (Cal. 2015).
- ³⁰ Id.
- ³¹ A.B. 243, 2015-2016, Reg. Sess., Health & Safety § 11362.777(c)(4) (Cal. 2015).
- ³² A.B. 243, 2015-2016, Reg. Sess., Bus. & Prof. § 19316(a) (Cal. 2015).
- ³³ A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. § 19315 (Cal. 2015).
- ³⁴ A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. § 19300.5 (aj) (Cal. 2015).
- ³⁵ See A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. § 19300.5(r) (Cal. 2015).
- ³⁶ See A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. § 19300.5(s) (Cal. 2015).
- ³⁷ A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. § 19332(c) (Cal. 2015).
- ³⁸ See A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. § 19300.5(g) (Cal. 2015).
- ³⁹ A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. §§ 19326, 19342, 19343 (Cal. 2015).
- ⁴⁰ A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. § 19344 (Cal. 2015).
- ⁴¹ A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. § 19347 (Cal. 2015).
- ⁴² S.B. 643, 2015-2016, Reg. Sess., Bus. & Prof. § 19332(e)(3) (Cal. 2015).
- ⁴³ S.B. 643, 2015-2016, Reg. Sess., Bus. & Prof. § 19332 (Cal. 2015).
- ⁴⁴ S.B. 643, 2015-2016, Reg. Sess., Bus. & Prof. § 19332(g) (Cal. 2015).
- ⁴⁵ S.B. 643, 2015-2016, Reg. Sess., Bus. & Prof. § 19332(a)(4) (Cal. 2015).
- ⁴⁶ A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. § 19341.
- ⁴⁷ S.B. 643, 2015-2016, Reg. Sess., Bus. & Prof. § 19332(a)(4) (Cal. 2015).
- ⁴⁸ Specific language to this effect could not be found, but the provisions appear to address off-premise operations. See A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. §§ 19300.5(n), 19334 (Cal. 2015).
- ⁴⁹ S.B. 643, 2015-2016, Reg. Sess., Bus. & Prof. § 19334(b)(c) (Cal. 2015).
- ⁵⁰ S.B. 643, 2015-2016, Reg. Sess., Bus. & Prof. § 2525.5 (Cal. 2015).
- ⁵¹ S.B. 643, 2015-2016, Reg. Sess., Bus. & Prof. § 19348 (Cal. 2015).
- ⁵² The new legislation does not impose any new state taxes. The Board of Equalization considers medical marijuana to be tangible property and therefore subject to California sales tax. See California State Board of Equalization, Special Notice: Information on Sales Tax and Registration for Medical Marijuana Sellers. June 2007. Available at: <https://www.boe.ca.gov/news/pdf/173.pdf>.
- ⁵³ A.B. 266, 2015-2016, Reg. Sess., Bus. & Prof. § 19320(d) (Cal. 2015).
- ⁵⁴ A.B. 266, 2015-2016, Reg. Sess. and S.B. 643, 2015-2016, Reg. Sess., Bus. & Prof. § 19320 (e) (Cal. 2015); A.B. 243, 2015-2016, Reg. Sess., Bus. & Prof. § 19350 (Cal. 2015).
- ⁵⁵ S.B. 643, 2015-2016, Reg. Sess., Bus. & Prof. § 19350 (Cal. 2015).
- ⁵⁶ S.B. 643, 2015-2016, Reg. Sess., Bus. & Prof. § 19351(d) (Cal. 2015).
- ⁵⁷ See A.B. 266, 2015-2016, Reg. Sess., and S.B. 643, 2015-2016, Reg. Sess., Bus. & Prof. §§ 19320(a), 19321(c) (Cal. 2015).
- ⁵⁸ Mosher, J. Protecting our Youth: Options for Marijuana Regulation in California. Oxnard, CA: Ventura County Behavioral Health Department, April 2015.
- ⁵⁹ Id.
- ⁶⁰ See Caulkins, J. Estimated Cost of Production for Legalized Cannabis. White Paper WR-764-RC. Santa Monica, CA: RAND Drug Policy Research Center, July 2010. Available at: http://www.rand.org/content/dam/rand/pubs/working_papers/2010/RAND_WR764.pdf. Caulkins estimates that 2.625 pounds of marijuana per harvest can be grown per 25 square feet of indoor space. Assuming three harvests per year, this translates to 31.5 pounds of marijuana per year per 100 square feet of indoor space. (Estimates are not provided for outdoor cultivation). This amounts to a 1.4 ounce allotment (30 or more cigarette-sized marijuana joints) per day for a single patient. A caregiver could grow approximately 157.5 pounds of marijuana in one year.
- ⁶¹ Mosher, J. Protecting our Youth: Options for Marijuana Regulation in California. Oxnard, CA: Ventura County Behavioral Health Department, April 2015.
- ⁶² Id.
- ⁶³ Id.
- ⁶⁴ Mosher, J. and Treffers, R. (2013). State preemption, local control, and alcohol retail outlet density regulation. *American Journal of Preventive Medicine* 44(4): pp. 399-405

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