Medical Marijuana Legislation in New York State

By Erin McGrath

On July 5, 2014, Governor Andrew Cuomo signed the Compassionate Care Act into law, and New York State became the twenty-third state to legalize medical marijuana. This new law was the result of a three-way agreement between the Executive, the Assembly, and the Senate, and allows health care practitioners in New York State to recommend medical marijuana to patients with serious illnesses[1] in a non-smokeable form. The law provides that the medical marijuana infrastructure will be completed by January 7, 2016, unless the Commissioner and the Superintendent of Police believe that the law cannot be implemented at that time without compromising public health and safety interests, and the law will sunset on July 7, 2021.

Under the law, patients may receive medical marijuana if a health care practitioner determines that "the patient is likely to receive therapeutic or palliative benefit from the primary or adjunctive treatment with medical use of marijuana for the serious condition." Once a health care practitioner makes this determination, he or she must issue a "certification" in order for the patient to receive medical marijuana from a registered organization. A "certification," rather than a prescription, must be used in order to avoid conflict with federal law, which labels marijuana a Schedule 1 controlled substance, thereby prohibiting its use for either medical or recreational purposes.

Patients are allowed to possess a 30-day supply of medical marijuana, and caregivers may possess a 30-day supply per patient (limited to five patients). That supply must be the in the form that was recommended by the certifying health care practitioner and be kept in the original package with all labeling intact. When patients use the medical marijuana allotted to them, they cannot consume the medical marijuana in a public place and must have their registry identification card in their immediate possession. If it is necessary, patients may consume their dosage using drug paraphernalia that would otherwise be prohibited under the General Business Law.

In order to purchase medical marijuana from a registered organization, patients and their caregivers, if designated, must register with the Department and receive a registry identification card. The patient or the caregiver will then present the registry identification to the registered organization at the time of purchase to show that he or she has been properly certified to receive medical marijuana. In addition to examining the registration identification card, the registered organization must also (i) consult I-STOP; (ii) ensure all dispensations comply with any recommendations or limitations; (iii) provide a safety insert; and (iv) provide a receipt. A copy of the receipt and the customer's registry ID must be kept by the registered organization for six years, and the registered organization must transmit these records to the Department immediately upon sale.

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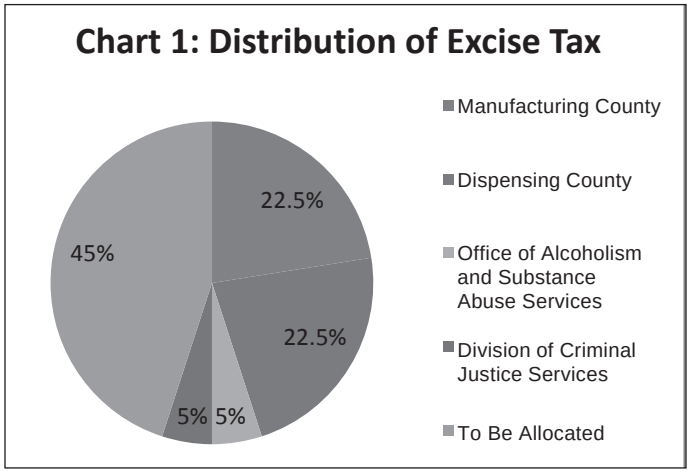
Initially, it is expected that most purchases will be made in cash, as many banks do not allow transactions from dispensaries on the debit or credit cards they issue, citing the Bank Secrecy Act (BSA), as well as the official rules of Visa, Discover, Master Card, and American Express, which forbid the use of their cards for purchasing illegal goods or services. Banking laws and the credit card official rules could pose a problem for registered organizations as well, as many banks have also refused to open checking and savings accounts or provide loans to organizations that cultivate or buy and sell medical and recreational marijuana.

Registered organizations will be "seed to sale" for-profit or nonprofit entities that are responsible for all activities related to medical marijuana cultivation and sale, including purchasing seeds, cultivation, harvest, internal and external clinical quality control, manufacture, packaging, sale, delivery, transport, and distribution of medical marijuana. Each of these activities must take place in indoor, enclosed, and secure facilities, which are subject to additional restrictions as determined by the Commissioner.

In response to concerns that legalization will allow for the proliferation of illegal marijuana use in New York State, the statute also contains provisions regarding the criminal diversion of medical marijuana, which do not apply to health care practitioners, registered organizations, or persons who act in good faith. Criminal diversion of medical marijuana in the first degree is a class E felony, and occurs when a health care practitioner provides a certification when he or she has reasonable grounds to know that: (i) the recipient has no medical need for medical marijuana; or (ii) the patient is seeking medical marijuana for purposes other than the treatment of a serious illness. Criminal diversion of medical mari-

juana in the second degree is a class B misdemeanor, and is when a person sells, trades, delivers, or otherwise provides medical marijuana to another person with reasonable grounds to know that he or she is not an individual who is registered to receive medical marijuana.

The new law also creates a 7% excise tax on all medical marijuana sold in New York State, which cannot be added on as a separate charge or line item. The excise taxes imposed on each registered organization will be determined from the filing of monthly returns to the Commissioner, and payment will be due to the Commissioner with that return on or before the twentieth of each month.



The taxes collected will be deposited into a special revenue fund known as the New York State Medical Marijuana Trust Fund. A portion of the funds will go the State, the municipality where the medical marijuana was grown, and the municipality where it was sold (see Chart 1). For the municipalities, the funds from the excise tax will be allocated in proportion to the gross sales originating from dispensation or manufacture of medical marijuana in each county.

Endnote

1. Cancer, HIV or AIDS, amyotrophic lateral sclerosis, Parkinson's disease, multiple sclerosis, damage to the nervous tissue of the spinal cord with intractable spasticity, epilepsy, inflammatory bowel disease, neuropathies, Huntington's disease, clinically associated symptoms or a complication of the diseases listed above or their treatments, including: Cachexia or wasting syndrome; severe or chronic pain; severe nausea; seizures; and severe or persistent muscle spasms. The Commissioner will also determine whether to add treatment of Alzheimer's, muscular dystrophy, dystonia, post-traumatic stress disorder, and rheumatoid arthritis by January 7, 2016.

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