# F I S C A L  I M P A C T  R E P O R T

**SPONSOR** McSorley **DATE TYPED** 2-17-05 **HB**

**SHORT TITLE** Lynn Pierson Compassionate Use Act **SB** 795

**ANALYST** Collard

## APPROPRIATION

| Appropriation Contained | | Estimated Additional Impact | | Recurring or Non-Rec | Fund Affected |
|---|---|---|---|---|---|
| FY05 | FY06 | FY05 | FY06 | | |
| | | | See Narrative | | |

(Parenthesis ( ) Indicate Expenditure Decreases)

Relates to SB 492

**SOURCES OF INFORMATION**
LFC Files

Responses Received From
Department of Health (DOH)
Administrative Office of the Courts (AOC)
Human Services Department (HSD)
Health Policy Commission (HPC)
Corrections Department (NMCD)
Public Education Department (PED)
Aging and Long-Term Services Department (ALTSD)

**SUMMARY**

Synopsis of Bill

Senate Bill 795, the Lynn Pierson Compassionate Use Act, would provide for the regulated use of medical cannabis by individuals suffering from specific debilitating illnesses including cancer, HIV/AIDS, glaucoma, multiple sclerosis, spinal cord injury, and epilepsy. The Lynn Pierson Compassionate Use Program would be administered by DOH. Physicians would apply to the program on behalf of patients who suffer from the defined debilitating illnesses and who might benefit from medical cannabis. Patients enrolled in the medical cannabis program would not be subject to arrest, prosecution or penalty for the possession of an amount of cannabis that was adequate to meet their medical needs.

Under the bill, oversight of the program would be provided by an advisory board of eight practitioners designated by the Secretary of Health and nominated by the New Mexico Medical Society who would define debilitating medical conditions eligible for enrollment, accept and review petitions to add medical conditions or diseases to the list of debilitating medical conditions, convene at least twice a year to conduct public hearings and evaluate petitions, issue recommendations concerning rules for enrollment, and recommend quantities of cannabis that constitute an adequate supply to meet medical needs.

The bill also amends the New Mexico Controlled Substances Act, Schedules I and II to except the use of cannabis for purposes of the Lynn Pierson Compassionate Use Act.

Significant Issues

DOH research indicates severe chronic pain, anorexia, and spasticity cause significant suffering among certain people living with cancer, HIV/AIDS, and neuromuscular diseases, including multiple sclerosis and spinal cord injury. In some instances, the suffering associated with those symptoms cannot be adequately controlled by the use of available prescription medications. Many patients have found that these symptoms are well controlled by the use of medical cannabis, and scientific evidence provides reasonable support for the contention that cannabis can play a therapeutic role in the treatment of these serious medical conditions.

The bill specifies that DOH would license producers of cannabis who are qualified to produce, possess, distribute, and dispense cannabis. The logistics of licensing marijuana production and intrastate distribution remain challenging in light of past and current United States Supreme Court cases involving compassionate cannabis use. In United States versus Oakland Cannabis Buyers' Cooperative, the Supreme Court ruled unanimously that the Oakland Buyers' Cooperative could not use a medical necessity argument as a defense against federal drug laws. Therefore, the proposed bill's medical necessity argument might conflict with federal laws regarding cannabis. In addition, in Ashcroft versus Raich, the United States, represented by Ashcroft, is currently arguing that any production of marijuana has relevance to the United States in general, is inherently commercial, thus the federal government has jurisdiction through the Supremacy Clause. The bill's "non-commercial" language might be challenged by precedent set by this case even though it explicitly prohibits production for any purpose outside of the compassionate use program. These two Supreme Court cases illustrate state versus federal government jurisdiction issues that complicate production and use of cannabis.

Similar bills were introduced during the 2001 legislative session (HB 431 and SB 319), the 2002 legislative session (SB 8), and the 2003 legislative session (HB 242 and HB 665).

HSD notes a major concern is reconciling with the federal government, which has not been accommodating in its position with respect to marijuana as a Schedule I drug. Since this would not be dispensed by pharmacies it is unlikely to become a Medicaid funded benefit

## FISCAL IMPLICATIONS

Although there is no appropriation, DOH indicates without staff, space, materials and support services it would not be able to administer the bill. A full time administrator would cost approximately $150 thousand per year.

## ADMINISTRATIVE IMPLICATIONS

Under this bill, DOH would be responsible for implementing the Lynn Pierson Compassionate Use Act. Based upon the experience of similar programs in other states, it is anticipated that program enrollment could be in the range of 50 to 200 patients. Several activities specified in the bill would require significant staff time.

- The advisory board, consisting of eight practitioners, would make recommendations to DOH which would promulgate rules and regulations governing the program. Staff would provide logistical support as well as expertise crafting the rules and regulations.
- The advisory board would define debilitating medical conditions eligible for enrollment, accept and review petitions to add medical conditions or diseases to the list of debilitating medical conditions, convene at least twice a year to conduct public hearings and evaluate petitions, issue recommendations concerning rules for enrollment, recommend quantities of cannabis that constitute an adequate supply to meet medical needs, review and approve applications, issue registry identification cards to qualifying patients, maintain a registry of enrolled patients, and be available to verify patient enrollment to law enforcement agencies if an individual patient's enrollment is in question.
- Administration of the program would require a full-time program administrator.
- The Office of the General Counsel in DOH would be responsible for promulgating program rules and regulations.

DOH would also be responsible for registering individuals who would supply marijuana to qualified individuals enrolled in the program. By implication, DOH would be responsible also for determining and regulating the safety and efficacy of marijuana. DOH would also be involved in ensuring the security of the marijuana. DOH indicates it has neither the authority nor the capacity to approve substances provided by individuals for medicinal use.

AOC notes there will be a minimal administrative cost for statewide update, distribution, and documentation of statutory changes. Any additional fiscal impact on the judiciary would be proportional to the enforcement of this law and commenced prosecutions. New laws, amendments to existing laws, and new hearings have the potential to increase caseloads in the courts, thus requiring additional resources to handle the increase. AOC does not indicate a dollar amount for these items.

## RELATIONSHIP

Senate Bill 795 relates to Senate Bill 492 that adds new material to the Compassionate Use of Medical Marijuana Act, amends provisions of the Controlled Substances Act by changing wording from "Controlled Substances Therapeutic Research Act" to "Compassionate Use Marijuana Act" and repeals the Controlled Substances Therapeutic Research Act. The Secretary of DOH would be responsible for adopting rules to establish a program for the topical use of marijuana to treat qualified patients with eligible medical conditions.

## TECHNICAL ISSUES

In order to prevent the misuse of medical marijuana, the bill should provide DOH appropriate oversight of the medical indications for the use of cannabis. A DOH physician should have authority and responsibility to review applications from physicians for appropriateness of medical indications in individual cases. The medical advisory board established in the bill should also

have the authority to review the decisions made by the DOH physician administrator, so that physicians whose applications for their patients are not approved by the DOH physician administrator may appeal these decisions on a timely basis.

DOH suggests changes to the definitions in Section 3. On page 2, paragraph B: definition of "debilitating medical conditions" – delete lines 13 and 18 (glaucoma and epilepsy).

HPC notes the act does not include an appropriation to DOH to staff, develop and implement its provisions. Additionally, the definition of "practitioner" is limited to physicians. Other practitioners licensed to prescribe controlled substances who may be treating patients with the defined "debilitating medical conditions" may therefore be prohibited from prescribing cannabis as a legal and viable treatment for their patients under the act.

**OTHER SUBSTANTIVE ISSUES**

DOH indicates the Institute of Medicine's review of the medical literature about medical cannabis does not support its use in glaucoma or epilepsy. Therefore, consideration should be given to removing these conditions from the list of qualifying medical conditions. Under this bill, the program's medical advisory board could review these conditions for inclusion at a later time if additional information becomes available to support benefit from the use of medical cannabis.

Thirty-six states, and the District of Columbia have passed legislation recognizing the medicinal value of marijuana and ten states currently allow patients legal access to marijuana. Eighty-one percent of New Mexico voters support making medicinal marijuana available to seriously ill or terminally ill patients in order to reduce their pain and suffering from debilitating diseases.

The concern that medical marijuana may send the wrong message to youth is not supported by some studies. In states that allow medical marijuana, surveys indicate recreational use among youth has not increased. An Institute of Medicine study in 1999 stated that there is no convincing data to support the increase of marijuana use among the general population due to use of medical marijuana.

The relief of physical pain and suffering must be a goal of compassionate medical care. Intractable pain and suffering can plague people with terminal cancer, AIDS and neuromuscular diseases, including muscular sclerosis and spinal cord injury. Often, prescription medications adequately relieve these symptoms. However, in many cases, there is no relief from suffering, relief is incomplete or the side effects of the prescription medications are intolerable. It has been the experience of many patients with these conditions that smoking small amounts of marijuana will provide relief from these symptoms when prescription medications do not. This is often the case even when smoking marijuana is compared to taking Marinol, a prescription oral preparation of one component of marijuana, tetrahydrocannabinol (THC).

Because cannabis can provide relief from pain and suffering among people with serious or terminal medical conditions, the therapeutic uses of the drug should be clearly distinguished from the illegal recreational uses of the drug. For example, we distinguish the appropriate medical uses of morphine and diazepam (for pain and anxiety relief, respectively) from their illegal recreational uses. In medical practice, it would not be considered acceptable to deny cancer patients access to opioid analgesics such as morphine simply because morphine has a potential for abuse as a recreational drug.

The therapeutic effects of cannabis in a medical context have been recognized. These effects include the control of intractable nausea and vomiting associated with cancer chemotherapy, stimulation of appetite in people suffering from the AIDS wasting syndrome, and the control of severe painful muscle spasms in people living with certain neuromuscular conditions, including spinal cord injury and multiple sclerosis.

In 1997, the White House Office of National Drug Control Policy (ONDCP) commissioned the Institute of Medicine of the National Academy of Sciences to review the scientific evidence regarding the medical use of marijuana. Their findings were published in 1999: "Marijuana and Medicine: Assessing the Science Base." The following are quotes from the Executive Summary of that report:

"The accumulated data indicate a potential therapeutic value for cannabinoid drugs, particularly for symptoms such as pain relief, control of nausea and vomiting, and appetite stimulation.... people vary in their responses to medications, and there will likely always be a subpopulation of patients who do not respond well to other medication. The combination of cannabinoid drug effects (anxiety reduction, appetite stimulation, nausea reduction, and pain relief) suggests that cannabinoids would be moderately well suited for particular conditions, such as chemotherapy-induced nausea and vomiting and AIDS wasting."

DOH cautions there are adverse effects associated with the medical use of cannabis, as is true of most effective prescription medications. However, real and potential adverse effects of medical cannabis must be weighed against the therapeutic benefits that could be realized for patients with serious or terminal illnesses. In some regards, risks associated with smoking marijuana are similar to those associated with smoking tobacco. These include the risk of developing chronic irritation and inflammation of the respiratory tract (chronic bronchitis). However, the Institute of Medicine report states, "there is no conclusive evidence that marijuana causes cancer in humans, including cancers usually related to tobacco use."

Concerns have been raised as to whether medical cannabis use among AIDS patients might result in further deterioration of immune function. Medical cannabis has been studied recently for the treatment of AIDS-associated wasting, in a study conducted at the University of California at San Francisco. In that study, the use of medical cannabis was shown to result in significant weight gain among physically wasted, terminal AIDS patients, while resulting in no significant deterioration in immune function.

Smoking marijuana may impair the ability to drive motor vehicles or operate machinery. This is true also for other medications used to treat pain and anxiety, including opioid analgesics (such as morphine) and benzodiazepines (such as diazepam). It will be important that the physician recommending the use of medical cannabis review these concerns thoroughly with patients. This bill explicitly states that the enrolled patient would not be protected from liability for damages or criminal prosecution arising out of activities not authorized in the Lynn Pierson Compassionate Use Act including the operation of a vehicle while under the influence of cannabis.

The medical use of cannabis is analogous to the therapeutic use of other powerful medicines (including morphine and diazepam) in the relief of pain and suffering. As is the case with those powerful prescription medications, a clear distinction should be drawn between the proper medical therapeutic use of cannabis and its illegal recreational use. As is the case with any medica-

tion, the benefits of medical cannabis must be weighed against its potential adverse effects in thorough discussions between a patient and their physician.

HPC researches medical cannabis use laws in other states and finds the most frequently specified illnesses covered in other states under medical cannabis laws are: cancer (21 states), glaucoma (19 states), pain/chronic illness (8 states), and HIV/AIDS (7 states). Seven states enacted laws that apply to all conditions and four enacted their laws after a 1999 Institute of Medicine report advocated the efficacy of medicinal cannabis to relieve some symptoms for some people. Four states do not specify any illnesses or symptoms to which their statutes apply.

The Supreme Court recently ruled that federal law makes no exceptions for growing or distributing cannabis, even if the goal is to help seriously ill patients using cannabis as a medicine. Laws in 10 states legalizing the medical use of cannabis remain in effect despite the Supreme Court rule; Alaska, Arizona, California, Colorado, Hawaii, Maine, Maryland, Nevada, Oregon and Washington. A committee in the South Dakota House of Representatives recently turned down a piece of legislation to allow medical cannabis. Additionally, at least 10 states allow "qualified eligible persons" to grow not more than seven cannabis plants of their own. However, court litigation is in process in several of these states.

HPC states, among 1,706 adults polled in AARP's random telephone survey in November 2004, 72 percent of respondents agreed "adults should be allowed to legally use cannabis for medical purposes if a physician recommends it." Those in the northeast (79 percent) and west (82 percent) were more receptive to the idea than in the midwest (67 percent) and southwest (65 percent). In southern states, 70 percent agreed with the statement.

HPC indicates it is difficult to compare cannabis with products that have received regulatory approval under more rigorous experimental conditions than those previously conducted on cannabis. More and better clinical trials and studies would be needed.

HPC cautions, when smoked, cannabis produces over 2,000 chemicals, including hydrogen cyanide, ammonia, carbon monoxide, acetaldehyde, acetone, phenol, cresol, naphtalene, and other well-known carcinogens, many in higher concentrations than found in tobacco smoke. Additionally, smoking cannabis causes cancer of the lungs, mouth, lip and tongue.

The National Institute of Allergy and Infectious Disease reported that the many carcinogens in cannabis smoke would be a health hazard for patients with compromised immune systems. The quality control of cannabis may be difficult to standardize and regulate.

NMCD notes, because the new crime created is a petty misdemeanor the creation of the new crime is likely to have very limited impact department.

The limited decriminalization of marijuana may reduce caseloads for probation officers and possibly the number of inmates housed. However the number of people convicted of possessing or using small amounts of marijuana is very small and even if a person is convicted possession of less than eight ounces is either a misdemeanor or a petty misdemeanor, which rarely results in probation or parole.

NMCD cautions additional impact maybe felt if registered users are convicted on other charges and request that the NMCD provide them with medical marijuana while in the custody and care

of the State of New Mexico. This situation maybe covered by the exemption from criminal or civil penalty in public place [(Sec. 5 (3) (d)] However this issue might end up in the courts.

The final way this bill might impact NMCD occurs if employees get a medical exception for marijuana. Currently the department has a zero tolerance policy for drug use and reserves the right to drug test employees. While use in the workplace is prohibited use by employees out of the work place is not and this could be an issue in the future.

PED indicates Title IV of the federal *No Child Left behind Act* specifies a drug-free school zone, which includes tobacco products, alcohol and illicit drugs, but does not address or regulate prescription drugs. A drug that is prescribed by a health care provider licensed to write prescriptions that may be administered to students during school hours must follow the procedures for medication administration. Inasmuch as the bill does not authorize the medical use of cannabis in a school bus or on school grounds or property, schools will not treat the possession or use of cannabis by a student who is an otherwise qualified patient as use of a prescription drug.

**ALTERNATIVES**

DOH states medical marijuana research programs could provide reasonable access to marijuana for a restricted number of patients. The Controlled Substances Therapeutic Research Act of 1978 mandated the establishment of a clinical research program (the Lynn Pierson Therapeutic Research Program) to study smoked marijuana as a therapeutic agent in certain debilitating medical conditions, including cancer and glaucoma. Medical marijuana clinical research was conducted at the University of New Mexico between 1978 and 1986, but was then discontinued. Quoting from the Report of the Lynn Pierson Therapeutic Research Program (Daniel A. Dansak, M.D.): "Results acquired under the State of New Mexico's Controlled Substances Therapeutic Research Act indicate that oral THC (Marinol) and inhaled marijuana are both effective anti-emetics and anti-nauseants. This conclusion is based on data gathered at the time of the initial dose. The efficacy of the inhaled form is superior to the oral form (Marinol), but this difference is statistically significant for vomiting only." In the past, DOH has had discussions with the University of New Mexico Health Sciences Center and the HIV service provider Southwest CARE Center about reinitiating medical cannabis research. The investigators felt that the relatively small number of potential study participants and the difficulty of acquiring approvals required by federal government made it unlikely such a research program could be sustained.

**KBC/lg**